FORDS

FACILITY ONCOLOGY REGISTRY DATA STANDARDS

REVISED FOR 2007

Commission
on Cancer

FORDS

Facility Oncology Registry Data Standards
Revised for 2007

(includes all updates since originally published in July 2002)

Table of Contents

Preface 2007

The *Facility Oncology Registry Data Standards (FORDS)* manual provides definitions and detailed instructions for coding patient diagnosis, treatment, and outcomes. The manual also describes the types of cases that must be abstracted and followed and explains the relationships among data items. Cancer registry data maintained with standardized quality control mechanisms supports meaningful evaluation and analysis.

FORDS: Revised for 2007

Following the initial release of *FORDS* in July 2002, the manual has undergone a series of modifications and revisions. In coordination with the SEER program, *FORDS: Revised for 2007* contains all of the necessary additional documentation to support changes in case reporting to accommodate non-malignant brain/CNS tumors, comorbidity and complications, Collaborative Staging, the *2007 Multiple Primary and Histology Rules*, National Provider Identifier codes, palliative care, and the override flag data items. Implementation of *FORDS: Revised for 2007* is required of all Commission on Cancer (CoC)-approved cancer programs starting with cases diagnosed on or after January 1, 2007.

In cooperation with other national standard-setters, the CoC has added some new material within this release of *FORDS: Revised for 2007*. A brief description of those changes follows.

New Multiple Primary and Histology Rules and Items

An inter-organizational group sponsored by SEER produced the *2007 Multiple Primary and Histology Coding Rules*.* These simplify and modernize the rules for assigning histology where more than one histology appears in the patient record, and for determining whether one or multiple case reports apply. The updated rules affect cancers diagnosed on or after January 1, 2007; the old rules apply for cases diagnosed prior to that date, even if they are first seen at the facility in 2007 or later. Registrars should refer to the SEER *2007 Multiple Primary and Histology Coding Rules* for site-specific and general instructions. The rules for benign and borderline intracranial and central nervous system tumors have not changed and are not reproduced in that publication. They are in this release of *FORDS* on page 17.

At the request of physicians—because patients with more than one tumor in a primary organ are treated differently and have different outcomes than patients with only one tumor—three new data items have been added to assist in analysis: *Date of Multiple Tumors* (NAACCR Item #445), *Multiple Tumors Reported as One Primary* (NAACCR Item #444) and *Multiplicity Counter* (NAACCR Item #446). These items are designed to augment the new Multiple Primary rules, and should not be used for cases diagnosed before January 1, 2007; they are required for all tumors diagnosed on or after that date. The new items are defined on pages 99E–99I in this release of *FORDS.*

New Ambiguous Terminology Items

Two new data items have been added to this release of *FORDS* to assist in interpreting cancers originally accessioned with ambiguous terminology diagnoses: *Ambiguous Terminology Diagnosis* (NAACCR Item #442) and *Date of Conclusive Diagnosis* (NAACCR Item #443). These items are defined on pages 99A–99E. They are required for all cases diagnosed on or after January 1, 2007.

National Provider Identifier (NPI)

The National Provider Identifier (NPI) is a unique identification number for health care providers that is scheduled for 2007–2008 implementation 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 will be required to use NPI codes by May 2007; small health plans will

be required to use NPI codes by May 2008. The numbers apply both to facilities and to individual health practitioners. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items. At present, both the NPI numbers and the facility and physician identifiers collected in the past should be recorded. Individual item descriptions in Section Two of this volume should be consulted for specific coding instructions.

One new physician code has been added to this release of *FORDS*, as an NPI number only: *NPI–Managing Physican* (NAACCR Item #2465), required for cases diagnosed on or after January 1, 2007.

Appendix C

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

* *Multiple Primary and Histology Coding Rules,* National Cancer Institute, Surveillance Epidemiology and End Results (SEER), Bethesda, Maryland, 2007. Available at http://seer.cancer.gov/ .

Acknowledgments

FORDS 2007

Editors

Jerri Linn Phillips, MA, CTR
Andrew K. Stewart, MA
Nancy Etzold, CTR

Developmental Editor

Kelly Hecht

Other Contributors

SEER Registry Staff
Multiple Primary and Histology Task Force (SEER)
Collaborative Staging Task Force Members (AJCC)
Uniform Data Standards Committee (NAACCR)

SECTION ONE:

Case Eligibility and Overview of Coding Principles

CASE ELIGIBILITY

The American College of Surgeons Commission on Cancer (CoC) requires registries in approved 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 (classes of case 0, 1, or 2), and pathologically and clinically diagnosed inpatients and outpatients must be included.

TUMORS REQUIRED BY THE CoC TO BE ACCESSIONED, ABSTRACTED, AND FOLLOWED

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:** 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 3**: Carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III) *are not required* by CoC.

Non-malignant 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).

As part of the registry case-finding activities, all pathology 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.

List of Ambiguous Diagnostic Terms	
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)	

*Fritz A, Percy C, Jack A, et al (eds): *ICD-O: International Classification of Diseases for Oncology*, Third Edition. Geneva, World Health Organization, 2000.
**additional terms for non-malignant primary intracranial and central nervous system tumors only

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

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

Examples of Diagnostic Terms:

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

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

Examples of Nondiagnostic Terms:

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

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

REPORTABLE-BY-AGREEMENT CASES

Registries may be requested to collect information about tumors that are not required to be abstracted by the CoC for approved programs. Ordinarily, such requests will come from the facility's cancer committee or the state central registry. The CoC does not require that reportable-by-agreement cases be accessioned, abstracted, or followed, 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 3 cases.
- The state central registry requests abstracting and reporting of pathology-only cases.

CASES *NOT* REQUIRED BY THE CoC TO BE ACCESSIONED

- Nonanalytic classes of case 3, 4, 5, 6, 7, 8, and 9.
- Patients seen only in consultation to confirm a diagnosis or treatment plan.
- Primary skin tumors (C44._) with histology codes 8000–8110.
- Carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia, grade III (CIN III, PIN III, VIN III, VAIN III, and AIN III)
- Patients who receive transient care to avoid interrupting a course of therapy started elsewhere.

CLASS OF CASE

All accessioned cases are assigned a *Class of Case* (NAACCR Item #610) based on the nature of involvement of the facility in the care of the patient.

Analytic Cases

Cases diagnosed at the accessioning facility and/or administered any of the first course of treatment there after the registry's reference date are analytic (class 0, 1, & 2).

A network clinic or outpatient center belonging to the facility is considered part of the facility.

Analytic cases class 1-2 are included in treatment and survival analysis.

Analytic cases, class 0, diagnosed on or after January 1, 2006, are not required to be staged or followed.

Nonanalytic Cases

Nonanalytic cases (*Class of Case* 3–9) are not usually included in routine treatment or survival statistics. The CoC does not require registries in approved programs to accession, abstract, or follow these cases.

Class of Case Definitions	
Case	**Includes**
Analytic Cases	
Class 0	Diagnosis at the accessioning facility and all of the first course of treatment was performed elsewhere or the decision not to treat was made at another facility. • Patients diagnosed at the accessioning facility who choose to be treated elsewhere. • Patients diagnosed at the accessioning facility who are referred elsewhere for treatment.
Class 1	Diagnosis at the accessioning facility, and all or part of the first course of treatment was performed at the accessioning facility. • Patients diagnosed at the accessioning facility whose treatment plan is either not to treat or watchful waiting. • Patients diagnosed at the accessioning facility who refuse treatment. • Patients diagnosed at the accessioning facility who are not treatable or who were given palliative care only due to age, advanced disease, or other medical conditions. • Patients diagnosed at the accessioning facility for whom it is unknown whether treatment was recommended or administered. • Patients diagnosed at the accessioning facility for whom treatment was recommended, but it is unknown whether it was administered. • Patients diagnosed at a staff physician's office who receive their first course of treatment at the accessioning facility. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility. • Patients diagnosed at the accessioning facility who received all or part of their first course of treatment in a staff physician's office.
Class 2	• Diagnosis elsewhere, and all or part of the first course of treatment was performed at the accessioning facility. • Diagnosed elsewhere and provided palliative care in lieu of first course treatment, or as part of the first course of treatment, at the accessioning facility.

Class of Case Definitions	
Case	**Includes**
Nonanalytic Cases	
Class 3	Diagnosis and all of the first course of treatment was performed elsewhere. • Patients treated at the accessioning facility for whom no information on first course of treatment is available. • Patients for whom the accessioning facility developed a treatment plan or provided "second opinion" services, but the diagnosis and treatment was provided elsewhere. • Patients treated for recurrence or progression for a previously diagnosed malignancy.
Class 4	Diagnosis and/or first course of treatment was performed at the accessioning facility prior to the reference date of the registry. • Patients for whom the accessioning facility manages or treats a recurrence or progression of disease after the reference date. • Patients for whom it is unknown whether the accessioning facility delivered the first course of treatment prior to the reference date.
Class 5	Diagnosed at autopsy. • Prior to autopsy, there was no suspicion or diagnosis of cancer.
Class 6	Diagnosis and all of the first course of treatment was completed by the same staff physician in an office setting. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility.
Class 7	Pathology report only. Patient does not enter the accessioning facility at any time for diagnosis or treatment. This category excludes cases diagnosed at autopsy.
Class 8	Diagnosis was established by death certificate only. *Used by central registries only*.
Class 9	Unknown. Sufficient detail for determining Class of Case is not stated in patient record. *Used by central registries only*. • Unknown if previously diagnosed. • Unknown if previously treated. • Previously diagnosed, date unknown.

DATE OF FIRST CONTACT

The *Date of First Contact* (NAACCR Item #580) is the date of the facility's first inpatient or outpatient contact with the patient for diagnosis or treatment of the cancer. In most instances, it is the patient's physical presence at the facility that denotes "contact." 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 additional contact with the facility occurs.

- 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 or pre-treatment work-up; and the *Class of Case* (NAACCR Item #610) is 1 if the diagnosing physician has admitting privileges at the facility or 2 for any other physician.

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 or pre-treatment work-up and the *Class of Case* is 1.

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 7. If a patient whose tumor was originally abstracted as a *Class of Case* 7 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 (NAACCR Item #550) and *Sequence Number* (NAACCR Item #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.
- The sequence number is the sequence of all tumors over the lifetime of a patient and is counted throughout the patient's lifetime.
- A registry may contain a single abstract for a patient with a sequence number of 02, because the first tumor had been either diagnosed and treated elsewhere or diagnosed and/or treated before the facility's reference date (the CoC does not require registries at approved cancer programs to accession Class of Case 3 or 4 cases). Because of differences in requirements, however, it is still 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 is scheduled for 2007-2008 implementation 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items. Individual item descriptions in Section Two of this volume should be consulted for specific coding instructions.

The new NPI data items are:

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

CANCER IDENTIFICATION

Follow the instructions in the ICD-O-3 section, "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 19–42) to code *Primary Site* (NAACCR Item #400), *Histology* (NAACCR Item #522), *Behavior Code* (NAACCR Item #523), and *Grade/Differentiation* (NAACCR Item #440).

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). Use the alphabetic index in ICD-O-3 to assign the most specific site if only a general location is specified in the record. The following guidelines should be followed for consistent analysis of primary sites for particular histologies.

Lymphoma

- Code lymphomas arising in lymphatic tissue or nodes to the site of origin. The lymphatic sites are Lymph Node(s) C77.–, Tonsil C09.–, Spleen C42.2, Waldeyer's ring C14.2, and Thymus C37.9.
- Code extralymphatic lymphomas (lymphatic cells in nonlymphatic organs such as intestine or stomach) to the organ of origin (Intestine C26.0, Stomach C16.0–C16.9).
- Code mycosis fungoides and cutaneous lymphomas to Skin (C44.–).
- Code to Lymph Nodes, NOS (C77.9) when:
    1) the site of origin is not identified for a lymphoma.
    2) a patient has diffuse lymphoma and a primary site is unknown or not specified.
    3) a lymphoma mass is identified as "retroperitoneal," "inguinal," "mediastinal," or "mesentery," and no specific information is available to indicate what tissue is involved.
    4) bone marrow metastases are present and the primary site of a lymphoma is unknown or not specified.
- Code to Lymph Nodes, Multiple Regions (C77.8) when multiple lymph node chains are involved with disease.

Note: Carefully identify the origin of the tumor. Do not code the biopsy site or a metastatic site as the primary site. Lymphoma may be present in both an extranodal organ and one or more lymph node chains. Code the primary site as the extranodal organ or the lymph nodes as directed by the managing physician or physician advisor.

Note: For purposes of analysis:

- Analyze the lymphatic sites C77._, C09._, C42.2, C14.2, and C37.9 together.
- Analyze extralymphatic lymphomas separately.

Kaposi Sarcoma

- Code Kaposi sarcoma to the site in which it arises.
- Code to Skin (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 (eg, "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.

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 (NAACCR Item #410) must be recorded for the following paired organs. Nonpaired organs (those not on this list and those explicitly excluded) are coded 0. Midline origins on sites listed are coded 9.

List of 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
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

List of Paired Organ Sites	
ICD-O-3	**Site**
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

Morphology: Histology Code
The instructions for coding histology and behavior are found in the "Morphology" section of the ICD-O-3 "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 27-30)

To code multiple or mixed histologies present in one primary, the SEER 2007 Multiple Primary and Histology Coding Rules replace all previous multiple histology rules. These rules are effective for cases diagnosed January 1, 2007 and after. Do not use these rules to abstract cases diagnosed on or earlier to December 31, 2006.

- Use the rules to make a decision on coding the histology for all reportable solid malignant tumors.
- Use the multiple primary rules to determine whether the patient has a single or multiple primaries before coding the histology. Code the histology for each primary in a separate abstract.

Use the ***Site-specific Rules*** for the following primary site groups:

Brain, malignant (C70.0, C70.1, C70.9, C71.0–C71.9, C72.0–C72.5, C72.8, C72.9, C75.1–C75.3)
Breast (C50.0–C50.9)
Colon (C18.0–C18.9)
Head and neck (C00.0–C14.8, C30.0–C32.9)
Kidney (C64.9)
Lung (C34.0–C34.9)
Malignant melanoma of the skin (C44.0–C44.9 with Histology 8720–8780)
Renal pelvis, ureter, bladder, and other urinary (C65.9, C66.9, C67.0–C67.9, C68.0–C68.9)

Use the ***Other Sites Rules*** for all solid malignant tumors that occur in primary sites not coded in the site specific rules.

Morphology: Grade

The instructions for coding grade and differentiation are found in the "Morphology" section of the ICD-O-3 "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 30–34).

For sites other than breast, prostate and kidney, code the tumor grade using the following priority order: 1) terminology; 2) histologic grade; 3) nuclear grade.

The grade of a tumor, including brain, can be established through magnetic resonance imaging (MRI) or positron emission tomography (PET) when there is no tissue diagnosis.

Grade astrocytomas (M-9383, 9484, 9400, 9401, 9410– 9412, 9420, 9421) according to ICD-O-3 rules: I (well differentiated), Code 1; II (intermediate differentiation), Code 2; III (poorly differentiated), Code 3; IV (anaplastic), Code 4. Do not automatically code glioblastoma multiforme as Grade IV if no grade is given, code 9 (Unknown). For primary tumors of the brain and spinal cord (C71.0–C72.9) do not record the WHO grade as the tumor *Grade/Differentiation* (NAACCR Item #440); record the WHO grade in the data item *CS Site-Specific Factor 1* (NAACCR Item #2880).

Coding Two-grade Systems

Two grade systems apply to colon, rectosigmoid junction, rectum (C18.0–C20.9), and heart (C38.0). Code these sites using a two-grade system; Low Grade (2) or High Grade (4). If the grade is listed as 1/2 or as Low Grade, then code 2. If the grade is listed as 2/2 or as High Grade, then code 4.

Code	Terminology	Histologic Grade
2	Low grade	1/2
4	High grade	2/2

Coding Three-grade Systems

Three grade systems apply to peritoneum (C48.1, C48.2), breast (C50.0–C50.9), endometrium (C54.1), fallopian tube (C57.0), prostate (C61.9), kidney (C64.9), and brain and spinal cord (C71.0–C72.9). For sites other than breast, prostate and kidney, code the tumor grade using the following priority order: 1) Terminology; 2) Histologic Grade; and 3) Nuclear Grade as shown in the table below.

Code	Terminology	Histologic Grade	Nuclear Grade
2	Low grade, well to moderately differentiated	I/III or 1/3	1/3, 1/2
3	Medium grade, moderately undifferentiated, relatively undifferentiated	II/III or 2/3	2/3
4	High grade, poorly differentiated to undifferentiated	III/III or 3/3	2/2, 3/3

Breast (C50. 0-C50.9)

For breast cancers, code the tumor grade using the following priority order: 1) Bloom-Richardson (Nottingham) Scores; 2) Bloom-Richardson Grade; 3) Nuclear Grade; 4) Terminology; and 5) Histologic Grade as shown in the table below.

Code	Bloom-Richardson (Nottingham) Scores	Bloom-Richardson Grade	Nuclear Grade	Terminology	Histologic Grade
1	3 -5 points	Low grade	1/3, 1/2	Well differentiated	I/III or 1/3
2	6, 7 points	Intermediate grade	2/3	Moderately differentiated	II/III or 2/3
3	8, 9 points	High grade	2/2, 3/3	Poorly differentiated	III/III or 3/3

Kidney (C64.9)

For kidney cancers, code the tumor grade using the following priority rules: 1) Fuhrman Grade; 2) Nuclear Grade; 3) Terminology (well diff, mod. diff.); 4) Histologic Grade. These prioritization rules do not apply to Wilm's tumor (M-8960).

Prostate (C61.9)

For prostate cancers, code the tumor grade using the table below following priority order: 1) Gleason Score (this is the sum of the patterns, e.g., if the pattern is 2+4 the score is 6); 2) Terminology; 3) Histologic Grade; and 4) Nuclear Grade.

Code	Gleason's Score (sum of primary and secondary patterns)	Terminology	Histologic Grade
1	2, 3, 4	Well differentiated	I
2	5, 6	Moderately differentiated	II
3	7, 8, 9, 10	Poorly differentiated	III

Tumor Grade and AJCC Staging

The *AJCC Cancer Staging Manual* may state that specific histologies are to be considered a specific grade. Follow AJCC instructions for "staging" only. Follow ICD-O-3 rules and rules in this section for assigning a grade to tumors recorded in your abstract.

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

Site	ICD-O-3
Heart, mediastinum, and pleura (soft tissue)	C38.0–C38.8
Bone	C40.0–C41.9
Peripheral nerves and autonomic nervous system (soft tissue)	C47.0–C47.9
Retroperitoneum and peritoneum (soft tissue)	C48.0–C48.8
Connective, subcutaneous and other soft tissues	C49.0–C49.9
Prostate (Stage IA only)	C61.9
Thyroid (undifferentiated carcinoma only)	C73.9

Multiple Primaries

The SEER 2007 Multiple Primary and Histology Coding Rules contain site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant brain. A separate set of rules addresses the specific and general rules for all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions. The complete

Multiple Primary and Histology Coding rules may be downloaded from the SEER Web site: http://seer.cancer.gov/registrars/ .

The SEER 2007 Multiple Primary and Histology Coding Rules do not apply to hematopoietic primaries (lymphoma and leukemia M9590-9989), Kaposi sarcoma (M9140) of any site, or to the reportable benign or borderline intracranial or CNS tumors. Use the tables in Appendix A of *FORDS* to decide whether differing histologies represent one or more primaries. Primary site and timing are not applicable for determining whether these malignancies represent one or more primaries.

Use the Multiple Primary rules to make a decision the number of primary malignancies to be abstracted for reportable solid malignant tumors. Each module is an independent, complete, set of coding rules.

Use the ***Site-specific Rules*** for the following primary site groups excluding leukemia and lymphoma (M9590–9989) and Kaposi sarcoma (M9140):

Brain, malignant (C70.0, C70.1, C70.9, C71.0–C71.9, C72.0–C72.5, C72.8, C72.9, C75.1–C75.3)
Breast (C50.0–C50.9)
Colon (C18.0–C18.9)
Head and neck (C00.0–C14.8, C30.0–C32.9)
Kidney (C64.9)
Lung (C34.0–C34.9)
Malignant melanoma of the skin (C44.0–C44.9 with Histology 8720–8780)
Renal pelvis, ureter, bladder, and other urinary (C65.9, C66.9, C67.0–C67.9, C68.0–C68.9)

Use the Other Sites Rules for solid malignant tumors that occur in primary sites not covered by site-specific rules.

Paired Organ Sites

A list of paired organ sites can be found earlier in this section with the coding instructions for *Laterality* (NAACCR Item #410).

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

EXCEPTION 1: The following are always single primaries:
Simultaneous bilateral involvement of the ovaries with a single histology
Simultaneous bilateral retinoblastomas
Simultaneous bilateral Wilm tumors

EXCEPTION 2: Disregard laterality for determination of single or multiple primaries for malignant (behavior of /2 or /3) tumors of the meninges (C70._), brain (C71._ and spinal cord, cranial nerves, and other parts of central nervous system (C72._).

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

Non-Malignant Primary Intracranial and CNS Tumors

Use the following for the determination of single or multiple primaries of nonmalignant (behavior /0 or /1) primary intracranial and central nervous system tumors (C70.0–C72.9, C75.1–C75.3).

Histologic Type	**ICD-O-3 Code**
Choroid plexus neoplasms	9390/0, 9390/1
Ependymomas	9383, 9394, 9444
Neuronal and neuronal-glial neoplasms	9384, 9412, 9413, 9442, 9505/1, 9506
Neurofibromas	9540/0, 9540/1, 9541, 9550, 9560/0
Neurinomatosis	9560/1
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571/0

Instructions

A. **Both** histologies are listed **in** the **table**:

1. Histologies that are in the same **grouping** or row in the table are the **same histology**. Histologies that are in the same grouping are a progression, differentiation or subtype of a single histologic category.

   –If one histology is an NOS and the other is more specific, then code the specific histology.

   –If both histologies are NOS or both are specific, then code the histology that was diagnosed first.

2. Histologies listed in **different groupings** in the table are **different histologies**.

B. One or both of the **histologies** is **not** listed **in** the **table**:

1. If the ICD-O-3 codes for both histologies have the identical first three digits, the histologies are the **same**.

   –If one histology is an NOS and the other is more specific, code the specific histology.

   –If both histologies are NOS or both are specific, code the histology that was diagnosed first.

2. If the first three digits of the histology code are different, the histology types are different.

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

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, and stage as the information becomes more complete. If the primary site 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 timing requirements for the respective staging system. Most cases that require revision are unknown primaries.

Example:
The institution clinically diagnoses a patient with carcinomatosis. The registry enters the case as an unknown primary (C80.9), carcinoma, NOS (8010/3), stage of disease unknown. Nine months later, a paracentesis shows serous cystadenocarcinoma. The physician says that the patient has an ovarian primary. Change the primary site to ovary (C56.9), histology to serous cystadenocarcinoma (8441/3), and diagnostic confirmation to positive cytologic study, no positive histology (code 2). If enough information is available that meets the AJCC timing requirements for staging, change the stage from not applicable (88) to the appropriate staging basis, TNM elements, and stage group.

Example:
A physician may decide 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. 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." Vital statistic 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 could 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 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.

COMORBIDITIES AND COMPLICATIONS

The CoC requires that the registry record include up to six comorbid conditions, factors influencing the health status of the patient, and treatment complications, to be copied from the patient record. All are considered secondary diagnoses. The information is recorded in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code form by hospitals, typically on the patient's discharge abstract or face sheet of the billing record.

Individual item descriptions in Section Two of this volume should be consulted for specific coding instructions.

The items describing patient comorbid conditions and complications are:

Comorbidities and Complications #1 (NAACCR Item #3110)
Comorbidities and Complications #2 (NAACCR Item #3120)
Comorbidities and Complications #3 (NAACCR Item #3130)
Comorbidities and Complications #4 (NAACCR Item #3140)
Comorbidities and Complications #5 (NAACCR Item #3150)
*Comorbidities and Complications #6 (*NAACCR Item #3160)
*Comorbidities and Complications #7 (*NAACCR Item #3161)
*Comorbidities and Complications #8 (*NAACCR Item #3162)
*Comorbidities and Complications #9 (*NAACCR Item #3163)
Comorbidities and Complications #10 (NAACCR Item #3164)

Comorbidities are preexisting medical conditions or conditions that were present at the time the patient was diagnosed with this cancer (e.g. chronic conditions such as COPD, diabetes, and hypertension). Comorbid conditions are identified by ICD-9-CM codes 001–139.8 and 240–999.9.

- Comorbid conditions, excluding neoplasms, are identified by ICD-9-CM codes 001–139.8 and 240–999.9.
- Comorbid conditions are coded without recording the decimal point and adding trailing 0s to the code value. Thus, 496 (COPD) is coded as 49600.

Complications are conditions that occur during the hospital stay, while the patient is being treated for the cancer (e.g. 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 the ICD-9-CM "E" codes which classify environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects.

- Only "E" codes that describe adverse effects occurring during medical care are collected in this data item. They are represented by ICD-9-CM codes E870–E879.9 (misadventures to patients during surgical and medical care) and E930–E949.9 (drugs and medicinal and biologic substances causing adverse effects in therapeutic use).

- Complications are coded with the leading character "E," without the decimal point, and trailing zeros. Thus, E930.0 is coded as E9300.

Factors influencing the health status of patients are circumstances or problems that are not themselves a current illness or injury and are identified by the ICD-9-CM "V" codes (e.g. women receiving post menopausal hormone replacement therapy, or a history of malignant neoplasm).

- Only specific "V" codes which describe health characteristics are collected in this data item. They are represented by ICD-9-CM codes V07.2–V07.39 (prophylactic measures), V10–V15.9 (personal health history), V22.2–V23.1 (pregnancy), V25.4 (contraception), V44–V45.89 (artificial opening and other post surgical states), V50.41–V50.49 (prophylactic organ removal).

- Factors influencing the health status of patients are coded with the leading character "V," without the decimal point, and trailing zeros. Thus, V23.1 is coded as V2310.

STAGE OF DISEASE AT INITIAL DIAGNOSIS

Surgical Diagnostic and Staging Procedures

Surgical Diagnostic and Staging Procedure (NAACCR Item #1350) and *Surgical Diagnostic and Staging Procedure at This Facility* (NAACCR Item #740) refer solely to surgical procedures performed specifically for diagnosis or staging of the tumor and do not apply to surgical treatment. *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280) refers to the date on which the surgical diagnostic and/or staging procedure was performed at any facility.

> **EXCEPTION:** Do not code surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease in the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350). Use the data item *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) to code these procedures. Additionally, do not record the date of surgical procedures that aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). Record the date of this surgical procedure in the data item *Date of First Course of Treatment* (NAACCR Item #1270) and/or *Date of First Surgical Procedure* (NAACCR Item #1200), as appropriate.

AJCC TNM STAGING

AJCC TNM Stage is based on the clinical, operative, and pathologic assessment of the anatomic extent of disease and is used to make appropriate treatment decisions, determine prognosis, and measure end results. The following general rules apply to AJCC staging of all sites.

- All cases should use the following time guidelines for evaluating stage: through first course of surgery or four months, whichever is longer.

- All cases should be confirmed microscopically for TNM classification (including clinical information). Rare cases that do not have biopsy or cytology of the tumor can be staged but should be analyzed separately and should not be included in survival analyses.

- The CoC requires registries in approved cancer programs to record the clinical and pathologic classifications of TNM and stage group.
- The CoC does not require Class 0 cases diagnosed on or after January 1, 2006 to be AJCC staged by the physician, but Collaborative Staging must be completed by the registrar.

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

- Code the T, N, M elements (clinical and pathologic) as recorded in the medical record by the appropriate person or persons.

- Code the AJCC Stage Group (clinical and pathologic); if no stage group was recorded by the appropriate person or persons, the registrar may enter stage group based on the components recorded.

- Code the stage (prefix/suffix) descriptor (clinical and pathologic).

- Code the edition number of the AJCC TNM stage system being used.

Refer to the most current edition of the *AJCC Cancer Staging Manual* for site-specific definitions of staging components and stage groups.

The AJCC items that must be coded are:

Clinical T (NAACCR Item #940)
Clinical N (NAACCR Item #950)
Clinical M (NAACCR Item #960)
Clinical Stage Group (NAACCR Item #970)
Clinical Stage (Prefix/Suffix) Descriptor (NAACCR Item #980)
Staged By (Clinical Stage) (NAACCR Item #990)
Pathologic T (NAACCR Item #880)
Pathologic N (NAACCR Item #890)
Pathologic M (NAACCR Item #900)
Pathologic Stage Group (NAACCR Item #910)
Pathologic Stage (Prefix/Suffix) Descriptor (NAACCR Item #920)
Staged By (Pathologic Stage) (NAACCR Item #930)

- If a patient has multiple primaries, stage each primary independently.
- If the stage group cannot be determined from the recorded components, 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 pathologic T, N, and M as well as stage group. If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes for both and do not code 88.

Ambiguous Terminology

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

List of Ambiguous Terms Describing Tumor Spread

Terms That Constitute Tumor Involvement/Extension		Terms That *Do Not* Constitute Tumor Involvement/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	

COLLABORATIVE STAGING

Collaborative Staging (CS) is to be used for cases diagnosed on or after January 1, 2004. It is not to be used for cases diagnosed prior to that date. Its introduction does not affect CoC requirements for physicians to assign AJCC staging or the requirement that the physician-assigned staging values be recorded in the registry.

How Collaborative Staging Works

Collaborative Staging was designed for registrar use. It relieves registrars from the necessity of staging a single case according to more than one staging system. It avoids the problems that can occur when it is necessary to consider multiple pieces of information simultaneously to assign a single code. For Collaborative Staging, registrars code discrete pieces of information once and the CS computer algorithm derives the values for AJCC T, N, M and Stage Group, Summary Stage 1977, and Summary Stage 2000. The derived stage codes are ideally suited for data analysis because of the consistency that can be obtained with objectively-recorded, identically-processed data items.

The timing rule for CS coding was designed to make use of the most complete information possible to yield the "best stage" information for the tumor at the time of diagnosis— "use all information gathered through completion of surgery(ies) in first course of treatment or all information available within four months of the date of diagnosis in the absence of disease progression, whichever is *longer*." Disease progression is defined as further direct extension or distant metastasis known to have developed after the diagnosis was established. Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression is documented should be excluded from the CS coding.

The following CS data items are coded by the registrar. Items with an asterisk (*) have site-specific variations for some codes.

CS Tumor Size (NAACCR Item #2800) *
CS Extension (NAACCR Item #2810) *
CS Tumor Size/Ext Eval (NAACCR Item #2820)
CS Lymph Nodes (NAACCR Item #2830) *
CS Reg Lymph Nodes Eval (NAACCR Item #2840)
Regional Lymph Nodes Examined (NAACCR Item #830)
Regional Lymph Nodes Positive (NAACCR Item #820)
CS Mets at DX (NAACCR Item #2850) *
CS Mets Eval (NAACCR Item #2860)
CS Site-Specific Factors 1-6, for some sites (NAACCR Item #s 2880, 2890, 2900, 2910, 2920, 2930) *

The CS algorithm produces the output items listed below. The derived AJCC items are separate from the physician-coded items; and the derived Summary Stage items are separate from the manually-coded items collected by the CoC in the past. The derived items must never be manually altered.

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

Finally, the registry software that runs the CS algorithm produces the following flags which describe how the derived items were computed.

Derived AJCC-Flag (NAACCR Item #3030)
Derived SS1997-Flag (NAACCR Item #3040)
Derived SS2000-Flag (NAACCR Item #3050)
CS Version First (NAACCR Item #2935)
CS Version Latest (NAACCR Item #2936)

Figure 1 illustrates the relationship between the input items and the derived output items. All output items are assigned a "storage value" which is stored in the computer and used for data transmission and analysis, and an associated "display value" which is displayed on the computer screen or in printed reports. The display values (for example, "N3c") were designed to be familiar and readily interpretable to registrars and physicians.

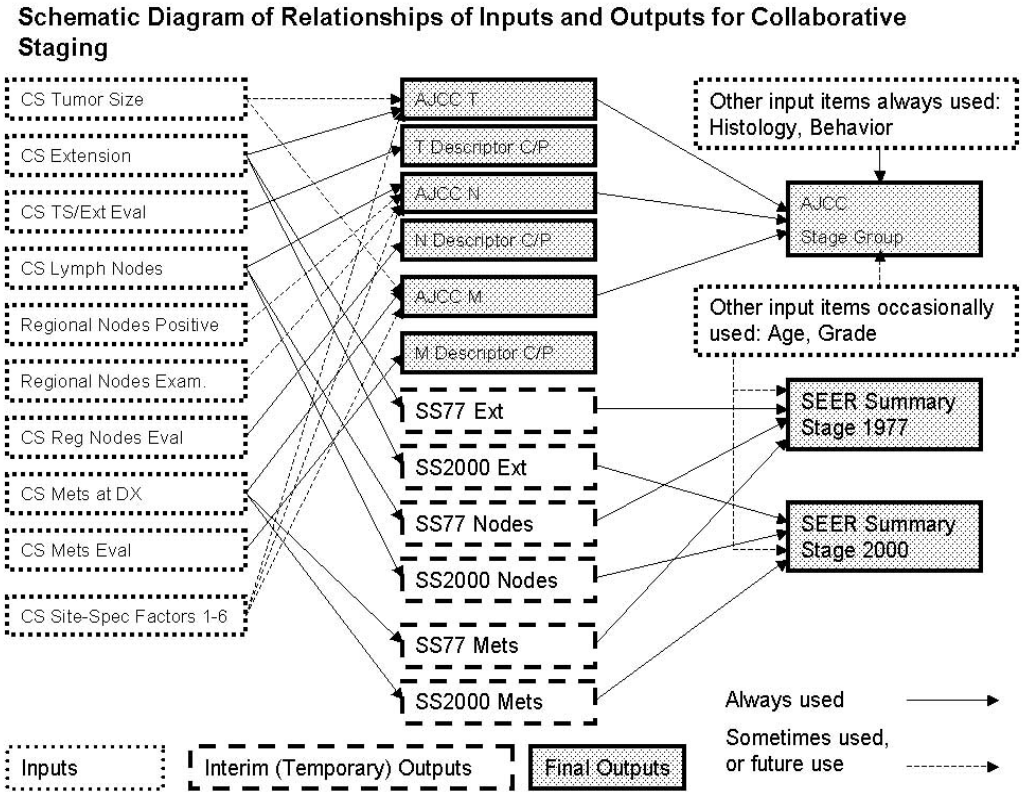

Figure 1. Relationships of inputs and outputs for CS. Collaborative Staging Task Force of the American Joint Committee on Cancer. *Collaborative Staging Manual and Coding Instructions, version 1.0.* Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2003.

Like the AJCC and Summary Stage codes that are derived from it, CS is a site-specific staging system. The CS algorithm uses tumor site and histology to determine which CS schema to apply. Depending on the schema, the coding instructions and code definitions will vary. Collaborative Staging codes are defined for every site and histology combination. The *AJCC Cancer Staging Manual* does not cover all sites, and some histologies are excluded from sites with an AJCC coding scheme. When the CS algorithm processes a site-histology combination that does not have an applicable AJCC code, it assigns the display string "NA" for "Not applicable." A blank display string for a derived item means the CS algorithm was not run for the case.

Coding CS Items

The complete instructions and site-histology defined codes are available in the *Collaborative Staging Manual and Coding Instructions (CS Manual) version 1.0.* Part I provides general instructions and the instructions and codes for generic (non site-specific) items. Part II contains the site-specific instructions and codes. The *CS Manual*, related information, and updates are available electronically on the AJCC Web site at *http://www.cancerstaging.org*.

- Code the CS items for every analytic case. Read the medical record carefully to identify the primary site and histology and determine their ICD-O-3 codes. While you are reviewing the record, make mental notes about the tissues and lymph nodes that are involved by tumor.

- If the histology is melanoma (8720-8790), Kaposi sarcoma (9140), retinoblastoma (9510-9514), lymphoma (9590-9699 and 9702-9729), mycosis fungoides (9700-9701), or hematopoietic and reticuloendothelial system (9731-9989), use the histology-specific schema for the appropriate histology-site combination.

- Otherwise, turn to the correct site-specific schema in Part II of the *CS Manual*. Schemas are in ICD-O-3 order by the first code that uses the schema. Verify that you are in the correct chapter by confirming that the code is in the list at the beginning of the schema.

- Begin assigning codes for the 15 Collaborative Staging data items. Be sure to read the notes and follow the site/histology-specific instructions at the beginning of each item. Some schemas may have site-specific factors associated with extension, lymph nodes or metastasis; keep these in mind as you assign the codes.

  - Code the tumor size in the *CS Tumor Size* item.
  - Code how far the tumor has spread directly in the *CS Extension* item.
  - Code how the farthest tumor spread was determined in the *CS Tumor Size/Ext Eval* item.
  - Code whether regional lymph nodes are involved in the *CS Lymph Nodes* item.
  - Code how the farthest lymph node spread was determined in the *CS Reg Node Eval* item.
  - Code the number of positive regional lymph nodes from the pathology report in the *Regional Nodes Positive* item.
  - Code the number of regional lymph nodes examined by the pathologist in the *Regional Nodes Examined* item.
  - Code the farthest distant metastasis (including distant lymph nodes) in the *CS Mets at Dx* item.
  - Code how the distant metastasis was determined in the *CS Mets Eval* item.
  - Code the six *CS Site-Specific Factors*. If the first site-specific factor is listed as "Not Applicable," then code 888 in all site-specific factors. Otherwise, code the specific information requested for each site-specific factor. When the next site-specific factor is 888 (Not Applicable), all the remaining site-specific factors will also be 888.

Depending on your software system, the final stage information may be derived now, when the case is saved, or prior to exiting the case. When the computer derives the final stage information, the program will check the histology code and other coded information to determine whether T, N, M and Stage

Group will be generated for the case. If the histology code is on the computer's exceptions list for that site, the T, N, M, and Stage Group will be reported as "Not Applicable." Summary Stage is generated for every case.

Site-Specific Factors

Some schema require prognostic information not required for most sites. *CS Site-Specific Factors 1-6* are designed to collect that information. The schema that make use of one or more site-specific factors are:

- Hodgkin Lymphoma and Non-Hodgkin Lymphoma (M9590–9729)
- Kaposi sarcoma (M9140/3)
- Mycosis Fungoides (M9700/3)
- Malignant melanoma of Skin, Vulva, Penis, Scrotum (C44.0–C44.9, C51.9, C60.9, C63.2 with Histology 8720–8780)
- Malignant melanoma of Conjunctiva (C69.0 with Histology 8720–8780)
- Malignant melanoma of Iris and Ciliary Body (C69.4 with Histology 8720–8780)
- Malignant melanoma of Other Eye (C69.9 with Histology 8720–8780)

The following schema include any histology not listed above:

- Head and Neck (C00.0–C14.8, C30.0–C32.9)
  (Including the following schema: upper lip; lower lip; other lip; base of tongue; anterior tongue; upper gum; lower gum and retromolar trigone; other gum; floor of mouth; hard palate; soft palate/uvula; other mouth; buccal mucosa; parotid gland; submandibular gland; other salivary glands; oropharynx; anterior surface of epiglottis; nasopharynx; pyriform sinus/hypopharynx; other pharynx; nasal cavity; middle ear; maxillary sinus; ethmoid sinus; other sinus; glottic larynx; supraglottic larynx; subglottic larynx; other larynx)
- Colon (C18.0–C18.9)
- Rectosigmoid, rectum (C19.9, C20.9)
- Liver (C22.0)
- Breast (C50.0–C50.9)
- Ovary (C56.9)
- Placenta (C58.9)
- Prostate (C61.9)
- Testis (C62.0–C62.9)
- Brain (C71.0–C71.9)
- Thyroid (C73.9)
- Pleura (C38.4)
- Other CNS (C70.1, C70.9, C72.0–C72.5, C72.8, C72-9)
- Other Endocrine (C37.9, C74.0, C74.1, C74.9, C75.0–C75.5, C75.8, C75.9)

Using CS Derived Values

Some differences in the ways that the CS algorithm operates and how the AJCC stage assignment rules are made can result in differences between the derived values for some patients and the physician-assigned stages. The differences of most interest to registrars are those that might explain discrepancies between the derived AJCC T, N, M and Stage Group values and the values recorded for the same cases by physicians.

First, as a "best stage" system, CS makes use of the most complete information available to stage the tumor. The *AJCC Cancer Staging Manual* distinguishes between clinical staging, based on information available prior to primary treatment, and pathologic staging, based on information gathered as a product of the treatment process (particularly surgery). It also has specific rules governing how the components gathered at different times in the process may be combined. The CS algorithm derives a clinical (c) or pathologic (p) descriptor for each of the T, N and M stage components based on the source of

information used to validate the most extensive spread of the tumor, and uses the components to derive a stage group without reference to the value of the descriptors. Some derived stage groups may involve combinations that are neither clinical nor pathologic according to AJCC rules, so a case that is unstageable for a physician applying AJCC rules may be assigned a Derived AJCC Stage Group value by the CS algorithm. Other cases may involve combinations that do not match either the physician-assigned clinical stage or the pathologic stage.

Second, the CS algorithm has a built-in set of histologies to which each site-specific CS schema applies when it derives AJCC stage and component values. That list, necessary for computer generation of derived values, is not as strictly defined by AJCC with respect to most sites. Consequently, it is possible a physician will provide an AJCC stage for a patient when the CS algorithm does not.

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. "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.

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 part of the patient's record in a JCAHO-approved program 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* (NAACCR Item #1270) is the earliest of *Date of First Surgical Procedure* (NAACCR Item #1200), *Date Radiation Started* (NAACCR Item #1210), *Date Systemic Therapy Started* (NAACCR Item #3230), or *Date Other Treatment Started* (NAACCR Item #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.
- Additional data items further define the parameters for specific treatments and treatment modalities, as described in the following sections.

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 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 (NAACCR Item #1290)
Scope of Regional Lymph Node Surgery (NAACCR Item #1292)
Surgical Procedure/Other Site (NAACCR Item #1294)
Surgical Margins of the Primary Site (NAACCR Item #1320)
Reason for No Surgery of Primary Site (NAACCR Item #1340)
Date of First Surgical Procedure (NAACCR Item #1200)
Date of Most Definitive Surgical Resection of the Primary Site (NAACCR Item #3170)
Date of Surgical Discharge (NAACCR Item #3180)
Readmission to the Same Hospital Within 30 Days of Surgical Discharge (NAACCR Item #3190)

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

Surgical Procedure of Primary Site at This Facility (NAACCR Item #670)
Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672)
Surgical Procedure/Other Site at This Facility (NAACCR Item #674)

Relationships Among Surgical Items

Date of First Surgical Procedure is the date that the first *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery,* or *Surgical Procedure/Other Site* was 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* is the same as *Date of First Course of Treatment*. Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.

Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, and *Surgical Procedure/Other Site* 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.

- *Surgical Procedure of Primary Site* 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* 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.

- *Surgical Procedure/Other Site* describes first course resection of distant lymph node(s) and/or regional or distant tissue or organs. That is, it describes procedures that remove tissue or organs beyond the primary site, beyond the tissue removed in continuity with the primary site, and beyond the regional lymph nodes that drain the primary site.

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.

With the release of *FORDS*, allowable codes and corresponding descriptions for most site-specific *Surgical Procedure of Primary Site* code sets have been changed to better reflect current treatment practices and to provide a consistent code structure.

- Codes 10 through 18 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.

- When multiple first course primary site surgical procedures are performed for a single tumor, the most extensive or definitive is the last performed, and the code represents the cumulative effect of the separate procedures.

- 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). Code 98 takes precedence over all other code values.

To the extent possible, codes and their definitions are the same as those previously assigned in *ROADS* 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

- The special code 98 applies to specific tumors that cannot be clearly defined in terms of primary or 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.

Scope of Regional Lymph Node Surgery has been modified so that it more accurately describes current surgical practice and is no longer site-specific. It now consistently 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* 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 has been simplified and is no longer site-specific with the implementation of *FORDS*. This item describes 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, Scope of Regional Lymph Node Surgery at This Facility, and Surgical Procedure/Other Site at This Facility are identical to Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, and Surgical Procedure/Other Site, respectively, except they each refer solely to surgery provided by the respective facility.

Five surgery items augment the information recorded in *Surgical Procedure of Primary Site. The items, Date of Most Definitive Surgical Resection of the Primary Site, Surgical Margins of the Primary Site, Date of Surgical Discharge, and Readmission to the Same Hospital Within 30 Days of Surgical Discharge* 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. When no surgical procedure of the primary site is performed, the reason is recorded in the item Reason for No Surgery of Primary Site.

- *Date of Most Definitive Surgical Resection* is the date on which the specific procedure recorded in *Surgical Procedure of Primary Site* 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.*

- *Surgical Margins of the Primary Site* 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*.

- *Date of Surgical Discharge* is the date the patient was discharged following the procedure recorded in *Surgical Procedure of Primary Site*. It is on or after the *Date of Most Definitive Surgical Resection.*

- *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* distinguishes a planned from an unplanned hospital admission and is used as a quality of care indicator.

- *Reason for No Surgery* 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

The radiation items in *FORDS* are clinically relevant and reflect contemporary practice. To better reflect the contribution of radiation oncology to the treatment of cancer patients, these items record regional and boost treatment information.

Individual item descriptions in Section Two should be consulted for specific coding instructions.

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

Date Radiation Started (NAACCR Item #1210)
Location of Radiation Treatment (NAACCR Item #1550)
Radiation Treatment Volume (NAACCR Item #1540)
Regional Treatment Modality (NAACCR Item #1570)
Regional Dose (cGy) (NAACCR Item #1510)
Boost Treatment Modality (NAACCR Item #3200)
Boost Dose (cGy) (NAACCR Item #3210)
Number of Treatments to This Volume (NAACCR Item #1520)
Radiation/Surgery Sequence (NAACCR Item #1380)
Date Radiation Ended (NAACCR Item #3220)
Reason for No Radiation (NAACCR Item #1430)

Relationships Among Radiation Items

Date Radiation Started 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* 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* is the same as *Date of First Course of Treatment*. Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.

- The special code 88888888 is used for *Date Radiation Started* when radiation is part of the planned first course of treatment, but that treatment has not yet started at the time the case is initially abstracted.

Location of Radiation Treatment 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 *Radiation Treatment Volume*. 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. The codes listed in *FORDS* have been expanded to include additional

anatomic sites not available in *ROADS*.

The type of regional dose therapy and its concomitant dose are captured by the items *Regional Treatment Modality* and *Regional Dose (cGy)*. These two items describe the type of radiation delivered to the patient and the most significant therapeutic dose delivered.

- Codes 20 through 32 of *Regional Treatment Modality* apply to the delivery of beam radiation. If the patient record does not specify the specific modality employed, then code the most general description of the modality, code 20.

- Codes 40 through 43 describe proton radiation (code 40) and specific type of stereotactic radiotherapy (codes 41–43). If stereotactic radiotherapy is delivered to a patient but the exact modality is not recorded, use code 41 (Stereotactic radiosurgery, NOS).

- Codes 50 through 55 are used to record different types of brachytherapy administration, also known as radioactive seed implants. Code 50 should be used to record the application of radioactive materials not otherwise specified.

- Codes 60 through 62 provide codes to describe the administration of specific radioisotopes. Code 60 (Radioisotopes, NOS) should be used when specific details of the radioisotope administration is not available.

- Code 98 is reserved for cases where it is known that radiation therapy was delivered but the modality is not recorded in the patient record.

- The unit of measure for radiologic dosing is the centigray (cGy), which has replaced the use of "rads" to describe radiation dose.

- If only one radiation treatment modality is delivered to a patient and it is not specified as either regional or boost treatment, assume it's regional treatment and code the items *Regional Treatment Modality* (NAACCR Item #1570) and *Regional Dose (cGy)* (NAACCR Item #1510) accordingly.

A boost treatment is provided to a smaller volume within the same volume as regional radiation in order to enhance the effect of the regional treatment.

- The boost dose may or may not employ the same treatment modality. For example, external beam radiation may be used for regional treatment and be followed by brachytherapy to provide the boost dose.

- Not all patients who receive radiation therapy receive a boost dose radiation. For these cases, boost modality and dose should be coded as 00 and 00000, respectively.

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 Treatments to This Volume* describes the total number of therapeutic treatments (regional and boost combined) delivered to the anatomic volume coded in *Radiation Treatment Volume*. Two items augment the information recorded in the radiation modality, dose, volume, and number of treatment items.

- *Radiation/Surgery Sequence* 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* 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 descriptions and relationships among the items have been revised to separate the description of the administration of systemic agents or drugs from medical procedures which affect the hormonal or immunologic balance of the patient.

Individual item descriptions in Section Two should be consulted for specific coding instructions.

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

Date Systemic Therapy Started (NAACCR Item #3230)
Chemotherapy (NAACCR Item #1390)
Hormone Therapy (NAACCR Item #1400)
Immunotherapy (NAACCR Item #1410)
Hematologic Transplant and Endocrine Procedures (NAACCR Item #3250)

The following items describe systemic therapy performed at this facility:

Chemotherapy at This Facility (NAACCR Item #700)
Hormone Therapy at This Facility (NAACCR Item #710)
Immunotherapy at This Facility (NAACCR Item #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 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 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.

Refer to *SEER*Rx* for a list of chemotherapeutic agents.

Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy 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 (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) 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*.

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 (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.

- Frequently, the initiation of first course systemic therapy can be delayed and the special code 88888888 is used for *Date Systemic Therapy Started* when systemic therapy is part of the planned first course of treatment, but that treatment has not yet started at the time the case is initially abstracted.

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. 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.

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.

Individual item descriptions in Section Two should be consulted for specific coding instructions.

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

Other Treatment (NAACCR Item #1420)
Other Treatment at This Facility (NAACCR Item #730)

Note that the treatment for reportable hematopoietic diseases can include supportive care, observation, or any treatment that does not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Supportive care and observation are not recorded in this data item, but for certain hematopoietic diseases that become reportable with publication of the ICD-O-3 (M9731/3–M9764/3, M9920/3–M9989/3) treatments such as phlebotomy, transfusions, and aspirin are defined below and should be coded 1.

- Phlebotomy may be called blood removal, blood letting, or venisection.

- Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.

- Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia. Record ONLY aspirin therapy to thin the blood for symptomatic control of thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:

  -Pain control is approximately 325–1000 mg every 3–4 hours.
  -Cardiovascular protection starts at about 160 mg/day.
  -Aspirin treatment for essential thrombocythemia is low dose, approximately 70–100 mg/day.

Palliative Care

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

Individual item descriptions in Section Two should be consulted for specific coding instructions.

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

Palliative Care (NAACCR #3270)
Palliative Care at This Facility (NAACCR Item # 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. Refer to the preceding discussion of the surgery, radiation and systemic therapy data items for specific coding guidelines.

- 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.

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 1 or 2 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* (NAACCR Item #1290) is delayed six months or more following the *Date of First Contact* (NAACCR Item #580).

- *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* (NAACCR Item #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 radiation or systemic treatment dates of 88888888 and treatment or "reason for no" treatment codes of 88 or 8 as ticklers to identify incomplete treatment information.

- 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 0 cases diagnosed on or after January 1, 2006 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* (NAACCR Item #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 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. Note that the first recurrence for some patients may be many years after the initial diagnosis and treatment.

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. In addition to the treatment and recurrence items, these include:

Patient Address–Current (NAACCR Item #2350)
City/Town–Current (NAACCR Item #1810)
State–Current (NAACCR Item #1820)
Postal Code–Current (NAACCR Item #1830)
Telephone (NAACCR Item #2360)
Date of Last Contact (NAACCR Item #1750)
Follow-Up Source, (NAACCR Item #1790)
Next Follow-Up Source (NAACCR Item #1800).
Following Registry (NAACCR Item #2440)

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

Once the patient's death has been 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

Individual item descriptions in Section Two should be consulted for specific coding instructions.

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

Abstracted By (NAACCR Item #570)
Facility Identification Number (*FIN)* (NAACCR Item #540)
Archive FIN (NAACCR Item #3100)

Abstracted By and *Facility Identification Number* (FIN) identify the individual and facility responsible for compiling the record.

- In a registry with more than one abstractor or serving more than one facility, it will ordinarily be necessary to enter *Abstracted By* or *Facility Identification Number* only when it changes.

A*rchive FIN* stores the identification number assigned to the original abstracting facility and is used to identify the original FIN assigned to a facility that has since merged with another.

All three items, *Abstracted By, Facility Identification Number,* and *Archive FIN* should be autocoded by the registry software.

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

EDITS Overrides

Individual item descriptions in Section Two should be consulted for specific coding instructions.

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

Override Acsn/Class/Seq (NAACCR Item #1985)
Override Age/Site/Morph (NAACCR Item #1990)
Override CoC— Site/Type (NAACCR Item #1987)
Override Site/Type (NAACCR Item #2030)
Override Histology (NAACCR Item #2040)
Override Leuk/Lymphoma (NAACCR Item #2070)
Override Site/Behavior (NAACCR Item #2071)
Override Site/Lat/Morph (NAACCR Item #2074)
Override HospSeq/DxConf (NAACCR Item #1986)
Override HospSeq/Site (NAACCR Item #1988)
Override Site/TNM-StgGrp (NAACCR Item #1989)
Override Surg/DxConf (NAACCR Item #2020)

A series of override items designed to work with the EDITS package have been added with the publication of *FORDS*. 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, no override entry is needed. 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.

Individual item descriptions in Section Two should be consulted for specific coding instructions for the override items.

Code Versions Used

Twelve 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.

Individual item descriptions in Section Two should be consulted for specific coding instructions.

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

CoC Coding System–Current (NAACCR Item #2140)
CoC Coding System–Original (NAACCR Item #2150)
Race Coding System–Current (NAACCR Item #170)
Race Coding System–Original (NAACCR Item #180)
Site Coding System–Current (NAACCR Item #450)
Site Coding System–Original (NAACCR Item #460)
Morphology Coding System–Current (NAACCR Item #470)
Morphology Coding System–Original (NAACCR Item #480)
ICD-O-2 Conversion Flag (NAACCR Item #1980)
ICD-O-3 Conversion Flag (NAACCR Item #2116)
TNM Edition Number (NAACCR Item #1060)
RX Coding System–Current (NAACCR Item #1460)

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 (*RX Coding System–Current* = 06).

The *ICD-O-3 Conversion Flag* identifies how conversion from ICD-O-2 to ICD-O-3 was accomplished, and the *ICD-O-2 Conversion Flag* 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.

SECTION TWO:
Coding Instructions

Patient Identification

ACCESSION NUMBER

Item Length: 9
NAACCR Item #550

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.

Instructions for Coding
- 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* (NAACCR Item #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 33rd 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* (NAACCR Item #560) will reflect this primary.
200300010	Patient is diagnosed in November 2002, at another facility. Enters the reporting facility in January 2003, and is the tenth case accessioned in 2003.
200300012	Patient is diagnosed in staff physician office in December 2002. Enters the reporting facility in January 2003, and is the 12th case accessioned in 2003.
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.
200300001	First patient diagnosed/treated and entered into the registry database for 2003.
200300999	999th patient diagnosed/treated and entered into the registry database for 2003.
200309999	9999th patient diagnosed/treated and entered into the registry database for 2003.
200401504	1504th patient diagnosed/treated and entered into the registry database for 2004.

SEQUENCE NUMBER

Item Length: 2
Allowable Values: 00–59, 60–88, 99
NAACCR Item #560

Description
Indicates the sequence of malignant and non-malignant 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.

Instructions for Coding
- Codes 00–59 and 99 indicate neoplasms of in situ or malignant 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 malignant 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 malignant 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.
- If two or more non-malignant 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 must be taken into account when sequencing subsequently accessioned tumors.
- Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

Malignant or in situ

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 malignant or in situ primaries
...	
...	(Actual sequence of this malignant or in situ primary)
...	
59	Fifty-nine or more independent malignant or in situ primaries
99	Unspecified malignant or in situ sequence number or unknown

Non-Malignant

Code	Definition
60	Only one non-malignant primary
61	First of two or more independent non-malignant primaries
62	Second of two or more independent non-malignant primaries
...	
...	(Consecutive number of non-malignant primaries)
...	
87	Twenty-seventh of twenty-seven independent non-malignant primaries
88	Unspecified number of neoplasms in this category.

Examples:

Code	Reason
00	A patient with no history of previous cancer is diagnosed with in situ breast carcinoma June 13, 2003.
01	The sequence number is changed when the patient with breast carcinoma diagnosed on June 13, 2003, is diagnosed with a subsequent skin melanoma on August 30, 2003.
02	The sequence number assigned to a skin melanoma diagnosed on August 30, 2003, following a breast carcinoma diagnosed on June 13, 2003.
04	A nursing home patient is admitted to a hospital for first course surgery for a colon adenocarcinoma. The patient had three previous primary cancers that the CoC requires to be accessioned, but was not seen for them at this facility. No sequence numbers 01, 02 or 03 are entered 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 skin melanoma diagnosed 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; 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: 11
Right Justified, Leading Blanks
NAACCR Item #2300

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.

Instructions for Coding
- Record the medical record number.
- When a patient enters a military hospital as a family member of a military sponsor, do not code the patient's relationship to the military sponsor in this field. See data item *Military Medical Record Number Suffix* (NAACCR Item #2310).

Examples:

Code	Reason
_ _ _ _ _000000	If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.
_ _ _ _ _ _ _ _ _ RT (Radiology) _ _ _ _ _ _ _ _ _ SU (One-day surgery clinic)	Record standard abbreviations for departments that do not use HIM medical record numbers.
_ _ _ _ _ _ _ _ UNK	The medical record number is unknown.

SOCIAL SECURITY NUMBER

Item Length: 9
NAACCR Item #2320

Description
Records the patient's Social Security number.

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

Instructions for Coding
- 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.

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

MILITARY MEDICAL RECORD NUMBER SUFFIX

Item Length: 2
Allowable Values: 01–20, 30–69, 98, 99
NAACCR Item #2310

Description
Records the patient identifier used by military hospitals to record the relationship of the patient to the sponsor.

Rationale
This data item supplements the medical record number in a military medical facility by describing the patient's relationship to the military sponsor.

Instructions for Coding
- Record the Family Member Prefix (FMP) codes assigned by individual military medical facilities.
- Leave blank for non-military facilities.

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

LAST NAME

Item Length: 25
Mixed Case
Left Justified
NAACCR Item #2230

Description
Identifies the last name of the patient.

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

Instructions for Coding
- Truncate name if more than 25 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 name to Smith-Jones.
UNKNOWN	If the patient's last name is unknown, enter UNKNOWN.

FIRST NAME

Item Length: 14
Mixed Case
Left Justified
NAACCR Item #2240

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.

Instructions for Coding
Truncate name if more than 14 letters long. Do not use punctuation.

Examples:

Code	Reason
Michael	Patient is admitted as Michael Hogan. Enter Hogan as the last name and Michael as the first name.
(leave blank)	If patient's first name is unknown, do not fill in the space.

MIDDLE NAME
(MIDDLE INITIAL)

Item Length: 14
Mixed Case
Left Justified
NAACCR Item #2250

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.

Instructions for Coding
Truncate the name if more than 14 letters long. Record the middle initial if the complete name is not provided. Do not use punctuation.

Examples:

Code	Reason
David	Patient is admitted as Michael David Hogan. Enter Hogan as the last name, Michael as the first name, and David as the middle name.
D	Patient is admitted as Michael D. Hogan. Enter Hogan as the last name, Michael as the first name, and D as the middle name.
(leave blank)	Leave blank. If patient does not have a middle name or initial, or if the middle name or initial are unknown, do not fill in the space.

PATIENT ADDRESS (NUMBER AND STREET) AT DIAGNOSIS

Item Length: 40
Upper-case
Left Justified
NAACCR Item #2330

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.

Instructions for Coding
- 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 (ie, 39.2 RD), slashes for fractional addresses (ie, 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (ie, 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 (ie, 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.

Code	Definition
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	If the patient's address is unknown, enter UNKNOWN.

PATIENT ADDRESS AT DIAGNOSIS –SUPPLEMENTAL

Item Length: 40
Upper-case
Left Justified
NAACCR Item #2335

Description
Provides the ability to store additional address information such as the name of a place or facility (ie, 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.

Instructions for Coding
- Record the place or facility (ie, 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.

Code	Definition
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: 20
Upper-case
Left Justified
NAACCR Item #70

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.

Instructions for Coding
- 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/town of residence changes.
- See "Residency Rules" in Section One for further instructions.

Code	Definition
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: 2
Upper-case
NAACCR Item #80

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.

Instructions for Coding
- U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/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	Definition
IL	If the state in which the patient resides at the time of diagnosis and treatment is Illinois, then use the USPS code for the state of Illinois.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is known.*
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is unknown.*
ZZ	Residence unknown.

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

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

The following are abbreviations for Canadian provinces and territories:

Province/Territory		Province/Territory	
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS	Canada, province unknown	CD

POSTAL CODE AT DIAGNOSIS (ZIP CODE)

Item Length: 9
Left Justified
NAACCR Item #100

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.

Instructions for Coding
- 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.

COUNTY AT DIAGNOSIS

Item Length: 3
Allowable Values: 001–997, 998, 999
NAACCR Item #90

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.

Instructions for Coding
- 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 *http://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 and is coded XX in *State at Diagnosis* (NAACCR Item #80), then code the patient's country of residence in this space.
- For country codes, see *The SEER Program Coding and Staging Manual*, (*http://seer.cancer.gov/*) or *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 11.1*, Eleventh Edition, (*http://www.naaccr.org*).*
- 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. It is not documented in the patient's medical record.

*Johnson C, ed. *The SEER Program Coding and Staging Manual 2004*, Revision 1. NIH, NCI Publication 04-5581, 2004.

*Havener L, Hultstrom D, eds. *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 11.1*, Eleventh Edition. Springfield, IL: North American Association for Central Cancer Registries, April 2006.

PATIENT ADDRESS (NUMBER AND STREET)–CURRENT

Item Length: 40
Upper-case
Left Justified
NAACCR Item #2350

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).

Instructions for Coding
- 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 (ie, 39.2 RD), slashes for fractional addresses (ie, 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (ie, 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 (ie, 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.

Code	Definition
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 CURRENT –SUPPLEMENTAL

Item Length: 40
Upper-case
Left Justified
NAACCR Item #2355

Description
Provides the ability to store additional address information such as the name of a place or facility (ie, 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.

Instructions for Coding
- Record the place or facility (ie, 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.

Code	Definition
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: 20
Upper-case
Left Justified
NAACCR Item #1810

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

Rationale
This data item provides a current city/town used for follow-up purposes. It is different from *City/Town at Diagnosis* (NAACCR Item #70).

Instructions for Coding
- 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/town of residence changes.
- Do not change this item when the patient dies.
- See "Residency Rules" in Section One for further instructions.

Code	Definition
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	The city in which the patient resides is unknown.

STATE–CURRENT

Item Length: 2
Upper-case
NAACCR Item #1820

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* (NAACCR Item #80).

Instructions for Coding
- U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/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	Definition
IL	If the state in which the patient resides at the time of diagnosis and treatment is Illinois, then use the USPS code for the state of Illinois.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is known.*
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is unknown*.
ZZ	Residence unknown.

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

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

The following are abbreviations for Canadian provinces or territories:

Province/Territory		Province/Territory	
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS	Canada, province unknown	CD

POSTAL CODE–CURRENT
(ZIP CODE)

Item Length: 9
Left Justified
NAACCR Item #1830

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* (NAACCR Item #100).

Instructions for Coding
- 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.

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.

TELEPHONE

Item Length: 10
NAACCR Item #2360

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.

Instructions for Coding
- 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	Definition
(fill spaces)	Number is entered without dashes.
0000000000	Patient does not have a telephone.
9999999999	Telephone number is unavailable or unknown.

PLACE OF BIRTH

Item Length: 3
Allowable Values: 000–750, 998, 999
NAACCR Item #250

Description
Records the patient's place 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.

Instructions for Coding
- Use the most specific code.
- Use the SEER Geocodes for "Place of Birth." These codes include states of the United States as well as foreign countries.
- For SEER Geocodes, see *The SEER Program Coding and Staging Manual*, (*http://seer.cancer.gov/*) or *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 11.1*, Eleventh Edition *(http://www.naaccr.org*).*

Code	Definition
000–750	SEER Geocode
998	Place of birth outside of the United States, no other detail known.
999	Place of birth unknown.

*Johnson C, ed. *The SEER Program Coding and Staging Manual 2004*, Revision 1. NIH, NCI Publication 04-5581, 2004.

*Havener L, Hultstrom D, eds. *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 11.1*, Eleventh Edition. Springfield, IL: North American Association for Central Cancer Registries, April 2006.

DATE OF BIRTH

Item Length: 8
NAACCR Item #240

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 patient cohort.

Instructions for Coding
Record the patient's date of birth as indicated in the patient record.

Code	Definition
MMDDCCYY	The date of birth is the month, day, and year that the patient was born. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Month	Day	Year
01 January	01	Use four-digit year
02 February	02	9999 Year unknown
03 March	03	
04 April	...	
05 May	...	
06 June	25	
07 July	31	
08 August	99 Day unknown	
09 September		
10 October		
11 November		
12 December		
99 Month unknown		

Examples:

Code	Reason
06301906	The patient's date of birth is June 30, 1906.
99991940	The patient is 60 years old on June 15, 2000. The medical record does not have a date of birth. Record unknown month (99) and day (99). Calculate the year as 1940.
99991927	The medical record contains only the year of birth (1927).

AGE AT DIAGNOSIS

Item Length: 3
Allowable Values: 000–120, 999
Right Justified, Zero-filled
NAACCR Item #230

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.

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

Code	Definition
000	Less than one year old.
001	One year old, but less than two years old.
002	Two years old.
...	Show actual age in years.
120	One hundred twenty years old.
999	Unknown age.

RACE 1

Item length: 2
Allowable Values: 01–14,
20–22, 25–28, 30–32, 96–99
NAACCR Item #160

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.

Instructions for Coding
- 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* (NAACCR Item #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* (NAACCR Item #161) through *Race 5* (NAACCR Item #164), and code all remaining *Race* items 88.
- 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.
- 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* (NAACCR Item #170) is less than six (6) for cases diagnosed prior to January 1, 2000, then *Race 2* through *Race 5* must be blank.
- If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System–Current* must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

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

Examples:

Code	Reason
01	A patient was born in Mexico of Mexican parentage. Code also *Spanish/Hispanic Origin* (NAACCR Item #190).
02	A black female patient. A specific 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.
05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded to *Race 2*). If a person’s race is recorded as a combination of white and any other race, code to the appropriate *other* race in this field and then code Caucasian as “White” in the next race field.
05	A patient’s race is listed as Asian and the birthplace is Japan. Code to birthplace. When the race is recorded as “Oriental,” “Mongolian,” or “Asian,” and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birthplace information.
07	A patient has a Hawaiian father, black mother, Japanese grandfather, and Korean grandmother. If a person’s race is recorded as a combination of Hawaiian and any other race(s), code the person’s primary race as Hawaiian and code the other races in *Race 2*, *Race 3*, *Race 4*, and *Race 5* as appropriate. In this case, black to *Race 2*; Japanese to *Race 3*; and Korean to *Race 4*.
08	A patient is of Korean and Asian ancestry. Do not code “Asian” in a subsequent race field if a specific Asian race(s) has already been coded.
25	A patient with a Polynesian mother, Tahitian father, and Samoan grandparents.
99	A patient’s race is unknown. *Race 2* through *Race 5* must also be 99.

RACE 2

Item Length: 2
Allowable Values: 01–14, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #161

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.

Instructions for Coding
- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 1* (NAACCR Item #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.
- 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.

Codes		Codes	
01	White	21	Chamorran
02	Black	22	Guamanian, NOS
03	American Indian, Aleutian, or Eskimo	25	Polynesian, NOS
04	Chinese	26	Tahitian
05	Japanese	27	Samoan
06	Filipino	28	Tongan
07	Hawaiian	30	Melanesian, NOS
08	Korean	31	Fiji Islander
09	Asian Indian, Pakistani	32	New Guinean
10	Vietnamese	88	No further race documented
11	Laotian	96	Other Asian, including Asian, NOS and Oriental, NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (including Khmer and Cambodian)	98	Other
14	Thai	99	Unknown
20	Micronesian, NOS		

RACE 3

Item Length: 2
Allowable Values: 01–14, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #162

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.

Instructions for Coding
- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 2* (NAACCR Item #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.
- 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.

Codes		Codes	
01	White	21	Chamorran
02	Black	22	Guamanian, NOS
03	American Indian, Aleutian, or Eskimo	25	Polynesian, NOS
04	Chinese	26	Tahitian
05	Japanese	27	Samoan
06	Filipino	28	Tongan
07	Hawaiian	30	Melanesian, NOS
08	Korean	31	Fiji Islander
09	Asian Indian, Pakistani	32	New Guinean
10	Vietnamese	88	No further race documented
11	Laotian	96	Other Asian, including Asian, NOS and Oriental, NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (including Khmer and Cambodian)	98	Other
14	Thai	99	Unknown
20	Micronesian, NOS		

RACE 4

Item Length: 2
Allowable Values: 01–14, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #163

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.

Instructions for Coding
- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 3* (NAACCR Item #162) 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.
- 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.

Codes		Codes	
01	White	21	Chamorran
02	Black	22	Guamanian, NOS
03	American Indian, Aleutian, or Eskimo	25	Polynesian, NOS
04	Chinese	26	Tahitian
05	Japanese	27	Samoan
06	Filipino	28	Tongan
07	Hawaiian	30	Melanesian, NOS
08	Korean	31	Fiji Islander
09	Asian Indian, Pakistani	32	New Guinean
10	Vietnamese	88	No further race documented
11	Laotian	96	Other Asian, including Asian, NOS and Oriental, NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (including Khmer and Cambodian)	98	Other
14	Thai	99	Unknown
20	Micronesian, NOS		

RACE 5

Item Length: 2
Allowable Values: 01–14, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #164

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.

Instructions for Coding
- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 4* (NAACCR Item #163) 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.
- 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.

Codes		Codes	
01	White	21	Chamorran
02	Black	22	Guamanian, NOS
03	American Indian, Aleutian, or Eskimo	25	Polynesian, NOS
04	Chinese	26	Tahitian
05	Japanese	27	Samoan
06	Filipino	28	Tongan
07	Hawaiian	30	Melanesian, NOS
08	Korean	31	Fiji Islander
09	Asian Indian, Pakistani	32	New Guinean
10	Vietnamese	88	No further race documented
11	Laotian	96	Other Asian, including Asian, NOS and Oriental, NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (including Khmer and Cambodian)	98	Other
14	Thai	99	Unknown
20	Micronesian, NOS		

SPANISH ORIGIN—ALL SOURCES
(SPANISH/HISPANIC ORIGIN)

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #190

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* (NAACCR Item #s 160–164).

Instructions for Coding
- 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: 1
Allowable Values: 1–4, 9
NAACCR Item #220

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.

Instructions for Coding
Record the patient's sex as indicated in the medical record.

Code	Label
1	Male
2	Female
3	Other (hermaphrodite)
4	Transsexual
9	Not stated in patient record

PRIMARY PAYER AT DIAGNOSIS

Item Length: 2
Allowable Values: 01, 02, 10, 20, 21, 31, 35, 60–68, 99
NAACCR Item #630

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.

Instructions for Coding
- Record the type of insurance reported on the patient's admission page.
- Codes 21and 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 negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
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 (eg. 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 62 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 (eg. HMO or PPO). The Managed Care plan pays for all incurred costs.

Code	Label	Definition
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: 5
Allowable Values: 00000, 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3110

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.

Instructions for Coding

- Secondary diagnoses must be reported for patients that have inpatient hospitalizations at your facility.
- Secondary diagnoses should be reported for patients receiving outpatient care or treated in oncology clinics at your facility when available.
- Consult the patient record for the discharge abstract. 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:
    a) following the most definitive surgery of the primary site
    b) 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* (NAACCR Item #3190) is coded 1, 2, or 3, then use available *Comorbidities and Complications* data items to record E codes appearing on the "readmission" discharge abstract.
- **Do not** record any neoplasms (ICD-9-CM codes 140–239.9) listed as secondary diagnoses for this data item.
- **Do not** record causes of injury and poisoning unrelated to the patient's medical care (ICD-9-CM codes E800–E869.9, E880–E929.9, or E950–E999).
- **Do not** record the following factors influencing health status and contact with health services (ICD-9-CM codes V01-V07.1, V07.4-V09.91, V16-V21.9, V23.2-V25.3, V25.5-V43.89, V46-V50.4, or V50.8-V83.89).
- If no 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 secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining "Comorbidities and Complications" data items blank.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
00000	No comorbid conditions or complications documented.

Examples:

Code	Reason
49600	COPD (ICD-9-CM code 496)
25001	Type 1 diabetes mellitus (ICD-9-CM code 250.01)
40100	Hypertension (ICD-9-CM code 401)
E8732	The patient was inadvertently exposed to an overdose of external beam radiation (ICD-9-CM code E873.2)
E8782	The patient with colon cancer underwent surgical resection and subsequently experienced an anastomotic leak (ICD-9-CM code E878.2)
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: 5
Allowable Values:00100–13980, 24000–99990, E8700–E8799, E9300–E9499,V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3120

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. Both 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.

Instructions for Coding
- 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 coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than two comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #3 (Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3130

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. Both 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.

Instructions for Coding
- If fewer than three 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 coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than three comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #4
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3140

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. Both 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.

Instructions for Coding
- If fewer than four 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 coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than four comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #5
(Secondary Diagnoses)

Item Length: 5
Allowable Values:00100–13980, 24000–99990, E8700–E8799, E9300–E9499, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3150

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. Both 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 risk adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Instructions for Coding
- If fewer than five 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 coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than five comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #6
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3160

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. Both 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.

Instructions for Coding
- If fewer than six 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 coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than six comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #7
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3161

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. Both 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.

Instructions for Coding
- *Comorbidities and Complications #7* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than seven 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 coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than seven comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #8
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3162

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. Both 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.

Instructions for Coding
- *Comorbidities and Complications #8* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than eight 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 coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than eight comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #9
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3163

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. Both 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.

Instructions for Coding
- *Comorbidities and Complications #9* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than nine 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 coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than nine comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #10
(Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499,E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3164

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. Both 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.

Instructions for Coding
- *Comorbidities and Complications #10* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than 10 comorbid conditions or complications are listed, then leave this data item blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than 10 comorbid conditions and complications documented.

NPI–MANAGING PHYSICIAN

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2465

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.

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

FOLLOWING PHYSICIAN
(FOLLOW-UP PHYSICIAN)

Item Length: 8
Left Justified
NAACCR Item #2470

Description
Records the identification number of the person 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.

Instructions for Coding
- The registry assigns a unique number to the following physician. Many registries use the physician's state medical license number.
- Change this data item when patient follow-up becomes the responsibility of another physician.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
99999999	The following physician is unknown or an identification number is not assigned.

NPI–FOLLOWING PHYSICIAN

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2475

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.

NPI–Following Physician is the NPI equivalent of *Following Physician* (NAACR Item #2470). Both are required during a period of transition.

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

PRIMARY SURGEON

Item Length: 8
Left Justified
NAACCR Item #2480

Description
Records the identification number of the physician who performed the most definitive surgical procedure.

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

Instructions for Coding
- The registry assigns a unique number to the primary surgeon. Many registries use the physician's state medical license number.
- 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.
- Do not update this data item.

Code	Definition
(fill spaces)	The identification number may include numbers and letters. *Note:* If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.
00000000	If the patient had no surgery and no surgical consultation.
88888888	If the physician who performed a surgical procedure was not a surgeon, i.e radiation oncologist, diagnostic radiologist, or general practitioner.
99999999	The primary surgeon is unknown or an identification number is not assigned.

NPI–PRIMARY SURGEON

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2485

Description
Identifies the physician who performed the most definitive surgical procedure.

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

NPI–Primary Surgeon is the NPI equivalent of *Primary Surgeon* (NAACCR Item #2480). Both are required during a period of transition.

Instructions for Coding
- 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.
- 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	Definitions
(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; or the physician who performed the surgical procedure was not a surgeon (i.e. general practitioner).

PHYSICIAN #3
(OTHER PHYSICIAN)

Item Length: 8
Left Justified
NAACCR Item #2490

Description
Records the identification number of another physician involved in the care of the patient. The Commission on Cancer recommends that this data 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.

Instructions for Coding
- The registry assigns a unique number to this data item. Many registries use the physician's state medical license number.
- If this item is used to identify the radiation oncologist, then the following definitions can be used. If the facility chooses to identify another physician, the facility will need to develop and implement definitions for analysis.
- 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.
- Do not update this data item.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
00000000	None; no additional physician.
99999999	Physician is unknown or an identification number is not assigned.

NPI–PHYSICIAN #3
(Radiation Oncologist–CoC Preferred Use)

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2495

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.

NPI–Physician #3 is the NPI equivalent of *Physician #3* (NAACCR Item #2490). Both are required during a period of transition.

Instructions for Coding
- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI.
- If this item is used to identify the primary radiation oncologist, then the following definitions pertaining to the radiation oncologist can be used. If the facility chooses to identify another physician, the facility should develop and implement definitions for analysis.
- 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	Definition
(fill spaces)	10-digit NPI number for the primary radiation oncologist.
(leave blank)	NPI for the primary radiation oncologist is unknown or not available.

PHYSICIAN #4
(OTHER PHYSICIAN)

Item Length: 8
Left Justified
NAACCR Item #2500

Description
Records the identification number of another 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.

Instructions for Coding
- The registry assigns a unique number to this data item. Many registries use the physician's state medical license number.
- If this item is used to identify the medical oncologist, then the following definitions can be used. If the facility chooses to identify another physician, the facility will need to develop and implement definitions for analysis.
- 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.
- Do not update this data item.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
00000000	None; no additional physician.
99999999	Physician is unknown or an identification number is not assigned.

NPI–PHYSICIAN #4
(Medical Oncologist–CoC Preferred Use)

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2505

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.

NPI–Physician #4 is the NPI equivalent of *Physician #4* (NAACCR Item #2500). Both are required during a period of transition.

Instructions for Coding
- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI.
- If this item is used to identify the medical oncologist, then the following definitions pertaining to the medical oncologist can be used. If the facility chooses to identify another physician, the facility should develop and implement definitions for analysis.
- 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 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	Definition
(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: 1
Allowable Values: 0–9
NAACCR Item #610

Description
Classifies cases recorded in the database**.**

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

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

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

Examples:

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

FACILITY REFERRED FROM

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

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

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

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

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

Examples:

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

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

NPI–INSTITUTION REFERRED FROM

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

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

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

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

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

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

FACILITY REFERRED TO

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

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

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

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

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

Examples:

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

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

NPI–INSTITUTION REFERRED TO

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

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

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

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

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

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

DATE OF FIRST CONTACT Item Length: 8
NAACCR Item #580

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

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

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

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

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

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

Year
Use four-digit year
9999 Year unknown

Examples:

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

DATE OF INITIAL DIAGNOSIS

Item Length: 8
NAACCR Item #390

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

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

Instructions for Coding
- Use the first date of diagnosis whether clinically or histologically confirmed.
- If the physician states that in retrospect the patient had cancer at an earlier date, then use the earlier date as the date of diagnosis.
- Use the date therapy was started as the date of diagnosis if the patient receives a first course of treatment before a definitive diagnosis.
- Refer to the list of "Ambiguous Terms" in Section One for language that represents a diagnosis of cancer.

- The date of death is the date of diagnosis for a Class of Case 5.
- Use the *Date of Birth* as the *Date of Initial Diagnosis* for an in-utero diagnosis.

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

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

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

Year
Use four-digit year
9999 Year unknown

Examples:

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

PRIMARY SITE

Item Length: 4
NAACCR Item #400

Description
Identifies the primary site.

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

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

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

Examples:

Code	Reason
C108	Overlapping lesion of oropharynx. Code overlapping lesion when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.
C678	Overlapping lesion of bladder. Code overlapping lesion of the bladder when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.
C679	Bladder, NOS. Use subcategory 9 when multiple lesions arise in both the bladder trigone (C67.0) and lateral wall (C67.2).
C189	Colon, NOS. Familial polyposis with carcinoma and carcinoma in situ throughout the transverse (C18.4) and descending colon (C18.6) would be one primary and coded to colon, NOS (C18.9). For a full explanation see the *SEER 2007 Multiple Primary and Histology Rules*.
C16–	Stomach (sub-site as identified). An extranodal lymphoma of the stomach would be coded to C16.– (sub-site as identified).

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

LATERALITY

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

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

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

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

Code	Definition
0	Organ is not considered to be a paired site.
1	Origin of primary is right.
2	Origin of primary is left.
3	Only one side involved, right or left origin not specified.
4	Bilateral involvement, side of origin unknown, stated to be a single primary. This includes: • Both ovaries simultaneously involved with a single histology • Bilateral retinoblastomas • Bilateral Wilms' tumors
9	Paired site, but lateral origin unknown; midline tumor.

HISTOLOGY

Item Length: 4
NAACCR Item #522

Description
Identifies the microscopic anatomy of cells.

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

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

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

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

Examples:

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

BEHAVIOR CODE

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

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

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

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

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

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

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

Example:

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

GRADE/DIFFERENTIATION

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

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

Rationale
This data item is useful for prognosis.

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

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

This page was intentionally left blank to maintain FORDS pagination.

DIAGNOSTIC CONFIRMATION

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

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

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

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

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is nondiagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5. (Adapted from SEER.)
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical/endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only (other than 5, 6, or 7)	The malignancy was reported by the physician in the medical record. Refer to Section One—Ambiguous Terminology.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually Class of Case 3).

AMBIGUOUS TERMINOLOGY DIAGNOSIS

Item Length: 1
Allowable Values: 0, 1, 2, and 9
NAACCR Item #442

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

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

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

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

Examples:

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

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

DATE OF CONCLUSIVE DIAGNOSIS

Item Length: 8
NAACCR Item #443

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

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

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

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

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

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

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

Year
Use four-digit year
9999 Year unknown

Examples:

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

DATE OF MULTIPLE TUMORS

Item length: 8
NAACCR Item #445

Description

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

Rationale

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

Instructions for Coding

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

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

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

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

Year
Use four-digit year
9999 Year unknown

Examples:

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

MULTIPLE TUMORS REPORTED AS ONE PRIMARY

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

Description

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

Rationale

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

Instructions for Coding

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

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

MULTIPLICITY COUNTER

Item length: 2
Allowable Values: 01–88, 99
NAACCR Item #446

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

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

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

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

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

Examples:

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

TUMOR SIZE

Item Length: 3
Allowable Values: 000–990, 999
NAACCR Item #780

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

Rationale
Tumor size is an important prognostic factor for cancer.

Instructions for Coding
- **Code this data item for cases diagnosed on or before December 31, 2003.**
- Code tumor size using *CS Tumor Size* (NAACCR Item #2800) for cases diagnosed on or after January 1, 2004.
- Code the exact size of the primary tumor in millimeters (mm).
  Converting units of measure:
  - 1 mm is one-tenth of a centimeter (cm), thus, a 20-mm or 2-cm tumor is coded as 020.

  EXCEPTION:
  - For melanomas of the skin (C44.0–C44.9), vulva (C51.0–C51.9), penis (C60.0–C60.9), scrotum (C63.2), and conjunctiva (C69.0), code the depth of invasion in HUNDREDTHS of millimeters.
  - Code 989 for melanomas of the skin (C44.0–C44.9), vulva (C51.0–C51.9), penis (C60.0–C60.0), scrotum (C63.3), and conjunctiva (C69.0) which are 9.89 mm or greater in depth.
- Code the largest dimension or diameter of the tumor, whether it is from a biopsy specimen or the complete resection of the primary tumor.
- Code the size of the primary tumor, not the size of polyps, ulcers, cysts, or metastases.
- Record the size of the tumor from the pathology report, if available.
- Information on tumor size from imaging/radiographic techniques can be used to code size, but should be taken as low priority, just above physical exam.
- Code 001 for tumors less than 1 mm in size.
- Code the size as stated for purely in situ tumors.
- If both an in situ and an invasive component are present, and each is measured, code the size of the invasive component even if it is smaller.
- Code 998 when following terms describe tumor involvement for these specified sites:
  - Esophagus (C15.0–C15.5, C15.8, C15.9): Entire circumference.
  - Stomach (C16.0–C16.6, C16.8, C16.9): Diffuse, widespread, ¾ or more, linitis plastica.
  - Colorectal (C18.0–C20.9 with M-8220/8221 and /2 or /3): Familial/multiple polyposis.
  - Lung and main stem bronchus (C34.0–C34.3, C34.8, C34.9): Diffuse, entire lobe or lung.
  - Breast (C50.0–C50.6, C50.8, C50.9): Inflammatory carcinoma; diffuse, widespread, ¾ or more of breast.
- Code 999, unknown, if only one size is given for a mixed *in situ* and invasive tumor.
- Code the size of the residual tumor if an excisional biopsy is performed and residual tumor at time of resection of the primary site is found to be larger than the excisional biopsy.
- **Do not** add pieces or chips together to create a whole; they may not be from the same location, or the may represent only a very small portion of a large tumor.
- Code 999 if the size of the tumor is unknown or the tumor size is not documented in the patient record.
- Code 999 for histologies or sites where size is not applicable:
  - Unknown or ill-defined primary (C76.0–C76.8, C80.9)
  - Hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease (C42.0, C42.1,
    C42.3, C42.4 and/or M-9750, 9760–9764, 9800-9820, 9826, 9831–9920, 9931–9964, 9980–9989)
  - Multiple myeloma (9732)
  - Letterer-Siwe disease (9754)

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

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

Examples:

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

REGIONAL LYMPH NODES EXAMINED

Item Length: 2
Allowable Values: 00–90, 95–99
NAACCR Item #830

Description

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

Rationale

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

Instructions for Coding

- Only record information about regional lymph nodes in this data item. Involved distant lymph nodes should be coded in *CS Mets at Dx* (NAACCR Item #2850).
- This data item is based on pathology information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, code 00.
- Record the total number of regional lymph nodes removed and examined by the pathologist.
  - The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
  - Code 98 if lymph nodes are aspirated and other lymph nodes are removed.
  - This data item is to be recorded regardless of whether the patient received preoperative treatment.
- If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, code 96.
- Code 99 for the following primary sites and histologies:

  Placenta (C58.9)
  Brain and Cerebral Meninges (C70.0, C71.0–C71.9)
  Other Parts of Central Nervous System (C70.1, C70.9, C72.0–C72.5, C72.8–C72.9)
  Hodgkin and non-Hodgkin Lymphoma (M-959–972) EXCEPT 9700/3 and 9701/3)
  Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms (M-9731–9734, 9740–9742, 9750–9758, 9760–9762, 9764–9769, 9800–9801, 9805, 9820, 9823, 9826–827, 9831–9837, 9840, 9860–9861, 9863, 9866–9867, 9870–9876, 9891, 9895–9897, 9910, 9920, 9930–9931, 9940, 9945–9946, 9948, 9950, 9960–9964, 9970, 9975, 9980, 9982–9987, 9989)
  Unknown and Ill-Defined Primary Sites (C42.0–C42.4, C76.0–C76.5, C76.7–C76.8, C77.0–C77.5, C77.8–C77.9, C80.9; Note: For C42._ and C77._, other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin Lymphomas as listed above, and Kaposi sarcoma 9140/3)

Code	Description
00	No nodes were examined.
01–89	1–89 nodes were examined. (Code the exact number of regional lymph nodes examined.)
90	90 or more nodes were examined.
95	No regional nodes were removed, but aspiration or core biopsy of regional nodes was performed.
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated.
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated.

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

REGIONAL LYMPH NODES POSITIVE

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

Description
Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Staging System (CS).

Rationale
This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Instructions for Coding
- Only record information about regional lymph nodes in this item. Involved distant lymph nodes should be coded in *CS Mets at Dx* (NAACCR Item #2850).
- This item is based on pathology information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, code 98.
- Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.
  - The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
  - This item is to be recorded regardless of whether the patient received preoperative treatment.
- Any combination of positive aspirated, biopsied, sampled or dissected lymph nodes is coded 97 if the number of involved nodes cannot be determined on the basis of cytology or histology.
- Code 99 for the following primary sites and histologies:
  Placenta (C58.9)
  Brain and Cerebral Meninges (C70.0, C71.0–C71.9)
  Other Parts of Central Nervous System (C70.1, C70.9, C72.0–C72.5, C72.8–C72.9)
  Hodgkin and non-Hodgkin Lymphoma (M-959–972 EXCEPT 9700/3 and 9701/3)
  Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
  (M-9731–9734, 9740–9742, 9750–9758, 9760–9762, 9764–9769, 9800–9801, 9805, 9820, 9823, 9826–9827, 9831–9837, 9840, 9860–9861, 9863, 9866–9867, 9870–9876, 9891, 9895–9897, 9910, 9920, 9930–9931, 9940, 9945–9946, 9948, 9950, 9960–9964, 9970, 9975, 9980, 9982–9987, 9989)
  Unknown and Ill-Defined Primary Sites
  (C42.0–C42.4, C76.0–C76.5, C76.7–C76.8, C77.0–C77.5, C77.8–C77.9, C80.9; Note: For C42._ and C77._ , other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin Lymphomas as listed above, and Kaposi sarcoma 9140/3)

Code	Description
00	All nodes examined are negative.
01–89	1–89 nodes are positive. (Code exact number of nodes positive)
90	90 or more nodes are positive.
95	Positive aspiration or core biopsy of lymph node(s) was performed.
97	Positive nodes are documented, but the number is unspecified.
98	No nodes were examined.
99	It is unknown whether nodes are positive; not applicable; not stated in patient record.

Stage of Disease at Diagnosis

DATE OF SURGICAL DIAGNOSTIC AND STAGING PROCEDURE

Item Length: 8
NAACCR Item #1280

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.

Instructions for Coding
Record the date on which the surgical diagnostic and/or staging procedure described in *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350) was performed at this or any facility.

Code	Definition
MMDDCCYY	The date of surgical diagnostic and staging procedure is the month, day, and year (MMDDCCYY) of the procedure at this or any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	When no surgical procedure was performed. Diagnosed at autopsy.
99999999	When it is unknown whether a surgical procedure was performed, the date is unknown, or the case was identified by death certificate only.

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

Note: Prior to January 1, 2003, the date recorded in this item may have indicated the date on which a palliative surgical procedure was performed.

Examples:

Code	Definition
09992005	If the exact date of the surgical diagnostic and/or staging procedure is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description “Spring,” 2003.
07992003	If information is limited to the description “The middle of the year,” 2003.
10992003	If information is limited to the description “Fall,” 2003.

Code	Definition
12992003 or 01992004	If information is limited to the description “Winter.” Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

SURGICAL DIAGNOSTIC AND STAGING PROCEDURE

Item Length: 2
Allowable Values: 00–07, 09
NAACCR Item #1350

Description
Identifies the surgical procedure(s) performed in an effort 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.

Instructions for Coding:
- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.
- 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).
- 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* (NAACCR Item #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* (NAACCR Item #1280). See instructions for *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292).
- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* (NAACCR Item #490). These are not considered surgical procedures and should not be coded in this item.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* (NAACCR Item #1290) to code these procedures.
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* (NAACCR Item #3270) to code these procedures.

Code	Definition
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. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site.
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: 2
Allowable Values: 00–07, 09
NAACCR Item #740

Description
Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage disease at this facility.

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

Instructions for Coding
- Record the type of procedure performed as part of the initial diagnosis and workup at this facility.
- 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).
- 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* (NAACCR Item #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* (NAACCR Item #1280). See instructions for *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292).
- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* (NAACCR Item #490). These are not considered surgical procedures and should not be coded in this item.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* (NAACCR Item #1290) to code these procedures.
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* (NAACCR Item #3270) to code these procedures.

Code	Definition
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than primary. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site.
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.

CLINICAL T

Item Length: 2
Alphanumeric
Upper-case
Left Justified
NAACCR Item #940

Description
Evaluates the primary tumor (T) and reflects the tumor size and/or extension as recorded by the physician.

Rationale
The CoC requires that AJCC TNM staging be used in its approved cancer programs. 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.

Instructions for Coding
- Code clinical T as recorded in the medical record.*
- Truncate the least significant subdivision of the category from the right as needed.
- For lung, occult carcinoma is coded TX.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

Code	Definition	Code	Definition
(leave blank)	Not recorded.	1C	T1c
X	TX	2	T2
0	T0	2A	T2a
A	Ta	2B	T2b
IS	Tis	2C	T2c
SU	Tispu	3	T3
SD	Tispd	3A	T3a
1M	T1mic	3B	T3b
1	T1	3C	T3c
1A	T1a	4	T4
A1	T1a1	4A	T4a
A2	T1a2	4B	T4b
1B	T1b	4C	T4c
B1	T1b1	4D	T4d
B2	T1b2	88	Not applicable

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

CLINICAL N

Item Length: 2
Alphanumeric
Upper-case
Left Justified
NAACCR Item #950

Description
Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis as recorded by the physician.

Rationale
The CoC requires that AJCC TNM staging be used in its approved cancer programs. 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.

Instructions for Coding
- Record clinical N as documented in the medical record.*
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

Code	Definition
(leave blank)	Not recorded.
X	NX
0	N0
1	N1
1A	N1a
1B	N1b
2	N2
2A	N2a
2B	N2b
2C	N2c
3	N3
3A	N3a
3B	N3b
3C	N3c
88	Not applicable

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

CLINICAL M

Item Length: 2
Alphanumeric
Upper-case
Left Justified
NAACCR Item #960

Description
Identifies the presence or absence of distant metastasis (M) as recorded by the physician.

Rationale
The CoC requires that AJCC TNM staging be used in its approved cancer programs. 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.

Instructions for Coding
- Record clinical M as recorded in the medical record.*
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.
- The AJCC has determined that staging of metastatic disease is *clinical* unless there is pathologic information confirming the presence of metastatic disease.
- Cases should be assumed to be cM0 unless there is documented clinical or pathologic evidence of metastasis of disease.

Code	Definition
(leave blank)	Not recorded.
X	MX
0	M0
1	M1
1A	M1a
1B	M1b
1C	M1c
88	Not applicable

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

CLINICAL STAGE GROUP

Item Length: 2
Alphanumeric
Upper-case
Left Justified
NAACCR Item #970

Description
Identifies the anatomic extent of disease based on the T, N, and M elements as recorded by the physician.

Rationale
The CoC requires that AJCC TNM staging be used in its approved cancer programs. 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.

Instructions for Coding
- Record the clinical Stage Group as recorded in the medical record.*
- If the clinical T, N, and M have been recorded in the medical record, the cancer registrar may complete the clinical Stage Group in the cancer registry database.
- When the T, N, and M components are not completed, the registrar is to record Stage Group 99 (unknown) in the cancer registry database.
- To assign Stage Group when some, but not all, of the T, N and/or M components were provided by the appropriate person, interpret the missing components as "X."
- If the value is only one digit, then record to the left and leave the second space blank.
- Truncate the least significant subdivision of the category from the right as needed.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.
- The CoC does not require Class 0 cases diagnosed on or after January 1, 2006 to be AJCC staged.

Code	Definition	Code	Definition
0	Stage 0	2B	Stage IIB
0A	Stage 0A	2C	Stage IIC
0S	Stage 0is	3	Stage III
1	Stage I	3A	Stage IIIA
1A	Stage IA	3B	Stage IIIB
A1	Stage IA1	3C	Stage IIIC
A2	Stage IA2	4	Stage IV
1B	Stage IB	4A	Stage IVA
B1	Stage IB1	4B	Stage IVB
B2	Stage IB2	4C	Stage IVC
1C	Stage IC	OC	Occult
1S	Stage IS	88	Not applicable
2	Stage II	99	Unknown
2A	Stage IIA		

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

CLINICAL STAGE (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1
Allowable Values: 0–6, 9
NAACCR Item #980

Description
Identifies the AJCC clinical stage (prefix/suffix) descriptor as recorded by the physician.

Rationale
Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the Stage Group. The CoC requires that AJCC TNM staging be used in its approved cancer programs. 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.

Instructions for Coding
- Record the clinical stage (prefix/suffix) descriptor as documented in the medical record.*
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

Code	Label	Description
0	None	There are no prefix or suffix descriptors that would be used for this case.
1	E–Extranodal, lymphomas only	A lymphoma case involving an extranodal site.
2	S– Spleen, lymphomas only	A lymphoma case involving the spleen.
3	M–Multiple primary tumors in a single site	This is one primary with multiple tumors in the primary site **at the time of diagnosis**.
4	Y–Classification during or after initial modality therapy, pathologic staging only	Not applicable for clinical stage.
5	E&S–Extranodal and spleen, lymphomas only	A lymphoma case with involvement of both an extranodal site and the spleen.
6	M&Y–Multiple primary tumors and initial multimodality therapy	A case meeting the parameters of both codes 3 (multiple primary tumors in a single site) and 4 (classification during or after initial multimodality therapy).
9	Unknown; not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

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

STAGED BY (CLINICAL STAGE)

Item Length: 1
Allowable Values: 0–9
NAACCR Item #990

Description
Identifies the person who recorded the clinical AJCC staging elements and the Stage Group in the patient's medical record.

Rationale
Data captured in this field can be used to evaluate the accuracy and completeness of physician staging and form the basis for quality management and improvement studies.

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

Code	Label	Definition
0	Not staged	Staging was not assigned.
1	Managing physician	Staging was assigned by the managing physician.
2	Pathologist	Staging was assigned by the pathologist only.
3	Pathologist and managing physician	Staging was assigned by the pathologist and the managing physician.
4	Cancer Committee chair, cancer liaison physician, or registry physician advisor	Staging was assigned by the Cancer Committee chair, cancer liaison physician, or the registry physician advisor during a quality control review.
5	Cancer registrar	Staging was assigned by the cancer registrar only.
6	Cancer registrar and physician	Staging was assigned by the cancer registrar and any of the physicians specified in codes 1–4.
7	Staging assigned at another facility	Staging was assigned by a physician at another facility.
8	Case is not eligible for staging	An AJCC staging scheme has not been developed for this site. The histology is excluded from an AJCC site scheme.
9	Unknown; not stated in patient record	It is unknown whether or not the case was staged.

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

PATHOLOGIC T

Item Length: 2
Alphanumeric
Upper-case
Left Justified
NAACCR Item #880

Description
Evaluates the primary tumor (T) and reflects the tumor size and/or extension as recorded by the physician.

Rationale
The CoC requires that AJCC TNM staging be used in its approved cancer programs. 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, to design follow-up strategies, and to assess early detection results.

Instructions for Coding
- Record pathologic T as recorded in the medical record.*
- Truncate the least significant subdivision of the category from the right as needed.
- For lung, occult carcinoma is coded TX.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

Code	Definition	Code	Definition
(leave blank)	Not recorded.	1C	T1c
X	TX	2	T2
0	T0	2A	T2a
A	Ta	2B	T2b
IS	Tis	2C	T2c
SU	Tispu	3	T3
SD	Tispd	3A	T3a
1M	T1mic	3B	T3b
1	T1	3C	T3c
1A	T1a	4	T4
A1	T1a1	4A	T4a
A2	T1a2	4B	T4b
1B	T1b	4C	T4c
B1	T1b1	4D	T4d
B2	T1b2	88	Not applicable

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

PATHOLOGIC N

Item Length: 2
Alphanumeric
Upper-case
Left Justified
NAACCR Item #890

Description
Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis as recorded by the physician.

Rationale
The CoC requires that AJCC TNM staging be used in its approved cancer programs. 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.

Instructions for Coding
- Record pathologic N as recorded in the medical record.*
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

Code	Definition
(leave blank)	Not recorded.
X	NX
0	N0
I-	N0(i-)
I+	N0(i+)
M-	N0(mol-)
M+	N0(mol+)
1	N1
1A	N1a
1B	N1b
1C	N1c
1M	N1mi
2	N2
2A	N2a
2B	N2b
2C	N2c
3	N3
3A	N3a
3B	N3b
3C	N3c
88	Not applicable

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

PATHOLOGIC M

Item Length: 2
Alphanumeric
Upper-case
Left Justified
NAACCR Item #900

Description
Identifies the presence or absence of distant metastasis (M) as recorded by the physician.

Rationale
The CoC requires that AJCC TNM staging be used in its approved cancer programs. 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.

Instructions for Coding
- Record pathologic M as recorded in the medical record.*
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.
- The AJCC has determined that staging of metastatic disease is *clinical* unless there is pathologic information confirming the presence of metastatic disease.
- Cases should be assumed to be pMX unless there is documented clinical or pathologic evidence of metastasis of disease.

Code	Definition
(leave blank)	Not recorded.
X	MX
0	M0
1	M1
1A	M1a
1B	M1b
1C	M1c
88	Not applicable

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

PATHOLOGIC STAGE GROUP

Item Length: 2
Alphanumeric
Upper-case
Left Justified
NAACCR Item #910

Description
Identifies the anatomic extent of disease based on the T, N, and M elements as recorded by the physician.

Rationale
The CoC requires that AJCC TNM staging be used in its approved cancer programs. 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.

Instructions for Coding
- Record the pathologic Stage Group as recorded in the medical record.
- If the pathologic T and N and either the clinical or pathologic M have been recorded by the appropriate person or persons*, the cancer registrar may complete the pathologic Stage Group in the cancer registry database.
- When the appropriate person or persons do not complete any of the T, N, and M components, the registrar is to record Stage Group 99 (unknown) in the cancer registry database.
- To assign Stage Group when some, but not all, of the T, N and/or M components were provided by the appropriate person, interpret the missing components as "X."
- If *Pathologic M* (NAACCR Item #900) is coded as either X or blank and *Clinical M* (NAACCR Item #960) is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging elements *pT, pN,* and *cM* (NAACCR Item #s 880, 890, 960) may be used to complete the pathologic Stage Group.
- If the value is only one digit, record to the left and leave the second space blank.
- Truncate the least significant subdivision of the category from the right as needed, if a specific code is not shown on the table below.
- 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.

Code	Definition	Code	Definition
0	Stage 0	2A	Stage IIA
0A	Stage 0A	2B	Stage IIB
0S	Stage 0is	2C	Stage IIC
1	Stage I	3	Stage III
1A	Stage IA	3A	Stage IIIA
A1	Stage IA1	3B	Stage IIIB
A2	Stage IA2	3C	Stage IIIC
1B	Stage IB	4	Stage IV
B1	Stage IB1	4A	Stage IVA
B2	Stage IB2	4B	Stage IVB
1C	Stage IC	4C	Stage IVC
1S	Stage IS	88	Not applicable
2	Stage II	99	Unknown

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

PATHOLOGIC STAGE (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1
Allowable Values: 0–6, 9
NAACCR Item #920

Description
Identifies the AJCC pathologic stage (prefix/suffix) descriptor as recorded by the physician.

Rationale
Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the Stage Group. The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging 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.

Instructions for Coding
- Record the pathologic stage (prefix/suffix) descriptor as documented in the medical record.*
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

Code	Label	Definition
0	None	There are no prefix or suffix descriptors that would be used for this case.
1	E—Extranodal, lymphomas only	A lymphoma case involving an extranodal site.
2	S—Spleen, lymphomas only	A lymphoma case involving the spleen.
3	M—Multiple primary tumors in a single site	This is one primary with multiple tumors in the organ of origin **at the time of diagnosis**.
4	Y—Classification during or after initial multimodality therapy–pathologic staging only	Not applicable for clinical stage.
5	E&S—Extranodal and spleen, lymphomas only	A lymphoma case with involvement of both an extranodal site and the spleen.
6	M&Y—Multiple primary tumors and initial multimodality therapy	A case meeting the parameters of both codes 3 (multiple primary tumors in a single site) and 4 (classification during or after initial multimodality therapy).
9	Unknown; not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

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

STAGED BY (PATHOLOGIC STAGE)

Item Length: 1
Allowable Values: 0–9
NAACCR Item #930

Description
Identifies the person who recorded the pathologic AJCC staging elements and the Stage Group in the patient's medical record.

Rationale
Data captured in this field can be used to evaluate the accuracy and completeness of physician staging and form the basis for quality management and improvement studies.

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

Code	Label	Definition
0	Not staged	Staging was not assigned.
1	Managing physician	Staging was assigned by the managing physician.
2	Pathologist	Staging was assigned by the pathologist only.
3	Pathologist and managing physician	Staging was assigned by the pathologist and the managing physician.
4	Cancer Committee chair, cancer liaison physician, or registry physician advisor	Staging was assigned by the Cancer Committee chair, cancer liaison physician, or the registry physician advisor during a quality control review.
5	Cancer registrar	Staging was assigned by the cancer registrar only.
6	Cancer registrar and physician	Staging was assigned by the cancer registrar and any of the physicians specified in 1–4.
7	Staging assigned at another facility	Staging was assigned by a physician at another facility.
8	Case is not eligible for staging	An AJCC staging scheme has not been developed for this site. The histology is excluded from an AJCC scheme.
9	Unknown; not stated in patient record	It is unknown whether or not the case was staged.

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

SEER SUMMARY STAGE 2000

Item Length: 1
Allowable Values: 0–5, 7, 9
NAACCR Item #759

Description
Provides a site-specific description of the extent of disease at diagnosis.

Rationale
SEER Summary Stage 2000 is used by the CoC to describe disease spread at diagnosis for cancers with no AJCC TNM staging schema. It is a prognostic factor used in the analysis of patient care and outcomes.

Instructions for Coding
- Code this data item for cases diagnosed prior to January 1, 2004.
- Record the SEER Summary Stage 2000 code for all cases that do not have a defined AJCC staging schema.
- Refer to the *SEER Summary Staging Manual 2000* for site-specific coding instructions. This information can be found online at *http://www.seer.cancer.gov/Publications/SummaryStage/*.

Code	Definition
0	In situ.
1	Localized.
2	Regional by direct extension.
3	Regional to lymph nodes.
4	Regional (both codes 2 and 3).
5	Regional, NOS.
7	Distant metastasis/systemic disease.
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified); death certificate only.

CS TUMOR SIZE

Item Length: 3
Allowable Values: 000–995, 999
NAACCR Item #2800

Description

Records the largest dimension or diameter of the **primary tumor**, and is always recorded in millimeters. To convert centimeters to millimeters, multiply the dimension by 10. If tumor size is given in tenths of millimeters, round down if between .1 and .5 mm, and round up if between .6 and .9 mm.

Rationale

Tumor size at diagnosis is an independent prognostic indicator for many tumors and it is used by Collaborative Staging to derive some TNM-T codes.

Instructions for Coding

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Record tumor size information in the following order:
  - Record tumor size from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.
  - If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the largest size of tumor whether prior to or following treatment.
  - 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.
  - If there is a difference in reported tumor size among imaging and radiographic techniques, record the largest size of tumor reported in the record.
- Record the exact size of the primary tumor for all sites/histologies except those for which it is stated to be not applicable. Code 999 if no size is given.
  - 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.
  - Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.
  - Record the size of the invasive component, if given.
  - 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.
  - **Additional rule for breast primaries:** 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.
  - For purely in situ lesions, code the size as stated.
  - Microscopic residual tumor does not affect overall tumor size.
  - Do **not** add pieces or chips together to create a whole. 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.
  - Code tumor size 999 for an incisional needle biopsy. On rare occasions, an incisional needle biopsy may remove an entire tumor. In this event, the tumor size may be recorded.
  - Record tumor size (lateral dimension) for malignant melanoma. Depth of invasion is coded in a site-specific factor.

- Special codes
  - Tumor dimension is to be recorded for all schemas, except as noted below.
  - The descriptions in code 998 take precedence over any mention of size. Code 998 is used only for the following sites:
    Esophagus (C15.0–C15.5, C15.8–C15.9): Entire circumference
    Stomach (C16.0–C16.6, C16.8–C16.9): Diffuse, widespread—¾ or more, linitis plastica
    Colorectal (M-8220/8221 with /2 or /3): Familial/multiple polyposis
    Lung and main stem bronchus (C34.0–C34.3, C34.8–C34.9): Diffuse, entire lobe or lung
    Breast (C50.0–C50.6, C50.8–C50.9): Diffuse.
  - Code 990, should be used when no gross tumor is seen and tumor is only identified microscopically. ***Note:*** The terms microscopic focus, microfocus, and microinvasion are **not** the same as [macroscopic] focal or focus. A macroscopic focus or foci indicates a very small or isolated area, pinpoint, or spot of tumor that may be visible grossly. Only tumor identified microscopically should be coded 990.
  - Codes 991 through 995 are non-specific size descriptions that, for some sites, are used to determine a T category. If a specific size is given, code the more precise size in the range 001–989.
  - See the individual site/histology schemas for further information and definitions.

Note: For the following diagnoses and/or primary sites, size is not applicable. Record as code 888.

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

Hodgkin and non-Hodgkin Lymphoma (M-959_–972 EXCEPT 9700/3 and 9701/3)

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

Code	Definition
000	Indicates no mass or no tumor found; for example, when a tumor of a stated primary site is not found, but the tumor has metastasized.
001–988	Exact size in millimeters.
989	989 millimeters or larger.
990	Microscopic focus or foci only; no size of focus is given.
991	Described as less than 1 cm.
992	Described as less than 2 cm; greater than 1 cm; or, between 1 cm and 2 cm.
993	Described as less than 3 cm; greater than 2 cm; or, between 2 cm and 3 cm.
994	Described as less than 4 cm; greater than 3 cm; or, between 3 cm and 4 cm.
995	Described as less than 5 cm; greater than 4 cm; or, between 4 cm and 4 cm.
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; size not stated; not stated in patient record.

Examples:

Code	Reason
001	Prostate needle biopsy shows 0.6 mm carcinoma *(round up six-tenths of mm).*
008	Thyroidectomy specimen yields 8 mm carcinoma.
014	Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive.
019	Duct carcinoma in situ covering a 1.9 cm area with focal areas of invasive ductal carcinoma.
022	Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives course of neoadjuvant combination chemotherapy. Pathologic size of tumor after total resection is 0.8 cm.
023	Infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm.
028	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.
033	A 3.3 cm tumor is 33 millimeters.
040	CT of chest shows 4 cm mass in RUL.
051	Tumor is described as 2.4 x 5.1 x 1.8 cm in size.
990	Cervix conization: severe dysplasia with focal areas of microinvasion. Code tumor size as microscopic focus, no size given.
999	Ovary specimen: extensive cystic disease with focal areas of tumor seeding. Disregard “focal” and code tumor size to unknown.

CS EXTENSION

Item Length: 2
Allowable Values: 00–80, 95, 99
NAACCR Item #2810

Description
Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in *CS Extension*. See site-specific schemas for detailed codes and coding instructions.

Rationale
Tumor extension at diagnosis is a prognostic indicator used by Collaborative Staging to derive some TNM-T codes and some SEER Summary Stage codes.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Code the farthest documented extension of the primary tumor. Do not include discontinuous metastases to distant sites which are coded in *CS Mets at Dx* (NAACCR Item #2850) except for ovary and corpus uteri.
- Record extension information in the following order:
  - Record extension from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.
  - If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest extension, whether it was identified clinically prior to treatment or pathologically following treatment.
  - Information on extent of disease from imaging/radiographic techniques can be used to code extension when there is no more specific extension information from a pathology or operative report.
  - If an involved organ or tissue is not mentioned in the schema, approximate the location and code by comparing it with listed organs or tissues in the same anatomic area.
  - With the exception of corpus uteri and ovary, all codes represent contiguous (direct) extension of tumor from the site of origin to the organ/structure/tissue represented in the code.
- Refer to the Ambiguous Terminology section of the *CS Manual* for terms that constitute tumor involvement or extension.
- If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the T category stated by the physician.
- If the only indication of extension in the record is the physician's statement of a T category from the TNM staging system or a stage from a site-specific staging system, such as Dukes' C, record the numerically lowest equivalent extension code for that T category.
- Some site or histology schemas include designations such as T1, NOS; T2, NOS; Localized, NOS; and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as T1a, T1b, T1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as T1 NOS" when the appropriate subset (e.g., T1a or T1b) cannot be determined.
- Distant metastases must be coded in *CS Mets at Dx* (NAACCR Item #2850).
- Do not code *CS Extension* as in situ if there is any evidence of nodal or metastatic involvement; use the code for 'Localized, NOS' if there is no better information.
- The presence of microscopic residual disease or positive tumor margins does not increase the extension code.

Code	Description	TNM Mapping	SS77 Mapping	SS2000 Mapping
00	In situ; non-invasive	Tis	IS	IS
	SITE/HISTOLOGY-SPECIFIC CODES			
80	Further contiguous extension			
95	No evidence of primary tumor	T0	U	U
99	Unknown extension; primary tumor cannot be assessed; not stated in patient record	TX	U	U

CS TUMOR SIZE/EXT EVAL

Item Length: 1
Allowable Values: 0–3, 5, 6, 8, 9
NAACCR Item #2820

Description
Records how the codes for the two items *CS Tumor Size* (NAACCR Item #2800) and *CS Extension* (NAACCR Item #2810) were determined, based on the diagnostic methods employed.

Rationale
This item is used by Collaborative Staging to describe whether the staging basis for the TNM-T code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Select the code that documents the report or procedure from which the information about the farthest extension or size of the primary tumor was obtained. This may not be the numerically highest eval code.
- For primary sites/histologies where tumor size is not a factor in determining the T category in TNM (see Table 5 in General Instructions of the *CS Manual*), code this data item on the basis of *CS Extension* (NAACCR Item #2810) only.
- For primary sites where both tumor size and extension determine the T category in TNM (see Table 4 in the General Instructions), select the code that best explains how the information in the *CS Tumor Size* (NAACCR Item #2800) and *CS Extension* (NAACCR Item #2810) data items were determined.
  - If there is a difference between the derived category for the tumor size and the CS extension, select the evaluation code that reflects how the worse or higher category was determined.
  - Code 0, 1, or 9 if the patient had no surgery.
    Exception: Lung cancer with mediastinoscopy showing direct extension into mediastinum. Use code 1. Staging algorithm will identify information as pathologic (p), because mediastinoscopy is defined as a pathologic procedure in TNM.
  - Code 3 or 9 if the patient had surgery followed by other treatment(s).
  - Code 3 or 6 if the size or extension of the tumor was greater after treatment than before treatment.
  - Code 5 or 6 if the size or extension of the tumor determined prior to treatment was the basis for neoadjuvant therapy.
  - Code 2 if the patient had an autopsy and the diagnosis was known or suspected prior to death.
  - Code 8 if the patient had an autopsy and the malignancy was not known or suspected prior to death.
- For sites/histologies where there is no TNM schema, this data item may be coded 9, "Not applicable." (See Table 6 in General Instructions of the *CS Manual*.)
- Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.
- Code 1 generally includes microscopic analysis of tissue insufficient to meet the requirements for pathologic staging in the TNM system. Pathologic staging requirements vary by site; for some site schemas, code 1 may be classified as pathologic. For specific classification rules, refer to the *AJCC Cancer Staging Manual, Sixth Edition*.

- Code 1 also includes observations at surgery, such as an exploratory laparotomy in which unresectable pancreatic cancer is identified, where further tumor extension is not biopsied. Use code 3 for a biopsy of tumor extension that meets the requirements for pathologic staging basis. That is, if the biopsy documents the highest T category, the biopsy meets the requirements for pathologic staging basis and *CS Tumor Size/Ext Eval* should be coded 3.

Code	Description	Staging Basis
0	No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques. No autopsy evidence used. Does not meet criteria for AJCC pathologic staging.	c*
2	No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation; **OR** surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed. Meets criteria for AJCC pathologic staging. Evaluation based on evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen.	p
5	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on clinical evidence.	c
6	Surgical resection performed WITH pre-surgical systemic treatment or radiation, BUT tumor size/extension based on pathologic evidence.	y
8	Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy).	a
9	Unknown if surgical resection done. Not assessed; cannot be assessed. Unknown if assessed. Not documented in patient record. For sites with no TNM schema: not applicable	c

* For some primary sites, code 1 may be a pathologic staging basis.

Examples:

Code	Reason
0	Tumor size for a breast cancer biopsy is 020 (maps to T1). There is ulceration of the skin (extension code 50, maps to T4). Use code 0; the evaluation is based on physical examination and the ulceration information from the physical examination results in a higher T category.
0	Patient has a chest x-ray showing an isolated 4 cm tumor in the right upper lobe. Patient opts for radiation therapy. Use code 0. Staging algorithm would identify information as clinical (c).
1	Fine needle aspiration biopsy (eval code 2) confirms adenocarcinoma of prostate. CT scan of pelvis (eval code 1) shows tumor extension through the prostatic capsule into adjacent connective tissues. Use code 1 since the CT scan showed more extensive tumor than the biopsy.
1	Colon cancer with colonoscopy and biopsy confirming cancer. Use code 1. Staging algorithm would identify information as clinical (c). The biopsy does not meet the criteria for pathologic staging.
1	Endoscopies for cervix or bladder. Use code 1. The staging algorithm would identify the information as clinical (c).

CS LYMPH NODES

Item Length: 2
Allowable Values: 0–80, 90
NAACCR Item #2830

Description
Identifies the regional lymph nodes involved with cancer at the time of diagnosis.

Rationale
The involvement of specific regional lymph nodes is a prognostic indicator used by Collaborative Staging to derive some TNM-N codes and SEER Summary Stage codes.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Record the specific regional lymph node chain farthest from the primary site that is involved by tumor either clinically or pathologically.
  - Regional lymph nodes are listed for each site/histology. In general, the regional lymph nodes in the chain closest to the primary site have the lower codes. Nodes farther away from the primary or in farther lymph node chains have higher codes. Record the highest applicable code.
    Exception: The higher codes for 'Regional lymph nodes, NOS'; 'Lymph nodes, NOS'; 'Stated as N1, no other information'; 'Stated a N2a, no other information', and so forth, should only be used when there is no available information as to the name(s) of the regional nodes involved.
  - Record involved regional lymph nodes from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.
  - If there is a discrepancy between clinical information and pathologic information about the same lymph nodes, the pathologic information takes precedence.
  - **For inaccessible sites, primarily for localized or early stage (T1, T2) cancers:** record regional lymph nodes as negative rather than unknown (based on clinical evaluation) when there is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing or surgical exploration, and the patient receives what would be usual treatment to the primary site (see the *CS Manual* for further discussion).
  - If there is direct extension of the primary tumor into a regional lymph node, record the involved node in this data item.
  - If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, the clinical status of the lymph nodes takes precedence.
- Code 00 for lymph node involvement when the *CS Extension* (NAACCR Item #2810) is coded in situ, even if no lymph nodes are removed, since "in situ" by definition means noninvasive.
- For solid tumors, the terms "fixed" or "matted" and "mass in the hilum, mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are considered involvement of lymph nodes.
  - Any other terms such as "palpable," "enlarged," "visible swelling," "shotty," or "lymph-adenopathy" should be ignored (except for adenopathy, enlargement, and mass in the hilum or mediastinum for lung primaries), unless there is a statement of involvement by the clinician.
  - For lymphomas, *any* mention of lymph nodes is indicative of involvement.
  - The terms "homolateral," "ipsilateral," and "same side" are used interchangeably.
  - Any unidentified nodes included with the resected primary site specimen are to be coded as 'Regional lymph nodes, NOS.'
  - Where more specific categories are provided, the codes for 'Regional lymph nodes, NOS' and 'Lymph nodes, NOS' should be used *only* after an exhaustive search for more specific information.

- When size of involved regional lymph nodes is required, code from pathology report, if available.
  - Code the size of the metastasis, not the entire node, unless otherwise stated in site-specific schemas. The size of the metastasis within the lymph node can be inferred if the size for the entire node falls within one of the codes. For example, a single involved node 1.5 cm in size can be coded to 'Single lymph node ≤ 2 cm' because the metastasis cannot be larger than 1.5 cm.
- If the only indication of lymph node involvement in the record is the physician's statement of an N category from the TNM staging system or a stage from a site-specific staging system, such as Dukes' C, record the numerically lowest equivalent *CS Lymph Nodes* code for that N category.
  - If there is a discrepancy between documentation in the medical record and the physician's assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM.
  - If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, lymph node involvement may be inferred from the N category stated by the physician.
- Some site or histology schemas include designations such as N1, NOS; N2, NOS, and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as N1a, N1b, N1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as N1 NOS" when the appropriate subset (e.g., N1a or N1b) cannot be determined.

Code	Description	TNM Mapping	SS77 Mapping	SS2000 Mapping
00	None; no regional lymph node involvement	N0	None	None
	SITE/HISTOLOGY-SPECIFIC CODES			
90	Unknown; regional lymph nodes cannot be assessed; not stated in patient record	NX	U	U

Examples:

Code	Reason
00	Axillary lymphadenopathy stated as "suspicious for involvement" noted on physical exam. After axillary dissection, all lymph nodes are negative. Use code 00.
10	Patient has needle biopsy-proven prostate cancer with no mention of involved lymph nodes on physical examination (Negative, code 00). He receives Lupron while deciding whether to undergo a radical prostatectomy. At the time of surgery, a laparoscopic pelvic node biopsy is reported to show metastases (Regional nodes involved, code 10) to lymph nodes and the prostatectomy is canceled. Use code 10 because the preoperative treatment (Lupron) had no effect on the lymph nodes.
50	Patient has a hard matted mass in the axilla (code 50) and a needle biopsy of the breast that confirms ductal carcinoma. Patient receives three months of chemotherapy. The pathology report from the modified radical mastectomy shows only scar tissue in the axilla with no involvement of axillary lymph nodes (Negative, code 00). Use code 50 because the chemotherapy apparently "sterilized" the lymph nodes.

CS REG NODES EVAL

Item Length: 1
Allowable Values: 0–3, 5, 6, 8, 9
NAACCR Item #2840

Description
Records how the code for *CS Lymph Nodes* (NAACCR Item #2830) was determined, based on the diagnostic methods employed.

Rationale
This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-N code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Select the code that documents the report or procedure from which the information about the farthest involved regional lymph nodes was obtained; this may not be the numerically highest eval code.
- Code 9 may be used for this data item for sites/histologies where there is no TNM schema (see Table 5 in General Instructions of the *CS Manual*).
- Select the code that best explains how the information for *CS Lymph Nodes* (NAACCR Item #2830) was determined.
  - Code 0, 1, or 9 if the patient had no removal of lymph node(s).
  - Code 3 or 9 if the patient had removal of lymph node(s) surgery followed by other treatment(s).
  - code 5 or 6 if the size, number, or extension of regional lymph node involvement determined prior to treatment was the basis for neoadjuvant therapy.
  - Code 3 or 6 if the size, number, or extension of regional lymph node involvement was greater after treatment than before treatment.
  - Code 2 if the patient had an autopsy and the diagnosis was known or suspected prior to death.
  - Code 8 if the patient had an autopsy and the malignancy was not known or suspected prior to death.
- Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.
- Code 1 includes microscopic analysis of tissue insufficient to meet the requirements for pathologic staging in the TNM system.
- Code 3 if the lymph node procedure meets the requirements for the pathologic staging basis of regional lymph nodes.
- Code 1 also includes observations at surgery, such as abdominal exploration at the time of a colon resection, where regional lymph nodes are not biopsied.

Code	Description	Staging Basis
0	No regional lymph nodes removed for examination. Evaluation based on physical examination, imaging, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No regional lymph nodes removed for examination. Evaluation based on endoscopic examination, diagnostic biopsy including fine needle aspiration of lymph node(s) or other invasive techniques. No autopsy evidence used. Does not meet criteria for AJCC pathologic staging.	c
2	No regional lymph nodes removed for examination, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
3	Regional lymph nodes removed for examination (removal of at least 1 lymph node) **without** pre-surgical systemic treatment or radiation; OR lymph nodes removed for examination, unknown if pre-surgical systemic treatment or radiation performed Meets criteria for AJCC pathologic staging.	p
5	Regional lymph nodes removed for examination **with** pre-surgical systemic treatment or radiation, and lymph node evaluation based on clinical evidence	c
6	Regional lymph nodes removed for examination **with** pre-surgical systemic treatment or radiation,**but** lymph node evaluation based on pathologic evidence	y
8	Evidence from autopsy; tumor was unsuspected or undiagnosed prior to autopsy	a
9	Unknown if lymph nodes removed for examination Not assessed; cannot be assessed Unknown if assessed Not documented in patient record For sites that have no TNM staging: Not applicable	c

Examples:

Code	Reason
0	Modified radical neck dissection for hypopharyngeal cancer shows one lower jugular node involved (*CS Reg LN* code 10, eval code 3). Physical exam shows hard, matted scalene (transverse cervical) node presumed to contain metastasis (*CS Reg LN* code 32, eval code 0). Code this data item 0 since the scalene node involvement was determined clinically rather than by examination of tissue.
1	Lung cancer with CT scan or MRI showing involved contralateral mediastinal nodes. Code this data item 1. Staging algorithm would identify information as clinical (c).
3	Prostate cancer with laparoscopic lymph node biopsy showing involved nodes; radical prostatectomy canceled. Code this data item 3. Staging algorithm would identify information as pathologic (p). A positive biopsy of one or more regional lymph nodes is sufficient to meet the pathologic staging basis for prostate cancer.

CS METS AT DX

Item Length: 2
Allowable Values: 00, 10, 40, 50, 99
NAACCR Item #2850

Description
Identifies the distant site(s) of metastatic involvement at time of diagnosis.

Rationale
The presence of metastatic disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- This data item represents distant metastases (the TNM M component or distant stage in Summary Staging) at the time of diagnosis. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to a site remote from the primary tumor.
  Note: The structure of this data item is based on the M category of TNM. In some schemas, there may be additional items in *CS Extension* (NAACCR Item #2810) or *CS Lymph Nodes* (NAACCR Item #2830) that map to distant stage in Summary Staging (77 and/or 2000) and there may be some items in *CS Mets at Dx* that map to regional stage in Summary Staging. Regardless of where such items are recorded, the staging algorithms will properly account for the information.
- Assign the highest applicable code for metastasis at diagnosis, whether the determination was clinical or pathological and whether or not the patient had any preoperative systemic therapy.
- Metastasis known to have developed after the extent of disease was established (also referred to as progression of disease) should not be recorded in this data item.
- Use code 00, rather than code 99, when the clinician proceeds with standard treatment of the primary site for localized or early (T1, T2) stage, since this action presumes that there are no distant metastasis that would otherwise alter the treatment approach. Code 99 can and should be used in situations where there is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastasis.

- If the only indication of extension in the record is the physician's statement of an M category from the TNM staging system or a stage from a site-specific staging system, such as Dukes' D, record the numerically lowest equivalent extension code for that M category. In most cases, this will be 40, 'Distant metastasis, NOS.'

Code	Description	TNM Mapping	SS77 Mapping	SS2000 Mapping
00	No; none	M0	None	None
10	Distant lymph node(s)	M1	D	D
40	Distant metastasis except code 10 Distant metastasis, NOS Carcinomatosis	M1	D	D
	SITE/HISTOLOGY-SPECIFIC CODES			
50	(40) + (10)	M1	D	D
99	Unknown; distant metastasis cannot be assessed; not stated in patient record	MX	U	U

CS METS EVAL

Item Length: 2
Allowable Values: 0–3, 5, 6, 8, 9
NAACCR Item #2860

Description
Records how the code for *CS Mets at Dx* (NAACCR Item #2850) was determined based on the diagnostic methods employed.

Rationale
This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-M code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Select the CS Mets Eval code that documents the report or procedure from which the information about metastatic involvement farthest from the primary site was obtained; this may not be the numerically highest eval code.
- Code 9 may be used for primary sites/histologies where there is no TNM schema (See Table 4 of the *CS Manual*).
- Select the code that best explains how the information in *CS Mets at Dx* (NAACCR Item #2850) was determined.
  - Code 0, 1, or 9 if the patient had no examination of metastatic tissue.
  - Code 3 if the patient had removal of presumed metastatic tissue (even though the pathology report was negative).
  - Code the method of evaluation for the site(s) farthest from the primary.
  - Code 8 if metastasis at diagnosis were identified at autopsy.
  - Code 2 if the patient had an autopsy and the diagnosis was known or suspected prior to death.
  - Code 8 if the patient had an autopsy and the malignancy was not known or suspected prior to death.
- Code 6 if biopsies taken after pre-operative treatment are negative for metastasis and clinical evidence of metastasis remains.
- Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.
- Code 1 includes microscopic analysis of tissue insufficient to meet the requirements for pathologic staging in the TNM system.
- Code 3 if the diagnosis of distant metastasis meets the requirements for the pathologic staging basis.
- Code 1 also includes observations at surgery, such as abdominal exploration at the time of a colon resection, where distant metastasis is not biopsied.

Code	Description	Staging Basis
0	No pathologic examination of metastatic tissue performed. Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No pathologic examination of metastatic tissue performed. Evaluation of distant metastasis based on endoscopic examination or other invasive technique. No autopsy evidence used. Does not meet criteria for AJCC pathologic staging of distant metastasis.	c
2	No pathologic examination of metastatic tissue done prior to death, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
3	Pathologic examination of metastatic tissue performed **without** pre-surgical systemic treatment or radiation; **OR** pathologic examination of metastatic tissue performed, unknown if pre-surgical systemic treatment or radiation performed Meets criteria for AJCC pathologic staging of distant metastasis.	p
5	Pathologic examination of metastatic tissue performed **with** pre-surgical systemic treatment or radiation, and metastasis based on clinical evidence	c
6	Pathologic examination of metastatic tissue performed **with** pre-surgical systemic treatment or radiation, **but** metastasis based on pathologic evidence	y
8	Evidence from autopsy; tumor was unsuspected or undiagnosed prior to autopsy	a
9	Not assessed; cannot be assessed; unknown if assessed; not documented in patient record. For sites with no TNM staging: Not applicable	c

Examples:

Code	Reason
0	Liver palpated and reported as normal during laparotomy for stomach cancer (eval code 1). CT scan of brain shows multiple metastatic nodules (eval code 0). Code this data item 0; the brain would be reported as involved but the liver would not be reported as involved.
0	Patient has diagnosis of colon cancer by biopsy. CT scan shows liver metastasis. Code this data item 0. Staging algorithm will indicate information is clinical (c).
0	Colon cancer patient has CT scan showing normal lungs. During the resection, the surgeon palpates the liver and finds it to be normal. Code this data item 0, since the CT scan shows that potential metastatic sites outside the surgical field are negative.
1	Lung cancer with endoscopy of contralateral lung showing involvement of contralateral mainstem bronchus. Code this data item 1. Staging algorithm will indicate information is clinical (c).
3	Prostate cancer with enlarged scalene node confirming as cancer on needle biopsy. Code this data item 3. Staging algorithm will indicate information is pathologic (p), since the biopsy of the metastatic site confirms M1 disease.

CS SITE-SPECIFIC FACTOR 1

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2880

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites/histologies use *Site-Specific Factor 1* to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and neck*	Size of Lymph Nodes
Colon	Carcinoembryonic Antigen (CEA)
Rectosigmoid, rectum	Carcinoembyronic Antigen (CEA)
Liver	Alpha Fetoprotein (AFP)
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Measured Thickness (Depth), Breslow's Measurement
Mycosis Fungoides	Peripheral Blood Involvement
Breast	Estrogen Receptor Assay (ERA)
Ovary	Carbohydrate Antigen 125 (CA-125)
Placenta	Prognostic Scoring Index
Prostate	Prostatic Specific Antigen (PSA) Lab Value
Testis	Alpha Fetoprotein (AFP)
Malignant Melanoma of Conjunctiva	Measured Thickness (Depth), Breslow's Measurement
Malignant Melanoma of Iris and Ciliary Body	CS Extension Iris
Malignant Melanoma of Choroid	Measured Thickness (Depth), Breslow's Measurement
Malignant Melanoma of Other Eye	Measured Thickness (Depth), Breslow's Measurement
Brain	WHO Grade
Thyroid	Solitary vs. Multifocal
Kaposi sarcoma	Associated with HIV/AIDS
Hodgkin Lymphoma and Non-Hodgkin Lymphoma	Associated with HIV/AIDS
Pleura	Pleural Effusion
Other CNS	WHO Grade
Other Endocrine	WHO Grade

*Refer to Section One for a list of head and neck schemas.

- Code 000 when there is a statement in the record that a test was not performed.
  - Code 999 if there is no report of a lab test in the patient record.
  - For Kaposi sarcoma, if AIDS status is not documented, use code 999 (Unknown), rather than 002 (Not Present).

Code	Description
000	None
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

CS SITE-SPECIFIC FACTOR 2

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2890

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites use *Site-Specific Factor 2* to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and neck*	Extracapsular Extension, Lymph Nodes for Head and Neck
Liver	Fibrosis Score
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Ulceration
Breast	Progesterone Receptor Assay (PRA)
Prostate	Prostatic Specific Antigen (PSA)
Testis	Human Chorionic Gonadotropin (HCG)
Hodgkin and non-Hodgkin Lymphoma	Symptoms at Diagnosis

*Refer to Section One for a list of head and neck schemas.

- Code 000 when there is a statement in the record that a test was not performed.
  - Code 999 if there is no report of a lab test in the health record.
  - For malignant melanoma of skin, if ulceration is not mentioned in the pathology report, code 000.

Code	Description
000	None
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

CS SITE-SPECIFIC FACTOR 3

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2900

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites use *Site-Specific Factor 3* to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and Neck*	Levels I-III, Lymph Nodes of Head and Neck
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Clinical Status of Lymph Node Mets
Breast	Number of Positive Ipsilateral Axillary Lymph Nodes
Prostate	CS Extension - Pathologic Extension
Testis	LDH (Lactate Dehydrogenase)
Lymphoma	International Prognostic Index (IPI) Score

*Refer to Section One for a list of head and neck schemas.

- Code 000 when there is a statement in the record that a test was not performed.
  - Code 999 if there is no report of a lab test in the health record.
  - For the lymphomas, if the IPI score is not stated in the record, code 999. It is not necessary to calculated the IPI score from other information in the record.

Code	Description
000	None
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

CS SITE-SPECIFIC FACTOR 4

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2910

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites use *Site-Specific Factor 4* to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and Neck*	Levels IV-V, Lymph Nodes of Head and Neck
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Lactate Dehydrogenase (LDH)
Breast	Immunohistochemistry (IHC) of Regional Lymph Nodes
Prostate	Prostate Apex Involvement**
Testis	Radical Orchiectomy Performed

* Refer to Section One for a list of head and neck schemas.
** Prior to version 01.02.00, Prostatic Acid Phosphatase

- Code 000 when there is a statement in the record that a test was not performed.
- Code 999 if there is no report of a lab test in the health record.

Code	Description
000	None
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

CS SITE-SPECIFIC FACTOR 5

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2920

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites use *Site-Specific Factor 5* to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and Neck*	Levels VI-VIII, Lymph Nodes of Head and Neck
Breast	Molecular Studies of Regional Lymph Nodes
Prostate	Gleason Primary Pattern and Secondary Pattern Value
Testis	Size of Metastasis in Lymph Nodes

*Refer to Section One for a list of head and neck schemas.

- Code 000 when there is a statement in the record that a test was not performed.
- Code 999 if there is no report of a lab test in the health record.

Code	Description
000	None
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

CS SITE-SPECIFIC FACTOR 6

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2930

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites use *Site-Specific Factor 6* to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	**Factor**
Head and Neck*	Parapharyngeal, Parotid, Preauricular, and Sub-Occipital Lymph Nodes, Lymph Nodes for Head and Neck
Breast	Size of Tumor--Invasive Component
Prostate	Gleason Score

*Refer to Section One for a list of head and neck schemas.

- Code 000 when there is a statement in the record that a test was not performed.
- Code 999 if there is no report of a lab test in the health record.

Code	Description	TNM Mapping	SS77 Mapping	SS2000 Mapping
000	None			
	SITE/HISTOLOGY-SPECIFIC CODES			
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record			

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

DERIVED AJCC T

Item Length: 2
NAACCR Item #2940

Description
This item is the derived AJCC "T" staging element from coded fields using the CS algorithm.

Rationale
Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive "best stage" for the major staging systems in current use. Derived AJCC T can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- The display string is the corresponding label that is displayed on the screen or in reports. The meaning of these display strings will be clear to the registrar or physician user.
- Refer to the applicable *AJCC Cancer Staging Manual* "T" descriptions.

T Storage Code	Display String
99	TX
90	T0
01	Ta
05	Tis
06	Tispu
07	Tispd
10	T1
11	T1mic
19	T1NOS
12	T1a
13	T1a1
14	T1a2
15	T1b
16	T1b1
17	T1b2
18	T1c
20	T2

T Storage Code	Display String
29	T2NOS
21	T2a
22	T2b
23	T2c
30	T3
39	T3NOS
31	T3a
32	T3b
33	T3c
40	T4
49	T4NOS
41	T4a
42	T4b
43	T4c
44	T4d
88	NA

DERIVED AJCC T DESCRIPTOR

Item Length: 1
NAACCR Item #2950

Description
This item is the derived AJCC "T Descriptor" from coded fields using the CS algorithm.

Rationale
Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive "best stage" for the major staging systems in current use. The Derived AJCC T Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- For those cases in which classification is performed during or following initial multimodality therapy, the category is identified by a "y prefix" to be derived from the computerized algorithm.
- Refer to the applicable *AJCC Cancer Staging Manual* for prefix definitions.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Surgical resection performed **after** pre-surgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC N

Item Length: 2
NAACCR Item #2960

Description
This item is the derived AJCC "N" staging element from coded fields using the CS algorithm.

Rationale
Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive "best stage" for the major staging systems in current use. Derived AJCC N can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- The display string is the corresponding label that is displayed on the screen or in reports. The meaning of these display strings will be clear to the registrar or physician user.
- Refer to the applicable *AJCC Cancer Staging Manual* for "N" descriptions.

N Storage Code	Display String
99	NX
00	N0
09	N0NOS
01	N0(i-)
02	N0(i+)
03	N0(mol-)
04	N0(mol+)
10	N1
19	N1NOS
11	N1a
12	N1b
13	N1c

N Storage Code	Display String
18	N1mi
20	N2
29	N2NOS
21	N2a
22	N2b
23	N2c
30	N3
39	N3NOS
31	N3a
32	N3b
33	N3c
88	NA

DERIVED AJCC N DESCRIPTOR

Item Length: 1
NAACCR Item #2970

Description
This item is the derived AJCC "N Descriptor" from coded fields using the CS algorithm.

Rationale
Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive "best stage" for the major staging systems in current use. The Derived AJCC N Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- For those cases in which classification is performed during or following initial multimodality therapy, the category is identified by a "y prefix" to be derived from the computerized algorithm.
- Refer to the applicable *AJCC Cancer Staging Manual* for prefix definitions.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Lymph nodes removed for examination **after** pre-surgical systemic treatment or radiation and lymph node evaluation based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC M

Item Length: 2
NAACCR Item #2980

Description
This item is the derived AJCC "M" staging element from coded fields using the CS algorithm.

Rationale
Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive "best stage" for the major staging systems in current use. Derived AJCC M can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- The display string is the corresponding label that is displayed on the screen or in reports. The meaning of these display strings will be clear to the registrar or physician user.
- Refer to the applicable *AJCC Cancer Staging Manual* for "M" descriptions.

M Storage Code	Display String
99	MX
00	M0
10	M1
11	M1a
12	M1b
13	M1c
19	M1NOS
88	NA

DERIVED AJCC M DESCRIPTOR

Item Length: 1
NAACCR Item #2990

Description
This item is the derived AJCC "M Descriptor" from coded fields using the CS algorithm.

Rationale
Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive "best stage" for the major staging systems in current use. The Derived AJCC M Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- For those cases in which classification is performed during or following initial multimodality therapy, the category is identified by a "y prefix" to be derived from the computerized algorithm.
- Refer to the applicable *AJCC Cancer Staging Manual* for prefix definitions.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Pathologic examination of metastatic tissue performed **after** pre-surgical systemic treatment or radiation and extension based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC STAGE GROUP

Item Length: 2
NAACCR Item #3000

Description
This item is the derived AJCC "Stage Group" from the detailed site-specific codes using the CS from the CS algorithm.

Rationale
Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive "best stage" for the major staging systems in current use. Derived AJCC Stage Group can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
Refer to the applicable *AJCC Cancer Staging Manual* for "Stage Group" descriptions.

AJCC Storage Code	Display String
00	0
01	0a
02	0is
10	I
11	INOS
12	IA
13	IA1
14	IA2
15	IB
16	IB1
17	IB2
18	IC
19	IS
23	ISA
24	ISB
20	IEA
21	IEB
22	IE
30	II
31	IINOS
32	IIA

AJCC Storage Code	Display String
33	IIB
34	IIC
35	IIEA
36	IIEB
37	IIE
38	IISA
39	IISB
40	IIS
41	IIESA
42	IIESB
43	IIES
50	III
51	IIINOS
52	IIIA
53	IIIB
54	IIIC
55	IIIEA
56	IIIEB
57	IIIE
58	IIISA
59	IIISB

AJCC Storage Code	Display String
60	IIIS
61	IIIESA
62	IIIESB
63	IIIES
70	IV
71	IVNOS
72	IVA
73	IVB
74	IVC
88	NA
90	OCCULT
99	UNK

DERIVED SS1977

Item Length: 1
Allowable Values: 0–5, 7, 9
NAACCR Item #3010

Description
This item is the derived "SEER Summary Stage 1977" from the CS algorithm.

Rationale
Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive "best stage" for the major staging systems in current use. Derived SS1977 can be used to evaluate patterns of disease spread at diagnosis, track treatment patterns, and analyze outcomes.

Instructions for Coding
Refer to the *SEER Summary Staging Manual, 1977* for site-specific categories.

Code	Description
0	In situ
1	Localized
2	Regional, direct extension only.
3	Regional, regional lymph nodes only.
4	Regional, direct extension and regional lymph nodes.
5	Regional, NOS.
7	Distant metastases/systemic disease.
9	Unstaged, unknown, or unspecified.
(leave blank)	Not derived.

DERIVED SS2000

Item Length: 1
Allowable Values: 0–5, 7, 9
NAACCR Item #3020

Description
This item is the derived "SEER Summary Stage 2000" from the CS algorithm.

Rationale
Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive "best stage" for the major staging systems in current use. Derived SS2000 can be used to evaluate patterns of disease spread at diagnosis, track treatment patterns, and analyze outcomes.

Instructions for Coding
Refer to the *SEER Summary Staging Manual, 2000* for site-specific categories.

Code	Description
0	In situ
1	Localized
2	Regional, direct extension only.
3	Regional, regional lymph nodes only.
4	Regional, direct extension and regional lymph nodes.
5	Regional, NOS.
7	Distant metastases/systemic disease.
9	Unstaged, unknown, or unspecified.
(leave blank)	Not derived.

First Course of Treatment

DATE OF FIRST COURSE OF TREATMENT

Item Length: 8
NAACCR Item #1270

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 dates if no treatment was given. Therefore, providing information about those instances in which a physician decides not to treat a patient or a patient's family or guardian declines treatment is important.

Instructions for Coding
- Record the earliest of the following dates: *Date of First Surgical Procedure* (NAACCR Item #1200), *Date Radiation Started* (NAACCR Item #1210), *Date Systemic Therapy Started* (NAACCR Item #3230), or *Date Other Treatment Started* (NAACCR Item #1250).
- In cases of nontreatment, 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.

Code	Definition
MMDDCCYY	The date of first course of treatment is the month, day, and year (MMDDCCYY) of the beginning of treatment (surgery, radiation, systemic, or other therapy) at any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	Diagnosed at autopsy.
99999999	When it is unknown whether any treatment was administered to the patient, the date is unknown, or the case was identified by death certificate only.

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

Examples:

Code	Reason
02142004	If a patient has an incisional, core, or fine needle biopsy on February 12, 2004 and subsequently undergoes an excisional biopsy or radical surgical procedure on February 14, 2004, then record the date of the excisional biopsy or radical surgery (February 14, 2004) as the date of first course of treatment. *Note:* If a biopsy is not stated to be excisional, but no residual cancer was found at a later resection, assume the biopsy was excisional. Do not record the date of incisional, core, or fine needle biopsies as the date of first course of treatment.
08112003	If a patient has an excisional biopsy on August 11, 2003 followed by a radical surgical procedure on September 18, 2003, then record the date of the excisional biopsy (August 11, 2003) as the date of first course of treatment.
12072010	If a patient has a surgical excision on December 7, 2010 and subsequently undergoes a radical surgical procedure on December 19, 2010, then record the date of the first surgical excision (December 7, 2010) as the date of first course of treatment.
04212005	If a patient begins receiving preoperative radiation therapy on April 21, 2005 and subsequent surgical therapy on June 2, 2005, then record the date of the preoperative radiation therapy (April 21, 2005) as the date of first course of treatment.
01992003	If a patient is diagnosed with cancer at your facility and receives radiation therapy in January 2003 at another facility before returning for surgery on February 2, 2003 at your facility, then record the date of the radiation therapy (January 2003) as the date of first course of treatment. Since the exact day of treatment is unknown or unavailable, use code 99.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description “Spring,” 2003.
07992003	If information is limited to the description “The middle of the year,” 2003.
10992003	If information is limited to the description “Fall,” 2003.
12992003 or 01992004	If information is limited to the description “Winter.” Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

DATE OF FIRST SURGICAL PROCEDURE

Item Length: 8
NAACCR Item #1200

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.

Instructions for Coding
- Record the date of the first surgical procedure of the types coded as *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Surgical Procedure/Other Site* (NAACCR Item #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* (NAACCR Item #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* (NAACCR Item #1270).

Code	Definition
MMDDCCYY	The date of first surgical procedure is the month, day, and year (MMDDCCYY) of the procedure at this or any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	When no surgical procedure was performed. Diagnosed at autopsy.
99999999	When it is unknown whether a surgical procedure was performed, the date is unknown, or the case was identified by death certificate only.

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

Examples:

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

DATE OF MOST DEFINITIVE SURGICAL RESECTION OF THE PRIMARY SITE

Item Length: 8
NAACCR Item #3170

Description
Records the date of the most definitive surgical resection 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* (NAACCR Item #3180) to calculate the duration of hospitalization following the most definitive primary site surgical procedure. This can then be used to evaluate treatment efficacy.

Instructions for Coding
- Record the date on which the surgery described by *Surgical Procedure of Primary Site* (NAACCR Item #1290) was performed at this or any facility.
- Code 00000000 if *Surgical Procedure of Primary Site* (NAACCR Item #1290) is 00 or 98.
- Code 99999999 if *Surgical Procedure of Primary Site* (NAACCR Item #1290) is 99.
- The date in this item may be the same as that in *Date of First Surgical Procedure* (NAACCR Item #1200), if the patient received only one surgical procedure and it was a resection of the primary site.

Code	Definition
MMDDCCYY	The date of the most definitive surgical resection is the month, day, and year that procedure was performed at this or any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	When no surgical resection of the primary site was performed. Diagnosed at autopsy.
99999999	When it is unknown if any surgical procedure of the primary site was performed, the date is unknown, or the case was identified by death certificate only.

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

Examples:

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

SURGICAL PROCEDURE OF PRIMARY SITE

Item Length: 2
Allowable Values: 00, 10–80, 90, 98, 99
L/R Justified, Zero-filled
NAACCR Item #1290

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.

Instructions for Coding
- 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.
- Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in this item.
- 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.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* (NAACCR Item #3270).
- 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.
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: 2
Allowable Values: 00, 10–80, 90, 98, 99
L/R Justified, Zero-filled
NAACCR Item #670

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.

Instructions for Coding
- 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.
- Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in this item.
- 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.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care at This Facility* (NAACCR Item #3280).

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.
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 MARGINS OF THE PRIMARY SITE

Item Length: 1
Allowable Values: 0–3, 7–9
NAACCR Item #1320

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.

Instructions for Coding
- 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.
- If no surgery of the primary site was performed, code 8.
- For lymphomas (M-9590–9596, 9650–9719, 9727–9729) 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-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980-9989), 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: 1
Allowable Values: 0–7, 9
NAACCR Item #1292

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.

Instructions for Coding
- 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* (NAACCR Item #1270) and/or *Date of First Surgical Procedure* (NAACCR Item #1200) as appropriate.
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- 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), code 9.
- For lymphomas (M-9590–9596, 9650–9719, 9727–9729) 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-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989), 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* (NAACCR Item #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* (NAACCR Item #3270).

Code	Label	Definition
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease.
2	Sentinel lymph node biopsy	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel node biopsy.
4	1–3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.

Code	Label	Definition
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery 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.

Examples:

Code	Reason
0	There was an attempt at regional lymph node dissection or 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 of right axilla, followed by right axillary lymph node dissection during the same surgical event.
9	**(C34.9-Lung)** Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of surgery in patient record.

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.*

SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #672

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.

Instructions for Coding
- 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* (NAACCR Item #1270) and/or *Date of First Surgical Procedure* (NAACCR Item #1200) as appropriate.
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- 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), code 9.
- For lymphomas (M-9590–9596, 9650–9719, 9727–9729) 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-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989), 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* (NAACCR Item #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* (NAACCR Item #3280).

Code	Label	Definition
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease.
2	Sentinel lymph node biopsy	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel node biopsy.
4	1–3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.

Code	Label	Definition
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery 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.

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*.

SURGICAL PROCEDURE/OTHER SITE

Item Length: 1
Allowable Values: 0–5, 9
NAACCR Item #1294

Description
Records the surgical removal of *distant lymph nodes* or other tissue(s)/organ(s) beyond the primary site.

Rationale
The removal of nonprimary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Instructions for Coding
- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s)* and/or regional/distant tissue or organs.
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site."
- 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-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989).
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* (NAACCR Item #3270).

Code	Label	Definition
0	None	No surgical procedure of nonprimary site was performed. Diagnosed at autopsy.
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	Nonprimary surgical procedure to other regional sites	Resection of regional site.
3	Nonprimary surgical procedure to *distant lymph node(s)*	Resection of *distant lymph node(s)*.
4	Nonprimary 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 biopsy 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: 1
Allowable Values: 0–5, 9
NAACCR Item #674

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 nonprimary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Instructions for Coding
- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s)* and/or regional/distant tissue or organs.
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site."
- 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-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989).
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care at This Facility* (NAACCR Item #3280).

Code	Label	Definition
0	None	No nonprimary surgical site resection was performed. Diagnosed at autopsy.
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	Nonprimary surgical procedure to other regional sites	Resection of regional site.
3	Nonprimary surgical procedure to *distant lymph node(s)*	Resection of *distant lymph node(s)*.
4	Nonprimary 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.

DATE OF SURGICAL DISCHARGE

Item Length: 8
NAACCR Item #3180

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* (NAACCR Item #1290), and *Date of Most Definitive Surgical Resection* (NAACCR Item #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* (NAACCR Item #3170), will allow for the calculation of a patient's length of hospitalization associated with primary site surgery.

Instructions for Coding

- Record the date the patient was discharged from the hospital following the event recorded in *Surgical Procedure of Primary Site* (NAACCR Item #1290).
- If the patient died following the event recorded in *Surgical Procedure of Primary Site* (NAACCR Item #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* (NAACCR Item #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* (NAACCR Item #3170).

Code	Definition
MMDDCCYY	The date of surgical discharge is the month, day, and year that the patient was discharged from the hospital following surgical treatment. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	When no surgical treatment of the primary site was performed. Diagnosed at autopsy.
99999999	When it is unknown whether surgical treatment was performed, the date is unknown, or the case was identified by death certificate only.

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

Examples:

Code	Reason
00000000	A patient is not a surgical candidate, but received inpatient radiation therapy.
07022003	A patient undergoes surgery of the primary site on June 29, 2003, and is discharged from the hospital on July 2, 2003.
09992003	If the exact date on which the patient was discharged is not available, then record an approximate date. For example, September 2003.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description “Spring,” 2003.
07992003	If information is limited to the description “The middle of the year,” 2003.
10992003	If information is limited to the description “Fall,” 2003.
12992003 or 01992004	If information is limited to the description “Winter.” Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

READMISSION TO THE SAME HOSPITAL WITHIN 30 DAYS OF SURGICAL DISCHARGE

Item Length: 1
Allowable Values: 0–3, 9
NAACCR Item #3190

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.

Instructions for Coding
- 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* (NAACCR Item #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* (NAACCR Item # 3110, 3120, 3130, 3140, 3150, 3160).
- 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	Definition
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: 1
Allowable Values: 0–2, 5–9
NAACCR Item #1340

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.

Instructions for Coding
- If *Surgical Procedure of Primary Site* (NAACCR Item #1290) is coded 00, then record the reason based on documentation in the patient record.
- Code 1 if the treatment plan offered multiple 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* (NAACCR Item #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.
- 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	Definition
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.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, 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. Diagnosed at autopsy or 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.

DATE RADIATION STARTED

Item Length: 8
NAACCR Item #1210

Description
Records the date on which radiation therapy 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 pathologic stage information.

Instructions for 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* (NAACCR Item #1270).
- The date when treatment started will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- Code 88888888 if radiation therapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.
- 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	Description
MMDDCCYY	The month, day, and year (MMDDCCYY) that the first course of radiation therapy began at any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	No radiation therapy administered. Diagnosed at autopsy.
88888888	When 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. The date should be revised at the next follow-up.
99999999	When it is unknown whether any radiation therapy was administered, the date is unknown, or the case was identified by death certificate only.

Month		Day		Year	
00		00		0000	
01	January	01		Use four-digit year	
02	February	02		8888	
03	March	03		9999	Year unknown
04	April	...			
05	May	...			
06	June	30			
07	July	31			
08	August	88			
09	September	99	Day unknown		
10	October				
11	November				
12	December				
88					
99	Month unknown				

Examples:

Code	Reason
12152003	A patient has external beam radiation on December 15, 2003.
10122003	A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on October 12, 2003.
06022003	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. Record the first date of radiation, regardless of the location of treatment.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description “Spring,” 2003.
07992003	If information is limited to the description “The middle of the year,” 2003.
10992003	If information is limited to the description “Fall,” 2003.
12992003 or 01992004	If information is limited to the description “Winter.” Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

LOCATION OF RADIATION TREATMENT

Item Length: 1
Allowable Values: 0–4, 8, 9
NAACCR Item #1550

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.

Instructions for 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* (NAACCR Item #3270) and/or *Palliative Care at This Facility* (NAACCR Item #3280), as appropriate.

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.
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; it is unknown whether radiation therapy was administered. 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.

RADIATION TREATMENT VOLUME

Item Length: 2
Allowable Values: 00–41, 50, 60, 98, 99
NAACCR Item #1540

Description
Identifies the volume or anatomic target of the most clinically significant regional radiation therapy delivered to the patient during the first course of treatment.

Rationale
This data item provides information describing the anatomical structures targeted by the regional radiation therapy 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 (local analysis of physician practices) and on a regional or national basis.

Instructions for Coding
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.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	Eye/orbit	The radiation therapy target volume is limited to the eye and/or orbit.
02	Pituitary	The target volume is restricted to the pituitary gland and all adjacent volumes are irradiated incidentally.
03	Brain (NOS)	Treatment is directed at tumors lying within the substance of the brain, or its meninges.
04	Brain (limited)	The treatment volume encompasses less than the total brain, or less than all of the meninges.
05	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the oropharyngeal complex, usually encompassing regional lymph nodes.
06	Head and neck (limited)	Limited volume treatment of a head and neck primary with the exception of glottis (code 7), sinuses (code 8), or parotid (code 9).
07	Glottis	Treatment is limited to a volume in the immediate neighborhood of the vocal cords.
08	Sinuses	The primary target is one or both of the maxillary sinuses or the ethmoidal frontal sinuses. In some cases, the adjacent lymph node regions my be irradiated.
09	Parotid	The primary target is one of the parotid glands. There may be secondary regional lymph node irradiation as well.
10	Chest/lung (NOS)	Radiation therapy is directed to some combination of hilar, mediastinal, and/or supraclavicular lymph nodes, and/or peripheral lung structures.
11	Lung (limited)	Radiation therapy is directed at one region of the lung without nodal irradiation.
12	Esophagus	The primary target is some portion of the esophagus. Regional lymph nodes may or may not be included in the treatment. Include tumors of the gastroesophageal junction.

Code	Label	Definition
13	Stomach	The primary malignancy is in the stomach. Radiation is directed to the stomach and possibly adjacent lymph nodes.
14	Liver	The primary target is all or a portion of the liver, for either primary or metastatic disease.
15	Pancreas	The primary tumor is in the pancreas. The treatment field encompasses the pancreas and possibly adjacent lymph node regions.
16	Kidney	The target is primary or metastatic disease in the kidney or the kidney bed after resection of a primary kidney tumor. Adjacent lymph node regions may be included in the field.
17	Abdomen (NOS)	Include all treatment of abdominal contents that do not fit codes 12–16.
18	Breast	The primary target is the intact breast and no attempt has been made to irradiate the regional lymph nodes. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy (C50.0–C50.9, Surgical Procedure of Primary Site [NAACCR Item #1290] codes 0–24).
19	Breast/lymph nodes	A deliberate attempt has been made to include regional lymph nodes in the treatment of an intact breast. See definition of intact breast above.
20	Chest wall	Treatment encompasses the chest wall (following mastectomy).
21	Chest wall/lymph nodes	Treatment encompasses the chest wall (following mastectomy) plus fields directed at regional lymph nodes.
22	Mantle, Mini-mantle	Treatment consists of a large radiation field designed to encompass all of the regional lymph nodes above the diaphragm, including cervical, supraclavicular, axillary, mediastinal, and hilar nodes (mantle), or most of them (mini-mantle). This code is used exclusively for patients with Hodgkin's or non-Hodgkin's lymphoma.
23	Lower extended field	The target zone includes lymph nodes below the diaphragm along the paraaortic chain. It may include extension to one side of the pelvis. This code includes the "hockey stick" field utilized to treat seminomas.
24	Spine	The primary target relates to the bones of the spine, including the sacrum. Spinal cord malignancies should be coded 40 (Spinal cord).
25	Skull	Treatment is directed at the bones of the skull. Any brain irradiation is a secondary consequence.
26	Ribs	Treatment is directed toward metastatic disease in one or more ribs. Fields may be tangential or direct.
27	Hip	The target includes the proximal femur for metastatic disease. In may cases there may be acetabular disease as well.
28	Pelvic bones	The target includes structures of the bones of the pelvis other than the hip or sacrum.
29	Pelvis (NOS)	Irradiation is directed at soft tissues within the pelvic region and codes 34–36 do not apply.
30	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 31 (Soft tissue).

Code	Label	Definition
31	Soft tissue	All treatment of primary or metastatic soft tissue malignancies not fitting other categories.
32	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.
33	Whole body	Entire body included in a single treatment.
34	Bladder and pelvis	The primary malignancy originated in the bladder, all or most of the pelvis is treated as part of the plan, typically with a boost to the bladder.
35	Prostate and pelvis	The primary malignancy originated in the prostate, all or most of the pelvis is treated as part of the plan, typically with a boost to the prostate.
36	Uterus and cervix	Treatment is confined to the uterus and cervix or vaginal cuff, usually by intracavitary or interstitial technique. If entire pelvis is included in a portion of the treatment, then code 29 (Pelvis, NOS).
37	Shoulder	Treatment is directed to the proximal humerus, scapula, clavicle, or other components of the shoulder complex. This is usually administered for control of symptoms for metastases.
38	Extremity bone, NOS	Bones of the arms or legs. This excludes the proximal femur, code 27 (Hip). This excludes the proximal humerus, code 37 (Shoulder).
39	Inverted Y	Treatment has been given to a field that encompasses the paraaortic and bilateral inguinal or inguinofemoral lymph nodes in a single port.
40	Spinal cord	Treatment is directed at the spinal cord or its meninges.
41	Prostate	Treatment is directed at the prostate with or without the seminal vesicles, without regional lymph node treatment.
50	Thyroid	Treatment is directed at the thyroid gland.
60	Lymph node region, NOS	The target is a group of lymph nodes not listed above. Examples include isolated treatment of a cervical, supraclavicular, or inguinofemoral region.
98	Other	Radiation therapy administered, treatment volume other than those previously categorized.
99	Unknown	Radiation therapy administered, treatment volume unknown or not stated in patient record; it is unknown whether radiation therapy was administered. Death certificate only.

Examples:

Code	Reason
01	Lymphoma of the orbit treated with 4 cm x 4 cm portals.
02	Pituitary adenomas receiving small opposed field or rotational treatment.
03	The entire brain is treated for metastatic disease.

Code	Reason
04	Limited field irradiation of an oligodendroglioma or glioblastoma.
05	Carcinoma of the left tonsil treated with opposed lateral fields to the neck and an anterior supraclavicular field.
06	Interstitial implant utilized to treat a small carcinoma of the lateral tongue.
07	Small lateral fields utilized to treat a T1 or T2 glottic tumor.
11	Small portal treatment is delivered to the right bronchial/hilar region to stop hemoptysis.
17	Irradiation for hypersplenism due to lymphoma.
19	Tangential fields deliberately arranged in a manner that will encompass internal mammary lymph nodes in a patient with a medial primary; breast tangential fields plus supraclavicular and/or axillary field in a patient with five positive lymph nodes.
20	Following mastectomy, a patient has prophylactic chest wall irradiation to prevent local recurrence; a thoracotomy scar is irradiated because of known contamination with tumor.
24	An inverted “T” field is utilized to treat painful metastases in the lumbar vertebrae and sacrum in a patient with prostate cancer.
25	Patient with myeloma receives total skull irradiation for numerous “punched out” lesions that are causing discomfort.
33	Patient with chronic lymphocytic leukemia receives five treatments of 10 cGy each to reduce adenopathy or lymphocyte count.
36	Patient receives intracavitary therapy alone for a high-grade Stage IA carcinoma of the endometrium.
38	The distal forearm is treated for a metastatic lesion involving the radius.
39	Stage IA Hodgkin’s disease presenting in an inguinal lymph node.
40	A portion of the spinal cord is treated for a primary ependymoma.
60	Ovarian carcinoma presenting with left supraclavicular lymphadenopathy as the only documented site of metastatic disease. The supraclavicular region is treated to prevent neurologic complications.
98	Anterior neck is treated for a primary thyroid lymphoma.

REGIONAL TREATMENT MODALITY

Item Length: 2
Allowable Values: 00, 20–32, 40–43, 50–55, 60–62, 98, 99
NAACCR Item #1570

Description
Records the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment.

Rationale
Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Instructions for Coding
- 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 regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.
- Note that in some circumstances the boost treatment may precede the regional treatment.
- For purposes of this data item, photons and x-rays are equivalent.
- Code IMRT or conformal 3D whenever either is explicitly mentioned.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt- 60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2–5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.
24	Photons (6–10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.
25	Photons (11–19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.

Code	Label	Definition
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, HDR	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
80*	Combination modality, specified*	Combination of external beam radiation and either radioactive implants or radioisotopes*
85*	Combination modality, NOS*	Combination of radiation treatment modalities not specified in code 80.*
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.

Examples:

Code	Reason
20	A patient with prostate carcinoma receives pelvic irradiation at the reporting facility, and is then referred to a major medical center for experimental proton therapy boost.
24	A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days. This is followed by 6 MV photon treatment of the entire breast. In this case, the "boost" precedes the regional treatment.
25	In an experimental program, a patient with as Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.
25	Patient receives 15 MV external pelvic treatment to 4,500 cGy for cervical carcinoma, and then receives two Fletcher intracavitary implants.
29	A patient with carcinoma of the parotid receives daily treatments of which 60% are delivered by 15 MV photons and 40% of the dose is delivered by 16 MV electrons.
99	A patient with a head and neck cancer was referred from another facility for an HDR brachytherapy boost. Detailed treatment records from the other facility are not available.

****Note:*** For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to *Vol. II, ROADS*, and *DAM* rules and **should not** be used to record regional radiation for cases diagnosed on or later than January 1, 2003.

REGIONAL DOSE: cGy

Item Length: 5
Right Justified, Zero-filled
NAACCR Item #1510

Description
Records the dominant or most clinically significant total dose of regional radiation therapy delivered to the patient during the first course of treatment. The unit of measure is centiGray (cGy).

Rationale
To evaluate patterns of radiation oncology care, it is necessary to capture information describing the prescribed regional radiation dose. Outcomes are strongly related to the dose delivered.

Instructions for Coding
- 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 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.
- Regional dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the total dose of regional radiation therapy may require assistance from the radiation oncologist for consistent coding.
- Do not include the boost dose, if one was administered.
- Code 88888 when brachytherapy or radioisotopes—codes 50–62 for *Regional Treatment Modality* (NAACCR Item #1570)—were administered to the patient.
- Note that dose is still occasionally specified in "rads." One rad is equivalent to one centiGray (cGy).

Code	Definition
(fill spaces)	Record the actual regional dose delivered.
00000	Radiation therapy was not administered. Diagnosed at autopsy.
88888	Not applicable, brachytherapy or radioisotopes administered to the patient.
99999	Regional radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered. Death certificate only.

Examples:

Code	Reason
05000	A patient with Stage III prostate carcinoma received pelvic irradiation to 5,000 cGy followed by a prostate boost to 7,000 cGy. Record the regional dose as 5,000 cGy.
06000	A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region. The dose is calculated at a prescribed depth of 3 cm. A secondary calculation shows a D_{max} dose of 6,450 cGy. Record the regional dose reflecting the prescribed dose of 6,000 cGy.
05500	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 lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm, and an interstitial boost in the primary tumor bed is delivered to a small volume in the breast. Record the primary target of the breast as 5,500cGy.

BOOST TREATMENT MODALITY

Item Length: 2
Allowable Values: 00, 20–32, 40–43, 50–55, 60–62, 98, 99
NAACCR Item #3200

Description
Records the dominant modality of radiation therapy used to deliver the most clinically significant boost dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or IMRT. External beam boosts may consist of two or more successive phases with progressively smaller fields generally coded as a single entity.

Rationale
Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Instructions for Coding
- Radiation boost treatment modalities will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- In the event that multiple radiation therapy boost modalities were employed during the treatment of the patient, record only the dominant modality.
- Note that in some circumstances, the boost treatment may precede the regional treatment.
- For purposes of this field, photons and x-rays are equivalent.

Code	Label	Definition
00	No boost treatment	A boost dose was not administered to the patient. Diagnosed at autopsy.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2–5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.
24	Photons (6–10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.
25	Photons (11–19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.

Code	Label	Definition
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, HDR	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered. Death certificate only.

Examples:

Code	Reason
29	A patient with carcinoma of the tonsil receives 4,500 cGy to the head and neck region with 6 MV photons. The primary site and involved regional lymph nodes are then boosted, ie, taken to a maximum dose of 7,400 cGy, using a sequence of beam arrangements involving 6 MV photons, 15 MV photons, and 12 MV electrons.

Code	Reason
30	In an experimental program, a patient with Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.
40	A patient with prostate carcinoma receives pelvic irradiation at the reporting facility and is referred to a major medical center for experimental proton therapy boost.
51	A patient receives external pelvic treatment to 4,500 cGy for cervical carcinoma, then receives two Fletcher intracavitary implants as boost treatment.
55	A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days.
99	A patient with a head and neck cancer is referred to another institution for an HDR brachytherapy boost. Detailed treatment records from the other institution are not available.

BOOST DOSE: cGy

Item Length: 5
Right Justified, Zero-filled
NAACCR Item #3210

Description
Records the additional dose delivered to that part of the treatment volume encompassed by the boost fields or devices. The unit of measure is centiGray (cGy).

Rationale
To evaluate patterns of radiation oncology care, it is necessary to capture information describing the prescribed boost radiation dose. Outcomes are strongly related to the dose delivered.

Instructions for Coding
- 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 dose as indicated in the summary chart. Consult the radiation oncologist for the exact dose, if necessary.
- Radiation boost treatment dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the additional boost dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- Do not include the regional dose. In general, the boost dose will be calculated as the difference between the maximum prescribed dose and the regional dose. Many patients will not have a boost.
- Code 88888 when brachytherapy or radioisotopes—codes 50–62 for *Boost Treatment Modality* (NAACCR Item #3200)—were administered to the patient.
- Note that dose is still occasionally specified in "rads." One rad is equivalent to one centiGray (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	Definition
(fill spaces)	Record the actual boost dose delivered.
00000	Boost dose therapy was not administered. Diagnosed at autopsy.
88888	Not applicable, brachytherapy or radioisotopes administered to the patient.
99999	Boost radiation therapy was administered, but the dose is unknown. Death certificate only.

Examples:

Code	Reason
02000	A patient with Stage III prostate carcinoma receives pelvic irradiation to 5,000 cGy followed by a conformal prostate boost to 7,000 cGy. Record the prescribed (and delivered) boost dose, 2,000 cGy (7,000 cGy minus 5,000 cGy).
00000	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 boost doses. In this case, there is no planned boost. Record the boost dose as 00000 cGy.
88888	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. The supraclavicular lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm, and an interstitial boost in the primary tumor bed is delivered to a small volume in the breast. Record the boost dose as 88888**.** Note that standards for describing an interstitial or intracavitary treatment with a single number are somewhat variable.

NUMBER OF TREATMENTS TO THIS VOLUME

Item Length: 2
Allowable Values: 00–99
Right Justified, Zero-filled
NAACCR Item #1520

Description
Records the total number of treatment sessions (fractions) administered during the first course of treatment.

Rationale
This data item is used to evaluate patterns of radiation therapy and the treatment schedules.

Instructions for Coding
- The number of treatments or fractions 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.
- Although a 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.
- The total number of treatment sessions (fractions) is the sum of the number of fractions of regional treatment and the number of fractions of boost treatment.
- Count brachytherapy or implants as a single treatment or fraction.

Code	Label	Definition
00	None	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01–98	Number of treatments	Total number of treatment sessions administered to the patient.
99	Unknown	Radiation therapy was administered, but the number of treatments is unknown. Or, it is unknown whether radiation therapy was administered. Death certificate only.

Examples:

Code	Reason
25	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 treatment portals. Twenty-five treatment sessions were given. Record 25 treatments.
35	A patient with Stage IIIB bronchogenic carcinoma received 25 treatments to the left hilum and mediastinum, given in 25 daily treatments over five weeks. A left hilar boost was then given in 10 additional treatments. Record 35 treatments.
50	A patient with advanced 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. Record 50 treatments.

RADIATION/SURGERY SEQUENCE

Item Length: 1
Allowable Values: 0, 2–6, 9
NAACCR Item #1380

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.

Instructions for Coding
- Surgical procedures include *Surgical Procedure of Primary Site* (NAACCR Item #1290); *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292); *Surgical Procedure/Other Site* (NAACCR Item #1294). If all of these procedures are coded 0, 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.

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No 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 no reconstructive surgery. Diagnosed at autopsy.
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	Radiation therapy given before and after any surgery to 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).
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).
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. It is unknown is radiation therapy was administered and/or it is unknown if 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. Death certificate only.

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: 8
NAACCR Item #3220

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.

Instructions for Coding
- The date when treatment ended 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.

Code	Definition
MMDDCCYY	The month, day, and year (MMDDCCYY) radiation therapy ended at any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	When no radiation was administered. Diagnosed at autopsy.
88888888	When radiation was administered and was still ongoing at the time of most recent follow-up. The date should be revised at the next follow-up.
99999999	When it is unknown whether any radiation therapy was administered, the date is unknown, or the case was identified by death certificate only.

Month
00
01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December
88
99 Month unknown

Day
00
01
02
03
...
...
30
31
88
99 Day unknown

Year
0000
Use four-digit year
8888
9999 Year unknown

Examples:

Code	Reason
01042005	A patient starts regional radiation treatment on December 15, 2004 and treatment continues until January 4, 2005.
04042006	A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on April 4, 2006.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description “Spring,” 2003.
07992003	If information is limited to the description “The middle of the year,” 2003.
10992003	If information is limited to the description “Fall,” 2003.
12992003 or 01992004	If information is limited to the description “Winter.” Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

REASON FOR NO RADIATION

Item Length: 1
Allowable Values: 0–2, 5–9
NAACCR Item #1430

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.

Instructions for Coding
- If *Regional Treatment Modality* (NAACCR Item #1570) is coded 00, then record the reason based on documentation in patient record.
- Code 1 if the treatment plan offered multiple 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.
- Cases coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple options, but it is unknown which treatment, if any, was provided.

Code	Definition
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, 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.
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 and autopsy cases only.

Example:

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.

DATE SYSTEMIC THERAPY STARTED

Item Length: 8
NAACCR Item #3230

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.

Instructions for Coding
- Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes *Chemotherapy* (NAACCR Item #1390), *Hormone Therapy* (NAACCR Item #1400), *Immunotherapy* (NAACCR Item #1410), and *Hematologic Transplant and Endocrine Procedures* (NAACCR Item #3250).
- Code 88888888 if systemic therapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.

Code	Definition
MMDDCCYY	The date systemic therapy started is the month, day, and year that systemic therapy was first administered. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. If the exact date on which systemic therapy was started is not available, then record an approximate date.
00000000	When no systemic therapy was administered. Diagnosed at autopsy.
88888888	When systemic 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. The date should be revised at the next follow-up.
99999999	When it is unknown if any systemic therapy was administered, the date is unknown, or the case was identified by death certificate only.

Month	Day	Year
00	00	0000
01 January	01	Use four-digit year
02 February	02	8888
03 March	03	9999 Year unknown
04 April	...	
05 May	...	
06 June	30	
07 July	31	
08 August	88	
09 September	99 Day unknown	
10 October		
11 November		
12 December		
88		
99 Month unknown		

Examples:

Code	Reason
12152003	A patient with breast cancer begins her regimen of chemotherapy on December 15, 2003, and is subsequently given tamoxifen on January 20, 2004.
06022003	A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2003. The patient is then started on a regime of hormonal agents on June 9, 2003.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description “Spring,” 2003.
07992003	If information is limited to the description “The middle of the year,” 2003.
10992003	If information is limited to the description “Fall,” 2003.
12992003 or 01992004	If information is limited to the description “Winter.” Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

CHEMOTHERAPY

Item Length: 2
Allowable Values: 00–03, 82, 85–88, 99
NAACCR Item #1390

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.

Instructions for Coding
- 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.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.
- 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 chemotherapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.
- 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.
- 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 *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of chemotherapeutic agents.
- 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* (NAACCR Item #3270).

Code	Definition
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).
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.

Code	Definition
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.
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	Following 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: 2
Allowable Values: 00–03, 82, 85–88, 99
NAACCR Item #700

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.

Instructions for Coding
- 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.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.
- 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 chemotherapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.
- 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.
- 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 *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs*, Third Edition, for a list of chemotherapeutic agents.
- 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* (NAACCR Item #3280).

Code	Definition
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).
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.

Code	Definition
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.
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
(HORMONE/STEROID THERAPY)

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #1400

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.

Instructions for Coding
- 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.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy.
- 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 hormone therapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.
- 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.
- Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, 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* (NAACCR Item #3270).

Code	Definition
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).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.

Code	Definition
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: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #710

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.

Instructions for Coding
- 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.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy.
- 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 hormone therapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.
- 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.
- Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, 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 at This Facility* (NAACCR Item #3280).

Code	Definition
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).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.

Code	Definition
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

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #1410

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.

Instructions for Coding
- 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 options, and the patient selected treatment that did not include immunotherapy.
- 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 immunotherapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.
- 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 *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, 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* (NAACCR Item #3270).

Code	Definition
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.

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: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #720

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 if immunotherapy was not administered.

Instructions for Coding
- 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 options, and the patient selected treatment that did not include immunotherapy.
- 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 immunotherapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.
- 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 *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, 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* (NAACCR Item #3280).

Code	Definition
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: 2
Allowable Values: 00, 10–12, 20, 30, 40, 82, 85–88, 99
NAACCR Item #3250

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.

Instructions for Coding
- 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 effect 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.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.
- 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 hematologic transplant or endocrine procedure was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.
- 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.
- 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* (NAACCR Item #3270) and/or *Palliative Care at This Facility* (NAACCR Item #3280), as appropriate.

Code	Definition
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.
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).
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: 1
Allowable Values: 0, 2–6, 9
NAACCR Item #1639

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.

Instructions for Coding
- *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* (NAACCR Item #1200).
- If none of the following surgical procedures was performed: *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292), *Surgical Procedure/Other Site* (NAACCR Item #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 Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292), or *Surgical Procedure/Other Site* (NAACCR Item #1294), then code this item 2–9, as appropriate.

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. Diagnosed at autopsy.
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	Systemic therapy was given before and after any 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.
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 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.

Code	Label	Definition
9	Sequence unknown	Administration of systemic therapy and 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) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if systemic therapy was administered and/or it is unknown if 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) were performed. Death certificate only.

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 a 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.

DATE OTHER TREATMENT STARTED

Item Length: 8
NAACCR Item #1250

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.

Instructions for Coding
- Other treatment is that which cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.
- 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* (NAACCR Item #1270).

Code	Definition
MMDDCCYY	The month, day, and year other treatment began at any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	When no other treatment was administered. Diagnosed at autopsy.
99999999	When it is unknown if other treatment was administered, the date is unknown, or the case was identified by death certificate only.

Month

00	
01	January
02	February
03	March
04	April
05	May
06	June
07	July
08	August
09	September
10	October
11	November
12	December
99	Month unknown

Day

00	
01	
02	
03	
...	
...	
30	
31	
99	Day unknown

Year

0000	
Use four-digit year	
9999	Year unknown

Examples:

Code	Reason
03162003	A patient with metastatic disease was started on an experimental therapy on March 16, 2003.
06022005	On June 2, 2005, a patient started treatment which cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description “Spring,” 2003.
07992003	If information is limited to the description “The middle of the year,” 2003.
10992003	If information is limited to the description “Fall,” 2003.
12992003 or 01992004	If information is limited to the description “Winter.” Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

OTHER TREATMENT

Item Length: 1
Allowable Values: 0–3, 6–9
NAACCR Item #1420

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.

Instructions for Coding
- Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the ususal definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Such treatments include phlebotomy, transfusions, and aspirin (see Section One), and should be coded 1.
- 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* (NAACCR Item #3270).
- Code 8 if other treatment was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.

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). Use this code for treatment unique to hematopoietic diseases (see Notes below).
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: 1
Allowable Values: 0–3, 6–9
NAACCR Item #730

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.

Instructions for Coding
- Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the ususal definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Such treatments include phlebotomy, transfusions, and aspirin (see Section One), and should be coded 1.
- 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* (NAACCR Item #3280).

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). Use this code for treatment unique to hematopoietic diseases (see Notes below).
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.

PAIN ASSESSMENT

This data item has been removed from FORDS.

PALLIATIVE CARE
(PALLIATIVE PROCEDURE)

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #3270

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.

Instructions for Coding
- 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 secondary malignant tissue.
- Palliative care is not used to diagnose or stage the primary tumor.

Code	Definition
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.

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* (NAACCR Item #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.
1	A thoracentesis is performed to alleviate pressure on the primary site; no cytology was performed on the withdrawn specimen.
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. [XRT and dose recorded in *Regional Treatment Modality* (NAACCR Item #1570) and *Regional Dose:cGy* (NAACCR Item #1510)]
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. [XRT and Dose recorded in *Regional Treatment Modality* (NAACCR Item #1570) and *Regional Dose: cGy* (NAACCR Item #1510)]
3	A patient is given palliative chemotherapy for Stage IIIB lung cancer. [Chemotherapy recorded in *Chemotherapy* (NAACCR Item #1390) and *Chemotherapy at this Facility* (NAACCR Item #700)]
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 referral for pain management. [Surgery recorded in *Surgical Procedure/Other Site* (NAACCR Item #1294) and XRT recorded in *Regional Treatment Modality* (NAACCR Item #1570) and *Regional Dose:cGy* (NAACCR Item #1510)]
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. [XRT and dose recorded in *Regional Treatment Modality* (NAACCR Item #1570) and *Regional Dose:cGy* (NAACCR Item #1510)]
7	A patient enters the facility with a clinical diagnosis of metastatic renal cell carcinoma for noninvasive palliation.
9	A patient enters the facility with a new diagnosis of widely disseminated Stage IV breast cancer, but the patient record does not state whether palliative care was provided.

PALLIATIVE CARE AT THIS FACILITY
(PALLIATIVE PROCEDURE AT THIS FACILITY)

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #3280

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.

Instructions for Coding
- 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.

Code	Definition
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: 8
NAACCR Item #1860

Description
Records the date of the first recurrence only.

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

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

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

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

Examples:

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

TYPE OF FIRST RECURRENCE

Item Length: 2
Allowable Values: 00, 04, 06, 10, 13–17, 20–22, 25–27, 30, 36, 40, 46, 51–59, 60, 62, 70, 88, 99
NAACCR Item #1880

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

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

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

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

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

Examples:

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

DATE OF LAST CONTACT OR DEATH

Item Length: 8
NAACCR #1750

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

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

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

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

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

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

Year
Use four-digit year
9999 Year unknown

Examples:

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

VITAL STATUS

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

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

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

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

Code	Label
0	Dead
1	Alive

Examples:

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

CANCER STATUS

Item Length: 1
Allowable Values: 1, 2, 9
NAACCR Item #1770

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

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

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

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

Examples:

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

FOLLOWING REGISTRY

Item Length: 10
Right Justified, Zero-filled
NAACCR Item #2440

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

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

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

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

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

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

NPI–FOLLOWING REGISTRY

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2445

Description
Records the registry responsible for following the patient.

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

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

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

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

FOLLOW-UP SOURCE

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

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

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

Instructions for Coding

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

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

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

Description
Identifies the method planned for the next follow-up.

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

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

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

Case Administration

ABSTRACTED BY

Item Length: 3
Left Justified
NAACCR Item #570

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.

Instructions for Coding
Code the initials of the abstractor.

Code	Definition
(fill spaces)	Initials or code of abstractor.

FACILITY IDENTIFICATION NUMBER (FIN)

Item Length: 10
Right Justified, Zero-filled
NAACCR Item #540

Description
Identifies the facility reporting the case.

Rationale
Each facility's identification number (FIN) is unique. The number is essential to the National Cancer Data Base (NCDB) for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Instructions for Coding
- *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.

Examples:

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

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

NPI–REPORTING FACILITY

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #545

Description
Identifies the facility submitting the data in the record.

Rationale
Each facility's NPI is unique. The number is essential to the National Cancer Data Base (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* (NAACCR Item #540). Both are required during a period of transition.

Instructions for Coding
- *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.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

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

ARCHIVE FIN

Item Length: 10
Right Justified, Zero-filled
NAACCR Item #3100

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.

Instructions for Coding
- *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* (NAACCR Item #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.
- 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: 10
Allowable Value: Ten digits
NAACCR Item #3105

Description
Identifies the facility that originally accessioned the tumor.

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* (NAACCR Item #3100). Both are required during a period of transition.

Instructions for Coding
- *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.
- For facilities that have not merged, the *NPI–Archive FIN* and the *NPI–Reporting Facility* (NAACCR Item #545) will be the same.
- 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	Definition
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the facility is unknown or not available.

OVERRIDE ACSN/CLASS/SEQ

Item Length: 1
Allowable Values: 1
NAACCR Item #1985

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* = 0, 1, or 6), then the first 4 characters of the *Accession Number* (NAACCR Item #550) must equal the year of the *Date of First Contact* (NAACCR Item #580).
- If the case is first diagnosed at autopsy (*Class of Case* = 5), 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* (NAACCR Item #1750) AND must equal the year of the *Date of First Contact*.
- If the case is first diagnosed at autopsy (*Class of Case* = 5), 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.

Instructions for Coding
- 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	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE HOSPSEQ/DXCONF

Item Length: 1
Allowable Values: 1
NAACCR Item #1986

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* (NAACCR Item #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.

Instructions for Coding
- 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	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE COC—SITE/TYPE

Item Length: 1
Allowable Values: 1
NAACCR Item #1987

Description
Used with the EDITS software to override the edit *Primary Site, Morphology-Type ICDO2 (CoC)* and/or the edit *Primary Site, Morphology-Type 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* (NAACCR Item #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.

Instructions for Coding
- 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 a review of all items in the error or warning message confirms they are correct and coded in conformance with coding rules.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE HOSPSEQ/SITE

Item Length: 1
Allowable Values: 1
NAACCR Item #1988

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.)
- C77.0-C77.9 (lymph nodes) and ICD-O-2 histology not in range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C42.0-C42.4 and ICD-O-2 histology not in range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. (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.

Instructions for Coding
- 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	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE SITE/TNM-STAGE GROUP

Item Length: 1
Allowable Values: 1
NAACCR Item #1989

Description
Used with the EDITS software to override the edit *Primary Site, AJCC Stage Group - Edition 6 (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, *Primary Site, AJCC Stage Group - Edition 6 (CoC)*, checks that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the *AJCC Cancer Staging Manual, Sixth Edition*, using the codes described for the items *Clinical Stage Group* (NAACCR Item # 970) and *Pathologic Stage Group* (NAACCR Item # 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 *Pathologic Stage Group* items. When neither clinical nor pathologic 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.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the edit, *Primary Site, AJCC Stage Group - Edition 6 (CoC)*.
- 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	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE AGE/SITE/MORPH

Item Length: 1
Allowable Values: 1
NAACCR Item #1990

Description
Used with the EDITS software to override the edits *Age, Primary Site, Morphology ICDO2 (SEER IF15); Age, Primary Site, Morphology ICDO3 (SEER IF15); Age, Primary Site, Morph ICDO3–Adult (SEER), and/or Age, Primary Site, Morph ICDO3–Pediatric (NPCR).*

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* require review if a site-morphology combination occurs in an age group for which it is extremely rare:

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.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the *Age, Primary Site, Morphology* 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	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE SURG/DXCONF

Item Length: 1
Allowable Values: 1
NAACCR Item #2020

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 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.

Instructions for Coding
- 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	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE SITE/TYPE

Item Length: 1
Allowable Values: 1
NAACCR Item #2030

Description
Used with the EDITS software to override the edits *Primary Site, Morphology-Type ICDO2 (SEER IF25); Primary Site, Morphology-Type ICDO3 (SEER IF25); Primary Site, Morphology-Type ICDO2 (CoC); and/or Primary Site, Morphology-Type ICDO3 (CoC).*

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* (NAACCR Item #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.

Instructions for Coding
- 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	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE HISTOLOGY

Item Length: 1
Allowable Values: 1, 2, 3
NAACCR Item #2040

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 *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
I. 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. **Note:** 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* (NAACCR Item #523) and *Diagnostic Confirmation* (NAACCR Item #490) have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

II. 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.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the edits of the types, *Diagnostic Confirmation, Morph* or *Morphology–Type/Behavior*.
- 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	Definition
(leave blank)	Not reviewed.
1	Reviewed: allow flag for edits of the type, Morphology–Type/Behavior
2	Reviewed: allow flag for edits of the type, Diagnostic Confirmation, Behavior Code
3	Reviewed: conditions 1 and 2 above both apply.

OVERRIDE LEUK, LYMPHOMA

Item Length: 1
Allowable Values: 1
NAACCR Item #2070

Description
Used with the EDITS software to override the edits *Diagnostic Confirmation, Histology ICDO2 (SEER IF48);* and/or *Diagnostic Confirmation, Histology ICDO3 (SEER IF48).*

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 (NAACCR Item #420) or ICD-O-3 (NAACCR Item #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.
- If histology is 9590–9717 for ICD-O-2 or 9590–9729 for ICD-O-3 (lymphoma), then *Diagnostic Confirmation* (NAACCR Item #490) cannot be 6 (direct visualization) or 8 (clinical).
- If histology is 9720–9941 for ICD-O-2 or 9731–9948 for ICD-O-3 (leukemia and other), then *Diagnostic Confirmation* cannot be 6 (direct visualization).

If an edit of the type, *Diagnostic Confirmation, Histology*, produces and error or warning message, check that the *Histology* and *Diagnostic Confirmation* are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in *Diagnostic Confirmation*) for leukemia.

Instructions for Coding
- 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	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE SITE/BEHAVIOR

Item Length: 1
Allowable Values: 1
NAACCR Item #2071

Description
Used with the EDITS software to override the edits *Primary Site, Behavior Code ICDO2 (SEER IF39); and/or Primary Site, Behavior Code ICDO3 (SEER IF39).*

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):

C26.9	Gastrointestinal tract, NOS	C68.9	Urinary system, NOS
C39.9	Ill-defined sites within respiratory system	C72.9	Nervous system, NOS
		C75.9	Endocrine gland, NOS
C55.9	Uterus, NOS	C76.0-C76.8	Ill-defined sites
C57.9	Female genital tract, NOS	C80.9	Unknown primary site
C63.9	Male genital organs, NOS		

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.

Instructions for Coding
- 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	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE SITE/LAT/MORPH

Item Length: 1
Allowable Values: 1
NAACCR Item #2074

Description
Used with the EDITS software to override the edits *Laterality, Primary Site, Morph ICDO2 (SEER IF42);* and/or *Laterality, Primary Site, Morph ICDO3 (SEER IF42).*

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* (NAACCR Item #400) is a paired organ and *Behavior Code* (NAACCR Item # 523) is in situ (2), then *Laterality* (NAACCR Item #410) must be 1, 2, or 3.
- If diagnosis year is less than 1988 and *Histology* (NAACCR Item #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 (9) or the rare combination is otherwise confirmed correct, enter code 1 for *Override Site/Lat/Morph.*

Instructions for Coding
- 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	Definition
(leave blank)	Not reviewed.
1	Reviewed.

COC CODING SYSTEM—CURRENT

Item Length: 2
Allowable Values: 00–08, 99
NAACCR Item #2140

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* (NAACCR Item #2150) if the record has been converted to a more recent coding system.

Instructions for Coding
- 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, 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)*
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.
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.

Code	Reason
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).*
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: 2
Allowable Values: 00–08, 99
NAACCR Item #2150

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.

Instructions for Coding
- 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, 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* (NAACCR Item #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)*
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: 1
Allowable Values: 1–6, 9
NAACCR Item #170

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.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	SEER <1988 (1-digit)
3	1988 + SEER & CoC (2-digit)
4	1991 + SEER & CoC (added codes 20–97)
5	1994 + SEER & CoC (added code 14)
6	2000 + SEER & CoC (no new codes added, new items *Race #2–Race #5* added)
9	Other

RACE CODING SYSTEM—ORIGINAL

Item Length: 1
Allowable Values: 1–6, 9
NAACCR Item #180

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.

Instructions for Coding
- This item is autocoded by the software provider.
- For cases diagnosed on or after January 1, 2000, this data item must be coded 6.

Code	Definition
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	SEER <1988 (1-digit)
3	1988 + SEER & CoC (2-digit)
4	1991 + SEER & CoC (added codes 20–97)
5	1994 + SEER & CoC (added code 14)
6	2000 + SEER & CoC (no new codes added, new items *Race #2–Race #5* added)
9	Other

SITE CODING SYSTEM—CURRENT

Item Length: 1
Allowable Values: 1–6, 9
NAACCR Item #450

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.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
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: 1
Allowable Values: 1–6, 9
NAACCR Item #460

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.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
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: 1
Allowable Values: 1–7, 9
NAACCR Item #470

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.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
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
9	Other

MORPHOLOGY CODING SYSTEM—ORIGINAL

Item Length: 1
Allowable Values: 1–7, 9
NAACCR Item #480

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.

Instructions for Coding
- This item is autocoded by the software provider.
- For cases diagnosed on or after January 1, 2000, this data item must be coded 7.

Code	Definition
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
9	Other

ICD-O-2 CONVERSION FLAG

Item Length: 1
Allowable Values: 0–4
NAACCR Item #1980

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.

Instructions for Coding
- 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	Definition
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: 1
Allowable Values: 0, 1, 3
NAACCR Item #2116

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.

Instructions for Coding
- 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	Definition
(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: 2
Allowable Values: 00–06, 88, 99
NAACCR Item #1060

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.

Instructions for Coding
This item is autocoded by the software provider.

Code	Label
00	Not staged (cases that have 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
88	Not applicable (cases that do not have an AJCC staging scheme).
99	Staged, but the edition is unknown.

ICD REVISION COMORBIDITIES AND COMPLICATIONS

Item length: 1
Allowable values: 0, 1, 9
NAACCR Item #3165

Description
This item indicates the coding system from which the *Comorbidities and Complications* (secondary diagnoses) codes are provided.

Rationale
Following the implementation of *FORDS*, it was determined that additional *Comorbidities and Complications* data items were needed.

Instructions for Coding
ICD Revision Comorbidities and Complications is to be recorded for patients diagnosed on or after January 1, 2006.

Code	Definition
0	No secondary diagnosis reported.
1	ICD-10
9	ICD-9

RX CODING SYSTEM—CURRENT

Item Length: 2
Allowable Values: 00–06, 99
NAACCR Item #1460

Description
Describes how treatment for this case is now coded.

Rationale
This information is used for some data analysis and for further item conversions.

Instructions for Coding
- This item is autocoded by the software provider.
- The *FORDS* manual **must** be used to record treatment for all cases diagnosed January 1, 2003, or later and this item **must** be coded 06.

Code	Definition
00	Treatment data not coded/transmitted, ie, 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.
99	Other coding, including partial or nonstandard coding.

DERIVED AJCC–FLAG

Item Length: 1
Allowable Values: 1, 2
NAACCR Item #3030

Description
Indicates the source data items used to derive AJCC Stage descriptors and Stage Group. It also indicates the target AJCC edition described by the derived AJCC Stage descriptors and Stage Group.

Rationale
AJCC Stage and component T, N, and M codes and rules change over time as does the method of deriving them. This item enables the analysis of cases grouped by coding and derivation version.

Instructions for Coding

Code	Description
(leave blank)	Not derived.
1	AJCC Sixth Edition derived from Collaborative Stage 2004 Edition.
2	AJCC Sixth Edition derived from EOD (prior to 2004).

DERIVED SS1977–FLAG

Item Length: 1
Allowable Values: 1, 2
NAACCR Item #3040

Description
Indicates the source data items used to derive SEER Summary Stage 1997.

Rationale
The derivation of SS1977 varies over time with the coding rules and codes in use when the components were coded. This item enables the analysis of cases grouped by coding and derivation version.

Instructions for Coding

Code	Description
(leave blank)	Not derived.
1	SS1977 derived from Collaborative Stage 2004 Edition.
2	SS1977 derived from EOD (prior to 2004).

DERIVED SS2000–FLAG

Item Length: 1
Allowable Values: 1, 2
NAACCR Item #3050

Description
Indicates the source data items used to derive SEER Summary Stage 2000.

Rationale
The derivation of SS2000 varies over time with the coding rules and codes in use when the components were coded. This item enables the analysis of cases grouped by coding and derivation version.

Instructions for Coding

Code	Description
(leave blank)	Not derived.
1	SS2000 derived from Collaborative Stage 2004 Edition.
2	SS2000 derived from EOD (prior to 2004).

CS VERSION FIRST

Item Length: 6
Numeric
NAACCR Item #2935

Description
This item indicates the number of the version initially used to code Collaborative Staging (CS) fields. The CS version number is returned as part of the output of the CS algorithm.

Rationale
Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

Instructions for Coding
This item is autocoded by the software provider.

CS VERSION LATEST

Item Length: 6
Numeric
NAACCR Item #2936

Description
This item indicates the Collaborative Staging (CS) version used most recently to derive the CS output fields. The CS version number is returned as part of the output of the CS algorithm.

Rationale
The CS algorithm may be re-applied to compute the CS Derived items; for example, when the data are to be used for a special study, transmitted, or when an updated CS algorithm is produced. This item identifies the specific algorithm used to obtain the CS Derived values in the data record.

Instructions for Coding
- This item is autocoded by the software provider.
- *CS Version Latest* is recorded the first time the CS output fields are derived and should be updated each time the CS Derived items are re-computed.
- This item should not be blank if the CS Derived items contain stored values.
- This item should be blank if the CS Derived items are empty or the CS algorithm has not been applied.

APPENDIX A

Appendix A:
Definitions of Single and Subsequent Primaries for Hematologic Malignancies

Based on ICD-O-3 reportable malignancies, effective with diagnoses 01/01/2001 and after

Cancer registrars are often faced with multiple pathology reports in patients with hematologic malignancies, and the diagnoses reported may require different morphology codes. This is due in part to the fact that more intensive diagnostic study may yield a more specific diagnosis, and in part due to the natural histories of hematopoietic diseases, which may progress from one diagnosis into another.

The following chart, provided to aid the registrar in determining single versus subsequent primaries, employs the following guidelines:

1. "Lymphoma" is a general term for hematopoietic solid malignancies of the lymphoid series. "Leukemia" is a general term for liquid malignancies of either the lymphoid or the myeloid series. While it is recognized that some malignancies occur predominantly (or even exclusively) in liquid or solid form, because so many malignancies can potentially arise as either leukemias or lymphomas (or both), all hematopoietic malignancies are assumed to have this potential.
2. Malignancies of the lymphoid series are considered to be different from those of the myeloid series. Therefore, a lymphoid malignancy arising after diagnosis of a myeloid malignancy (or myelodysplastic or myeloproliferative disorder) would be considered a subsequent primary; however, a myeloid malignancy diagnosed after a previous myeloid malignancy would not count as a subsequent primary. Histiocytic malignancies are considered different from both lymphoid and myeloid malignancies.
3. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma (NHL). Among the NHLs, B-cell malignancies are considered different from T-cell/NK cell malignancies. Therefore, a B-cell malignancy arising later in the course of a patient previously diagnosed with a T-cell malignancy would be considered a subsequent primary; however, a T-cell malignancy diagnosed later in the same patient would not be considered a subsequent primary.
4. The sequence of diagnoses affects whether a diagnosis represents a subsequent primary. In some cases, the order of occurrence of the two diagnoses being compared is a factor in the decision whether the second diagnosis is a new primary.

We gratefully acknowledge the assistance of Drs. Charles Lynch, Charles Platz, and Fred Dick of the University of Iowa. Dr. Tim Cote of the SEER Program, Jennifer Seiffert, MLIS, CTR, and Annette Hurlbut, RHIT, CTR for their assistance with this project.

To use the table, assign the ICD-O-3 code to the first diagnosis and find the row containing that code. Assign the ICD-O-3 code for the second diagnosis and find the column containing that code. In the cell at the intersection of the first diagnosis row and second diagnosis column, a "**S**" symbol indicates that the two diagnoses are most likely the **same** disease process (prepare/update a single abstract) and a "**D**" indicates that they are most likely **different** disease processes (prepare more than one abstract).

Note 1: If one of the two diagnoses is an NOS (not otherwise specified) term and the other is more specific and determined to be the same disease process, code the more specific diagnosis regardless of the sequence. For example, if a diagnosis of non-Hodgkin lymphoma, NOS is followed by a diagnosis of follicular lymphoma, assign the morphology code for the follicular lymphoma.

Note 2: The table "Single versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases" (pages X-X) and the "Complete Diagnostic Terms for Table (based on ICD-O-3)" (page X) display only the ICD-O-3 primary (boldfaced) term associated with the code. Refer to the *International Classification of Disease, Third Edition* (ICD-O-3) for a complete list of related terms and synonyms.

Source: SEER Program, NCI E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 1 SECOND DX ACROSS FIRST DX DOWN		1. 9590 Malig lymphoma, NOS	2. 9591 NHL, NOS	3. 9596 Compos HD/NHL	4. 9650-9667 Hodgkin lymphoma	5. 9670-9671 ML, small B lymph	6. 9673 Mantle cell lymph	7. 9675-9684 ML, diff large B-cell	8. 9687 Burkitt lymphoma	9. 9689,9699 Marg zn, B-cl lym	10. 9690-9698 Follicular lymphoma
1. Malignant lymphoma, NOS	9590	**S**	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	**S**	D	D	S	S	S	S	S	S
3. Composite HD/NHL	9596	S	S	**S**	S	S	S	S	S	S	S
4. Hodgkin lymphoma	9650-9667	S	D	D	**S**	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	S	D	D	**S**	D	S	D	D	D
6. Mantle cell lymphoma	9673	S	S	D	D	D	**S**	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	D	D	S	D	**S**	S	D	S
8. Burkitt lymphoma	9687	S	S	D	D	D	D	D	**S**	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	S	S	D	D	D	D	D	D	**S**	D
10. Follicular lymphoma	9690-9698	S	S	D	D	D	D	S	D	D	**S**
11. Mycos fung, Sezary disease	9700-9701	S	S	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	S	S	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	S	S	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	S	S	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	S	S	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	S	S	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	D	D	S	D	S	D	D	D
21. Waldenstrom macroglob	9761	S	S	D	D	S	D	S	D	D	D
22. Heavy chain disease, NOS	9762	S	S	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	S	S	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	S	D	D	D	D	D	S	D	D
25. Acute biphenotypic leukem	9805	S	S	D	D	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	D	D	D	D	S	D	S
27. BCLL/SLL	9823	S	S	D	D	S	D	S	D	D	D
28. Burkitt cell leukemia	9826	S	S	D	D	D	D	D	S	D	D
29. Adult T-cell leuk/lymph	9827	S	S	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	S	S	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	S	S	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	S	S	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	S	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 2 SECOND DX ACROSS FIRST DX DOWN		11. 9700-9701 MF, Sezary disease	12. 9702-9719 T/NK-cell lymphoma	13. 9727 Precurs lym'blas lymph NOS	14. 9728 Precurs lym'blas lymph B-cl	15. 9729 Precurs lym'blas lymph T-cl	16. 9731-9734 Plasma cell tumors	17. 9740-9742 Mast cell tumors	18. 9750-9756 Histiocytos; LCH	19. 9757-9758 Dendritic cell sarc	20. 9760 Immunoprolif dis
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	D	D	D	S	S
3. Composite HD/NHL	9596	S	S	S	S	S	D	D	D	D	S
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	S
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	**S**	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	**S**	D	D	D	D	D	D	D	S
13. Precurs lym'blas lymph NOS	9727	D	D	**S**	S	S	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	**S**	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	**S**	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	**S**	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	**S**	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	**S**	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	**S**	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	S	D	D	D	**S**
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	S
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	S
23. Immun sm intest disease	9764	D	D	D	D	D	S	D	D	D	S
24. Leuk/Acute leuk, NOS	9800-9801	D	S	S	S	S	D	D	D	D	D
25. Acute biphenotypic leukem	9805	S	S	S	S	S	D	D	D	D	D
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	S	S	S	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	S	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	S	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	D	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 3 SECOND DX ACROSS FIRST DX DOWN		21. 9761 Waldenstrom	22. 9762 Heavy chain dis	23. 9764 Imm sm intest dis	24. 9800-9801 Leuk/Acu leuk NOS	25. 9805 Acute biphenotypic leuk	26. 9820 Lym'cyt leuk, NOS	27. 9823 BCLL/SLL	28. 9826 Burkitt leukemia	29. 9827 Adult T-cell leuk/lym	30. 9832 Prolym leuk, NOS
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	S	S	S	S	D
3. Composite HD/NHL	9596	S	S	S	S	D	S	S	S	S	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	S	S	S	D	D	S
6. Mantle cell lymphoma	9673	D	D	D	D	S	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	S	D	S	S	S	D	D	S
8. Burkitt lymphoma	9687	D	D	D	S	S	S	D	S	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	S	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	S	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	S	S	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	S	S	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	S	S	S	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	S	S	S	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	S	S	S	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	S	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	**S**	D	D	D	D	S	S	D	D	D
22. Heavy chain disease, NOS	9762	D	**S**	S	D	D	S	S	D	D	D
23. Immun sm intest disease	9764	D	S	**S**	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	D	**S**	S	S	D	S	S	D
25. Acute biphenotypic leukem	9805	D	D	D	S	**S**	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	S	S	**S**	S	S	S	S
27. BCLL/SLL	9823	D	D	D	D	S	S	**S**	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	S	S	S	D	**S**	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	S	S	D	D	**S**	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	S	S	D	D	**S**
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	S	S	D	D	S
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	S	S	D	D	S	S
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	S	S	S	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	S	S	S	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	S	S	S	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	S	S	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	S	S	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	S	S	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	S	S	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	S	S	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	S	S	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	S	S	D	D	D	D	D
43. NK-cell leukemia	9948	D	D	D	S	S	S	D	D	D	D
44. Polycythemia vera	9950	D	D	D	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	S	S	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	S	S	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	S	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	S	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	S	S	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	S	S	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	S	S	D	D	D	D	D
Codes: S--one primary only; D--presumably a subsequent primary					SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov						

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 4 SECOND DX ACROSS FIRST DX DOWN		31. 9833 Prolym leuk, B-cell	32. 9834 Prolym leuk, T-cell	33. 9835 Precurs leuk, NOS	34. 9836 Precurs leuk, B-cell	35. 9837 Precurs leuk, T-cell	36. 9840-9910 Myeloid leukemias	37. 9920 Therapy rel AML	38. 9930 Myeloid sarcoma	39. 9931 Acute panmyelosis	40. 9940 Hairy cell leukemia	41. 9945 Chr myelomono leu
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	D	D	S	S	S	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	S	S	S	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	S	S	S	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	S	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	S	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	S	S	S	S	S	S	D	D	S
25. Acute biphenotypic leukem	9805	S	S	S	S	S	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S	D
27. BCLL/SLL	9823	S	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	S	S	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	**S**	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	**S**	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	**S**	S	S	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	**S**	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	**S**	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	**S**	S	S	S	D	S
37. Therapy related AML	9920	D	D	D	D	D	S	**S**	S	S	D	S
38. Myeloid sarcoma	9930	D	D	D	D	D	S	S	**S**	S	D	S
39. Acute panmyelosis	9931	D	D	D	D	D	S	S	S	**S**	D	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	**S**	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	S	S	S	S	D	**S**
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	S	S	S	S	D	S
43. NK-cell leukemia	9948	D	D	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	S	S	S	S	D	S
46. Myelosclerosis	9961	D	D	D	D	D	S	S	S	S	D	S
47. Essen thrombocythem	9962	D	D	D	D	D	S	S	S	S	D	S
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	S	S	S	S	D	S
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	S	S	S	S	D	S
50. Refractory anemias	9980-9986	D	D	D	D	D	S	S	S	S	D	S
51. Therapy related MDS	9987	D	D	D	D	D	S	S	S	S	D	S
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	S	S	S	S	D	S

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 5 SECOND DX ACROSS FIRST DX DOWN		42. 9946 Juv myelomono leu	43. 9948 NK-cell leukemia	44. 9950 Polycythemia vera	45. 9960 Chr myeloprolif dis	46. 9961 Myelosclerosis	47. 9962 Ess thrombocythem	48. 9963 Chr neutrophil leu	49. 9964 Hypereosin syndr	50. 9980-9986 Refract anemias	51. 9987 Therapy rel MDS	52. 9989 Myelodys syn NOS
1. Malignant lymphoma, NOS	9590	S	S	D	D	D	D	D	D	D	D	D
2. NHL, NOS	9591	D	D	D	D	D	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	D	D	D	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	D	D	S	S	D	S	S	D	S	S
25. Acute biphenotypic leukem	9805	S	S	D	S	S	D	D	D	S	S	S
26. Lymphocytic leukem, NOS	9820	D	S	D	D	D	D	D	D	D	D	D
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	S	D	D	S	S	S	S	S	D	S	S
37. Therapy related AML	9920	S	D	D	D	S	D	D	D	D	S	S
38. Myeloid sarcoma	9930	S	D	D	S	S	S	S	D	D	S	S
39. Acute panmyelosis	9931	S	D	D	D	S	D	D	D	D	S	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	S	D	D	S	S	D	S	D	D	S	S
42. Juvenile myelomonocy leuk	9946	**S**	D	D	D	S	D	D	D	D	S	S
43. NK-cell leukemia	9948	D	**S**	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	**S**	S	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	**S**	S	S	S	D	D	D	D
46. Myelosclerosis	9961	S	D	D	S	**S**	S	S	D	D	S	S
47. Essen thrombocythem	9962	D	D	D	S	S	**S**	S	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	S	S	**S**	D	D	D	D
49. Hypereosinophilic syndrome	9964	S	D	D	S	S	D	D	**S**	D	D	D
50. Refractory anemias	9980-9986	S	D	D	S	S	D	D	D	**S**	S	S
51. Therapy related MDS	9987	S	D	D	S	S	D	D	D	S	**S**	S
52. Myelodysplastic syndr, NOS	9989	S	D	D	S	S	D	D	D	S	S	**S**

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

COMPLETE DIAGNOSTIC TERMS FOR TABLE (BASED ON ICD-O-3)

1	9590	Malignant lymphoma, NOS
2	9591	Malignant lymphoma, non-Hodgkin, NOS
3	9596	Composite Hodgkin and non-Hodgkin lymphoma
4	9650-9667	Hodgkin lymphoma (all subtypes)
5	9670-9671	Malignant lymphoma, small B lymphocytic
6	9673	Mantle cell lymphoma
7	9675-9684	Malignant lymphoma, diffuse large B-cell
8	9687	Burkitt lymphoma
9	9689, 9699	Marginal zone B-cell lymphoma
10	9690-9698	Follicular lymphoma
11	9700-9701	Mycosis fungoides and Sezary syndrome
12	9702-9719	T/NK-cell non-Hodgkin lymphoma
13	9727	Precursor cell lymphoblastic lymphoma, NOS
14	9728	Precursor B-cell lymphoblastic lymphoma
15	9729	Precursor T-cell lymphoblastic lymphoma
16	9731-9734	Plasma cell tumors
17	9740-9742	Mast cell tumors
18	9750-9756	Histiocytosis/Langerhans cell histiocytosis
19	9757-9758	Dendritic cell sarcoma
20	9760	Immunoproliferative disease, NOS
21	9761	Waldenstrom macroglobulinemia
22	9762	Heavy chain disease, NOS
23	9764	Immunoproliferative small intestinal disease
24	9800-9801	Leukemia, NOS/Acute leukemia, NOS
25	9805	Acute biphenotypic leukemia
26	9820	Lymphoid leukemia, NOS
27	9823	B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
28	9826	Burkitt cell leukemia
29	9827	Adult T-cell leukemia/lymphoma (HTLV-1 positive)
30	9832	Prolymphocytic leukemia, NOS
31	9833	Prolymphocytic leukemia, B-cell type
32	9834	Prolymphocytic leukemia, T-cell type
33	9835	Precursor cell lymphoblastic leukemia, NOS
34	9836	Precursor B-cell lymphoblastic leukemia
35	9837	Precursor T-cell lymphoblastic leukemia
36	9840-9910	Myeloid leukemias
37	9920	Therapy related acute myelogenous leukemia
38	9930	Myeloid sarcoma
39	9931	Acute panmyelosis with myelofibrosis
40	9940	Hairy cell leukemia
41	9945	Chronic myelomonocytic leukemia, NOS
42	9946	Juvenile myelomonocytic leukemia
43	9948	Aggressive NK-cell leukemia
44	9950	Polycythemia vera
45	9960	Chronic myeloproliferative disease, NOS
46	9961	Myelosclerosis with myeloid metaplasia
47	9962	Essential thrombocythemia
48	9963	Chronic neutrophilic leukemia
49	9964	Hypereosinophilic syndrome
50	9980-9986	Refractory anemias
51	9987	Therapy related myelodysplastic syndrome, NOS
52	9989	Myelodysplastic syndrome, NOS

Version 1.01. Codes corrected for terms in rows 7 and 9 on pages 2-5.

APPENDIX B:
Site-Specific Surgery Codes

ORAL CAVITY

Lip C00.0–C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0–C02.9, Gum C03.0–C03.9, Floor of Mouth C04.0–C04.9, Palate C05.0–C05.9, Other Parts of Mouth C06.0–C06.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–27.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PAROTID AND OTHER UNSPECIFIED GLANDS

Parotid Gland C07.9, Major Salivary Glands C08.0–C08.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–27.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PHARYNX

Tonsil C09.0–C09.9, Oropharynx C10.0–C10.9, Nasopharynx C11.0–C11.9 Pyriform Sinus C12.9, Hypopharynx C13.0–C13.9, Pharynx C14.0

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimens sent to pathology from surgical events 20–28.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ESOPHAGUS

C15.0–C15.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–27.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

STOMACH

C16.0–C16.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–27.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

COLON

C18.0–C18.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–29.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

RECTOSIGMOID

C19.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–27.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

RECTUM

C20.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–28.

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

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ANUS

C21.0–C21.8

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–27.

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).

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LIVER AND INTRAHEPATIC BILE DUCTS

C22.0–C22.1

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–26.

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 a bile duct PLUS partial hepatectomy

75 Bile duct and hepatectomy WITH transplant

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PANCREAS

C25.0–C25.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

LARYNX

C32.0–C32.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–28.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LUNG

C34.0–C34.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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
Specimen sent to pathology from surgical events 20–25.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

HEMATOPOIETIC/RETICULOENDOTHELIAL/ IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE C42.0, C42.1, C42.3, C42.4 (with any histology) or M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989 (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).

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-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–-9989)

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
Specimen sent to pathology from surgical events 25–26.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SPLEEN

Spleen C42.2

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SKIN

C44.0–C44.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–27.

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 does not have microscopically negative margins greater than 1 cm, use the appropriate code, 20–36.

60 Major amputation

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BREAST

C50.0–C50.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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 is the removal of breast tissue without the nipple and areolar complex or overlying skin.

40 Total (simple) mastectomy
- 41 WITHOUT removal of uninvolved contralateral breast
- 43 Reconstruction NOS
  - 44 Tissue
  - 45 Implant
  - 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast
- 47 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.

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).

If 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.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CERVIX UTERI

C53.0–C53.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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)

Specimen sent to pathology from surgical events 20–29.

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.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CORPUS UTERI

C54.0–C55.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–26.

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.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

OVARY

C56.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 25–28.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PROSTATE

C61.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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
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
- 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

Specimen sent to pathology from surgical events 20–26.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

TESTIS

C62.0–C62.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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
Specimen sent to pathology from surgical event 20.

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)

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–27.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BLADDER

C67.0–C67.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980-9989)

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

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

Specimen sent to pathology from surgical events 20–27.

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Radical cystectomy (male only)
- 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)

70 Pelvic exenteration, NOS
- 71 Radical cystectomy (female only); anterior exenteration

A radical cystectomy in a female includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra.
- 72 Posterior exenteration
- 73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.
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).

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

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-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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 as tumor destruction. It should be recorded in the radiation treatment items.

20 Local excision (biopsy) of lesion or mass
Specimen sent to pathology from surgical event 20.

40 Partial resection

55 Gross total resection

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

THYROID GLAND

C73.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 25–27.

20 Lobectomy and/or isthmectomy
- 21 Lobectomy ONLY
- 22 Isthmectomy ONLY
- 23 Lobectomy WITH isthmus

30 Removal of a lobe and partial removal of the contralateral lobe

40 Subtotal or near total thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LYMPH NODES

C77.0–C77.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

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-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–27.

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.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

UNKNOWN AND ILL-DEFINED PRIMARY SITES
C76.0–C76.8, C80.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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).

APPENDIX C:
FORDS Page Revisions

FORDS: An Evolving Data Manual

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

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

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

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

CHANGES TO *FORDS* SECTION ONE

2006

9/1/06

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

Examples of Diagnostic Terms:

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

Examples of Nondiagnostic Terms:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

facility's database:" (p.28G)
Added new text to third bullet: "Use radiation or systemic treatment dates of 88888888 and treatment or "reason for no" treatment codes of 88 or 8 as ticklers to identify incomplete treatment information.
Added new bullet (fifth): "The CoC does not require Class 0 cases diagnosed on or after January 1, 2006 to be followed."
Rephrased lead-in statement: "While the patient is alive, be sure that contact information is kept current. In addition to the treatment and recurrence items, these include:" (p.28H)
Added: *Following Registry* (NAACCR Item #2440) to the list of contact information that should be kept current.
Revised statement: "Follow-up for *Vital Status* (NAACCR Item #1760) and *Cancer Status* (NAACCR Item # 1770) should be conducted annually for all analytic cases in the cancer program's registry. Class of Case 0 patients that are not followed will have current information as of the *Date of Last Contact*." (p.28H)

2005

06/1/05

The entire text under the heading "Analytic Cases" was changed. (p.5)
Added bullet: "The CoC does not require Class 0 cases diagnosed on or after January 1, 2006 to be AJCC staged by the physician, but Collaborative Staging must be completed by the registrar." (p.23)
Text revised to read: (Class of Case codes 1 or 2) (p.23)
Added section of text: "OUTCOMES" added prior to existing "CASE ADMINISTRATION" section. (p.28I); text moved (re-flowed) on pages 28I through 28L.

2004

09/01/04

Added statement: "Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only, and do not constitute diagnosis." (p.4)
Tumor grade for prostate cancers: Reference to the following table was added; pattern 2-4 was changed to 2+4; and nuclear grade was noted as being obsolete for reporting tumor grade for these cancers. (p.14)

04/01/04

Definition of case eligibility modified to read: "...follow-up activities for required **tumors** diagnosed and/or initially treated at the abstracting facility. The **tumors** must meet..." (p.3)
Heading modified to read: "**TUMORS** REQUIRED BY THE CoC..." (p.3)
Under the heading *Histology Differences*: Exception 4 was replaced with revised instructions. (p.18)
Under the heading *Examples of single or multiple primary coding*: Example #10 was revised to read: "A patient had a **ganglioma, NOS (9505/1)** in the right.... Last week, a **desmoplastic infantile astrocytoma (9412/1)** of the right .... They represent a single tumor with the morphology, **9412/1, the more specific histology**." (p.21)
Description of boost treatment and dose changed to read: "A boost treatment is provided to a smaller volume within the same volume as regional radiation, in order to enhance the effect of the regional treatment." (p.28E)

01/01/04

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

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

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

2003

01/22/03

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

01/22/03

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

2002

12/04/02

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

09/19/02

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

CHANGES TO *FORDS* SECTION TWO

2006

Patient Identification

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

09/01/06

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

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

09/01/06

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

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

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

Definition for code XX was changed to read: "Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is known*."
Definition for code YY was changed to: "Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is unknown*."
Definition of code ZZ was changed to read: "Residence unknown."
Added new code: *United States, state unknown (US)* was added to the list of "Common abbreviations."
Added new code: *Canada, province unknown (CD)* was added to the list of "Common abbreviations."

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

References: Updated references for country codes.

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

Removed text: (NUMBER AND STREET) was removed from data item name.
New coding instruction was added: "Do not use this data item to record the number and street address of the patient."

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

Definition for XX changed to read: "Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is known*."
Definition for YY changed to: "Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is unknown*."
Definition of ZZ changed to read: "Residence unknown."
Added new code: *United States, state unknown (US)* was added to the list of "Common abbreviations."
Added new code: *Canada, province unknown (CD)* was added to the list of "Common abbreviations."

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

References: Updated references for SEER geocodes.

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

This data item was added.

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

This data item was added.

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

This data item was added.

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

This data item was added.

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

This data item was added.

Cancer Identification

NPI–INSTITUTION REFERRED FROM (p. 85A; NAACCR Item # 2415)
09/01/06
This data item was added.

NPI–INSTITUTION REFERRED TO (p. 86A; NAACCR Item # 2425)
09/01/06
This data item was added.

DATE OF FIRST CONTACT (p.87; NAACCR Item #580)
09/01/06
New coding instruction was added: "When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility."

HISTOLOGY (p.93; NAACCR Item #522)
09/01/06
New coding instruction was added: "Use the SEER 2007 Multiple Primary and Histology Coding Rules when coding the histology for all reportable solid malignant tumors. These rules are effective for cases diagnosed January 1, 2007 or later. Do not use these rules to abstract cases diagnosed prior to January 1, 2007."

AMBIGUOUS TERMINOLOGY DIAGNOSIS (p.99A; NAACCR Item #442)
09/01/06
This data item was added.

DATE OF CONCLUSIVE DIAGNOSIS (p.99C; NAACCR Item #443)
09/01/06
This data item was added.

DATE OF MULTIPLE TUMORS (p.99E; NAACCRItem #445)
09/01/06
This data item was added.

MULTIPLE TUMORS REPORTED AS ONE PRIMARY (p.99G; NAACCR Item #444)
09/01/06
This data item was added.

MULTIPLICITY COUNTER (p. 99H; NAACCR Item #446)
09/01/06
This data item was added.

REGIONAL LYMPH NODES EXAMINED (p.102; NAACCR Item #830)
09/01/06
Definition for code 95 revised: "No regional nodes were removed, but aspiration or core biopsy of regional nodes was performed."

REGIONAL LYMPH NODES POSITIVE (p.103; NAACCR Item #820)
09/01/06
Definition for code 95 revised: "Positive aspiration or core biopsy of regional node(s) was performed."

Stage of Disease at Diagnosis

SURGICAL DIAGNOSTIC AND STAGING PROCEDURE (p.109; NAACCR Item #1350)
09/01/06

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

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

New coding instruction was added: "Code clinical T as recorded in the medical record."
Definition for code "leave blank" revised: "Not recorded."
Revised "Note" to read: "*Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging."*

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

New coding instruction was added: "Code clinical N as recorded in the medical record."
Definition for code "leave blank" revised: "Not recorded."
Revised "Note" to read: "*Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging."*

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

New coding instructions were added:

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

Definition for code "leave blank" revised: "Not recorded."
Revised "Note" to read: "*Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging."*

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

New coding instructions were added:

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

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

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

New coding instruction was added: "Record the clinical stage (prefix/suffix) descriptor as documented in the medical record."
Revised "Note" to read: "*Please refer to the current CoC Cancer Program Standards to determine*

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

STAGED BY (CLINICAL STAGE) (p.117; NAACCR Item #990)
09/01/06

New coding instructions were added:

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

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

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

PATHOLOGIC T (p.118; NAACCR Item #880)
09/01/06

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

Definition for code "leave blank" revised: "Not recorded."

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

PATHOLOGIC N (p.119; NAACCR Item #890)
09/01/06

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

Definition for code "leave blank" revised: "Not recorded."

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

PATHOLOGIC M (p.120; NAACCR Item #900)
09/01/06

New coding instructions were added:

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

Definition for code "leave blank" revised: "Not recorded."

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

PATHOLOGIC STAGE GROUP (p.121; NAACCR Item #910)
09/01/06

New coding instructions were added:

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

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

• To assign Stage Group when some, but not all, of the T, N and/or M components were provided by the appropriate person, interpret the missing components as "X."

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

Two coding instructions were modified:

• Truncate the least significant subdivision of the category from the right as needed, if a specific code is not shown on the table below.

• Refer to the current *AJCC Cancer Staging Manual* for staging rules.

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

PATHOLOGIC STAGE (PREFIX/SUFFIX) DESCRIPTOR (p.122; NAACCR Item #920)
09/01/06

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

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

STAGED BY (PATHOLOGIC STAGE) (p.123; NAACCR Item #930)
09/01/06

New coding instructions were added:

• The CoC Approvals Program requires that all eligible analytic cases are staged in the medical record.

• Record the person or persons who documented the AJCC clinical staging elements and the Stage Group in the medical record.

• If code 1, 2, 4, or 5 is used, then all of the staging elements (T, N, M, and Stage Group) must have been assigned by the same person.

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

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

CS TUMOR SIZE (p.125; NAACCR Item #2800)
09/01/06

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

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

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

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

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

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

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

CS EXTENSION (p.125C; NAACCR Item #2810)
09/01/06

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

CS LYMPH NODES (p.125H; NAACCR Item #2830)
09/01/06
Updated reference: *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*
Removed code 80 and its description from the table.

CS REG NODES EVAL (p.125J; NAACCR Item #2840)
09/01/06
Updated reference: *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*

CS METS AT DX (p.125L; NAACCR Item #2850)
09/01/06
Updated reference: *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*
Revised text description for codes 41–49 to read: "SITE/HISTOLOGY-SPECIFIC CODES"

CS METS EVAL (p.125M; NAACCR Item #2860)
09/01/06
Updated reference: *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*

CS SITE-SPECIFIC FACTOR 1 (p.125O; NAACCR Item #2880)
09/01/06
Updated reference: *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*
Added four sites with SSF1 defined: Pleura, Other CNS, Other Endocrine, Lymphoma

CS SITE-SPECIFIC FACTOR 2 (p.125Q; NAACCR Item #2890)
09/01/06
Updated reference: *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*
Revised Site/Histology list: "Malignant Melanoma of Iris and Ciliary Body" and its corresponding **Factor**, "CS Extension of Ciliary Body," was removed from the list of sites with SSF2 defined.

CS SITE-SPECIFIC FACTOR 3 (p.125R; NAACCR Item #2900)
09/01/06
Updated reference: *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*
Defined LDH: Lactate Dehydrogenase

CS SITE-SPECIFIC FACTOR 4 (p.125S; NAACCR Item #2910)
09/01/06
Updated reference: *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*
Revised Site/Histology list: The **Factor** corresponding to "Prostate" was changed from "Prostatic Acid Phosphatase (PAP)" to "Prostate Apex Involvement" and a note was added for clarification.

CS SITE-SPECIFIC FACTOR 5 (p.125T; NAACCR Item #2920)
09/01/06
Updated reference: *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*

CS SITE-SPECIFIC FACTOR 6 (p.125U; NAACCR Item #2930)
09/01/06
Updated reference: *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*

First Course of Treatment

REGIONAL TREATMENT MODALITY (p.155; NAACCR Item #1570)
09/01/06
New coding instruction was added: "Code IMRT or conformal 3D whenever either is explicitly mentioned."

Clarified code 98 (Other, NOS) definition to read: "Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown."
Clarified code 99 (Unknown) definition to read: "It is unknown whether radiation therapy was administered**."**

Outcomes

NPI–FOLLOWING REGISTRY (p.202A; NAACCR Item #2445)
09/01/06
This data item was added.

Case Administration

NPI–REPORTING FACILITY (p.208A; NAACCR Item #545)
09/01/06
This data item was added.

NPI–ARCHIVE FIN (p.209A; NAACCR Item #3105)
09/01/06
This data item was added.

OVERRIDE ACSN/CLASS/SEQ (p.210; NAACCR Item #1985)
09/01/06
Italicized "*CoC*"when used in an edit name.

OVERRIDE HOSPSEQ/DXCONF (p.211; NAACCR Item #1986)
09/01/06
Italicized "*CoC*"when used in an edit name.

OVERRIDE COC—SITE/TYPE (p.212; NAACCR Item #1987)
09/01/06
Italicized "*CoC*"when used in an edit name.
Updated edit name: *Morphology-Type Check* was changed to *Morphology-Type ICDO2*.
Revised coding instruction to read: "Leave blank if the EDITS program does not generate an error message for edits of the type *Primary Site*, *Morphology-Type*."

OVERRIDE HOSPSEQ/SITE (p.213; NAACCR Item #1988)
09/01/06
Italicized "*CoC*"when used in an edit name.
Updated edit name: *Seq Num–Hosp, Primary Site, Morph ICDO2 (CoC)*

OVERRIDE AGE/SITE/MORPH (p.215; NAACCR Item #1990)
09/01/06
Updated edit names: *Age, Primary Site, Morphology ICDO2 (SEER IF15); Age, Primary Site, Morphology ICDO3 (SEER IF15); Age, Primary Site, Morph ICDO3–Adult (SEER), and/or Age, Primary Site, Morph ICDO3–Pediatric (NPCR)*
Removed obsolete Age/Morphology/Site table.
Revised coding instruction to read: "Leave blank if the EDITS program does not generate an error message for the edit *Age*, *Primary Site*, *Morphology* edits."

OVERRIDESURG/DXCONF (p.216; NAACCR Item #2020)
09/01/06
Updated edit names: *RX Summ–Surg Prim Site, Diag Conf (SEER IF76); RX Summ–Surgery Type, Diag Conf (SEER IF46); and/or RX Summ–Surg Site 98-02, Diag Conf (SEER 106)*

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

Updated edit names: *Primary Site, Morphology-Type ICDO2 (SEER IF25); Primary Site, Morphology-Type ICDO3 (SEER IF25); Primary Site, Morphology-Type ICDO2 (CoC); and/or Primary Site, Morphology-Type ICDO3 (CoC)*
Revised coding instruction to read: "Leave blank and correct any errors for the case if any item is discovered to be incorrect."

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

Updated edit names: *Diagnostic Confirmation, Behavior ICDO2 (SEER IF31); Diagnostic Confirmation, Behavior ICDO3* (SEER IF31); *Morphology–Type/Behavior ICDO2 (SEER MORPH)*; *Morphology–Type/Behavior ICDO3 (SEER MORPH);* and/or *Morph (1973-91) ICD-O-1 (SEER MORPH)*
Revised coding instruction to read: "Leave blank if the EDITS program does not generate an error message for the edits of the types, *Diagnostic Confirmation, Morph* or *Morphology–Type/Behavior*."

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

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

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

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

Updated edit names: *Primary Site, Behavior Code ICDO2 (SEER IF39); and/or Primary Site, Behavior Code ICDO3 (SEER IF39)*
Revised coding instruction to read: "Leave blank if the EDITS program does not generate an error message for *Primary Site, Behavior* edits."

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

Updated edit names: *Laterality, Primary Site, Morph ICDO2 (SEER IF42);* and/or *Laterality, Primary Site, Morph ICDO3 (SEER IF42)*
Revised coding instruction to read: "Leave blank if the EDITS program does not generate an error message for the *Laterality, Primary Site, Morphology* edits."

Appendix C
09/01/06

Appendix C was completely revised and reorganized.

2005

Patient Identification

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

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

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

New coding instruction was added: "Leave blank for non-military facilities."

PRIMARY PAYOR AT DIAGNOSIS (p.67; NAACCR Item#630)
06/01/05

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

COMORBIDITIES AND COMPLICATIONS #1–#10
(pp.69-75D; NAACCR Item #s 3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, 3164)
06/01/05

Code V0740 deleted from allowable values. Example removed. (p.70)
Added four new data items: Comorbidities and Complications #7–#10. (p.75A–75D); all Comorbidities and Complications data items revised to reflect "up to 10" comorbid conditions and complications.

Stage of Disease at Diagnosis

CLINICAL STAGE GROUP (p.115; NAACCR Item #970)
06/01/05

New coding instructions were added:
• If the clinical T, N, and M have been recorded by the physician the cancer registrar may complete the clinical stage group in the cancer registry database.
• If the managing physician does not complete the T,N,M, components or stage group, the registrar is to leave the appropriate fields blank.
• When the physician does not complete any of the T, N, and M components, the registrar is to record stage group 99 (unknown) in the cancer registry database.
• To assign stage group when some, but not all, T, N and/or M components were provided by the physician, interpret missing components as "X."
• As of January 1, 2006, the CoC does not require Class 0 cases to be AJCC Staged.
New allowable code value and definition was added: 1C and Stage IC, respectively.

PATHOLOGIC STAGE GROUP (p.121; NAACCR Item #910)
06/01/05

New coding instructions were added:
• If the clinical T, N, and M have been recorded by the physician the cancer registrar may complete the clinical stage group in the cancer registry database.
• If the managing physician does not complete the T,N,M, components or stage group, the registrar is to leave the appropriate fields blank.
• When the physician does not complete any of the T, N, and M components, the registrar is to record stage group 99 (unknown) in the cancer registry database.
• To assign stage group when some, but not all, T, N and/or M components were provided by the physician, interpret missing components as "X."
• As of January 1, 2006, the CoC does not require Class 0 cases to be AJCC Staged.
New allowable code value and definition was added: 1C and Stage IC, respectively.

First Course of Treatment

SURGICAL PROCEDURE OF PRIMARY SITE (p.135; NAACCR Item #1290)
06/01/05

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

READMISSION TO THE SAME HOSPITAL WITHIN 30 DAYS OF SURGICAL DISCHARGE (p.146; NAACCR Item #3190)
06/01/05

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES
(p.182; NAACCR Item #3250)
06/01/05

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

SYSTEMIC/SURGERY SEQUENCE (p.183A-183B; NAACCR Item #1639)
06/01/05
New data item added to manual: SYSTEMIC/SURGERY SEQUENCE.

OTHER TREATMENT (p.186; NAACCR Item #1420)
06/01/05
New coding instruction was added: "Code 8 if other treatment was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up."

Outcomes

DATE OF FIRST RECURRENCE (p.195; NAACCR Item #1860)
06/01/05
Item Description was modified to read: "Records the date of first recurrence only."
Coding instruction was modified to read: "Record the date the physician diagnoses the first progression, metastasis, or recurrence of disease after a disease-free period."

TYPE OF FIRST RECURRENCE (p.197; NAACCR Item #1880)
06/01/05
Instructions for Coding were revised: Original first instruction was removed; four new instructions added.

DATE OF LAST CONTACT OR DEATH (p. 199; NAACCR Item #1750)
06/01/05
New coding instruction was added: "As of January 1, 2006, the CoC does not require class 0 cases to be followed.

FOLLOWING REGISTRY (p. 202; NAACCR Item #2440)
06/01/05
New coding instruction was added: "As of January 1, 2006, the CoC does not require class 0 cases to be followed."

NEXT FOLLOW-UP SOURCE (p.204; NAACCR Item #1800)
06/01/05
New coding instruction was added: "As of January 1, 2006, the CoC does not require class 0 cases to be followed."

Case Administration

ICD REVISION COMORBIDITIES AND COMPLICATIONS (p.234A; NAACCR Item #3165)
06/01/05
New data item added to manual: ICD REVISION COMORBIDITIES AND COMPLICATIONS

2004

Patient Identification

ACCESSION NUMBER (p.33; NAACCR Item #550)
01/01/04
New coding instruction was added: A patient's accession number is never reassigned.
New coding instruction was added: If a patient is first accessioned into the registry, then the registry later changes its reference date and the patient is subsequently accessioned into the registry with a new primary, use the original accession number associated with the patient and code the data item *Sequence Number* (NAACCR Item #560) appropriately.
New example was added: Code: 199100067; Reason: Patient enters the hospital in 1991, and is diagnosed

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

SEQUENCE NUMBER (p.34; NAACCR Item #560)
09/01/04
Last coding example was changed to read: "**Myeloproliferative disease (9975/1)** is diagnosed..."
01/01/04
Item description was modified to read: "Indicates the sequence of **malignant and non-malignant** neoplasms over the lifetime of the patient."
Item rationale was modified to read: "...select patients with only one **malignant** primary tumor..."
All coding instructions for this item have been modified to accommodate the inclusion of non-malignant tumors.
The table name "CoC-Required" has been changed to: "Malignant or in situ"
The table name "Reportable-By-Agreement" has been changed to: "Non-Malignant"

LAST NAME (p.39; NAACCR Item #2230)
01/01/04
Coding instruction was modified to read: "...apostrophes are allowed. Do not use other punctuation."

STATE AT DIAGNOSIS (p.45; NAACCR Item #80)
01/01/04
Abbreviation for Canadian province of Newfoundland and Labrador was changed:
From NF to NL

COUNTY AT DIAGNOSIS (p.48; NAACCR Item #90)
01/01/04
Rationale was modified to read: "...to measure the cancer **incidence** in a particular geographic area."
Publications mentioned in the coding instructions were updated to read:
The SEER Program Coding and Staging Manual, First Edition
Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 10.1, Eighth Edition
References were updated to read:
Johnson C, ed. *SEER Program Coding and Staging Manual*, First Edition. Bethesda MD, NIH, NCI, 2003.
Hulstrom D, Havener L, eds. *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 10.1*, Eighth Edition. Springfield IL: North American Association for Central Cancer Registries, March 2003.

PATIENT ADDRESS (NUMBER AND STREET) - CURRENT (p. 49; NAACCR Item #2350)
09/01/04
New coding instruction was added: "Do not change this item when the patient dies."
New code definition added: UNKNOWN - Patient's street address is unknown.

PATIENT ADDRESS (NUMBER AND STREET) CURRENT - SUPPLEMENTAL (p. 50; NAACCR Item #2355)
09/01/04
New coding instruction was added: "Do not change this item when the patient dies."

CITY/TOWN - CURRENT (p. 51; NAACCR Item #1810)
09/01/04
New coding instruction was added: "Do not change this item when the patient dies."

STATE–CURRENT (p.53; NAACCR Item #1820)
09/01/04
New coding instruction was added: "Do not change this item when the patient dies."

01/01/04

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

PLACE OF BIRTH (p.56; NAACCR Item #250)
01/01/04

Publications mentioned in the coding instructions were updated to read:
The SEER Program Coding and Staging Manual, First Edition
Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 10.1, Eighth Edition.

References were updated to read:

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

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

RACE 1 (p.59; NAACCR Item #160)
01/01/04

Coding instruction was modified to read: "If the patient is multiracial, then code all races using *Race 2* (NAACCR Item #161) through *Race 5* (NAACCR Item #164)**,** and code all remaining Race items 88."
New coding instruction was added: "If *Race 1* is coded 99, then *Race 2* through *Race 5* must all be coded 99."
New coding instruction was added: "If *Race Coding System–Current* (NAACCR Item #170) is less than six (6) for cases diagnosed prior to January 1, 2000, then *Race 2* through *Race 5* must be blank."
New coding instruction was added: "If a patient is diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System–Current* (NAACCR Item #170) must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88."

RACE 2 (p.61; NAACCR Item #161)
01/01/04

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

RACE 3 (p.62; NAACCR Item #162)
01/01/04

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

RACE 4 (p. 63; NAACCR Item #163)
01/01/04

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

RACE 5 (p.64; NAACCR Item #164)
01/01/04

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

SPANISH ORIGIN—ALL SOURCES (p.65; NAACCR Item #190)
09/01/04

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

01/01/04

Rationale was modified to read: "...other populations that may be included in the 01 (White category) of *Race 1* through *Race 5* (NAACCR Item #s 160-164)."
Coding instruction was modified to read: "Code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons."

COMORBIDITIES AND COMPLICATIONS #1–#10
(pp.69-75D; NAACCR Item #s 3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, 3164)
01/01/04

List of allowable values was modified to include: V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049.
Item Descriptions were modified to read: "Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during...."
Item Rationales were modified to read: "...preexisting medical conditions, factors influencing health status, and/or complications may..."
Instructions for coding these items have been extensively clarified.
Definitions for codes were changed to read: "*Note:* For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters."

PHYSICIAN #3 (p.78; NAACCR Item #2490)
01/01/04

Definition for code 00000000 was changed to read: "None; no additional physician."
Definition for code 99999999 was modified to read: "Physician is unknown or an identification number is not assigned."

PHYSICIAN #4 (p.79; NAACCR Item #2500)
01/01/04

Definition for code 00000000 was changed to read: "None; no additional physician."
Definition for code 99999999 was modified to read: "Physician is unknown or an identification number is not assigned."

Cancer Identification

DATE OF FIRST CONTACT (p.87; NAACCR Item #580)
01/01/04

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

DATE OF INITIAL DIAGNOSIS (p. 89; NAACCR Item #390)
09/01/04

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

PRIMARY SITE (p.91; NAACCR Item #400)
01/01/04

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

HISTOLOGY (p.93; NAACCR Item #522)
01/01/04

NAACCR Item Number was corrected to read: #522

BEHAVIOR CODE (p.94; NAACCR Item #523)

04/01/04

Rational, Instructions for Coding, and Code/Definition table all revised:
Rationale changed to read: "**The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or malignant (3).**"
Instruction for Coding removed: The instruction "Record only tumors with behavior codes 2 or 3." was removed.
The Exception following the instructions for coding changed to a Note, and reads: "**The ICD-O-3 behavior code for juvenile astrocytoma (9421/1) should be coded as 3. Refer to "Case Eligibility" in Section One for information.**"
Table of code definitions expanded: The table listing allowable codes and their definitions was expanded to include behavior codes 0 and 1.

01/01/04

Definitions for code 2 were revised to include only three categories [Bowen disease was removed]:
Andenocarcinoma in an adenomatous polyp with no invasion of stalk
Clark level 1 for melanoma (limited to epithelium)
Comedocarcinoma, noninfiltrating (C50._)

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

01/01/04

Coding instruction was modified to read: "Code the grade for in situ lesions if the information is available. If the lesion is both invasive and in situ, code only the invasive portion. If the invasive component grade is unknown, then code 9."
Coding instruction was modified to read: "Codes 5–8 define T-cell or B-cell origin..."
Coding instruction was modified to read: "Do not use the WHO grade to code this data item."
New coding instruction was added: "If no grade is given for astrocytomas, then code 9 (Unknown)."
New coding instruction was added: "If no grade is given for glioblastoma multiforme, then code 9 (Unknown).
Grade/Cell values in the table were modified:

Grade I, 1, i
Grade II, 2, ii, I/III, or 1/3
Grade III, 3, iii, II/III, or 2/3
Grade IV, 4, iv, III/III, or 3/3

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

5 - T cell; T-precursor
8 - NK (natural killer) cell (effective with diagnosis year 1/1/95 and after)
9 - Cell type not determined, not stated or not applicable; unknown primaries; high grade dysplasia (adenocarcinoma in situ)

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

DIAGNOSTIC CONFIRMATION (p.99; NAACCR Item #490)

01/01/04

New coding instruction was added: "Code 1 for positive hematologic findings and bone marrow specimens for leukemia, including peripheral blood smears and aspiration biopsies."
New coding instruction was added: "Code 2 for positive brushings, washings, cell aspirations and hematologic findings (except for leukemia)."

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

09/01/04

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

01/01/04

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

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

REGIONAL LYMPH NODES EXAMINED (p.102; NAACCR Item #830)
01/01/04

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

REGIONAL LYMPH NODES POSITIVE (p.103; NAACCR Item #820)
01/01/04

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

Stage of Disease at Diagnosis

SURGICAL DIAGNOSTIC AND STAGING PROCEDURE (p.109; NAACCR Item #1350)
01/01/04

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

Examples provided for codes 00 and 01 have been revised.

SURGICAL DIAGNOSTIC AND STAGING PROCEDURE AT THIS FACILITY
(p.111 NAACCR Item #740)
01/01/04

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

CLINICAL T (p.112; NAACCR Item #940)
09/01/04

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

CLINICAL N (p.113; NAACCR Item #950)
9/01/04

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

CLINICAL M (p.114; NAACCR Item #960)
9/01/04

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

CLINICAL STAGE GROUP (p.115; NAACCR Item #970)
9/01/04

Added sentence to second bullet: "Interpret missing components as 'X'"
Modified note: "Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging."

01/01/04

New allowable code value and definition was added: OC and Occult, respectively.

CLINICAL STAGE (PREFIX/SUFFIX) DESCRIPTOR (p.116; NAACCR Item #980)
9/01/04

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

STAGED BY (CLINICAL STAGE) (p.117; NAACCR Item #990)
9/01/04

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

PATHOLOGIC T (p.118; NAACCR Item #880)
9/01/04

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

PATHOLOGIC N (p. 119; NAACCR Item #890).
09/01/04

New allowable code values were added: I-, N0(i-); **I+**, N0(I+); **M-**, N0(mol-); **M+**, N0(mol+).
Modified note: "Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging."

PATHOLOGIC M (p.120; NAACCR Item #900)
9/01/04

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

PATHOLOGIC STAGE GROUP (p.121; NAACCR Item #910)
9/01/04

Added sentence to second bullet: "Interpret missing components as 'X'"
Modified note: "Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging."

PATHOLOGIC STAGE (PREFIX/SUFFIX) DESCRIPTOR (p. 122; NAACCR Item #920)
9/01/04

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

First Course of Treatment

SURGICAL PROCEDURE OF PRIMARY SITE (p.135; NAACCR Item #1290)
01/01/04

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

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

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

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

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

SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY
(p.140; NAACCR Item #672)
01/01/04

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

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

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

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

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

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

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

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

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

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

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

Rationale was changed to read: "This data item provides information related to the quality of care and describes why primary site surgery was not performed."
Coding instruction was modified to read: "If Surgical Procedure of Primary Site (NAACCR Item #1290) is coded 00, then record..."
New coding instruction was added: "Code 1 if *Surgical Procedure of Primary Site* (NAACCR Item #1290) is coded 98."

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

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

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

Definition for code 00 was modified to include cases: " Diagnosed at autopsy."
Definition for code 18 was modified to read: "The primary target is the intact breast and no attempt has been made to irradiate the regional lymph nodes. Intact breast includes tissue that either was not surgically treated or received a lumpectomy or partial mastectomy (C50.0–C50.9, *Surgical Procedure of Primary Site* (NAACCR Item #1290] codes 0–24)."
Definition for code 19 was modified to read: "A deliberate attempt has been made to include lymph nodes in the treatment of an intact breast. See definition of intact breast above."
Definition for code 99 was modified to include cases diagnosed by: "Death certificate only."

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

Definition for code 00 was modified to include cases: " Diagnosed at autopsy."
Definition for code 99 was modified to include cases diagnosed by: "Death certificate only."

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

Definition for code 00000 was modified to include cases: "Diagnosed at autopsy."
Definition for code 99999 was modified to include cases diagnosed by: "Death certificate only."

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

Definition for code 00 was modified to include cases: "Diagnosed at autopsy."
Definition for code 99 was modified to include cases diagnosed by: "Death certificate only."

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

Definition for code 00000 was modified to include cases: "Diagnosed at autopsy."
Definition for code 99999 was modified to include cases diagnosed by: "Death certificate only."
Code value changed: Stage II breast carcinoma example, code changed from 02500 to 88888.

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

Definition for code 0 was modified to include cases: "Diagnosed at autopsy."
Definition for code 9 was modified to include cases diagnosed by: "Death certificate only."

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

New coding instruction was added: "If the patient received both radiation therapy and any one of the following surgical procedures: *Surgical Procedure of Primary Site*, *Regional Lymph Node Surgery*, or *Surgical Procedure/Other Site*, then code this item 2–9, as appropriate."
Definition for code 0 was modified to include cases: "Diagnosed at autopsy."
Definition for code 9 was modified to include cases diagnosed by: "Death certificate only."

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

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

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

New coding instruction was added: "If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy provided in the item *Palliative Care* (NAACCR Item #3270)."
Definition for code 00 was modified to include cases: "Diagnosed at autopsy."

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

New coding instruction was added: "If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy provided in the item *Palliative Care at This Facility* (NAACCR Item #3280)."
Definition for code 00 was modified to include cases: "Diagnosed at autopsy."

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

New coding instruction was added: "If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy provided in the item *Palliative Care* (NAACCR Item #3270)."
Definition for code 00 was modified to include cases: "Diagnosed at autopsy."

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

New coding instruction was added: "If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy provided in the item *Palliative Care at This Facility* (NAACCR Item #3280)."
Definition for code 00 was modified to include cases: "Diagnosed at autopsy."

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

New coding instruction was added: "If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy provided in the item *Palliative Care* (NAACCR Item #3270)."
Definition for code 00 was modified to include cases: "Diagnosed at autopsy."

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

New coding instruction was added: "If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy provided in the item *Palliative Care at This Facility* (NAACCR Item #3280)."
Definition for code 00 was modified to include cases: "Diagnosed at autopsy."

HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES
(p.182; NAACCR Item #3250)
01/01/04

New coding instruction was added: "If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hematologic transplant or endocrine procedure provided in the item *Palliative Care* (NAACCR Item #3270) or *Palliative Care at This Facility* (NAACCR Item #3280), as appropriate."
Definition for code 00 was modified to include cases: "Diagnosed at autopsy."
Definition for code 20 was modified to read: "Stem cell harvest and infusion."

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

New coding instruction was added: "If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care* (NAACCR Item #3270)."
Definition for code 0 was modified to include cases: "Diagnosed at autopsy."
Definition for code 9 was modified to include cases diagnosed by: "Death certificate only."
The 'Note' following the table of codes and definitions was moved to Section One of the manual.

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

New coding instruction was added: "If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care at This Facility* (NAACCR Item #3280)."
Definition for code 0 was modified to include cases: "Diagnosed at autopsy."
Definition for code 9 was modified to include cases diagnosed by: "Death certificate only."
The 'Note' following the table of codes and definitions was moved to Section One of the manual.

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

The name of this data item has been changed to PALLIATIVE CARE.
Item Description was modified to read: "...alleviate symptoms. Palliative care is performed to..."
Item Rationale was modified to read: "...to track care that is considered palliative rather than diagnostic or curative in intent."
All coding instructions for this item have been changed.
Definition for code 1 was modified to include cases: "Diagnosed at autopsy."
Definition for code 7 was expanded to read: "...Palliative care was provided that does not fit the descriptions for codes 1–6."
Coding examples have been changed to reflect changes made to the coding instructions for this item.

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

The name of this data item has been changed to PALLIATIVE CARE AT THIS FACILITY.
Item Description was modified to read: "...alleviate symptoms. Palliative care is performed to..."
Item Rationale was modified to read: "...to track care that is considered palliative rather than diagnostic or curative in intent."
All coding instructions for this item have been changed.
Definition for code 1 was modified to include cases: "Diagnosed at autopsy."
Definition for code 7 was expanded to read: "...Palliative care was provided that does not fit the descriptions for codes 1–6."

Outcomes

CANCER STATUS (p.201; NAACCR Item #1770)
01/01/04

Item Description was changed to accommodate follow-up of non-malignant brain/CNS tumors and reads: "...clinical evidence of the patient's malignant or non-malignant tumor as of the..."
Labels were changed for codes 1 and 2: The word 'cancer' was replaced with 'tumor.'
Second example was changed to replace the word 'cancer' with 'tumor' in the first sentence: "...February 2, 2004 with no evidence of this tumor..."

Case Administration

OVERRIDE ITEMS (pp. 210–221; NAACCR Item #s 1985–1990, 2020, 2030, 2040, 2070, 2071, 2074)
01/01/04

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

OVERRIDE SITE/TNM-STAGE GROUP (p. 214; NAACCR Item #1989)
09/01/04

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

OVERRIDE AGE/SITE/MORPH (p. 215; NAACCR Item #1990)
04/01/04

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

RACE CODING SYSTEM–CURRENT (p.226; NAACCR Item #170)
01/01/04

Item Description was modified to read: "Describes how race is currently coded..."
Item Rationale was modified to read: "Race codes (NAACCR Items #160–164) have changed over time..."

RACE CODING SYSTEM–ORIGINAL (p.227; NAACCR Item #180)
01/01/04

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

MORPHOLOGY CODING SYSTEM–ORIGINAL (p.231; NAACCR Item #480)
01/01/04

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

ICD-O-2 CONVERSION FLAG (p.232; NAACCR Item #1980)
01/01/04

Item Description was changed to read: "Specifies whether or how site and morphology codes were converted to ICD-O-2."
Second coding instruction was modified to read: "...automated morphology conversion from ICD-O-1 or ICD-O-3 to ICD-O-2."

TNM EDITION NUMBER (p.234; NAACCR Item #1060)
01/01/04

New coding instruction was added: "This item is autocoded by the software provider."

CS FLAGS and VERSION ITEMS (pp.235A–235E)
01/01/04

Five new data items introduced by the Collaborative Staging System have been incorporated into this portion of *FORDS*.

Derived AJCC–Flag (NAACCR Item #3030)
Derived SS1977–Flag (NAACCR Item #3040)
Derived SS2000–Flag (NAACCR Item #3050)
CS Version First (NAACCR Item #2935)
CS Version Latest (NAACCR Item #2936)

2003

First Course Treatment

SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY
(p.140; NAACCR Item #672)
03/06/03

List of brain/CNS primary sites in fourth coding instruction was corrected to include:
(C70.0-C70.9, C71.0-C71.9, C72,0-C72.9)

RADIATION TREATMENT VOLUME (p.151; NAACCR Item #1540)
03/06/03

Definition for code 06 corrected to read: "Limited volume treatment of a head and neck primary with the exception of glottis (code 7), sinus (code 8), or parotid (code 9)."

REGIONAL TREATMENT MODALITY (p.155; NAACCR Item #1570)
01/03/03

Definition for code 22 was corrected: The code now indicates that intracavitary use of Cobalt-60 or Cesium-137 should be coded as 50 or 51.

BOOST TREATMENT MODALITY (p.159; NAACCR Item #3200)
01/03/03

Definition for code 22 was corrected: The code now indicates that intracavitary use of Cobalt-60 or Cesium-137 should be coded as 50 or 51.

2002

Patient Identification

LAST NAME (p.39; NAACCR Item #2230)
12/04/02

Typographical error in item length was corrected: Item length was changed to 25.
First coding instruction was modified to read: "Truncate name if more than 25 letters long. Blanks, spaces, hyphens and apostrophes are allowed. Do not use other punctuation."

STATE AT DIAGNOSIS (p.45; NAACCR Item #80)
12/04/02

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

09/19/02

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

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

12/04/02

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

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

12/04/02

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

09/19/02

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

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

12/04/02

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

COMORBIDITIES AND COMPLICATIONS #1–#10

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

09/19/02

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

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

Cancer Identification

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

12/04/02

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

10/02/02

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

Code 00000000 was removed as a defined code.

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

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

12/04/02

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

Corresponding code definitions were corrected:

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

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

10/02/02

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

09/19/02

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

REGIONAL LYMPH NODES POSITIVE (p.103; NAACCR Item #820)
12/04/02

Definitions for codes were corrected: The codes and definitions for this item were rewritten to be consistent with the item as it was described in *ROADS, Vol II, 1998*.
Allowable values were changed to: 00-99
New coding instruction was added, directly following the second instruction: "Code 96 when 96 or more nodes are positive."
The third coding instruction (now the fourth) was changed from "Code 95..." **to read:** "Code 97...."
The morphology code specification was changed in the seventh coding instruction (now the eighth) to: From M-9720 to M-9750
The table was updated accordingly to include codes 00, 01-95, 96, 97, 98, and 99 and their respective descriptions.

Stage of Disease at Diagnosis

CLINICAL T (p.112; NAACCR Item #940)
12/04/02

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

CLINICAL N (p.113; NAACCR Item #950)
12/04/02

New allowable code values and definitions were added:
1A and N1a, respectively.
1B and N1b, respectively.

PATHOLOGIC T (p.118; NAACCR Item #880)
12/04/02

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

PATHOLOGIC STAGE GROUP (p.121; NAACCR Item #910)
12/04/02

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

First Course of Treatment

SURGICAL PROCEDURE OF PRIMARY SITE (p.135; NAACCR Item #1290)
12/04/02

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

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

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

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

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

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

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

08/17/02

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

SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY
(p.140; NAACCR Item #672)
08/17/02

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

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

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

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

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

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

New coding instruction was added: "Code 88888 when brachytherapy or radioisotopes, *Regional Treatment Modality* (NAACCR Item #1570) codes 50–62, was administered to the patient."
New code was added: 88888 (Not applicable, brachytherapy or radioisotopes administered to the patient)

09/19/02

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

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

New coding instruction was added: "Code 88888 when brachytherapy or radioisotopes, *Boost Treatment Modality* (NAACCR Item #3200) codes 50 - 62, was administered to the patient."
New code was added: 88888 (Not applicable, brachytherapy or radioisotopes administered to the patient)

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

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

RADIATION/SURGERY SEQUENCE (p.164; NAACCR Item #1380)
09/19/02

Label for code 9 was changed to read: "Sequence Unknown."
Definition for code 9 was expanded to read: "Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown whether radiation therapy was administered and/or it is unknown whether surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed."

PAIN ASSESSMENT (p.188; NAACCR Item #3260)
10/02/02

This item was removed from *FORDS*.

PALLIATIVE PROCEDURE (p. 189; NAACCR Item #3270)
09/18/02

First coding instruction was rewritten to read: "Record the type of palliative procedure administered during the first course of treatment or in lieu of treatment."

PALLIATIVE PROCEDURE AT THIS FACILITY (p.191; NAACCR Item #3280)
09/18/02

First coding instruction was rewritten to read: "Record the type of palliative procedure administered during the first course of treatment or in lieu of treatment."

Case Administration

ICD-O-2 CONVERSION FLAG (p.232; NAACCR Item #1980)
12/04/02

Allowable code list was corrected to include codes 5 and 6.
Definition for code 5 was added to read: "Morphology converted from ICD-O-3 without review."
Definition for code 6 was added to read: "Morphology converted from ICD-O-3 with review."

CHANGES TO APPENDIX B: SITE-SPECIFIC SURGERY CODES

2004

09/01/04

Lymph Nodes (p. 283)

Coding reminder was modified following code 25: From "Less than a full chain, includes a lymph node biopsy." **to** "Less than a full chain, includes an excisional biopsy of a single lymph node."

01/01/04

Anus (p.260)

Coding reminder was added following codes 60–63: "The lymph node dissection should also be coded under *Scope Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope Regional Lymph Node Surgery at This Facility* (NAACCR Item #672)."

Lung (p.264)

Coding reminder was added following codes 30 and 33: "The lymph node dissection should also be coded under *Scope Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope Regional Lymph Node Surgery at This Facility* (NAACCR Item #672)."
Coding reminder was modified following codes 55 and 56, and 70 to read: "The lymph node dissection should also be coded under *Scope Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope Regional Lymph Node Surgery at This Facility* (NAACCR Item #672)."

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

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

Bones, Joints, etc. (p.266)

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

Spleen (p.267)

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

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

Skin (p.268)

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

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

Breast (p.269)

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

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

Cervix Uteri (p.272)

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

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

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

Corpus Uteri (p.274)

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

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

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

Ovary (p.275)

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

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

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

Definition for code 74 was modified to read: "Extended exenteration."

Testis (p.278)

Definition for code 30 was modified to read: "Excision of testical WITHOUT cord."
Definition for code 40 was modified to read: "Excision of testical WITH cord or cord not mentioned (radical orchiectomy)."

Bladder (p.280)

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

Brain (p. 281)

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

All Other Sites (p. 280)

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

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

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

2003

03/06/03

Breast (pp.269–270)

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

2002

12/04/02

Oral Cavity (p.249)

Code 10 and its definition were aligned with code 00.

Prostate (p.277)

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

Lymph Nodes (p.283)

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

08/17/02

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

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

Bones, Joints, etc. (p.266)

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

Brain (p.281)

Site definition was clarified to read: "Meninges C70.0–C70.9."

All Other Sites (p. 284)

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

INDEX

(Updated 09/06)

Index