2018-2019 Cancer Reporting Handbook

Rules and Guidelines for Cancer Reporting in Texas

Texas Cancer Registry

Publication No. E10-10677
Released May 2019

TEXAS Health and Human Services

Texas Department of State Health Services

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INTRODUCTION TO CANCER REPORTING

TEXAS CANCER REGISTRY

Preface

With original authorization from the *1979 Texas Cancer Control Act* and the *Texas Cancer Incidence Reporting Act,* Chapter 82, Health and Safety Code (amended April 2015), the Texas Cancer Registry (TCR) of the Texas Department of State Health Services (DSHS) collects information on each patient seeking diagnosis and/or treatment for cancer at health care facilities, clinical laboratories, as well as physician and other outpatient offices (in certain circumstances), within the State of Texas. Texas Administrative Code, Title 25, Part 1, Chapter 91, Subchapter A (amended April 2017) specifies the rules necessary to implement this act. The cancer reporting law and rules may be accessed on the TCR website at the following location: https://www.dshs.texas.gov/tcr/lawrules.aspx.

The mission of the TCR is to collect, maintain, and disseminate high quality cancer data that contribute towards cancer prevention and control, research, improving diagnoses, treatment, survival, and quality of life for all cancer patients. It is estimated that there will be 1,762,450 new cancers and 606,880 cancer deaths in the United States in 2019. A statewide cancer registry is the foundation for cancer prevention and control. The effectiveness of the Cancer Registry is dependent on complete, timely and accurate reporting.

The TCR is the 4th largest cancer registry in the United States. Over 242,509 reports of cancer are received annually from over 600 hospitals, cancer treatment centers, ambulatory surgery centers, and pathology laboratories located throughout the state. The Texas Cancer Registry *2018-2019 Cancer Reporting Handbook* serves as the instruction manual to provide rules and guidelines which assure the consistent collection and coding of relevant cancer case information. This edition should be used for reportable cases diagnosed January 1, 2018 and forward. The contents of this manual are based on the guidelines and standards for cancer reporting established by the National Program of Cancer Registries (NPCR) at the Centers for Disease Control and Prevention (CDC), the North American Association of Central Cancer Registries (NAACCR), the Surveillance, Epidemiology, and End Results Program (SEER) at the National Cancer Institute (NCI), and the American College of Surgeons (ACoS).

The handbook may be accessed on the TCR website on the following page: https://www.dshs.texas.gov/tcr/training/2018-2019-handbook.aspx.

For any problems please contact the TCR. Please remember to monitor the TCR website for training opportunities. This information can be found at https://www.dshs.texas.gov/tcr/training.aspx.

HANDBOOK SOURCES

The following sources were used in the preparation of this handbook:

- *SEER Program Coding and Staging Manual 2018* (Updated January, 2019). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. https://seer.cancer.gov/tools/codingmanuals/.
- *SEER Summary Stage 2018 V1.1* Ruhl JL, Callaghan C, Hurlbut, A, Ries LAG, Adamo P, Dickie L, Schussler N (eds.) Summary Stage 2018: Codes and Coding Instructions, National Cancer Institute, Bethesda, MD, 2018. https://seer.cancer.gov/tools/ssm
- ***ST****andards for* ***O****ncology* ***R****egistry* ***E****ntry (STORE 2018): Released 2018. Version 1.0* Commission on Cancer, American College of Surgeons, https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals
- *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 18* (Revised: posted 3/2/18; revised 3/13/18; 3/22/18; 4/2/18; 4/13/18; 5/16/18; 5/18/18; 6/7/18) 8/20/18; 8/31/18; 9/6/18; 9/7/18, 9/18/18, 9/20/18, 10/12/18, 11/7/18). North American Association of Central Cancer Registries, Springfield, IL 62704-4194. https://www.naaccr.org/data-standards-data-dictionary/.
- *Texas Cancer Incidence Reporting Act* (Amended April 2015), Texas Health and Safety Code, Chapter 82; and Rules, Title 25 Texas Administrative Code, Chapter 91, Subchapter A. Cancer Registry (Effective April 2017). https://www.dshs.texas.gov/tcr/lawrules.aspx.
- *Solid Tumor Rules* (Published January 2019) https://seer.cancer.gov/tools/solidtumor/ Dickie L., Johnson, CH., Adams, S., Negoita, S. (June 2018). *Solid Tumor Rules*. National Cancer Institute, Rockville, MD 20850.
- *Site-Specific Data Items(SSDI) /Grade* Last updated: February 2019 *Version 1.5* https://apps.naaccr.org/ssdi/list/
- *Hematopoietic and Lymphoid Neoplasm Coding Manual* (Published January 2019). Ruhl J, Adamo M, Dickie L., Negoita, S. (January 2019). https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf.
- *SEER*Rx Interactive Antineoplastic Drugs Database* (Web-based). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. https://seer.cancer.gov/seertools/seerrx/.
- *SEER Inquiry System (SINQ).* Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. https://seer.cancer.gov/seerinquiry/index.php.
- *Physician Data Query (PDQ).* National Cancer Institute, Bethesda, MD 20850-9765. https://www.cancer.gov/publications/pdq

Acknowledgment

We wish to acknowledge that some information presented in this handbook was taken verbatim from the SEER Program Coding and Staging Manual 2018 [Adamo M, Dickie L, Ruhl J. (January 2018) *SEER Program Coding and Staging Manual 2018*. National Cancer Institute, Bethesda, MD 20850-9765.] U.S. Department of Health and Human Services National Institutes of Health National Cancer Institute.

HELPFUL WEBSITES

https://www.dshs.texas.gov/tcr/

https://seer.cancer.gov/registrars/

https://www.cancer.gov/

https://www.ncra-usa.org/

https://www.naaccr.org/

https://www.cancer.org/

https://codes.iarc.fr/

http://cancerbulletin.facs.org/forums/help

https://cancercontrolplanet.cancer.gov/

https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals

https://cancerstaging.org/CSE/Registrar/Pages/default.aspx

https://tools.usps.com/go/ZipLookupAction_input

https://www.zip-codes.com/zip-code/78734/zip-code-78734.asp

https://www.melissa.com/lookups/addressverify.asp

https://wwwn.cdc.gov/nioccs3/SingleCoding.aspx

https://www.bls.gov/soc/

https://www.nccn.org/

http://www.breastcancer.org/

https://www.nlm.nih.gov/

http://www.anatomyatlases.org/

http://oralcancerfoundation.org/

http://www.pathologyoutlines.com/

https://www.txhima.org/

http://www.whonamedit.com/

http://docfinder.docboard.org/tx/df/txsearch.htm

ACRONYMS

ACS	American Cancer Society
ACoS	American College of Surgeons
AJCC	American Joint Committee on Cancer
CDC	Centers for Disease Control and Prevention
CESB	Cancer Epidemiology and Surveillance Branch
CNS	Central Nervous System
CoC	Commission on Cancer
CRH	Cancer Reporting Handbook
CS	Collaborative Stage
DSHS	Department of State Health Services
FIPS	Federal Information Processing Standards
ICD-O-3	International Classification of Diseases for Oncology, 3rd Edition
ICD-O-2	International Classification of Diseases for Oncology, 2nd Edition
MP/H	Multiple Primary and Histology Coding Rules
NAACCR	North American Association of Central Cancer Registries
NPCR	National Program of Cancer Registries, CDC
HSR	Health Service Region
SEER	Surveillance, Epidemiology, and End Results Program, NCI
SINQ	SEER Inquiry System
SSDI	Site-Specific Data Items
STORE	**ST**andards for **O**ncology **R**egistry **E**ntry
TCR	Texas Cancer Registry
TNM	T=Tumor N=Lymph Nodes M=Metastases
WHO	World Health Organization
VSU	Vital Statistics Unit

TCR CODING AND STAGING REQUIREMENT SUMMARY

Coding Cancer Cases

For cancer coding, the correct ICD-O version must be used for all cases according to the year in which the cancer case was diagnosed. If the diagnosis year is unknown, use the year and month in which the case was accessioned. If this process is not applied the cancer case will fail required edits and will not be accepted by the TCR.

The *International Classification of Diseases for Oncology, 3rd Edition* (ICD-O-3) **must** be used to code the primary cancer site (topography NAACCR item #400) and the cell type (morphology, behavior, and grade, NAACCR item # 522 and 523) of the tumor for all cases diagnosed/admitted on January 1, 2001 and forward.

In 2010 several newly reportable conditions and new ICD-O histology terms and codes were added for hematopoietic and lymphoid neoplasms. In 2018 these newly reportable conditions are included in the updated Hematopoietic Database and Manual.

The 2018 ICD-O-3 Update Guidelines includes comprehensive tables listing all changes to ICD-O-3 effective for cases diagnosed 1/1/2018 forward. The guidelines also provide background on the project and issues encountered during review of the WHO Classifications of Tumors. Direction on these updates are also found in Appendix K and links to access the necessary tables which must be reviewed for additional direction and terms of reportable neoplasms. Also, refer to the 2018 Solid Tumor Rules and the Multiple Primary and Histology rules for site specific histology rules.

Use the 2018 Solid Tumor coding rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2018 and forward. The Solid Tumor coding rules and the 2018 General Instructions **replace** the 2007 Multiple Primary & Histology (MP/H) Rules for the following sites **ONLY**:

- Breast
- Colon (includes rectosigmoid and rectum for cases diagnosed 1/1/2018 forward)
- Head & Neck
- Kidney
- Lung
- Malignant CNS and Peripheral Nerves
- Non-malignant CNS
- Urinary Sites

Revision Status for Remaining 2007 Multiple Primary and Histology Site Rules

SEER is currently working on revisions to the remaining two MP/H site groups. Release date has not yet been determined. The 2007 MP/H and 2007 General Instructions are to be used, with a few exceptions, for cases for the following site groups until instructed to do otherwise.

Cutaneous Melanoma

Based on the recent WHO 4th Ed Tumors of Skin, SEER does not expect major changes to the cutaneous melanoma rules.

Other Sites

The 2017 Multiple Primary and Histology Rules must be used for all the sites in the Other Sites except for the following sites:

- Rectosigmoid and rectum which are now included in 2018 Solid Tumor Rules under Colon
- Peripheral nerves which are now included in the 2018 Solid Tumor Rules under Malignant CNS

For all cases diagnosed on January 1, 1992–December 31, 2000, the *International Classification of Diseases for Oncology, 2nd Edition* (ICD-O-2) **must** be used to code the primary cancer site (topography) and the cell type (morphology, behavior and grade, NAACCR item 420 and 430).

Note: These cases must be converted to ICD-O-3 codes. Third party software automatically convert these codes appropriately, for Web Plus users this is a manual process.

Staging Cancer Cases

Directly Coded SEER Summary Stage 2018 is required from all facilities for reporting year 2018. TNM data items is required only from facilities accredited by the American College of Surgeons (ACoS) and only for analytical cases. For hospitals and cancer centers that are not ACoS accredited, these data items are required for analytical cases only *as available* (class of case 00-22). The TCR currently does not collect EOD 2018 for cases diagnosed in 2018.

For staging cancer cases, all cases must be staged and the corresponding stage data fields must be completed according to the correct staging guidelines for the year the cancer was diagnosed. If the diagnosis year is unknown, the correct guidelines for the year in which the case is accessioned must be used. Otherwise, the cancer case will fail required edits and will not be accepted by the TCR.

TCR CODING AND STAGING MANUALS

Table 1.1 TCR Coding and Staging Requirement Summary

Coding and Staging Schema	Diagnosis Year
SEER April 1977 Summary Staging Guide	Prior to 2001
International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)	2001 – forward
International Classification of Diseases for Oncology, 2nd Edition (ICD-O-2)	1995 – 2000*
Collaborative Stage Data Collection System Coding Instructions, vs. 02.05	2004 – 2015
SEER Summary Staging Manual 2000 (SSSM2K)	2001 – 2003 2015 – 2017
SEER Summary Stage 2018	2018 - forward

Coding and Staging Schema	Diagnosis Year
Multiple Primary and Histology Rules	2007 - 2017
Solid Tumor Rules 2018	2018 – forward
Hematopoietic and Lymphoid Neoplasm Coding Manual	2010 – forward
AJCC Cancer Staging Manual, Seventh Edition	2015 – 2017
AJCC Cancer Staging Manual, Eighth Edition	2018 - forward

*The TCR no longer requires reporting of cases diagnosed prior to 1995.

Note:

- Specific CS SSFs are required for 2017 diagnosis cases.
- SSDI's are replacing CS SSF for 2018 diagnosis cases.
- Per SEER, the new coding and staging instructions/guidelines replaces the old for their respective time periods.

TCR REQUIRED SITE SPECIFIC DATA-ITEMS

There are additional data items required for cases diagnosed beginning January 1, 2018. Some of this information was previously captured in the CS Site Specific Factors (SSF) prior to 2018 but will now be captured in the Site Specific Data Items (SSDI) beginning 2018 and forward. (See more on SSDI's in the SSDI manual)

Required SSDI's

NAACCR Item #	Item name	Primary site
3816	Molecular Markers-Brain	Brain Histologies 9400/3, 9401/3, 9440/3, 9450/3, 9451/3, 9471/3, 9478/3
3817	Breslow Tumor Thickness	Melanoma of skin Previously collected in CS SSF#1
3827	Estrogen Receptor Summary	Breast Previously collected in CS SSF#1
3835	Fibrosis Score	Liver Previously collected in CS SSF#2
3855	HER2 Overall Summary	Breast Previously collected in CS SSF#15
3890	Microsatellite Instability (MSI)	Site Specific, when available Colon/ Rectum Previously collected in CS SSF#7

NAACCR Item #	Item name	Primary site
3915	Progesterone Receptor Summary	Breast Previously collected in CS SSF#2
3920	PSA Lab Value	Prostate Previously collected in CS SSF#1
3926	*Schema Discriminator 1	Used to assign AJCC ID
3927	*Schema Discriminator 2	Used to assign AJCC ID
3932	LDH PreTxValue	Plasma Cell Myeloma and Melanoma of the Skin

*Schema Discriminator 1 - (#3926) Bile Ducts Distal/Bile Ducts Perihilar/Cystic Duct

- Esophagus GE Junction (EGJ)/Stomach
- Histology Discriminator for 9591/3
- Lacrimal Gland/Sac
- Melanoma Ciliary Body/Melanoma Iris
- Nasopharynx/Pharyngeal Tonsil C11.1 only
- Occult Head and Neck Lymph Nodes
- Plasma Cell Myeloma Terminology
- Primary Peritoneum Tumor
- Thyroid Gland/Thyroglossal Duct
- Urethra/Prostatic Urethra

*Schema Discriminator 2 - (#3927) Esophagus and Esophagogastric Junction/Histology Discriminator for 8020/3

- Undifferentiated carcinoma with squamous component
- Undifferentiated carcinoma with glandular component
- Undifferentiated carcinoma, NOS

*Schema Discriminator 2 - (#3927) Oropharyngeal page 16

- p16 expression of weak intensity or limited distribution
- p16 without an immunostain performed

TCR Required New Data Items

(# 1506) Phase I Radiation Treatment Modality (replaces Radiation Modality (#1570) and RX Summ—Radiation (#1360)

(# 764) Directly assigned Summary Stage 2018

(#3843) Grade Clinical

(#3844) Grade Pathological

CDC NPCR

Beginning with cases diagnosed 1/1/2018 and forward, CDC-NPCR will adopt the new record layout and data collection requirements as published in the Data Standards and Data Dictionary, Version 18. The majority of the 2018 changes relate to the final transition from Collaborative Stage V2 (CSv2) to directly assigned Summary Stage 2018, EOD 18, ICD-O-3 changes, AJCC-TNM 8th Edition Clinical and Pathological Stage and changes to Radiation Treatment. Refer to the CDC-NPCR requirements listed in the Data Standards and Data Dictionary, Version 18, Chapter VIII Required Status Table. **SEE Appendix F Comparisons of Data Sets on page 364.**

Note: **Please see page 6 specific TCR coding and staging requirements**. Beginning with cases diagnosed January 1, 2018, the Texas Cancer Registry (TCR) is requiring the TNM data items from facilities who are accredited by the American College of Surgeons (ACoS) and on analytical cases only. For hospitals and cancer centers that are not ACoS accredited, these data items are only required for analytical cases (class of case 00-22) if available.

STANDARD SETTERS STAGING REQUIREMENTS

SEER Summary Stage 2018

Directly Coded SEER Summary Stage 2018 is required for all cases diagnosed January 1, 2018 and forward from all facilities. Please see the SEER Summary Stage 2018 Manual for detailed coding instructions.

Summary Stage is the most basic way of categorizing how far a cancer has spread from its point of origin. Historically, Summary Stage has also been called General Stage, California Stage, historic stage, and SEER Stage.

The 2018 version of Summary Stage applies to every site and/or histology combination, including lymphomas and leukemias. Summary Stage uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease. Many central registries report their data by Summary Stage as the staging categories are broad enough to measure the success of cancer control efforts and other epidemiologic efforts.

There are six main categories in Summary Stage. In addition, the main category of Regional stage is subcategorized by the method of spread. The code structure is list in this table.

Code	Description
0	In situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND regional lymph nodes
7	Distant site(s)/node(s) involved
8	Benign, borderline*
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death certificate only

Note: **For SS2018, code 5 for "Regional, NOS" can no longer be coded. Code 5 (Regional, NOS) is still applicable for SS2000.**

NEW DATA ITEMS FOR 2018

Site-Specific Data Items (SSDI's)

There are 223 data items that are new for the Data Standards and Data Dictionary, Version 18. Among them are 137 Site Specific Data Items (SSDIs) plus a Schema ID [3800], all of which are described in detail in the 2018 SSDI Manual prepared by the *NAACCR SSDI* Taskforce.

Collaborative Stage Site-Specific Factors (CS SSFs) have been discontinued and Site-Specific Data Items (SSDIs) are used for collection of site-specific information for cases diagnosed on or after January 1, 2018. See the Data Standards and Data Dictionary, Version 18, Chapter VIII Required Status Table to determine which staging data items are required to be collected by the various standard setters.

The Site-Specific Data Item (SSDI) manual is the primary resource for documentation and coding instructions for site-specific data items introduced in 2018. Information in the SSDI Manual is similar to that provided in the Collaborative Stage v2 (CSv2) Manual Part I, Section II for Site Specific Factors (SSF).

Before using the Manual as an information resource for specific data items, it is important to review the introductory materials and general instructions carefully. Although the majority of data items that are collected as SSDIs were previously collected as SSFs, the format of the data items and allowable values have changed substantially, particularly for laboratory values.

An important new concept introduced in 2018 is the use of a **Schema ID** to define the applicable SSDIs and grade table for a particular tumor, based on primary site, histology, and in some cases, additional information. The appropriate Schema ID will be defined by registry software and will not have to be assigned by the registrar. However, a Schema ID Table defining the Schema ID number, description and associated SSDIs is provided in the SSDI Manual for reference purposes. The Schema ID Table will also be useful for registrars abstracting cases before their software is available. In addition to Schema IDs, the Schema ID Table provides the AJCC 8th Edition Chapter for which the SSDIs and grade table defined by the Schema ID apply, with a hyperlink to the page on which the description of the relevant SSDIs begins. A hyperlink at the end of the information on each SSDI can be used to return to the Schema ID Table.

For each SSDI, the SSDI Manual includes:

- NAACCR Data Item Name
- Item Length
- NAACCR Item #
- NAACCR Alternative Name
- AJCC 8th Edition Chapter(s)
- Description – a brief summary used to define the data item in the NAACCR data dictionary.
- Rationale – describes the reason why the data item is collected, such as required for staging or recommended for registry data collection by AJCC. If the data item was collected in CSv2, the primary site and SSF# is included in the rationale.

- Definition – provides additional background on the data item and its clinical importance. This information was previously included in the CSv2 Manual, Part I, Section II.
- Additional Information – may include source documents, other names, normal reference ranges and any other information deemed relevant for a particular SSDI. This information was previously included in the CSv2 Manual, Part I, Section II.
- Coding instructions and Codes
  - Coding instructions are provided as numbered notes.
  - Codes are provided in a table.
  - Codes and coding instructions are usually provided in registry software.

New for 2018

- Decimals are allowed
  - Record actual values
- Record by name not number
  - PSA not SSF1 in Prostate
- No "not done" codes
  - Code like "unknown"

See the SSDI manual for full coding instructions.

Grade

2018 Grade Coding Instructions and Tables

Beginning with cases diagnosed in 2018 grade information will be collected in three different data fields: **Clinical Grade, Pathological Grade, and Post-Therapy Grade**. **The TCR requires the clinical grade and pathological grade.** Within the Grade Manual you will find definitions for the three new grade data items, coding instructions, and the site/histology specific grade tables.

Please see the Grade Manual for full coding instructions.

2018 SOLID TUMOR CODING RULES

(Formerly known as Multiple Primary And Histology Rules)

The 2018 Solid Tumor Coding Rules will be used for cases diagnosed January 1, 2018 and forward as well as the 2017 Multiple Primary and Histology Rules for Cutaneous Melanoma and Other Sites (excluding rectum and rectosigmoid, peripheral nerves). The 2018 Solid Tumor Rules must be used for all sites mentioned in the General Guidelines. As the chapters for Cutaneous Melanoma and Other Sites are completed the 2017 MPH Rules manual will only be used for cases diagnosed prior to 2018. Please visit the SEER website to download the manual. The 2018 Solid Tumor Coding Rules are a comprehensive revision to the 2007 site-specific Multiple Primary and Histology Rules, which were developed to promote consistent and standardized coding for cancer surveillance.

How to Use the Solid Tumor Rules

1. To choose the appropriate module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors), determine the **number of tumors**.
   a. Do not count **metastatic** lesions when determining which module to use.
   b. When the number of tumors is **unknown/not documented**, use the "Unknown if Single or Multiple Tumors" module. When there is a tumor or tumors with separate microscopic foci, ignore the microscopic foci.
   c. When the patient has a **single tumor**, use the "Single Tumor" module.
   d. When the patient has **multiple tumors**, use the "Multiple Tumor" module.
2. When the rules return a single primary, prepare one abstract.
3. When the rules return multiple primaries, prepare two or more abstracts.
4. For those sites/histologies which have recognized **biomarkers**, the biomarkers frequently identify the histologic type. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.

How to Use the Histology Rules

Note 1*:* Do not use these rules to determine case reportability.

Note 2: First use the Multiple Primary Rules to determine whether this is a single primary or multiple primaries. Determine the histology for each case.

1. Rules are divided into two sections: Single Tumor and Multiple Tumors Abstracted as a Single Primary
   a. Each section is a complete set of rules.
   b. Within each section, the rules are hierarchical. Use the first rule that applies and **STOP**. Do not continue through the rules.
2. Code the histology diagnosis prior to **neoadjuvant therapy**. Neoadjuvant therapy can change the histological profile of the tumor.
3. A list of terms which can be used and terms which cannot be used to code histology precede each set of histology rules.
4. Do not code histologies or subtypes/variants described by **ambiguous terms**:

- Apparently
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

Note: Histology described by ambiguous terminology is coded **ONLY** when a case is accessioned based on ambiguous terminology and no other histology information is available/documented.

Ambiguous terminology from the SEER Manual and CoC Manual is used to determine reportability, not to determine histology.

Timing Rules

Each Solid Tumor site group includes timing rules in the Multiple Primary Rules. It is important to remember that timing rules differ by site. Please see examples on page 8 in the Solid Tumor Rules 2018 General Instructions section.

Site Specific Changes From 2007 MP/H Rules to Solid Tumor Rules 2018

Please note that the following information is not inclusive of all sites and does not list the Multiple Primary and Histology rules. This section summarizes the changes from the 2007 MPH rules to 2018. Please go to the 2018 Solid Tumor Rules for full coding instructions on all sites. These changes are effective with cases diagnosed 1/1/2018 and later.

Breast

- **NST (N**o **S**pecial **T**ype**), mammary carcinoma NST, and carcinoma NST** are the new terms for duct or ductal carcinoma. Previously, it was thought that carcinoma originated in the ducts or lobules of the breast, hence the names duct carcinoma and lobular carcinoma. Current thinking is that carcinoma originates in the "terminal duct lobular unit" therefore the preferred term is NST or carcinoma NST.
- Mammary carcinoma is a synonym for carcinoma no special type (NST)/duct carcinoma not otherwise specified (NOS) 8500. It will no longer be coded as carcinoma NOS 8010
- **DCIS/Carcinoma NST in situ** has a major classification change. It is very important to code the grade of all DCIS
  - Code grade as designated in current AJCC Manual, SEER Coding Manual, and CoC Coding Manual
  - The current breast **WHO** edition emphasizes coding the **grade** of tumor rather than the **subtype/variant**.
  - The WHO editions are used internationally by pathologists to keep their nomenclature and histology identification current.
  - Over time, **subtypes/variants** will be diagnosed **less frequently.**
- The subtype/variant is coded **ONLY** when it comprises **greater than or equal to 90%** of the tumor. This change has been implemented in both the WHO and in the CAP protocols.

Colon

- **Rectum** and **Rectosigmoid** are now included with the Colon Rules. In the 2007 MPH Rules, they were included with Other Sites.
- There are new multiple primary rules which address **anastomotic recurrence.**

- Neuroendocrine tumors (formerly carcinoid) arising in the appendix are reportable for cases diagnosed 1/1/2015 and forward.
- **Rule clarification: Pseudomyxoma peritonei** (accumulation of mucin in the abdominal or pelvic cavity) now has a **two-tiered system** (WHO 2010) that classifies pseudomyxoma peritonei as either **high-grade** or **low-grade** (see below)**.** Pseudomyxoma peritonei is usually associated with **mucinous** tumors of the appendix and is rarely associated with ovarian mucinous tumors.
  - **High-**grade pseudomyxoma peritonei is **malignant** /3
  - **Low**-grade pseudomyxoma peritonei is **not malignant** /0
  - See **Histology Rules** for **coding instructions**
- **Polyps** are now **disregarded** when coding histology. For example, adenocarcinoma in an adenomatous polyp is coded as adenocarcinoma 8140.

Head and Neck

Two bone sites, mandible C410 and maxilla C411, have been added to the Head and Neck Rules. External ear C442 has been added to the Head and Neck Rules. Basal cell carcinoma and all non-malignant neoplasms are excluded. Autonomic nervous system C479 has been added as a primary site for paragangliomas which are reported as malignant.

Lung

- Changes are implemented slowly over time, so it is not unusual for a pathology report to use an obsolete term. Obsolete terms and codes can be used when they are the only information available.
- WHO 4th Ed Tumors of Lung 2015 has a new classification of adenocarcinoma which is a significant change from the 2004 WHO classification. One of the major changes is discontinuing usage of the term **bronchioloalveolar carcinoma (BAC)** beginning with cases diagnosed 1/1/2018 and forward. The preferred term for BAC is now mucinous adenocarcinoma **8253.**
- **New** and **changed** ICD-O histology codes have been added to **Table 3** and are identified by an asterisk. Some of those changes include:
  - **In situ** and **minimally invasive terms** and codes
  - **Terms** assigned a **new histology** code
  - **Histology codes** assigned a **different preferred term** (18 codes with new preferred terms)
- The following new terms and codes have been added. The new terms and codes are for **lung** only. See notes in Table 3.
  - Mucinous carcinoma/adenocarcinoma
    - **8257/3** when behavior unknown/not documented (use staging form to determine behavior when available) or Invasive
    - **8257/3** when Microinvasive or Minimally invasive
    - **8253/2** when Preinvasive or In situ

    Note: Previously, only invasive /3 codes were available for mucinous adenocarcinoma of the

lung. It has been recognized that not all lung cancers are invasive /3 so new codes were implemented.

- Non-mucinous carcinoma/adenocarcinoma
  - **8256/3** when Microinvasive or Minimally invasive
  - **8250/2** when Preinvasive or In situ

Kidney

- **New histology terms and codes were included** (identified by asterisks (*) in the histology table in the Terms and Definitions).
  - Histologies with terms that indicate they are **hereditary** (hereditary leiomyomatosis and renal cell carcinoma syndrome–associated RCC **8311**)
  - Histologies with **genetic anomalies** (succinate dehydrogenase–deficient RCC)
- Some histologies are rare and are not listed in the tables; refer to ICD-O and all updates.

  Note: Renal cell spindle cell carcinoma 8318 is no longer a recommended term.

Non-malignant CNS (previously called benign and borderline)

- Clarifications:
  - The following meningiomas are reportable: Intraosseous, cavernous sinus, and sphenoid wing.
  - Multiple cerebral meningiomas are a single primary.
  - Multiple brain tumors (same histology) are a single primary.
  - Bilateral optic nerve gliomas/pilocytic astrocytomas are a single primary. Laterality is not used to determine multiple primaries.
  - Timing is not used to determine multiple primaries.
  - The brain C710-C719 is a single primary site.
  - Neurofibromatosis NOS, Neurofibromatosis 1 (NF1), and Neurofibromatosis 2 (NF2) and schwannomatosis are genetic syndromes and not reportable neoplasms
- The 2016 World Health Organization (WHO) Classification of Tumors of the Central Nervous System (CNS) contains newly recognized histologies and subtypes/variants. New codes/terms are identified by asterisks (*) in Tables 5 and 6 in the Terms and Definitions.

Malignant CNS & Peripheral nerves

- 2016 CNS WHO presents major restructuring of the diffuse gliomas, medulloblastomas and other embryonal tumors, and incorporates new entities that are defined by both histology and molecular features, including glioblastoma, IDH-wildtype and glioblastoma, IDH-mutant; diffuse midline glioma, H3 K27M-mutant, RELA fusion-positive ependymoma, medulloblastoma, WNT-activated and medulloblastoma, SHH-activated, and embryonal tumor with multilayered rosettes, C19MC-altered. The 2016 edition has added newly recognized neoplasms and has referred to some entities, variants and patterns as “not recommended” (previously called obsolete).

  - It has been determined that these "not recommended" terms no longer have diagnostic and/or biological relevance.
  - Terms which are not recommended are not included in the tables. When one of these terms are used, refer to the ICD-O and all updates for the correct histology code
- **Rule change:** The 2007 rules said a glioblastoma multiforme (GBM) following an astrocytic or glial tumor was a single primary (recurrence). In the 2018 Solid Tumor Rules, GBM subsequent to an astrocytic or glial tumor is a multiple primary.

  GBM is now being collected as a new primary so it is possible to analyze the frequency with which these tumors recur in a more aggressive form (GBM)
- **Clarification**: The following meningiomas are reportable: intraosseous, cavernous sinus and sphenoid wing.
- **Clarification**: Multiple cerebral meningiomas are a single primary.
- **Clarification**: Multiple brain tumors (same histology) are a single primary.
- The 2016 World Health Organization (WHO) Classification of Tumors of the Central Nervous System (CNS) contains newly recognized histologies and subtypes/variants. New codes/terms are identified by asterisks (*) in **Table 3** in the Terms and Definitions.

Please see the 2018 Solid Tumor Rules for more information and for full coding instructions for all sites above.

ICD-O-3 HISTOLOGIES

The 2018 ICD-O-3 histology code and behavior update includes comprehensive tables listing all changes to ICD-O-3 effective for solid tumor cases diagnosed 1/1/2018 and forward.

IMPORTANT REMINDER:

Please check the 2018 ICD-O-3 Update Table first to determine if the histology is listed. If the histology is not included in the update, then review ICD-O-3 and/or Hematopoietic and Lymphoid Database and/or Solid Tumor Rules (MP/H) 2018 ICDO 3 Coding Guidelines.

Comprehensive updates have been made to ICD-O-3 histologies and behaviors collected for cases diagnosed January 1, 2018 and forward. Please refer to the 2018 NAACCR Implementation Guidelines ICD-O-3 Coding Guidelines and 2018 ICD-O-3 Coding Table, ICD-0-3 HISTOLOGIES.

The ICD-O-3 Implementation Task Force has approved new codes, changes in behavior codes, and new terms associated with current codes. These changes reflect updates to the WHO Classifications for Tumors (Blue Books). The new codes, new terms, and change to behavior codes are for all cases diagnosed 1/1/18 and later. The new codes, new terms, and codes with changes to behavior are listed in the .pdf table and in the excel table. The two tables are identical.

Below is a small sample of the new ICD-0-3 terms and new codes table. Remember these ICD-O-3 codes, behaviors and terms are site specific. Please see the full table at NAACCR website 2018 Implementation guide.

Effective January 1, 2018
ICD-O-3 codes, behaviors and terms are site-specific
Updated 8/22/2018
Numeric Order by Morphology Code

Status	ICD-O-3 Morphology Code	Term	Reportable Y/N	Comments
New Term	8010/3	Urachal carcinoma **(C65.9, C66.9, C67. _, C68. _)**	Y	
New Term	8013/3	Combined large cell neuroendocrine carcinoma **(C34. _, C37.9)**	Y	
New code/term	8023/3	Midline carcinoma of children and young adults with NUT rearrangement **(C30.0, C31.9, C34. _)**	Y	
New code/term	8023/3	**NUT carcinoma (C30.0, C31.9, C34. _)**	Y	
New code/term	8023/3	NUT midline **(C30.0, C31.9, C34. _)**	Y	
New Term	8041/3	High-grade neuroendocrine carcinoma **(C54. _, C55.9)**	Y	
New Term	8041/3	Neuroendocrine carcinoma, poorly differentiated **(C50. _)**	Y	
New Term	8041/3	Small cell carcinoma pulmonary type **(C56.9)**	Y	
New Term	8044/3	Small cell carcinoma, hypercalcemic type **(C56.9)**	Y	
New code/term	8054/3	Condylomatous carcinoma **(C60.0-C60.2, C60.9)**	Y	Cases diagnosed prior to 1/1/2018 use code 8051/3 All other sites use 8051/3 2018 forward
New code/term	8054/3	**Warty carcinoma (C60.0-C60.2, C60.9)**	Y	Cases diagnosed prior to 1/1/2018 use code 8051/3 All other sites use 8051/3 2018 forward
Behavior code/term	8071/2	Differentiated penile intraepithelial neoplasia **(C60. _)**	N	Not reportable for 2018
Behavior code/term	8071/2	Differentiated-type vulvar intraepithelial neoplasia **(C51. _)**	N	Not reportable for 2018

SEER HEMATOPOIETIC AND LYMPHOID NEOPLASM DATABASE

The updated SEER Hematopoietic and Lymphoid Neoplasm Database will be applicable for cases diagnosed 2010 and forward. This manual and the corresponding database are to be used for coding cases diagnosed January 1, 2010 and forward. The changes made do not require registrars to recode old cases.

Important changes for 2018

Preferred terms from **WHO** updated

- Grade no longer applicable – **grade is blank**

  (Exception: Lymphoma of adnexa of eyes)
- Expanded ambiguous terms
- Online version only

2018 Revisions

The 2018 revisions include:

- Rule clarifications and revisions
- Correction of typographical errors (in both manual and database)
- Grade is no longer applicable for cases diagnosed 2018 and forward. Grade is still required for cases diagnosed prior to 2018
- Non-reportable terms removed from Hematopoietic Manual Appendix F and added to the database
- Glossary removed from the Manual and entered into the new Glossary database

Deleted Sections: Several sections have been deleted from the Hematopoietic manual because they are no longer relevant

- Appendix E: Obsolete Hematopoietic Histology Codes: This section covered the neoplasms that were made obsolete as of 1/1/2010 and forward. This information is in the database. In January 2015, all cases that included one of these codes for 1/1/2010 and forward were converted to the current applicable code
- Obsolete Terms as Defined in ICD-O Hematopoietic and Lymphoid Neoplasms (part of Appendix A). The obsolete terms are part of the Hematopoietic database.
- Appendix D: New Histology Terms and Codes Hematopoietic and Lymphoid Neoplasms: These were the new histology codes as of 1/1/2010. These are no longer new.

Source: https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

COMPLIANCE

To assure timely and complete cancer case reporting in Texas, the TCR monitors compliance with the Texas Cancer Incidence Reporting Act. The TCR health service regions routinely monitor facility submissions of case reports. If submissions are not received complete and in a timely manner according to our current law and rules, the facility registrar/reporter will be contacted regarding the

delinquent reporting status. Further action, which may include cost recovery procedures, will be instituted if submissions continue to be delinquent. These actions are necessary to meet the state and national requirements for timely cancer data submissions. To be compliant with the law, **all records must be submitted within 6 months of initial diagnosis, or admission with active disease, or treatment for cancer at your facility.** Cancer reporting rules require monthly submissions from health care facilities with an annual caseload of greater than 400 and at least quarterly submissions for health care facilities with an annual caseload of 400 or fewer. **Weekly submissions from all facilities is strongly recommended.**

Table 1.2 Case Submission Requirements

Caseload	Submission
>400	Monthly
Equal to or <400	≥ Quarterly

Small Cancer Caseload Facilities (125 or fewer)

The TCR developed the "Small Facility Casefinding and Data Collection Program" with the goal to increase and improve the reporting and data quality of cancer cases, as required by the Texas Cancer Incidence Reporting Act (Chapter 82, Texas Health and Safety Code), from Texas facilities with 120 or fewer expected cancer cases. TCR staff will conduct the casefinding and data collection activities for these facilities. Facilities will be contacted regarding their facility's compliance and eligibility for participation in this program.

Note: Hospital Reporting instructions, as well as reporting laws and rules can be found on the TCR website: https://www.dshs.texas.gov/tcr/

Timeliness of Data Submission

Timeliness of case reporting is important, however, data quality and completeness must be assured as well. Researchers, epidemiologists, health planners, clinicians, and laypersons benefit from access to the most current information. Due to reporting requirements of CDC and TCR, **all reports of cases shall be submitted to the TCR within six months of initial diagnosis or admission** at their facility with active disease and/or treatment of cancer. This information is in *Section 91.5(a) (When to Report*) of the Cancer Registry Rules. Refer to the TCR's Cancer Reporting Law and Rules webpage for more information regarding reporting timeliness: https://www.dshs.texas.gov/tcr/lawrules.aspx

Timely Reporting Calendar

Due to the delay of national standard setters providing the necessary 2018 resources and guidelines in a timely manner, the TCR is delaying the 2018 reporting deadline by three months. The TCR Reporting Calendar reflects this extension and can be found at https://www.dshs.texas.gov/tcr/reporting/hospitals.aspx.

2018 Timely Reporting Calendar
Texas Cancer Registry
Texas Department of State Health Services

Cases admitted in:	Reported no later than:
January 2018	June 2019
February 2018	July 2019
March 2018	August 2019
April 2018	September 2019
May 2018	October 2019
June 2018	November 2019
July 2018	December 2019
August 2018	January 2020
September 2018	February 2020
October 2018	February 2020
November 2018	March 2020
December 2018	March 2020

REGIONAL CONTACTS

Table 1.3 Regional Contacts

REGISTRY OPERATIONS MANAGERS **Southwest Texas Registry Operations** **Miriam Robles, CTR** HSR 1, 7, 8, 9, 10, 11 Austin, TX 512-776-3609 Miriam.Robles@dshs.texas.gov **Northeast Texas Registry Operations** HSR 2, 3, 4, 5, 6 Austin, TX 512-776-3618	**Senior Registry Operations Manager** **Susan Perez, RHIT, CTR** Austin, TX 512-776-3605 Susan.perez@dshs.texas.gov **Quality Assurance Manager** **Cindy Dorsey, CTR** Austin, TX 512-776-3631 Cindy.Dorsey@dshs.texas.gov
HEALTH SERVICE REGIONS 2, 3, 4 **Debra Anderson, BS, CTR** Regional Program Specialist (Team Lead) Texas Department of State Health Services Texas Cancer Registry 1301 S. Bowen Rd., Ste. 200 Arlington, TX 76013 Phone: 817-264-4594 Fax: 817-264-4597 Debra.Anderson@dshs.texas.gov	**HEALTH SERVICE REGIONS 1,7,9** **Jodi Vasquez, CTR, RHIT** Regional Program Specialist (Team Lead) 1100 W. 49th Street Austin, TX 78756 Phone: 512-776-3607 Fax: 512-776-7681 Jodi.Vasquez@dshs.texas.gov
HEALTH SERVICE REGIONS 5, 6 **Marie Gallegos, CTR** Regional Program Specialist (Team Lead) Texas Department of State Health Services Texas Cancer Registry 5425 Polk Ave. Houston, TX 77023-1497 Phone: 713-767-3183 Fax: 713-767-3284 Marie.Gallegos@dshs.texas.gov	**HEALTH SERVICE REGIONS 8, 10, 11** **Allison Vasquez, BS, CTR** Regional Program Specialist (Team Lead) 1100 W. 49th Street Austin, TX78756 Phone: 512-776-2794 Fax: 512-776-7681

Visit https://www.dshs.texas.gov/tcr/contact.aspx#regions to see a map of the Health Service Regions and to view the most current regional contact list.

2

STANDARDS FOR CONFIDENTIALITY, DISCLOSURE OF DATA, AND QUALITY ASSURANCE

CONFIDENTIALITY

Data obtained under the Texas Cancer Incidence Reporting Act are for the confidential use of the Texas Department of State Health Services, including persons, and public or private entities that are necessary to carry out the public health interests of the Act. The data are privileged and may not be divulged or made public in a manner that discloses the individual identity of any patient. All reporting entities that are performing in compliance with the Act are immune from civil and criminal liability for furnishing the required information.

DISCLOSURE OF DATA

All data reported to the TCR are available for use in aggregate form for analysis by facility registry staff, physicians, health care workers, cancer researchers, and the public. Reports of cancer incidence are available on the TCR website under Cancer Statistics. A Web Query Tool which generates customized maps and tables of Texas cancer incidence and mortality rates is also available on the website at https://www.dshs.texas.gov/tcr/data.aspx. Public access to aggregate data is available through published reports, or through the TCR, if in accordance with its data release policies and procedures.

The TCR **may** exchange patient-specific data with the respective reporting facility, any other cancer-control agency, clinical facility, pathology laboratories, or physician's offices for the purpose of obtaining information necessary to complete the abstract or follow-up information, provided that these agencies and facilities comply with the TCR's confidentiality policies. However, no facility-specific patient information can be released unless authorized under law. The TCR will not release information from one facility to a different facility under any circumstances.The TCR can contact the facility where the patient was seen and obtain consent to release information other than that authorized by law under special circumstances.

To achieve complete case ascertainment, the TCR **may** exchange patient-specific data with other state cancer registries if reciprocal data sharing agreements and confidentiality provisions are implemented.

The TCR **may** grant researchers access to confidential information concerning individual cancer patients, provided that those researchers comply with the provisions and confidentiality policies mandated by the Texas Department of State Health Services Institutional Review Board.

QUALITY ASSURANCE

The TCR implements an extensive series of quality assurance procedures that are based on the SEER Program, CDC recommendations, and NAACCR standards. These procedures, which consist of both internal and external processes, ensure the reliability, completeness, consistency, and comparability of TCR data.

INTERNAL PROCESS

Submission Review

The TCR's data upload system currently checks all submitted abstracts for errors. The TCR uses CDC's Registry Plus Software Suite to upload submitted data. As abstracts are uploaded into the system, they are intensely scrutinized for:

- Possible duplicate submission of existing abstracts.
- Unacceptable codes for any field or inter-field inconsistencies.
- Invalid or unusual site/sex, age/site, age/morphology or site/morphology combinations.
- Running data submissions through NAACCR and TCR edits

Currently, the TCR is not rejecting cases at upload, but this could change and you will be notified by TCR when this change is implemented.

Note: *Facilities* ***must*** *run their data through the appropriate NAACCR and TCR edits and make necessary corrections before submitting a file to the TCR.*

EXTERNAL PROCESS

Facility Training

TCR staff provides technical assistance, training, and continuing education for cancer registrars and medical records personnel on standards and procedures for reporting. Requests for training and technical assistance should be directed to the Austin Central Office Training Specialist Lead Worker. To request training please submit your training needs using the online training request forms found on the Education and Training section of the TCR website: https://www.dshs.texas.gov/tcr/training.aspx. You can also contact the TCR Training Lead Worker at TCR.Training@dshs.texas.gov.

Inpatient/Outpatient Casefinding Follow-back Audit

The TCR has implemented a new *Inpatient/Outpatient Casefinding and Death Clearance Follow-back Audit* process. The pilot originally consisted of inpatient/outpatient and Texas deaths which showed facility visits that did not reflect a cancer billing code. This did not yield significant missed cases for the amount of work for reporters and moving forward this process will only include inpatient and outpatient visits with cancer billing codes and Texas deaths linkage results.

This audit will ensure that complete and timely statewide cancer data is received from all Texas facilities and available for our annual Centers for Disease Control and Prevention (CDC) and North American Association of Central Cancer Registries (NAACCR) Calls for Data submissions. In addition, this data will also be available to use in cancer surveillance, program planning, and evaluation activities. The audit will be conducted on a semi-annual basis to identify potentially missed cases.

The TCR will use the Texas Hospital Inpatient/Outpatient Data and Texas deaths to conduct this audit. This data will be obtained by the TCR biannually. We will use this data to perform a linkage on each individual facility to identify cases that have not been reported to the TCR. Once the linkage is complete, each facility will be provided with a listing of potentially missed cases for your review, abstraction, and submission. This may include multiple primaries. This process combines the Death Clearance Only Audit performed in previous years as well as Casefinding Data Quality Audits. This process will help reporters and TCR staff identify possible missed resources to identify reportable cases (pathology, cytology, ambiguous terminology etc.).

All follow-back cases will be available for facilities on one report and will contain the casefinding source, for example: DCO or Inpatient/Outpatient. This will eliminate multiple listing requests for facilities and it will be performed annually.

Note: Small Casefinding and Data Collection (CFDC) facilities are not required to abstract missed cases. CFDC facilities must submit all medical records to the TCR for review and abstraction. This process will remain the same.

Data Quality Audits

A data quality audit is a systematic method of reviewing the facility's data quality. The audit is a tool to improve a facility's data quality and is not a punitive measure. There are several triggers for these audits such as a new reporter, a pattern of edit errors, changes in national guidelines, or inconsistencies identified during one of our various internal data quality processes. TCR staff or a TCR representative will request documents from a facility's medical records and compare the abstracting and coding to the submitted abstracts. The results are shared with the facility as a learning tool. Results from a specific facility's data quality audit are not shared with other entities without the facility's approval.

Reabstracting Data Quality Audits

TCR staff, or a TCR representative, performs complete re-abstracting of a sample of reported cases without reference to the original abstract. If discrepancies are identified, they are used to assess the facility's cancer case reporting and training needs.

Ambulatory Surgery Centers Guidelines for 2018

Texas ambulatory surgery centers (ASC) that diagnose and/or treat cancer patients provide valuable treatment information, that is otherwise not available to the Texas Cancer Registry.

If an ASC is affiliated with a health care system, cancer center, and/or hospital, that healthcare system, cancer center, and/or hospital is responsible for reporting cancer case(s) on the ASC's behalf.

If an ASC is a free-standing facility, the TCR will conduct a linkage with the Texas Health Care Information Council Outpatient Data to identify reportable cases that are not otherwise reported to the TCR, as well as missing surgical cancer treatment information. The linkage is done to minimize any additional reporting burden on the part of the ASC and the TCR. The free-standing ASC is then required to provide the requested medical records to the TCR for review and possible inclusion in the registry.

Pathology Laboratory Guidelines for 2018

Pathology Laboratories, both state and national, that diagnose cancer for Texas health care providers and residents provide valuable case-finding and diagnostic information that is not otherwise available to the TCR. Receiving pathology reports from pathology laboratories is a critical source of information for comprehensive population-based cancer reporting.

The preferred electronic reporting formats are versions 2.3.1 or 2.5.1 HL7 standard protocols, in accordance with the North American Association of Central Cancer Registries, Pathology Laboratory Electronic Reporting, Volume 5 central registry standards.

In order to securely transmit pathology laboratory data to the TCR, there are two strongly preferred options:

1. The Texas Department of State Health Services maintains the Public Health Information Network Messaging System (PHIN MS), a secure messaging platform provided by the Centers for Disease Control and Prevention (CDC) for receiving data from pathology laboratories. Information about the PHIN MS system can be found at: http://www.cdc.gov/phin/tools/PHINms/index.html.

   Contact us for additional information on submitting data through PHIN MS.

2. Pathology reporting, either in HL7 formats, or as scanned pdf documents may also be securely uploaded to the TCR using Web Plus, a web-based application also provided by the CDC. With this data submission method you must obtain a Web Plus account by completing the Online Web Plus Account Registration and submitting the Web Plus Use and Confidentiality Statement via fax at 512-776-7681, or scan and email. More information on Web Plus can be found on our website: https://www.dshs.texas.gov/tcr/webplus.aspx.

   Required information in the pathology report includes not only information about the patient's cancer, but also patient identifiers and demographics, such as name, date of birth, sex, and patient address and social security number. Other fields which are encouraged if available are race/ethnicity and primary payer. If these data items are not on the pathology report, they can be included on a separate Excel spreadsheet that can be uploaded using WebPlus. For your convenience, a template is available on the TCR website: https://www.dshs.texas.gov/tcr/CancerReporting/Pathology-Lab-Reporting.aspx

Sending paper pathology reports via mail/FedEx or fax are strongly discouraged. These reporting methods result in significantly more manual processing by the TCR, and are not as secure as electronically submitting reports using either PHIN MS or Web Plus.

The accountability for any HIPAA breach using mail/FedEx or fax to submit reports to the TCR falls on the pathology laboratory deviating from the TCR recommended method of reporting. Any laboratory sending paper records to the TCR should follow HIPAA guidance for securely sending patient records through U.S. mail and needs to ensure the guidance is followed correctly.

Current guidance provided to the TCR includes instructions to double envelope the pathology reports and write "CONFIDENTIAL" on the outside envelope prior to sending the paper records. Before choosing this method, please consider one of the more secure electronic methods discussed previously.

Please reference our Who Do I Call list for the appropriate representative to call if you have additional questions. https://www.dshs.texas.gov/tcr/contact.aspx

3

CASEFINDING FOR COMPLETENESS OF REPORTING

CASEFINDING FOR COMPLETENESS OF REPORTING

The *Texas Cancer Incidence Reporting Act (Chapter 82, Health and Safety Code)* requires every health care facility, clinical laboratory, and health care practitioner center to submit cancer information for each reportable diagnosis.

Casefinding is a process used to identify all eligible cases to be reported to the TCR. Casefinding sources include disease indices, pathology and laboratory reports, patient logs, and similar resources specific to each facility. Refer to the Casefinding sources list below for a more detailed list. Every inpatient and/or outpatient with active disease and/or receiving cancer-directed therapy must be reported to the TCR regardless of the patient's state. TCR is no longer requiring cancer cases for foreign residents. The requirements for reporting depend on the governing agencies of the registry. For example, hospitals participating in the Approvals Program of the Commissions on Cancer (CoC) of the American College of Surgeons follow the guidelines set forth by CoC; however, they must also adhere to the TCR reporting criteria.

Remember that cases diagnosed prior to 1995 and foreign residents are no longer required to be reported.

CASEFINDING METHODS

There are two types of casefinding methods-**active** and **passive**:

1. **Active casefinding:** The personnel responsible for reporting obtain and review all sources for eligible cases. This method is more comprehensive and precise.
2. **Passive casefinding:** The personnel responsible for reporting rely on others to notify the reporter of possible eligible cases. There is a greater potential for missed cases using this method.

A combination of active and passive casefinding is a more effective method and ensures fewer missed cases. It is strongly recommended that every facility have a Casefinding Policy and Procedure in place. The procedures should be evaluated from time to time and amended as facility procedures or services change.

Casefinding Sources

1. Medical Records Department
    a. Disease index
    b. Admission and discharge reports
2. Pathology Department
    a. Histology reports
    b. Cytology reports
    c. Hematology reports
    d. Autopsy reports
    e. Bone Marrow reports
3. Surgery Department
4. Outpatient Departments
5. Medical and Diagnostic Imaging
6. Radiation Oncology
7. Medical Oncology\Hematology
8. Emergency Room reports
9. Lab reports

CASEFINDING PROCESS

Cooperation and a good working relationship between reporting personnel and other departments are essential for accurate case ascertainment. The reporter is responsible for identifying all casefinding sources under their facility licensure and arranging access to these sources, for example, rural health clinics, surgery centers across town or off campus.

Electronic Disease Indices in Excel format is preferred and should include a *non- reportable column. It should be obtained after medical records are completed and coded (monthly or quarterly). The indices must include both inpatient and outpatient admissions and must be based on year of admission. It must be sorted alphabetically by last name and include the following: last name, first name, DOB, etc. SSN#'s are now moving toward a different method of identifiers, but internal linkages to either the billing department or accounts receivable could possibly interface and provide the SSN number.

Please note that the Excel format **Non Reportable* column should be marked if it is deemed to be a non- reportable. Please refer to the NR list page. Please use the codes found on page 62 Attachment B.

The ICD-10 CM parameter codes to review at 100% are found on Table 3.2 found on page 40. The ICD-10 CM 5% supplemental codes table found on pages 51-56. Please review at the end of your completed submission year.

Note: Keep in mind the MISSED CASEFINDING/DCO linkage project stems from the facility's Case finding processes.

Disease indices should be obtained after medical records are completed and coded (monthly or quarterly). The indices must include both **inpatient and outpatient** admissions **and must** be based on **year of admission.** It must be sorted **alphabetically** by last name and include the following: **last name, first name, medical record number, admission/discharge date, date of birth, social security number, all primary and secondary ICD-10* or ICD-10 diagnosis codes and admission type.**

Attachment A (page 61) is an example of a disease index that can be modified for individual facilities. See page 49 for further instructions on disease index procedures.

The following list includes some helpful hints for the casefinding process:

Review the disease index for reportable cancer **ICD-10-CM** codes to ensure the facility has reported all of its reportable cases to the TCR.

- Request a TCR Facility Data Report from your regional office when needed during the reporting year. A Facility Data Report is a complete listing of cases submitted by a facility.
- Compare the patients with reportable codes on the disease index to the TCR Facility Data Report.
- Review any patient charts with reportable codes that are missing from the TCR Facility Data Report for reportability.
- Prepare an abstract for each reportable case missing from the TCR Facility Data Report.
- If a previously reported patient is found to have a subsequent primary, assign the new primary the patient's original registry number. Change the sequence number to reflect the new primary and abstract the pertinent cancer information.

Note: If a facility uses an automated casefinding method (for example: the hospital's mainframe extracts possible reportable cases and places these into cancer registry software suspense file), a manual disease index should be run at the end of the reporting year. **Ensure that the ICD-10-CM codes used are the most current for the reporting year**. This disease index is then checked against the cancer registry database to ensure that all cases were either reported or clearly documented as non-reportable with the reason it is not reportable.

TCR now provides an avenue for following back to each facility for potentially missed cases. It is the facility's responsibility to maintain a reportable and non-reportable list to assist in the review process of the potentially missed cases list provided annually.

REPORTABLE CANCER CASES

Cases of cancer to be reported to the TCR include:

1. All neoplasms with a **behavior code** of /2 (in situ) or /3 (malignant) in the *International Classification of Diseases for Oncology 3rd Edition (ICD-O-3)*, with some exceptions (see pages 47-48).
2. Report **benign** and **borderline** primary **intracranial** and **central nervous sytem (CNS)** tumors with a **behavior code** of /0 (benign), /1 (borderline), or /3 (malignant) occurring in any of the following sites:
   a. Meninges (C700-C709), brain (C710-C719), spinal cord (C720), cauda equina (C721), cranial nerve or nerves (C722-C725), or any other part of the central nervous system (CNS) (C728- C729)
   b. Intraosseous, cavernous sinus, and sphenoid wing meningiomas **are reportable**.
   c. Pituitary gland (C751), craniopharyngeal duct (C752), or pineal gland (C753)
   d. Neoplasm and tumor are reportable terms for brain and CNS because they are listed in ICD-O-3 and approved ICD-O-3 updates with behavior codes of /0 and /1

Table 3.1 Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors

TERM	SPECIFIC SITES	ICD-O-3 TOPOGRAPHY CODE
Meninges	Cerebral meninges	C700
	Spinal meninges	C701
	Meninges, NOS	C709
Brain	Cerebrum	C710
	Frontal lobe	C711
	Temporal lobe	C712
	Parietal lobe	C713
	Occipital lobe	C714
	Ventricle NOS	C715
	Cerebellum, NOS	C716
	Brain stem	C717

TERM	SPECIFIC SITES	ICD-O-3 TOPOGRAPHY CODE
	Overlapping lesion of brain	C718
	Brain, NOS	C719
Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord	C720
	Cauda equina	C721
	Olfactory nerve	C722
	Optic nerve	C723
	Acoustic nerve	C724
	Cranial nerve, NOS	C725
	Overlapping lesion of brain and central nervous system	C728
	Nervous system, NOS	C729
Pituitary, craniopharyngeal duct and pineal gland	Pituitary gland	C751
	Craniopharyngeal duct	C752
	Pineal gland	C753

Note:

- Benign and borderline CNS cases diagnosed prior to 2004 are no longer required to be submitted to the TCR.
- Benign and borderline tumors of the cranial bones (C410) are **not reportable.**

DIAGNOSIS PRIOR TO BIRTH

SEER reportability requirements apply to diagnoses made in utero. Diagnoses made in utero are reportable **only when the pregnancy results in a live birth**. In the absence of documentation of stillbirth, abortion or fetal death, assume there was a live birth and report the case.

Disease Regression

When a reportable diagnosis is confirmed prior to birth and disease is not evident at birth due to regression, accession the case based on the pre-birth diagnosis.

Instructions for Reporting Solid Tumors

Instructions in this section apply to solid tumors. For hematopoietic and lymphoid neoplasms, see the Reportability Instructions in the *Hematopoietic and Lymphoid Neoplasm Coding Manual* and *Database*.

CASES DIAGNOSED CLINICALLY ARE REPORTABLE

In the absence of a histologic or cytologic confirmation of a reportable neoplasm, accession the case based on the **clinical diagnosis** (when a recognized medical practitioner states the patient has a cancer, carcinoma, malignant neoplasm, or reportable neoplasm). A clinical diagnosis may be recorded in the final diagnosis, on the face sheet, in a clinic note, or in other parts of the medical record.

Note: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a biopsy or fine-needle aspiration that disproves the clinical diagnosis the case is not reportable.

Exception: If the physician treats a patient for cancer in spite of a negative biopsy, accession the case.

Note: Standard treatments for cancer may be given for non-malignant conditions. Follow back with the physician to clarify if needed.

Exception: If enough time has passed that it is reasonable to assume that the physician has seen the negative pathology report, and the clinician continues to call this a reportable disease, accession the case. A reasonable amount of time would be 6 months or more.

Example

In February 2018 a patient has a CT that shows possible lung cancer. The physician states this is probably lung cancer. A fine-needle aspiration is non-diagnostic and the physician advises the patient to have further tests. The patient refuses any further work-up or treatment. In

September 2018 the physician sees the patient again and states that this is probable lung cancer based on previous x-rays, continued symptoms, and further decline in health. This case is reportable.

REPORTABLE NEOPLASMS

The following lists are intended to assist the cancer data reporter in identifying the reportable neoplasms.

- Malignant neoplasms (exclusions noted on page 47)
- Benign and borderline tumors of central nervous system (CNS) diagnosed 2004 and forward
- Pituitary adenomas diagnosed as of 2004
- *Carcinoma in-situ (exclusions noted on page 47)
- Carcinoid, NOS (Carcinoid NOS of the appendix is reportable as of 01/01/2015, the ICD-0-3 behavior code changed from /1 to /3.)
- Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.
- Solid pseudopapillary neoplasm of the pancreas
- Cystic pancreatic endocrine neoplasm (CPEN)
- Mature Teratoma of the testes in adults is malignant and reportable as 9080/3
- Pilocytic/juvenile astrocytoma is reportable and should be coded to 9421/3 per ICD-O-3 errata
- Lobular carcinoma in situ (LCIS) of breast
- Reportable Intraepithelia neoplasia, grade III - Examples: (not a complete list)
  - Anal Intraepithelial neoplasia (AIN III) of the anus or anus canal (C210-C211)
  - High grade biliary intraepithelial neoplasia (BiIN III) of the gallbladder (C239)
  - Laryngeal intraepithelial neoplasia (LIN III) (C320-C329)
  - Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)
  - Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)

  - Penile intraepithelial neoplasia III (PeIN III) are reportable (C600-C609)
  - Squamous intraepithelial neoplasia (SIN III) excluding cervix and skin sites coded to C44_
  - Vaginal Intraepithelial neoplasia (VAIN III (C529)
  - Vulvar intraepithelial neoplasia (VIN III) (C510-C519)
- GIST tumors and thymomas are reportable when there is evidence of multiple foci, lymph node involvement or metastasis
- Reportable skin tumors such as adnexal carcinomas (carcinomas of the sweat gland, ceruminous gland, and hair follicle), adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumor **must be reported regardless of site**. Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in skin.
- Urine cytology positive for malignancy is reportable for diagnoses in 2013 and forward
  - Code the primary site to C689 in the absence of any other information
  - Do not implement new/additional casefinding methods to capture these cases
  - **Exception**: When a subsequent biopsy of a urinary site is negative, do not report.

Do not report cytology cases with ambiguous terminology (see page 61 for ambiguous terms)

Note: Malignant neoplasms of the skin of genital sites **are reportable**. These sites include: clitoris (C512), vulva (C519), vagina (C529), prepuce (C600), penis (C609), and scrotum (C632).

Brain or CNS Neoplasms

- A brain or a CNS neoplasm identified only by diagnostic imaging is reportable.
- **Neoplasm** and **tumor** are **reportable** terms for brain and CNS because they are listed in ICD-O-3 with behavior codes of /0 and /1

  Note: Benign and borderline tumors of the cranial bones (C410) are **not reportable**

  Note: Benign and borderline tumors of the peripheral nerves (C47_) are **not reportable**
- Report benign and borderline primary intracranial and central nervous system (CNS) tumors with behavior code of /0 or /1 in ICD-0-3, effective with cases diagnosed 1/1/2004 and later.
- See Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors table 3.1 on page 32.
- Report **Pilocytic/Juvenile astrocytomas**; code the histology and behavior as 9421/3

Notes*:*

- **Mass** and **lesion** are **not** reportable terms for brain and CNS because they are not listed in ICD-O-3 with behavior codes of /0 or /1.
- According to AJCC high grade/severe dysplasia may be synonymous with in situ carcinoma within the gastrointestinal tract. However, they give no further instruction. Each facility should consult their cancer committee, physician advisor, and pathologists to determine how the phrase is used within the facility. This will determine whether or not a case diagnosed as high grade or severe dysplasia should be reported.

- All tumors and neoplasms of the brain and other CNS sites must have a morphology term and code in ICD-O-3. If there is no morphology term and code, it is not reportable. Tumors and neoplasms diagnosed prior to 2001 must have a morphology term and code in ICD-O-2 to be reportable.
- Gastrointestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, for cases diagnosed January 1, 2013 or later, they must be abstracted and assigned a *Behavior* Code of *3* if they are noted to have: Multiple foci, Metastasis, Positive lymph nodes.

Reportable Examples

Example 1. Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high-grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high-grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive (8470/2).

Example 2. Report mature teratoma of the testis when diagnosed after puberty (malignant) and do not report when diagnosed in a child (benign). Do not report Mature Teratoma of the testis when it is not known whether the patient is prepubescent or postpubenscent. Pubescence can take place over a number of years; review physical history and do not rely only on age. For testis: Mature teratoma in adults is malignant (9080/3); therefore, is a reportable neoplasm.

Example 3. Hemangioma, NOS (9120/0) and cavernous hemangioma (9121/0) arising in the dura and parenchyma of the brain/CNS are reportable.

Example 4. Cystic pancreatic endocrine neoplasm (CPEN) is reportable. Assign 8150/3 unless specified as a neuroendocrine tumor, Grade 1 (8240/3) or neuroendocrine tumor, Grade 2 (8249/3).

Example 5. Solid pseudopapillary neoplasm of the pancreas is reportable as 8452/3

Example 6. Rathke pouch tumor (C751, 9350/1) is a reportable neoplasm for cases diagnosed 2004 and later. Rathke cleft cyst and Rathke pouch tumor are different conditions. Rathke cleft cyst is not reportable.

Example 7. "Carcinoid of the appendix found on appendectomy." Carcinoid tumor, NOS, is reportable (8240/3).

Example 8. Report liver cases with an LI-RADS category LR-5 or LR-5V based on the 2014 American College of Radiology definitions, http://nrdr.acr.org/lirads. Use the date of the LR-5 or LR-5V scan as the date of diagnosis when it is the earliest confirmation of the malignancy. Do not report cases based **only** on an LI-RADS category of LR-4.

Example 9. "Atypical fibroxanthoma (superficial malignant fibrous histiocytoma)." The case is reportable because the information in parentheses provides more detail and confirms a reportable malignancy.

Example 10. "Positive histology from needle biopsy followed by negative resection." This case is reportable based on positive needle biopsy.

Example 11. "Biopsy-proven squamous cell carcinoma of the nipple with a subsequent areolar resection showing foreign body granulomatous reaction to suture material and no evidence of

residual malignancy in the nipple epidermis." This case is reportable. The fact that no residual malignancy was found in the later specimen does not disprove the malignancy diagnosed by the biopsy.

Example 12. Final diagnosis from dermatopathologist: ulcerated histologically malignant spindle cell neoplasm, consistent with atypical fibroxanthoma.

Note: An exhaustive immunohistochemical work-up shows no melanocytic, epithelial or vascular differentiation. Atypical fibroxanthoma is a superficial form of a malignant fibrous histiocytoma. This case is reportable. The pathologist has the final say on behavior for a particular case. In this case, the pathologist states that this tumor is malignant.

Example 13. "Aggressive adult granulosa cell tumor with one of two lymph nodes positive for malignant metastatic granulosa cell tumor." This case is reportable because malignant granulosa cell tumor is reportable. The lymph node metastases prove malignancy.

Example 14. "Ovarian mucinous borderline tumor with foci of intraepithelial carcinoma." This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).

Example 15. Dermoid cyst of the brain is reportable.

Example 16. Tectal plate lipoma is a reportable brain tumor. It is a benign neoplasm of the mid brain (brain stem).

Example 17. Report as either 8240/3 or 8151/3 when the pathology diagnosis is a neuroendocrine tumor (/3) and the clinical diagnosis is an insulinoma (/0).

NON-REPORTABLE NEOPLASMS

(Exclusions)

- Basal cell carcinoma (8090–8110) of the skin (C440-C449) **except genital sites**
- Basal and squamous cell carcinoma (8070–8110) of skin of anus (C445)
- Epithelial carcinomas (8010–8046) of the skin (C440-C449)
- Papillary and squamous cell carcinomas (8050–8084) of the skin (C440-C449) **except genital sites**
- Malignant neoplasms, NOS (8000–8005) of the skin (C440-C449)
- In situ neoplasms of cervix regardless of histology (behavior /2; C53_)
- SIN III of the cervix (C530-C539)
- Cervical Intraepithelial neoplasms (CIN III) (8077/2; C530-C539)
- Prostatic intraepithelial neoplasia (PIN III)(8148/2; C619)
- Borderline cystadenomas (8442, 8451, 8462, 8472, 8473) of the ovaries (C569) with behavior code 1 are **not** collected as of January 01, 2001
- Cases diagnosed **prior to 1995** are not reported
- Benign and borderline CNS cases diagnosed **prior to 2004** are not reported

- Benign and borderline tumors of the cranial bones (C410)
- Cysts or lesions of the brain or CNS diagnosed January 01, 2004 or later which have no ICD-O-3 morphology code

Note:

- Do not report even if patient is receiving treatment.
- Cholesteatoma in the cerebral meninges is not a reportable CNS case since there is no code for cholesteatoma listed in *ICD-O-3*.
- Carcinoid tumorlets in the lung are not reportable.
- "AIN II-III," "AIN II/III," "VAIN II-III," "VAIN II/III," "VIN II-III," "VIN II/III," etc. are not reportable (II-III or II/III is stating 2 of 3 and **not** 2 to 3). **VAIN III, AIN III, and VIN III are reportable.**
- Squamous cell carcinoma of the perianal skin (C445) is not reportable. Squamous cell carcinoma of the anus (C210) **is reportable**.
- Cases designated "BIRADS 4" or "BIRADS 5" without any additional information are not reportable.
- Squamous cell carcinoma of the canthus (C441) is not reportable.
- Lobular intraepithelial neoplasia grade 1 is not reportable.
- Subdural hygroma is not reportable – it is not a neoplasm. Subdural hygroma is a collection of cerebrospinal fluid in the sub-dural space. It may be related to a head injury.
- Noninvasive mucinous cystic neoplasm (MCM) of the pancreas with low or intermediate grade dysplasia is not reportable.
- For ovary: Mature teratoma is benign (9080/0); therefore, is not a reportable neoplasm.
- Intraductal papillary mucinous neoplasms with low or moderate grade dysplasia, also called IPMN adenomas, are not reportable.
- The terms "high grade dysplasia" (HGD) and "severe dysplasia" are not reportable. For the purposes of cancer registry reporting, they are not synonymous with in situ for tumors in the gastrointestinal tract (such as colon, stomach, esophagus). These cases are only reportable when the pathologist documents carcinoma in situ, or intraepithelial neoplasia grade III, or when the registry includes in their policies and procedures the pathologist's statement that HGD is equivalent to carcinoma in situ.
- Venous angiomas (9122/0) are not reportable wherever they arise. The primary site for venous hemangioma arising in the brain is blood vessel (C490). The combination of 9122/0 and C490 is not reportable. This is a venous abnormality. Previously called venous angiomas, these are currently referred to as developmental venous anomalies (DVA).
- Lymphomatoid papulosis (9718/1) is not reportable.

Non-Reportable Examples

Example 1. Left thyroid lobectomy shows microfollicular neoplasm with evidence of minimal invasion. Micro portion of path report states "The capsular contour is focally distorted by a finger of the microfollicular nodule which appears to penetrate into the adjacent capsular and thyroid tissue." Do not report this case based on the information provided. There is no definitive statement of malignancy. Search for additional information in the record. Contact the pathologist or the treating physician.

Example 2. Sclerosing hemangioma of the lung with multiple regional lymph nodes involved with sclerosing hemangioma. This case is not reportable. The lymph node involvement is non-malignant. According to the WHO Classification of Lung Tumours, sclerosing hemangioma "behaves in a clinically benign fashion...Reported cases with hilar or mediastinal lymph node involvement do not have a worse prognosis."

Example 3. Low grade appendiceal mucinous neoplasm (LAMN) is not reportable. The WHO classification designates LAMN as /1 with uncertain malignant potential.

Example 4. Diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (DIPNECH) is not reportable. It is a generalized proliferation of scattered single cells, small nodules (neuroendocrine bodies), or linear proliferation of pulmonary neuroendocrine cells (PNCs), according to the WHO classification of lung tumors.

Example 5. Lentiginous melanocytic lesion is not reportable.

Example 6. Lobular intraepithelial neoplasia grade 1 and grade 2 are not reportable.

Example 7. Brain lesions associated with multiple sclerosis are not reportable. These brain lesions are not neoplastic; they are part of the disease process of multiple sclerosis.

Example 8. High grade squamous intraepithelial lesion (HGSIL or HSIL) of the vulva or vagina is not reportable. These are not the same as VIN III or VAIN III which **are reportable**.

Example 9. HGSIL, HSIL, carcinoma in situ (CIS), and AIN III (8077) arising in **perianal skin (C445)** are not reportable.

COMPREHENSIVE REPORTABLE LISTS ICD-10-CM CODES

The following comprehensive lists are intended to aid appropriate staff (for example: Information Services, Data Management) in creating the disease index (DI) with the required reportable neoplasms and ICD-10-CM codes.

Two separate DI's must be requested:

1. A DI with reportable ICD-10-CM codes - 100% review required. This DI will include the Inpatient and Outpatient admissions based on ICD-10-CM primary and secondary diagnosis codes.
2. A DI with supplementary ICD-10-CM codes - 5% review: The purpose of this review is to guarantee complete case ascertainment and improve casefinding outcomes. This can assist in determining codes requiring additional review for the facility. The 5% review of this list will be based on number of patients and not number of diagnosis codes. If a patient on this DI also appears on the DI with a reportable code, they may be crossed off this list to avoid duplicate

reviews. After removing duplicate patients, review 5% of the total number of remaining patients. If cases for a particular code were identified as reportable, this information should be documented, and the following year this code should be reviewed 100%. If no reportable cases are identified after reviewing the supplementary list for a year then it may be acceptable to omit this process for the next 2 to 3 years. However, in the event that circumstances change (for example, new coders are hired or new codes are added to the list), then the supplementary list should be reviewed sooner to ensure complete casefinding. Some facilities may find that it works best to review the supplementary codes every 3 or every 6 months.

All admissions (inpatient and outpatient) with the following reportable diagnosis codes must be reviewed for reportability.

Note: Some of the codes contain conditions that are not reportable. The records need to be reviewed and evaluated separately to determine whether they are reportable to TCR.

Table 3.2 Reportable ICD-10-CM Codes

EFFECTIVE DATES: 10/1/2017-9/30/2019

ICD-10-CM CODE (100% Review Required)	DESCRIPTION
C00.0-C43.9 C4A.0-C4A.9 C45.0-C96.9	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies. NEW for FY 2018: C96.20 Malignant mast cell neoplasm, unspecified, C96.21 Aggressive systemic mastocytosis, C96.22 Mast cell sarcoma, C96.29 Other malignant cell neoplasm
C44.131-C44.1392	Sebaceous Cell Carcinoma of Skin (effective 10/1/2018)
C49.A0-C49.A9	Gastrointestinal Stromal Tumors (GIST) Note: GIST is only reportable when it is malignant(/3). GIST, NOS (not states whether malignant or benign) is a /1 and is not reportable
D00.00 - D03.9 D05.0-D05.92 D07.0-D09.9	In-situ neoplasms (*Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*).
D18.02	Hemangioma of intracranial structures and any site
D32.0 - D32.9	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.0 – D33.9	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.0- D43.9	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46.0-D46.9	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)

D47.02	Systemic mastocytosis
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3)
D47.4	Osteomyelofibrosis (9961/3)
D47Z1-D47.Z9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

^International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2017

Source: https://seer.cancer.gov/tools/casefinding/case2018-icd10cm.html

SUPPLEMENTARY ICD-10-CM CODES

Table 3.3 Supplementary ICD-10-CM Code List Effective 10/1/2017-9/30/2019

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
B20	Human immunodeficiency virus [HIV] disease with other diseases
B97.33, B97.34, B97.35	Human T-cell lymphotrophic virus,(type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomavirus as the cause of diseases classified elsewhere
D10.0 - D31.92, D34, D35.0, D35.1, D35.5_ D35.9, D36.0-D36.9	Benign neoplasms (see "must collect" list for reportable benign neoplasms) ***Notes:*** • Screen for incorrectly coded malignancies or reportable by agreement tumors • Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.
D3A.0-D3A.8 D3A.00-D3A.098	Benign carcinoid tumors
D37.0 - D41.9	Neoplasms of uncertain or unknown behavior (see "must collect" list for reportable neoplasms of uncertain or unknown behavior) ***Note:*** *Screen for incorrectly coded malignancies or reportable by agreement tumors*

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
D44.0 - D44.2 D44.6-D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands (see "must collect" list for D44.3-D44.5) ***Note:*** *Screen for incorrectly coded malignancies or reportable by agreement tumors*
D47.01	Cutaneous mastocytosis (9740/1) Note: Effective 10/1/2017
D47.09	Other mast cell neoplasms of uncertain behavior Note: Effective 10/1/2017
D47.2	Monoclonalgammopathy ***Note:*** *Screen for incorrectly coded Waldenstrom's macroglobulinemia*
D47.Z2	Castleman disease
D48.0-D48.9	Neoplasm of uncertain behavior of other and unspecified sites
D49.0 - D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)
D61.1	Drug-induced aplastic anemia (also known as "aplastic anemia due to antineoplastic chemotherapy") ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug
D61.810	Antineoplastic chemotherapy induced pancytopenia
D61.82	Myelophthisis *ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50. _)*
D63.0	Anemia in neoplastic disease
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia *Note: Screen for incorrectly coded thrombocythemia*
D70.1	Agranulocytosis secondary to cancer chemotherapy
D72.1	Eosinophilia (*Note: Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosonophilic syndrome."*)
D75.81	Myelofibrosis (note: this is not primary myelofibrosis [9961/3] ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)
D76.1-D76.3	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified *Note: Review for miscodes*
D89.40-D89.49	Mast cell activation syndrome and related disorders *Note: Effective 10/1/2016*
E08	Diabetes mellitus due to underlying condition *ICD-10-CM Coding instruction note: Code first the underlying condition, such as: malignant neoplasm (C00-C96)*
E31.20-E31.9	Multiple endocrine neoplasia [MEN] syndromes *ICD-10-CM Coding instruction: Code also any associated malignancies and other conditions associated with the syndromes*
E34.0	Carcinoid syndrome
E83.52	Hypercalcemia
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G13.0	Paraneoplastic neuromyopathy and neuropathy ICD-10-CM Coding instruction note:: Code first underlying neoplasm (C00-D49)
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease *ICD-10-CM Coding instruction note:: Code first underlying neoplasm (C00-D49)*
G32.8-G32.81	Other specified degenerative disorders of nervous system in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: cerebral degeneration (due to) neoplasm (C00-D49)
G53	Cranial nerve disorders in diseases classified elsewhere *Note: Code first underlying neoplasm (C00-D49)*
G55	Nerve root and plexus compressions in diseases classified elsewhere *ICD-10-CM Coding instruction note: code also underlying disease, such as neoplasm (C00-D49)*
G63	Polyneuropathy in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: neoplasm (C00-D49)
G73.1	Lambert-Eaton syndrome in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)*
G89.3	Neoplasm related pain (acute)(chronic)
G99.2	Myelopathy in diseases classified elsewhere *ICD-10-CM Coding instruction: Code first underlying disease, such as: neoplasm (C00-D49)*

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
H47.42	Disorders of optic chiasm in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
H47.521-H47	Disorders of visual pathways in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*
H47.63-	Disorders of visual cortex in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
J34.81	Nasal mucositis (ulcerative)
J91.0	Malignant pleural effusion ICD-10-CM Coding instruction: Code first underlying neoplasm
J93.12	Secondary spontaneous pneumothorax *ICD-10-CM Coding instruction: Code first underlying condition, such as:* *Malignant neoplasm of bronchus and lung (C34._)* *Secondary malignant neoplasm of lung (C78.0_)*
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.33	Oral mucositis (ulcerative) due to radiation
K22.711	Barrett's esophagus with high grade dysplasia
K62.7	Radiation proctitis
K62.82	Dysplasia of anus (AIN I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
M36.0	Dermato(poly)myositis in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)
M36.1	Arthropathy in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm, such as: Leukemia (C91-C95), malignant histiocytosis (C96.A), multiple myeloma (C90.0)
M84.50-M84.576	Pathologic fracture in neoplastic disease ICD-10-CM Coding instruction: Code also underlying neoplasm (C00-D49)
M90.60-M90.69	Osteitis deformans in neoplastic disease *ICD-10-CM Coding instruction: Code first the neoplasm (C40._, C41._)*
N42.3	Dysplasia of prostate (PIN I and PIN II)
N76.81	Mucositis (ulcerative) of vagina and vulva
N87._	Dysplasia of cervix uteri (CIN I and CIN II)

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
N89.0,N89.1, N89.3	Vaginal dysplasia (VIN I and VIN II)
N90.0,N90.1, N90.3	Vulvar dysplasia (VAIN I and VAIN II)
O01.-	Hydatidiform mole Note: Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00- C97 range
O9A.13	Malignant neoplasm complicating pregnancy, childbirth and the puerperium (conditions in C00-C96) *ICD-10-CM Coding instruction: Use additional code to identify neoplasm*
Q85.0-	Neurofibromatosis (nonmalignant) (9540/1) *Note: Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable*
R18.0	Malignant ascites *ICD-10-CM Coding instruction: Code first malignancy, such as: Malignant neoplasm of ovary (C56._), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)*
R53.0	Neoplastic (malignant) related fatigue *ICD-10-CM Coding instruction: Code first associated neoplasm*
R59.-	Enlarged lymph nodes
R85.6-	Abnormal findings on cytological and histological examination of digestive organs. ***Note:*** *see "must collect" list for R85.614*
R87.61-, R87.62-	Abnormal findings on cytological/histological examination of female genital organs. ***Note:*** *see "must collect" list for R87.614 and R87.624*
R92.-	Abnormal findings on diagnostic imaging of breast
R97.-	Abnormal tumor markers
T38.6-	Poisoning by antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified
T38.8- T38.996	Poisoning by hormones and their synthetic substitutes
T45.1-	Poisoning by, adverse effect of and under dosing of antineoplastic and immunosuppressive drugs
T45.8-, T45.96	Poisoning by primary systemic and hematological agent, unspecified
T66	Unspecified effects of radiation
T80.1	Vascular complications following infusion, transfusion and therapeutic injection
T80.2-	Infections following infusion, transfusion and therapeutic injection

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
T80.810	Extravasation of vesicant antineoplastic chemotherapy
T80.818	Extravasation of other vesicant agent
T86.0	Complications of bone marrow transplant ICD-10-CM Coding instruction: Use addition code to identify other transplant complications, such as: malignancy associated with organ transplant (C80.2) or post-transplant lymphoproliferative disorders (PTLD) (D47.Z1)
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z12.-_	Encounter for screening for malignant neoplasms
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z15.0	Genetic susceptibility to malignant neoplasm ICD-10-CM Coding instruction: Code first, if applicable, any current malignant neoplasm (C00-C75, C81-C96); Use additional code, if applicable, for any personal *history of malignant neoplasm (Z85._)*
Z17.0, Z17.1	Estrogen receptor positive and negative status
Z40.0_	Encounter for prophylactic surgery for risk factors related to malignant neoplasms
Z42.1	Encounter for breast reconstruction following mastectomy
Z48.3	Aftercare following surgery for neoplasm *ICD-10-CM Coding instruction: Use additional code to identify the neoplasm*
Z48.290	Encounter for aftercare following bone marrow transplant
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1-	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare
Z79.81-	Long term (current) use of agents affecting estrogen receptors and estrogen levels *ICD-10-CM Coding instruction: Code first, if applicable, malignant neoplasm of breast (C50._), malignant neoplasm of prostate (C61)*

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
Z85._	Personal history of malignant neoplasm
Z86.0_, Z86.01_, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior
Z92.21, Z92.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z94.81, Z94.84	Bone marrow and stem cell transplant status

^International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2017

NON-REPORTABLE ICD-10-CM CODES

The codes in the following supplementary list are not reportable as such but they should alert registrars to look for the first malignant neoplasm associated with these codes.

Table 3.4 Non-Reportable Codes

ICD-10-CM CODE^	DESCRIPTION
E31.21 E31.22 E31.23	Multiple endocrine neoplasia (MEN) type I, IIA and IIB (rare familial cancer syndrome) ***Note**:* use additional codes to identify any malignancies and other conditions associated with the syndrome.
D61.82	Myelophthisis
D63.0	Anemia in neoplastic disease ***Note***: Assign also a code for the neoplasm causing the anemia Excludes: anemia due to antineoplastic chemotherapy, new code 285.3
D75.81	Myelofibrosis (NOS) ***Note***: Not every case of myelofibrosis is associated with a malignancy. Review terms included in ICD-O-3 to determine if case is reportable. See the current ICD-9-CM.
G99.2	Myelopathy in other diseases classified elsewhere
G89.3	Neoplasm related pain (acute, chronic); Cancer associated pain; Pain due to malignancy (primary/secondary); Tumor associated pain
G63	Polyneuropathy in malignant disease
G73.1	Eaton-Lambert syndrome in neoplastic disease (Effective 10/1/2011)
J91.0	Malignant pleural effusion ***Note***: Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned.

ICD-10-CM CODE^	DESCRIPTION
R18.0	Malignant ascites ***Note***: Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned

^International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2017

OTHER CASEFINDING METHODS

Other methods for identifying reportable cancer cases should be developed to assure complete case reporting. Since the patient's medical record is the primary source of information, arrangements should be made so the appropriate charts can be routed to the personnel responsible for reporting.

Pathology

The pathology department reports must be routinely checked. The best procedure is to have copies of **all** pathology reports routed to the personnel responsible for reporting. All pathology reports (both positive and negative) must be reviewed by the reporter to ensure all eligible cases are identified. The reporter should request that all cytology, hematology, bone marrow biopsies, and autopsies be included. Both computerized and manual methods of reviewing pathology reports must include a way to track reports to ensure that every report has been included in the review. Facilities that send all pathology specimens to outside labs should keep a log of all specimens, to include date sent out, date received, and the diagnosis. The reporter should be given a copy of all reports.

Note: If a hospital sends a specimen to another hospital to be read, and the patient is never seen at the reading facility, only the hospital that performed diagnostic procedures or administered treatment for a cancer diagnosis is responsible for reporting the case. The reading facility should document this process in their policy and procedure for consistency.

Exception: To ensure complete reporting, if the specimen is sent from a **physician's office** to a reading facility, the reading facility would be responsible for reporting the case.

Radiation Oncology

For facilities with radiation oncology departments, a procedure must be established to identify patients receiving radiation therapy. This should include all inpatient and outpatient treatments.

Different options, such as providing copies of the treatment summary, a treatment card, or even a daily appointment book may be available to identify these cases. Many cancer patients are seen in the outpatient department, hematology clinic, laboratory, emergency room, nuclear medicine, and diagnostic radiology and oncology departments. A method to identify reportable cases from these departments must also be established.

Oncology/Hematology

Many facilities now have a designated oncology/hematology unit where patients receive chemotherapy treatments as an inpatient. In some cases, patients receive chemotherapy in an ambulatory setting, a freestanding facility, or a physician's office. The registrar/reporter must establish a policy and procedure for identifying patients who receive chemotherapy in these settings if affiliated with their facility.

SUSPENSE FILE

A reportable case should be abstracted after review of the patient's complete record, not just from the unit record for the admission in question. If reportable cases are identified at the time of discharge, the complete medical record may not be available at the time the case is abstracted. A suspense file should be compiled of all cases identified as eligible or potentially eligible for abstracting. The suspense file can be something as simple as a manila folder to hold the various casefinding source documents (monthly disease index, pathology reports and outpatient log sheets and so forth) in alphabetical order and/or by date of diagnosis to assess timeliness of the abstracting process.

NON-REPORTABLE LIST

Personnel responsible for reporting should review the table of terms that indicate a diagnosis of cancer on page 50. Upon review of the disease index (DI), cases may be identified as TCR non-reportable cases. Examples of these would be basal and squamous cell carcinoma of the skin (C44.0 – C44.9) (excluding genital sites), and CIN of the cervix (D06.9). A list of these cases **must be kept each year**.

The TCR will review the disease index and the non-reportable list when it conducts casefinding audits after facilities have completed reporting for a given year (see page 40). The non-reportable list will answer any questions TCR staff may have regarding the non-reporting of these cases. The list should include patient name, date of birth, social security number, medical record number, admission date, casefinding source, and the reason the case was not reportable.

Attachment B (page 72) is a sample form that can be used as a history file of the non-reportable cases. Non-reportable cases can also be documented on the disease index. Place the notation "NR" next to the patient information and include a justification if the case is determined not reportable. Another method would be to develop an electronic spreadsheet that can be sorted alphabetically, such as Excel or Word. An alphabetical index card file can also be used.

Note: There is no non-reportable log in the Web Plus system. Reporters using Web Plus may create and use a form such as the sample Attachment B, or make a not reportable notation for each case on the disease index.

The following examples are resources to determine if a case is reportable to the TCR. It is critical that these scenarios be applied appropriately. If a patient has active disease and/or is on cancer directed therapy, the case must be reported, unless it is a non-reportable condition.

Non-Reportable Examples

Example 1. The IDC-10-CM billing code indicates current disease. Reason for admission was radiology and laboratory testing. Radiology and laboratory findings do not indicate active disease. This case is not reportable since there is no indication that the patient has current disease.

Example 2. The discharge summary and face sheet states history of cancer and there is no other information within the chart to indicate active or stable disease. This case is not reportable because the patient has a history of cancer with no evidence of active disease.

Example 3. A patient is admitted for evaluation of congestive heart failure. The patient had a mastectomy for breast cancer 8 years ago and there is no evidence of recurrent or metastatic disease. This case is not reportable because there is no indication that the patient has current disease.

Example 4. A patient comes in for lab work. Face sheet states lung cancer. No other information or documentation indicating active disease is available. This case is not reportable because there is no information regarding whether the patient has current lung cancer.

Example 5. A patient comes in for a bone scan. The physician orders state prostate cancer, but the bone scan report states no evidence of disease. There is no other information in the chart. Do not report this case since there is no evidence of disease and no mention of current treatment.

Reportable Examples

Example 1. Patient is admitted for staging procedures. Radiology reports no abnormal findings. The discharge summary states that the patient has recently been diagnosed with prostate cancer and is in the process of deciding treatment options. This case is reportable because even though the radiology report shows no abnormal findings, the discharge summary states the patient has prostate cancer.

Example 2. A patient was diagnosed with adenocarcinoma of the stomach in 1985 with no evidence of recurrent or metastatic disease. In 2018, the patient was admitted and diagnosed with small cell carcinoma of the lung. The lung cancer is reportable for 2018 because the patient has active lung cancer.

Example 3. Discharge summary diagnosis states cancer and the ICD-10-CM billing code indicates current disease. All laboratory findings are negative for active disease, but one radiology report indicates active disease compatible with malignancy. This case is reportable because according to the radiology report the patient has active disease.

Example 4. A patient is admitted to your facility with an acute cerebrovascular accident. The H&P states the patient was diagnosed with metastatic lung cancer four months prior to admission. He was treated with palliative care and referred to the Hospice program. All indications are that this patient still has active cancer. This case is reportable because apparently the patient has active disease.

Example 5. A patient was diagnosed with cervical cancer in 2000 and has had no recurrence. She is now admitted and diagnosed with a second primary in the lung. The lung case is reportable because the patient has active lung cancer.

Example 6. A patient comes to your facility for port-a-cath insertion to allow for chemotherapy for a malignancy. Documentation indicates the patient has active disease. This case is reportable because the patient has active disease and is receiving cancer directed therapy, even though the therapy may be given at a different facility.

Example 7. Patient with a recent excisional biopsy for melanoma of skin of arm is admitted to your facility for a wide excision. The pathology report shows no residual melanoma. This case is reportable because the wide excision is considered treatment for the melanoma.

Example 8. In 2018 a patient comes to your facility for a colonoscopy. The record states that the patient was diagnosed with breast cancer in 2014. She is still being treated with Tamoxifen which was part of the first course of treatment. It is unknown if the patient has evidence of disease at this time. This case is reportable because the patient is still receiving hormone treatment.

Note: When Tamoxifen or other hormonal therapy, such as Arimidex, is used as adjuvant therapy for breast cancer it is generally prescribed for 5 years. It has been shown that when taken for 5 years it reduces the chance of the original breast cancer coming back in the same breast or metastasizing. Therefore, if the patient has a history of breast cancer and is on hormonal treatment ***and****:*

- It is known that the diagnosis was within the past 5 years, report the case.
- It is unknown how long ago the breast cancer was diagnosed, report the case.
- It is known that the diagnosis of breast cancer was greater than 5 years ago and there is no evidence of disease, and no evidence of other treatment being given at the time of admit, it is not necessary to report the case.

Example 9. A patient is admitted to the hospital after a heart attack. The chart states the patient has a history of prostate cancer and is on Lupron. There is no other information regarding the patient's history. Report this case because the patient is on treatment that could be related to the history of prostate cancer.

Example 10. A patient comes to your facility for a bone scan. The physician orders state the patient was recently diagnosed with prostate cancer. Regardless of the results, report this case since the patient was stated to be recently diagnosed; the bone scan is being done for staging purposes.

Summary

If there is any indication within the medical record that the patient has evidence of disease, or is on cancer **directed** treatment, the case is reportable except for those morphologies listed under non-reportable neoplasms on page 47. This would include but not limited to radiology reports, pathology reports, consults, history and physicals, and clinic notes.

Note: Use the 2018 Solid Tumor coding rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2018 and forward: https://seer.cancer.gov/tools/solidtumor/

AMBIGUOUS TERMINOLOGY FOR SOLID TUMORS

In most cases, the patient's record clearly presents the diagnosis by use of specific terms which are synonymous with cancer. However, there will be times when a physician is not certain or the documented language is not definitive. Ambiguous terminology may originate from any source document, such as pathology report, radiology report or a clinical report. *The entire medical record*

should be reviewed before basing reportability on one of these terms. The ambiguous terms listed below are reportable when they are used with a term such as cancer, carcinoma, sarcoma, etc.

Ambiguous Terms That Are Reportable (used to determine reportability only)

- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

Note:

- Do not substitute synonyms such as "supposed" for presumed or "equal" for comparable. Do not substitute "likely" for "most likely."
- This list should be used only for determining case reportability. Do not use this list to determine the appropriate histology or stage. For histology always follow the *Solid Tumor Rules 2018 and the Hematopoietic and Lymphoid Neoplasm Coding Manual*.

How to Use the Ambiguous Terminology for Case Ascertainment

In situ and Invasive (Behavior codes/2 and 3/)

1. If any of the reportable ambiguous terms precede a word that is synonymous with an in situ or an invasive tumor, accession the case. Please refer to page 127-128 for terms synonymous for in situ.

   ***Example*:** Pathology report states: "Prostate biopsy with markedly abnormal cells typical of adenocarcinoma." **Accession the case because "typical (of)" is an ambiguous term that is reportable.**

   ***Negative example*:** The final diagnosis on the outpatient report reads: Rule out pancreatic cancer. Do not accession the case.

2. Discrepancies

   a. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.

      Do not accession a case when the original source document used a **non**-reportable ambiguous term and subsequent documents refer to the history of cancer.

      ***Example*:** Report from the dermatologist is "possible melanoma." Patient admitted later for unrelated procedure and physician listed history of melanoma. Give priority to the information from the dermatologist and **do not** report this case. "Possible" is **not** a reportable ambiguous term. The later information is less reliable in this case.

   b. Accept the reportable term and accession the case when there is a single report in which both reportable and non-reportable terms are used.

***Example*:** Abdominal CT reveals a 1cm liver lesion. "The lesion is consistent with hepatocellular carcinoma" appears in the discussion section of the report. The final diagnosis is "1 cm liver lesion, possibly hepatocellular carcinoma." Accession the case. "Consistent with" is a reportable ambiguous term. Accept "consistent with" over the non-reportable term "possibly."

Exception: Do not accession a case based ONLY on suspicious cytology. If cytology is reported using an ambiguous term, do not interpret this as a diagnosis of cancer. **Report the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings or if cancer directed therapy is administered.** Cytology is the examination of cells obtained by aspiration, washing, smear, or scraping.

Important*:* Accession cases with cytology diagnoses that are positive for malignant cells.

As of January 2013, (SEER Program Coding and Staging Manual 2018, Reportability, page 7 and 10) a positive urine cytology is reportable.

- Do not report cytology cases with ambiguous terminology
- If no information about primary site, code to C68.9.
- Do not report if subsequent biopsy of urinary site is negative
- Do not implement new/additional casefinding methods.

Example 1. A patient with persistent hematuria has a urinalysis done in your facility and the cytology report states cells **suspicious** for malignancy. The patient does not return for any further work-up. **Do not** report this case based on the **suspicious cytology alone**. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended.

Example 2. A fine needle aspirate of a thyroid nodule is suspicious for follicular carcinoma. The patient has a thyroid biopsy which shows papillary follicular carcinoma. This case should be reported because the biopsy was positive for malignancy.

c. Cytology using only ambiguous terminology is not reportable.

Do **not** accession a case based ONLY on **suspicious** cytology. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended.

***Note*:** "Suspicious cytology" means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable in this manual.

d. Use the reportable ambiguous terms when **screening** diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing with the exception of tumor markers.

e. Do not accession a case when resection, excision, biopsy, cytology, or physician's statement proves the ambiguous diagnosis is not reportable.

Example 1. Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not accession the case.

Example 2. CT report states "mass in the right kidney, highly suspicious for renal cell carcinoma." CT-guided needle biopsy with final diagnosis "neoplasm suggestive of oncocytoma. A malignant neoplasm cannot be excluded." Discharged back to the nursing home and no other information available. Do not accession the case. The suspicious CT finding was biopsied and not proven to be malignant. "Suggestive of" is not a reportable ambiguous term.

Example 3. Stereotactic biopsy of the left breast is "focally suspicious for DCIS" and is followed by a negative needle localization excisional biopsy. Do not accession the case.

Example 4. The needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven to be false.

Example 5. Esophageal biopsy with diagnosis of "focal suspicious for adenocarcinoma in situ." Diagnosis on partial esophagectomy specimen "with foci of high grade dysplasia; no invasive carcinoma identified." Do not accession the case. The esophagectomy proved that the suspicious biopsy result was false.

- When phrases such as strongly suspicious or highly favors are used, disregard the modifying term and refer to the guidelines above regarding the primary term. A patient stated to have "known" cancer should be reported to the TCR.
- If the word or an equivalent term does not appear on the reportable list and is not a form of a word on the reportable list, the term is not diagnostic of cancer. Do not accession the case. If forms of the word are used such as: "Favored" rather than "Favor(s)"; "appeared to be" rather than "appears", the case is reportable. Do not substitute synonyms such as "supposed" for presumed or "equal" for comparable.
- If one section of the medical record(s) uses a reportable term such as "apparently" and another section of the medical record(s) uses a term that is not on the reportable list, accept the reportable term and accession the case.

Exception: If the ambiguous diagnosis is proven to be not reportable by biopsy, cytology, or physician's statement, do not accession the case.

Benign and borderline primary intracranial and CNS tumors

1. **Use the above "ambiguous terms that are reportable"** list to identify benign and borderline primary intracranial and CNS tumors that are reportable.
2. If any of the reportable **ambiguous terms precede** either the word **"tumor"** or the word **"neoplasm",** accession the case.
3. Neoplasm and tumor are reportable terms for brain and CNS because they are listed in ICD-O-3 with behavior codes of /0 and /1
4. Mass and lesion **are not** reportable terms for brain and CNS because they are not listed in ICD-O-3 with behavior codes of /0 or /1

   ***Example*:** The mass on the CT scan is **consistent with** pituitary tumor. Accession the case.

5. **Discrepancies**
   a. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.

      Do not accession a case when subsequent documents refer to history of tumor and the original source document used a non-reportable ambiguous term.

   b. Accept the reportable term and accession the case when there is a single report and one section of a report uses a reportable term such as "apparently" and another section of the same report uses a term that is not on the reportable list.

      Exception: Do not accession a case based ONLY on ambiguous **cytology** (the reportable term is preceded by an ambiguous term such as apparently, appears, compatible with, etc.)
6. Use these terms when **screening** diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing other than tumor markers.
7. **Do not** accession the case when resection, excision, biopsy, cytology or physician's statement proves the ambiguous diagnosis is not reportable.

Note: AJCC does **NOT** define ambiguous terminology and does **NOT** mandate how words should be interpreted. AJCC instructs registrars to review physician's statements, consider treatment choices, assess physical exam, medical history, symptoms, imaging, lab tests, diagnostic procedures and all other available information in order to decide cancer involvement, exercise critical thinking.

Ambiguous Terminology Lists: References of Last Resort

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

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

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

CASEFINDING INSTRUCTIONS FOR HEMATOPOIETIC & LYMPHOID NEOPLASMS

See the Reportability Instructions in the Hematopoietic and Lymphpoid Neoplasm Coding Manual at https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf . (Reportability Instructions begin on page 25).

1. Search the Heme DB to determine case reportability.
2. Report all cases with morphology codes 9590-9992 with a /3 behavior.
3. Report hematopoietic and lymphoid neoplasms with morphology codes 9590-9992 listed in ICD-O as /1 that are described as malignant by a physician. Apply the matrix rule and change behavior code to /3.
4. Report the case when the diagnosis of a hematopoietic neoplasm is preceded by one or more of the ambiguous terms listed below:
    a. This instruction pertains to reportability and casefinding only.
    b. See the Histology Coding Instructions in the Heme Coding Manual for instructions on assigning histology with ambiguous terminology.
        - Apparently
        - Appears
        - Comparable with
        - Compatible with
        - Consistent with
        - Favor(s)
        - Malignant appearing
        - Most likely
        - Presumed
        - Probable
        - Suspect(ed)
        - Suspicious (for)
        - Typical (of)

    Note: Use these terms when screening all reports other than cytology and tumor markers.
5. Report the case when the patient is **treated** for a reportable neoplasm.
6. Report the case when there is a clinical diagnosis (physician's statement) of reportable hematopoietic or lymphoid neoplasm.
7. Report the case when a reportable diagnosis appears in any text or report described as a Definitive Diagnostic Method in the Heme DB.

For reportability examples, exceptions and notes please see the Hematopoietic and Lymphoid Neoplasm Coding Manual "Case Reportability Instructions" section on page 25.

CASEFINDING LISTS

Current and previous casefinding lists are available on the SEER website: https://seer.cancer.gov/tools/casefinding/. Use the casefinding lists to screen prospective cases and identify cancer cases for inclusion in the registry.

A casefinding list is **not** the same as a reportable list. Casefinding lists are intended for searching a variety of sources so as not to miss any reportable cases.

Definition of Casefinding (case ascertainment): Process of identifying all reportable cases through review of source documents and case listings. Casefinding covers a range of cases that need to be assessed to determine whether or not they are reportable.

ADDITIONAL GUIDELINES FOR CASE REPORTING

In some instances it is unclear whether cancer cases seen in a clinic are reportable through an associated facility. The cases **should be included** in the facility's caseload when:

1. The clinic is owned by the facility.
2. The facility is legally responsible for the medical charts in the clinic.
3. The facility receives revenue from the medical charts at the clinic.
4. The clinical charts are filed in the same location as the facility charts, or
5. The facility pays the physicians to work in the clinic.

- Cases diagnosed and/or treated for cancer prior to admission **should be reported** if there is evidence of **active disease**, whether or not diagnostic or therapeutic procedures were performed. **Stable disease indicates active disease.**
- Cases diagnosed at autopsy are reportable.
- Patients with active cancer coming into a facility for "consultation only" should be reported.
- Abstract cases with a reportable diagnosis using the medical record from the first admission (inpatient or outpatient) to your facility. Use information from subsequent admissions to supplement documentation and to include all first course treatment information**. Do not submit a report for each admission; submit one report per primary tumor.**
- Cases in which the disease is **no longer active** should only be reported if the patient is still receiving cancer-directed therapy. For instance, a patient with a history of leukemia in remission, but is still receiving chemotherapy.

***Example*:** A patient diagnosed 6 months ago with acute myelocytic leukemia is now in remission and on a maintenance dose of chemotherapy. The patient was admitted for evaluation of neutropenia following the most recent course of chemotherapy. If this is the first admission to your facility, this patient should be reported because cancer-directed treatment (chemotherapy) is being administered.

Note: Remember, physicians may refer to patients diagnosed with cancer prior to coming to a facility as having a "history of" cancer. These cases should be reviewed closely to determine if the patient has active disease and/or is receiving cancer-directed treatment. If you have any questions regarding the eligibility of a case, call your TCR health service region.

Examples for Determining Case Reportability

Example 1. A patient comes to a facility for a bone scan. The face sheet has been coded to prostate cancer. The bone scan is negative and there is no other information to indicate that this patient has active disease or is receiving cancer directed treatment. **This case is not reportable because there is no information to indicate if this patient has active disease.**

Example 2. A patient comes to the emergency room. He tells the attending physician that he had cancer years ago. There is no other information documented to indicate that he has active disease

or is on cancer-directed therapy. **This case is not reportable because there is no information confirming the patient has active disease**.

Example 3. A patient comes into the emergency room for a broken wrist. The history/physical states that the patient is currently undergoing chemotherapy for lung cancer, but the facility does not render any treatment for the cancer; the patient is only treated for the broken wrist. **This case is reportable because the patient is currently undergoing cancer directed treatment at another facility.**

Example 4. A patient is admitted to a facility with a breast lump. The H&P states that the patient was diagnosed elsewhere with breast cancer seven years ago and treated with a lumpectomy. There is now recurrence of the disease and the patient was referred for a mastectomy. **This case is reportable due to active disease.**

Example 5. A patient comes to your facility for lab work only. The face sheet states "cancer". The only other information available is the lab results. **This case is not reportable. A physician must state the patient has active disease, recurrence, or metastatic disease.**

Note: Every effort should be made to identify multiple primary tumors. Refer to the 2018 Solid Tumor Rules and to the *Hematopoietic and Lymphoid Neoplasm Coding Manual t*o prevent reporting the same primary twice for a patient, compare the patient name and primary cancer site from the registry database to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.

Complete cancer reporting is an important element in a cancer registry quality assurance program. The TCR performs casefinding audits to determine the completeness of case ascertainment and timeliness of reporting at facilities across the state. These audits are a part of TCR's data quality procedures and are necessary to assure complete and accurate cancer information and to meet the state's federal funding obligations. The results of a casefinding audit are reported back to the facility.

HELPFUL HINTS TO CONDUCT CASEFINDING

- All possible sources of cancer cases in a facility should be reviewed to achieve complete and accurate casefinding.
- Review pathology reports monthly.
- Review disease index monthly.
- Review radiation oncology logs weekly.
- Have coders route medical charts to the registrar/reporter on all identified cancer patients.
- Review outpatient and emergency room visits for reportability. Arrangements can be made to have these routed to the registrar/reporter, or the registrar/reporter can physically review them in the department.
- Maintain a list of non-reportable cases or document non-reportable cases on the disease index.

When reporting is complete for the year, it is the facility's responsibility to maintain a reportable and non-reportable list to assist in the review process of the potentially missed cases list provided annually.

Note: For more information on cancer reporting visit the Cancer Reporting page on the TCR website, located at https://www.dshs.texas.gov/tcr/reporting.aspx.

Contact your regional representative for an assessment of your casefinding procedures. This will better prepare you for an audit.

Determining Multiple Primaries

Solid Tumors

Apply the general and site-specific instructions for determining multiple primaries in the 2018 Solid Tumor Rules: https://seer.cancer.gov/tools/solidtumor/

Site-specific multiple primary rules cover the following:

Primary Site	Topography Codes
Head and Neck	C000-C148, C300-C329
Colon, Rectosigmoid, Rectum	C180-C189
Lung	C340-C349
Breast	C500-C506, C508-C509
Kidney	C649
Urinary sites	C659, C669, C670-C679, C680-C689
Non-malignant CNS	C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
Malignant CNS and Peripheral Nerves	C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
Other sites	Excludes Head and Neck, Colon, Rectosigmoid, Rectum, Lung, Cutanous Melanoma, Breast, Kidney, Urinary Sites, Peripheral Nerves, CNS

The General rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site, cutaneous, Other Sites. The head and neck, colon, rectosigmoid and rectum, breast, kidney, urinary sites, and malignant CNS and peripheral nerves rules exlude lymphoma and leukemia (M9590-M9992) and Kaposi sarcoma (M9140). All Other Sites rules exlude lymphoma and leukemia M)(9590- M9992).

Hematopoietic and Lymphoid Neoplasms

Updates to the *Hematopoietic and Lymphoid Neoplasm Coding Manual and Database* have been made for 2018 cases. The updates reflect changes based on updates of the WHO Classification of Tumors (Blue Books) , AJCC 8th edition Staging Manual, and clarifications to current rules. Apply the Multiple Primary Rules in the Hematopoietic & Lymphoid Neoplasm Database (Heme DB).

Transplants

Transplanted organs or tissue may originate from:

- organs or tissue from the patient's own body (called autograft)
- another human donor (homograft or allograft)

Accession a new primary in the transplanted organ as you would any new primary, applying the 2018 Solid Tumor Rules. Code the primary site to the location of the transplanted organ, i.e., code the malignancy where it resides/lies.

Example: Diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus. Document the situation in a text field.

ATTACHMENT A: Sample Facility Disease Index

Cancer Cases with 2018/2019 Admission Date

ICD-10 Codes

MR#	NAME	DOB	SS#	SEX	PT CLASS/ TYPE	ADMISSION DATE	DISCHARGE DATE	DIAGNOSIS/ DESCRIPTION
123123	Roberts, Jim	2/10/1959	455-66-9090	M	IN, MCR	05/02/18 (19)	05/03/18 (19)	C7A.010 Mal Carcinoid Tumor Duodenum
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	04/05/18 (19)	04/07/18 (19)	Z51.11 Chemo Encounter
C5412	Smith, Bob	6/29/1938	422-23-2323	M	SCD, MCR	05/11/18 (19)	05/11/18 (19)	C64.9 Mal Neo Kidney
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	09/06/18 (19)	09/14/18 (19)	C79.1 Sec Mal Neo Brain
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	10/15/18 (19)	10/22/18 (19)	C64.9 Mal Neo of Unsp Kidney
MR421	Sun, Len	11/4/1980	566-66-6666	M	IN, OTH	10/16/18 (19)	10/20/18 (19)	D63.0 Anemia in Neoplastic Disease
MR311	Timms, Emma	6/15/1959	500-00-5000	F	CLL, MCR	03/22/18 (19)	03/22/18 (19)	D24.1 Benign Neo Breast
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/18 (19)	06/02/18 (19)	C50.419 Mal Neo Breast UOQ
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/18 (19)	06/02/18 (19)	C77.3 Mal Neo Lymph-Axilla
MR311	Timms, Emma	6/15/1959	500-00-5000	F	RCR, MCR	07/13/18 (19)	07/23/18 (19)	Z51.0 Encounter for Antineoplastic Radiation Therapy
MR311	Timms, Emma	6/15/1959	500-00-5000	F	RCR, MCR	8/23/2018 (19)	11/13/18 (19)	D49.9 GIST

ATTACHMENT B: Non-Reportable List

Facility Name: _____ Facility ID#___ Reviewed by: ___ Telephone: _____

PATIENT NAME	MED REC #	ADMIT DATE	DATE OF BIRTH	SS#	CASEFINDING SOURCE	N/R CODE

***KEEP A COPY FOR YOUR RECORDS

NON-REPORTABLE (N/R) CODES:

01 – Benign

02 – Non-Reportable Skin Cancer (Site=C44.*, Morph=8000-8110)

03 – No Evidence of Disease (NED) (History of Cancer but No Evidence of Treatment Currently and No Evidence of Cancer Currently)

04 – Cancer Not Proven

05 – Duplicate Case (This Cancer has already been reported to TCR)

06 – In situ Cancer of Cervix, CIN III

07 – No Cancer Mentioned in Record

08 – Diagnosed prior to 1995

09 – Lab only

10 – Other (Include Explanation)

4

DEMOGRAPHICS AND PATIENT INFORMATION

Reporting Facility Number

(NAACCR Item #540)

Description

Identifies the facility or institution reporting the case.

Explanation

This data item is used for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Coding Instructions

1. Enter the three-digit facility number assigned by the TCR. This is a 10 digit code. The three digit facility number should be coded with 7 leading zeros.
2. If you do not know your facility number, contact your Health Service Region office or the Central Office in Austin. See page 32 for contact information.

Type of Reporting Source

(NAACCR Item #500) (SEER pages 26-28)

Description

This data item identifies the source documents used to abstract the case being reported. This will not necessarily be the document that identified the case but the document that provided the best information.

Explanation

This field provides the source of the documents used to report the case, e.g., inpatient or outpatient charts, cases diagnosed in physician's offices, patients diagnosed at autopsy, pathology report only, or diagnosed by death certificate only.

Coding Instructions

Enter the code for the source of the facility and/or documents used to abstract the case.

Table 4.1 Type of Reporting Source Codes

CODE	LABEL	SOURCE DOCUMENTS	PRIORITY
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records	Hospital inpatient Offices/facilities with a comprehensive, unified record • HMO physician office or group • HMO affiliated free-standing laboratory, surgery, radiation or oncology clinic	1

CODE	LABEL	SOURCE DOCUMENTS	PRIORITY
		Includes outpatient services of HMOs and large multi-specialty physician group practices with unified records	
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)	Facilities with a stand-alone medical record • Radiation treatment centers • Medical oncology centers (hospital- affiliated or independent) There were no source documents from code 1.	2
3	Laboratory Only (hospital-affiliated or independent)	Laboratory with stand-alone medical record There were no source documents from codes 1, 2, 8, or 4.	5
4	Physician's Office/Private Medical Practitioner (LMD)	Physician's office that is NOT an HMO or large multi-specialty physician group practice. There were no source documents from codes 1, 2 or 8.	4
5	Nursing/Convalescent Home/Hospice	Nursing or convalescent home or a hospice. There were no source documents from codes 1, 2, 8, 4, or 3.	6
6	Autopsy Only	Autopsy The cancer was first diagnosed on autopsy. There are no source documents from codes 1, 2, 8, 4, 3, or 5.	7
7	Death Certificate Only	Death certificate is the only source of information; follow-back activities did not identify source documents from codes 1, 2, 8, 4, 3, 5 or 6. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1, 2, 8, 4, 3 or 6.	8
8	Other hospital outpatient units/surgery centers	Other hospital outpatient units/surgery centers. Includes but not limited to, outpatient surgery and nuclear medicine services. There are no source documents from codes 1 or 2.	3

Note: When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source: Codes: 1, 2, 8, 4, 3, 5, 6, 7. (SEER Program Coding and Staging Manual, page 28)

Definitions

Comprehensive, unified medical record: A hospital or managed health care system that maintains a single record for each patient. That record includes all encounters in affiliated locations.

Stand-alone medical record: An independent facility; a facility that is not part of a hospital or managed care system. An independent medical record containing only information from encounters with that specific facility.

Managed health plan: Any facility where all of the diagnostic and treatment information is maintained in one unit record (all records for the patient from all departments, clinics, offices, etc. in a single file with the same medical record number). The abstractor is able to use the unit record when abstracting the case

***Examples*:** HMOs or other health plans such as Kaiser, Veterans Administration, or military facilities.

Physician office: A physician office performs examinations and tests. Physician offices may perform limited surgical procedures.

***Note**:* The category "physician's office" also includes facilities that are called surgery centers when surgical procedures under general anesthesia cannot be performed in these facilities.

Surgery center: Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. The patient usually does not stay overnight.

Note: The category "physician's office" also includes facilities that are called surgery centers when surgical procedures under general anesthesia cannot be performed in these facilities.

Priority Order for Assigning Type of Reporting Source

Code the source that provided the best information used to abstract the case.

Example 1. A patient is admitted to your facility and expires before any treatment is rendered. An autopsy is performed and cancer is found in the lung. Code the reporting source to 6 (autopsy only). The autopsy report is the only document used for your cancer information. The patient was not known to have cancer prior to the autopsy.

Example 2. A patient is admitted to your hospital and is diagnosed with lung cancer. Code the reporting source to 1 (Facility Inpatient/ Outpatient or Clinic). All documents in the medical record are used to gather the cancer information.

Example 3. The only patient record available for a physician office biopsy is the pathology report identified from a freestanding laboratory. Assign code 3 [Laboratory Only (hospital-affiliated or independent)]. Reporting source should reflect the lab where this case was identified. The MD office added nothing to the case, not even a confirmation of malignancy.

When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source: Codes: 1, 2, 8, 4, 3, 5, 6, 7. (SEER Program Coding and Staging Manual, page 28)

Date of Admit/Date of First Contact

(NAACCR Item #580)

Description

The date of first admission/contact with the reporting facility for diagnosis and/or treatment of this cancer. If previously diagnosed/treated elsewhere, the date of first admission to your facility with diagnoses of active cancer.

Explanation

This data item allows the facility to document the first contact with the patient. It can be used to measure the time between admission and when the case is abstracted and the length of time between the first contact and treatment.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
2. Enter the date of the first admission to your facility for a diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.
3. Date format is YYYYMMDD

   ***Example*:** The patient is first seen at this facility on January 4, 2018 with a diagnosis of cancer. Record the date of admit: 20180104
4. A date **must** be entered in this field. If the patient was never an inpatient, enter the date of the first outpatient visit e.g., biopsy, x-ray, laboratory test, or emergency room visit at your facility with active cancer.
5. For autopsy-only or death certificate-only cases, use the date of death as the date of first contact.
6. For "read only" or "pathology only" cases, enter the date the specimen was collected. These are cases where a specimen is sent to be read by the pathology department and the patient is never seen or admitted at the reporting facility. These cases are reportable if the pathology department generates revenue for the reporting facility and is **NOT** a free standing entity. The class of case should be coded to 43 and the reporting source would be 3.

***Note:* STORE 2018** instructions (**see STORE 2018 page 18**) differ from TCR instructions. STORE 2018 requires that for analytic cases Date of First Contact is the date the patient qualifies as an analytic case Class of Case 00-22. If the patient was admitted for non-cancer-related reasons, the Date of First Contact is the date the cancer was first suspected during the hospitalization. TCR will continue to instruct that the date be recorded as the admit date if the diagnosis is made at the reporting facility. It is understood that ACoS facilities will continue to follow the rules according to the STORE 2018 Manual.

Example 1. A patient is admitted to the hospital on January 31, 2018, with chest pains. On February 2, 2018, a CT scan shows that the patient has a lung mass consistent with malignancy. Record the date of first contact as 20180131.

Example 2. A patient has a biopsy in a staff physician's office on March 17, 2018, and the specimen is sent to the reporting facility's pathology department on that same day. The pathologist reads the specimen as malignant melanoma. The patient enters the same reporting facility on March 21, 2018, for a wide re-excision. Record the date of first contact as 20180317.

Example 3. A patient has a lymph node biopsy at a small hospital on May 15, 2018. The specimen is sent to your hospital to be evaluated in your pathology department. The pathologist reports diffuse large b- cell lymphoma. The patient never enters your hospital. Record 20180515 as the date of first contact.

Registry/Accession Number

(NAACCR Item #550) (STORE 2018 page 47)

Description

A registry or accession number is a unique number assigned to identify each patient regardless of the number of primary cancers.

Explanation

This data item serves as a reference number to protect the identity of the patient.

Coding Instructions

1. The first four digits identify the calendar year the patient was first seen at the facility with a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year's accession/registry number will start with **00001**.

   ***Example*:** 201800001 would indicate the first 2018 case reported from a facility.

2. **Do not** assign a new registry number to a patient previously reported to the TCR with a new primary cancer. Within a registry, all primaries for an individual must have the same accession number.

Note: Web Plus does not auto populate Accession Number.

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.

Medical Record Number

(NAACCR Item #2300) (STORE 2018 page 51)

Description

The number assigned to a patient's medical record by the reporting facility's health information management (HIM) department. The CoC STORE manual instructs registrars to record numbers assigned by the facility's Health Information Management (HIM) Department only, not department-specific numbers.

Explanation

This number identifies the individual patients within a reporting facility. It allows a reporting facility to easily locate a patient's health information. This health information is referenced when abstracting or updating a cancer case or to help identify multiple reports and primaries on the same patient.

Coding Instructions

1. Enter the eleven digit medical record number used to identify the patient's first admission with active cancer and/or on cancer treatment. Medical record numbers with less than 11 digits and alpha characters are acceptable.

2. If a number is not available (outpatient clinic charts or ER visit reports), enter OP followed by nine 0's in this field. See Table 4.2 for other optional medical record identifiers.

Table 4.2 Optional Medical Record Identifier Codes

CODE	DESCRIPTION
ER	Emergency Room patient without a medical record number
OP	Outpatient without a medical record number
RT	Radiation Therapy department patient without HIM number
SU	One-day surgery clinic patient without HIM number
UNK	Medical record number unknown

Note: Other standard abbreviations may be used to indicate departments within the facility for patients without HIM numbers assigned.

Class of Case

(NAACCR Item #610) (STORE pages 122-125)

Description

Class of case identifies the role of the reporting facility in the patient's diagnosis and treatment.

Explanation

This data item divides case records into analytic and non-analytic categories. The class of case determines which cases should be included in the analysis of the facility's cancer experience.

Note: All reporting facilities must report their non-analytic cases to the TCR, regardless of their approval status with the ACoS.

1. **Analytical cases (codes 00-22):** Diagnosed at the reporting facility or in a staff physician's office and/or received any of the first course treatment at the reporting facility. Abstracting for class of case 00 through 14 is to be completed within six months of diagnosis. This allows for treatment

information to be documented in the patient's medical record. Abstracting for class of case 20 through 22 is to be completed within six months of first contact with the reporting facility. These cases are analyzed because the facility was involved in the diagnostic and therapeutic decision-making.

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

2. **Non-analytical cases (codes 30-49 and 99):** Diagnosed and received all of the first course of treatment at another facility, or cases which were diagnosed and/or received all or part of the first course of treatment at the reporting facility prior to the registry's reference date (reference date applies to ACoS facilities, facilities striving for ACoS certification, or facilities that follow ACoS standards and do not seek certification). Abstracting for non-analytical cases should be completed within six months of first contact with reporting facility. Non-analytical cases (classes 30-49 and 99) are usually excluded from a facility's routine treatment or survival statistics.

   Note: Per TCR reporting guidelines, non-analytical cases are reportable by all facilities for cases diagnosed January 1, 1995 and forward when there is documentation of active cancer or if the patient is receiving cancer directed therapy. Foreign residents are no longer required to be reported.

   Note: Non-analytical class of case codes 49 and 99, are to be used solely by the central registry.

Coding Instructions

1. Code the *Class of Case* that most precisely describes the patient's relationship to the facility.
2. Code 00 applies only when it is known the patient went elsewhere for treatment. If that information is not available, code *Class of Case* 10.
3. Code 34 or 36 if the diagnosis is benign or borderline (*Behavior* 0 or 1) for any site diagnosed before 2004 **OR** for any site other than meninges (C70_), brain (C71_), spinal cord, cranial nerves, and other parts of central nervous system (C72_), pituitary gland (C751) craniopharyngeal duct (C752), and pineal gland (C753) that were diagnosed in 2004 or later.

   Note: These types of cases are not required by TCR. These would be used for reportable by agreement only cases.

4. Use code 34 or 36 intraepithelial neoplasia grade III (8077/2 or 8148/2) of the cervix (CIN III) or prostate (PIN (III).

   Note: These types of cases are not required by TCR. These would be used for reportable by agreement only cases.

5. A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there. Treatment provided in a staff physician's office is provided "elsewhere". That is because care given in a physician's office is not within the hospital's realm of responsibility.
6. If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not, as with any other physician.

Table 4.3 Class of Case Definitions

ANALYTIC CASES	
INITIAL DIAGNOSIS AT REPORTING FACILITY	
Class 00*	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done ELSEWHERE. Cases include: • Patients who choose to be treated elsewhere. • Patients referred elsewhere for treatment due to lack of special equipment; proximity of a patient's residence to the treatment center; financial, or rehabilitative considerations, etc. **Note:** Code 00 applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code Class of Case 10.
Class 10*	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND PART OR ALL of first course treatment or a decision not to treat was done at the reporting facility, NOS. **Note:** ACoS facilities should include cases in which patients are diagnosed at the reporting facility prior to the registry's reference date and all or part of the first course of treatment was received at the reporting facility after the registry's reference date.
Class 11	Initial diagnosis in an office of a physician with admitting privileges AND PART of first course treatment was done at the reporting facility.
Class 12	Initial diagnosis in an office of a physician with admitting privileges AND ALL first course treatment or a decision not to treat was done at the reporting facility.
Class 13*	Initial diagnosis at the reporting facility AND PART of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
Class 14*	Initial diagnosis at the reporting facility AND ALL first course treatment or a decision not to treat was done at the reporting facility.
INITIAL DIAGNOSIS ELSEWHERE, FACILITY INVOLVED IN FIRST COURSE OF TREATMENT OR A DECISION NOT TO TREAT	
Class 20*	Initial diagnosis elsewhere AND ALL OR PART of first course treatment was done at the reporting facility, NOS.
Class 21*	Initial diagnosis elsewhere AND PART of first course treatment was done at the reporting facility; part or first course treatment was done elsewhere.
Class 22*	Initial diagnosis elsewhere AND ALL first course of treatment or a decision not to treat was done at the reporting facility.

NON-ANALYTIC CASES

Patient appears in person at reporting facility; both initial diagnosis and treatment elsewhere. Classes of Case not required by CoC to be abstracted. May be required by Cancer Committee, state or regional registry, or other entity.	
Class 30*	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in DIAGNOSTIC WORKUP (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere).
Class 31*	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent/port placement). **Note: *In-transit care*** is given when a patient is temporarily away from the patient's usual practitioner for continuity of care. Monitoring an oral medication started elsewhere is coded to this class of case. If the patient begins first course therapy (radiation or chemo) elsewhere and continues at the reporting facility and the care is not in-transit, then case is analytic (Class of case 21)
Class 32*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease RECURRENCE OR PERSISTENCE (active disease).
Class 33*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease HISTORY ONLY (***disease not active***).
Class 34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment done by reporting facility.
Class 35	Case diagnosed before program's Reference Date, AND initial diagnosis AND PART OR ALL of first course treatment by reporting facility.
Class 36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND part or all of first course treatment by reporting facility.
Class 37	Case diagnosed before program's Reference Date, AND initial diagnosis elsewhere AND all or part of first course treatment by facility.
Class 38*	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death.
PATIENT DOES NOT APPEAR IN PERSON AT REPORTING FACILITY	
Class 40	Diagnosis AND all first course treatment given at the same staff physician's office.
Class 41	Diagnosis and all first course treatment given in two or more different staff physician offices with admitting privileges.
Class 42	Non-staff physician or non-CoC approved clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility).
Class 43*	Pathology or other lab specimens only.
Class 49*	Death certificate only. **Note: Used by central registries only.**
UNKNOWN RELATIONSHIP TO REPORTING FACILITY	
Class 99	Case not required by CoC to be abstracted; Of unknown relationship to facility (not for use by CoC approved cancer programs for analytic cases). **Note: Used by central registries only.**

*Indicates C*lass of Case* codes appropriate for abstracting cases from non-hospital sources such as physician offices, ambulatory surgery centers, freestanding pathology laboratories, radiation therapy

centers. When applied to these types of facilities, the non-hospital source is the reporting facility. The codes are applied the same way as if the case were reported from a hospital.

By using *Class of Case* codes in this manner for non-hospital sources, the central cancer registry is able to retain information reflecting the facility's role in managing the cancer consistent with the way it is reported from hospitals. Using C*lass of Case* in conjunction with *Type of Reporting Source* (500) which identifies the source documents used to abstract the cancer being reported, the central cancer registry has two distinct types of information to use in making consolidation decisions.

Table 4.4 Class of Case Examples

CODE	REASON
00	Reporting facility admits patient due to dizziness and falling. The patient receives clinical workup which includes CT and MRI of the brain. The results are positive for brain metastasis. The patient is discharged to another hospital for treatment for lung cancer with brain metastasis. Leukemia was diagnosed at reporting facility and all care was given in a staff physician's office.
10	Patient is diagnosed with lung cancer at the reporting facility. Due to age and comorbidities the decision was made not to treat. Reporting facility found cancer in a biopsy, but was unable to discover whether the homeless patient actually received any treatment elsewhere.
11	A patient is diagnosed with melanoma in a staff physician's office. He has a wide excision at the reporting facility, and then is treated with interferon at another facility. Patient was diagnosed by staff physician, received neoadjuvant radiation at another facility, and then underwent surgical resection at the reporting facility.
12	A diagnosis of prostate cancer is made in a staff physician's office. The patient receives radiation therapy at the reporting facility, and no other treatment is given.
13	A patient is diagnosed with colon cancer at the reporting facility and undergoes a hemicolectomy there. She then receives chemotherapy at an outside clinic.
14	Reporting facility admits patient with hemoptysis. Workup reveals adenocarcinoma. The patient undergoes surgery followed by radiation therapy at the reporting facility. The patient did not receive any other treatment.
20	Patient was diagnosed with primary breast cancer at another facility. The patient then comes to the reporting facility for surgery. It is unknown if she received any other treatment.
21	Patient diagnosed at another facility with breast cancer and received neo-adjuvant chemotherapy. She now presents to the reporting facility for modified radical mastectomy.
22	Patient had a biopsy at another facility and the diagnosis was breast cancer. She underwent a mastectomy at the reporting facility and did not receive any further treatment.
31	Patient receives chemotherapy while visiting relatives in the reporting facility city, then returned to the originating facility for subsequent treatments.
32	Patient was diagnosed and treated for primary bladder cancer prior to admission to reporting facility. Reporting facility admits patient for cystectomy for recurrent bladder cancer. After treatment failure, the patient was admitted to the facility for supported care.

CODE	REASON
38	Patient admitted to reporting facility with chest pain and expires. Autopsy performed at reporting facility identifies patient has pancreatic cancer.
43	A physician does a skin biopsy in his office and sends the biopsy specimen to a reading pathology/lab. The diagnosis is malignant melanoma. The pathology/lab facility is responsible for reporting the case.

Last Name

(NAACCR Item #2230) (STORE 2018 page 53) (SEER page 32)

Description

Identifies the last name of the patient.

Explanation

This data item is used as a patient identifier.

Coding Instructions

1. Enter the last name of the patient in **CAPITAL LETTERS.**
2. Blanks, spaces, hyphens, apostrophes are allowed; do **not** use other punctuation
3. Truncate name if longer than 40 characters
4. Do not leave the data field blank. If the patient's last name is not known, enter UNKNOWN in this field. This should be done only as a last resort. Every resource should be exhausted to obtain this information.

   Note: Document in *Text Remarks - Other Pertinent Information:* Last name unknown.
5. Update this field if the name changes.

Examples

Example 1. Record De Leon with a space as DE LEON.

Example 2. Record O'Hara with an apostrophe as O'HARA.

Example 3. If Janet Smith marries Fred Jones and changes her name to Smith-Jones record SMITH-JONES with the hyphen.

First Name

(NAACCR Item #2240) (STORE 2018 page 54) (SEER page 31)

Description

Identifies the first name of the patient.

Explanation

This data item is used to differentiate between patients with the same last name.

Coding Instructions

1. Truncate first name if longer than 40 characters
2. Enter the first name of the patient in **CAPITAL LETTERS**.
3. Blanks, spaces, hyphens and apostrophes are allowed; do **not** use other punctuation.
4. This field may be updated if the name changes.
5. If the patient's first name is unknown, enter UNKNOWN. Do not leave the field blank. This should be done only as a last resort. Every resource should be exhausted to obtain this information.

Note: Document in *Text Remarks - Other Pertinent Information:* First name unknown.

Middle Name

(NAACCR Item #2250) (STORE 2018 page 55)

Description

Identifies the middle name or middle initial of the patient.

Explanation

This data item is used to differentiate between patients with identical first and last names.

Coding Instructions

1. Enter the middle initial if the complete middle name is not provided.
2. Blanks, spaces, hyphens and apostrophes are allowed. Do not use other punctuation.
3. This field may be updated if the name changes.
4. If the patient does not have a middle name or initial, or it is unknown, **leave blank**. Do not code UNK for unknown or NA for not applicable.

Maiden Name

(NAACCR Item #2390)

Description

Identifies the female patients who are or have been married.

Explanation

This data item is useful for matching multiple records for the same patient and is useful in identifying Spanish/Hispanic origin.

Coding Instructions

1. Enter the maiden name of female patients who are or have been married if the information is available. Blanks, spaces, hyphens, apostrophes, and punctuation marks **ARE** allowed.
2. If the patient does not have a maiden name, or it is unknown, **leave blank**.

Alias Name

(NAACCR Item #2280)

Description

Records an alternate name or "AKA" (also known as) used by the patient, if known. Note that maiden name is entered in Name-Maiden [2390] not in this data item.

Explanation

A patient may use a different name or nickname. These different names are aliases. This item is useful for matching multiple records on the same patient.

Coding Instructions

1. If the patient does not use an alias leave blank. Do not record the patient's first and last name again.
2. Record the **alias** last name followed by a blank space and then the **alias** first name.
3. Mixed case, embedded spaces, hyphens and apostrophes are allowed.
4. No other special characters are allowed.

Examples

Example 1. Ralph Williams uses the name Bud Williams. Record Williams Bud in the **NAME-ALIAS** field.

Example 2. Janice Smith uses the name Janice Brown. Record Brown Janice in the **NAME-ALIAS** field.

Example 3. Samuel Clemens uses the name Mark Twain. Record Twain Mark in the **NAME-ALIAS** field.

Street Address

(NAACCR Item #2330) (STORE 2018 page 56)

Description

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

Explanation

Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes. A patient's physical address takes precedence over a post office box. If a patient has multiple primary tumors the address may be different if diagnosed at different times. Do not update this field if the patient moves after diagnosis.

Note: ACoS facilities **are** required to provide information for this field regardless of class of case.

Coding Instructions

1. Enter the number and street of the patient's residence at the time the cancer is diagnosed in **60 characters or less.** If the address contains more than 60 characters, omit the least important element, such as the apartment or space number.
2. Do not omit elements needed to locate the address in a census tract, such as house number, street, direction or quadrant, and street type (street, drive, lane, road, etc.).
3. Punctuation marks are limited to periods, slashes, hyphens and pound signs in this field.
4. Only use the post office box or the rural mailing address when the physical address is not available. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Every effort should be made to obtain complete valid address information.
5. Abbreviate as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service (USPS). These include but are not limited to:

Table 4.5 Street Address Abbreviations

ABBREV.	DESCRIPTION	ABBREV.	DESCRIPTION	ABBREV.	DESCRIPTION
APT	Apartment	FL	Floor	S	South
AVE	Avenue	N	North	SE	Southeast
BLDG	Building	NE	Northeast	SQ	Square
BLVD	Boulevard	NW	Northwest	ST	Street
CIR	Circle	PLZ	Plaza	STE	Suite
CT	Court	PK	Park	SW	Southwest
DEPT	Department	PKWY	Parkway	UNIT	Unit
DR	Drive	RD	Road	W	West
E	East	RM	Room		

***Example*:** Patient's street address is 1232 Southwest Independence Apartment 400. Record: 1232 SW Independence Apt 400

6. If the patient's address is not available in the medical record, record **NO ADDRESS** or **UNKNOWN. Do not** leave blank. These cases should be rare and every effort should be made to obtain a valid address. The address data fields for these cases should be recorded as the city **Unknown**, the state as **ZZ,** the zip code should be **99999** and the FIPS as **999**. **Do not record the reporting facility's city, state, zip and FIPS.**

   Note: Document in *Text Remarks - Other Pertinent Information:* Patient address is unknown. Be aware that an excessive amount of unknown addresses will result in additional efforts by TCR staff to obtain a valid address which may include contacting the reporting facility or managing/following physician.

7. Use https://www.usps.com/ for help in completing address information.
8. Alternatively, you can also use https://www.melissa.com/lookups/AddressCheck.asp

Persons with Moret han One Residence:

1. Code the residence where the patient spends the majority of time (usual residence).
2. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

Note: These include snowbirds who live in the south for the winter months, sunbirds who live in the north during the summer months. This also includes persons with vacation residences which they occupy for a portion of the year.

Persons with no Usual Residence, including Homeless People and Transients

Code the patient's residence at the time of diagnosis as unknown.

Note: Under pertinent information document that patient is homeless. An unknown address is not the same as homeless.

Temporary Residents:

1. Code the place of usual residence rather than the temporary address for:
   a. Migrant workers
   b. Persons temporarily residing with family during cancer treatment
   c. Military personnel on temporary duty assignment
   d. Boarding school students below the college level (code the parent's residence)
2. Code the residence where the student is living while attending **college**
3. Code the address of the institution for **Persons in Institutions**.
   a. Persons who are incarcerated

b. Persons who are physically or mentally handicapped or mentally ill who are residents of homes, schools, hospitals, or wards

c. Residents of nursing and rest homes

d. Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships (Merchant Marine)

1. **Armed Forces-**For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.
2. **Personnel Assigned to Navy, Coast Guard, and Maritime Ships-**The US Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and its homeport. Refer to US Census Bureau Publications for detailed rules at www.census.gov.

Deceased Persons

Use residency information from a **death certificate** only when the residency from other sources is coded as unknown. Review each case carefully and apply the U.S. Census Bureau for determining residence. For example, the death certificate may give the person's previous home address rather than the nursing home address as the place of residence. If the person was a resident of a nursing home at diagnosis, use the nursing home address as the place of residence.

Address at Dx - Supplemental

(NAACCR Item #2335) (STORE 2018 page 58)

Description

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

Explanation

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

Coding Instructions

1. Record the place or facility (for example a nursing home or name of an apartment complex) of the patient's usual residence when the tumor was diagnosed
2. Do not use this data item to record the number, street, apartment, unit, suite, room, lot, space or department number of the patient's address.
3. Do not update this data item if the patient's address changes.
4. If this address space is not needed, **leave blank**.

City

(NAACCR Item #70) (STORE 2018 page 59)

Description

Identifies the name of the city or town in which the patient resides at the time of diagnosis. Do not update this field if the patient moves after being diagnosed.

Explanation

Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes.

Coding Instructions

1. Enter the city of residence at the time the cancer is diagnosed. If the patient resides in a rural area, record the name of the city used in the mailing address.
2. 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.
3. If the patient has multiple primaries, the address may be different for subsequent primaries.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

State

(NAACCR Item #80) (STORE 2018 page 60) (SEER page 40)

Description

Identifies the patient's state of residence at the time of diagnosis/admission. This field should not be updated if the patient moves after being diagnosed.

Explanation

It allows for analysis of geographic and environmental studies and inclusion in state and national cancer publications/studies.

Coding Instructions

1. Record the appropriate **two-letter abbreviation** for state of residence at the time of diagnosis.
2. If the patient is a resident of Canada, record the appropriate **two-letter abbreviation** for the country of residence at time of diagnosis/admission. If the province or territory of Canada is known, record the abbreviation. See page 91 for a list of Canadian Provinces/Territories.

3. If the patient is a foreign resident, other than Canada, record either **XX** or **YY** depending on the circumstance. Refer to the table below for specific instructions.
4. If the patient has multiple primaries, the state of residence may be different for subsequent cases.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS.**

Table 4.6 State Codes

CODE	DESCRIPTION
TX	If the state in which the patient resides at the time of diagnosis and treatment is Texas, then use the USPS code for the state of Texas.
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
CD	Resident of Canada, NOS; Use the specific abbreviation of Canadian Provinces/Territories if this information is provided.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **known. No longer required to report foreign residents.**
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **unknown. No longer required to report foreign residents.**
ZZ	Residence unknown.

Examples:

Example 1. A patient's country of residence is documented as France; record XX in the state field. No longer required to report to the TCR.

Example 2. Documentation in the patient's medical record states the patient is a resident of a foreign country and no other address documentation provided; record YY in the state field. No longer required to report to the TCR.

Example 3. The patient's medical record states the patient lives in the United States or in a territory, commonwealth, or possession of the United States and no other address documentation is provided; record US in the state field.

Example 4. If every valid attempt has been made to obtain the address and it is still unknown, record ZZ in the state field. If there is not enough information to determine patient is a foreign resident the case must be reported to the TCR.

Table 4.7 Canadian Provinces/Territories

PROVINCE/TERRITORY	
Alberta	AB

PROVINCE/TERRITORY	
Nunavut	NU

British Columbia	BC
Manitoba	MB
New Brunswick	NB
Newfoundland and Labrador	NF
Northwest Territories	NT
Nova Scotia	NS

Ontario	ON
Prince Edward Island	PE
Quebec	QC
Saskatchewan	SK
Yukon	YT

Table 4.8 State and Territory Abbreviations

(Refer to the ZIP Code directory for further listings).

STATE	
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
District of Columbia	DC
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS

STATE	
Kentucky	KY
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC

STATE	
North Dakota	ND
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Table 4.9 Other US Territories

OTHER U.S. TERRITORIES	
American Samoa	AS
Guam	GU
Puerto Rico	PR
Virgin Islands	VI

Zip Code

(NAACCR Item #100) (STORE 2018 page 62)

Description

Identifies the postal code of the patient's address at the time of diagnosis/admission. If the patient has multiple tumors, the postal code may be different for each tumor.

Explanation

It allows for the analysis of cancer clusters, geographic or environmental studies and health services research.

Coding Instructions

1. Enter the patient's zip code at time of diagnosis/admission. Enter the nine-digit extended zip code if known. If recording the full nine-digit zip code, **no dash** should be placed between the first five and the last four digits. The five-digit zip code is allowed if this is all the information available. Blanks follow the five-digit code if the four-digit extension is not coded.
2. If the zip code is not available, refer to the *National Zip Code Directory* or to the USPS website: https://tools.usps.com/go/ZipLookupAction!input.action. This website is useful in obtaining missing address information in order to record a complete address.
3. If the patient is a resident of a foreign country at the time of diagnosis, record **88888** for the zip code. TCR no longer requires for these cases to be reported.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

Table 4.10 Zip Code

CODE	DESCRIPTION
123456789	The patient's nine-digit U.S. extended postal code. Do not record dashes.
88888	Permanent address in a country other than Canada, United States, or U.S. possessions.
99999	Resident of the United States (including its possessions, etc.) or Canada and the postal code cannot be verified using the *National Zip Code Directory* or the USPS website.
99999	After every effort is made to obtain a valid address the information remains unknown.
M6G2S8	The patient's valid six character Canadian postal code left justified followed by three blanks.

Examples:

Example 1. A patient's country of residence is documented as France; record 88888 in the zip code field. This case would no longer be reported to the TCR.

Example 2. A patient's address is in Canada and the zip code cannot be verified; record 99999 in the zip code field.

Example 3. A patient's address is not documented in the medical record and remains unknown after researching all your facility's resources; record 99999 in the zip code field. If there is not enough information to determine patient is a foreign resident the case must be reported to the TCR.

FIPS County Code at Diagnosis

(NAACCR Item #90) (STORE 2018 page 64)

Description

Identifies the county of the patient's residence at the time of diagnosis. If the patient has multiple tumors, the county codes may be different for each tumor.

Explanation

This data item may be used for epidemiological purposes (for example: to measure the cancer burden in a particular geographical area).

Coding Instructions

1. Enter the appropriate three-digit code for the county of residence. Use codes issued by the Federal Information Processing Standards (FIPS) publication, Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas. U.S. Census Bureau's online FIPS County Code Look-up Tool: https://www.nrcs.usda.gov/wps/portal/nrcs/
2. Refer to Appendix C for the list of Texas FIPS county codes.
3. If the patient has multiple tumors, the FIPS county codes may be different for each tumor.
4. Do not update this data item if the patient's county of residence changes after diagnosis.
5. ACoS facilities following STORE guidelines must code 999 if patient is not a US resident. This case would no longer be reported to the TCR.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as Unknown in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.** If there is not enough information to determine patient is a foreign resident the case must be reported to the TCR.

Table 4.11 Fips County Code at Diagnosis

CODE	DESCRIPTION	DEFINITION
001–507	County at diagnosis	Valid Texas FIPS code
998	Outside state/country & code is unknown	Known town, city, state, or country of residence, but county code not known **AND** a resident outside the state of Texas (must meet all criteria)
999	Unknown county	The county is unknown and not documented in the patient's medical record

Address at Dx - Country

(NAACCR Item #102) (STORE 2018 page 63)

Description

Identifies the country of the patient's residence at the time of diagnosis. If the patient has multiple tumors, the country codes may be different for each tumor.

Explanation

This data item may be used for epidemiological purposes (for example: to measure the cancer burden in a particular geographical area).

Coding Instructions

Enter the appropriate alpha-3-digit code for the country of residence. Use codes issued by the United States Postal Service.

Table 4.12 Country Code Examples:

CODE	COUNTRY
USA	United States
CAN	Canada
MEX	Mexico
SLV	El Salvador
VNM	Viet Nam

Note: For other country codes please refer to the International Standards Organization (ISO) 3166-1 Country Three Character Codes: https://www.iso.org/obp/ui/#search. Foreign residents are no longer reportable to the TCR.

Social Security Number

(NAACCR Item #2320) (STORE 2018 page 52)

Description

Identifies the patient by social security number.

Explanation

This item is used by the TCR in internal processes such as linking for resolution of duplicate primaries and consolidation.

Coding Instructions

1. Every effort should be made to obtain the social security number. Research all resources from your facility for this information.
2. Enter the patient's nine-digit social security number in this field.
3. If the social security number is unavailable or unknown, enter all 9's in this field. Document in Text Remarks-Other Pertinent Information that the social security information is unavailable.
4. If only the last 4 digits are available, enter it in the following format: enter leading 7's and the last 4 digits of the SS # provided in the 9 character field:

   a. Example: 777771234

   Note: All efforts must be made to obtain the complete social, but if only the last four digits are provided they now can be used in the social security number field and not just documented in the pertinent information text box.
5. A patient's Medicare number may not be identical to the person's social security number.
6. Do not put dashes or slashes in this field.

Note: Social security numbers are used for Medicare benefits. Suffix A on a social security number indicates the number is the patient's Medicare number. Other suffixes identify another person's Medicare number under which the patient may be entitled to receive benefits. **Take caution to enter the patient's social security number and not the spouse's or guardian's number.**

The following are not allowed:

- First 3 digits= 000, 666, or 900-999
- Fourth and fifth digits= 00
- Last four digits= 0000
- First digit 9 (except for 999999999)

Date of Birth

(NAACCR Item #240) (STORE 2018 page 76; SEER pages 55-56)

Description

Identifies the patient's century, year, month, and day of birth.

Explanation

This item is used by the TCR to match records, and to calculate age at diagnosis.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed.
2. The patient's date of birth **must be entered.** Cases cannot be processed without the date of birth.
3. Date format is:
   a. YYYYMMDD - when the complete date is known and valid.

      ***Example*:** The patient's date of birth is June 28, 1983. Code the date of birth as 19830628.

   b. YYYYMM - when the year and month are known and valid, and the day is unknown.

      ***Example*:** The patient was born in November of 1981, but the day is unknown. Code 198111.

   c. YYYY when the year is known and valid but the month and day are unknown.

      ***Example*:** The record indicates the patient was born in 1978 but no month or day is given. Code 1978.

   Note: If the complete date of birth is not available, documentation must be provided in *Other Pertinent Information.* For example: Medical records indicate only month and year of date of birth.
4. If only the age of the patient is known, calculate the year of birth from age and year of diagnosis and leave the day and month of birth unknown.

   ***Example*:** A 50 year old patient diagnosed in 2010 is calculated to have been born in 1960.
5. The year of birth *must* be recorded. TCR will not accept unknown year of birth. Every effort must be made to obtain this information as it is critical for analysis.
6. If the patient's age is 100 years or older, check the accuracy of the date of birth and date of diagnosis, and document both in a text field.

Table 4.13 Date of Birth Code

CODE	DESCRIPTION
YYYYMMDD	The date of birth is the year, month and day the patient was born. The first four digits are the year, the fifth and sixth digits are the month, and the seventh and eighth digits are the day.

Birthplace - State

(NAACCR Item #252) (STORE 2018 page 74; SEER page 53)

Description

Identifies the patient's state of birth. USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient was born. If the patient has multiple primaries, the state of birth is the same for each tumor.

Explanation

Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and for epidemiological analyses.

Coding Instructions

1. Record the patient's state of birth (if available) using the US Postal Service. If the state of birth is unknown, code to ZZ.
2. Use the most specific code. A complete list of state and county codes may be found at https://seer.cancer.gov/manuals/2018/SPCSM_2018_AppendixB.pdf

Table 4.14 Birthplace - State Examples

CODE	DESCRIPTION
TX	If the patient is stated to have been born in Texas, then use the USPS code for the state of Texas.
US	If the patient is stated to have been born in the United States, NOS (state/commonwealth/territory/possession unknown)
CD	If the patient is stated to have been born in Canada, NOS; Use the specific abbreviation of Canadian Provinces/Territories if this information is provided.
	Born in another country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **known, reference SEER Appendix B.**
YY	Born in a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **unknown.**
ZZ	Residence unknown.

Birthplace - Country

(NAACCR Item #254) (STORE 2018 page 75; SEER page 54)

Description

Identifies the patient's country of birth.

Explanation

Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and for epidemiological analyses.

Coding Instructions

1. Record the patient's country of birth (if available) using the US Postal Service. If the country of birth is unknown, code to ZZU.
2. Use the most specific code.

Table 4.15 Birthplace Country Examples

CODE	COUNTRY
USA	United States
CAN	Canada
MEX	Mexico
SLV	El Salvador
ZZC	Central America NOS
VNM	Viet Nam
ZZU	Place of birth is unknown, no mention in patient record

Note: For other country codes please refer to the SEER 2018 Manual at https://seer.cancer.gov/manuals/2018/SPCSM_2018_AppendixB.pdf

Race 1

(NAACCR Item #160) (STORE 2018 page 79-88; SEER pages 61-65)

Description

Identifies the primary race of the person.

Explanation

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 accurate national comparisons. Race is defined by specific physical, hereditary and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Coding Instructions

1. Record the two-digit code to identify the primary race(s) of the patient in fields race 1, race 2, race 3, race 4, and race 5. The five race fields allow for coding of multiple races consistent with the Census 2000. **Refer to SEER Appendix D, Race and Nationality Descriptions from 2000 Census** http://www.seer.cancer.gov/tools/codingmanuals/

2. Race is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. If the patient has multiple tumors, all records should have the same race code.
3. Code race using the highest priority source available according to the list below (a is the highest and c is the lowest) when race is reported differently by two or more sources.
   a. The patient's self-declared identification
   b. Documentation in the medical record
   c. Death Certificate
4. Assign the same race code(s) for all tumors for one patient.
5. Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2000.
6. Code as **01** (white) when
   a. The race is described as White or Caucasian regardless of place of birth.
   b. There is a statement that the patient is Hispanic or Latino(a) and no further information is available.

   Example*:* There is a statement that Sabrina Fitzsimmons is a Latina but no further information is available. Code race as **01** (White).

   Note*:* Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually White.
7. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white (01) in the next race field.
8. Codes **02-32**, **96-98** take priority over code **01.**
9. Code **07** takes priority over all other codes.

   Example: Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Hawaiian), Race 2 as 05 (Japanese)
10. Code only the specific race when both a specific race code and a non-specific race code apply.
    a. Codes 04-17 take priority over code 96
    b. Codes 16-17 take priority over code 15
    c. Codes 20-32 take priority over code 97
    d. Codes 02-32 and 96-97 take priority over code 98
    e. Code 98 takes priority over code 99
11. Code race as **02** (Black) when the stated race is African-American, Black, or Negro.
12. Assign code **03** for any person stated to be
    a. Native American (Western Hemisphere) OR
    b. Indian, whether from North, Central South or Latin America.

13. Assign a specific code when a specific Asian race is stated. Do not use code 96 when a specific race is known.
14. Code the race based on birthplace information 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.

    Example 1. Race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 (Japanese)

    Example 2. The patient describes himself as an Asian-American born in Laos. Code race as 11 (Laotian) because it is more specific than 96.
15. Do not use codes 96, 97 or 98 for "multi-racial".
16. If no race is stated in the medical record or available from other sources in your facility, review the documentation for a statement of a race category such as a patient described as a "Japanese female."
17. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 (Other Race) in Race 1 and 88 in Race 2 - Race 5.
18. In using the patient name to determine race:
    a. Do not code race from name alone, especially for females with no maiden name given.
    b. A Spanish name alone may not be used to determine the race code. A statement about race or place of birth must be documented.
    c. Refer to Appendix D in SEER Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics when race is unknown or not stated in the medical record and birth place is recorded. In some cases, race may be inferred from the nationality. Use Appendix D to identify nationalities from which race codes may be inferred.

    Example: Record states: "the patient was Nigerian" Code race as 02 (Black) per the Appendix.

    Exception: Code Race 1 through Race 5 as 99 (Unknown) when patient's names is incongruous with the race inferred on the basis of nationality. Do not code the inferred race when the patient's name in incongruent with the race inferred on the basis of nationality.

    Example: Patient's name is Siddharta Rao and birthplace is listed as England. Code Race 1 through Race 5 as 99 (Unknown).
19. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to code non-white first.
20. Death certificate information may be used to supplement ante mortem race information only when race is unknown in the patient record or when the death certificate information is more specific.
21. If only one race is reported for a person, Race 2- Race 5 must be coded to 88.
22. If Race 1 is coded to 99, unknown, Race 2- Race 5 must also be coded 99, unknown.

23. A unique race code (other than 88 or 99) can be coded only once in race 1 through race 5.
24. Patient photographs may be used with caution to determine race in the absence of any other information. Use caution when interpreting a patient photograph to assist in determining race. Review the patient record for a statement to verify race. The use of photographs alone to determine race may lead to a misclassification of race.
25. If the face sheet states "Other race" and there is not more information about race in the medical record, if no further information is found, code Race 1 as 99, and code Race 2-5 as 99.), and document that patient face sheet indicates "Race Other" and no further information race is available.
26. Document the specified race code in the *Text Remarks - Other Pertinent Information* field. A more specific race that is not included in the list of race codes such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

Table 4.16 Race Codes 1 - 5

CODE	DESCRIPTION	CODE	DESCRIPTION
01	White	17	Pakistani
02	Black	20	Micronesian, NOS
03	American Indian, Aleutian, Eskimo (includes all indigenous populations of the Western hemisphere)	21	Chamorro/Chamoru
04	Chinese	22	Guamanian, NOS
05	Japanese	25	Polynesian, NOS
06	Filipino	26	Tahitian
07	Hawaiian	27	Samoan
08	Korean	28	Tongan
10	Vietnamese	30	Melanesian, NOS
11	Laotian	31	Fiji Islander
12	Hmong	32	New Guinean
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS	98	Other
16	Asian Indian	99	Unknown
88	No additional races (Race 2-Race 5)		

- The **White** category usually includes Mexican, Puerto Rican, Cuban, Arab, and all other Caucasians including those from Europe and the Middle East.
- The **Black** category includes the designation African-American.

Table 4.17 Race Code 1 Examples

CODE	DESCRIPTION
01	• A patient was born in Mexico of Mexican parentage. • A patient stated to be German-Irish. • A person from Iran or Saudi Arabia. • An immigrant from Sweden. • A patient is described as Middle Eastern. • A patient is described as Greek.
02	A black female patient. **Note:** 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.
04	A patient is of Chinese and Korean ancestry. Code 04, Chinese in Race 1. Code 08, Korean, in Race 2. Patient is stated to be Chinese and black. Code Race 1 as 04 (Chinese), code Race 2 as 02 (Black).
05	A patient has a Japanese father and a Caucasian mother. Code 05 Japanese in Race 1 and 01 White in Race 2.
07	A patient's race is a combination of Hawaiian and any other race(s). Code 07, Hawaiian, in Race 1 and Race 2–Race 5 as appropriate.
11	A patient is stated to be Asian. The place of birth is Laos. Code Race 1 as 11, Laotian, because it is more specific than 96, Asian, NOS.
25	Patient states she has a Polynesian mother and Tahitian father. Code race 1 as 25 (Polynesian), race 2 as 26 (Tahitian) and Race 3-5 as 88.
99	A patient's race is unknown. Code Race 1 as Unknown, code 99. Race 2–Race 5 must also be coded 99. If a patient has a Spanish last name and she is stated to be a native of Indiana, code to 99, Unknown, because nothing is known about her race. Exception is done when Race is noted as "other" in face sheet; use code **99** for Race 1 and code 88 for Race 2-5.

Race 2, Race 3, Race 4, Race 5

(NAACCR Items #161, 162, 163, 164) (STORE 2018 pages 81-88; SEER pages 61-65)

Description

Identifies the patient's additional races. Race is defined by specific physical, heredity, and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Explanation

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 accurate national comparisons.

Coding Instructions

1. Record the two-digit code to identify a multi-racial patient.
2. Race is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. If the patient has multiple tumors, all records should have the same race code.
3. Do not use codes 96, 97 or 98 for "multi-racial"
4. All resources in the facility must be used to determine the race of the patient.
5. If more than the *Race 1* code is entered, and if any race is **99**, then all race codes (*Race 1, 2, 3, 4* and *5*) must be **99**. If more than the *Race 1* code is entered, and if any race codes (for *Race 2, 3, 4* and *5*) are **88** (no further race documented), then all **subsequent** race codes must also be **88**.
6. If a person's race is a combination of Hawaiian and any other race(s), code *Race 1* as 07 Hawaiian and code the other race(s) in *Race 2*, *Race 3, Race 4*, and *Race 5* as appropriate.
7. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white (01) in the next race field.
8. Codes **02-32**, **96-98** take priority over code **01.**
9. Code **07** takes priority over all other codes.
10. Code only the specific race when both a specific race code and a non-specific race code apply.
    a. Codes 04-17 take priority over code 96
    b. Codes 16-17 take priority over code 15
    c. Codes 20-32 take priority over code 97
    d. Codes 02-32 and 96-97 take priority over code 98
    e. Code 98 takes priority over code 99
11. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to code non-white first.
12. Death certificate information may be used to supplement ante mortem race information only when race is unknown in the patient record or when the death certificate information is more specific.
13. If only one race is reported for a person, Race 2- Race 5 must be coded to 88.
14. If Race 1 is coded to 99, unknown, Race 2- Race 5 must also be coded 99, unknown.
15. A unique race code (other than 88 or 99) can be coded only once in race 1 through race 5.

16. When the patient face-sheet indicates "Race Other," look for other descriptions of the patient's race. When **no further race information is available**, code race as 99 (Unknown) and document that patient face-sheet indicates "Race Other," and no further race information is available.
17. Document the specified race code in the *Text Remarks - Other Pertinent Information* field. A more specific race that is not included in the list of race codes such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

Spanish/Hispanic Origin

(NAACCR Item #190) (STORE 2018 page 89; SEER page 69)

Description

Identifies persons of Spanish or Hispanic origin. If a patient has multiple tumors, all records should have the same code.

Explanation

This is used 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.*

Coding Instructions

1. The information is coded from the medical record or is based on Spanish/Hispanic names.
2. Use all information to determine the Spanish/Hispanic Origin including:
    a. The ethnicity stated in the medical record
        i. Self-reported information takes priority over other sources of information
    b. Hispanic origin stated on the death certificate
    c. Birthplace
    d. Information about life history and/or language spoken found in the abstracting process
    e. A last name or maiden name found on a list of Hispanic/Spanish names. Coding Spanish surname or origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
3. Assign code 6 when there is more than one ethnicity/origin (multiple codes), such as Mexican (code 1) and Dominican Republic (code 8). There is no hierarchy among the codes 1-5 or 8.
4. Use code 7 if race in the medical record is classified as White and he/she has a Spanish/Hispanic last name, or the only evidence of the patient's Hispanic origin is a surname or maiden name and there no evidence that the patient is Hispanic. Ordinarily used at the central registry level
5. Portuguese, Brazilians and Filipinos are not presumbed to be Spanish or non-Spanish.
    a. Assign code 7 the patient is Portuguse, Brazilian, or Filipino and their name appears on a Hispanic surname list.

b. Assign code 0 when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list.

Note: Refer to the list of Spanish/Hispanic surnames on the TCR website at: https://www.dshs.texas.gov/tcr/training/handbook/Appendix-Spanish-Hispanic-Surnames.pdf

Table 4.18 Spanish/Hispanic Origin Codes

CODE	DESCRIPTION
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic (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 other information the person is not Hispanic. Ordinarily for central registry use only.
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not; not stated in patient record

Note: Use **code 0** if patient has a Spanish/Hispanic name and there is reason to believe he/she is **not** Hispanic. For example, patient is Filipino or patient is a woman with a Hispanic married name but she is known to be non-Hispanic.

- Use codes 1–5 if specific ethnicity is known.
- Use code 6 when you know the patient is Hispanic but cannot classify him/her to codes 1–5.
- Use code 9 when Spanish/Hispanic origin is not documented or is unknown.

Examples

Example 1. Married female, no married name, Race 99, born in Mexico, married name is not on Spanish surname list. Code as 1 (Mexican) using coding instruction 2.c.

Example 2. Married female, no maiden name, Race 01, born in Philippines, married last name not on Spanish surname list and medical record states "Hispanic." Code as 6 (Hispanic, NOS) using coding instruction 2.a.

Example 3. Married female, no maiden name, Race 99, born in Peru, married last name is on Spanish surname list, no statement regarding ethnicity available. Code as 4 (South or Central America) using coding instruction 2.c.

Example 4. Patient has two last names, one of the last names is on the Spanish surname list. Code as 7 (Spanish surname only) using coding instruction 4.

Sex

(NAACCR Item #220) (STORE 2018 page 90; SEER page 74)

Description

Identifies the sex of the patient.

Explanation

This data item is used to compare cancer rates and outcomes by site.

Coding Instructions

Code the sex (gender) of the patient.

Table 4.19 Patient Sex Codes

CODE	DESCRIPTION
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not Stated/Unknown

Definitions:

Intersex: A person born with ambiguous reproductive or sexual anatomy; chromosomal genotype and sexual phenotype other than XY male and XX female.

Transsexual: A person who was assigned to one gender at birth based in physical characteristics but who self-identifies psychologically and emotionally as the other gender.

Transgender: See Transsexual.

Transgendered person: A person who identifies with or expresses a gender identity that differs from the one which corresponds to the person's sex at birth.

Hermaphrodite: A person having both male and female reproductive organs.

Coding Instructions

1. Assign code 3 for Intersexed (person with sex chromosomes abnormalities) or Hermaphrodites

   Note: Hermaphrodite is an outdated term.
2. Codes 5 and 6 may be used for cases diagnosed prior to 2015
3. Assign code 5 for transsexuals who are natally male or transsexuals with primary site of C600-C639
4. Assign code 6 for transsexuals who are natally female or transsexuals with primary site of C510-C589

5. Assign code 4 for transsexuals with unknown natal sex and primary site is not C510-C589 or C600-C639
6. When gender is not known
   a. Assign code **1** when the primary site is C600 – C639
   b. Assign code **2** when the primary site is C510 – C589
   c. Assign code **9** for primary sites not included above

Text Usual Industry

(NAACCR Item #320)

Description

Text area for information about the patient's usual industry, also known as usual kind of business/industry.

Explanation

Used to identify work-related health hazards; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

Definition

Type of business or industry where the patient worked in his or her usual occupation. Examples include manufacturing of tires, dry cleaning services, training of dogs, hospital.

Coding Instructions

1. Document the patient's usual (longest held) industry to the extent that the information is available in the medical record.
2. Be descriptive and specific.

   Examples:

   Inadequate: "Automobile industry"

   Adequate: "Automobile manufacturing"

   Inadequate: "Mine"

   Adequate: "Copper mine"

   Inadequate: "Retail"

   Adequate: "Retail bookstore"
3. When recording government agencies record the level (federal, state, county, municipal) and the division.

   Example:

Inadequate: "Census"

Adequate: "U.S. Census Bureau"

4. Be complete. If the primary activity of the industry is unknown, record the name of the company (with city or town) in which the patient worked the most number of years before diagnosis.

   Example:

   Inadequate: "ABC, Inc."

   Adequate: "ABC, Inc., Kyle, TX"

5. If the patient's usual industry is not available or is unknown, but the patient's current or most recent occupation is recorded, the information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry. If no information is available regarding patient's industry, document "Unknown" in the text field. This should be used only as a last resort.

Text Usual Occupation

(NAACCR Item #310)

Description

Text area for information about the patient's usual occupation, also known as usual type of job or work.

Explanation

Used to identify work-related health hazards; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Definition

Type of job the patient was engaged in for the longest time. It is not necessarily the highest paid job or the job considered the most prestigious, but the one that accounted for the greatest number of working years. Examples include police officer, bank teller, or nurse.

Exception

If a patient has been a homemaker for most of her adult life, but has ever worked outside the home, report the occupation held outside the home.

Coding Instructions

1. Document the patient's usual occupation, the kind of work performed during most of the patient's working life before diagnosis of this tumor, to the extent that the information is available in the medical record. Make sure the recorded usual occupation matches the recorded industry. Do not record "retired."

2. Be descriptive, specific and complete: Record the word or words which most clearly describe the kind of work or type of duties performed by the patient.

   Examples:

   Inadequate: "Teacher"

   Adequate: "Preschool teacher," "high school teacher"

   Inadequate: "Laborer"

   Adequate: "Residential bricklayer"

   Inadequate: "worked in a warehouse," "worked in a shipping department"

   Adequate: "warehouse forklift operator"

   Inadequate: "Engineer"

   Adequate: "Chemical engineer," "Railroad engineer"

   Inadequate: "Self-employed"

   Adequate: "Self-employed auto mechanic"

3. If the patient's usual occupation is not known, record the patient's current or most recent occupation, or any available occupation. If no information is available regarding patient's occupation document "Unknown" in the text field. This should be used only as a last resort.

Commonly confused occupations

Contractor vs. skilled worker—

a. A contractor mainly obtains contracts and supervises work
b. A "skilled worker" works with his or her own tools as a carpenter, plasterer, plumber or electrician.

Machine operator vs. machinist vs. mechanic—

a. A "machine operator" operates machines.
b. A "machinist" sets up and operates machines.
c. A "mechanic" repairs, installs, and adjusts machines

Text Remarks - Other Pertinent Information

(NAACCR Item #2680)

Description

Includes text area for information that is coded on the patient's disease and adequate or appropriate space is not provided for supporting text. Overflow or problematic coding issues can be documented in this text field.

Explanation

Information documenting the disease process should be entered manually from the medical record and not be generated from coded values. Such documentation should include additional staging information, additional treatment documentation, documentation of race and sex, history of the disease, comments regarding lack of information in the medical record and cause of death. The name of the following (Follow Up) physicians should also be noted here. See the Text Documentation Section for detailed instructions.

Physician Follow Up

(NAACCR Item #2470)

Description

Identifies the physician currently responsible for the patient's medical care. The TCR requires the physician's state license number.

Explanation

The follow-up (or "following") physician is the first contact for obtaining information on the patient's status. This information may be used for outcome studies.

Coding Instructions

1. Record the state license number of the physician currently responsible for the patient's care. Physician license numbers for Texas can be found at the following website: http://www.tmb.state.tx.us/page/look-up-a-license.
2. Cancer reporters using third party software must check with their vendor to ensure the physician's state license number transmits to the TCR.
3. This field must be populated for cases diagnosed 2006 and forward. If the information is unknown code 99999999 and document in *Text Remarks - Other Pertinent Information* that the follow up physician is unknown.

***Note*:** This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required). TCR will continue to require this data item.

Sequence Number

(NAACCR Item #560) (STORE 2018 page 49)

Description

Indicates the chronological sequence of all reportable neoplasms (malignant and non-malignant) over the lifetime of the patient regardless of when or where the case was diagnosed. Each neoplasm is assigned a different number. Sequence number 00 indicates patient has only one reportable malignant neoplasm. Reportable neoplasms not included in the facility registry are also allotted a sequence number. For example, an ACoS registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the facility's reference date.

Explanation

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

Coding Instructions

1. Codes 00–59 and 99 indicate reportable cases of malignant or in situ behavior.
2. Code 00 if the patient has a single reportable primary. If the patient develops a subsequent reportable primary, notify the Texas Cancer Registry. The TCR will change the code for the first primary from 00 to 01, and number subsequent primaries sequentially.
3. If two or more reportable primaries are diagnosed simultaneously, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
   a. Base the prognosis decision on the primary site, histology, and extent of disease for each of the primaries
   b. If there is no difference in prognosis, the sequence numbers may be assigned in any order.
4. Codes 60–88 indicate non-malignant neoplasms (benign and borderline) that are reportable by agreement cases (e.g., those cases required by state registries). All benign or borderline neoplasms diagnosed/admitted to your facility should be sequenced according to this guideline. This includes benign and borderline CNS neoplasms.
5. Code 60 if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first primary from 60 to 61, and number subsequent non-malignant primaries sequentially (62, 63…).
6. Sequence numbers should be reassigned in the database if the facility learns later of an unaccessioned tumor that would affect the sequence.
7. The *Sequence Number* refers to the number of malignant or non-malignant primaries **in the patient's lifetime**.
8. Sequence number should not be changed if the patient develops metastasis.

Table 4.20 Sequence Number: Malignant Neoplasms

ONE PRIMARY	MORE THAN ONE PRIMARY	SEQUENCE UNKNOWN
00 One primary only	01 First of two or more primaries	99 Unspecified
	02 Second of two or more primaries	
	03 Third of three or more primaries	

Table 4.21 Sequence Number: Non-Malignant Neoplasms

ONE PRIMARY	MORE THAN ONE PRIMARY	SEQUENCE UNKNOWN

60 One primary only	61 First of two or more primaries	88 Unspecified
	62 Second of two or more primaries	
	63 Third of three or more primaries	

Note: Squamous and/or basal cell carcinoma of the skin (except genital sites) **are no longer** considered when assigning the appropriate sequence number.

***Examples*:**

Example 1. A person is diagnosed with one malignant primary. Code the sequence number to 00.

Example 2. A person was diagnosed with lung cancer in 2001. A colon cancer is diagnosed in 2018. Code the sequence number of the colon cancer to 02 and change the sequence number of the lung cancer to 01.

Example 3. A person was diagnosed with breast cancer in April 2010 and metastasis to the lungs in June 2018. Since the lung is a metastatic site and not a second primary, it would not be abstracted. Code the sequence number of the breast cancer to 00.

Example 4. A person was diagnosed with signet ring cell carcinoma of the bladder in 2017. In 2019, this person developed a benign meningioma in the temporal area of the brain. Code the bladder to sequence number 00, and code the brain to sequence number 60.

Example 5. A person was diagnosed with carcinoma of the stomach in 2016, squamous cell carcinoma of the left forearm (a non-reportable neoplasm) in 2017, and non-Hodgkin's lymphoma in 2018. Code the sequence number of the stomach to 01. The sequence number of the left forearm would not be sequenced, abstracted or reported. Code the sequence number of the lymphoma to 02.

Example 6. A person was diagnosed with a benign meningioma in June 2016. MRI at your facility in 2019 shows no change. Code the sequence number to 60 for the benign meningioma.

Other Primary Tumors

(Site, Morphology, Date) (NAACCR Item #2220)

Description

State-specific text field to capture information on other reportable tumors.

Explanation

Records tumor specific information on other reportable tumors in the patient's lifetime.

Coding Instructions

1. Record the site, morphology, and date of diagnosis of other primaries. **Do not** include metastatic lesions or the primary currently being reported in this field. **Do not** leave this area blank due to lack of specific information. Record the information you have available.

Example 1. The patient had a history of duct cell carcinoma of the left breast in 2005 and is admitted in 2018 for adenocarcinoma of the lung. Complete an abstract on the lung tumor, and document duct cell carcinoma of left breast in 2005 in this field.

Example 2. The patient has a history of prostate cancer, no date or specific morphology is given. Patient is admitted in 2019 with a malignant melanoma of left leg. Document: history of prostate cancer, unknown date.

2. This field may be left blank if the sequence number is 00 for a malignant neoplasm or 60 for a non-malignant neoplasm.

Primary Payer At Diagnosis

(NAACCR Item #630) (STORE 2018 page 91)(SEER pages 76-77)

Description

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

Explanation

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

Coding Instructions

1. Record the type of insurance reported on the patient's admission page.
2. Code the **first** insurance mentioned when multiple insurance carriers are listed in one admission record.
3. If the patient's payer or insurance carrier changes, do not change the initially recorded code.
4. Consult with your facility's billing department if the primary payer information is unclear.
5. Code the type of the insurance reported **closest to the date of diagnosis** when there are multiple insurance carriers reported from multiple admissions and/or multiple physician encounters.

Note: Codes 21 and 65-68 are to be used for patients diagnosed on or after January 1, 2006.

Table 4.22 Primary Payer at Diagnosis Codes

CODE	LABEL	DESCRIPTION
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 types listed in codes 20, 21, 31, 35, 60-68

CODE	LABEL	DESCRIPTION
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 Medicaid described in code 35.
35	Medicaid-Administered through a Managed Care plan	Patient is enrolled in **Medicaid** through a Managed Care program (e.g. HMO or PPO). The managed care plan pays for all incurred costs.
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 65 years of age or older, or are chronically disabled (Social Security insurance eligible). Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.
62	Medicare-Administered through a Managed Care plan	Patient is enrolled in **Medicare** through a Managed Care plan (e.g. HMO or PPO). The Managed Care plan pays for all incurred costs.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare.
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement.
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents. Formally known as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)
66	Military	Military personnel or their dependents treated at a military facility

CODE	LABEL	DESCRIPTION
67	Veterans Affairs	Veterans treated in Veterans Affairs facilities
68	Indian/Public Health Services	Patient who receives care at an Indian Health Services facility or at another facility and 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.

Example 1. An indigent patient is admitted with no insurance coverage. Code the *Primary Payer at Diagnosis* as 01.

Example 2. A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO. Code the *Primary Payer at Diagnosis* as 20.

Example 3. 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. Code the *Primary Payer at Diagnosis* as 62.

Example 4. A patient has managed Medicare listed in Insurance #1 and Medicaid listed as Insurance #2. Code the *Primary Payer at Diagnosis* as 64.

Example 5. Patient comes to your facility originally diagnosed with prostate cancer in 2000. Now he has bone metastasis. Code the *Primary Payer at Diagnosis* as 99 because the information from the facility where originally diagnosed is not available.

Height

(Non-NAACCR Standard Item 9960) (Source CDC/NPCR-CER)

Description

Height is required for all sites/histologies when chemotherapy and/or other drugs are given.

Coding Instructions

1. Different tumors for the same patient may have different values.
2. Height should be collected from source records once for each cancer.
3. Height should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's hospital medical record or physician office record.
4. The height entered should be that listed at or around the time of diagnosis. If no height was listed on the date of diagnosis, use the height recorded on the date closest to the date of diagnosis and before treatment was started.

5. Enter height as a 2 digit number measured in inches. Round all inches values to the nearest whole number; values with decimal place x.5 and greater should be rounded up (code 62.5 inches as 63 inches).
6. Do not leave this field blank. If the information is not available use code 99 (Unknown)

Note: An online conversion calculator is available at http://manuelsweb.com/ft_in_cm.htm.

Table 4.26 Height Codes

CODE	DESCRIPTION
XX	Exact number in inches (up to 98 inches)
98	98 inches or greater
99	Unknown height

Weight

(Non-NAACCR Standard Data Item 9961) (Source CDC/NPCR-CER)

Description

Weight is required for all sites/histologies when chemotherapy and/or other drugs are given.

Coding Instructions

1. Different tumors for the same patient may have different values.
2. Weight should be collected from source records once for each cancer.
3. Weight should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's medical record or physician office record.
4. The weight entered should be that listed on the date of diagnosis. If no weight was listed on the date of diagnosis, please use the weight recorded on the date closest to the date of diagnosis and before treatment was started.
5. Enter the weight as a 3 digits number measured in pounds. Round values to the nearest whole number. Values with decimal place x.5 should be rounded up (Code 155.5 pounds as 156). Code a weight of less than 100 pounds with a leading 0 (Code 95 pounds as 095).
6. Do not leave this field blank. If the information is not available use code 999 (Unknown).

Note: An online conversion calculator is available at http://manuelsweb.com/kg_lbs.htm.

Table 4.27 Weight Codes

CODE	DESCRIPTION
XXX	Exact weight in pounds
999	Unknown weight

Tobacco Use Cigarettes

(Non-NAACCR Standard Data Item 9965) (Source CDC/NPCR-CER)

Description

Records the patient's past or current cigarette smoking. This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview, Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions

1. If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).
2. If the medical record indicates "None," use 0 (Never used).
3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Table 4.28 Tobacco Use Cigarettes Codes

CODE	DESCRIPTION
0	Never used
1	Current user (as of Date of diagnosis)
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated/no smoking specifics provided

Tobacco Use Other Smoke

(Non-NAACCR Standard Data Item 9966) (Source CDC/NPCR-CER)

Description

Records the patient's past or current use of smoking tobacco products other than cigarettes (pipes, cigars, and kreteks). This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions

1. If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).
2. If the medical record indicates "None," use 0 (Never used).
3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Table 4.29 Tobacco Use Other Smoke Codes

CODE	DESCRIPTION
0	Never used

1	Current user (as of Date of Diagnosis)
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated/no smoking specifics provided

Tobacco Use Smokeless

(Non-NAACCR Standard Data Item 9967) (Source CDC/NPCR-CER)

Description

Records the patient's past or current use of smokeless tobacco products (chewing tobacco, snuff, etc.) This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions

1. If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).
2. If the medical record indicates "None," use 0 (Never used).
3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Table 4.30 Tobacco Use Smokeless Codes

CODE	DESCRIPTION
0	Never used
1	Current user (as of Date of Diagnosis)
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated/no smoking specifics provided

Tobacco Use NOS

(Non-NAACCR Standard Data Item 9968) (Source CDC/NPCR-CER)

Description

Records the patient's past or current use of tobacco when tobacco use is indicated but type is not specified. This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions

1. If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).
2. If the medical record indicates "None," use 0 (Never used).
3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Table 4.31 Tobacco Use NOS Codes

CODE	DESCRIPTION
0	Never used
1	Current user (as of Date of Diagnosis)
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated/no smoking specifics provided

5

CANCER INFORMATION

Date of Initial Diagnosis

(NAACCR Item #390) (STORE 2018 page 131; SEER pages 79-83)

Description

The date of initial diagnosis is the earliest date this primary reportable neoplasm is diagnosed clinically or microscopically by a recognized medical practitioner, regardless of whether the diagnosis was made at the reporting facility or elsewhere.

Explanation

The date of initial diagnosis is essential in the analysis of staging and treatment of the cancer, for epidemiology purposes, and for outcomes analysis. The timing for staging and treatment of cancer begins with the date of initial diagnosis for cancer.

Coding Instructions

1. Date format is:

   a. YYYYMMDD - when the complete date is known and valid

   ***Example*:** The patient has a CT on March 25, 2018 and the diagnosis is lung cancer. Code the diagnosis date as 20180325.

   b. YYYYMM - when year and month are known and valid, and day is unknown.

   ***Example*:** A mammogram done in January 2018 shows that the patient has a malignancy in the upper outer quadrant of the right breast, but the day is unknown. Code the diagnosis date as 201801.

2. The initial diagnosis date may be from a clinical diagnosis, for example, when a radiologist views a chest x-ray and the diagnosis is lung carcinoma. If later confirmed by a pathology specimen, the diagnosis date remains the date of the initial clinical diagnosis.

   Note: The Commission on Cancer does not recognize the BI-RADs schema for mammography as a case-finding source. However, if the radiologist states suspicious for malignancy (not neoplasm) in his/her impression, the case is reportable and the date of the mammogram would be considered the date of initial diagnosis for breast cancer.

3. The date of diagnosis based on a pathology report should be the date the specimen was taken, not the date the pathology report was read or created.

4. Refer to the *List of Ambiguous Terms* language that represents a diagnosis of cancer. When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis.

   Example: Area of microcalcifications in breast suspicious for malignancy on 2/13/18. Biopsy positive for ductal carcinoma on 2/28/18. The date of diagnosis 2/13/18.

5. If a recognized medical practitioner states that, in retrospect, the patient had cancer at an earlier date, record the date of diagnosis as the earlier date. If later documentation shows the diagnosis was an earlier date, record the earlier date and document in the *Summary Stage Documentation* text field.

   Example 1. The patient has an excision of a benign fibrous histiocytoma on January 3, 2018. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The pathologist reviews the original slides and documents that the previous tumor (benign fibrous histiocytoma) was malignant. Code the diagnosis date as 20180103.

   Note: Do not back date if there is no review of previous slides with a revised physician statement of diagnosis of cancer or reportable tumor.

   Example 2. The patient had a total hysterectomy and bilateral salpingo-oophorectomy (BSO) in June 2018 with pathologic diagnosis of papillary cystadenoma of the ovaries. On December 6, 2018 the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2018 are not reviewed and there is no physician statement saying the previous tumor was malignant. The date of initial diagnosis should be coded 20181206.

   Note: Remember to check with your TCR health service regional office regarding the appropriate procedure to follow when there is updated information on an abstract already submitted to the TCR. **Do NOT resubmit the abstract**. These cases will result in duplicate records and require manual resolution. TCR does not accept updated modified (M) records.

6. For autopsy- and death-certificate only cases the date of initial diagnosis will be the date of death.

7. Use the actual date of diagnosis for an in utero diagnosis (For cases diagnosed before January 1, 2009, assign the date of birth).

   ***Example*:** An ultrasound done on 2/2/2018 to determine expected date of birth shows an unborn baby has a brain tumor. After the baby is born on 4/12/2018, resection shows malignant teratoma. Code the date of diagnosis 20180202.

8. Use the date therapy was started as the date of diagnosis if the patient receives first course of treatment before a definitive diagnosis.

9. Positive tumor markers alone are not diagnostic of cancer. Use the date of positive clinical, positive histologic, or positive cytologic confirmation as the date of diagnosis. Positive tumor markers alone are never used for case ascertainment.

   Example: The patient has an elevated PSA and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the prostate. The biopsy is positive for adenocarcinoma. The date of diagnosis is the date of the biopsy (do not code the date of the PSA or the date the procedure was dictated or transcribed).

10. Do not use cytology as a basis for diagnosis when ambiguous terms are used. Ambiguous cytology is not diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

- "Ambiguous" cytology means that the diagnosis is preceded by an ambiguous term such as apparently, appears, compatible with, etc.
- Do not use ambiguous cytology alone for case ascertainment.
- Cytology is the examination of cells rather than tissue. This would include sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluids, spinal fluid, peritoneal fluid, urinary sediment, and cervical and vaginal smears.

11. In the absence of an exact date of initial diagnosis, record the best approximation. For vague dates, estimate the date of diagnosis for month and year using all available information. An approximate date is preferable to an unknown date of diagnosis. Refer to the table and examples below. Documentation that the exact date of diagnosis is not available in the medical record must be provided in *Summary Stage Documentation* text field.
12. Code the year and month of admission when there is no basis for estimation and document "Date of DX unknown" in the *Summary Stage Documentation* text field. *This should be used only as a last resort.*

    Note: Every resource available at the reporting facility must be reviewed in order to determine the date of diagnosis.

    ***Example*:** Patient admitted to your facility on April 26, 2018 with recurrent melanoma but the original date of diagnosis is unknown. Code the date of diagnosis as 201804. Record in the *Summary Stage Documentation* text field "Date of DX Unknown."

Table 5.1 Date of Initial Diagnosis – Date Estimates

DOCUMENTATION	DATE CODE/DESCRIPTION
Spring	Use April (04) for the month
Summer	Use July (07) for the month
Fall/Autumn	Use October (10) for the month
Winter	Determine if this means the beginning or the end of the year. Use December (12) or January (01) for the month as determined.
Early in Year	Use January (01) for the month
Middle of Year	Use July (07) for the month
Late in Year	Use December (12) for the month
Recently	Use the year and month of admission and leave the day blank. If patient was admitted during the first week of a month, use the previous month.
Several Months Ago	If the patient was not previously treated or if first course treatment started elsewhere was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown (blank).
A Couple of Years	Code to two years earlier
A Few Years	Code to three years earlier

Example 1. A patient was admitted to your facility on March 15, 2018. The History and Physical states the patient has prostate carcinoma diagnosed about two months ago. Record the date of diagnosis as 201801.

Example 2. A patient was admitted to your facility on September 10, 2019. The History and Physical states the patient has bone and brain metastasis from malignant melanoma diagnosed in the spring. Record the date of diagnosis as 201904.

Example 3. On March 12, 2018, a mammogram reveals a mass in the upper outer quadrant of the patient's right breast. The radiologist's impression states: compatible with carcinoma. On March 20, 2018, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Record the date of diagnosis as 20180312.

Note: For users of Web Plus always press the calculator icon in order to calculate age at diagnosis. If diagnosis date or date of birth are changed the calculator must be pressed to recalculate the age at diagnosis.

Morphology ICD-O-2: Type and Behavior

(NAACCR Item #420, 430)

The International Classification of Diseases for Oncology, (ICD-O) 2nd Edition, is to be used for coding and reporting the morphology and behavior of tumors diagnosed before January 1, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Morphology ICD-O-3: Type and Behavior

(NAACCR Item #522, #523) (STORE 2018 pages 136-137] (SEER pages 98-100)

Description

Identifies the microscopic structure of cells and the behavior of the tumor being reported.

Explanation

The histological (morphologic) type helps to determine staging and treatment options. It also assists in determining the disease course and prognosis, and in identifying multiple primaries. The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or malignant (3).

The 2018 Solid Tumor Rules, the 2018 ICD-O-3 updates at https://www.naaccr.org/2018-implementation, the *International Classification of Diseases for Oncology*, Third Edition (ICD-O-3) the *Hematopoietic and Lymphoid Neoplasm Coding Manual*, and the *Hematopoietic and Lymphoid Neoplasm Database* are the standard references for histology codes.

Note: Solid tumor histology can be coded only after the determination of single vs. multiple primaries has been made. Refer to Solid Tumor Rule 2018 rules to determine the number of primaries for solid tumors.

Using the Solid Tumor Manual

https://seer.cancer.gov/tools/solidtumor/STM_2018.pdf

- Apply the general instructions and instructions for coding histologic type in the 2018 Solid Tumor Rules
- Apply the site-specific histology coding rules in the 2018 Solid Tumor rules.
- Site specific histology coding rules cover the following:

Primary Site	Topography
Head and Neck	C000-C148, C300-C329, C410, C411, C442
Colon Rectosigmoid, and Rectum	C180-C189, C199, C209
Lung	C340-C349
***Cutaneous Melanoma**	C440-C449 with Histology 8720-8780
Breast	C500-C506, C508-C509
Kidney	C649
Urinary Sites	C659, C669, C670-C679, C680-C681, C688-C689
Non-malignant CNS	C700, C701, C709,C710-C719, C720-C725, C728, C729, C751-C753
Malignant CNS and Peripheral Nerves	C470-C479,C700,C701,C709,C710-C719, C720-C725, C728, C729,C751-C753
***Other sites**	Excludes Head and Neck, Colon, Rectosigmoid, Rectum, Lung, Cutaneous Melanoma, Breast, Kidney, Urinary Sites, Peripheral Nerves, CNS

***** Instructions for Cutaneous Melanoma and Other sites instructions are in the 2007 Multiple Primary Rules https://seer.cancer.gov/tools/mphrules/

Note: Do not use these rules to determine case reportability, tumor grade, or behavior.

Using The ICD-O-3 Changes Effective For January 1, 2018

https://www.naaccr.org/implementation-guidelines/#ICDO3.

The 2018 ICD-O-3 Update Guidelines includes comprehensive tables listing all changes to ICD-O-3 effective for cases diagnosed 1/1/2018 forward. The guidelines also provide background on the project and issues encountered during review of the WHO Classifications of Tumors. [Issues not covered in the 2018 update include reportability of GIST and histology codes with terms that include the words “high grade neoplasia” or “high grade dysplasia” or “severe dysplasia” in digestive system sites.]

For 2018, 37 new codes and terms were proposed for addition to ICD-O-3. Twenty-three are reportable malignant (/3) tumors, two are reportable in situ (/2) tumors, three are reportable borderline (/1) tumors of primary intracranial and central nervous system tumors, and four are non-reportable tumors. Nine of the 32 new codes were listed in the prior cross-walk effective for January 1, 2015.

Table 5.2 Effective January 1, 2018 ICD-O-3 codes, behaviors and terms are site-specific Last Updated 8/22/2018

Please see full ICD-O-3 coding table and errata at NAACCR website**:**
https://www.naaccr.org/implementation-guidelines/#ICDO3

Effective January 1, 2018
ICD-O-3 codes, behaviors and terms are site-specific
Alpha Order
Last updated 8/22/18

Status	ICD-O-3 Morphology Code	Term	Reportable Y/N	Comments
New Term	8551/3	Acinar adenocarcinoma **(C34. _)**	**Y**	Lung primaries diagnosed prior to 1/1/2018 use code 8550/3 For prostate (all years) see 8140/3
New Term	8140/3	Acinar adenocarcinoma **(C61.9 ONLY)**	**Y**	For prostate only, do not use 8550/3
New Term	8572/3	Acinar adenocarcinoma, sarcomatoid **(C61.9)**	**Y**	
New Term	8550/3	Acinar cell carcinoma	**Y**	Excludes C61.9- see 8140/3
New Term	8316/3	Acquired cystic disease-associated renal cell carcinoma (RCC) **(C64.9)**	**Y**	
New code/term	8158/1	ACTH-producing tumor	**N**	
New Term	8574/3	Adenocarcinoma admixed with neuroendocrine carcinoma **(C53. _)**	**Y**	
Behavior Code/term	8253/2	**Adenocarcinoma in situ, mucinous (C34. _)**	**Y**	**Important note**: lung primaries ONLY: For cases diagnosed 1/1/2018 forward do not use code 8480 (mucinous adenocarcinoma) for in-situ adenocarcinoma, mucinous or invasive mucinous adenocarcinoma.

Using The ICD-O-3 Manual

1. Record the morphology code using the Alphabetic Index (ICD-O-3 pages 95-216) and the Numerical Index (ICD-O-3 pages 53-94). Review both of these sections of the ICD-O-3 to ensure accurate coding.

   Note: For primaries diagnosed prior to January 1, 2001 use ICD-O-2.

2. Follow the coding rules outlined on pages 14-30 of ICD-O-3.

3. The term [obs] in ICD-O-3 indicates a diagnosis for which a better diagnostic term(s) is available, but which may still be used to code the cancer in certain circumstances. Obsolete terms are retained in ICD-O-3 for historical reference.
4. Adequate text documentation must be provided to support coding. Auto coding of the ICD-O-3 code description is not considered adequate text documentation.

Coding Instructions for Hematopoietic and Lymphoid Neoplasms (9590/3-9992/3):

For hematopoietic and lymphoid diseases code histology after the Hematopoietic and Lymphoid Neoplasm Database has been searched for reportability at http://seer.cancer.gov/seertools/hemelymph/

Use the *Hematopoietic and Lymphoid Neoplasm Database (Heme DB)* at http://seer.cancer.gov/seertools/hemelymph/ for coding primary site, histology, grade, and to determine the number of primaries for morphology codes 9590-9992. Follow the steps in priority order for using the *Hematopoietic and Lymphoid Neoplasm Database* and Coding Manual.

For cases diagnosed prior to 2010 use the link to the table "Definitions of Single and Subsequent Primaries for Hematologic Malignancies" found in the Heme DB once you select the diagnosis year from the diagnosis year dropdown menu.

Note: If the patient has a hematopoietic or lymphoid neoplasm diagnosed prior to 2010 and a new one diagnosed January 1, 2010 or later, use the *Hematopoietic and Lymphoid Neoplasm Database and Manual*.

Behavior Coding Instructions

Table 5.3 Behavior Codes

CODE	DESCRIPTION
0	Benign (Reportable for intracranial and CNS sites only)
1	Uncertain whether benign or malignant, borderline malignancy, low malignant potential, and uncertain malignant potential (Reportable for intracranial and CNS sites only)
2	Carcinoma in situ; intraepithelial; noninfiltrating; noninvasive
3	Malignant, primary and/or metastatic site (invasive)

Note: Gastrointestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, for cases diagnosed January 1, 2013 or later, they must be abstracted and assigned a *Behavior* Code of *3* if they are noted to have: **Multiple foci; Metastasis; Positive lymph nodes.**

Note: The TCR does not accept cases coded with a metastatic (/6) behavior code. If the only pathology specimen is from a **metastatic** site, code the appropriate histology code and the malignant behavior code /3. The primary site and its metastatic site(s) have the same basic histology. See *ICD-O-3*, page 27.

***Example*:** A patient is diagnosed with metastatic brain tumors and a fine needle aspiration biopsy shows that the tumor is metastatic small cell carcinoma (8041/6). The pathology report indicates that the tumor originated in the lung. Code the primary site as lung and the morphology as small cell carcinoma (8041/3).

Code the behavior as malignant (/3) when malignant metastasis is present. Metastasis could be regional, nodal, or distant. The exception is with in situ breast cancer; code as non-invasive (/2) in the presence of isolated tumor cells or if cells are artifactually displaced from a previous procedure.

Example: GIST with lymph nodes positive for malignancy. Code the behavior as malignant (/3).

1. Behavior codes benign /0 and borderline /1 are reportable for intracranial and CNS sites only. These tumors are reportable to TCR for cases diagnosed in **2004** and forward. (C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753).
2. Code the behavior from CT scan, Magnetic Resonance Imaging (MRI), or Positron Emission Tomography (PET) report when there is no tissue diagnosis (pathology or cytology report). Code the behavior listed on the scan. Do no use the WHO grade to code behavior.
3. Clinical evidence alone cannot identify the behavior as in situ; the code must be based on **pathologic** examination and documentation.
4. Code the behavior as malignant (/3) if any portion of the primary tumor is invasive no matter how limited, i.e. microinvasion

   Example:Pathology from mastectomy specimen: Large mass composed of intraductal carcinoma with a single focus of invasion. Code the behavior as infiltrating duct carcinoma (8500/3).
5. Re-code the behavior as malignant (/3) when metastases are attributed to a tumor originally thought to be in situ (See page 102 of SEER Coding and Staging Manual 2018).

   Example: Right colon biopsy reveals tubulovillous adenoma with microfocal carcinoma in situ; right hemicolectomy is negative for residual disease. Later core liver biopsy consistent with metastatic adenocarcinoma of gastrointestinal origin. Oncologist states most likely colon primary. Change the behavior code for the colon primary from /2 to/3. There were no other colon primaries in this case.
6. Code the behavior as in situ /2 if the pathology report describes the histology as in situ/2 and the ICD-O-3 histology is listed only with an invasive /3 behavior code.
7. Code the behavior as invasive /3 if the pathology report describes the histology as invasive /3 and the ICD-O-3 histology code is listed only with an in situ /2 behavior.
8. Certain histologies will never have in situ behaviors (8000–8005, 8020, 8021, 8331, 8332, 8800–9055, 9062, 9082, 9083, 9110–9493, 9501–9989).
9. If more than one behavior is reported, select the morphology code with the higher behavior code (the invasive tumor).

Table 5.4 Behavior Codes Examples

CODE	FIFTH DIGIT TERM	DESCRPIPTION
2	In situ and/or carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Bowen disease (not reportable for C440–C449)
		Clark's Level I for melanoma (limited to epithelium)

CODE	FIFTH DIGIT TERM	DESCRPIPTION
		Comedocarcinoma, noninfiltrating (C50_)
2	Terms synonymous with in situ	Confined to epithelium
		AIN III (C211)
		Behavior code /2
		Hutchinson's melanotic freckle, NOS (C44_)
		Intracystic, non-infiltrating (carcinoma)
		Intraductal (carcinoma)
		Intraepidermal, NOS (carcinoma)
		Intraepithelial, NOS (carcinoma)
		Involvement up to, but not including the basement membrane
		Lentigo maligna (C44_)
		LIN III (C320-C329)
		Lobular, noninfiltrating(C50_) (carcinoma)
		Noninfiltrating (carcinoma)
		Noninvasive (carcinoma only)
		No stromal invasion/involvement
		Papillary, non-infiltrating or intraductal (carcinoma)
		Precancerous melanosis (C44_) Preinvasive
		Queyrat's erythroplasia (C60_)
		SIN III
		Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)
		VAIN III (C529)
		VIN III (C51_)
3	Invasive	Invasive or microinvasive

Primary Site

(NAACCR Item #400) (STORE 2018 page 133; SEER pages. (88-91)

Description

Identifies the primary site of the cancer.

Explanation

The primary site helps to determine stage and treatment options and shapes disease course and prognosis.

Refer to the Solid Tumor Rules (2018) at https://seer.cancer.gov/tools/solidtumor/ to determine the number of primaries for solid tumors. The 2018 Solid Tumor Rules contain additional coding instructions for some primary sites, including Head and Neck, Lung and Urinary. Use all of the available information to code the site.

Refer to the Hematopoietic and Lymphoid Neoplasm Database and Coding Manual at https://seer.cancer.gov/seertools/hemelymph/ for hematopoietic and lymphoid neoplasms to determine multiple primaries and histology.

Adequate text documentation must be provided to support coding. Auto coding of the ICD-O-3 code description is not considered adequate text documentation. In general, when a primary site is preceded by carcinoma of…, or malignancy of…, code to that primary site.

See the *Coding Guidelines for Topography and Morphology* in the introduction of the ICD-O-3 for additional details. Primary site codes for solid tumors may be found in the *ICD-O-3 Topography*,

Numerical List Section (*ICD-O-3*, page 31) and in the *Alphabetic Index* (*ICD-O-3*, page 95). The topography code consists of an initial character (the letter C) followed by two numeric digits, a decimal point, and one additional numeric digit. The decimal point is not entered as part of the morphology code.

Example 1. The pathology report says the primary site is the cardia of the stomach. The code (C160) is found in the *Alphabetic Index* under either "stomach" or "cardia." Enter the code as (C160); do not record the decimal point.

Note: The exact location of the primary tumor is not always stated in the pathology report or discharge diagnosis. It is necessary to review the entire medical record in order to obtain the most precise description of the primary site.

Example 2. The pathology report states right breast resection specimen. The discharge diagnosis states carcinoma in the right breast. The History and Physical states examination of the right breast reveals a mass in the upper outer quadrant. **Code to the more detailed description from the History and Physical, upper outer quadrant of the right breast (C504).**

Coding Instructions for Solid Tumors

1. Unless otherwise instructed, use all available information in the medical record to code the site.
2. Code the site in which the primary tumor originated, even if it extends into an adjacent "subsite."

   Example 1. Final diagnosis is adenocarcinoma of the upper lobe of the right lung. Code the topography to lung, upper lobe (C341).

   Example 2. Pathology report shows adenocarcinoma arising in an ectopic patch of endometriosis on the sigmoid colon. Code primary site to sigmoid colon (C187) where the cancer originated.

   Example 3. Patient has a right branchial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the branchial cleft cyst. Thyroidectomy pathology is negative. Code primary site to branchial cleft (C104).

   Example 4. The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for non- cancer reasons. She now has widespread cystadenocarcinoma in

the peritoneum. Code the primary site to peritoneum, NOS (C482). (The chart may or may not state that the patient has extra-ovarian or primary peritoneal carcinoma).

Example 5. The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. Code primary site to upper inner quadrant of breast (C502).

3. Code the last digit of the primary site code to "8" when a single tumor **overlaps** an adjacent subsite(s) of an organ and the point of origin cannot be determined.

   Example 1. The patient has a 5 cm tumor overlapping the base of tongue and anterior 2/3 of tongue. Code the primary site to C028 (overlapping lesion of tongue).

   Example 2. 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.

   Example 3. 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.

   Notes:

   - Do not use 8 when the primary site of origin is known or when more than one tumor is identified in different subsites.
   - Skin cancers overlapping site in the head and neck ONLY. Assign the primary site code for the site where the bulk of the tumor is or where the epicenter is; do not nuse C448.

4. Code the site of the **invasive** tumor when there is an invasive tumor and an in situ tumor in different subsites of the same anatomic site.

   ***Example*:** Patient has an invasive breast tumor in the upper-outer quadrant of the left breast and in situ tumor in multiple quadrants of the left breast. Code the primary site to C504 (upper outer quadrant of breast).

5. Code the last digit of the primary site code to 9 for single primaries, when **multiple tumors arise in different subsites** of the same anatomic site and the point of origin cannot be determined.

   Example 1. During a TURB, the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).

   Example 2. Patient has an infiltrating duct carcinoma in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. Code the primary site as breast, NOS (C509).

6. Some histology/behavior terms in *ICD-O-3* have **a related site code** in parenthesis; e.g., hepatoma (C220).

   Note: Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a different primary site is specified in the medical record.

***Example*:** The pathology report says "infiltrating duct carcinoma of the head of the pancreas." The listing in *ICD-O-3* is infiltrating duct carcinoma 8500/3 (C50). Code the primary site to head of pancreas, C250, NOT to breast as suggested by the *ICD-O-3*.

Note: Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or the primary site is unknown.

Example 1. The biopsy is positive for hepatoma, but there is no information available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.

Example 2. The patient has an excision of the right axillary nodes which reveals metastatic infiltrating duct carcinoma. The right breast is negative. The *ICD-O-3* shows duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).

***Note**:* Use the site code suggested by ICD-O-3 when there is no information available indicating a different primary site.

Example: Biopsy of lymph node diagnosed as metastatic non-small cell carcinoma. Patient expired and there is no information available about the primary site. Assign C349 based on the site code suggested in ICD-O-3.

7. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).

   Note: If at any time a specific primary site is identified, change the site code from Unknown Primary (C809) to the specified primary site. Contact the TCR regional office for the appropriate procedure if this case has already been submitted to the TCR. Changing the Primary Site may be other associated fields that need to be changed appropriately.

8. See the site-specific Coding Guidelines in Appendix A for helpful primary site coding guidelines for the following sites:

   - Breast
   - Bladder
   - Colon and Rectum
   - Esophagus
   - Lung
   - Skin - Melanoma
   - Malignant Brain and CNS
   - Non Malignant Brain and CNS

9. See below for primary site coding guidelines for Sarcoma.
10. Angiosarcoma:
    a. Code C422 (Spleen) as the primary site for angiosarcoma of spleen with mets to bone marrow.
    b. Code C50._ (Breast) for angiosarcoma of breast. Although angiosarcoma actually originates in the lining of the blood vessels, an angiosarcoma originating in the breast has a poorer prognosis than many other breast tumors.
11. Gastrointestinal Stromal Tumors (GIST): code the primary site to the location where the malignant GIST originated.

12. Transplants

    a. Code the primary site to the location of the transplanted organ when a malignancy arises in a transplanted organ, i.e., code the primary site to where the malignancy resides or lies.

       Example: There is a diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus. Document the situation in a text field.

    b. For information about organ or tissue transplants, see the section Determining Multiple Primaries.

    c. For additional information about hematopoietic-related transplants, refer to the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database.

13. In the ***absence of any additional information***, assign the codes listed for these primary sites:

Primary Site	Code
Anal margin	C445
Angle of the stomach	C162
Book-leaf lesion (mouth)	C068
Colored/lipstick portion of the upper lip	C000
Cutaneous leiomyosarcoma	C44_
Distal conus	C720
Edge of tongue	C021
Frontoparietal (brain)	C718
Gastric angular notch	C163
Glossotonsillar sulcus	C109
Infrahilar area of lung	C349
Leptomeninges	C709
Masticatory space	C069
Melanoma, NOS	C449
Nail bed thumb	C446
Pancreatobiliary	C269
Parapharyngeal space	C490
Perihilar bile duct	C240

14. When the medical record does **not** contain **enough information** to assign a primary site:

    a. Consult a physician advisor to assign the site code.

b. Use Table 5.5 (page 125) when the described histologies appear only with an ill-defined site description (such as "abdominal" or "arm"). Code to the tissue in which such tumors arise rather than the ill-defined region (C76_) of the body, which contains multiple tissues.

c. Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category.

d. Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site

***Note*:** Assign C760 for Occult Head and Neck primaries with positive cervical lymph nodes. Schema Discrimator 1: Occult Head and Neck Lymph Nodes is used to discrimate between these cases and other uses of C760.

e. Assign the NOS code for the body system when there are two or more possible primary sites documented and all are within the same system.

Example: Two possible sites are documented in the GI system such as colon and small intestine; code to the GI tract, NOS (C269). Document the possible primary sites in the appropiate text field.

For lymph node biopsy positive for squamous cell carcinoma deemed to be a head and neck primary with no head and neck tumor found, see the Schema Discriminator in the SSDI manual.

https://apps.naaccr.org/ssdi/list/ or https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1552600606 page 40

f. Code unknown primary site when there is a physician statement of unknown primary site **ONLY** when **none of the above instructions can be applied.**

Table 5.5 Primary Site Codes

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

HISTOLOGY	DESCRIPTION	CODE TO THIS SITE
8940-8941	Mixed tumor, salivary gland type	C07_ for Parotid Gland C08_ for Other and Unspecified Major Salivary Glands

Common Metastatic Sites

If the final diagnosis reflects carcinoma of one of the common metastatic sites listed below, carefully review documentation in the medical record to confirm the primary site.

- Bone
- CNS Sites (brain, spinal cord, meninges)
- Liver
- Lymph Nodes (excluding lymphoma)
- Pericardium (excluding mesothelioma)
- Pleura (excluding mesothelioma)
- Peritoneum
- Retroperitoneum

Sarcoma Coding Instructions

The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system. The musculoskeletal system includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones and cartilage. The default code for sarcomas of unknown primary site is **C49.9, soft tissue, NOS,** rather than C80.9. Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. Code the primary site to the organ of origin.

- For carcinosarcoma of the uterine corpus, code the primary site to corpus uteri (C549).
- For rhabdomyosarcoma of ethmoid sinus, code primary site to C311.
- For Bone Sarcomas (C40._, C41._) do not use C76._ codes (Other and Ill-defined Sites) such as “arm”, “leg”, “trunk”.
- For Soft tissue sarcomas (C49._, C47._, C48._, C38.1-C38.3), do not use C76._ codes (Other and Ill-defined Sites) such as “arm”, “leg”, “trunk”.

Code the organ of origin as the primary site when leiomyosarcoma arises in an organ. Do not code sodt tissue as the primary site in this situation.

Example: Leiomyosarcoma arises in kidney. Code the orimary site to kidney (C649).

Example: Leiomyosarcoma arises in prostate. Code primary site to prostate (C619)

Kaposi Sarcoma Coding Instructions

Kaposi sarcoma is a rare condition. When not AIDS-related, it usually presents as localized disease with an easily recognized primary site. AIDS-related Kaposi sarcoma usually presents as a disseminated disease with involvement of **mucosal surfaces, visceral surfaces of organs, and skin**. It is important to review consecutive records carefully to determine the extent of involvement at diagnosis. Review of a single record may reveal only the site being treated during that admission.

1. Code Kaposi Sarcoma to the site in which it arises.
2. If the Kaposi Sarcoma is present in the skin and another site simultaneously, code to the specified skin site, (C44_).
3. If the primary site is unknown or cannot be determined, code skin, NOS (C44.9)**.**

Melanoma Coding Instructions

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

Additional Guidelines for Coding Primary Site

- A subareolar/retroareolar carcinoma is coded to the central portion of the breast (C50.1), which indicates that the tumor arose in the breast tissue beneath the nipple, not the nipple itself.
- Mycosis Fungoides is coded to skin (C44_).
- Intestinal type adenocarcinoma (8144) is a gastric histology term and is not listed in the WHO Histological Classification of Tumors of the Colon and Rectum. This code **should not** be used for colon and rectum primaries.

Other Primary Site Instructions (STORE 2018 page 21-22)

Occult Cervical Lymph Node

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

- C76.0 if the neck node has not been tested or is negative for both HPV and EBV. The AJCC Chapter 6 Cervical Lymph Nodes and Unknown Primary Tumor of the Head and Neck will be used.
- C10.9 if the neck node is p16 positive indicating human papilloma virus (HPV). The AJCC Chapter 10 HPV-Mediated (p16+) Oropharyngeal Cancer will be used.
- C11.9 if the neck node is EBER positive, or both EBER and p16 positive, indicating Epstein-Barr Virus (EBV). The AJCC Chapter 9 Nasopharynx will be used.

Cutaneous Carcinoma of the Head and Neck

Beginning with cases diagnosed 1/1/2018 and later, for skin cancers overlapping sites in the head and neck ONLY, assign the primary site code for the site where the bulk of the tumor is or where the

epicenter is. These cases will be staged with AJCC Cutaneous Carcinoma of the Head and Neck. Do not use code C44.8 Overlapping lesions of the skin. Cases coded to C44.8 will represent skin lesions overlapping between head and neck sites AND/OR skin in other parts of the body. These cases will not be staged with AJCC 8th Edition.

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

Coding Instructions for Hematopoietic and Lymphoid Neoplasms Guidelines:

Refer to Hematopoietic and Lymphoid Neoplasms (9590-9992)

Heme DB at https://seer.cancer.gov/seertools/hemelymph/

Coding tips:

1. Do **not** use ambiguous terms to code a specific histology.
2. **Primary site C400-C419 (Bone**). The following histology is always coded to primary site C400-C419: 9731/3-Solitary plasmacytoma of bone

   Note: 9731/3 for plasmacytomas of the bone. If there is an extramedullary plasmacytoma (not occurring in bone) see histology 9734/3. (See also PH3 & PH4).
3. **Primary site C379 (Thymus) or C383 (Mediastinum, NOS).** Assign primary site to C379 or C383 when the histology is: 9679/3-Primary mediastinal (thymic) large B-cell lymphoma

   Note: Do not code this histology based only on mediastinal involvement. Only assign this histology code when the diagnosis is stated as "primary mediastinal" large B-cell lymphoma.
4. **Primary site C421 (Bone marrow).** Assign primary site C421 (Bone marrow) when the histology is:
   - 9732/3-Plasma cell myeloma
   - 9741/3-Systemic mastocytosis with an associated hematological neoplasm
   - 9742/3-Mast cell leukemia
   - 9761/3-Waldenstrom Macroglobulinemia **(for cases diagnosed 1/1/2018 and forward)**
   - 9800/3-Leukemia, NOS
   - 9801/3-Acute leukemia, NOS
   - 9806/3-Mixed-phenotype acute leukemia with t(9;22)(q34.1;q11.2); BCR-ABL1
   - 9807/3-Mixed-phenotype acute leukemia with t(v;11q23.3); KMT2A-rearranged
   - 9808/3- Mixed-phenotype acute leukemia, B/myeloid, not otherwise specified
   - 9809/3-Mixed-phenotype acute leukemia, T/myeloid, not otherwise specified
   - 9820/3-Lymphoid leukemia, NOS
   - 9826/3-Burkitt cell leukemia
   - 9831/3-T-cell large granular lymphocytic leukemia
   - 9832-3-Prolymphocytic leukemia, NOS

- 9833/3-B-cell prolymphocytic leukemia
- 9834/3-T-cell prolymphocytic leukemia
- 9840/3-Pure erythroid leukemia
- 9860/3-Myeloid leukemia
- 9861/3-Acute myeloid leukemia, NOS
- 9863/3-Chronic myeloid leukemia

See the full list of codes in the Hematopoietic and Lymphoid Neoplasm Coding Manual (page 36.).

Primary site coding instructions begin on **page 33** in the Hematopoietic and Lymphoid Neoplasm Coding Manual.

Grade Clinical

NAACCR Item # 3843 (STORE 2018 page 138; SEER (page 104)

Description

Grade Clinical is new for 2018. This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). For some sites, grade is required to assign the clinical stage group

For cases diagnosed January 1, 2018 and later, this data item, along with Grade Pathological and Grade Post Therapy, replaces the data item Grade [NAACCR Item #440] as well as site specific factors for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason].

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

Rationale

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

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

Allowable values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S

When coding grade for hematopoietic and lymphoid neoplasms remember to follow the instructions given at the current hematopoietic and lymphoid neoplasm manual:
https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

***Note*: Grade is no longer applicable for cases diagnosed 2018 and forward**. Grade is still required for cases diagnosed prior to 2018. Please see 2018 Revisions on **page 8** in the Hematopoietic and Lymphoid Neoplasm Coding Manual at the URL above.

Grade Pathological

NAACCR Item # 3844 and 3844 (STORE 2018 page 140; SEER page 105)

Description

Grade Pathological is new for 2018. This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup.

For cases diagnosed January 1, 2018 and later, this data item, along with Grade Clinical and Grade Post Therapy, replaces the data item Grade [NAACCR Item #440] as well as site specific factors for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason].

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

Rationale

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

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

Laterality

(NAACCR Item #410) (STORE 2018 page 135; SEER pages 92-94)

Description

Identifies the side of a paired organ or the side of the body where the tumor originated.

Explanation

Aids in staging and extent of disease information, and may indicate the number of primaries.

Coding Instructions

1. Starting with cases diagnosed January 1, 2004 and later, laterality is coded for specified invasive, benign, and borderline primary intracranial and CNS tumors. See Paired Organ Sites Table beginning on page 139.
2. Code laterality using codes **1-9** for all sites listed in the table 5.17: **Sites For Which Laterality codes must be recorded**
3. Non-paired sites are coded to 0.
4. Unknown (C809) and Ill-defined (C760–C768) sites are coded to 0.

5. Assign code 9 when the disease originated in a paired site, but the laterality is unknown **AND** there is no statement that only one side of the paired organ is involved.

   ***Example*:** Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer. Assign code 9.

6. **Do not** code metastatic sites as bilateral involvement.

   ***Example*:** Patient is diagnosed with adenocarcinoma of the left lung and the physician states patient has metastasis to the right lung. Assign laterality code 2, left origin of primary.

7. For primaries of in situ behavior, if laterality is not known, code to 3 (only one side involved, right or left origin of primary not indicated). Laterality for in situ behavior cannot be coded to 9 or 4.

8. Assign code 3 if laterality is unknown but the tumor is confined to a single side of a paired organ.

   ***Example*:** Pathology report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.

9. Assign code 5 for a midline tumor of a paired site. (C700, C710-C714, C722-C725, C443, C445).

   Note: Midline for code 5 refers to the point where the right and left sides of paired organs come into direct contact and a tumor forms at that point such as skin of trunk (C445). Most paired sites cannot develop midline tumors. **Do not** assign code 5 to sites not previously listed above.

   Example 1. A melanoma of the skin of back is described as midline. Record laterality as 5. Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0.

   Example 2. Patient has an excision of a melanoma located just above the umbilicus (C445, laterality 5).

   Example 3. Patient has a midline meningioma of the cerebral meninges (C700, laterality 5).

10. Document the laterality in the appropriate text field.

Table 5.6 Laterality Codes

CODE	DESCRIPTION
0	Not a paired site
1	Right origin of primary
2	Left origin of primary
3	Only one side involved, right or left origin of primary not indicated
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or: • Both ovaries simultaneously involved with a single histology • Bilateral retinoblastomas • Bilateral Wilms' tumors **Note**: If both lungs have nodules or tumors and the lung of origin is not known, assign code 4

CODE	DESCRIPTION
5	Paired site: midline tumor
9	Unknown site; paired site, lateral origin unknown

Bilateral Sites

Laterality must be recorded for the following bilateral sites. Only major headings are listed. Laterality should be recorded for all anatomic sub-sites included in *ICD-O-3* unless specifically excluded. Such exclusions are coded 0.

Code laterality using codes 1–5 or 9 for all of the sites listed in the following table:

Table 5.7 Bilateral Site Codes

PAIRED ORGAN SITES - ALPHABETIC ORDER	
PRIMARY SITE	**ICD-O-3 CODE**
Acoustic nerve	C724
Adrenal gland [cortex, medulla]	C740–C749
Breast	C500–C509
Carotid body	C754
Cerebral meninges, NOS	C700
Cerebrum	C710
Conjunctiva, lacrimal gland, orbit, cornea, retina, choroid, ciliary body, iris, sclera, lens, eyeball	C690
Connective, subcutaneous and other soft tissues of lower limb & hip	C492
Connective, subcutaneous and other soft tissue of upper limb & shoulder	C491
Cranial nerve, NOS	C725
Epididymis	C630
Fallopian tube	C570
Frontal lobe	C711
Frontal sinus	C312
Kidney, NOS	C649
Long bones of upper limb, scapula and associated joints	C400
Long bones of lower limb and associated joints	C402
Lung	C341–C349
Main bronchus [excluding carina]	C340
Maxillary sinus [antrum]	C310
Middle ear [tympanic cavity]	C301
Nasal cavity [excluding nasal cartilage and nasal septum code 0]	C300
Occipital lobe	C714
Olfactory nerve	C722
Optic nerve	C723
Ovary	C569
Overlapping lesion of the eye and adnexa; Eye, NOS; Eye and lacrimal Gland	C690–C699

PAIRED ORGAN SITES - ALPHABETIC ORDER	
PRIMARY SITE	**ICD-O-3 CODE**
Parietal lobe	C713
Parotid gland	C079
Pelvic Bones and associated joints [excluding sacrum, coccyx and symphysis pubis - code 0]	C414
Peripheral nerves and autonomic nervous system of lower limb and Hip	C472
Peripheral nerves and autonomic nervous system of upper limb and shoulder	C471
Pleura	C384
Renal pelvis	C659
Rib, clavicle, and associated joints [excluding sternum - code 0]	C413
Short bones of upper limb and associated joints	C401
Short bones of lower limb and associated joints	C403
Skin of external ear	C442
Skin of eyelid	C441
Skin of other and unspecified parts of face [midline code 5]	C443
Skin of upper limb and shoulder	C446
Skin of lower limb and hip	C447
Skin of trunk [midline code 5]	C445
Spermatic cord	C631
Sublingual gland	C081
Submandibular gland	C080
Temporal lobe	C712
Testis	C620–C629
Tonsil, NOS and Overlapping lesion of Tonsil	C098–C099
Tonsillar fossa	C090
Tonsillar pillar	C091

Table 5.8 Bilateral Site Codes

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3 CODE	**PRIMARY SITE**
C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
C090	Tonsillar fossa
C091	Tonsillar pillar
C098	Overlapping lesion of tonsil
C099	Tonsil, NOS
C300	Nasal cavity [excluding nasal cartilage and nasal septum code 0]
C301	Middle ear [tympanic cavity]
C310	Maxillary sinus [antrum]

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3 CODE	**PRIMARY SITE**
C312	Frontal sinus
C340	Main bronchus [excluding carina]
C341–C349	Lung
C384	Pleura
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C413	Rib and clavicle [excluding sternum code 0]
C414	Pelvic bones [excluding sacrum, coccyx, and symphysis pubis code 0]
C441	Skin of eyelid
C442	Skin of external ear
C443	Skin of other and unspecified parts of face [midline code 5]
C445	Skin of trunk [midline code 5]
C446	Skin of upper limb and shoulder
C447	Skin of lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of lower limb and hip
C500–C509	Breast
C569	Ovary
C570	Fallopian tube
C620–C629	Testis
C630	Epididymis
C631	Spermatic cord
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter
C690–C699	Eye and adnexa
C700	Cerebral meninges , NOS
C710	Cerebrum [effective with cases diagnosed 01/01/2004]
C711	Frontal lobe [effective with cases diagnosed 01/01/2004]
C712	Temporal lobe [effective with cases diagnosed 01/01/2004]
C713	Parietal lobe [effective with cases diagnosed 01/01/2004]
C714	Occipital lobe [effective with cases diagnosed 01/01/2004]
C722	Olfactory nerve [effective with cases diagnosed 01/01/2004]
C723	Optic nerve [effective with cases diagnosed 01/01/2004]
C724	Acoustic nerve [effective with cases diagnosed 01/01/2004]
C725	Cranial nerve, NOS [effective with cases diagnosed 01/01/2004]

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3 CODE	**PRIMARY SITE**
C740–C749	Adrenal gland [cortex, medulla]
C754	Carotid body

Notes:

- A laterality code of 1–5 or 9 **must** be assigned for the above sites except as noted. If the site is not listed on the table, assign code 0 for laterality.
- Never use code 4 for bilateral primaries for which separate abstracts are prepared, or when the side of origin is **known** and the tumor has spread to the other side. Code 4 is seldom used EXCEPT for the following diseases:
  - Both ovaries involved simultaneously, single histology, or epithelial histologies (8000-8799)
  - Diffuse bilateral lung nodules
  - Bilateral retinoblastoma
  - Bilateral Wilms tumors

  Example: A left breast primary with metastasis to the right breast is coded to 2 (left). This would not be coded to 4 (bilateral).
- Sometimes the physician may describe the site of the tumor in an organ as right or left. This is a descriptive term and does not refer to a bilateral site or organ.

  ***Example*:** Patient admitted for surgical resection of tumor in right colon. Code to 0, not a paired site. Do not code to 1. Right colon refers to the ascending colon. The colon is not a paired site.

Final Diagnosis - Morphology/Behavior, Grade, Primary Site, and Laterality Documentation

(NAACCR Items #2580 [Final Diagnosis (Primary, Laterality)], #2590 [Final Diagnosis (Morphology, Behavior, Grade)]

Text to support morphology/behavior, grade, primary site, and laterality codes **must** be provided.

Documenting Instructions

1. Record the morphology/behavior, grade, primary site, and laterality descriptions.
2. Do not use the generic ICD-10-CM code statement found on the face sheet.

   Example 1. Morphology: Moderately well differentiated mucin-producing adenocarcinoma
   Primary Site: Colon, ascending

   Example 2. Morphology: Grade 3, infiltrating ductal and lobular carcinoma
   Primary Site: Right breast, upper outer quadrant

   Example 3. Morphology: Anaplastic astrocytoma
   Primary Site: Brain, frontal-parietal lobe

   Example 4. Morphology: Intermediate grade large cell carcinoma
   Primary Site: Left lung lower lobe

Lymphovascular Invasion

(NAACCR Item #1182) (STORE 2018 page 152) (SEER page 118)

Description

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

Explanation

Lymphovascular invasion is an indicator of prognosis.

Note: TCR collects this data item only for Penis (C60) and Testis (C62)

Coding Instructions

1. Code from pathology report(s). Code the absence or presence of lymphovascular invasion as described in the medical record.
   a. The primary sources of information about lymphovascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician's statement, in that order.
   b. Do not code perineural invasion in this field.
   c. Information to code this field can be taken from any specimen from the primary tumor.
   d. If lymphovascular invasion is identified anywhere in the resected specimen, it should be coded as present/identified.
2. Use of codes:
   a. Use code 0 when the pathology report indicates that there is no lymphovascular invasion. This includes cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane.
   b. Use code 1 when the pathology report or a physician's statement indicates that lymphovascular invasion (or one of its synonyms) is present in the specimen.

   Note: Synonyms for lymphovascular invasion include LVI, lymphovascular invasion, vascular invasion, blood vessel invasion, and lymphatic invasion. Lymph node involvement is **not** the same as lymphovascular invasion.

c. Use code 9 when:

- There is no microscopic examination of a primary tissue specimen.
- The primary site specimen is cytology only or a fine needle aspiration.
- The biopsy is only a very small tissue sample.
- It is not possible to determine whether lymphovascular invasion is present.
- The pathologist indicates the specimen is insufficient to determine lymphovascular invasion.

- Lymphovascular invasion is not mentioned in the pathology report.

d. This field may be defaulted to a 9 or left blank for sites which do not require it to be collected. Use code 8 for Lymphoma and Hematopoietic diseases or leave it blank. Leaving the default as 9 for Lymphoma and Hematopoietic will create an edit error.

Table 5.9 Lymphovascular Invasion Codes

CODE	DESCRIPTION
0	Lymphovascular invasion not present (absent)/Not identified
1	Lymphovascular invasion present/Identified
8	Not applicable
9	Unknown if lymphovascular invasion present ; Indeterminate

Diagnostic Confirmation

(NAACCR Item #490); (STORE 2018 pages 142-144; SEER pages (95-97)

Description

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

Explanation

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

Coding Instructions for Solid Tumors

1. The codes are in **priority order**; code 1 has the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods.
2. Change to a lower code if at ANY TIME during the course of disease the patient has a diagnostic confirmation that has a higher priority. There is no time limit for this field.
3. If diagnosed elsewhere, copies of the previous pathology or radiology reports included in the medical record may be used to code this field.
4. All diagnostic reports in the medical record must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer. This review must cover the entire medical history in regard to the primary tumor. If diagnosed prior to admission to the reporting facility, review the history section of the record to identify information regarding previous diagnostic tests and treatments.
5. If the information in the medical record indicates a biopsy or resection of the tumor has been performed, assume the diagnostic confirmation is histological even if the pathology report is not available.

   ***Example*:** A patient comes in for a bone scan for staging of a known prostate cancer. It is noted

in the record that the patient had a prostate biopsy two weeks prior. Use diagnostic confirmation code 1, positive histology.

6. Assign **code 1** when the microscopic diagnosis is based on:
   a. Tissue specimens from biopsy, surgery, autopsy or Dilatation & Curettage
   b. Bone marrow specimens (aspiration and biopsy)
7. Assign **code 2** when the microscopic diagnosis is based on:
   a. Examination of cells (rather than tissue) including but not limited to: sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears.
   b. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.
8. Assign **code 4** when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.
9. Assign **code 5** when the diagnosis of cancer is based on laboratory tests or marker studies **with** a clinical diagnosis for that specific cancer.

   Example 1. The patient has elevated alpha-fetoprotein **with** a clinical diagnosis of liver cancer.

   Example 2. The workup for a prostate cancer patient is limited to a highly elevated PSA and the physician diagnoses and/or treats the patient based only on that PSA.
10. Assign **code 6** when the diagnosis is based only on:
    a. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined.
    b. Gross autopsy findings (no tissue or cytologic confirmation).
11. Assign **code 7** when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/sonography.
12. Assign **code 8** when the case was diagnosed by any clinical method not mentioned in preceding codes. The diagnostic confirmation is coded 8 when the only confirmation of disease is a physicians's clinical diagnosis.

    Example: CT diagnosis is possible lung cancer. Patient returns to the nursing home with a DO NOT RESUSCITATE (DNR) order. Physician enters a diagnosis of lung cancer in the medical record. Code diagnostic confirmation to 8: there is a physician's clinical diagnosis – clinical diagnosis made by the physician using the information available for the case.
13. Assign **code 9** when it is unknown how the diagnosis was confirmed. Death certificate only cases will be assigned **code 9**.

    Note: The diagnostic code must be changed to the lower (more specific) code if a more definitive code confirms the diagnosis during the course of the disease, **regardless of time frame**.

Examples:

Example 1. Mammography indicates a lesion suspicious for cancer. The diagnostic confirmation code is 7. Two weeks later a biopsy confirms infiltrating ductal carcinoma. **The correct diagnostic confirmation code is 1.**

Example 2. MRI originally diagnosed a patient with a glioblastoma. The diagnostic confirmation code is 7. A year later a surgical biopsy is obtained**. The diagnostic confirmation code would be changed to 1.**

Example 3. A thoracentesis is performed for a patient who is found to have a large pleural effusion. Cytology reveals malignant cells consistent with adenocarcinoma. **The diagnostic confirmation code is 2.**

Example 4. CAT scan of abdomen reveals metastatic deposits in the liver and a large lesion in the ascending colon. Biopsy and later resection of the colon lesion revealed mucin-producing adenocarcinoma. **The diagnostic confirmation code is 1.**

Example 5. Fine needle aspiration (FNA) is positive for malignant cells. **The diagnostic confirmation code is 2.**

Table 5.9 Diagnostic Confirmation Codes for Solid Tumors

CODE	DESCRIPTION	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Histological confirmation (tissue microscopically examined). In situ behavior must be microscopically confirmed.
2	Positive cytology	Cytological confirmation (no tissue microscopically examined; fluid cells microscopically examined). Includes pap smears, bronchial brushings, FNA and peritoneal fluid, cervical and vaginal smears, diagnoses based on paraffin block specimens from concentrated spinal, pleural or peritoneal fluid.
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	Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which clinically diagnostic for that specific cancer. Positive laboratory test/marker study Note: Includes cases with positive immunophenotyping or genetic studies and no histological confirmation
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical/endoscopic procedure only with no tissue resected for microscopic exam.

CODE	DESCRIPTION	DEFINITION
MICROSCOPICALLY CONFIRMED		
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 physician documented the tumor in the medical record. The diagnostic confirmation is coded 8 when the only confirmation of disease is a physician's clinical diagnosis.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate only cases.

Instructions for Coding Diagnostic Confirmation of Hematopoietic or Lymphoid Tumors (9590-9992)

- Other than microscopic confirmation (1-4) taking priority over clinical diagnosis only (5-8), there is no priority order or hierarchy for coding the Diagnostic Confirmation for hematopoietic or lymphoid neoplasms. Most commonly the bone marrow provides several provisional diagnoses and the specific histologic type is determined through immunophenotyping or genetic testing
- For cases diagnosed January 1, 2010 and later see the *Hematopoietic and Lymphoid Neoplasm Database and Coding Manual* at http://seer.cancer.gov/seertools/hemelymph/ for information on the definitive diagnostic confirmation code for specific types of neoplasm.
- Use **Code 1** when **ONLY** the tissue, bone marrow, or blood was used to diagnose the specific histology. Do **not** use code 1 if the provisional diagnosis was based on tissue, bone marrow, or blood **and** the immunophenotyping or genetic testing on that same tissue, bone marrow, or blood identified the specific disease (See code 3).
- .If a neoplasm is originally confirmed by histology (code 1), and later has immunophenotyping, genetic testing or JAK2 which confirms a more specific neoplasm and there is no evidence of transformation, change the histology code to the more specific neoplasm and change the diagnostic confirmation to code 3. Do **not** use diagnostic confirmation code 3 for cases diagnosed prior to January 1, 2010.

Code 1: Positive histology

Code 1 includes a provisional diagnosis and/or several provisional (differential) diagnoses which may or may not be preceded by approved ambiguous terminology.

Assign Code 1 for:

1. Tissue from lymph node(s), organ(s) or other tissue specimens from biopsy, frozen section, surgery or autopsy;
2. Bone marrow specimens (aspiration and biopsy)

3. Peripheral blood smear
   a. Can be used as a histological diagnosis for any of the hematopoietic histologies (9590/3-9992/3)
4. Leukemia only (9800/3-9948/3): positive histology also includes
   a. Complete blood count (CBC)
   b. White blood count (WBC)
5. Neoplasm microscopically confirmed **AND**
   a. immunophenotyping, genetic testing, or JAK2 not done OR
   b. immunophenotyping, genetic testing, or JAK2 done but negative (non-diagnostic) for the neoplasm being abstracted

   ***Example*:** Acute myelomonocytic leukemia (9867/3) CD10+. CD10+ is not listed under Immunophenotyping for this histology, so diagnostic confirmation should be 1.
6. IHC studies are done, but the patient has a provisional (NOS) diagnosis or one or more provisional diagnoses.
7. Historical cases not already in the database if information states that there was histologic confirmation

   Example: Patient diagnosed in 2012 with Stage III mantle cell lymphoma, diagnosed by LN biopsy. Mantle cell lymphoma not in the database. Now presents with DLBCL in 2015.

Code 2: Positive cytology

Code 2 is rarely used for Hematopoietic and Lymphoid neoplasms.

Assign code 2 for:

1. Examination of fluid such as spinal fluid, peritoneal fluid, or pleural fluid
2. Paraffin block specimens from concentrated spinal fluid, peritoneal fluid, or pleural fluid
3. A specimen that fails to provide enough tissue to do a histologic examination - in this case, the report will be a cytology report rather than a pathology report

Code 3: Positive histology PLUS positive immunophenotyping or genetic testing

Code 3 can be used for cases diagnosed **2010+** with histologic confirmation (see code 1) **AND** immunophenotyping, genetic testing, or JAK2 confirmation

Assign code 3 for:

1. Cases with positive histology for the neoplasm being abstracted (including acceptable ambiguous terminology and provisional diagnosis) AND Immunophenotyping, genetic testing, or JAK2 is listed in the Definitive Diagnosis in the Heme DB AND the testing
   a. Confirms the neoplasm OR
   b. Identifies a more specific histology (not preceded by ambiguous terminology)

- Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when preceded by ambiguous terminology.
- Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when the test result is preceded by "patchy weak staining."

2. NOS histology diagnosed and not a provisional diagnosis and genetics/immunophenotyping was performed.

Example 1. ***Identifying a more specific histology:*** Bone marrow biopsy positive for acute myeloid leukemia (9861/3). Genetic testing positive for AML with inv (16) (p13.1q22) (9871/3). Code Diagnostic Confirmation code 3, positive histology and positive genetic testing, which identified a more specific histology.

Example 2. ***(Identifying a more specific histology:*** Peripheral blood smear with lymphoblastic lymphoma (9671/3). Bone marrow biopsy with immunophenotyping showing CD5 negative and IgM positive, diagnosis Waldenstrom Macroglobulinemia (9761/3). Code Diagnostic Confirmation code 3, positive histology and positive immunophenotyping testing which identified a more specific histology.

Example 3. ***Confirming the histologic diagnosis:*** Bone marrow biopsy diagnosis is plasma cell dyscrasia. Peripheral blood smear is compatible with plasma cell leukemia. FISH and chromosome analysis revealed plasma cell myeloma. Both plasma cell leukemia and plasma cell myeloma are coded to the same ICD-O code, 9732/3, so there is only one disease process.

Example 4. The peripheral blood smear is histologic diagnosis for the plasma cell leukemia and FISH confirmed the diagnosis of multiple myeloma/plasma cell myeloma. Code Diagnostic Confirmation 3, positive histology and positive genetic testing.

Example 5. ***Histologic confirmation plus genetic and immunophenotyping confirmation:*** Patient diagnosed with CLL by CBC and flow cytometry that was positive for both the genetic and CD antigens (immunophenotyping) for CLL. A bone marrow biopsy not performed. Since this is leukemia, the CBC is histologic confirmation, so this patient had histologic confirmation, genetic, and immunophenotyping positive for CLL. Code Diagnostic Confirmation 3, positive histology and positive genetic testing/immunophenotyping.

Example 6. ***Ambiguous terminology used with immunophenotyping***: Bone marrow biopsy shows B lymphoblastic leukemia. Abnormal FISH results most likely represent a hyperdiploid clone. Code the histology to 9811 (B-ALL, NOS) and assign a diagnostic confirmation code of 1. Neither Diagnostic confirmation code 3 nor the more specific hyperdiploidy histology is coded because the associated FISH result is preceded by ambiguous terminology.

Tip: Alphabet Soup Method for Genetics Data

When determining whether to use Code 3 for Hematopoietic or Lymphoid Neoplasm, think about alphabet soup. If you see letters, numbers, and plus signs in the diagnosis, it is a Code 3. Those letters, numbers, and plus signs would not be in the diagnosis documentation unless immunophenotyping or genetic testing was done.

Examples:

- ABL-1 at 9q34
- BCR-ABL fusion protein
- Fusion of BCR at 22q11.2
- p190 kd BCR-ABL1 fusion protein
- p210 kd fusion protein
- Immunophenotyping
  - CD10+
  - CD19+
  - TdT+

It is important to consult the Hematopoietic Database under the histology for the Definitive Diagnostic Methods. Assign Code 3 for cases with a positive histology for the neoplasm being abstracted (including acceptable ambiguous terminology and provisional diagnosis) AND immunophenotyping, genetic testing, or JAK2 is listed in the Definitive Diagnosis Methods in the Hematopoietic Database AND the testing confirms the neoplasm OR identifies a more specific histology (not proceeded by ambiguous terminology).

Code 4: Positive microscopic confirmation, method not specified

Code 4 is rarely used for Hematopoietic and Lymphoid neoplasms.

Assign code 4 when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.

Code 5: Positive laboratory test/marker study

Assign code 5 when the diagnosis of cancer is based on laboratory tests, tumor marker studies, genetics or immunophenotyping that are clinically diagnostic for that specific cancer. Laboratory tests are listed under Definitive Diagnostic Methods in the Hematopoietic Database. Do not assign code 5 when there is histologic confirmation (See code 3).

Example: CT scan consistent with plasma cell myeloma (9732/3). Twenty-four-hour urine protein elevated with the presence of Bence-Jones kappa. Assign code 5 because the diagnosis is based on the positive Bence-Jones and there is no histologic confirmation in this case. Bence-Jones protein is a lab test listed in the Heme DB as one of the definitive diagnostic methods for plasma cell myeloma.

Code 6: Direct visualization without microscopic confirmation

Code 6 is rarely used for Hematopoietic and Lymphoid neoplasms.

Assign code 6 when:

1. The operative report states the patient had lymphoma, but no biopsy or cytology was done
2. The diagnosis is determined by gross autopsy findings (no tissue or cytologic confirmation)

Code 7: Radiology and other imaging techniques without microscopic confirmation

Code 7 is rarely used for Hematopoietic and Lymphoid neoplasms.

Assign code 7 when the diagnosis is confirmed by radiology or other imaging techniques only

Example*:* Terminally ill patient who has a CT scan with the impression: suspicious for lymphoma. The patient refused further workup.

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

Assign code 8 when:

1. While clinical diagnosis is seldom used for solid tumors, it is a valid diagnostic method for certain hematopoietic neoplasms.
2. The Heme DB will list Clinical Diagnosis as the definitive diagnostic method for certain hematopoietic neoplasms. For these neoplasms, biopsy, immunophenotyping, and genetic testing do not confirm the neoplasm.
3. The diagnosis is determined based on the physician's clinical expertise, combined with the information from the biopsy, equivocal or negative tests, and the clinical symptoms. This is called a "diagnosis of exclusion" because the physician's judgment and the work-up literally exclude all other possible diagnoses, leaving one diagnosis. Ambiguous terminology may precede the diagnosis.

Example: Bone marrow biopsy shows anemia NOS; physician notes states the patient's overall clinical presentation of hypercalcemia, fever, and anemia is consistent with Myelodysplastic Syndrome, unclassifiable (9989/3). Code Diagnostic Confirmation 8, clinical diagnosis only.

Code 9: Unknown whether or not microscopically confirmed; death certificate only

Assign code 9 when it is unknown if the diagnosis was confirmed microscopically:

1. For death-certificate-only (DCO) cases
2. For historical cases not already in the database when there is no information available

Example**:** "History of follicular lymphoma in 2010, now presents with DLBCL." Follicular lymphoma not in the database. Assign diagnostic confirmation of 9 for the follicular lymphoma.

Table 5.10 Diagnostic Confirmation Codes for Hematopoietic or Lymphoid Tumors (9590-9992)

CODE	DESCRIPTION	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Tissue from lymph node(s), organ(s) or other tissue specimens from biopsy, frozen section, surgery or autopsy; Bone marrow specimens (aspiration and biopsy), Peripheral blood smear • Can be used as a histological diagnosis for any of the hematopoietic histologies (9590/3-9992/3) Leukemia only (9800/3-9948/3): positive histology also includes • Complete blood count (CBC) • White blood count (WBC) • Neoplasm microscopically confirmed AND immunophenotyping, genetic testing, or JAK2 not done OR immunophenotyping, genetic testing, or JAK2 done but negative (non-diagnostic) for the neoplasm being abstracted IHC studies are done, but the patient has a provisional (NOS) diagnosis or one or more provisional diagnoses. Historical cases not already in the database if information states that there was histologic confirmation **Example:** Patient diagnosed in 2012 with Stage III mantle cell lymphoma, diagnosed by LN biopsy. Mantle cell lymphoma not in the database. Now presents with DLBCL in 2015.
2	Positive cytology, no positive histology	This code is rarely used for Hematopoietic and Lymphoid neoplasms. This code includes examination of fluid such as spinal fluid, peritoneal fluid, or pleural fluid. This code also includes paraffin block specimens from concentrated spinal fluid, peritoneal fluid, or pleural fluid. When a small-gauge needle (fine needle aspirations or FNA), or other method is used to obtain a specimen and there is not enough tissue to do a histologic examination the report will be a cytology report rather than a pathology report.

CODE	DESCRIPTION	DEFINITION
3	Positive histology PLUS: • Positive immunophenotyping AND/OR • Positive genetic studies (**Effective for cases diagnosed 1/1/2010 and later**)	Cases with positive histology for the neoplasm being abstracted (including acceptable ambiguous terminology and provisional diagnosis) AND Immunophenotyping, genetic testing, or JAK2 is listed in the Definitive Diagnosis in the Heme DB AND the testing • Confirms the neoplasm OR • Identifies a more specific histology (not preceded by ambiguous terminology) ***Note:*** • Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when preceded by ambiguous terminology. • Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when the test result is preceded by "patchy weak staining." NOS histology diagnosed and not a provisional diagnosis and genetics/immunophenotyping was performed.
4	Positive microscopic confirmation, method not specified	This code is rarely used for Hematopoietic Lymphoid neoplasms The diagnosis is stated to be microscopically confirmed but the method is not specified or unknown.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker study	This code is rarely used for Hematopoietic and Lymphoid neoplasms. If there no provisional diagnosis or clinical suspicion of cancer, immunophenotyping or genetic testing would not be done. **Example**: CT scan consistent with multiple myeloma (9732/3). Twenty-four hour urine protein elevated with the presence of Bence-Jones kappa. Code 5 for diagnosis based on the positive Bence-Jones, which is listed as one of the diagnostic confirmation methods in the Heme DB and is also a lab test. Code 1 and 3 do not apply because there is no histologic confirmation and positive immunophenotyping and or genetic studies in this example.
6	Direct visualization without microscopic confirmation	This code is rarely used for hematopoietic and lymphoid neoplasms. The operative report may state that the patient had lymphoma but no biopsy or cytology was done or the the diagnosis is determined by gross autopsy findings (no tissue or cytologic confirmation).

CODE	DESCRIPTION	DEFINITION
7	Radiography and other imaging techniques without microscopic confirmation	This code is rarely used for Hematopoietic and Lymphoid neoplasms. Assign code 7 when the diagnosis is confirmed by radiology or other imaging techniques only.
8	Clinical diagnosis only (other than 5, 6, or 7)	While clinical diagnosis is seldom used for solid tumors, it is a valid diagnostic method for certain hematopoietic neoplasms. The Heme DB will list Clinical Diagnosis as the definitive diagnostic method for certain hematopoietic neoplasms. For these neoplasms, the biopsy, immunophenotyping, and genetic testing do not confirm the neoplasm. The diagnosis is determined based on the physician's clinical expertise, combined with the information from the biopsy, equivocal or negative tests, and the clinical symptoms. This is called a "diagnosis of exclusion" because the physician's judgment and the work-up literally exclude all other possible diagnoses, leaving one diagnosis. **Example**: Bone marrow biopsy shows anemia NOS; physician notes states the patient's overall clinical presentation of hypercalcemia, fever, and anemia is consistent with Myelodysplastic Syndrome, NOS (9989/3). Code Diagnostic Confirmation 8, clinical diagnosis only.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate only cases.

Changing Abstract Information

There are some circumstances under which the information originally coded in the abstract should be updated.

1. To correct coding or abstracting errors when identified.
2. When better information is available at a later date.
   - Earlier or more specific diagnosis date
   - Better histology or grade
   - More specific primary site
   - Lower diagnostic confirmation code

Example 1. At the time of diagnosis a patient is diagnosed with liver metastasis but primary site cannot be determined and the abstract is submitted as an unknown primary. At a later date the physician determines that the patient has a colon primary. Change the primary site from

unknown to colon. Be sure to make any necessary changes in *Staging* and *Surgery Codes*. Document the new information in the appropriate text fields.

Example 2. A patient is diagnosed with lung cancer by CT exam alone. An abstract is submitted with the histology of cancer (8000/3) and diagnostic confirmation code 7. At a later admit the H&P states that the patient has squamous cell carcinoma of the lung diagnosed by fine needle aspiration. The *Histology* should be changed from cancer to squamous cell carcinoma (8070/3), and the *Diagnostic Confirmation* should be changed to 2, cytology. These findings should also be documented in the text fields.

Note: Contact the TCR health service regional office regarding the appropriate procedure to follow when there is updated information on an abstract already submitted to the TCR. **Do NOT resubmit the abstract.** These cases will result in duplicate records and require manual resolution. The TCR does not accept modified abstracts.

6

STAGING

STAGING

Do not enter text in every text field when treatment is either not done, or unknown if done. Document "Not done" or "Unknown if done" in only one text field.

Summary Stage Documentation

(NAACCR Item #2600)

Description

Additional text area for staging information not already entered in other Text fields.

Explanation

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values and should not be generated electronically from coded values. Information documenting the disease process should be entered manually from the medical record. Staging should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.

Suggestions for Text

- Date(s) of procedure(s), including clinical procedures, which provided information for assigning stage; organs involved by direct extension
- Size of tumor, status of margins

- Number and sites of positive lymph nodes
- Site(s) of distant metastasis
- Physician‘s specialty and comments

Summary Stage Documentation - PE

(NAACCR Item #2520)

Description

Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor.

Suggestions for Text

- Date of physical exam
- Age, sex, race/ethnicity
- History that relates to cancer diagnosis
- Primary site
- Histology (if diagnosis prior to this admission)
- Tumor location
- Tumor size
- Palpable lymph nodes
- Record positive and negative clinical findings; record positive results first
- Impression (when stated and pertains to cancer diagnosis)
- Treatment plan

Summary Stage Documentation - Xray/Scan

(NAACCR #2530)

Description

Text area for manual documentation from all X-rays, scans, and/or other imaging examinations that provide information about staging.

Suggestions for text

- Date(s) and type(s) of X-ray/Scan(s)
- Primary site
- Histology (if given)
- Tumor location

- Tumor size
- Lymph nodes
- Record positive and negative clinical findings; record positive results first
- Distant disease or metastasis

Summary Stage Documentation - Scopes

(NAACCR Item #2540)

Description

Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

Suggestions for Text

- Date(s) of endoscopic exam(s)
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Record site and type of endoscopic biopsy
- Record positive and negative clinical findings; record positive results first

Summary Stage Documentation - Lab tests

(NAACCR Item # 2550)

Description

Text area for manual documentation of information from laboratory examinations other than cytology or histopathology.

Suggestions for Text

- Type of lab test/tissue specimen(s)
- Record both positive and negative findings; rcord positive test results first
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Date(s) of lab test(s)
- Tumor markers included, but are not limited to:
  - Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu

- Prostate Cancer – Prostatic Specific Antigen (PSA)
- Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

Summary Stage Documentation - OP

(NAACCR Item # 2560)

Description

Text area for manual documentation of all surgical procedures that provide information for staging.

Suggestions for Text

- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived
- Number of lymph nodes removed
- Size of tumor removed
- Documentation of residual tumor
- Evidence of invasion of surrounding areas
- Reason primary site surgery could not be completed

Summary Stage Documentation - Path

(NAACCR Item # 2570)

Description

Text area for manual documentation of information from cytology and histopathology reports.

Suggestions for Text

- Date(s) of procedure(s).
- Anatomic source of specimen.
- Type of tissue specimen(s).
- Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.).
- Gross tumor size.
- Extent of tumor spread.
- Involvement of resection margins.
- Number of lymph nodes involved and examined.
- Record both positive and negative findings. Record positive test results first.

Note: **I**f pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo. Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored.

STAGE PROGNOSTIC FACTORS

Tumor Size Summary

(NAACCR Item #756) (STORE 2018 page 174-177)

Description

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

Explanation

Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Table 6.1 Tumor Size Summary

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm (0.1 cm or less than 0.1 cm)
002-988	Exact size in millimeters (2 mm to 988 mm) (0.2 cm to 98.8cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given
998	SITE-SPECIFIC CODES Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis • Rectosigmoid and rectum (C19.9, C20.9) • Colon (C18.0, C18.2-C18.9) **If no size is documented**: Circumferential: • Esophagus (C15.0-C15.5, C15.8-C15.9) Diffuse; widespread: 3/4s or more; linitis plastica:

Code	Description
	• Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) Diffuse, entire lung or NOS: • Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9) Diffuse: • Breast (C50.0-C50.6, C50.8-C50.9)
999	Unknown; size not stated Not documented in patient record Size of tumor cannot be assessed No excisional biopsy or tumor resection done The only measurement(s) describes pieces or chips Not applicable

Instructions for coding

Note*: All measurements should be in millimeters (mm). Here is a link to one of the websites to convert cms to mms:* http://www.rapidtables.com/convert/length/cm-to-mm.htm

Record size in specified order:

1. Size measured on the surgical resection specimen, when **surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.**
   a. If there is a discrepencey among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report (checklist). If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.

   Example 1. *Example*: chest X-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).

   Example 2. *Example*: Pathology report states lung carcinoma is 2.1 cm x3.2 cm x 1.4 cm. Record tumor size as 032 (32mm).

2. If neoadjuvant therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size 999.

   Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22mm).

3. If no surgical resection, then the largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures priotr to any other form of treatment (See coding rules below)
4. If 1, 2, and 3 do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Coding Instructions

1. Tumor size is the **diameter** of the tumor, **not the depth or thickness** of the tumor.
2. **Recording 'less than'/ 'greater than' Tumor Size**
   a. If tumor size is reported as less than x mm or less than x cm, the reported tumor size should be 1 mm less; for example if size is < 10 mm, code size as 009. Often these are given in cm such as < 1 cm, which is coded as 009; < 2 cm is coded as 019; < 3 cm is coded as 029; < 4 cm is coded as 039; < 5 cm is coded as 049. If stated as less than 1 mm, use code 001.
   b. If tumor size is reported as more than x mm or more than x cm, code size as 1 mm more; for example if size is > 10 mm, size should be coded as 011. Often these are given in cm such as > 1 cm, which is coded as 011; > 2 cm is coded as 021; > 3 cm is coded as 031; > 4 cm is coded as 041; > 5 cm is coded as 051. If described as anything greater than 989 mm (98.9 cm), code as 989.
   c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two ("between 2 and 3 cm" is coded as 025).
3. **Rounding**: Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000). If tumor size is greater than 1 millimeter, round tenths of millimeters in the 1- 4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point one space to the right, converting the measurement to millimeters).

   Example 1. Breast cancer described as 6.5 millimeters in size. Round up Tumor Size as 007.

   Example 2. Cancer in polyp described as 2.3 millimeters in size. Round down Tumor Size as 002.

   Example 3. Focus of cancer described as 1.4 mm in size. Round down as 001.

   Example 4. 5.2 mm breast cancer. Round down to 5 mm and code as 005.
4. **Priority of imaging/radiographic techniques**: Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, over a physical exam.
5. **Tumor size discrepancies among imaging and radiographic reports**: If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.

6. **Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis**. However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.
7. **Record the size of the invasive component, if given.**
   a. If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller.

      Example: Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014 (14 mm)

   b. If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

      Example 1: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).

      Example 2: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).
8. **Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.**

   ***Example*:** Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).
9. **Record the size as stated for purely in situ lesions.**
10. **Disregard microscopic residual or positive surgical margins when coding tumor size**. Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data field.
11. **Do not add the size of pieces or chips together to create a whole**. They may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.
12. **Multifocal/multicentric tumors**: If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor or if all of the tumors are in situ, code the size of the largest in situ tumor.
13. **Tumor size code 999 is used when size is unknown or not applicable**. Sites/morphologies where tumor size is not applicable are listed here.
    - Hematopoietic, Reticuloendothelial, and and Myeloproliferative neoplasms: (histology codes 9590- 9992)
    - Kaposi Sarcoma
    - Melanoma Choroid
    - Melanoma Ciliary Body
    - Melanoma Iris

- Unknown Primary Site

14. Document the information to support coded tumor size in the appropriate text field of the abstract.

SEER STAGING

The SEER program, has collected staging information on cases since its inception in 1973. Summary Stage groups cases into broad categories of in-situ, local, regional, and distant. Summary Stage can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time.

Summary Stage 2018

NAACCR Item #: 764 (STORE 2018 page 190; SEER page 141)

The 2018 Summary Stage will apply to January 1, 2018 diagnoses and forward. It is extremely important to thoroughly read all clinical and pathological documentation, including imaging studies, operative and pathology reports, and the clinician's narrative descriptions of tumor involvement.

Summary Stage is the most basic way of categorizing how far a cancer has spread from its point of origin. Historically, Summary Stage has been called General Stage, California Stage, historic stage, and SEER Stage.

The 2018 version of Summary Stage applies to every site and/or histology combination, including lymphomas and leukemias. Summary Stage uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease. Many central registries report their data by Summary Stage as the staging categories are broad enough to measure the success of cancer control efforts and other epidemiologic efforts.

There are six main categories in Summary Stage, each of which is discussed in detail. In addition, the main category of Regional stage is subcategorized by the method of spread.

Description

Summary Stage 2018 is new for 2018 and stores the directly assigned Summary Stage 2018. Effective for cases diagnosed January 1, 2018 and later. Refer to **SEER*RSA** for additional information.

Note: For SS2018, code 5 for "Regional, NOS" can no longer be coded. Code 5 (Regional, NOS) is still applicable for SS2000.

CODE	DESCRIPTION
0	In Situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND regional lymph nodes

CODE	DESCRIPTION
7	Distant site(s)/node(s) involved
8	Benign, borderline *
9	Unknown if extension or metastatis (unstaged, unknown, or unspecified) Death certificate only case

*Applicable for the following Summary Stage 2018 Chapters: Brain, CNS Other, Intracranial Gland.

Site-specific Data Items (SSDIs)

(STORE 2018 page 229-230; SEER page 145-146)

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank. SEER has developed a staging tool referred to as **SEER*RSA** that provides information (primary site/histology/other factors defined) about each cancer schema. The following tables lists the site-specific schema discriminators and site-specific data items (SSDIs) that are new and are required for collection in 2018.

The **first table lists** schema discriminators with the corresponding NAACCR item number and description. The **second table** lists SSDIs required for staging. For additional required data items, see **NAACCR Version 18 Required Status Table** and the **SSDI Manual**. Refer to **SEER*RSA** and the SSDI manual for codes and coding instructions.

Table 1. Schema Discriminators

Schema Discriminator	NAACCR Item #	New Data Items for 2018
Schema Discriminator 1	3926	Naspoharynx/Pharyngeal Tonsil
Schema Discriminator 1	3926	BileDucts/Distal/Bile/Ducts Perihilar/Cystic Duct
Schema Discriminator 1	3926	Primary Peritoneum Tumor
Schema Discriminator 1	3926	Urethra/Prostatic Urethra
Schema Discriminator 1	3926	MelanomaCiliary Body/Melanoma Iris
Schema Discriminator 1	3926	Lacrimal Gland/Sac
Schema Discriminator 1	3926	Thyroid Gland/Thyroglossal Duct
Schema Discriminator 1	3926	PlasmaCell Myeloma Terminology
Schema Discriminator 1	3926	Histology Discriminator for 9591/3

Schema Discriminator	NAACCR Item #	New Data Items for 2018
Schema Discriminator 2	3927	Histology Discriminator for 8020/3
Schema Discriminator 2	3927	Oropharynx (p16-)
Schema Discriminator 2	3927	HPV-Mediated (p16+)
Schema Discriminator 2	3927	Oropharynx (p16+)

Table 2. SSDI's required for staging

Schema	NAACCR Item #	SSDI
Breast	3827	Estrogen Receptor Summary
Breast	3855	HER 2 Overall Summary
Breast	3904	OncoType DX Recurrence
Breast	3915	Progesterone Receptor Summary
Corpus Adenocarcinoma	3911	Peritoneal Cytology
Corpus Carcinoma and Carcinosarcoma	3911	Peritoneal Cytology
Corpus Sarcoma	3911	Peritoneal Cytology
Esophagus and Esophagus GE Junction (Squamous)	3829	Esophagus and EGJ Tumor Epicenter
Mycosis Fungoides	3910	Peripheral Blood Involvement
Prostate	3920	PSA (Prostate Specific Antigen) Lab value
Testis	3923	S Category Clinical
Testis	3924	S Category Pathological

Please see the list of SSDI's required by the TCR for cases diagnosed in 2018 on page 8. The TCR will collect the appropriate SSDI's from ACoS facilities on analytical cases needed to derive the AJCC TNM stage and analytical cases from others as available.

AJCC TNM STAGING SYSTEM

From 2004 through 2015 AJCC TNM was derived based on Collaborative Staging. Beginning with cases diagnosed January 1, 2015 directly coded AJCC TNM fields are requested as available. Beginning with cases diagnosed January 1, 2018 and forward, AJCC Cancer Staging Manual 8th edition should be used to directly code AJCC TNM fields analytical cases.

AJCC TNM is a system to describe the amount and spread of cancer in a patient's body.

- **T** describes the size of the tumor and any spread of cancer into nearby tissue.
- **N** describes spread of cancer to nearby lymph nodes.
- **M** describes metastasis (spread of cancer to other parts of the body).

This system was created and is updated by the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC). The AJCC staging system is used to describe most types of cancer.

Starting with the 8th Edition in 2018, the clinical T category can now be cTis and pathological T category will be pTis if appropriate.

- This rule change for the 8th Edition does not affect cases staged with previous editions prior to 2018.
- Starting in 2018 for the 8th Edition, other valid T and N categories with the appropriate c and p prefix will be introduced based on 8th Edition rules.

Rationale

The decision to change the rules occurred after thoughtful deliberation by many physicians. The main reason for the previous pTis was to emphasize the need for microscopic or histologic evidence of in situ carcinoma. The diagnosis of carcinoma in situ can never be made on imaging alone.

It was decided to change the clinical T category to cTis, indicating it was a diagnosis made on a diagnostic core needle or incisional biopsy and not based on complete examination of a surgical resection specimen. The pathological T category based on the surgical resection specimen will be pTis. There will now be separate designations, cTis and pTis, indicating the timeframe and type of specimen. During the clinical staging classification, all diagnostic biopsies will be cT regardless of whether the microscopic evidence shows an in situ or an invasive cancer, e.g., cTis, cT1a.

This differentiation is especially important when the resection specimen shows invasive tumor. Use of this approach will mitigate potential confusion regarding the specimen used for the T category. In past editions, pTis could be based on a diagnostic biopsy or could be based on the resection specimen, depending on whether it was the clinical stage T category or the pathological stage T category. Especially if the diagnostic biopsy showed carcinoma in situ, pTis, and the resection specimen showed invasive carcinoma, pT1a (AJCC. (n.d.). In Situ Neoplasia. Retrieved from https://cancerstaging.org).

AJCC 8th edition

New chapters/staging systems

- Risk Assessment Models
- Cervical Nodes and Unknown Primary Tumors of the Head and Neck
- Oropharynx, HPV-Mediated (p16+)
- Cutaneous Carcinoma of the Head and Neck (includes cutaneous carcinoma of external lip)
- Thymus
- Bone: Appendicular Skeleton/Trunk/Skull/Face, Pelvis, and Spine

- Soft Tissue Sarcoma of the Head and Neck
- Soft Tissue Sarcoma of the Trunk and Extremities
- Soft Tissue Sarcoma of the Abdomen and Thoracic Visceral Organs
- Soft Tissue Sarcoma of the Retroperitoneum
- Soft Tissue Sarcoma—Unusual Histologies and Sites
- Parathyroid
- Leukemia

Divided chapters

- Oral Cavity (previously Lip and Oral Cavity)
- Cutaneous carcinoma of the external lip (previously Lip and Oral Cavity) is now staged with Cutaneous Carcinoma of the Head And Neck
- Oropharynx (p16−) and Hypopharynx (previously Pharynx)
- Nasopharynx (previously Pharynx)
- Pancreas—Exocrine (previously Endocrine/Exocrine Pancreas)
- Neuroendocrine Tumors of the Pancreas (previously Endocrine/Exocrine Pancreas)
- Neuroendocrine Tumors of the Stomach
- Neuroendocrine Tumors of the Duodenum and Ampulla of Vater
- Neuroendocrine Tumors of the Jejunum and Ileum
- Neuroendocrine Tumors of the Appendix
- Neuroendocrine Tumors of the Colon and Rectum
- Thyroid—Differentiated and Anaplastic
- Thyroid—Medullary
- Adrenal Cortical Carcinoma
- Adrenal—Neuroendocrine

Merged chapters

- Ovary, Fallopian Tube, and Primary Peritoneal Carcinoma

Deleted chapters

- Cutaneous Squamous Cell Carcinoma and Other Cutaneous Carcinomas for all topographies

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

The descriptor data item was replaced with the T suffix and N suffix, and by incorporating post therapy "y" staging into its own data items previously shared with pathological staging.

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

TNM Clin T

(NAACCR Item #1001) (STORE 2018 page 193)

Description

Detailed site-specific codes for the clinical tumor (T) as defined by AJCC and recorded by the physician. This field is manually coded.

Effective January 1, 2018, the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries.

Explanation

Clinical T reflects the tumor size and/or extension of the primary tumor *prior* to the start of treatment.

Coding Instructions

1. The clinical T category staging data item must be recorded for *Class of Case* 10-22.
2. Code as documented by the first treating physician or managing physician per the medical record where possible; otherwise, use available information to code the clinical T.
3. Code 88 for clinical and pathological or post -therapy T,N,and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are staged according to the current AJCC edition.
4. Refer to the most recent AJCC Cancer Staging Manual, Eight Edition for detailed staging rules.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2018 manual for specifications for codes and data entry rules.

TNM Clin N

(NAACCR Item #1002) (STORE 2018 page 197)

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastatis of the tumor known prior to the start of any therapy. Detailed site-

specific values for the clinical tumor (N) as defined by the current AJCC edition. This field is manually coded.

Explanation

Clinical N indicates the presence or absence of regional lymph node metastasis prior to the start of treatment.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. The clinical N category staging data item must be assigned for Class of Case 10-22.
3. Record clinical N category as documented by the first treating physician or the managing physician in the medical record.
4. If the managing physician has not recorded clinical N, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
5. Code 88 for clinical and pathological or post therapy T,N,M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
6. The valid codes and labels for the AJCC Cancer Staging Manual, Eight Edition have been expanded and are now consistent for clarity.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE manual for specifications for codes and data entry rules

TNM Clin M

(NAACCR Item #1003) (STORE 2018 page 200)

Description

Detailed site-specific codes for the clinical tumor (M) as defined by AJCC and recorded by the physician. This field is manually coded.

Rationale

Beginning in 2016, new T, N, M categories were implemented in the AJCC TNM data items (940, 950, 960, 880, 890 and 900). These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathologic TNM categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathologic staging/classification timeframe rules while abstracting. Additional TNM categories will be added and use of existing categories will be expanded with the implementation of the AJCC 8th edition Manual.

Explanation

Clinical M indicates the presence or absence of distant metastasis prior to the start of treatment.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Code as documented by the first treating physician or managing physician per the medical record where possible; otherwise, use available information to code the clinical M.
3. Code 88 for clinical and pathological or post therapy TNM as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2018 manual specifications for codes and data entry rules.

TNM Clinical Stage Group

(NAACCR Item #1004) (STORE 2018 page 203)

Description

Identifies the anatomic extent of disease based on the T,N,M category data items known prior to the start of any therapy. Detailed site-specific values for the clinical stage group is defined by the current AJCC edition.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Code as documented by the first treating physician or managing physician per the medical record where possible; otherwise, use available information to code the clinical stage group.
3. Code the value only and not the 'Stage' component (do not include the word 'Stage'); convert Roman numerals to Arabic numerals and lower case to upper case; for example, Stage IIA2 is recorded as 2A2.
4. If stage group cannot be determined from the TNM components, then record it as unknown, code 99.
5. If pediatric staging is used and not AJCC staging, use code 88 for clinical and pathologic T, N, M, and Stage Group. If AJCC staging is used for pediatric staging, code using the appropriate AJCC values.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2018 manual for specifications for codes and data entry rules.

TNM Path T

(NAACCR Item #1011) (STORE 2018 page 206)

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known ***following*** the completion of surgical therapy. Detailed site-specific values for the pathological tumor (T) as defined by the current AJCC edition. This field is manually coded.

Explanation

Pathologic T reflects the tumor size and/or extension of the primary tumor after completion of surgical treatment.

*See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups.

Coding Instructions

1. The pathological T category staging data item must be assigned for *Class of Case* 10-22.
2. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
3. Code 88 for clinical and pathological or post therapy TNM as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
4. Code as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic T.
5. Code the value only and not the 'T' component and convert lower case to upper case; for example, T3b is recorded as 3B.
6. The code for occult carcinoma of the lung is TX; record X.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE manual specifications for codes and data entry rules.

TNM Path N

(NAACCR Item #1012) (STORE 2018 page 210)

Description

Detailed site-specific codes for the pathologic tumor (N) as defined by AJCC and recorded by the physician. This field is manually coded.

Explanation

Identifies the absence or presence of regional lymph node (N) metastasis and decribes the extent of regional lymph node metastatis of the tumor known ***following*** the completion of surgical therapy.

*See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. The pathological N category staging data item must be assigned for *Class of Case* 10-22.
3. Code as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic N.
4. If the managing physician has not recorded pathological N category, registrar will *assign* this item based on the best available information, without necessarily requiring additional contact with the physician.
5. Code 88 for clinical and pathological or post therapy TNM as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
6. Code the value only and not the 'N' component and convert lower case to upper case; for example, N2c is recorded as 2C.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE manual for specifications for codes and data entry rules.

TNM Path M

(NAACCR Item #1013) (STORE 2018 page 213)

Description

Detailed site-specific codes for the pathologic metastases (M) as defined by AJCC and recorded by the physician. This field is manually coded.

Explanation

Identifies the presence or absence of distant metastatis (M) of the tumor known following the completion of surgical therapy.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. The pathological M category staging data item must be assigned for *Class of Case* 10-22.
3. If the managing physician has not recorded pathological M categoryy, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic M.
5. Code the value only and not the 'M' component and convert lower case to upper case; for example, M1c is recorded as 1C.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE manual for specifications for codes and data entry rules.

TNM Pathological Stage Group

(NAACCR Item #1014) (STORE 2018 page 215)

Description

Pathologic Stage Group is the detailed site-specific field used to code the pathologic stage group as defined by AJCC. This field is manually coded. The standard setters require a non-BLANK value for the Pathologic Stage Group.

Explanation

Pathologic stage group identifies the extent of disease based on the pathologic T, N, and M data items ***following*** the completion of surgical treatment.

See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Code as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic stage group.
3. If the managing physician has not recorded the pathological stage, registrar will assign this item based on the best available information, without necessarily requiring additional contact with the physician (s).
4. If pathologic M is blank and clinical M is coded as 0, 1, 1A, 1B, or 1C, then pT, pN, and cM may be used to stage the case. If stage group cannot be determined from the TNM components, then record it as unknown. The standard setters require a non-BLANK value for the Pathologic Stage Group.
5. If pediatric staging is used and not AJCC staging, use code 88 for clinical and pathologic T, N, M, and Stage Group. If AJCC staging is used for pediatric staging, code using the appropriate AJCC values.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE manual for specifications for codes and data entry rules.

7

TREATMENT INFORMATION

First Course of Treatment

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

All Diseases (including benign and borderline malignancy intracranial & CNS tumors) Except Hematopoitic and Lymphoid Neoplasms http://seer.cancer.gov/tools/heme/index.html

Definitions

- **Active Surveillance:** A treatment plan that involves closely watching a patient's condition but not giving any treatment unless there are changes in test results that show the condition is getting worse. Active surveillance may be used to avoid or delay the need for treatments such as radiation therapy or surgery, which can cause side effects or other problems. During active surveillance, certain exams and tests are done on a regular schedule. It may be used in the treatment of certain types of cancer, such as prostate cancer, urethral cancer, and intraocular (eye) melanoma. It is a type of expectant management. (Source: http://www.cancer.gov/dictionary?CdrID=616060)
- **Cancer tissue:** Proliferating malignant cells; an area of active production of malignant cells. Cancer tissue includes primary tumor and metastatic sites where cancer tissue grows. Cells in fluid such as pleural fluid or ascitic fluid are not "cancer tissue" because the cells do not grow and proliferate in the fluid.
- **Concurrent therapy**: A treatment that is given at the same time as another, such as chemotherapy and radiation therapy
- **Disease recurrence:** For solid tumors, see the *2018 Solid tumor Rules* and for hematopoietic and lymphoid neoplasms see the *Hematopoietic and Lymphoid Neoplasm Coding Manual* and the hematopoietic database to determine disease recurrence.
- **First course of therapy:** All treatments administered to the patient after the original diagnosis of cancer in an attempt to destroy or modify the cancer tissue. See below for detailed information on timing and treatment plan documentation requirements.
- **Hospice**: A program that provides special care for people who are near the end of life and for their families, either at home, in freestanding facilities, or within hospitals. Hospice care may include treatment that destroys or modifies cancer tissue. If performed as part of the first course, treatment that destroys or modifies cancer tissue is collected when given in a hospice setting. "Hospice, NOS" is not specific enough to be included as first course treatment.
- **Neoadjuvant therapy:** Systemic therapy or radiation therapy given prior to surgery to shrink the tumor.

- **Palliative treatment:** The World Health Organization describes palliative care as treatment that improves the quality of life by preventing or relieving suffering. Palliative therapy is also part of the first course of therapy when the treatment destroys or modifies cancer tissue.

  Example: The patient was diagnosed with stage IV cancer of the prostate with painful boney metastases. The patient starts radiation treatment intended to shrink the tumor in the bone and relieve the intense pain. The radiation treatments are palliative because they relieve the bone pain; the radiation is also first course of therapy because it destroys proliferating cancer tissue.
- **Surgical Procedure:** Any surgical procedure coded in the fields Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional or Distant Sites.
- **Treatment:** Procedures that destroy or modify primary (primary site) or secondary (metastatic) cancer tissue.
- **Treatment failure:** The treatment modalities did not destroy or modify the cancer cells. The tumor either became larger (disease progression) or stayed the same size after treatment.
- **Watchful waiting:** Closely watching a patient's condition but not giving treatment unless symptoms appear or change. Watchful waiting is sometimes used in conditions that progress slowly. It is also used when the risks of treatment are greater than the possible benefits. During watchful waiting, patients may be given certain tests and exams. Watchful waiting is sometimes used in prostate cancer. It is a type of expectant management. (Source: http://www.cancer.gov/dictionary?CdrID=45942)

Treatment Timing

Use the following **in hierarchical order:**

1. Use the **documented** first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is **completed**. (No matter how long it takes to complete the plan).

   Example 1. The first course of therapy for a breast cancer patient is surgery, chemotherapy, and radiation. The patient completes surgery and chemotherapy. Bone metastases are diagnosed before the radiation was started. The physician says that the patient will start the radiation treatment as planned. Code the radiation as first course of therapy since it was given in agreement with the treatment plan and the treatment plan was not changed as a result of disease progression.

   Example 2. Hormonal therapy (e.g. Tamoxifen) after surgery, radiation, and chemotherapy. First course ends when hormonal therapy is completed, even if this takes years, unless there is documentation of disease progression, recurrence, or treatment failure (see #2 below).

2. First course of therapy ends when there is documentation of disease progression, recurrence, or treatment failure.

   Example 1. The documented treatment plan for sarcoma is pre-operative (neoadjuvant) chemotherapy, followed by surgery, then radiation or chemotherapy depending upon

the pathology from surgery. Scans show the tumor is not regressing after pre-operative chemotherapy. Plans for surgery are cancelled, radiation was not administered, and a different type of chemotherapy is started. Code only the first chemotherapy as first course. Do not code the second chemotherapy as first course because it is administered after documented treatment failure.

Example 2. The documented treatment plan for a patient with locally advanced breast cancer includes mastectomy, chemotherapy, radiation to the chest wall and axilla, and hormone therapy. The patient has the mastectomy and completes chemotherapy. During the course of radiation therapy, the liver enzymes are rising. Workup proves liver metastases. The physician stops the radiation and does not continue with hormone therapy (the treatment plan is altered). The patient is placed on a clinical trial to receive Herceptin for metastatic breast cancer. Code the mastectomy, chemotherapy, and radiation as first course of treatment. Do not code the Herceptin as first course of therapy because it is administered after documented disease progression.

3. When there is **no documentation** of a treatment plan or progression, recurrence or a treatment failure, first course of therapy ends one year after the date of diagnosis. Any treatment given after one year is second course of therapy in the absence of a documented treatment plan or a standard of treatment.

Coding Instructions

1. Code all treatment fields to 0 or 00 (Not done) when physician decides to do **watchful waiting/active surveillance** for a patient who has prostate cancer. The first course of therapy is no treatment. When the disease progresses or the patient becomes symptomatic, any prescribed treatment is second course.
   - Code Treatment Status (RX Summ--Treatment Status) to 2
2. Code the treatment as first course of therapy if the patient refuses treatment but changes his/her mind and the prescribed treatment is implemented less than one year from the date of diagnosis, AND there is no evidence of disease progression.
3. The first course of therapy is **no treatmen**t when the patient **refuses** treatment. Code the treatment fields to Refused.
   - Keep the refused code even if the patient later changes his/her mind and decides to have the prescribed treatment either more than one year after diagnosis or when there is evidence of disease progression before treatment is implemented.
4. Code all treatment that was started and administered, whether completed or not.

   Example: The patient completed only the first dose of a planned 30-day chemotherapy regimen. Code chemotherapy as administered.
5. Code the treatment on both abstracts when a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary.

   Example 1. The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate cancer was treated with radiation to the prostate and pelvis. The

pelvic radiation includes the regional lymph nodes for the bladder. Code the radiation as treatment for both the bladder and prostate cases.

Example 2. The patient had a hysterectomy for ovarian cancer. The pathology report reveals a previously unsuspected microinvasive cancer of the cervix. Code the hysterectomy as surgical treatment for both the ovarian and cervix primaries.

6. Code the treatments only for the site that is affected when a patient has multiple primaries and the treatment affects only one of the primaries.

   Example: The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and regional nodes. Do not code the radiation for the colon. Do not code the hemicolectomy for the tonsil.

7. Code the treatment given as first course even if the correct primary is identified later when a patient is diagnosed with an unknown primary.

   Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Code the chemotherapy as first course of treatment.

   a. Do not code treatment as first course when added to the plan after the primary site is discovered. This is a change in the treatment plan.

      Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code the chemotherapy as first course of treatment. The hormone therapy is second course because it was not part of the initial treatment plan.

Notes*:*

- The first course of treatment includes all treatment planned and administered by the physician(s) from the initial diagnosis of cancer. Treatment can include multiple methods and may last a year or more. Any treatment delivered after the first course is considered subsequent treatment.
- Should there be a change of therapy due to apparent failure of the originally delivered treatment or because of the progression of the disease, the later therapy is not considered first course.

First Course Treatment for Hematopoietic and Lymphoid Neoplasms

Refer to the Hematopoietic and Lymphoid Neoplasm Database to determine the correct coding of treatment for hematopoietic diseases.

Leukemia and Lymphomas

Treatment varies by the type of hematopoietic neoplasm.

Lymphomas can be treated with surgery (extranodal or nodal), chemotherapy, and radiation, while leukemias are often treated with chemotherapy and bone marrow transplants. In addition, immunotherapy (biologic response modifiers) and hormones are frequently used to treat hematopoietic neoplasms. Also, for many of these diseases, the principal treatment is either supportive care, observation, or another type of treatment that does not meet the usual definition of treatment that "modifies, controls, removes or destroys proliferating cancer tissue."

Starting in 2010, some neoplasms that have undergone a transformation are reported as new primaries (see rules M10-M13 for specific instructions), and treatment can affect this. For purposes of determining multiple primaries in the Hematopoietic diseases, "treatment" refers to the patient receiving at least one form of cancer-directed treatment such as surgery or systemic therapy, not passive treatment plans like supportive care or observation.

Coding Instructions

1. When there is only one neoplasm (one primary), use the documented first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is completed, no matter how long it takes to complete the plan.
2. Chronic neoplasm followed by an acute neoplasm
   a. The presence/absence of treatment DOES NOT affect the number of primaries when a chronic neoplasm transforms to an acute neoplasm

      Example: Patient diagnosed in 2000 with follicular lymphoma. Patient refused treatment. Patient returns in 2014 with DLBCL. Abstract the DLBCL as a second primary even though there was no treatment for the follicular lymphoma.

   b. First course of treatment for the chronic neoplasm may or may not be completed when the chronic neoplasm transforms to the acute neoplasm.
3. Acute neoplasm followed by a chronic neoplasm
   a. The presence/absence of treatment DOES impact the determination of the number of primaries when the acute neoplasm reverts to a chronic neoplasm (see Rules M12 and M13).
   b. The planned first course of therapy may not have been completed when a biopsy/pathologic specimen shows only chronic neoplasm after an initial diagnosis of an acute neoplasm.
   c. The patient may have completed the first course of treatment and have been cancer free (clinically, no evidence of the acute neoplasm) for an interim when diagnosed with the chronic neoplasm.
   d. The patient may not have been cancer free, but completed the first course of treatment and biopsy/pathology shows only chronic neoplasm.

Code the treatment on both abstracts when a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary.

Example: Patient is diagnosed in May 2014 with both multiple myeloma (9732/3) and mantle cell lymphoma (9673/3), which are separate primaries per rule M15. The oncologist states she began Velcade chemotherapy for the lymphoma. Velcade would affect both primaries, so it should be coded on both abstracts.

Other Treatment for Hematopoietic Diseases

Record all treatment as described above. The following treatments are coded as "other" in Other Treatment even though they do not "modify, control, or destroy proliferating cancer tissue."

a. Collect phlebotomy for polycythemia vera ONLY. Phlebotomy also may be referred to as blood

removal, bloodletting or venesection.

b. Collect blood-thinners and/or anti-clotting agents for essential thrombocythemia (9962/3) **ONLY**

Notes:

- Blood transfusions and aspirin therapy are not collected as treatment.
- Donor Leukocyte Infusions: the use of donor leukocyte infusions for treatment of hematopoietic neoplasms, specifically leukemias, is increasing. Abstract as immunotherapy when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion, even if it is not listed in the treatment section of the Heme DB for the specific neoplasm.
- To learn more about leukemia treatments visit https://www.cancer.gov/types/leukemia/hp

Date of Initial Treatment

(NAACCR Item #1260, 1270)

Date Therapy Initiated *(SEER page 152-154) NAACCR Item# 1260)*

Date of First Course of Treatment *(STORE 2018 page 232) NAACCR Item #1270)*

Description

The date the first course of treatment (surgery, radiation, systemic or other) started at any facility, hospital and non-hospital setting.

Explanation

This field is used to measure the delay between diagnosis and onset of treatment. A secondary use is as a starting point for survival statistics. This date cannot be calculated from the respective first course treatment dates if no treatment was given. Therefore, providing information about these instances is important when a physician decides not to treat a patient or the patient, patient's family or guardian declines treatment.

Coding Instructions

1. Record the earliest date of the following treatment in this field:
   - RX Date-Surgery NAACCR Data Item #1200
   - RX Date-Radiation NAACCR Data Item #1210
   - RX Date-Chemotherapy NAACCR Data Item #1220
   - RX Date-Hormone Therapy NAACCR Data Item #1230
     - Code the date that the prescription was written
   - RX Date Immunotherapy NAACCR Data Item #1240
   - RX Date-Other NAACCR Data Item #1250
   - RX. Summary - Scope of Reg Ln Surgery NAACCR Item #1292
   - RX Summ - Surg Other Reg/Dist RX NAACCR Item #1294

- RX Summ - Transplant/Endocrine NAACCR Item #3250

2. Code the date of **excisional biopsy** as the date therapy initiated when it is the first treatment. Code the date of a biopsy documented as incisional if further surgery reveals no residual or only microscopic residual.

   Example: Breast core needle biopsy with diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual tumor noted. Code the date of the needle biopsy as the excisional biopsy date. Code the date of the biopsy as the date of initial treatment.

3. Date format

   a. YYYYMMDD when the complete date is known and valid.

      Example**:** A patient was found to have a large polyp during a colonoscopy on January 8, 2018. A polypectomy on that date confirmed adenocarcinoma of the descending colon. The polypectomy is considered cancer directed surgery, so code the *Date of Initial Treatment* 20180108.

   b. YYYYMM when year and month are known and valid, and day is unknown.

      Example**:** Patient had pre-op chemo in March 2018 followed by a mastectomy. The exact chemo start date is unknown. Code the *Date of Initial Treatment* as 201803.

   c. YYYY - when year is known and valid, and the month and day are unknown.

   d. Treatment dates for a fetus prior to birth are to be assigned the actual date of the event. Record the type of treatment in the appropriate date item, for example, *Surgery of Primary Site.*

      Example**:** On 1/3/2018 a fetus is diagnosed with malignant teratoma. The teratoma is resected in utero 1/10/2018. Live birth is on 3/8/2018. Code the surgery date 20180110.

4. Code the date unproven therapy was initiated as the date therapy initiated.

5. Code the date of admission to the hospital for inpatient or outpatient treatment when the exact date of the first treatment is **unknown**

6. Leave blank:

   a. When no treatment is given during the first course

   b. When Treatment Status is coded 2, Active surveillance (watchful waiting). If you are a CoC facility follow CoC definition of first course.

   c. When it is unknown whether the patient had treatment

   d. For Death Certificate only (DCO) cases when the date is unknown and cannot be estimated

   e. Autopsy only cases

Estimating Dates

- Month
  - Code “spring of” to April.
  - Code “summer “or “middle of the year” to July.

- Code “fall” or “autumn” as October.
- For “winter of,” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.
- Code “early in year” to January.
- Code “late in year” to December.
- Use whatever information is available to calculate the month.
- Code the month of admission when there is no basis for estimation.
- Leave month blank if there is no basis for approximation.

- Year
  - Code “a couple of years” to two years earlier.
  - Code “a few years” to three years earlier.
  - Use whatever information is available to calculate the year.
  - Code the year of admission when there is no basis for estimation.

Note: STORE 2018 instructions (see STORE 2018 page 232) differ from TCR instructions. STORE 2018 instructs for Date of First Course of Treatment to record the date when the decision of active surveillance or watchful waiting is selected as the first course of treatment. TCR will accept STORE 2018 guidelines for this field but will continue to follow SEER guideline for this data item. Facilities following STORE 2018 guidelines will not receive an edit on this data item.

Date of Initial RX Flag

(NAACCR Item #1261) (SEER page 155)

Description

This flag explains why there is no appropriate value in the corresponding date field, Date of Initial RX-SEER (1260).

Explanation

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

Coding Instructions

1. Leave this item blank if *Date of Initial Treatment* has a full or partial date recorded.
2. Assign code 10 when it is unknown whether any treatment was administered.
   - For Death Certificate Only (DCO) cases.
3. Assign code 11 when no treatment is given during the first course, the first course is active surveillance (watchful waiting) or the initial diagnosis was at autopsy.

4. Assign code 12 if the Date of Initial Treatment cannot be determined or estimated, and the patient **did** receive first course treatment. Use this code **only** as a last resource.

Table 7.1 Date of Initial RX Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if therapy was administered).
11	No proper value is applicable in this context (for example, no treatment given or autopsy only).
12	A proper value is applicable but not known (for example, therapy was administered and date is unknown).
(blank)	A valid date value is provided in item *Date of Initial Treatment* (NAACCR Item #1260).

RX Summary - Scope of Reg Ln Surgery

(NAACCR Item #1292) (STORE 2018 page 248; SEER pages 165-167)

Description

Indicates the removal, biopsy, or aspiration of **regional** lymph nodes at the time of surgery of the primary site or during a separate surgical procedure performed during the initial work-up of first course of therapy.

Explanation

This information is used to compare and evaluate the extent of surgical treatment.

Coding Instructions

1. Use the operative reports as the primary source document to determine whether the operative procedure was a SLNBx, or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.
2. Record all surgical procedures that remove, biopsy, or aspirate regional lymph nodes even if surgery of the primary site is not performed. The regional lymph node surgical procedure(s) may be done to **diagnose** cancer, **stage** the disease, or as part of the initial **treatmen**t. Codes 0–7 are hierarchical. Code the procedure that is numerically higher.
3. Assign Code **0** when:
   a. Regional lymph node removal procedure was not performed

      Note: Excludes all sites and histologies that would be coded 9 (See coding instructions # 10 below)

   b. First course of treatment was active surveillance/watchful waiting

c. If the operative report lists a lymph node dissection but no nodes were found by the pathologist, code the *SCOPE OF REG LN SURGERY* to **0** (No lymph nodes removed).

4. Information to be coded for this data field is **cumulative**. It is appropriate to add the number of all the lymph nodes removed during each surgical procedure performed as part of the first course treatment.

   Example: Patient has excision of a positive cervical node. The pathology report from a subsequent node dissection identifies three cervical nodes. Assign code 5 (4 or more regional lymph nodes removed).

   a. Lymph node aspirations

   b. Do not double-count when a regional lymph node is aspirated and that node is in the resection field. Do not add the aspirated node to the total number.

   c. Count as an additional node when a regional lymph node is aspirated and that node is NOT in the resection field. Add it to the total number.

5. Code only regional lymph node procedures in this data item. Include lymph nodes that are coded as regional in the **current AJCC** Staging Manual. **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).

   ***Example*:** Melanoma with no primary skin site identified. One axillary lymph node removed revealing melanoma. No other tumors found. The axillary lymph node is coded as regional for CS lymph node coding. Include this lymph node in *Scope of Regional LN Surgery*.

6. Include lymph nodes obtained or biopsied during any procedure within the first course of treatment. A separate lymph node surgery is not required. Coded the removal of intra-organ lymph nodes in Scope of Regional LN Surgery.

   Example: Local excision of breast cancer. Specimen includes an intra-mammary lymph node. Assign code 4 (1 to 3 regional lymph nodes removed).

7. Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site. The regional lymph node surgical procedure(s) may be done to **diagnose** cancer, **stage** the disease or as a part of the initial **treatment.**

   Example: Patient has a sentinel node biopsy of a single lymph node. Assign code **2** (Sentinel lymph node biopsy [only]).

8. If the patient has two primaries with common regional lymph nodes, code and document the removal of regional nodes for both primaries.

   ***Example*:** Patient has a cystoprostatectomy and pelvic lymph node dissection for papillary transitional cell cancer of the bladder. Pathology identifies prostate adenocarcinoma as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. Code *Scope of Regional Lymph Node Surgery* to 5 (4 or more regional lymph nodes removed) for both primaries.

9. Code to 9 for:

   a. Primaries sites

   - Meninges (C700-C709), OR

- Brain (C710-C719), OR
- Spinal cord (C710-C719), OR
- Cranial nerves and other parts of the central nervous system (C720-C729, C75.1-C75.3)
- Unknown or ill-defined sites (C760-C768, C809) (all histologies) (including cases diagnosed at autopsy)

b. Lymphomas with primary site in lymph node (C770–C779) AND
   - 9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940,9948 and 9971, OR

c. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C420, C421, C423, C424 or 9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), OR

d. Death Certificate only (DCO) cases.

Notes:

- This table is also available in the Quick Reference.
- See Appendix A for additional instructions specific to Breast Surgical Codes (RX Summary-Scope of Reg LN Surgery).

Table 7.2 RX. Summary- Scope of Reg Ln Surgery Codes

CODE	DESCRIPTION	DEFINITION	GENERAL INSTRUCTIONS
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 nodes, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement.	Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed and it did not include the use of dye or tracer for a SLNBx procedure (coded 2). If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.
2	Sentinel lymph node biopsy (only)	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	The operative report states that a SLNBx was performed. Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph

CODE	DESCRIPTION	DEFINITION	GENERAL INSTRUCTIONS
		radio label at the site of the primary tumor.	node (possibly more than one) for removal/examination. When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional nonsentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx 2. If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6
3	Number of regional lymph 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 lymph node biopsy.	The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure). Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7). Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLN Bx only. Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes were examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive
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.	
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.	

CODE	DESCRIPTION	DEFINITION	GENERAL INSTRUCTIONS
			regional lymph node dissection during the same, or separate, procedure (code 6 or 7). Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical procedure with code 3, 4, or 5; or code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.	SNLBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However it is possible for these procedures to harvest only a few nodes. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.)When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.
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.	SNLBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes.

CODE	DESCRIPTION	DEFINITION	GENERAL INSTRUCTIONS
			If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.
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.	The status of regional lymph node evaluation should be known for surgically-treated cases (i.e., cases coded 19-90 in the data item *Surgery of Primary Site* [NAACCR Item #1290]). Review surgically treated cases coded 9 in *Scope of Regional Lymph Node Surgery* to confirm the code.

Example 1. Patient has a radical neck dissection and the number of lymph nodes removed is not stated. The appropriate code would be 3.

Example 2. The patient has modified radical mastectomy with sentinel lymph node biopsy and axillary lymph node dissection. The final diagnosis is infiltrating ductal carcinoma with 2/12 axillary lymph nodes positive. The appropriate code would be 6, sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated.

Example 3. Transverse colon: Adenocarcinoma with extension into subserosa, 3/10 pericolic lymph nodes are positive. The appropriate code would be 5, four or more regional lymph nodes removed.

Regional Lymph Nodes Positive

(NAACCR item # 820) (STORE 2018 page 170) (SEER page 176-178)

Description

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

Rationale

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

Table 7.3 Regional Nodes Positive

Codes	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 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

Instructions for Coding

Note: When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual use the AJCC definition.

Regional lymph nodes only. Record information only about regional lymph nodes in this field. Involved distant lymph nodes should be coded in the M (distant metastasis) field and not counted as positive regional nodes. Inlcude lymph nodes that are regional in the current AJCC Staging Manual or EOD 2018.

1. **This field is based on pathological information only**. This field is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.
2. True **in situ cases** cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed.
3. **Nodes positive is cumulative**. Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.
    a. The number of regional nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.
    b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Use of Code 95 below.

        Example 1. Lung cancer patient has a mediastinoscopy and positive core biopsy of hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. **Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.**

Example 2. Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive. **Code Regional Nodes Positive as 01 and Regional Nodes Examined as 06.**

c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.

Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. **Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.**

d. If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.

Example: Patient record states that lymph node core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. **Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.**

4. **Priority of lymph node counts**. If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic description, gross description.

5. **Positive Nodes in Multiple Primaries in Same Organ**. If there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive, the registrar should first try to determine the histology of the metastases in the nodes and code the nodes as positive for the primary with that histology. If no further information is available, code the nodes as positive for all primaries.

Example: A breast case is two separate primaries as determined by the SEER multiple primary rules. The pathology report states "3 of 11 lymph nodes positive for metastasis" with no further information available. **Code Regional Nodes Positive as 03 and Regional Nodes Examined as 11 for both primaries**

6. **Isolated Tumor Cells (ITCs)** in lymph nodes. For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.

   a. For cutaneous melanoma and Merkel cell carcinoma, count nodes with ITCs as positive lymph nodes.

7. **Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

   a. Use code 95 when a positive lymph node is aspirated and there are no surgically resected lymph nodes.

Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. **Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.**

b. Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative.

Example: Lung cancer patient has aspiration of suspicious hilar mass, which shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes neoadjuvant (preoperative) radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes. **Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected.**

8. **Code 97**. Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.

   a. **Note 1:** For primary sites where the number of involved nodes must be known in order to map to N1, N2, etc., code 97 maps to N1 and therefore should be avoided, even if this means slightly undercounting the number of nodes positive.

   b. **Note 2:** If the aspirated node is the only one that is microscopically positive, use code 95.

   c. **Note 3**: Avoid using Regional Nodes Positive code 97 if possible, even if this means slightly undercounting the number of nodes positive.

   Example: Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant (preoperative) chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection "several" of 10 nodes are positive; the remainder of the nodes showchemotherapy effect. **Code Regional Nodes Positive as 97 because the total number of positive nodes biopsied and removed is unknown, and code Regional Nodes Examined as 10.**

9. **Code 98** may be used in several situations:

   a. When the assessment of lymph nodes is clinical only.

   b. When no lymph nodes are removed and examined.

   c. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

   d. If Regional Nodes Positive is coded as 98, Regional Nodes Examined is usually coded 00.

10. **Code 99**. If it is unknown whether regional lymph nodes are positive.

    For the following schemas, the Regional Nodes Positive field is always coded as 99:

    - Brain and Cerebral Meninges
    - CNS Other
    - Hodgkin and non-Hodgkin Lymphoma
    - Other and Ill-Defined Primary Sites (includes unknown primary [C809])
    - Intracranial Gland

- Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
- Myeloma Plasma Cell Disorder
- Placenta

Regional Lymph Nodes Examined

(NAACCR item # 830) (STORE page 167) (SEER page 179-181)

Description

Records the total number of regional lymph nodes that were removed and examined by by the pathologist. Beginning with cases diagnosed on or after January 1, 2014, this item became a component of the Collaborative Staging System (CS). In 2016 use of CS was discontinued, however this data item continued to be required.

Rationale

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

Table 7.4 Regional Nodes Examined

Code	Description
00	No nodes were examined
01-89	1-89 nodes are examined (code exact number of nodes examined)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration OR core biopsy 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
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 are examined; not applicable; not stated in patient record

Instructions for coding

Note: When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual use the AJCC definition

1. **Regional lymph nodes only**. Record information only about regional lymph nodes in this field. Involved distant lymph nodes should be coded in the M (distant metastasis) field and not counted as positive regional nodes.

2. **This field is based on pathologic information only**. This field is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.
3. Code **00** may be used in several situations
    a. When the assessment of lymph nodes is clinical.
    b. When no lymph nodes are removed and examined.
    c. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
    d. If Regional Nodes Examined is coded 00, Regional Nodes Positive is coded as **98**.
4. Nodes removed and examined is cumulative. Record the total number of regional lymph nodes removed and examined by the pathologist.
    a. 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.
    b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.

        Example: Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. **Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.**
    c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.

        Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.
    d. If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.

        ***Example*:** Patient record states that lymph node core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.
5. **Priority of lymph node counts**. If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic description, gross description.
6. **Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. **Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.**

7. **Lymph node excision biopsy**. If a lymph node excision biopsy was performed, code the number of nodes removed, if known.
8. Definition of **"sampling" (code 96).** A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy and, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.
9. Definition of **"dissection" (code 97).** A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, and lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.
10. **Multiple lymph node procedures**. If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.
11. When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use **code 98.**
12. **Code 99**. If it is unknown whether nodes were removed or examined, code as 99.

    Primary sites always coded 99. For the following schemas, the Regional Nodes Examined field is always coded as 99.

    a. Brain and Cerebral Meninges
    b. CNS Other
    c. Ill-Defined Other (includes unknown primary [C809])
    d. Intracranial Gland
    e. Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
    f. Hodgkin and non-Hodgkin Lymphoma
    g. Myeloma Plasma Cell Disorder
    h. Placenta

RX Date - Surgery

(NAACCR ITEM #1200) (STORE 2018 page 236; SEER page 157)

Description

The date of the first cancer-directed surgical procedure performed at any facility.

Explanation

Documents the date of the first cancer-directed surgical procedure. This date may or may not reflect the date of the most definitive surgical procedure.

This item can be used to sequence multiple treatment modalities and to evaluate the time intervals between treatments.

Coding Instructions

1. Record the date of the first surgical procedure of the types coded as *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery,* or *Surgical Procedure/Other Site.*

2. Date format is:

    a. YYYYMMDD - when the complete date is known and valid.

    ***Example*:** A patient was found to have a large polyp during a colonoscopy on January 8, 2018. A polypectomy on that date confirmed adenocarcinoma of the descending colon. The polypectomy is considered cancer directed surgery, so the date of first surgery should be coded 20180108.

    b. YYYYMM - when year and month are known and valid, and day is unknown.

    ***Example*:** Patient is seen for treatment recommendations following a mastectomy in March 2018. The exact day of surgery is unknown. Code the date of surgery as 201803.

    c. YYYY - when year is known and valid, and the month and day are unknown.

    Example: A patient had a radical prostatectomy in 2018 and is now seen with bone mets. The month and day of the surgery are unknown. Code the date of surgery as 2018.

    d. Blank - when no known date applies (no surgery was done or it is unknown if surgery was done).

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

4. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery.

5. If surgery was done do not leave this field blank. If the date is unknown record the year of diagnosis as the surgery date and leave the month and day blank. Document in the text field that the date of surgery is unknown.

Example 1. An incisional biopsy is performed on March 3, 2018 followed by a resection on March 17, 2018. Record the date of the resection (20180317) as the date of the first surgical procedure. An incisional biopsy is a diagnostic procedure, not a cancer-directed surgery.

Example 2. February 1, 2018 a patient had a fine needle aspiration of a right breast mass, consistent with infiltrating ductal carcinoma. On February 15, 2018, the patient underwent a right modified radical mastectomy. The date of surgery would be recorded as 20180215.

Example 3. Patient had a lumpectomy as part of first course of treatment for breast cancer in 2018, but the date is unknown. On June 3, 2018 she comes to your facility to begin chemotherapy. Record the date of surgery as 2018.

RX Date Surgery Flag

(NAACCR Data Item #1201) (STORE 2018 page 237; SEER page 158)

Description

This flag explains why there is no appropriate value in the corresponding date field, *RX Date Surgery*, NAACCR Item 1200.

Explanation

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

Coding Instructions

1. Leave this item blank if *Surgical Procedure of Primary Site* (NAACCR Item #1200) has a full or partial date recorded.
2. Code 10 if it is unknown whether any surgery was performed.
3. Code 11 if no surgical procedure was performed.
4. Code 12 if the *Date of First Surgical Procedure* cannot be determined or estimated, but the patient did receive first course surgery. Use this code **only** as a last resort.

Table 7.5 RX Date Surgery Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated. (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of First Surgical Procedure* (NAACCR Item #1200).

RX Date - Most Definitive Surgical Resection of Primary Site

(NAACCR Item #3170) (STORE page 238; SEER page 159)

Description

Date of most definitive surgical resection of the primary site performed as part of the first course of treatment.

Explanation

This item is used to measure the lag time between diagnosis and the most definitive surgery of the primary site. This may or may not be the date of **RX Date - Surgery.** The most definitive surgery is the most extensive resection of the primary site done during the first course of treatment.

Example 1. The patient undergoes an excisional biopsy for right breast cancer on 1/2/2018, then undergoes a right modified radical mastectomy on 1/25/18. The RX Date – Surgery is 1/2/2018 since this is the date of the first surgery done as first course of treatment. 1/25/2018 is the date of the most definitive treatment, since the right modified mastectomy is more extensive than the excisional biopsy.

Enter the date of the most definitive surgery even if the specimen is negative for residual malignancy.

Example 2. The patient undergoes a colonoscopy on 2/20/18 and is found to have a suspicious polyp. A polypectomy is performed and is positive for adenocarcinoma. The patient proceeds to a segmental resection of the colon for margins done on 3/2/18. The resection shows no residual disease. The RX Date – Surgery is 2/20/18. The RX Date – MostDefSurg is 3/2/18 even though no cancer is found in the specimen.

RX Date - Mst Defn Srg Flag

(NAACCR Item #3171) (STORE 2018 page 239; SEER page 160)

Description

This flag explains why no appropriate value is in the field, RX Date Most Defn Srg.

Explanation

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

Coding Instructions

1. Leave this item blank if *RX Date-Most Definitive Surgical Resection of Primary Site* (NAACCR Item #3170) has a full or partial date recorded.
2. Code 10 if it is unknown whether any surgery was performed.
3. Code 11 if no surgical procedure was performed.
4. Code 12 if the *RX Date-Most Definitive Surgical Resection of Primary Site* (NAACCR Item #3170) cannot be determined or estimated, but the patient did receive first course surgery. Use this code **only** as a last resort.

Table 7.6 RX Date – Mst Defn Srg Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).

11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated. (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date-Mst Defn Srg* (NAACCR Item #3170).

Surgical Procedure of Primary Site

(NAACCR Item #1290) (STORE 2018 page 240; SEER pages 161-162)

Description

Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site that is performed as part of the initial diagnostic and staging work-up or first course of therapy. Code the most definitive surgical procedure of the primary site performed at any facility as part of the first course of treatment. This field is for surgery of primary site only.

Explanation

Identifies the specific cancer-directed surgery of the primary site.

Coding Instructions

1. Code the type of surgery the patient received as part of the **first course of treatment** at any facility.
2. Code **00** if **no surgery** is performed on the primary site, **or** first course of treatment was active surveillance/watchful waiting, **or** if the case was diagnosed at autopsy; **excludes all sites and histologies that would be coded as 98**.
3. Use the site-specific coding scheme corresponding to the primary site or histology. Refer to the Site-specific Surgery Codes in Appendix B of the STORE 2018 Manual on page 439:
4. Or, Appendix C of the 2018 SEER Coding and Staging Manual: https://seer.cancer.gov/manuals/2018/appendixc.html

Table 7.7 Surgical Procedure of Primary Site Codes

CODE	TYPE	DESCRIPTION
00	None	No surgical procedure of primary site. Diagnosed at autopsy only.
10–19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to *Appendix B in the STORE 2018 manual* for correct site-specific procedure code.
20–80	Site-specific codes; resection	Refer to *Appendix B in the STORE 2018 manual* for correct site-specific procedure code.
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 surgery codes; special	Special code for hematopoietic neoplasms; ill-defined sites; and unknown primaries. Refer to *Appendix B in the STORE 2018 manual* for correct site-specific procedure code.
99	Unknown	Medical record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

5. Code the most **invasive, extensive, or definitive** surgery if the patient has multiple surgical procedures of the primary site even if there is no tumor found in the pathologic specimen. Codes 00–80 are listed in **hierarchical** but **not necessarily numerical order**. Code the procedure listed furthest down the list within the codes 10–80.

   ***Example*:** Patient has excisional breast biopsy that is positive for carcinoma. The patient chooses to have a modified radical mastectomy. The pathologic examination of the mastectomy specimen shows no residual tumor. Code the modified radical mastectomy.

6. Code **98** is used for hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease and for unknown or ill-defined sites unless the case is death certificate only.

   a. Hematopoietic and Lymphoid Neoplasms

   b. Any case coded to primary site C420, C421, C423, or C424

   c. Cervical Lymph Nodes and Unknown Primary

   d. Unknown or ill-defined sites: C760-C768, C809 (all histologies)

      i. Excluding Spleen (C422) and C770-779 (Lymph Nodes)

7. Excisional biopsies that remove the entire tumor and/or leave only microscopic margins are coded in this field if no further more definitive surgery is done.

   a. Code an **excisional biopsy**, even when documented as **incisional,** when:

      a. All disease is removed (margins free) OR

      b. All gross disease is removed and there is only **microscopic residual at the margin.**

      Example: Breast core needle biopsy with diagnosis of infiltrating duct carcincoma; subsequent re-excision with no residual tumor noted. Code as excisional biopsy.

   b. Do **not** code an excisional biopsy when there is macroscopic residual disease.

   c. Shave or punch biopsies are most often diagnostic. Code as a surgical procedure **only** when the entire tumor is removed and margins are clear.

   For ACoS facilities, per STORE page 150:

   If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery the surgical margins are clear (i.e., no tumor remains), DO NOT consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the Surgical Diagnostic and Staging Procedure at this Facility

[740] data item and the excisional biopsy or more extensive surgery in the Surgical Procedure of the Primary Site at this Facility data item [670].

8. Code total **removal of the primary site** when a previous procedure resected a portion of the site and the current surgery removed the rest of the organ. The previous procedure may have been cancer directed or non-cancer directed surgery.
9. Code surgery for extra-lymphatic lymphoma using the **site-specific** surgery coding scheme for the primary site. Do **not** use the lymph node scheme
10. Surgery to remove regional or distant tissue or organs is coded in this field only if the tissue or organs are removed in continuity with the primary site (en bloc), except where noted in *Appendix B in the STORE 2018 manual.* Specimens from an en bloc resection may be submitted to pathology separately.

    SEER Note: In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily as a single specimen. Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

11. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is **not** considered cancer-directed surgery. Brushings, washings, and aspiration of cells are not surgical procedures.
12. Assign the surgery code(s) that best represents the extent of the surgical procedure that was actually carried out when surgery is aborted. If the procedure was aborted before anything took place, assign code 00.
13. For brain tumors, gross total resection (of tumor or mass) should be coded to 20, and not 55. Code 55 would indicate total resection of a lobe of the brain.
14. Code **80** or **90** only when there is no specific information.
15. Code **99** for death certificate only (DCO) cases

Reason for No Surgery of Primary Site

(NAACCR Item #1340) (STORE 2018 page 269; SEER pages 184-186)

Description

Records the reason that no surgery was performed on the primary site. This field applies only to surgery of primary site. This data item records the reason that surgery of the **primary site** was not part of the first course of treatment.

Explanation

This data item provides information related to quality of care.

Coding Instructions

1. Assign code 0 when Surgery of Primary Site is coded in the range of 10-90 (surgery of the primary site was performed).

2. Assign a code in the range of 1-8 if Surgery of Primary Site is coded 00 or 98.

   Note: Referral to a surgeon is equivalent to a recommendation for surgery.

   a. Assign code **1** when

      1. There is no information in the patient's medical record about surgery and either:

         - It is known that surgery is not usually performed for this type and/or stage of cancer

           OR

         - There is no reason to suspect that the patient would have had surgery of primary site.

           Example: The patient would not be a surgical candidate because of advance stage.

      2. The treatment plan offered multiple treatment options and the patient selected treatment that did not include surgery of the primary site.

         Example**:** Prostate cancer patient is offered three treatment options: a. Radical prostatectomy, b. Radiation therapy, or c. Hormone therapy. The patient chose radiation therapy. Assign code 1. Surgery of the primary site was not performed because it was not part of the planned first-course treatment. The treatment plan was for the patient to receive ONE of three treatment modality options. At no time did the physician recommend that the patient have all three treatments.

      3. Patient elected to pursue no treatment following the discussion of surgery. Unless the patient is referred to surgeon this discussion does not mean surgery was recommended. This is when possible options are being discussed.

      4. Watchful waiting/active surveillance (prostate).

   b. Assign code **6** when it is **KNOWN** that surgery was recommended **AND** it is known that surgery was not performed **AND** there is no documentation explaining why surgery was not done.

   c. Assign code **7** when the patient refuses recommended surgery **OR** makes a blanket statement that he/she refused all treatment when surgery is a customary option for the primary site/histology.

   Note: Coding *Reason for No Surgery of Primary Site* as "refused" does not affect the coding of the other treatment fields. Code 7 means surgery is exactly what was recommended by the physician and the patient refused. If two treatment alternatives were offered and surgery was not chosen, code *Reason for No Surgery of Primary Site* as 1.

   d. Assign code **8** when surgery is recommended, but it is unknown if the patient had the surgery.

***Example*:** There is documentation in the medical record that the primary care physician referred the patient to a surgical oncologist. Follow-back to the surgical oncologist and primary care physician yields no further information. Assign code 8.

3. Code **9** if the treatment plan offered multiple choices, but it is unknown which treatment, if any, was provided. For death certificate only (DCO) cases, and autopsy only cases.

Note: This table is also available in Quick Reference, Appendix H.

Table 7.8 Reason for No Surgery Codes

CODE	DESCRIPTION
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 the 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 the patient's record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Death certificate only. Diagnosed at autopsy.

Example 1. A patient with primary tumor of the liver is not recommended for surgery due to advanced cirrhosis. The reason for no primary site surgery is 2, not recommended due to comorbid conditions.

Example 2. A patient is referred to another facility for recommended surgical resection of a non-small cell lung carcinoma. There is no further information from the facility to which the patient was referred. The reason for no surgery of primary site is 8, recommended but unknown if performed.

RX Summ - Surg Other Reg/Dist RX Code

(NAACCR Item #1294) (STORE 2018 pages 261-264; SEER page 182)

Description

Indicates the surgical removal of other regional site(s), distant site(s), or distant lymph node(s) beyond the primary site. Code the surgical procedure of other sites the patient received, at any facility, as part of the first course of treatment.

Explanation

Documents the extent of surgical treatment and is useful in evaluating the extent of metastatic disease.

Coding Instructions

1. The codes are **hierarchical.** Record the **highest numbered code** that describes the surgical resection of *distant lymph nodes or regional/distant tissues or organs* the patient received as part of the **first course of treatment** at any facility.
2. Do not code tissues or organs such as an appendix that were removed incidentally, and the organ was not involved with cancer.

   Note: Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer. Examples of incidental removal of organ(s) would be removal of appendix, gallbladder, etc., during abdominal surgery.

3. Codes 1-5 have priority over codes 0 and 9.

Table 7.9 RX Summ– Surg Other Reg/Dist RX Codes

CODE	DESCRIPTION	DEFINITION
0	None	No surgical procedure of non-primary site was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical procedure to other site(s), unknown if the site(s) is regional or distant.
2	Non-primary surgical procedure to other regional sites	Resection of regional site.
3	Non-primary surgical procedure to distant lymph node(s)	Resection of distant lymph node(s).
4	Non-primary surgical procedure to distant sites	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a non-primary site was performed. Death certificate only (DCO) cases.

Example 1. The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon is coded to 0.

Example 2. Surgical biopsy of metastatic lesion from liver with an unknown primary is coded to 1.

Example 3. Surgical ablation of solitary liver metastasis with a hepatic flexure primary is coded to 2 (Site regional by stage).

Example 4. Excision of distant metastatic lymph nodes with a rectosigmoid primary is coded to 3.

Example 5. Removal of a solitary brain metastasis with a lung primary is coded to 4 (site distant by stage).

Example 6. Excision of a solitary liver metastasis and hilar lymph node with a rectosigmoid primary is coded to 5.

Assign code 1:

- When any surgery is performed to remove tumors and the primary site is unknown or ill-defined (C760-C768, C809).
- When any surgery is performed for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C420, C421, C423, C424 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992).
- When the involved contralateral breast is removed for a single primary breast cancer.

Note: For **single** primaries only, code removal of involved contralateral breast under the data item Surgical Procedure/Other Site.

Example of a single bilateral breast primary would be inflammatory carcinoma involving both breasts (Rule M6).

RX Text Surgery

(NAACCR Item #2610)

Description

Text area for information describing all surgical procedures performed as part of treatment.

Explanation

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information **MUST BE PROVIDED BY ALL FACILITIES.**
2. Document all first course surgery regardless of where it was done, in date order.
3. Document if no surgery was done, or if it cannot be determined if intended surgery was done.

Example: 5/1/17 patient had a right lobe thyroidectomy. On 6/8/17 patient had completion thyroidectomy.

*Note***:** See the Text Documentation section of the 2017 TCR CRH for further explanation and examples. D**o NOT enter text in this fields when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.**

Date Radiation Started

(NAACCR Item #1210) (STORE 2018 page 272; SEER page 187)

Description

The date the radiation therapy began at any facility as part of the first course of treatment.

Explanation

Identifies the date radiation therapy was initially started.

Coding Instructions

1. Record the date of the first cancer-directed radiation therapy.
2. Date format is:
    a. YYYYMMDD - when the complete date is known and valid

       Example**:** A patient with breast cancer begins external beam radiation therapy on April 10, 2018. Code the date of radiation therapy as 20180410.

    b. YYYYMM - when year and month are known and valid, and day is unknown.

       Example: A patient was diagnosed with prostate cancer and underwent brachytherapy in January 2018 but the day is not known. Record date of radiation therapy as 201801.

    c. YYYY - when year is known and valid, and the month and day are unknown.

       Example**:** A patient is seen with brain cancer in July 2018. It is known that the patient had radiation therapy earlier in the year, but the month and day are unknown. Record the date of radiation therapy as 2018.

    d. Blank - when no known date applies (no radiation therapy was given or it is unknown if radiation was given).

       Example**:** A patient with a malignant brain tumor has refused all therapy including radiation therapy. Leave the date of radiation therapy blank.
3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. If two or more types of radiation therapy are delivered, (for example: beam and isotopes; beam and implants) enter the date for the **first** type of radiation therapy.
5. If radiation therapy is given do not leave this field blank. If the date is not known record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the date of radiation therapy is unknown.

RX Date Radiation Flag

(NAACCR Item #1211) (STORE 2018 page 274; SEER page 188)

Description

This flag explains why there is no appropriate value in the corresponding date field *Date Radiation Started.*

Explanation

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

Coding Instructions

1. Leave this item blank if *Date Radiation Started* has a full or partial date recorded.
2. Code 10 if it is unknown whether any radiation was given.
3. Code 11 if no radiation is planned or given, or the initial diagnosis was at autopsy.
4. Code 12 if *Date Radiation Started* cannot be determined, but the patient did receive first course radiation. Use this code **only** as a last resource.
5. Code 15 if radiation is planned, but has not yet started and the start date is not yet available.

Table 7.10 RX Date Radiation Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if any radiation was given).
11	No proper value is applicable in this context (for example, no radiation given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (for example, radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item *Date Radiation Started* (NAACCR Item 1210).

Radiation Treatment Modality--Phase I

(NAACCR Item #1506) (STORE 2018 pages 285-286;SEER pages 189-192)

NAACCR Name: Phase I Radiation Treatment Modality

Radiation Treatment Modality--Phase I is new for 2018. This data item identifies the radiation modality administered during the first phase of radiation treatment delivered during the first course of treatment. **NOTE: The TCR only requires NAACCR item # 1506 Phase I Radiation Treatment Modality for cases diagnosed in 2018.**

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities

Definitions

Chemoembolization: A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

Radioembolization: Tumor embolization combined with injecting small radioactive beads or coils into an organ or tumor.

Tumor embolization: The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Coding Instructions

1. Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into Phases and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.

2. The first phase may be commonly referred to as an initial plan and subsequent phase may be referred to as a boost or code down, and would be recorded as Phase II, Phase III, etc. accordingly. TCR does not collect Phase II or III.

3. For purposes of this data item, photons, x-rays and gamma- rays are equivalent.

4. Use code 13 -Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90

    a. Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.

    b. Yttrium-90 microsphere radioembolization is an FDA-approved, non-surgical procedure used to treat inoperable liver cancer. With yttrium-90 microsphere radioembolization, a catheter is inserted through a tiny incision in the groin and threaded through the arteries until it reaches the hepatic artery. Once the catheter is properly placed in the hepatic artery, millions of tiny beads, or microspheres, which contain the radioactive element yttrium-90, are released into the blood stream. These microspheres lodge in the smaller blood vessels that feed the tumor. In addition to preventing blood flow to the tumor, the microspheres emit radiation that helps destroy the cancerous cells.

5. Code as brachytherapy (Radioactive implants-code 2) when the tumor embolization is performed using a radioactive agent or radioactive seeds.
6. This data item replaces the Rad- Regional RX Modality (1570) and includes converted historical values. Conversion took place upon upgrade to NAACCR v18 -compliant software, as of 2018 this data item is required for all cases regardless of diagnosis year.

Codes

Code	Description
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Treatment radiation modality unknown; Unknown if radiation treatment administered

RX Text Radiation

(NAACCR Item #2620 and 2630)

Description

Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor. Text information regarding treatment of the tumor being reported with beam radiation and/or other radiation therapy.

Explanation

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support radiation treatment **MUST BE PROVIDED BY ALL FACILITIES.**

2. Document all first course therapy radiation treatment regardless of where it was done, in date order.

3. Document if no radiation therapy was done, or if it cannot be determined if intended radiation therapy was done.

***Example*:** External beam radiation therapy completed on 6/15/18, start date not given. Estimate start date 5/2018.

***Note*:** See the **Text Documentation** section of the 2018-2019 Handbook for further explanation and examples.

DO NOT TO ENTER TEXT IN THIS FIELD WHEN TREATMENT IS EITHER NOT DONE, OR UNKNOWN IF DONE. THIS INFORMATION IS CONVEYED BY THE TREATMENT FLAGS.

RX Summary - Surgery/Radiation Sequence

(NAACCR Item #1380) (STORE 2018 page 338-339; SEER page 193-194)

Description

Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Explanation

The sequence of radiation and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions

1. For the purpose of coding radiation sequence with surgery, "Surgery" is defined as a surgical procedure to the primary site (codes 10–90) or scope of regional lymph node surgery (codes 1–7) or surgical procedure of other site (codes 1–5). If all of these procedures are coded 0, then this item should be coded 0.

2. Assign code 0 when:

    a. The patient did not have either surgery or radiation.

    b. The patient had surgery but not radiation.

    c. The patient had radiation but not surgery.

    d. It is unknown whether or not the patient had surgery and/or radiation.

        i. For death certificate only (DCO) cases

3. If a 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 of another site, then code this item 2–9 as appropriate.

4. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

   a. Assign code 4 when there at least two courses, episodes, or fractions of radiation therapy given before and at least two more after surgery to the primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).

      Example: Preoperative radiation therapy was administered to shrink a large, bulky lesion. Resection was performed. Postoperative radiation therapy was administered after resection.

   b. Assign code **7** when there are at least two surgeries; radiation was administered between one surgical procedure and a subsequent surgical procedure.

      Example 1. Sentinel lymph node biopsy. Radiation therapy. Surgery of primary site. Code Radiation Sequence with Surgery as 7 (surgery both before and after radiation).

      Example 2. Lymph node aspiration. Radiation. Surgery of primary site. Code Radiation Sequence with Surgery as 7 (surgery both before and after radiation) BECAUSE lymph node aspiration is coded in Scope of Regional Lymph Node Surge.

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.11 RX Summary-Surgery/Radiation Sequence Codes

CODE	LABEL	DESCRIPTION
0	No radiation therapy and/or surgical procedures	No radiation therapy given or **unknown** if radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s) or it is **unknown** whether any surgery was given.
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	Radiation therapy both before and after surgery	At least two courses of radiation therapy are given before and surgery to the primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).

CODE	LABEL	DESCRIPTION
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
7	Surgery both before and after radiation (for cases diagnosed 1/1/2012 and later)	Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown, but both surgery and radiation were given	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.

Example 1. Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. Use code 0.

Example 2. Patient received radiation therapy prior to resection of a lung lesion. Use code 2.

Example 3. A patient underwent excisional biopsy of a right breast mass followed by radiation therapy to breast. Use code 3.

Example 4. Preoperative radiation therapy was given to a large bulky vulvar lesion, followed by a lymph node dissection. Radiation therapy was then given to treat positive lymph nodes. Use code 4.

Example 5. A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma. Use code 5.

Example 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. Use code 6.

Example 7. A primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. Use code 9.

Example 8. Patient has an unknown primary. A radical neck dissection is done followed by radiation therapy. Use code 3.

Reason For No Radiation

(NAACCR Item #1430) (STORE 2018 page 343) (SEER page 195)

Description

Records the reason that no regional radiation therapy was administered to the patient.

Explanation

When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's failure to recommend that treatment, or due to the refusal of the patient, a family member, or the patient's guardian.

Coding Instructions

1. If *Regional Treatment Modality* Phase I (NAACCR Item #1506) is coded 00, then record the reason based on documentation in patient record.

2. Code **1** if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include radiation therapy.

   ***Example*:** A patient with Stage I prostate cancer is offered either surgery OR brachytherapy to treat his disease. The patient elects to be surgically treated. Code *Reason for No Surgery* 1.

3. 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.

4. Code **8** if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.

5. Cases coded **8** should be followed and updated to a more definitive code as appropriate.

6. Code **9** if the treatment plan offered multiple alternative treatment options, but it is unknown which treatment, if any, was provided.

Table 7.12 Reason for No Radiation Codes

CODE	DESCRIPTION
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment. Diagnosed at autopsy.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation).
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.

CODE	DESCRIPTION
9	It is unknown if radiation therapy was recommended or administered. Death certificate cases only.

Date Chemotherapy Started

(NAACCR Item 1220) (STORE 2018 page 349; SEER page 198)

Description

The date of initiation of chemotherapy that is part of the first course of treatment.

Explanation

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

1. Record the first or earliest date on which chemotherapy was administered by any facility.
2. Date format is:
   a. YYYYMMDD - when the complete date is known and valid.

      ***Example*:** A patient with colon cancer begins 5-FU on February 5, 2018. Record the date as 20180205.

   b. YYYYMM - when year and month are known and valid, and day is unknown.

      ***Example*:** A patient started chemotherapy in March 2018 but the exact day is not known. Record 201803.

   c. Blank - when no known date is applicable (no chemotherapy was given or it is unknown if chemotherapy was given).
3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. Do not leave the date blank if chemotherapy was administered. If the date is unknown code the year of diagnosis as the start date and leave the day and month blank. Document in the text field that the complete first date of chemotherapy is not known.

   ***Example*:** The patient had breast cancer diagnosed in April 2018. She has completed chemotherapy and now comes to your facility for radiation therapy. Record the date of chemotherapy as 2018.

RX Date Chemo Flag

(NAACCR Item #1221) (STORE 2018 page 350; SEER page 199)

Description

This flag explains why there is no appropriate value in the corresponding date field.

Explanation

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

Coding Instructions

1. Leave this item blank if *Date Chemotherapy Started* has a full or partial date recorded.
2. Code 10 if it is unknown whether any chemotherapy was given.
3. Code 11 if no chemotherapy is planned or given.
4. Code 12 if the *Date Chemotherapy Started* cannot be determined or estimated, but the patient did receive first course chemotherapy. Use this code **only** as a last resort.
5. Code 15 if chemotherapy is planned, but not yet started.

Table 7.13 RX Date Chemo Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if chemotherapy was given).
11	No proper value is applicable in this context (no chemotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy was given but the date is unknown and cannot be estimated).
15	Information is not available at this time, but it is expected that it will be available later (chemotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *Date Chemotherapy Started* (NAACCR Item #1220). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Chemotherapy Started* (NAACCR Item #1220) at that time.

RX Summ - Chemo (Chemotherapy)

(NAACCR Item #1390) (STORE 2018 pages 351-353; SEER pages 200-205)

Important update effective for diagnosis date January 1, 2013 and forward

A comprehensive review of chemotherapeutic drugs currently found in the SEER *Rx -Interactive Drug Database was performed and in keeping with the U.S. Food and Drug Administration (FDA), the six (6) drugs listed in the table below have changed categories from Chemotherapy to BRM/Immunotherapy.

Drug name/Brand name	Previous Category	New Category	Effective Date
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno	01/01/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno	01/01/2013
Rituximab/Rituxan	Chemotherapy	BRM/Immuno	01/01/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno	01/01/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno	01/01/2013
Cetuximab/Erbitux	Chemotherapy	BRM/Immuno	01/01/2013

Description

Chemotherapy is a chemical (or group of chemicals) administered to treat cancer. Chemotherapy consists of a group of anti-cancer drugs that inhibit the reproduction of cancer cells. Chemotherapeutic agents may be administered by intravenous infusion or given orally.

Explanation

This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy.

Coding Instructions

1. Refer to *SEER*RX* for direction on coding systemic therapy appropriately.
2. Code the chemotherapeutic agents whose actions are chemotherapeutic only; **do not code** the method of **administration**.
3. When chemotherapeutic agents are used as radiosensitizers or radioprotectants, they are given at a much lower dosage and do not affect the cancer. Radiosensitizers and radioprotectants are classified as ancillary drugs. **Do not code as chemotherapy**.

   Note: Do not assume that a chemo agent given with radiation therapy is a radiosensitizers. Seek additional information. Compare the dose given to the dose normally given for treatment.
4. The physician may change a drug during the first course of therapy because the patient cannot tolerate the original agent .
   a. This is a continuation of the first course of therapy when the chemotherapeutic agent that is substituted belongs to the same group (alkylating, antimetabolites, natural products, or other miscellaneous).
   b. Do **not** code the new agent as first course therapy when the original chemotherapeutic agent is changed to one that is NOT in the same group. Code only the original agent as first course.

c. Use *SEER*RX* and compare the subcategory of each chemotherapy agent to determine whether or not they belong to the same group (subcategory). See "Chemotherapeutic Agents" below for the groups and their definitions.

5. Code as treatment for both primaries when the patient receives chemotherapy for invasive carcinoma in one breast and also has in situ carcinoma in the other breast. Chemotherapy would likely affect both primaries.
6. Assign Code 00 when:
   a. The medical record documents chemotherapy was not given, was not recommended, or was not indicated.
   b. There is no information in the patient's medical record about chemotherapy **AND**
      i. It is known that chemotherapy is not usually performed for this type and/or stage of cancer **OR**
      ii. There is no reason to suspect that the patient would have had chemotherapy
   c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include chemotherapy.
   d. Patient elects to pursue no treatment following the discussion of chemotherapy. **Discussion does not equal a recommendation.**
   e. Watchful waiting/active surveillance is the first course of treatment (e.g., CLL).
   f. Patient diagnosed at autopsy.

   Example: Patient is diagnosed with plasma cell myeloma. There is no mention of treatment or treatment plans in the medical record. Follow-back finds that the patient died three months after diagnosis. There are no additional medical records or other pertinent information available. Assign code 00 since there is no reason to suspect that the patient had been treated.
7. Do not code combination of ancillary drugs administered with single agent chemotherapeutic agents as multiple chemotherapy. For example, the administration of 5-FU (antimetabolite) and Leucovorin (ancillary drug) is coded to single agent (Code 02).
8. Code to **01** if chemotherapy was administered as first course treatment, but the type and number of agents is not documented in the patient record.
9. Assign Code **02** when single agent chemotherapy was administered as first course therapy.

   Single agent chemotherapy: Only one chemotherapeutic agent was administered to destroy cancer tissue during the first course of therapy. The chemotherapeutic agent may or may not have been administered with other drugs classified as immunotherapy, hormone therapy, ancillary, or other treatment.

   Note: Do not code combination of ancillary drugs administered with single agent chemotherapeutic agents as multiple chemotherapy. For example the administration of 5-FU (antimetabolite) and Leucovorin (ancillary drug) is coded to single agent (Code 02).
10. Assign code **03** if multiagent chemotherapy was administered as first course therapy.

Multiple agent chemotherapy: Planned first course of therapy included two or more chemotherapeutic agents and those agents were administered. The planned first course of therapy may or may not have included other agents such as hormone therapy, immunotherapy, or other treatment in addition to the chemotherapeutic agents.

11. Assign code **82** when chemotherapy is a customary option for the primary site/histology but it was not administered due to patient risk factors such as advanced **age** or **comorbid** conditions(s) (heart disease, kidney failure, other cancer etc.).
12. Assign code **87** if the patient **refused** the recommended chemotherapy, made a **blanket refusal** of all recommended treatment, or **refused all treatment** before any was recommended and chemotherapy is a customary option for the primary site/histology.
13. Assign code **88** when the only information available is that the patient was **referred** to an oncologist or there was an insertion of a **port-a-cath**.
    a. Review cases coded **88** periodically for later confirmation of chemotherapy. If follow-up indicates the patient was never seen by the oncologist, change the code to 00.
    b. A referral to a clinical oncologist is equivalent to a recommendation.

    Chemotherapy recommended: A consult recommended chemotherapy, or the attending physician documented that chemotherapy was recommended. A referral to a clinical oncologist is equivalent to a recommendation.
14. Assign code **99** when there is no documentation that chemotherapy was recommended or administered. For death certificate only (DCO) cases.

Chemotherapeutic Agents

Chemotherapeutic agents are chemicals that affect cancer tissue by means other than hormonal manipulation. Chemotherapeutic agents can be divided into five groups:

- Alkylating agents
- Antimetabolites
- Natural Products
- Targeted therapy
- Miscellaneous

Alkylating Agents

Alkylating agents are **not cell-cycle-specific**. Although they are toxic to all cells, they are most active in the resting phase of the cell. Alkylating agents directly damage DNA to prevent the cancer cell from reproducing. Alkylating agents are used to treat many different cancers including acute and chronic leukemia, lymphoma, Hodgkin disease, multiple myeloma, sarcoma, and cancers of the lung, breast and ovary. Because the drugs damage DNA they can cause long-term damage to the bone marrow and can, in rare cases, lead to acute leukemia. The risk of leukemia from alkylating agents is “dose-dependent.” Examples of alkylating agents include:

- Mustard gas derivatives/nitrogen mustards: Mechlorethamine, Cyclophosphamide, Chlorambucil, Melphalan, and Isosfmide

- Ethylemines: Thiotepa and Hexamethylmelamine
- Alkylsulfonates: Busulfan
- Hydrazines and Trizines: Alkretamine, Procarbazine, Decarbazine, and Temozolomide
- Nitrosureas: Camustine, Lomustine and Streptozcin. Nitrosureas are unique because they can cross the blood-brain barrier and can be used in treating brain tumors
- Metal salts: Carboplatin, Cisplatin, and Oxaliplatin

Antimetabolites

Antimetabolites are **cell-cycle specific**. Antimetabolites are very similar to normal substances within the cell. When the cells incorporate these substances into the cellular metabolism, they are unable to divide. Antimetabolites are classified according to the substances with which they interfere.

- Folic acid antagonist: Methotrexate
- Pyrimidine antagonist: 5-Florouracil, Foxuridine, Cytarabine, Capecitabine, and Gemcitabine
- Purine antagonist: 6-Mercaptopurine and 6-Thioguanine
- Adenosine deaminase inhibitor: Cladribine, Fludarabine, Nelarabine, and Pentostatin

Natural Products

1. Plant Alkaloids are **cell-cycle specific** which means they attack the cells during various phases of division. They block cell division by preventing microtubule function. Microtubules are vital for cell division. Without them, division cannot occur. Plant alkaloids, as the name implies, are derived from certain types of plants.
    - Vinca alkaloids: Vincristine, Vinblastine, and Vinorelbine
    - Taxanes: Paclitaxel and Docetaxel
    - Podphyllotoxins: Etoposide and Tenisopide
    - Camptothecan analogs: Innotecan and Topotecan
2. Antitumor antibiotics are also **cell-cycle specific** and act during multiple phases of the cell cycle. They are made from natural products and were first produced by the soil fungus Streptomyces. Antitumor antibiotics form free radicals that break DNA strands, stopping the multiplication of cancer cells.
    - Anthracyclines: Doxorubicin, Danorubicin, Epirubicin, Mitoxantone, and Idabicin
    - Chromomycins: Dactinomycin and Plicamycin
    - Miscellaneous: Mitomycin and Bleomycin
3. Topoisomerase inhibitors interfere with the action of topoisomerase enzymes (topoisomerase I and II). They control the manipulation of the structure of DNA necessary for replication.
    - Topoisomerase I inhibitors: Ironotecan, Topotecan
    - Topoisomerase II inhibitors: Amasrine, Etoposide, Etoposide phosphate, Tenisopide

Targeted therapy

Targeted cancer therapies are drugs or other substances that block the growth and spread of cancer by interfering with specific molecules ("molecular targets") that are involved in the growth, progression, and spread of cancer. Targeted cancer therapies are sometimes called "molecularly targeted drugs," "molecularly targeted therapies," "precision medicines," or similar names. Examples of molecularly targeted therapy are imatinib (Gleevec), lapatinib (Tykerb), erlotinib (Tarceva), sunitinib (Sutent).

Molecular targeted therapy

MTT. Agents in this type of therapy are vastly different from the traditional chemotherapeutic agents. These new drugs are designed to target unique or abnormally-expressed molecules within cancer cells while sparing normal cells.

Miscellaneous

Miscellaneous antineoplastics that are unique—

- Ribonucleotide reductase inhibitor: Hydroxyurea
- Adrenocortical steroid inhibitor: Mitotane
- Enzymes: Asparaginase and Pegaspargase
- Antimicrotubule agent: Estramustine
- Retinoids: Bexatene, Isotretinoin, Tretinoin (ATRA)

Coding for Tumor Embolization

The American College of Surgeons Commission on Cancer (CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the SEER Program have collaborated to clarify and refine coding directives for tumor embolization and are jointly issuing the following instructions.

Definitions

- **Chemoembolization:** A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.
- **Radioembolization:** Embolization combined with the injection of small radioactive beads or coils into an organ or tumor.
- **Tumor embolization:** The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Coding Instructions

Code as Chemotherapy when the embolizing agent(s) is a chemotherapeutic drug(s). Use https://seer.cancer.gov/seertools/seerrx/ to determine whether the drugs used are classified as chemotherapeutic agents. Use codes 01, 02, 03 as specific information regarding the agent(s) is documented.

Example: The patient has hepatocellular carcinoma (primary liver cancer). From a procedure report: Under x-ray guidance, a small catheter is inserted into an artery in the groin. The catheter's tip is threaded into the artery in the liver that supplies blood flow to the tumor. Chemotherapy is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the tumor.

Do not code pre-surgical (pre-operative) embolization of hypervascular tumors with particles, coils or alcohol as a treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.14 Chemotherapy Codes

CODE	DESCRIPTION
00	None; chemotherapy was not part of the first course of therapy.
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., 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 the patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Example 1. A patient with primary liver cancer is known to have received chemotherapy. The type(s) of agent(s) delivered is not documented in the medical record. Record **code 01** and document the information in the treatment documentation text field.

Example 2. A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the fluorouracil as a single agent and the levamisole as an immunotherapeutic agent. Record **code 02** and document the information in the treatment documentation data field.

Example 3. A patient with early stage breast cancer receives chemotherapy. The medical record indicated a **combination regimen** containing doxorubicin is to be administered. Record **code 03** and document the information in the treatment documentation data field.

Example 4. Following surgical resection of an ovarian mass the physician recommends chemotherapy. The medical record states chemotherapy was not delivered and the reason is not documented. Record **code 86** and document that the medical record states chemo not delivered but no reason given.

Example 5. Patient has hepatocellular carcinoma. Under x-ray guidance, a small catheter is inserted into an artery in the groin. The catheter's tip is threaded into the artery in the liver that supplies blood flow to the tumor. A chemotherapy agent is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the diseased tissue. Record **code 02** and document that chemoembolization was done.

RX Text Chemo

(NAACCR Item # 2640)

Description

Text area for documentation of information regarding chemotherapy treatment of the reported tumor.

Explanation

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support chemotherapy treatment information **MUST BE PROVIDED BY ALL FACILITIES.**
2. Document all first course therapy chemotherapy information regardless of where it was done, in date order.
3. Document if no chemotherapy was given, or if it cannot be determined if intended chemotherapy was given.

***Example*:** 3/15/17 Oncologist recommends 4 cycles adjuvant taxol and carboplatin. PT wants treatment closer to home, referred to oncologist in his area. PT seen on 10/4/17 and physician notes patient has completed 4 cycles of taxol and carboplatin.

Note: See the Text Documentation section of the 2018-2019 Handbook (page 245) for further explanation and examples.

Do not to enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Date Hormone Therapy Started

(NAACCR Item #1230) (STORE 2018 page 258; SEER page 206)

Description

Records the date of initiation of hormone therapy that is part of the first course of treatment.

Explanation

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

1. Record the first or earliest date on which hormone therapy was administered by any facility.
2. Date format is:
    a. YYYYMMDD - when the complete date is known and valid.

    ***Example*:** A patient with recently diagnosed prostate cancer begins Lupron therapy on January 21, 2018. Record the date as 20180121.

    b. YYYYMM - when year and month are known and valid, and day is unknown.

    ***Example*:** A patient with breast cancer completed chemotherapy and then began Tamoxifen in April 2018, but the exact day is not known. Record the start date as 201804.

    c. YYYY - when the year is known and valid, and the month and day are unknown.

    ***Example*:** A patient with prostate cancer started Lupron therapy earlier this year, but there is no information regarding the month and day. Record 2018 as the start date.

    d. Blank - when no known date applies (no hormone therapy was given, or it is unknown if any hormone therapy was given).
3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. If hormone therapy was administered do not leave the date blank. If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the date of hormone treatment is unknown.

RX Date - Hormone Flag

(NAACCR ITEM #1231) (STORE 2018 pages 359; SEER page 207)

Description

This flag explains why there is no appropriate value in the corresponding date field *Date Hormone Therapy Started*.

Explanation

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

Coding Instructions

1. Leave this item blank if *Date Hormone Therapy Started* has a full or partial date recorded.
2. Code 10 if it is unknown whether any hormone therapy was given.

3. Code 11 if no hormone therapy is planned or given.
4. Code 12 if the *Date Hormone Therapy Started* cannot be determined or estimated, but the patient did receive first course hormone therapy. Use this code **only** as a last resort.
5. Code 15 if hormone therapy is planned, but not yet started.

Table 7.15 RX Date-Hormone Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if any hormone therapy was given).
11	No proper value is applicable in this context (no hormone therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, hormone therapy was given but the date is unknown and cannot be estimated).
15	Information is not available at this time, but it is expected that it will be available later (hormone therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date is provided in item *Date Hormone Therapy Started* (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Hormone Therapy Started* NAACCR Item #1230) at that time.

RX Summ - Hormone - Hormone Therapy (Hormone/Steroid Therapy)

(NAACCR Item #1400) (STORE 2018 pages 360; SEER pages 208-210)

Description

Hormone therapy is a drug or group of drugs that is delivered to change the hormone balance. Hormone therapy may affect a long-term control of the cancer growth. It is not usually curative.

Note: Hormone therapy is administered to treat cancer tissue and is considered to achieve its effect through change of the hormone balance. Some cancers, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone-responsive. Other primaries and histologic types may be hormone-responsive, such as melanoma and hypernephroma.

Explanation

This data item allows for the analysis of hormone treatment as part of the first course of therapy.

Coding Instructions

1. Code the type of hormone therapy the patient received as part of the **first course of treatment** at any facility. Hormone therapy may involve the delivery of one or a combination of agents.
2. Refer to *SEER*Rx* for direction on coding hormone therapy appropriately.
3. Code the hormonal agent given as part of combination chemotherapy regimen, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone), or COPP (cyclophosphamide, vincristine, procarbazine, prednisone), whether it affects the cancer cells or not.

   Note: Do not code prednisone as hormone therapy when it is administered for reasons other than

chemotherapeutic treatment.

4. Some types of cancers are slowed or suppressed by hormones. These cancers are treated by administering hormones and should be coded in this data field.

   ***Example*:** Endometrial cancer may be treated with progesterone. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer and should be coded.

5. Assign code **00** when
   a. The medical record states that hormone therapy was not given, was not recommended, or was not indicated
   b. There is no information in the patient's medical record about hormone therapy **AND**
      i. It is known that hormone therapy is not usually performed for this type and/or stage of cancer **OR**
      ii. There is no reason to suspect that the patient would have had hormone therapy
   c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include hormone therapy
   d. Patient elected to pursue no treatment following the discussion of hormone therapy treatment. Discussion does not equal a recommendation
   e. Watchful waiting, active surveillance (prostate)
   f. Patient diagnosed at autopsy
   g. Hormone treatment was given for a non-reportable condition or as chemoprevention prior to diagnosis of a reportable condition

   Example 1. Tamoxifen given for hyperplasia of breast four years prior to breast cancer diagnosis. Code 00 in Hormone therapy. Do not code tamoxifen given for hyperplasia as treatment for breast cancer.

   Example 2. Patient with a genetic predisposition to breast cancer is on preventative hormone therapy. Do not code hormone therapy given before cancer is diagnosed.

6. Code to **01** for thyroid replacement therapy, which inhibits the thyroid stimulating hormone (TSH). TSH is a product of the pituitary gland that stimulates tumor growth.
7. Code to 82, 85, 86, or 87 if it is known that hormone therapy is usually delivered for this type and stage of cancer, but it was not delivered.
8. Code to **87** if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment and hormone therapy is a customary option for the primary site/histology, or refused all treatment before any was recommended and hormone therapy is a customary option for the primary site/histology.
9. Code **88** when the only information available is that the patient was referred to an oncologist.

   Note: Review cases coded **88** periodically for later confirmation of hormone therapy. If follow-up with the oncologist indicates that the patient was never there, change code to 00.

10. Do not code as hormone replacement therapy when it is given because it is necessary to maintain normal metabolism and body function.
11. If prednisone or other hormone is delivered for other reasons, **do not** code as hormone therapy.

Example 1. A patient is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy. Code to 00.

Example 2. A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy. Code to 00.

Exception: Decadron is coded as hormonal treatment **for lymphoid leukemias, lymphomas, and multiple myelomas only.** It is delivered to achieve its effect on cancer tissue through change of the hormone balance.

Hormone Categories

Hormones may be divided into several categories—

- Androgens: Fluoxymesterone
- Anti-androgens: Bicalutamide (Casodex), flutamide (Eulexin), and nilutamde (Nilandron)
- Corticosteroids: Adrenocorticotrophic agents
- Estrogens
- Progestins
- Estrogen antagonists, Anti-estrogens: Fulvestrant (Faslodex), tamoxifen, and toremifene (Fareston).
- Aromatase inhibitors, Antiaromatase: Anastrozole (Arimidex), exemestane (Aromasin), and letrozole (Femara)
- GnRH or LH-RH: Lupron, Zoladex
- Polypeptid hormone release suppression: Octreotide
- Somatostatin analog: Octreotide
- Thyroid hormones: Levothyroxine, liothyronine, Synthroid

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.16 Hormone Therapy Codes

CODE	DESCRIPTION
00	None; hormone therapy was not part of the planned first course of therapy; not usually administered for this type and/or stage of cancer; Diagnosed at autopsy only
01	Hormone therapy was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration).

CODE	DESCRIPTION
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. 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.

Example 1. A patient diagnosed with metastatic prostate cancer is administered flutamide (an anti-androgenic agent) as part of the first course of therapy. Code to 01 and document the information in the Treatment Documentation data field**.**

Example 2. A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) as part of the first course of therapy and the refusal is documented in the medical record. Code to 87 and document the information in the Treatment Documentation data field**.**

Example 3. Patient with endometrial cancer is treated with **progesterone**. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer. Code to 01 and document the information in the Treatment Documentation data field.

Example 4. A patient with **follicular** or **papillary** cancers of the thyroid is treated with thyroid hormone to suppress/inhibits serum thyroid stimulating hormone (TSH). If a patient with papillary and/or follicular cancer of this is given **TSH**, code the treatment in this field. Code to 01 and document the information in the Treatment Documentation data field**.**

Example 5. Lupron is a hormonal treatment for prostate cancer. Code as hormonal treatment when **Lupron** is given for prostate cancer.

Example 6. Bromocriptine suppresses the production of prolactin, which causes growth in pituitary adenoma. Code bromocriptine as hormone treatment for pituitary adenoma.

Note: Surgical removal of organs for hormone manipulation (such as orchiectomy for prostate cancer) is not coded in this data item. Code these procedures in the data field Hematologic Transplant and Endocrine Procedures.

RX Text Hormone

(NAACCR Item #2650)

Description

Text area for information about hormonal treatment.

Explanation

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support hormone therapy MUST BE PROVIDED BY ALL FACILITIES.
2. Document all first course hormone therapy regardless of where it was done.
3. Document if no hormone therapy was given, or if it is unknown if intended hormone therapy was given.

***Example*:** After being diagnosed with adenocarcinoma of the prostate on 1/11/18, the patient opted for hormonal treatment and started Lupron on 2/1/18.

Do not enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Date Immunotherapy Started

(NAACCR Item #1240) (STORE 2018 page 365; SEER page 211)

Description

Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment.

Explanation

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

1. Record the first or earliest date on which immunotherapy or a biologic response modifier was administered by any facility. This date corresponds to administration of the agents coded in *Immunotherapy.*
2. Date format is:
    a. YYYYMMDD - when the complete date is known and valid.

    ***Example*:** A patient with multiple myeloma begins treatment with interferon on March 12, 2018. Record the date as 20180312.

    b. YYYYMM - when the month and year are known and valid and the day is unknown.

    ***Example*:** A patient with melanoma received lymphokine-activated killer cells in January 2018 the day is not known. Code 201801.

    c. YYYY - when the year is known and valid, and the month and day are unknown.

***Example*:** A patient diagnosed with lung cancer with malignant pleural effusion earlier in 2018 has been treated with Picibanil, but the exact date is not known. Record 2018 as the date immunotherapy started.

d. Blank - when no known date applies (no immunotherapy was given or it is unknown if immunotherapy was given).

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. If immunotherapy was administered do not leave the date blank. If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the start date is unknown.

RX Date - Immunotherapy Flag

(NAACCR Item #1241) (STORE 2018 pages 365; SEER page 212)

Description

This flag explains why there is no appropriate value in the corresponding date field.

Explanation

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

Coding Instructions

1. Leave this item blank if *Date Immunotherapy Started* has a full or partial date recorded.
2. Code 10 if it is unknown whether any immunotherapy was given.
3. Code 11 if no immunotherapy was planned or given.
4. Code 12 if *Date Immunotherapy Started* cannot be determined or estimated, but the patient did receive first course immunotherapy or a biologic response modifier. Use this code **only** as a last resort.
5. Code 15 if immunotherapy is planned, but not yet started.

Table 7.17 RX Date-Immunotherapy Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if immunotherapy was given).
11	No proper value is applicable in this context (no immunotherapy given)
12	A proper value is applicable but not known. This event occurred, but date is unknown (that is, immunotherapy was given but the date is unknown and cannot be estimated).
15	Information is not available at this time, but it is expected that it will be available later (immunotherapy is planned as part of first course treatment, but had not yet been started at the time of the last follow-up)

CODE	DESCRIPTION
(blank)	A valid date is provided in item *Date Immunotherapy Started* (NAACCR Item #1240). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Immunotherapy Started* (NAACCR Item #1240) at that time.

RX Summ - BRM (Immunotherapy)

(NAACCR Item #1410) (STORE 2018 pages 367; SEER pages 213-215)

Description

Immunotherapy uses the body's immune system, either directly or indirectly, to fight cancer or to reduce the side effects that may be caused by some cancer treatments. Record only those treatments that are administered to affect the cancer cells.

Explanation

This data item allows for the analysis of the administration of immunotherapeutic (biological therapy, biotherapy or biological response modifier) agents as part of the first course of therapy.

Immunotherapy is designed to:

- Make **cancer cells** more r**ecognizable** and therefore more **susceptible** to destruction by the immune system.
- **Boost** the killing power of **immune** system cells, such as T-cells, NK-cells, and macrophages.
- **Alter** the **growth patterns** of cancer cells to promote behavior like that of healthy cells.
- **Block** or **reverse** the process that **changes** a normal cell or a pre-cancerous cell into a cancerous cell.
- **Enhance** the body's ability to **repair** or **replace** normal cells damaged or destroyed by other forms of cancer treatment, such as chemotherapy or radiation.
- **Prevent** cancer cells from **spreading** to other parts of the body.

Types of Immunotherapy

- **Cancer Treatment vaccines:** Also called therapeutic vaccines, are a type of immunotherapy. The vaccines work to boost the body's natural defenses to fight a cancer. Doctors give treatment vaccines to people already diagnosed with cancer. The vaccines may:
  - Prevent cancer from returning
  - Destroy any cancer cells still in the body after other treatment
  - Stop a tumor from growing or spreading. Please refer to SEER*Rx to determine how to code non-FDA approved vaccines.
- **Interferons**: Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including

multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

- **Interleukins (IL-2)**: are often used to treat kidney cancer and melanoma.
- **Monoclonal Antibodies**: Monoclonal antibodies (Mab) are produced in a laboratory. The artificial antibodies are used in a variety of ways in systemic therapy and can be chemotherapy, immunotherapy, or ancillary drugs. Some are injected into the patient to seek out and disrupt cancer cell activities. When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy. Other Mabs are linked to radioisotopes (conjugated monoclonal antibodies). The Mab finds and attaches to the target tumor cells and brings with it the radioisotope that actually kills the tumor cell. The monoclonal antibody itself does nothing to enhance the immune system. Conjugated monoclonal antibodies such as tositumomab (Bexxar) or ibritumomab (Zevalin) are coded to the part of the drug that actually kills the cells, usually radioisotopes. A third function of Mab is to enhance the immune response against the cancer, either by identifying tumor cells that are mimicking normal cells, or by boosting the body's natural defenses that destroy foreign cells. Consult SEER*Rx for the treatment category in which each monoclonal antibody should be coded.

Coding Instructions

1. Assign code **00** when:
    a. The medical record states that immunotherapy was not given, not recommended, or not indicated
    b. There is no information in the patient's medical record about immunotherapy **AND**
        i. It is known that immunotherapy is not usually given for this type and/or stage of cancer

        OR

        ii. There is **no reason to suspect** that the patient would have had immunotherapy
    c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include immunotherapy
    d. Patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation.
    e. Active surveillance, watchful waiting is the first course of treatment (e.g., prostate)
    f. Patient diagnosed at autopsy
    g. Anti-thymocyte globulin treatment is given. Anti-thymocyte globulin is used to treat transplant rejection. Do not code as immunotherapy.
2. Code **87** when
    a. The patient refused recommended immunotherapy
    b. The patient made a blanket refusal of all recommended treatment and immunotherapy is a customary option for the primary site/histology

c. The patient refused all treatment before any was recommended and immunotherapy is a customary option for the primary site/histology

3. Code to **88** when the only information available is that the patient was referred to an oncologist.
    a. Review cases coded 88 periodically for later confirmation of immunotherapy
4. Code to **99**
    a. When there is no documentation that immunotherapy was recommended or performed **AND**
    b. Immunotherapy is usually given for this type and/or stage of cancer **OR**
    c. For death certificate only (DCO) cases

Table 7.18 Immunotherapy Codes

CODE	DESCRIPTION
00	None, immunotherapy was not part of the first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only
01	Immunotherapy administered as first course of therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration).
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 treatment. 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 immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: Table is also available in the Quick Reference, Appendix H.

RX Text Immunotherapy

(NAACCR Item #2660)

Description

Text information describing all immunotherapy or Biological Response Modifiers given as part of first course of treatment.

Explanation

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information **MUST BE PROVIDED BY ALL FACILITIES** if treatment was given, completed, or incompleted.
2. Document all first course immunotherapy regardless of where it was done.
3. Document if no immunotherapy was given, or if it cannot be determined if intended immunotherapy was given. Do not include irrelevant information.

Note: See the Text Documentation section of the 2018-2019 Handbook (page 245) for further explanation and examples.

Do not to enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

RX Summ – Hematologic Transplant/Endocrine Procedures

(NAACCR Item #3250) (STORE 2018 pages 371-372; SEER pages 216-218)

Description

This data item records systemic therapeutic procedures administered as part of the first course of treatment. These procedures include bone marrow transplants (BMT) and stem cell harvests with rescue (stem cell transplant), endocrine surgery and/or radiation performed for hormonal effect (when cancer originates at another site), and a combination of transplants and endocrine therapy.

Explanation

This treatment involves the alteration of the immune system or changes the patient's response to tumor cells, but does not involve the delivery of antineoplastic agents.

Definitions

- **Bone marrow transplant (BMT)**: Procedure where bone marrow is used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.
- **BMT Allogeneic**: Receives bone marrow from a donor. This includes haploidentical (or half-matched) transplants.
- **BMT Autologous**: Uses the patient's own bone marrow. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.

  Note: Used for breast cancer, lymphoma, leukemia, aplastic anemia, myeloma, germ cell tumors, ovarian cancer, and small cell lung cancer.
- **BMT Syngeneic**: Bone marrow received from an identical twin

- **Conditioning**: High-dose chemotherapy with or without radiation administered prior to transplant such as BMT and stem cells to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field and the radiation is coded in the Radiation field.
- **Hematopoietic Growth Factors**: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.
- **Non-Myeloablative Therapy**: Uses immunosuppressive drugs pre- and post-transplant to ablate the bone marrow. These are not recorded as therapeutic agents.
- **Peripheral Blood Stem Cell Transplant (PBSCT)**: Rescue that replaces stem cells after conditioning.
- **Rescue**: Rescue is the actual BMT or stem cell transplant done after conditioning.
- **Stem Cells:** Immature cells found in bone marrow, blood stream and umbilical cords. The stem cells mature into blood cells.
- **Stem cell transplant**: Procedure to replenish supply of healthy blood-forming cells. Also known as bone marrow transplant or umbilical cord blood transplant, depending on the source of the stem cells.
- **Umbilical cord stem cell transplant**: Treatment with stem cells harvested from umbilical cord blood.
- **Donor Leukocyte Infusions:** A type of therapy in which lymphocytes from the blood of a donor are given to a patient who has already received a stem cell transplant from the same donor. The donor lymphocytes may kill remaining cancer cells. Donor lymphocyte infusion is used to treat chronic myelogenous leukemia (CML) that has come back and myeloma. It is being studied in the treatment of other types of cancer. The use of donor leukocyte infusions for treatment of hematopoietic neoplasms, specifically leukemias, is increasing. Abstract as bone marrow transplant when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion, even if it is not listed in the treatment section of the Heme DB for the specific neoplasm.

Coding Instructions

1. Assign code **00** when:
    a. The medical record states that there was no hematologic transplant or endocrine therapy, or these were not recommended, or not indicated.
    b. There is no information in the patient's medical record about transplant procedure or endocrine therapy **AND**
        i. It is known that transplant procedure or endocrine therapy is not usually performed for this type and/or stage of cancer **OR**
        ii. There is no reason to suspect that the patient would have had transplant procedure or endocrine therapy.

c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include transplant procedure or endocrine therapy.

d. Patient elects to pursue no treatment following the discussion of transplant procedure or endocrine therapy. Discussion does not equal a recommendation.

e. Active surveillance/watchful waiting is the first course of treatment (e.g., CLL).

f. Patient diagnosed at autopsy.

2. Assign code **10** if the patient has "mixed chimera transplant (mini-transplant or non-myeloablative transplant). These transplants are a mixture of the patient's cells and donor cells.

3. Codes **11** and **12** have priority over code 10 (BMT, NOS).

4. Assign code **12** (allogeneic) for a syngeneic bone marrow transplant (from an identical twin) or for a transplant from any person other than the patient, or donor leukocyte infusion.

5. Assign code **20** when the patient has a stem cell harvest followed by a rescue or reinfusion (stem cell transplant, including allogenic stem cell transplant) as first course therapy. If the patient does not have a rescue, code the stem cell harvest as 88, recommended, unknown if administered. Use code **20** for umbilical cord stem cell transplant (single or double).

6. Assign code **30** for endocrine radiation and/or surgery. Endocrine irradiation and/or endocrine surgery are 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. 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 qualify as endocrine surgery or endocrine radiation.

Example 1. Bilateral orchiectomy for prostate cancer.

Example 2. Bilateral oophorectomy for breast cancer.

Example 3. Bilateral adrenalectomy for microadenoma.

Example 4. Bilateral hypophysectomy for pituitary cancer

Example 5. Bilateral radiation to ovaries for breast cancer, or to testicles for prostate cancer

7. Code 86 if the treatment plan offered multiple options which included a transplant, and the patient selected treatment that did include a transplant procedure.

8. Code to 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.

9. Assign code **88** when the only information available is that the patient was referred to an oncologist for consideration of hematologic transplant or endocrine procedure.

10. Assign code **99** when there is no documentation that transplant procedure or endocrine therapy was recommended or performed. For death certificate only (DCO) cases.

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.19 RX Summ– Hematiologic Transplant/Endocrine Codes

CODE	DESCRIPTION
00	No transplant procedure or endocrine therapy was administered as part of first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only
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 (Stem cell transplant) and infusion.
30	Endocrine surgery and/or endocrine radiation therapy as first course of therapy
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20) as first course of therapy.
82	Transplant procedure and/or endocrine therapy was not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of disease prior to administration).
85	Transplant procedure and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy.
86	Transplant procedure and/or endocrine surgery/radiation were not administered. It was recommended by the patient's physician, but was not administered as part of first course therapy. No reason was noted in the planned or recommended therapy.
87	Transplant procedure and/or endocrine surgery/radiation were 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	Transplant procedure and/or endocrine therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether transplant procedure or endocrine therapy was recommended or administered because it is not documented in the medical record. Death certificate only.

RX Summary Systemic/Surgery Sequence

(NAACCR Item #1639) (STORE 2018 pages 373-374; SEER pages 219-220)

Description

Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Explanation

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 item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Systemic therapy is defined as:

- Chemotherapy

- Hormone therapy
- Biological response therapy/immunotherapy
- Bone marrow transplant
- Stem cell harvests
- Surgical and/or radiation endocrine therapy

Coding Instructions

1. 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).
2. If none of the following surgical procedures were performed: *Surgical procedure of primary site* (NAACCR Item #1290), S*cope of Regional Lymph Node Surgery* (NAACCR Item #1292), S*urgical Procedure/Other Site* (NAACCR Item #1294), then this item should be coded 0.
3. 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), S*cope of Regional Lymph Node Surgery* (NAACCR Item #1292), *Surgical Procedure/Other Site* (NAACCR Item #1294), then code this item 2–9, as appropriate.
4. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

***Example*:** The sequence chemo, then surgery, then hormone therapy, then surgery is coded 4 for "chemo then surgery then hormone."

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.20 RX Summary Systemic/Surgery Sequence Codes

CODE	LABEL	DESCRIPTION
0	No systemic therapy and/or surgical procedures; Unknown if surgery and/or systemic therapy given	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. Death certificate only.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	At least two courses of systemic therapy were given, before and 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.

CODE	LABEL	DESCRIPTION
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.
7	Surgery both before and after systemic therapy (effective for cases diagnosed 1/1/2012 and later)	Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes, surgery to other regional site(s), distant site(s), or distant lymph node(s)
9	Sequence unknown	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.

Example 1. Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. Record **code 0** and document the information in the treatment documentation data field.

Example 2. Patient with prostate cancer received hormone therapy prior to a radical prostatectomy. Record **code 2** and document the information in the treatment documentation data field.

Example 3. Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen. Record **code 3** and document the information in the treatment documentation data field.

Example 4. Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen. Record **code 4** and document the information in the treatment documentation data field.

Example 5. Patient with intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity. Record **code 5** and document the information in the treatment documentation data field.

Example 6. Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver followed by 5-FU. Record **code 6** and document the information in the treatment documentation data field.

Example 7. 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. Record **code 9** and document the information in the treatment documentation data field.

Date Other Treatment Started

(NAACCR Item #1250) (STORE 2018 page 376; SEER page 221)

Description

The date other treatment began as first course of therapy.

Explanation

Records the date **other** treatment is delivered that is not included in surgery, radiation therapy, and systemic treatment.

Coding Instructions

1. Record the date the other treatment was delivered.
2. Date format is:
    a. YYYYMMDD - when the complete date is known and valid.

    ***Example*:** A patient with polycythemia vera was first treated with phlebotomy on February 20, 2018. Record Date of Other Treatment as 20180220.

    b. YYYYMM - when year and month are known and valid, and day is unknown.

    ***Example*:** A patient with pancreatic cancer is enrolled in a double-blind clinical trial in May 2018, but the day is not known. Record Date of Other Treatment as 201805.

    c. YYYY - when year is known and valid, and the month and day are unknown.

    ***Example*:** A patient diagnosed with essential thrombocythemia in 2018 and has since been treated with aspirin, but the exact date is unknown. Code the date as 2018.

    d. Blank - when no known date applies (no other therapy was given or it is unknown if other therapy was given).
3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. Do leave blank if other treatment is given. If the date is unknown record the year of diagnosis and leave the month and day blank. Document in the text field that the date is unknown.

RX Date - Other Treatment Flag

(NAACCR Item #1251) (STORE 2018 page 377; SEER page 222)

Description

This flag explains why there is no appropriated value in the corresponding date field, *Date Other Treatment Started,* NAACCR Item #1250.

Explanation

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

Coding Instructions

1. Leave this item blank if *Date Other Treatment Started* (NAACCR Item #1250) has a full or partial date recorded.
2. Code 10 if it is unknown whether any other treatment was given (*Other Treatment,* NAACCR Item #1420, is 9).
3. Code 11 if no other treatment is planned or given (*Other Treatment* 0, 7 or 8).
4. Code 12 if *Date Other Treatment Started* cannot be determined or estimated, but the patient did receive first course other treatment. Use this code **only** as a last resort.

Table 7.21 RX Date-Other Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any Other Treatment was given).
11	No proper value is applicable in this context (for example, no Other Treatment given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, Other treatment was given but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (immunotherapy is planned as part of first course treatment, but had not yet been started at the time of the last follow-up)
(blank)	A valid date value is provided in item *Date Other Treatment Started* (NAACCR Item #1250).

Other Treatment

(NAACCR Item #1420) (STORE 2018 page 378-379; SEER pages 223-225)

Description

Date Other Treatment Started is the date when an alternative treatment other than surgery, radiation, chemotherapy, immunotherapy, and hematologic transplant and endocrine procedure is initiated/started as part of the first course of therapy. Examples include phlebotomy or aspirin when administered as forms of treatment.

Explanation

Used to evaluate treatment practices and for special studies.

Coding Instructions

1. Assign code **0** when:

a. There is noinformation in the patient's medical record about other therapy **AND**
    i. It is known that other therapy is not usually performed for this type and/or stage of cancer **OR**
    ii. There is no reason to suspect that the patient would have had other therapy.
b. First course of treatment was active surveillance/watchful waiting.
c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy.
d. Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation.
e. Patient was diagnosed at autopsy.

2. Assign code **1** for
    a. Hematopoietic treatments such as: phlebotomy for polycythemia vera (9950/3) **only**

    Note: Do not code blood transfusion as treatment.

    Rationale: Blood transfusions may be used for any medical condition that causes anemia. It would be virtually impossible for the registrar to differentiate between blood transfusions used for a co-morbidity (i.e., anemia) from those given as prophylactic treatment of a hematopoietic neoplasm
    b. PUVA (Psoralen (P) and long-wave ultraviolet radiation (UVA)) in the RARE event that it is used as treatment for extremely thin melanomas or cutaneous T-cell lymphomas (e.g. Mycosis Fungoides).
    c. Photophoresis. This treatment is used ONLY for thin melanoma or cutaneous T-cell lymphoma (Mycosis Fungoides).
    d. Cancer treatment that could not be assigned to the previous treatment fields (surgery, radiation, chemotherapy, immunotherapy, or systemic therapy).
3. Assign code **2** for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy.

    Note: Hyperbaric oxygen has been used to treat cancer in clinical trials, but it is also used to promote tissue healing following head and neck surgeries. Do not code the administration of hyperbaric oxygen to promote healing as an experimental treatment.
4. Assign code **3** when the patient is enrolled in a double blind clinical trial. When the trial is complete and the code is broken, review and recode the therapy.
5. Assign code **6** for
    a. Cancer treatment administered by nonmedical personnel.
    b. **Unconventional** methods whether they are the only therapy or are given **in combination** with conventional therapy.
    c. **Alternative** therapy ONLY if the patient receives no other type of treatment.

   d. **Example:** Lupron given for breast cancer. Assign code 6. Lupron is not an approved hormone treatment for breast cancer and should not be coded in the hormone field.

6. Assign code **8** when **other therapy** was recommended by the physician **but there is no information** that the treatment was given.
7. Assign code **9** when there is no documentation that other therapy was recommended or performed
   a. For death certificate only (DCO) cases.

Note: Do not code ancillary drugs in this field. There is no coding scheme for ancillary drugs such as Leucovorin.

A quote from the website for the National Cancer Institute (NCI), Office of Cancer Complementary and Alternative Medicine (OCCAM) defines Complementary and Alternative Medicine (CAM) as any medical system, practice, or product that is not thought of as "western medicine" or standard medical care.

- Complementary medicine means it is used along with standard medicine, also called conventional medicine.
- Alternative medicine is used in place of standard treatments.

CAM treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation.

The OCCAM was established to coordinate and enhance activities of the NCI in complementary and alternative medicine research as it relates to the prevention, diagnosis, and treatment of cancer, cancer-related symptoms and side effects of conventional cancer treatment.

See complete information on types of complementary and alternative medicine specific to cancer at http://www.cancer.gov/about-cancer/treatment/cam. For additional information on cancer and other diseases, please visit https://nccih.nih.gov/health/integrative-health.

Coding for Tumor Embolization

The American College of Surgeons Commission on Cancer (CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the SEER Program have collaborated to clarify and refine coding directives for tumor embolization and are jointly issuing the following instructions.

Definitions

- **Chemoembolization**: A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.
- **Radioembolization**: Tumor embolization combined with injecting small radioactive beads or coils into an organ or tumor.
- **Tumor embolization**: The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Coding Instructions

Code as "Other Therapy" when tumor embolization is performed using alcohol as the embolizing agent. Use code 1.

Example: For head and neck primaries: Ideally, an embolic agent is chosen that will block the very small vessels within the tumor but spare the adjacent normal tissue. Liquid embolic agents, such as ethanol or acrylic, and powdered particulate materials can penetrate into the smallest blood vessels of the tumor.

Use code **1** for embolization of a tumor in a site other than the liver when the embolizing agent is unknown. **Do not** code pre-surgical (pre-operative) embolization of hypervascular tumors with agents such as particles, coils, or alcohol as a treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.22 Other Treatment Codes

CODE	TYPE	DESCRIPTION
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases. *See **Examples**
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-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 non-medical 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 patient record.
8	Recommended; unknown if done	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.

Example 1. A patient with polycythemia vera is treated with phlebotomies. Use code 1 for polycythemia vera ONLY according to the *Hematopoietic and Lymphoid Neoplasm*

Coding Manual page 22 for cases diagnosed January 2010 and later. Phlebotomy may be called blood removal, bloodletting, or venisection.

Example 2. A patient with pancreatic cancer is enrolled in a double-blind clinical trial. The treatment agents are unknown. Use code 3.

Example 3. A patient was treated for melanoma with PUVA (psoralen and long-wave ultraviolet radiation). Code this treatment as *Other Treatment,* code 1.

RX Text Other

(NAACCR Item #2670)

Description

Text area for information describing all other treatment given as part of first course of treatment.

Explanation

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information MUST BE PROVIDED BY ALL FACILITES.
2. Document all first course other treatment regardless of where it was done, in date order.
3. Document if no other treatment was given, or if it is unknown if intended other treatment was given.

Note: See the Text Documentation section of the 2018 TCR Handbook for further explanation and examples.

Do not enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

RX Summ - Treatment Status

(NAACCR Item #1285) (STORE 2018 page 234; SEER page 156)

Description

This data item summarizes whether the patient received any treatment or the tumor was under active surveillance.

Explanation

This item documents active surveillance (watchful waiting) and eliminates searching each treatment modality to determine whether treatment was given.

Coding Instructions

1. This item may be left blank for cases diagnosed prior to 2010.

2. Treatment given after a period of active surveillance is considered subsequent treatment and it is not coded in this item.
3. Use code 0 when treatment is refused or the physician decides not to treat for any reason such as the presence of comorbidities.
4. Assign code 1 when the patient receives treatment collected in any of the following fields:
    a. Surgery of primary site
    b. Scope of regional lymph node surgery
    c. Surgical procedure of other site
    d. Radiation
    e. Chemotherapy
    f. Hormone therapy
    g. Immunotherapy
    h. Hematologic transplant and endocrine procedures
    i. Other therapy

Note: Any type of first course cancer directed treatment, including surgery, is to be coded as "Treatment given".

Table 7.23 RX Summ - Treatment Status Codes

CODE	DESCRIPTION
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

Example 1. An elderly patient with pancreatic cancer requested no treatment. Use code 0.

Example 2. Patient is expected to receive radiation, but it has not occurred yet (*Reason for No Radiation* [NAACCR Item #1430] = 8). Use code 0 for this field.

Example 3. Treatment plan for a lymphoma patient is active surveillance. Use code 2.

Date of Last Contact or Death

(NAACCR Item #1750) (STORE 2018 page 394; SEER page 228-230)

Description

The date of last contact with the patient or the date the patient expired.

Explanation

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

Coding Instructions

1. Record the date the patient was last seen at your facility, date of last contact, or date of death.
2. Date format is YYYYMMDD.
3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the *Text Remarks-Other Pertinent Information* text area, document that the patient is deceased and the date of death is not available.

Vital Status

(NAACCR Item #1760) (STORE 2018 page 396) (SEER page 232)

Description

Records the vital status of the patient as of the *date of last contact or death* known to the reporting facility through all available resources. If the patient has multiple tumors, vital status should be the same for all tumors.

Explanation

This information is used for outcome studies.

Coding Instructions

1. Code the patient's vital status as of the date recorded in the *date of last contact or death* field. Use the most current and accurate information available.
2. If a patient has multiple primaries **simultaneously**, all records should have the same vital status.

Table 7.24 Vital Status Codes

CODE	DESCRIPTION
0	Dead
1	Alive

Place of Death - State

(NAACCR Item #1942)

Description

State where the patient died and where certificate of death is filed.

Explanation

When a hospital reports a place of death, the information can help in death certificate matching.

Coding Instructions

See Appendix B of the *SEER Program Code Manual* at https://seer.cancer.gov/tools/codingmanuals/index.html for numeric and alphabetic lists of places and codes. Leave blank if patient alive.

Place of Death - Country

(NAACCR Item #1944)

Description

Code for the country in which the patient died and where certificate of death is filed.

Explanation

When a hospital reports a place of death that is outside of the registry's country, the information can signal a death for which the death certificate will not be available from another state or through the NDI linkage.

Coding Instructions

Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes. Leave blank if patient alive.

Table 7.25 Place of Death Sample Codes

CODE	DESCRIPTION
USA	United States
ZZN	North America NOS
ZZC	Central America NOS
ZZX	Non-US NOS
ZZU	Unknown

Date Abstracted

(NAACCR Item #2090)

Description

Record the date the registrar determined the tumor report was complete (all first course therapy administered or treatment plan coded and documented) and the case has passed edits.

Explanation

This field is used for TCR data quality and timeliness evaluation.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
2. Record the year, month, and day (YYYYMMDD) the form was completed.

Abstractor Initials

(NAACCR Item #570) (STORE 2018 page 401)

Description

Records the initials or assigned code of the individual abstracting the case.

Explanation

This data item is used for providing feedback for quality control.

Coding Instruction

Record the initials of the person abstracting the case.

TNM Edition Number

(NAACCR Item #1060) (STORE 2018 page 436)

Description

A code that indicates the edition of the AJCC manual used to stage the case. This applies to the manually coded TNM values for the patient. It does not apply to the Derived AJCC T, N, M and AJCC Stage Group fields.

Explanation

TNM codes have changed over time and conversion is not always simple. Therefore, a case-specific indicator is needed to allow grouping of cases for comparison.

Code	Decription
00	Not staged (cases that have AJCC staging scheme and staging was not done)
01	First Edition
02	Second Edition (published 1983)
03	Third Edition (published 1988)
04	Fourth Edition (published 1992), for use for cases diagnosed 1993-1997
05	Fifth Edition (published 1997), for use for cases diagnosed 1998-2002

06	Sixth Edition (published 2002), for use for cases diagnosed 2003-2009
07	Seventh Edition (published 2009), for use with cases diagnosed 2010+
08	Eighth Edition (published 2016), for use with cases diagnosed 2018+
88	Not applicable (cases that do not have an AJCC staging scheme)
99	Edition unknown

Coding Instruction

Code based on the edition of the AJCC manual that was used to stage the case.

8

DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

TEXT DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

(NAACCR Text Item #s 2220, 2520, 2530, 2540, 2550, 2560, 2570, 2590, 2580, 2600, 2610, 2620, 2640, 2650, 2660, 2670, 2680)

Text information to support cancer diagnosis, stage, and treatment codes **MUST BE PROVIDED BY ALL FACILITIES**. Document all types of the **first course** of definitive treatment administered, regardless of where the treatment was received, in chronological order.

Text documentation is an important element of a complete abstract. It is critical for quality assurance and special studies. Text is used to support coded values and to provide supplemental information not transmitted within coded values. Complete text documentation facilitates consolidation of information from multiple reporting sources. The text field must contain a description that has been entered by the abstractor. Cancer Registry software generating text automatically from coded data cannot be utilized to support coded values. Information documenting the disease and treatment must be entered manually from the medical record. **TNM staging is not an acceptable substitute for stage documentation**.

Text documentation should explain where the cancer started, where it went (lymph nodes, other organs) and how it got there (direct extension, metastasis, implants). Clinical and pathological findings should be documented.

NO treatment: Do not enter text in the treatment text fields when treatment either not done, or unknown if done. This information is conveyed by the treatment flags. Do not use words such as "none" or "unknown" or N/A.

Always use text to document certain basic information:

1. The date of the examination or procedure (Example: 6/15/2018); keep dates in chronological order.
2. The name of the examination or procedure (Example: excisional biopsy).
3. The results of the examination or procedure-any pertinent positive or negative information (Examples: negative margins, chest X-ray negative, liver biopsy positive for metastasis).
4. The diagnostic impression, final diagnosis, or final conclusion if one is given (Example: Ductal carcinoma of left breast).
5. The planned treatment, whether or not it is known if treatment was given (Example: chemotherapy planned after left modified mastectomy).
6. The date and type of treatment given, even if it was done at another institution (Example: 6/15/2018 5FU administered at ABC hospital).
7. Specific subsite of primary site (Example: upper outer quadrant of left breast).
8. Specific number, chain of lymph nodes examined and results (Example: 3/16+ left axillary lymph nodes).
9. Specific information about metastatic spread of disease to lymph nodes and/or other organs and tissues (Example: metastasis to 15 supraclavicular lymph nodes; brain metastasis).

10. Documentation is used to verify all coded fields regarding the patient, disease, extent of disease and spread of disease. Text should be documented in the appropriate text fields.
11. Demographic information such as age at diagnosis, race and sex of the patient should also be recorded in text fields (Example: 76 year old Caucasian male).

Unknown is used when there is insufficient information to determine stage or extent of disease. If the primary site is unknown (C809) then the Summary Stage must be unknown. Document where the cancer was found if the primary site is unidentified.

Documentation is necessary to verify all coded fields regarding types and timing of treatment. Please **do not** enter text in treatment fields, including "unknown" or "n/a", when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags. If a port is placed for chemotherapy, record this information but do not code that chemotherapy was given unless it is known that it was.

Call your Health Service Region for technical assistance if additional direction is needed to determine the appropriate information to document. TCR staff may request copies of the necessary reports with your data submission in order to assist you.

Types of Reports to Review

- **Medical imaging** can provide key information for evaluating clinical extent of disease. For example, a CT of the lung can show the size and location of the tumor within the lung. It can demonstrate the presence of pleural effusion, or extension of the tumor to other tissues such as ribs, chest wall or pleura. Bone scans and MRI or CT of the brain are often used to evaluate for metastatic sites. History and Physical reports sometimes give the results from outside imaging studies. Documentation of all positive and negative findings from imaging exams should be recorded in the Summary Stage Documentation field.
- **Physical exam** or **History and Physical (H&P)** can provide the size for palpable masses and information regarding palpable lymph nodes. For example, during a digital rectal exam (DRE) the prostate is palpated. The physician will note findings such as nodularity, induration, fixation of seminal vesicles, enlargement, firmness, etc. All positive and negative findings pertinent to the patient's cancer are an important aspect of Staging and must be noted in the Summary Stage Documentation field to support coding. Patient demographics can also be found in the H&P. Record age, race and sex when available. This information is useful in record consolidation.
- **Pathology reports provide** key information including **cell type**, **grade**, **size** and **location** of tumor, **number of lesions or foci**, **depth of invasion**, **spread of tumor to other organs**, and **lymph node involvement**. Record each of these items in the Summary Stage Documentation. Be sure to record the furthest extension that the pathologist mentions, for example: confined to mucosa; into subserosa; through full thickness of abdomen wall, etc.
- **Operative reports** will often contain the surgeon's observations regarding involvement or lack of involvement of lymph nodes or other organs. The operative report will also contain detailed information of the exact type of surgery performed, tissue or organ(s) excised, and tissue or organ(s) left intact. Record these findings in the Summary Stage Documentation.
- **Discharge summaries, clinical notes, or progress reports** are good sources for treatment information. Review all available reports and document all planned treatment, as well as the date

and modalities of known treatment in the Treatment Documentation. Give specific information when available such as type and number of courses of chemotherapy. If no treatment is planned or the patient refuses recommended treatment, include this information in the text field.

- **Lab results** are used to code many of the Site Specific Data Items (SSDI's). Source documents for many of the SSDI's can be found in Appendix A, General Coding Information.

Specific Instruction on Involvement

- **Lymph Node Involvement:** Per **SEER** Summary Stage 2018, page 14, :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 recorded as involvement of lymph nodes. Other terms, such as "palpable," "enlarged," "visibly swelling," "shotty," or "lymphadenopathy" should be ignored for solid tumors. If these terms are used and there is no treatment to indicate lymph node involvement, treat the case as having no lymph node involvement." **AJCC** guidelines are different and encourages critical thinking by the abstractor.
- **Exception: Lymphomas: *Any* mention of lymph nodes is indicative of involvement**. In staging lymphomas, bilateral node involvement should be considered 2 chains for the purpose of assigning a stage. For example, bilateral involvement of inguinal lymph nodes would be considered 2 chains. Refer to **AJCC** manual, 8th ed, Chapter 79 under criteria for organ involvement for further instructions.
- **SEER Note: Inaccessible lymph nodes**: For certain primary sites, regional lymph nodes are not easily examined by palpation, observation, physical examination, or other clinical methods. These are lymph nodes within body cavities that in most situations cannot be palpated, making them inaccessible. Bladder, colon, corpus uteri, esophagus, kidney, liver, lung, ovary, prostate, and stomach are examples of inaccessible sites (this is not an all-inclusive list). When the tumor is localized and standard treatment for a localized site is done, it is sufficient to determine negative regional lymph nodes.
- **Venous Invasion:** An assessment of blood vessels **within** the primary organ. This does not constitute regional or distant spread of malignancy.
- **Lymphatic Invasion:** A microscopic assessment of involvement of the lymphatic channels **within** the primary organ and at the margins of resection. This is an assessment of the potential, from the primary tumor, to metastasize to lymph nodes, even though the tumor has extended no further than the lymph channels and is still confined to the primary site.
- **Residual Tumor:** Refers to the status of the margins after a surgical procedure of the primary site. It is important to document this information if it is available in the pathology and/or operative report. ***Microscopic residual tumor*** is identified by the pathologist through the microscope but is not grossly visualized. An example would be a positive margin of resection when the surgeon stated that the tumor was completely removed. ***Macroscopic residual tumor*** is identified during the procedure by the surgeon and is a tumor that is grossly visualized. An example of this would be tumor adhering to another structure that the surgeon could not remove.

Note: When there is doubt about assigning the appropriate stage, assign the lesser stage.

Do not over stage.

Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. The following list of terms may be used to determine involvement for **SEER Summary Staging only.**

Note: Do not use these lists for case finding or to determine multiple primaries or histology.

Table 8.1 - Consider as Involvement (SEER SS 2018)

adherent	induration
apparent(ly)	infringe/infringing
appears to	into*
comparable with	intrude
compatible with	invasion to, into, onto, out onto
consistent with	most likely
contiguous/continuous with	onto*
encroaching upon*	overstep
extension to, into, onto, out onto	presumed
features of	probable
fixation to a structure other than primary**	protruding into (unless encapsulated)
fixed to another structure**	suspected
impending perforation of	suspicious
impinging upon	to*
impose/imposing on	up to
incipient invasion	

*interpreted as involvement whether the description is clinical or operative/pathological

**interpreted as involvement of other organ or tissue

Table 8.2 - Do Not Consider as Involvement (SEER SS 2018)

abuts	extension to without invasion/involvement of
approaching	kiss/kissing
approximates	matted (except for lymph nodes)
attached	possible
cannot be excluded/ruled out	questionable
efface/effacing/effacement	reaching
encased/encasing	rule out
encompass(ed)	suggests
entrapped	very close to
equivocal	worrisome

Text Field Examples

The following table lists **suggestions** for the type of text to include for each text field.

Table 8.3 Text Field Examples

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
Other Pertinent Information #2680	• Age, sex and race of patient • Spanish/Hispanic Origin • Place of birth • Country of Birth • Insurance/primary payer information • Name of Follow Up Physician • Unknown demographic information (unknown SS#, unknown address at diagnosis) • Overflow or problematic coding issues	Date of Birth **#240** Country of Birth #**254** Sex #**220** Race 1-5 **#160-164** Spanish/Hispanic Origin **#190** Place of Birth **#250** Physician Follow Up **#2470** Primary Payer at Dx **#630**
Other Primary Tumors #2220	• Site of *Other Primary* • Morphology of *Other Primary* • DX Date of *Other Primary*	Sequence Number **#560**
Summary Stage Documentation #2600	• Date(s) of procedure(s) including biopsies and clinical procedures that provide staging information such as x-rays • Organs involved by direct extension • Size of tumor • Status of margins • Number and sites of positive lymph nodes • Metastatic sites	Date of Initial Diagnosis **#390** Diagnostic Confirmation **#490** Primary site **#400** Morphology/Behavior # **522, 523**

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
	• Physician's specialty (Surgeon, Oncologist, etc.) • Physician's comments	Regional Nodes Positive **#820** Regional Nodes Examined **#830** Laterality **#410**
Summary Stage Documentation –PE #2520	• Date of diagnosis • History relating to cancer diagnosis • Impression pertaining to cancer diagnosis • Positive and negative clinical findings • Palpable lymph nodes • Treatment plan	Date of First Contact **#580** Date of Diagnosis **#390** Race 1-5 **#160-164** Span/Hispanic Origin **#190** Sex **#220** Primary Site **#400** Laterality **#410** Histology ICD-O-3 **#522** Sequence # Hospital **#560** SEER Summary Stage 2018 **#764**
Summary Stage Documentation-Xray/Scan #2530	• Date and type of X-ray or Scan • Primary site • Histology (if given) • Tumor location • Tumor size • Lymph nodes • Record positive and negative findings • Distant disease or mets	Date of Diagnosis **#390** Primary Site **#400** Laterality **#410** Histology ICD-O-2 **#420** Histology ICD-O-3 **#522** SEER Summary Stage 2018 **#764**
Summary Stage Documentation-Scopes #2540	• Dates of endoscopic exams • Primary site • Histology • Tumor location • Tumor size • Site and type of endoscopic biopsy • Positive and negative clinical findings	Date of Diagnosis **#390** Diagnostic Confirmation **#490** Primary Site **#400** Laterality **#410** Histology ICD-O-2 **#420** Histology ICD-O-3 **#522** SEER Summary Stage 2018 **#764** RX Date-Surgery **#1300**
Summary Stage Documentation-Lab Tests #2550	• Type of lab test/tissue specimen • Both positive and negative findings • Tumor markers, special studies etc. Including : Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu, Human Chorionic Gonadotropin (hCG)	Primary Site **#400** Grade Clin **#3843 and** Grade Path **#3844** Diagnostic Confirmation **#490** Date of Diagnosis **#390** SSDIs **#3803-3933**

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
	• Date of lab tests	
Summary Stage Documentation-Op #2560	• Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived • Number of lymph nodes removed • Size of tumor removed • Documentation of residual tumor • Evidence of invasion of surrounding areas • Reason primary site surgery could not be completed	Date of Diagnosis **#390** Diagnostic Confirmation **#490** Primary Site **#400** SSDIs **#3803-3933** SEER Summary Stage 2018 **#764** Reason for No Surgery **#1340**
Summary Stage Documentation Path #2570	• Dates of procedures • Anatomic source of specimen • Type of tissue specimen • Tumor type and grade (include all modifying adjectives: predominantly, with features of etc.) • Gross tumor size • Extent of tumor spread • Involvement of resection margin • Number of lymph nodes involved and examined • Both positive and negative findings • Record any additional comments from the pathologist, including differential diagnosis considered and any ruled out or favored	Date of Diagnosis **#390** Primary Site **#400** Laterality **#410** Histologic Type ICD-O-3 **#522** Grade Clin **#3843 and** Grade Path **#3844** SSDIs **#3803-3933** Diagnostic Confirmation **#490** RX Summ-Surg Prim Site **#670** RX Sum-Scope Reg LN Sur **#1392** RX Summ-Surg Oth Reg/Dis **# 1394** SEER Summary Stage 2018 **#764** Regional Nodes Positive **#820** Regional Nodes Examined **#830** RX Date-Surgery **#1300** Reason for No Surgery **#1340** RX Summ-Surg/Rad Seq **#1380** RX Summ-Systemic/Sur Seq **#1639**

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
Final Diagnosis (Primary, Laterality) #2580	• Location of primary site of tumor • Information on laterality of tumor	Primary site **#400** Laterality **#410**
Final Diagnosis (Morphology, Behavior, Grade) #2590	• Morphology/Behavior • Grade of tumor	Morphology/Behavior **#522, #523** Clin Grade **#3843** and Path Grade **#3844**
Rx Text Surgery #2610	• Date of each surgical procedure • Type(s) of surgical procedure(s), including surgery to other and distant sites • Lymph nodes removed • Regional tissues removed • Metastatic Sites • Facility and date for each procedure • Record positive and negative findings. Record Positive findings first. • Reason for no surgery • Other treatment information, e.g. planned procedure aborted.	DX confirmation **#490** RX Date Surgery **#1300** Surgery Rx Code **#1390** RX Summ Scope of Reg LN Surgery **#1392** RX Summ-Surg Other/Dist RX Code **#1394** Reason for No Surgery **#1340** RX-Summ-Radiation # **1360**
Rx Text-Radiation #2620	• Date radiation treatment began and ended • Where treatment given • Type(s) of radiation • Planned doses • Other treatment information (discontinued after 2 treatments.)	Date Radiation Started **#1310** Phase I Radiation Treatment Modality Code **#1506** RX Summ-Surg/Rad Sequence **#1380**
Rx Text-Chemo #2640	• Date when chemotherapy began and ended • Where chemotherapy was given • Type of chemotherapy (name of agent(s) and doses planned/received • Other treatment information (treatment cycle incomplete.)	Chemotherapy Code **#1390** RX Date-Systemic **#3230** Systemic/Surgery Sequence **#1639** RX Date Chemo **#1220**
Rx Text-Hormone #2650	• Planned hormone treatment • Date treatment was started • Where treatment was given • Type of hormone or antihormone • Type of endocrine surgery or radiation • Other treatment Information, e.g. Treatment cycle incomplete.	Hormone Code **#1400** RX Date-Systemic **#3230** Systemic/Surgery Sequence **#1639**
Rx Text-BRM Immunotherapy #2660	• Date treatment began	Immunotherapy Code #**1340**

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
	• Where treatment was given e.g. at this facility, at another facility • Planned immunotherapy treatment • BRM procedures, e.g. bone marrow transplant, stem cell transplant • Type of immunotherapy given • Type of BRM agent, e.g. Interferon, BCG • Other treatment information e.g. treatment cycle incomplete.	
Rx Text-Other #2670	• Date treatment was started • Where treatment was given • Type of other treatment • Other treatment information (incomplete)	Date of Initial Treatment **#1360** RX Summ-Other **#1420** RX Date-Other **#1350**

The pertinent information in the following examples has been documented in **bold lettering** for easier identification of required text.

Do not enter text in treatment fields, including "unknown" or "n/a", when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags

EXAMPLES

Case #1 Lung

- IMAGING REPORTS
  - 2/18/18 VA Clinic: CT Chest: Findings: Supraclavicular, axillary, and mediastinal structures unremarkable. No mediastinal or hilar adenopathy. There is a 2.8 x 2.4 x 4.8cm mass in the right lower lobe. The margins are well defined with minimal peripheral ground-glass opacity, probably some degree of obstructive pneumonitis. The remainder of the lungs is clear.
  - Impression: Lobulated soft tissue mass in the right lower lobe consistent with neoplasm. No evidence of adenopathy, mediastinal or hilar spread.
  - 2/28/18 CT Brain Your Hospital: Impression: No evident disease process.
- PATHOLOGY REPORTS
  - 2/28/18 Your Hospital: Final Diagnosis: Fine Needle Aspirate, right lower lobe lung: positive for malignant cells
  - 3/1/18 Your Hospital: Final Diagnosis: Superior segment right lower lobe, resection: moderately differentiated squamous cell carcinoma, maximum tumor diameter 5.0cm, 2nd nodule in right lower lobe measures 0.5cm, resection margin free of tumor, peribronchial lymph node negative for tumor, right lower paratracheal lymph node negative for tumor, right pretracheal lymph node negative for tumor.
- CLINIC REPORTS

- 3/15/18: Oncologist recommended 4 cycles of adjuvant taxol and carboplatin. The patient would rather receive treatment closer to home and has been referred to an oncologist in that area.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

2/18/18 CT Chest: 4.8cm mass in RLL c/w neoplasm, supraclavicular, axillary, and mediastinal structures unremarkable, no mediastinal or hilar lymphadenopathy, probably some obstructive pneumonitis, remainder of lungs clear

2/28/18 Fine Needle Aspirate RLL lung: positive for malignant cells

2/28/18 Ct Brain: No evident dz process

3/1/18 RLL Resection: MD Squamous cell car, 2 nodules 5cm and 0.5cm, margin free, 0/3 peribronchial, paratracheal and pretracheal lns

Treatment Documentation (2610, 2620, 2640, 2650, 2660, 2670)

3/1/18 RLL lobectomy with mediastinal ln dissection

3/15/18 Oncologist recommends 4 cycles adjuvant taxol and carboplatin. PT wants treatment closer to home, referred to oncologist in his area, unknown if chemo done.

Case #2 Lung

- IMAGING REPORTS
  - 6/25/18 River Ranch Radiology CT Chest: I see no pneumothorax or pleural effusion. There is an 11.7 x 8.5cm soft tissue mass in the right apex. There is associated marked mediastinal lymphadenopathy with enlarged nodes in the anterior mediastinum, enlarged nodes lying lateral to the main pulmonary artery, and enlarged nodes in the pretracheal and precarinal region. There are enlarged nodes around the right hilum. The left lung appears normal.
  - Conclusion: Right upper lobe mass with associated marked mediastinal lymphadenopathy. The findings are highly suspicious for a primary carcinoma of the lung.
  - 7/1/18 Oncology Associates Bone scan: Non-specific increased uptake at L3 and L5, no obvious metastasis.
  - 7/1/18 Oncology Associates MRI brain: Diffuse cerebral atrophy
- BRONCHOSCOPY REPORT
  - 6/26/18 Bronchoscopy: The vocal cords were visualized and appeared to move normally. The bronchoscope was passed to the trachea, which was widely patent. No endobronchial lesions were noted. There was a small amount of bleeding from the right upper orifice. No lesions were noted at the right lower lobe or right middle lobe. Endobronchial biopsy was performed times six at the right upper lobe. Bleeding was minimal.
- PATHOLOGY REPORT
  - 6/26/18 Right upper lobe mass biopsy Final Diagnosis: non-small cell carcinoma

- CLINICAL REPORTS
  - 7/5/18 Oncology Clinic Consultation: This patient has at least Stage 3b disease. This condition can best be treated with a combination of chemotherapy and radiation therapy concurrently. We want to start treatment as soon as possible
  - 7/15/18 Discharge Summary: The patient has been treated with VP-16 times three days along with daily radiation therapy for a diagnosis of non-small cell carcinoma. He was hospitalized because of shortness of breath and iron deficiency anemia. At this time his condition has stabilized.

Summary Stage Documentation ((2520, 2530, 2540, 2550, 2560, 2570, 2600)

6/25/18 CT chest: no pneumothorax or pleural effusion, 11.7cm mass in rt apex, highly suspicious for lung carcinoma, marked mediastinal lymphadenopathy, enlarged nodes in anterior mediastinum, enlarged nodes lateral to main pulmonary artery, in pretracheal and precarinal region and in rt hilum, lft lung appears normal

6/26/18 Bronchoscopy: vocal cords appear to move normally, no endobronchial, rll or rml lesions

6/26/18 RUL mass bx: Non-small cell carcinoma

7/1/18 Bone Scan: no mets

7/1/18 MRI brain: diffuse cerebral atrophy

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

7/5/18 concurrent chemo/radiation therapy recommended

7/15/18 Discharge Summary: PT has been treated with VP-16 x 3 days along with daily radiation therapy

Case #3 Breast

- IMAGING REPORTS
  - 1/2/18 Mammogram: Left breast: No dominant masses, or suspicious calcifications, or architectural disturbances are present. In the right breast there is a 3.5 x 4.6cm irregular spiculated mass in the lower-outer quadrant.
  - Impression: Large mass in the lower-outer quadrant of the right breast, biopsy is recommended.
  - 1/13/18 CT Chest: COPD with mild parenchymal scarring. No evidence of cardiomegaly. There is bone destruction of posterior ribs/spine. CT Abdomen and Pelvis no abnormal findings.
  - Impression: Bone destruction of posterior ribs/spine, probably mets from known breast cancer.
- PATHOLOGY REPORTS

- 1/10/18 Core biopsy right breast lower outer quadrant: Final Diagnosis: Infiltrating ductal carcinoma, poorly differentiated, ER and PR positive, HER2 ICH 0, negative.

- CLINICAL REPORTS
  - 1/15/18 Surgery consult: Patient noted a mass in the lower-outer quadrant of her right breast. There is marked lymphadenopathy in the right axilla. The left breast is within normal limits.
  - HEENT: Clear conjunctivae, pupils equal, round and reactive to light. Nasal passages clear without drainage.
  - Neck: Supple, full range of motion. No thyromegaly, trachea is midline.
  - Lungs: No wheezing or crackles. There are no bronchial breath sounds or pleural rub.
  - Abdomen: Soft, non-tender, non-distended without hepatosplenomegaly or masses. Normal bowel sounds.
  - Patient will be referred to Radiation Oncology for consideration of radiation therapy to known bony mets.
  - 2/1/18 Oncology Note: Patient has decided to try alternative therapy and has declined radiation therapy and chemotherapy.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

1/2/18 Mammogram: Lt breast no masses, Rt breast 4.6cm mass in LOQ, biopsy recommended.

1/10/18 Bx rt breast LOQ Infil ductal car, PD, ER and PR positive, HER2 IHC 0-Negative

1/13/18 CT Chest: Bone destruction posterior ribs/spine, probably mets from breast ca, CT Abdomen/Pelvis: no abnormal findings

1/15/18 Surg consult: marked lymphadenopathy in rt axilla

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

1/15/18 Surg Consult: Patient referred to radiation oncology for consideration of radiation therapy to bony mets.

2/1/18 Oncology note: Pt has decided to try alternative therapy, declined radiation therapy and chemotherapy.

Case #4 Breast

- IMAGING REPORTS
  - 6/1/18 Mammogram: In the right breast there is a 1.2 x 1.5cm mass in the upper-outer quadrant. There is no evidence of axillary lymphadenopathy. The left breast appears normal.
  - 6/14/18 Chest Xray: Within normal limits
  - 6/14/18 Bone Scan: Impression: No evidence of skeletal disease. Thoracic and lumbar spine negative for metastases.

- PATHOLOGY REPORTS
  - 6/8/18 Right breast fine needle aspiration cytology: Adenocarcinoma
  - 6/15/18 Right breast modified radical mastectomy: Final Diagnosis: Infiltrating ductal carcinoma, tubular type, 1.4cm, margins clear, Bloom Richardson score 3, no dermal or lymphatic invasion, no evidence of tumor in 32 regional lymph nodes, Estrogen and Progesterone Receptors negative, HER2 IHC 3+, positive.
- CLINICAL REPORTS
  - 6/1/18 History and Physical: Family physician noted 2cm mass in right breast on physical exam. No pain or tenderness; no nipple discharge; no skin changes. Slight nipple retraction. Freely movable mass. Left breast: no masses palpated. No enlarged lymph nodes.
  - 10/13/18 Oncology Clinic Follow-up Note: Patient started 3 cycles of adjuvant Adriamycin and Cytoxan on 7/20/18, recently completed and now has begun Tamoxifen.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

6/1/18 Mammogram: 1.5cm mass rt breast UOQ, no lymphadenopathy, lt breast appears normal

6/1/18 H&P 2cm mass in right breast, no masses palpated in lt breast, no enlarged lymph nodes

6/14/18 CXR: WNL; Bone Scan: no evident mets

6/8/18 Rt Breast fine needle aspiration = adenoca

6/15/18 Rt breast mastectomy: infiltrating duct carcinoma, tubular type, 1.4cm, margin clear, Bloom Richardson score 3, 0/32 LNS positive, ER/PR negative, HER2 IHC 3+ positive.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

6/15/18 Rt breast modified radical mastectomy

10/13/18 Oncology note: pt had 3 cycles Adriamycin and Cytoxan begun on 7/20/17, recently completed and has begun Tamoxifen.

Case #5 Colon/Rectum

- IMAGING REPORTS:
  - 4/20/2018 CT Abdomen and Pelvis
    1. Two areas of circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the right lower quadrant/right pelvic region with multiple low-density lesions being noted in the liver. Although these could represent incidental benign hepatic cysts, metastatic liver disease cannot be excluded at this time as colonic carcinoma is one of the causes of cystic liver metastasis. It should be noted although there are shotty lymph nodes present, there is no definite lymphadenopathy demonstrated.

2. History of uterine cancer in 2003 with evidence of prior hysterectomy. This is not usually a cause of cystic liver metastasis.
3. Otherwise, unremarkable CT scan of the abdomen and pelvis with other incidental findings as noted above.

- 4/25/18 Whole Body PET Scan

  Conclusion: Radionuclide uptake in the left abdomen, representing a nonspecific finding.

  No focal areas of increased uptake are seen in the liver to suggest hepatic metastasis.

- PATHOLOGY REPORTS:
  - 4/15/2018 Final Diagnosis: Colon biopsy at 135cm moderately differentiated adenocarcinoma, mucin producing signet ring cell, high grade
  - 5/1/2018 Final Diagnosis right hemicolectomy
    A. High-grade mucin-producing signet ring cell carcinoma, 4 cm in size and located in colon near ileocolic junction, tumor invades pericolonic adipose tissue, (PT3)
    B. No evidence of lymph node metastasis among seven lymph nodes. (PNO)
    C. Excision margin is negative.
    D. Microsatellite Instability-Stable
    E. KRAS mutated
    F. Normal heterozygous state (Normal LOH)
- OPERATIVE REPORT:
  - Date of Procedure: 5/1/18
  - PREOPERATIVE DIAGNOSIS: Right colon cancer
  - POSTOPERATIVE DIAGNOSIS: Right colon cancer, with adhesive bowel disease.
  - PROCEDURES PERFORMED: Exploratory laparotomy, lysis of adhesions, right hemicolectomy.
  - Findings: On exploration of the abdomen, the liver was palpated found to be unremarkable. There were no lesions in the colon other than in the right colon. In the small bowel, there were adhesions, especially in the terminal ileum, adherent to the cecum.
- ONCOLOGY CONSULT: 5/15/18
  - HISTORY OF PRESENT ILLNESS: Patient is a 56-year old female who had a diagnosis of endometrial cancer, status post-surgery followed by radiation therapy fifteen years ago. A few weeks ago the patient had a routine colonoscopic examination and the patient was found to have lesions in the right side of the colon. The patient underwent surgery on May 1, 2018.
  - ASSESSMENT: The patient has a new diagnosis of high-grade mucin producing signet ring cell adenocarcinoma of colon. This is about 4 cm in size with pericolonic tissue invasion. Based on these reports and findings, the patient may benefit from adjuvant chemotherapy.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

4/15/18 Colon biopsy at 135cm: Moderately differentiated adenoca, mucin producing signet ring cell, high grade.

4/20/18 Ct Abdomen and Pelvis: 2 areas circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the rt lower quadrant/rt pelvic region. Multiple liver lesions could represent benign hepatic cysts, mets liver dz cannot be excluded; shotty lymph nodes present, no definitive lymphadenopathy, otherwise unremarkable CT abdomen and pelvis; pt has a history of uterine cancer in 2003 with evidence of hysterectomy

4/25/18 Whole body PET scan: no focal areas of increased uptake in liver to suggest hepatic mets

5/1/18 Operative report: Liver palpated, found to be unremarkable, no lesion in colon other than rt colon

5/1/18 Right hemicolectomy: High-grade mucin producing signet ring cell carcinoma, 4cm, located near ileocolic junction, invades pericolonic adipose tissue, 0/7LNS positive, excision margin is negative; MSI-stable, KRAS mutated, normal LOH

5/15/18 Oncology consult: The patient may benefit from adjuvant chemotherapy; unknown if chemotherapy given.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/1/18 Right Hemicolectomy

Case #6 Melanoma

- IMAGING REPORTS
  - 5/10/18 CT Chest: Impression: Probably malignant involvement of left axillary lymph nodes. Several lymph nodes seen in supraclavicular region too small to characterize. The remainder of the exam is normal
- PATHOLOGY REPORTS
  - 5/3/18 Final Diagnosis: Shave biopsy skin of left forearm, Malignant melanoma
  - 5/11/18 Final Diagnosis: Wide excision of skin of left forearm, Malignant melanoma, nodular type, Clark's Level III, Breslow's depth 1.0mm, papillary dermis invaded, no ulceration present no mitosis present. Margins of resection free, but within less than 2mm. LDH Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay
- ONCOLOGY REPORT
  - 6/15/18 The patient was started on an interferon regimen today.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

5/3/18 Shave bx skin of lt forearm: Malignant melanoma

5/10/18 CT chest: Probably malignant involvement of lt axillary lymph nodes, remainder of exam normal

5/11/18 Wide exc skin of lt forearm: Malignant melanoma, nodular type, Clark's Level 3, Breslow's depth 1.0mm, papillary dermis invaded, no ulceration, no mitosis, margin free but within less than 2mm, LDH Range 1: Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/11/18 Wide excision of skin of lt forearm

6/15/18 started interferon regimen

Case #7 Melanoma

- IMAGING REPORTS
  - 11/18/2018 Chest Xray: Within normal limits
  - 11/24/18 CT Chest, Abdomen and Pelvis: Impression: Nonspecific soft tissue nodule in the right upper lobe. This is nonspecific but would be consistent with benign parenchymal scar or granuloma. The remainder of the lungs is clear.
  - There is no evidence of metastatic disease in the chest, abdomen or pelvis.
- PATHOLOGY REPORTS
  - Outside Facility:
    - 11/13/18 Final Diagnosis: Excision of lesion on right side of neck, 1.5 x .0.8 x 0.5 cm specimens contains a pigmented, 0.4 x 0.3cm area consistent with malignant melanoma in situ, extending to margins of excision.
  - Your Facility:
    - 11/25/18 Final Diagnosis: Wide re-excision skin of right neck, Inflammation and organizing granulation tissue, negative for any residual melanoma, margins of resection negative.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

11/18/18 CXR: Within normal limits

11/24/18 CT Chest/abdomen/pelvis: No evidence of mets in chest, abdomen or pelvis

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

11/13/2018 Exc of lesion rt side of neck: 0.4x0.3cm malignant melanoma in situ, Ext to margin

11/25/18 Wide re-excision of skin rt neck, negative for residual melanoma, margins negative

Case #8 Lymphoma

- IMAGING REPORTS
  - 2/2/18 CT Chest Impression: Extensive right and left hilar lymphadenopathy, enlarged lymph nodes in the mediastinum.
  - 2/2/18 CT Abdomen Impression: Splenomegaly, otherwise within normal limits.
  - 2/4/18 PET scan: Intense focus of tracer uptake seen in peri-portal region consistent with lymphoma.
- PATHOLOGY REPORTS
  - 2/3/18 Biopsy of left axillary lymph nodes, Follicular Lymphoma, Gr 1
  - H&P
  - 2/2/18 Patient presents with bilateral cervical and axillary lymphadenopathy, night sweats, and fevers for last couple of months.
- ONCOLOGY CONSULT
  - 2/13/18 The patient was started on combination chemotherapy including Rituxan on February 5 and has done well with the exception of nausea. We will start him on a trial of antiemetics.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

2/2/18 H&P Pt has bilateral cervical and axillary lymphadenopathy, hx of night sweats, fevers

2/2/18 CT Chest: rt and lt hilar lymphadenopathy, enlarged lymph nodes in the mediastinum

2/2/18 CT Abdomen: Splenomegaly, otherwise within normal limits

2/3/18 Biopsy lt axillary lns: Follicular Lymphoma, Gr 1

2/4/18 PET scan: focus of tracer uptake in peri-portal region consistent with lymphoma

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

2/5/18 Combination chemotherapy including Rituxan, other types of chemo not mentioned

***Case #9* Prostate**

- IMAGING REPORTS
  - 4/14/18 CT Abdomen/Pelvis Impression:
    - Tiny cyst in the liver.
    - No lymphadenopathy in abdomen or pelvis

  - 4/14/18 Bone scan Impression: Evidence of previous fracture in right 13th rib, otherwise negative bone scan
- PATHOLOGY REPORTS
  - 4/1/18 Final Diagnosis: Prostate core needle biopsy, adenocarcinoma present in 8 of 13 cores, Gleason Score 3+3=6
- CLINICAL REPORTS
  - 3/27/18 Surgical consult: Patient is seen in consultation because PSA elevated at 6. DRE shows slightly enlarged prostate with no nodularity or induration. The abdomen and pelvis are examined and show no palpable abnormalities
  - 7/1/18 Patient was counseled regarding various treatment options including radiation therapy, surgery and hormonal treatment. He decided to proceed with external beam radiation therapy and this was completed on 6/15/18.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

3/27/18 PE: DRE shows slightly enlarged prostate with no nodularity or induration, abdomen and pelvis with no palpable abnormalities, PSA 6

4/1/18 Prostate core needle biopsy: adenocarcinoma in 8/13 cores, Gleason Score 3+3=6

4/14/18 CT Abdomen/Pelvis: no lymphadenopathy in abdomen or pelvis

4/14/18 Bone scan: negative

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

External beam radiation therapy completed on 6/15/18, start date not given; estimate start date 5/2018

A

APPENDIX A:
CODING GUIDELINES AND RECORDING INSTRUCTIONS

Appendix A consists of Coding Guidelines and Instructions for recording information such as Site-Specific coding, lab tests, tumor markers, and other reports for Site Specfic Data Items (SSDI's) The information comes from SEER, STORE 2018, NAACCR Required Status Table in the Data dictionary and other sources.

SSDI's collected by the TCR:

- The site specific surgery codes are from The American College of Surgeons Commission on Cancer Standards for Oncology Registry Entry (STORE 2018).
- The Site-Specific Surgery Codes can be found in Appendix B of the STORE Manual on page 439

This appendix combines the coding guidelines and instructions for recording information per site-specific sites such as the breast, bladder, colon and rectosigmoid, esophagus, lung and Malignant and benign brain and CNS tumors. It includes links to instruction manuals (SEER Program Coding and Staging Manual and 2018 Solid Tumor Rules), SSDI manual, grade manual, and surgery codes. You will also have access to links for SSDI schema per site. This appendix should not replace the 2018 manuals and resources for cases diagnosed in 2018 and forward.

SEER Program Coding and Staging Manual Includes data item descriptions, codes, and coding instructions for cases diagnosed 01/01/2018 and forward. Provides detailed instructions and examples to promote consistent abstracting and coding.

2018 Solid Tumor Rules

2007 MPH Rules and 2018 Solid Tumor Rules are used based on **date of diagnosis**.

- Tumors diagnosed 01/01/2007 through 12/31/2017: Use 2007 MPH Rules
- Tumors diagnosed 01/01/2018 and later: Use 2018 Solid Tumor Rules
- The original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2018 or later in the same primary site: Use the 2018 Solid Tumor Rules

  Notes:

  - The 2007 Multiple Primary & Histology rules and the 2007 General Instructions are to be used for cases diagnosed 01/01/2007 to 12/31/2009 for Cutaneous Melanoma, Other Sites.
  - Rectosigmoid and Rectum are included in the 2018 Colon rules.
  - Peripheral nerves are included in the 2018 Colon rules.

Refer to the 2018 Solid Tumor Rules for determining the site, number of primaries, and histology.

ICD-O-3 Book & 2018 Guidelines (for ICD-0-3 Histology Code and Behavior Updates) are used to determine the histology if the information cannot be found in the Solid Tumor Rules.

Grade Manual is the primary resource for documentation and coding instructions for Grade for cases diagnosed on or after 01/01/2018.

2018 Summary Staging Manual Provides instructions for categorizing how far a cancer has spread from its point of origin using a combination of precise clinical and pathological documentation of the extent of the disease. This staging system applies to all primary sites and histologies.

AJCC 8th Edition Cancer Staging Manual provides instructions on the TNM staging rules for applicable

sites. Click here for a quick 1-page resource on the general rules and rationale.

Site-Specific Data Item (SSDI) Manual The Site-Specific Data Item (SSDI) manual is the primary resource for documentation and coding instructions for site-specific data items introduced in 2018. An important new concept introduced in 2018 is the use of a Schema ID to define the applicable SSDIs and grade table for a particular tumor, based on primary site, histology, and in some cases, additional information. The appropriate Schema ID will be defined by registry software and will not have to be assigned by the registrar. However, a Schema ID Table defining the Schema ID number, description and associated SSDIs is provided in the SSDI Manual (see page 31) for reference purposes.

In addition to Schema IDs, the Schema ID Table provides the AJCC 8th Edition Chapter for which the SSDIs and grade table defined by the Schema ID apply (see page 28).

SSDI/Grade Schema List by site can be found on the NAACCR website

SITE-SPECIFIC CODING GUIDELINES

Breast

https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Breast_2018.pdf

Site codes

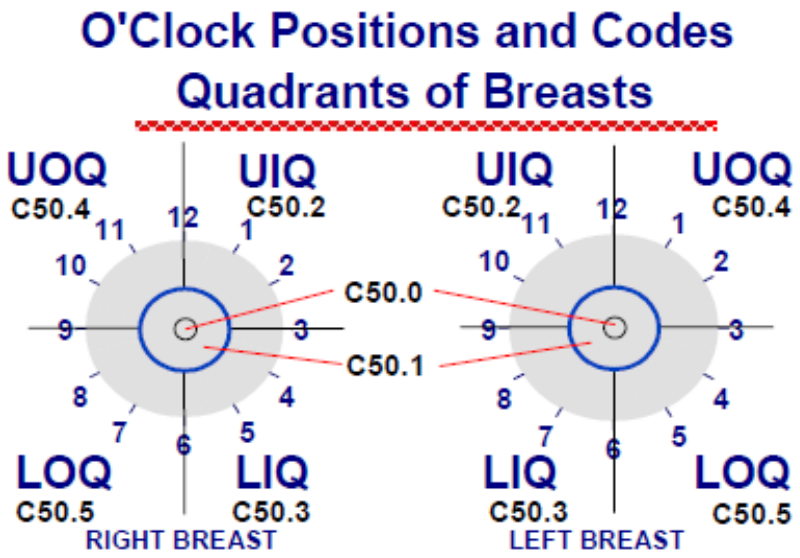
The Site Code Table contains terms used in **mammograms, clinical diagnosis,** and less frequently the **operative and pathology reports** to describe the **location** of the tumor. Find the **term** in Column 1 and use the **site code** in Column 2.

Refer to the **SEER Program Coding and Staging Manual** and **COC STORE Manual** for a **priority list** for using documents such as mammograms, operative reports, and pathology reports to determine the tumor location

Terms and Descriptive Language	Site Term and Code
Areolar Nipple Paget disease **without** underlying tumor *Note:* Paget with underlying tumor is coded to the quadrant of breast in which the underlying tumor is located	Nipple **C500**
Above nipple Area extending 1 cm around areolar complex Behind the nipple Below the nipple Beneath the nipple Central portion of breast Cephalad to nipple Infra-areolar Lower central Next to areola NOS Next to nipple Retroareolar Subareolar Under the nipple Underneath the nipple	Central portion of breast **C501**
Superior inner Superior medial Upper inner quadrant (UIQ) Upper medial	Upper inner quadrant of breast **C502**

Terms and Descriptive Language	Site Term and Code
Inferior inner Inferior medial Lower inner quadrant (LIQ) Lower medial	Lower inner quadrant of breast **C503**
Superior lateral Superior outer Upper lateral Upper outer quadrant (UOQ)	Upper outer quadrant of breast **C504**
Inferior lateral Inferior outer Lower lateral Lower outer quadrant (LOQ)	Lower outer quadrant of breast **C505**
Axillary tail of breast Tail of breast NOS Tail of Spence	Axillary tail of breast **C506**
12:00 o'clock 3:00 o'clock 6:00 o'clock 9:00 o'clock Inferior breast NOS Inner breast NOS Lateral breast NOS Lower breast NOS Medial breast NOS Midline breast NOS Outer breast NOS Overlapping lesion of breast Superior breast NOS Upper breast NOS	Overlapping lesion of breast **C508** *Note:* This is a **single tumor which overlaps quadrants/subsite.**

Additional Subsite Descriptors
The position of the tumor in the breast may be described as the positions on a clock



Code the primary site to **C508** when:

- There is a single tumor in two or more subsites and the subsite in which the tumor originated is unknown
- There is a single tumor located in the 1,3,6, or 9 o'clock position on the breast

Code the primary site to **C509** when

- There are two non-contiguous tumors in different quadrants/subsites of the same breast
- Unknown/unable to identify in which quadrant/subsite the tumor is located
- Inflammatory carcinoma; diffuse tumor

Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with; (duct **and** lobular is equivalent to duct **with** lobular)

  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**.
- Behavior code /2; DCIS; intraductal; noninfiltrating; noninvasive; carcinoma in situ
- Carcinoma; adenocarcinoma
- De novo; new tumor; frank (obsolete term)
- Duct; ductal; NST (no special type); carcinoma NST; mammary carcinoma
- Mammary; breast
- Majority; major; predominantly; greater than 50%
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Topography; site code

Ambiguous Terminology

Code the histology when described by ambiguous terminology **ONLY** when:

- Histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)

  Example*:* The pathology diagnosis is carcinoma NST consistent with pleomorphic carcinoma. The oncology consult says the patient has pleomorphic carcinoma of the right breast. This is clinical confirmation of the diagnosis, code pleomorphic carcinoma. The case meets the criteria in bullet 1.
- Patient is receiving treatment based on the histology described by an ambiguous term

  Example*:* The pathology diagnosis is sarcoma consistent with liposarcoma. The treatment plan says the patient will receive the following treatment for liposarcoma of the breast. Treatment plan confirms liposarcoma; code liposarcoma. The case meets the criteria in bullet 2.
- Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

***Example**:* Outpatient biopsy says probably apocrine carcinoma. The case is accessioned (entered into the database) as required by both SEER and COC. No further information is available. Code the histology apocrine carcinoma. The case meets the criteria in bullet 3.

List of Ambiguous Terminology

- Apparently
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

Note: If the histology described by ambiguous terminology does not meet any of the criteria in bullets 1, 2, or 3, **DO NOT CODE** the histology.

Priority Order for Using Documentation to Identify Histology

Use documentation in the following priority order to identify the **histology type(s):**

1. Biomarkers
2. Tissue or pathology report from primary site (in priority order)
    A. Addendum(s) and/or comment(s)
    B. Final diagnosis / synoptic report as required by CAP
    C. CAP protocol

    ***Notes**:*

    - Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
    - The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority. The final diagnosis is often the synoptic CAP report.

- The CAP protocol is a checklist which:
  - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care.
  - Allows physicians to check multiple histologies

3. Cytology (nipple discharge or fine needle aspirate (FNA) of primary site)
4. Tissue/pathology from a metastatic site
   - Code the behavior /3.
   - The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan.
5. Radiography: The following list is not in priority order because they are not a reliable method for identifying specific histology(ies). They are, however, valuable in diagnosing a malignancy.
   A. Mammography
   B. Ultrasound
   C. CT
   D. MRI
6. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
   A. Treatment Plan
   B. Documentation from Tumor Board
   C. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
   D. Physician's reference to type of cancer (histology) in the medical record

   ***Notes**:*
   - Code the specific histology when documented.
   - *Note 2:* Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

When a histology term is not found in Table 3 (2018 STR Breast page 25), refer to ICD-0 and any errata. If not found, then consult Ask a SEER Registrar: https://seer.cancer.gov/registrars/contact.html

The following data items are used to collect ER and PR information:

- Estrogen Receptor Summary [NAACCR Data Item #3827]
- Progesterone Receptor Summary [NAACCR Data Item #3915]

Do not use results from the following tests to record ER or PR results

- Oncotype Dx
- MammaPrint

- EndoPredict
- PAM 50 (Prosigna)
- Any other test that records HER2

(see page 170 of SSDI Manual: https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547)

Site-Specific Data Items (SSDI)/Clinical Grade and Pathological Grade

https://apps.naaccr.org/ssdi/schema/breast/?breadcrumbs=(~schema_list~)

Primary Site	Histology
C500-C506, C508-C509	8000-8700, 8982-8983, 9700-9701
C501-C506, C508-C509	8720-8790

Name	Default Value	Used for Staging	NAACCR Item	Required By
ER Summary	9	Yes	NAACCR #3827	All
PR Summary	9	Yes	NAACCR #3915	All
HER2 Overall Summary	9	Yes	NAACCR #3855	All
Grade Clinical	9	Yes	NAACCR #3843	All
Grade Pathological	9	Yes	NAACCR #3844	All

Grade ID 12-Clinical Grade and Pathological Grade Instructions (see pages 71 and 73)

Grade Coding Instructions and Tables

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00480	Breast	48.1	Breast: DCIS and Paget
00480	Breast	48.2	Breast: Invasive Breast Cancers

Surgery Codes

C50.0–C50.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Click here for surgery codes for the breast.

Additional Resources

- Click here for the 2018 Solid Tumor Rules for breast.
- Click here for the SSDI Manual for coding breast (see page 170)

Bladder

https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Bladder_2018.pdf

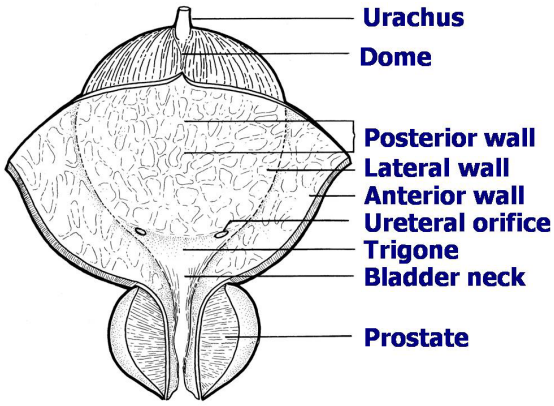
Site codes

Use the following table to determine the correct site code.

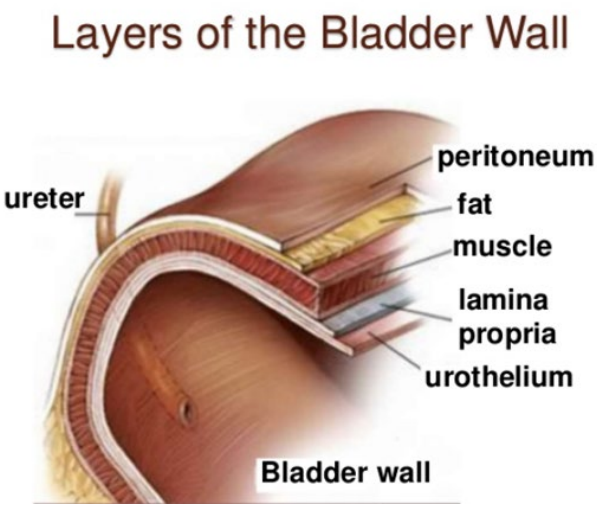
Column 1 contains the site term and ICD-O code.

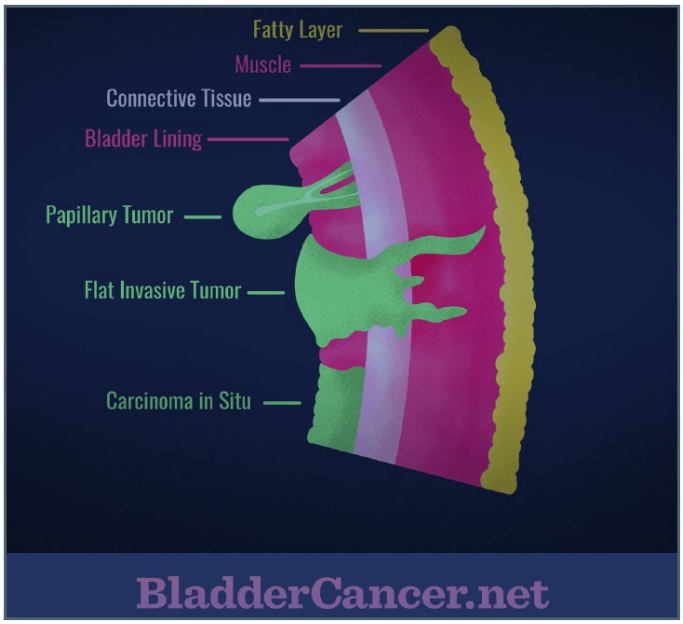
Column 2 contains synonyms for the site code and term in column 1.

Site Term and code	Synonyms
Bladder, anterior wall **C673**	-
Bladder, dome **C671**	Roof Vault Vertex
Bladder, lateral wall **C672**	Lateral to ureteral orifice Left wall Right wall Sidewall
Bladder neck **C675**	Internal urethral orifice Vesical neck
Bladder NOS **C679**	Lateral posterior wall (**no hyphen**)
Bladder, overlapping lesion **C678**	Fundus Lateral-posterior wall (**hyphen**)
Bladder, posterior wall **C674**	-
Bladder, trigone **C670**	Base of bladder Below interureteric crest Below interureteric field Below interureteric ridge Floor of bladder
Bladder, urachus **C677**	Mid umbilical ligament
Bladder, ureteric orifice **C676**	Just above ureteric orifice
Overlapping lesion of urinary organs **C688**	-
Paraurethral gland **C681**	-
Renal pelvis **C659**	Pelvis of kidney Pelviureteric junction Renal calyces Renal calyx
Ureter **C669**	-
Urethra **C680**	Cowper gland Prostatic utricle Urethral gland
Urinary system NOS **C689**	-



Source: TNM Atlas, 3rd edition, 2nd revision





Priority for Coding Primary Site

The following list is in priority order:

1. Code overlapping lesion of urinary bladder **C678** when:
    a. A single tumor of any histology overlaps subsites of the bladder
    b. A single tumor or discontinuous tumors which are:
        i. **Urothelial carcinoma in situ 8120/2 AND**
        ii. Involves only bladder and one or both ureters (no other urinary sites involved)

***Note*:** Overlapping non-invasive tumors of the bladder and ureter almost always originate in the bladder. They extend/overlap into the ureter by spreading along the mucosa. It is important to code these primaries to bladder C678, NOT to overlapping lesion of urinary organs C688.

2. Code bladder NOS **C679** when there are **multiple non-contiguous tumors** within the **bladder AND** the subsite/origin is unknown/not documented.
3. Code overlapping lesion of urinary organs **C688** when a single tumor overlaps two urinary sites and the origin is unknown/not documented.

   Note: See the following examples of contiguous urinary sites where overlapping tumor could occur:

   c. Renal pelvis and ureter

   d. Bladder and urethra

   e. Bladder and ureter (for all histologies other than in situ urothelial cell)
4. Code Urinary System NOS C689 when there are multiple discontinuous tumors in multiple organs within the urinary system.

   Note: The physician subject matter experts (SME) discussed the issue of coding primary site for multifocal/multicentric urinary tract carcinoma. Although the SMEs understood and acknowledged the importance of coding a specific primary site, there is no literature or criteria for determining the organ of origin for multiple tumors involving multiple urinary sites.

Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with

  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**. Urothelial carcinoma **and** small cell neuroendocrine carcinoma is **equivalent** to urothelial carcinoma **with** small cell neuroendocrine carcinoma.
- Carcinoma; adenocarcinoma
- Flat transitional cell carcinoma; flat urothelial carcinoma; urothelial carcinoma in situ; noninvasive flat carcinoma; in situ transitional cell carcinoma
- Multifocal; multicentric
- Noninvasive may describe either in situ papillary carcinoma or flat urothelial cell carcinoma
- Papillary transitional cell carcinoma; papillary urothelial carcinoma
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Topography; site code
- Tumor; mass; tumor mass; lesion; neoplasm

- The terms tumor, mass, tumor mass, lesion, and neoplasm are **not** used in a standard manner in clinical diagnoses, scans, or consults. **Disregard** the terms **unless** there is a physician's statement that the term is malignant/cancer
- These terms are used **ONLY** to determine multiple primaries
- **Do not** use these terms for casefinding or for determining reportability

- Type; subtype; variant
- Urothelial carcinoma; transitional cell carcinoma
- Urothelium; epithelium; transitional epithelium

Terms That Are Not Equivalent

- Noninvasive; papillary urothelial carcinoma; flat urothelial carcinoma

  Note: Noninvasive is not equivalent to either papillary urothelial or flat urothelial carcinoma. Both Ta and Tis tumors are technically noninvasive. Code the histology specified by the pathologist.

In US, 90% of bladder tumors are urothelial carcinoma; less than 5% are pure squamous cell carcinoma or pure adenocarcinoma.

For all sites except breast and CNS, 2018 Rules instruct "Code the most specific histology from biopsy or resection. When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor)."

Priority Order for Using Documentation to Identify Histology

1. Code the histology diagnosed prior to neoadjuvant treatment.
   a. Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
   b. Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
2. Code the histology using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable for staging.

The priority list is used for single primaries (including multiple tumors abstracted as a single primary)

Use documentation in the following priority order to identify the histology type(s):

Code the most specific pathology/tissue from either resection or biopsy.

- The term "most specific" usually refers to a subtype/variant.
- The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
- When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

1. Biomarkers
2. Tissue or pathology report from primary site (in priority order)
    a. Addendum(s) and/or comment(s)
    b. Final diagnosis / synoptic report as required by CAP
    c. CAP protocol
    - Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
    - The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority. The final diagnosis is often the synoptic CAP report.
    - The CAP protocol is a checklist which:
        - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care
        - Allows physicians to check multiple histologies
3. Cytology (usually urine)
4. Tissue/pathology from a metastatic site
    - Code the behavior /3.
    - The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan and only physician documentation.
5. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
    a. Treatment Plan
    b. Documentation from Tumor Board
    c. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
    d. Physician's reference to type of cancer (histology) in the medical record
    - Code the specific histology when documented.
    - Code the histology to 8000 (cancer/malignant neoplasm NOS) or as stated by the physician when nothing more specific is documented.
6. Scans: CT, MRI. There is no priority order because scans are not a very reliable method for identifying specific histology(ies) for these sites.

Coding Rules

1. Code the most specific histology or subtype/variant, regardless of whether it is described as:

a. The majority or predominant part of tumor
b. The minority of tumor
c. A component

- The terms above must describe a carcinoma or sarcoma.
- When the most specific histology is described as differentiation or features, see #2.

2. Code the histology described as differentiation or features/features of ONLY when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
   - Do not code differentiation or features when there is no specific ICD-O code.
   - A NOS with features or differentiation is a single histology. Go directly to the rules.
3. Code the histology described by ambiguous terminology (list follows) ONLY when:
   - Histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)
   - Example: The pathology diagnosis is sarcoma NOS consistent with leiomyosarcoma. The oncology consult says the patient has leiomyosarcoma of the bladder. This is clinical confirmation of the diagnosis, code leiomyosarcoma. The case meets the criteria in bullet 1.
   - Patient is receiving treatment based on the histology described by an ambiguous term
   - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

List of Ambiguous Terminology

- Apparently
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

Note: If the histology described by ambiguous terminology does not meet any of the criteria in

bullets 1, 2, or 3, DO NOT CODE the histology.

Do not code histology when described as:

- Architecture
- Configuration
- Foci; focus; focal
- Pattern

Bladder Wall Pathology

The bladder wall is composed of three layers. There may be "sub layers" within the major layers of the bladder.

Bladder Layer	Sub layer	Synonyms	Staging	Description
Mucosa		Epithelium, transitional epithelium, urothelium, mucosal surface, transitional mucosa	No blood vessels, in situ/noninvasive	First layer on inside of bladder; Lines bladder, ureters, and urethra
	Basement membrane		No invasion of basement membrane is in situ Invasion/penetration of basement membrane is invasive	Single layer of cells that lies beneath the mucosal layer separating the epithelial layer from the lamina propria
	Submucosa	Submucous coat, lamina propria, areolar connective tissue	Invasive	Areolar connective tissue interlaced with the muscular coat. Contains blood vessels, nerves, and in some regions, glands
Lamina propria		Submucosa, Suburothelial connective tissue, subepithelial tissue, stroma, muscularis mucosa, transitional epithelium	Invasive	
Muscle	Bladder wall	Muscularis, muscularis propria, muscularis externa, smooth muscle	Invasive	

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

Grade Coding Instructions and Table

Primary Site	Histology
C670-C679	8000-8700, 8720-8790, 9700-9701

Site- Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

Name	Default Value	Used for Staging	NAACCR Item	Required By
Grade Clinical Grade Pathological	9	No	NAACCR #3843 NAACCR #3844	CCCR/Canada COC NPCR SEER

Grade ID 19-Clinical and Pathological Grade Instructions (see page 96 and 97)

Grade Coding Instructions and Tables

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00610	Kidney Renal Pelvis	61.1	Renal Pelvis and Ureter: Urothelial Carcinomas
00610	Kidney Renal Pelvis	61.2	Renal Pelvis and Ureter: Squamous Cell Carcinoma and Adenocarcinoma
00620	Bladder	62.1	Urinary Bladder: Urothelial Carcinomas
00620	Bladder	62.2	Urinary Bladder: Squamous Cell Carcinoma and Adenocarcinoma

Surgery Codes

Bladder C670–C679

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

For the surgery codes for the bladder, visit
https://seer.cancer.gov/manuals/2018/AppendixC/Surgery_Codes_Bladder_2018.pdf

Additional resources

- SEER Program Coding and Staging Guidelines for the bladder: https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Bladder_2018.pdf
- 2018 Solid Tumor Rules for the bladder: https://seer.cancer.gov/tools/solidtumor/Urinary_STM.pdf

Colon and Rectum

Colon: https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Colon_2018.pdf

Rectum: https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Rectosigmoid_2018.pdf

Site Codes

Site Term and Code	Parts of the Colon and Rectum
C180	Cecum 6x9 cm pouch covered with peritoneum
C181	Appendix A vermiform diverticulum located in the lower cecum
C182	Ascending colon, Right colon 20-25 cm long, located behind the peritoneum
C183	Hepatic flexure Lies under right lobe of liver
C184	Transverse colon Lies anterior in abdomen, attached to gastrocolic ligament
C185	Splenic flexure Near tail of pancreas and spleen
C186	Descending colon, left colon 10-15 cm long, located behind the peritoneum
C187	Sigmoid colon, Pelvic Loop extending distally from border of left posterior major psoas muscle

Site Term and Code	Parts of the Colon and Rectum
C188	Rectosigmoid segment Between 10 and 15 cm from anal verge
C189	Colon, NOS
C199	Rectosigmoid, Colon & Sigmoid
C209	Rectum 12 cm long; upper third covered by peritoneum; no peritoneum on lower third which is also called the rectal ampulla. About 10 cm of the rectum lies below the lower edge of the peritoneum (below the peritoneal reflection), outside the peritoneal cavity
C211	Anal canal Most distal 4-5 cm to anal verge

Primary Site

Code the subsite with the most tumor when the tumor overlaps two subsites of the colon and the point of origin cannot be determined.

Code C188 when both subsites of the colon are equally involved.

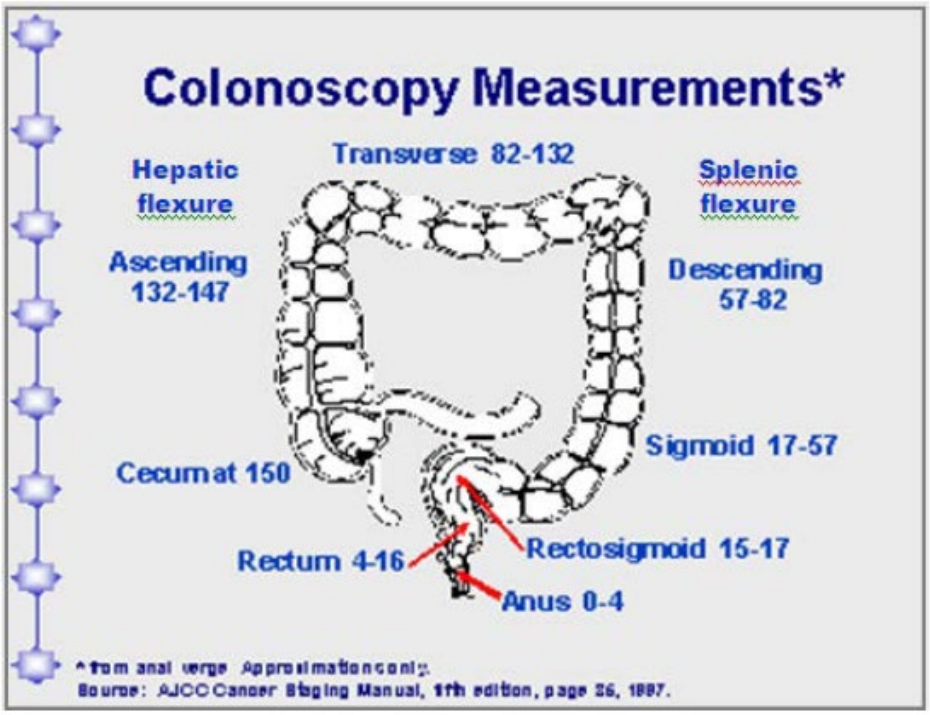
A tumor is classified as rectosigmoid when differentiation between rectum and sigmoid is not possible.

A tumor is classified as rectal if:

- lower margin lies less than 16 cm from the anal verge or
- any part of the tumor is located at least partly within the supply of the superior rectal artery

Terminology

- Anal verge: The lower (distal) end of the anal canal, junction between the skin of the anal canal and the perianal skin.
- Anorectal ring: Top (proximal end) of the anal canal.
- Dentate line: An anatomic landmark located between the anal verge and the anorectal ring indicating where the rectum changes to the anal canal. Also called the pectinate line.
- Tenia coli: (Plural: teniae coli). Any one of three longitudinal bands of smooth muscle in the colon. They extend from the cecum to the sigmoid colon. Each band is approximately 8 mm wide throughout most of the colon. The widths of the teniae increase in the sigmoid colon and eventually fuse into a covering of longitudinal muscle in the rectum.



Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with

  Note: "And" and "with" are used as synonyms when describing multiple histologies within a single tumor.
- Carcinoid; NET; neuroendocrine tumor
- Carcinoma; carcinoma NOS; adenocarcinoma; adenocarcinoma NOS; intestinal type adenocarcinoma 8140
- De novo; frank adenocarcinoma (obsolete)
- Familial polyposis; familial adenomatous polyposis (FAP) 8220
- Intramucosal; lateral extension within the mucosal layer of the GI tract
- Invasion through colon wall; extension through colon wall; transmural

  Note: The term "transmural" is used to describe extension through all layers of the wall, but not past the wall OR extension through the serosa into the mesentery. Read the pathology report carefully.
- Mucinous; mucoid; mucous; colloid
- Neuroendocrine carcinoma; NEC
- Polyp; adenoma; polyp NOS; adenomatous polyp
  - The term "polyp" means projecting from a surface.

  - There are many kinds of polyps. Most common are adenomas, which are part of the adenoma-cancer sequence.
  - Other types of polyps include hyperplastic, juvenile, Peutz-Jeghers and serrated adenoma/polyp.
- Serosa; visceral peritoneum
- Simultaneous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- Tumor; mass; tumor mass; lesion; neoplasm
  - The terms tumor, mass, tumor mass, lesion, and neoplasm are not used in a standard manner in clinical diagnoses, scans, or consults. Disregard the terms unless there is a physician's statement that the term is malignant/cancer
  - These terms are used ONLY to determine multiple primaries
  - Do not use these terms for casefinding or determining reportability

Terms That Are Not Equivalent Or Equal

- Component is not equivalent to subtype/variant

  Note: Component is only coded when the pathologist specifies the component as a second carcinoma.
- The words "exophytic" and "polypoid" are not synonymous with either an adenoma or an adenomatous polyp. The terms "exophytic" and "polypoid" refer to anything projecting from the bowel mucosa into the lumen. The lesion may be benign, malignant, or inflammatory
- Polypoid adenocarcinoma is not equivalent to adenocarcinoma in a polyp

Priority Order for Using Documentation to Identify Histology

- Code the histology diagnosed prior to neoadjuvant treatment.
  - Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
  - Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
- Code the histology assigned by the physician. Do not change histology in order to make the case applicable to staging.
- Code the **most specific** pathology/tissue from either **resection or biopsy**.
  - The term "most specific" usually refers to a subtype/variant.
  - The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
  - When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

1. Biomarkers
2. Tissue or pathology report from primary site (in priority order)
    A. Addendum(s) and/or comment(s)
    B. Final diagnosis
    C. CAP protocol
    - Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
    - The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority.
    - The CAP protocol is a checklist which:
    - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care
    - Allows physicians to check multiple histologies
    - The CAP protocol must be documented in one location. Most frequently, in the:
        - The pathology final diagnosis
        - Addendum to the path report
3. Tissue/pathology from a metastatic site
    a. Code the behavior /3.
    b. The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan.
4. Scan: The following list is in priority order.
    A. CT
    B. PET
    C. MRI
5. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
    A. Documentation from Tumor Board
    B. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
    C. Physician's reference to type of cancer (histology) in the medical record
    - Code the specific histology when documented.
    - Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

6. Cytology (seldom used for colon, rectosigmoid and rectum)

Note: Only code differentiation or features when there is a specific code for the NOS with differentiation or the NOS with features in Table 1 or the ICD-O and all updates. This instruction applies to single and multiple histologies.

Ninety-eight percent of colon cancers are adenocarcinoma and adenocarcinoma subtypes

Polyps are now disregarded when coding histology. For example, adenocarcinoma in an adenomatous polyp is coded as adenocarcinoma 8140. For the purposes of determining multiple primaries, tumors coded as adenocarcinoma in a polyp for pre-2018 cases should be treated as adenocarcinoma 8140.

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

https://apps.naaccr.org/ssdi/schema/colon_rectum/?breadcrumbs=(~schema_list~)

Colon and Rectum

Primary Site	Histology
C180, C182-C189, C199, C209	8000-8149, 8154, 8157, 8160-8231, 8243-8248, 8250-8682, 8690-8700, 8720-8790, 9700-9701

SSDI Data Items

Name	Default Value	Used for Staging	NAACCR Item	Required By
Grade Clinical	9	No	NAACCR #3843	CCCR/Canada COC NPCR SEER
Grade Pathological	9	No	NAACCR #3844	
Microsatellite Instability (MSI)	8	No	NAACCR #3890	CCCR/Canada COC SEER

Grade ID 02-Clinical Grade and Pathological Grade Instructions

Grade Coding Instructions and Tables (see page 40 and 41)

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00200	Colon and Rectum	20	Colon and Rectum

Surgery Codes

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

- Colon C180–C189: https://seer.cancer.gov/manuals/2018/AppendixC/Surgery_Codes_Colon_2018.pdf

- Rectosigmoid C199: https://seer.cancer.gov/manuals/2018/AppendixC/Surgery_Codes_Rectosigmoid_2018.pdf
- Rectum C209: https://seer.cancer.gov/manuals/2018/AppendixC/Surgery_Codes_Rectum_2018.pdf

Additional resources

- SEER Program Coding and Staging guidelines for the colon: https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Colon_2018.pdf
- 2018 Solid Tumor Rules for the colon: https://seer.cancer.gov/tools/solidtumor/Colon_STM.pdf

Esophagus

https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Esophagus_2018.pdf

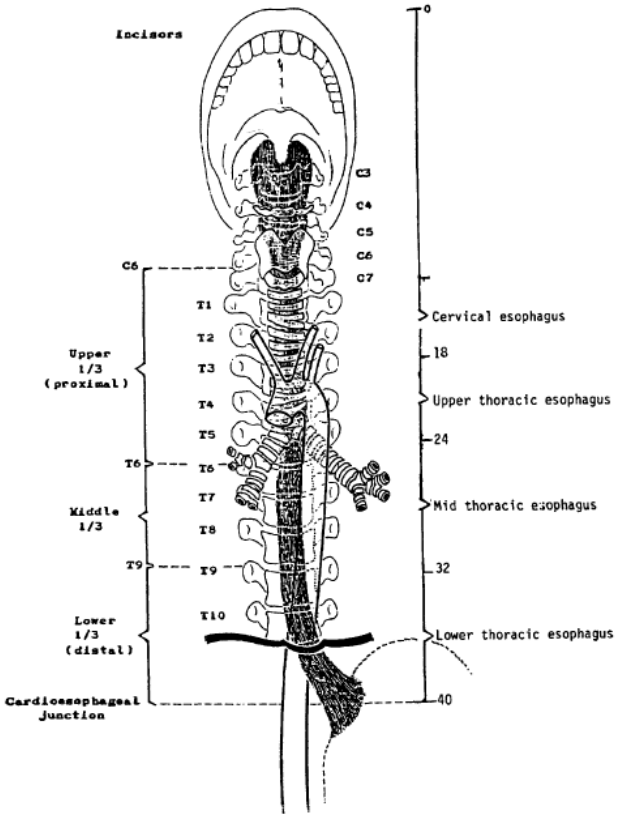
Site codes

Code	Site
C15	Esophagus
C15.0	Cervical esophagus
C15.1	Thoracic esophagus
C15.2	Abdominal esophagus
C15.3	Upper third of esophagus
	Proximal third of esophagus
C15.4	Middle third of esophagus
C15.5	Lower third of esophagus
	Distal third of esophagus
C15.8	Overlapping lesion of esophagus
C15.9	Esophagus, NOS

There are two systems that divide the esophagus into three subsites. The first system divides the esophagus into the upper third, middle third, and lower third. The second system describes the subsites as the cervical esophagus, upper thoracic esophagus, mid thoracic esophagus, and lower thoracic (abdominal) esophagus. The subsites for these two different systems are not identical.

Assign the ICD-O-3 topography code that describes the primary site documented in the medical record. See the following image for an illustration of both systems.

Measurements of the Esophagus (From the Incisors to the Stomach)



Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

https://apps.naaccr.org/ssdi/schema/esophagus_gejunction/?breadcrumbs=(~schema_list~)

Esophagus (Including GE Junction) (Excluding Squamous)

Primary Site	Histology	Schema Discriminator 1	Schema Discriminator 2
C150-C155, C158-C159	8000-8015, 8021-8046, 8060, 8071-8073, 8075-8076, 8078-8082, 8084-8552, 8561-8700, 8720-8790, 9700-9701		
C160	8000-8015, 8021-8046, 8060, 8071-8073, 8075-8076, 8078-8082, 8084-8149, 8154, 8157, 8160-8231, 8243-8248, 8250-8552, 8561-8682, 8690-8700, 8720-8790, 9700-9701	2	
C150-C155, C158-C159	8020		2
C160	8020	2	2

Name	Default Value	Used for Staging	NAACCR Item	Required By
Schema Discriminator 1	<*BLANK*>	Yes	NAACCR #3926	All
Schema Discriminator 2	<*BLANK*>	Yes	NAACCR #3927	All
Grade Clinical Grade Pathological	9 9	No Yes	NAACCR #3843 NAACCR #3844	CCCR/Canada COC NPCR SEER

Esophagus (Including GE Junction) Squamous

https://apps.naaccr.org/ssdi/schema/esophagus_including_ge_junction_squamous/?breadcrumbs=(~schema_list~)

Primary Site	Histology	Schema Discriminator 1	Schema Discriminator 2
C150-C155, C158-C159	8050-8054, 8070, 8074, 8077, 8083, 8560		
C160	8050-8054, 8070, 8074, 8077, 8083, 8560	2	
C150-C155, C158-C159	8020		1, 9
C160	8020	2	1, 9

Name	Default Value	Used for Staging	NAACCR Item	Required By
Schema Discriminator 1	<*BLANK*>	Yes	NAACCR #3926	All

Grade ID 03-Clinical Grade and Pathological Grade Instructions

Grade Coding Instructions and Tables (see page 43 and 44)

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00161	Esophagus (including GE junction) Squamous	16.1	Esophagus and Esophagogastric Junction: Squamous Cell Carcinoma

00169	Esophagus (including GE junction) (excluding Squamous)	16.9	Esophagus and Esophagogastric Junction: Adenocarcinoma

Surgery Codes

Esophagus C150–C159

(Except for M9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Surgery codes of the esophagus:
https://seer.cancer.gov/manuals/2018/AppendixC/Surgery_Codes_Esophagus_2018.pdf

Additional Resources

- 2018 Solid Tumor Rules of the esophagus: https://seer.cancer.gov/tools/solidtumor/Other_sites_STM.pdf
- SSDI Manual for coding the esophagus: https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547

Lung

https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Lung_2018.pdf

Cancers **from many primary sites metastasize** to the **lung**. It is important to **rule out metastases** from another organ/site before abstracting a lung primary.

Site Codes

Use this table to determine the correct site code. Do not use for other fields such as laterality.

- Column 1 contains the terminology used by physicians or on scans to describe lung "masses" (not lymph nodes).
- Column 2 indicates whether the term is used only for the right lung, or only for the left lung, or if it is used for both the right or left lung.
- Column 3 contains the ICD-O term and site code

Terminology	Laterality	Site Term and Code
Bronchus intermedius **Carina** **Hilus of lung** **Perihilar**	Bilateral	Mainstem bronchus **C340** *Note*: **Bronchus intermedius** is the portion of the **right mainstem bronchus** between the upper lobar bronchus and the origin of the middle and lower lobar bronchi
Lingula of lung	Left	Upper lobe **C341**
Apex **Apex of lung** **Lung apex** **Pancoast tumor** **Superior lobar bronchus** **Upper lobe bronchi**	Bilateral	Upper lobe **C341**
Middle lobe **Middle lobe bronchi**	Right	Middle lobe **C342**
Base of lung **Lower lobar bronchus** **Lower lobe** **Lower lobe bronchi** **Lower lobe segmental bronchi**	Bilateral	Lower lobe **C343**
Overlapping lesion of lung	Bilateral	Overlapping lesion of lung **C348** *Note*: **One** lesion/tumor which **overlaps two or more** lobes

Terminology	Laterality	Site Term and Code
Bronchus NOS **Bronchogenic** **Extending up to the hilum** **Extending down to the hilar region** **Lung NOS** **Pulmonary NOS** **Suprahilar NOS**	Bilateral	Lung NOS **C349** *Note*: Includes • Multiple tumors in different lobes of ipsilateral lung **OR** • Multiple tumors in ipsilateral lung; unknown if same lobe or different lobe **OR** • Tumor in bronchus, unknown if mainstem or lobar bronchus **OR** • Tumor present, unknown which lobe
Lobar bronchi NOS **Lobar bronchus NOS**	Bilateral	Code the lobe in which the lobar bronchus tumor is present **C34__** *Note*: When **lobe** of origin is **not documented/unknown**, **code** to lung NOS **C349**

Coding Rules

1. The mainstem bronchus starts at the trachea and extends only a few centimeters into the lung where it connects with the secondary bronchus and divides into secondary bronchi.
    a. Each lobe of the lung has secondary bronchi
        i. The right lung has 3 secondary bronchi, one in each of the three lobes: upper; middle, and lower
        ii. The left lung has 2 secondary bronchi, one in each of the two lobes: upper and lower
    b. Code to mainstem bronchus C340 when it is specifically stated in the operative report and/or documented by a physician.
    c. When only called bronchus, code to the lobe in which the bronchial tumor is located
2. Refer to the SEER Program Coding and Staging Manual (see page 88) for a priority list for using documents such as radiographic reports, operative reports, and pathology reports to determine the tumor location.

Equivalent or Equal Terms

These terms can be used interchangeably:

- Adenocarcinoma, carcinoma
- And; with

  Note: "And" and "with" are used as synonyms when describing multiple histologies within a single tumor.
- Carcinoma; adenocarcinoma
- Majority; major; predominantly; greater than 50%
- Non-small cell carcinoma 8046; a broad category which includes all histologies in Table 3 (see page 3 STR) except for small cell carcinoma/neuroendocrine tumors (NET Tumors) 8041 and all subtypes
- Simultaneous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- Squamous cell carcinoma, SCC, epidermoid carcinoma
- Tumor, mass, tumor mass, lesion, neoplasm, nodule
  - The terms tumor, mass, tumor mass, lesion, neoplasm and nodule are not used in a standard manner in clinical diagnoses, scans, or consults. Disregard the terms unless there is a physician's statement that the term is malignant/cancer
  - These terms are used ONLY to determine multiple primaries
  - Do not use these terms for casefinding or determining reportability
- Type; subtype; variant

Terms That Are Not Equivalent Or Equal

This is a list of terms that are not equivalent. There are no casefinding implications.

- Bilateral is NOT equivalent to either single primary or multiple primaries. See Multiple Primary rules for instructions.
- Bronchus is not always equivalent to mainstem bronchus. The mainstem bronchus only extends a few centimeters into the lung.
  - Code to mainstem bronchus C340 when it is specifically stated in the operative report and/or documented by a physician
  - When only called bronchus, code to the lobe in which the bronchial tumor is located
- Component is not equivalent to subtype/variant

  Note: Component is only coded when the pathologist specifies the component as a second carcinoma.
- Mucinous; colloid (for lung only)

Note: The new codes for mucinous adenocarcinoma were implemented so mucinous carcinoma and colloid carcinoma could be analyzed separately.

- Mucin-producing/mucin-secreting carcinoma 8481 is not equivalent to mucinous carcinoma 8253 (new code for lung primaries only)
  - Mucin-producing/secreting tumors produce mucin, but not enough to be classified as mucinous carcinoma
  - The terms mucin-producing and mucin-secreting are still reportable. This bullet simply states they are not equivalent or equal to mucinous carcinoma
- Multilocular is not equivalent to multinodular (see glossary for further information. The electronic glossary will be available in 2019)

For all sites except breast and CNS, 2018 Rules instruct "Code the most specific histology from biopsy or resection. When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor)."

Priority Order for Using Documents to Identify Histology

- Code the histology diagnosed prior to neoadjuvant treatment.
  - Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
  - Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
- Code the histology assigned by the physician. Do not change histology in order to stage.

The priority list is used for single primaries (including multiple tumors abstracted as a single primary)

Code the most specific histology from either resection or biopsy.

- The term "most specific" usually refers to a subtype/variant.
- The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
- When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

1. Biomarkers
2. Tissue or pathology report from primary site (in priority order)
   a. Addendum(s) and/or comment(s)
   b. Final diagnosis
   c. CAP protocol
   - Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.

- The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority.
- The CAP protocol is a checklist which:
  - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care.
  - Allows physicians to check multiple histologies
  - The CAP protocol must be documented in one location. Most frequently, in the:
    - Pathology final diagnosis
    - Addendum to the path report

3. Cytology (Fine needle biopsy, pleural fluid) from primary site
4. Tissue/pathology from a metastatic site
   a. Code the behavior /3.
   b. The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan.
5. Scan: The following list is in priority order.
   a. CT
   b. PET
   c. MRI
   d. Chest X-ray
6. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
   a. Documentation from Tumor Board
   b. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
   c. Physician's reference to type of cancer (histology) in the medical record
   - Code the specific histology when documented.
   - Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

Site-Specific Data Items (SSDI)/Grade

https://apps.naaccr.org/ssdi/schema/lung/?breadcrumbs=(~schema_list~)

Primary Site	Histology
C340-C343, C348-C349	8000-8700, 8720-8790, 8972, 8980, 9700-9701

SSDI Data Items

Name	Default Value	Used for Staging	NAACCR Item	Required By
Grade Clinical	9	No	NAACCR #3843	CCCR/Canada
Grade Pathological	9	No	NAACCR #3844	COC NPCR SEER

Grade ID 02-Clinical and Pathological Grade Instructions

Grade Coding Instructions and Tables (see pages 40 and 41)

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00360	Lung	36	Lung

Surgery Codes

Lung C340–C349

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Surgery codes for the lung:
https://seer.cancer.gov/manuals/2018/AppendixC/Surgery_Codes_Lung_2018.pdf

Additional resources

- SEER Program Coding and Staging guidelines for the lung:
  https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Lung_2018.pdf
- 2018 Solid Tumor Rules for the lung: https://seer.cancer.gov/tools/solidtumor/Lung_STM.pdf

Skin

https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Melanoma_2018.pdf

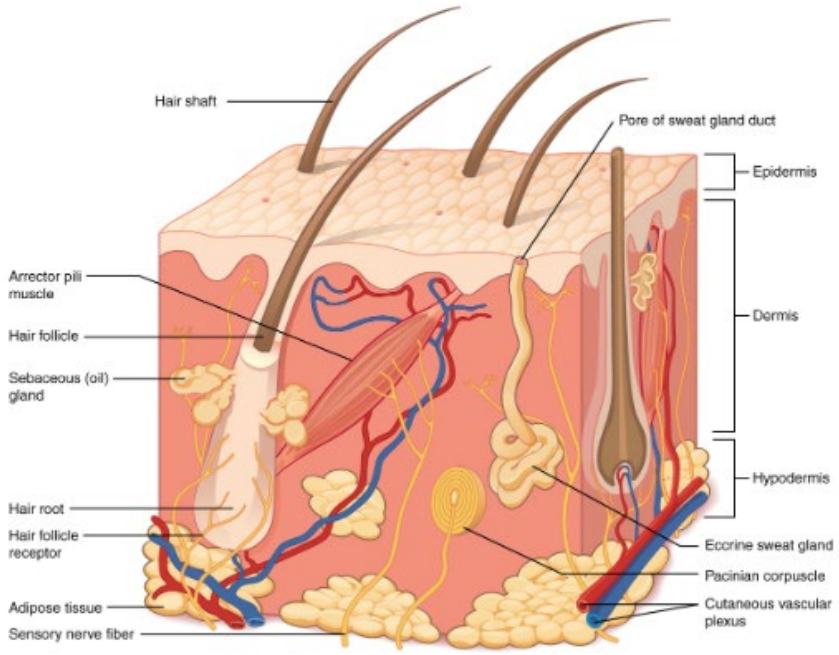
Melanoma C440-C449 with Histology 8720-8780

Cases diagnosed 01/01/2018 or later, early or evolving melanoma of any type is not reportable. This includes both invasive and in situ melanomas; early or evolving are not reportable.

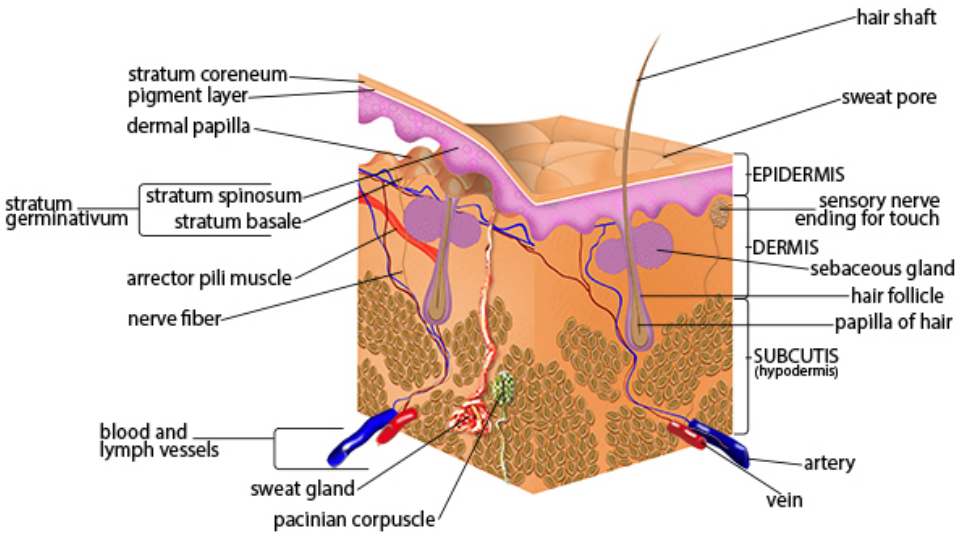
Site codes

Site code	Term
C44.0	Skin of lip, NOS

C44.1	Eyelid
C44.2	External ear
C44.3	Skin of other and unspecified parts of face
C44.4	Skin of scalp and neck
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C44.8	Overlapping lesion of skin
C44.9	Skin, NOS
C51.0	Labium majus
C51.1	Labium minus
C51.2	Clitoris
C51.8	Overlapping lesion of vulva
C51.9	Vulva, NOS
C60.0	Prepuce
C60.1	Glans penis
C60.2	Body of penis
C60.8	Overlapping lesion of penis
C60.9	Penis, NOS
C63.2	Scrotum, NOS



Credit: https://opentextbc.ca/anatomyandphysiology/chapter/5-1-layers-of-the-skin/ . Retrieved 05/10/2019



Credit: https://training.seer.cancer.gov/melanoma/anatomy/ Retrieved 05/10/2019

Melanomas are divided into 5 main types, depending on their location, shape and whether they grow outward or downward into the dermis:

- Acral melanoma: occurs on the palms of the hand, soles of the feet, or nail beds

- Desmoplastic melanoma: is a rare malignant melanoma marked by non-pigmented lesions on sun-exposed areas of the body
- Lentigo maligna: usually occur on the faces of elderly people
- Superficial spreading or flat melanoma: grows outwards at first to form an irregular pattern on the skin with an uneven color
- Nodular melanomas: are lumpy and often blue-black in color and may grow faster and spread downwards

These types account for the majority of melanomas occurring in the US population. For a more complete listing of histologic types of melanoma, see the AJCC Cancer Staging Manual, 6th Ed.

Melanoma can also start in the mucous membranes of the mouth, anus and vagina, in the eye or other places in the body where melanocytes are found. This scheme is used only for melanomas that occur on the skin.

Equivalent or Equal Terms

- And; with

  Note: "And" and "with" are used as synonyms when describing multiple histologies within a single tumor.
- Tumor; mass; tumor mass; lesion; neoplasm
  - The terms tumor, mass, tumor mass, lesion, and neoplasm are not used in a standard manner in clinical diagnoses scans, or consults. Disregard the terms unless there is a physician's statement that the term is malignant/cancer
  - These terms are used ONLY to determine multiple primaries
  - Do not use these terms for casefinding or determining reportability
- Type, subtype, predominantly, with features of, major, or with ___differentiation.
- Giant pigmented nevus, giant congenital nevus
- Mole, Nevus
- Mixed epithelioid and spindle cell melanoma (8770): Epithelioid melanoma and spindle cell melanoma

Synonyms for In Situ

- Behavior code 2
- Clark level 1 (limited to the epithelium)
- Hutchinson freckle (See synonyms for Hutchinson freckle)
- Intraepidermal, NOS
- Intraepithelial, NOS
- Lentigo maligna

- Noninvasive
- Precancerous melanoma of Dubreuilh
- Stage 0
- Tis

Synonyms for Hutchinson freckle

- Circumscribed precancerous melanosis
- Intraepidermal malignant melanoma
- Lentigo maligna
- Precancerous melanosis of Dubreuilh

Priority Order for Using Documentation to Identify Histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of melanoma in the medical record
- PET scan

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

https://apps.naaccr.org/ssdi/schema/melanoma_skin/?breadcrumbs=(~schema_list~)

Melanoma Skin

Primary Site	Histology
C000-C002, C006, C440-C449, C500, C510-C512, C518-C519, C600-C602, C608-C609, C632	8720-8790

SSDI Data Items

Name	Default Value	Used for Staging	NAACCR Item	Required By
Grade Clinical	9	No	NAACCR #3843	CCCR/Canada COC NPCR SEER
Grade Pathological	9	No	NAACCR #3844	
Breslow Thickness	XX.8	Yes	NAACCR #3817	All

Grade ID 98-Clinical and Pathological Grade Instructions

Grade Coding Instructions and Tables (see page 122 and 123)

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00460	Merkel Cell Carcinoma	46	Merkel Cell Carcinoma
00470	Melanoma of the Skin	47	Melanoma of the Skin

Surgery Codes

Skin C440–C449

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Surgery codes for melanoma of the skin:
https://seer.cancer.gov/manuals/2018/AppendixC/Surgery_Codes_Skin_2018.pdf

Additional resources

- SEER Program Coding and Staging guidelines for cutaneous melanoma:
  https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Melanoma_2018.pdf
- 2018 Solid Tumor Rules for cutaneous melanoma:
  https://seer.cancer.gov/tools/solidtumor/Melanoma_STM.pdf

Brain and Central Nervous System

https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Brain_2018.pdf

Site codes

Site Group	Reportable Subsite Terms and Code
Brain	Brain NOS **C719** Brain stem **C717** Cerebellum NOS **C716** Cerebrum **C710** Frontal lobe **C711** Occipital lobe **C714** Overlapping lesion of brain **C718** Parietal lobe **C713** Temporal lobe **C712** Ventricle NOS **C715**

Site Group	Reportable Subsite Terms and Code
Cranial Nerves	Abducent (cranial nerve VI) **C725** Accessory (cranial nerve XI) **C725** Acoustic (cranial nerve VIII) **C724** Cranial nerve NOS **C725** Facial (cranial nerve VII) C**725** Glossopharyngeal (cranial nerve IX) **C725** Hypoglossal (cranial nerve XII) **C725** Oculomotor (cranial nerve III) **C725** Olfactory (cranial nerve I) **C722** Optic (cranial nerve II) **C723** Trigeminal (cranial nerve V) **C725** Trochlear (cranial nerve IV) **C725** Vagus (cranial nerve X) **C725**
Ill-Defined Sites Central Nervous System	Nervous system NOS **C729** Overlapping lesion of brain and central nervous system **C728**
Intracranial Duct and Glands	Craniopharyngeal duct **C752** Pineal gland **C753** Pituitary gland **C751**
Meninges	Cerebral meninges **C700** Meninges NOS **C709** Spinal meninges **C701**

Site Group	Reportable Subsite Terms and Code
Peripheral Nerve and Autonomic Nervous System	Abdomen **C474** Autonomic nervous system NOS **C479** Head, face and neck **C470** Lower limb and hip **C472** Overlapping lesion of peripheral nerves and autonomic nervous system **C478** Thorax **C473** Pelvis **C475** Trunk NOS **C476** Upper limbs and shoulder **C471** Spinal Nerve NOS **C479**
Spinal Sites	Cauda equina/conus medullaris/filum terminale **C721** Meninges NOS **C709** Spinal cord **C720** Spinal meninges **C701**

Note: Behavior determines which set of CNS rules should be used: malignant or non-malignant.

Priority Order for Using Documentation to Assign Behavior

1. Pathology: Tissue from resection
    a. Use the pathologist's description of malignant/invasive behavior
    b. Cases are reportable as malignant when pathology states a WHO Grade 3 or 4
    c. WHO Grade 2 may be either non-malignant or malignant. Use the pathologist's description of behavior (priority #1).
    d. Never change behavior described by pathologist
2. Pathology: Tissue from biopsy
3. Cytology (usually cerebrospinal fluid)
4. Physician's documentation (no pathology report) in the following priority order:
    a. Tumor Board
    b. Documentation of original pathologic diagnosis and behavior
    c. Documentation of behavior, no mention of original diagnosis
5. Scan, use behavior information from radiography in the following priority order:
    a. MRI

   b. CT
   c. PET
   d. Angiogram
6. When instructions 1-5 do not apply, use Table 1 (see page 7) to determine behavior.

Priorities for Coding Primary Site

- Always check the operative report(s) which will have information on whether the surgery or biopsy was intracranial (inside the cranium/skull) or intraspinal (within the dura/meninges covering the spinal cord).
- Code the specific primary site. Use an NOS site code only when a specific site is not known.

Use the list in hierarchical order:

1. Resection
   a. Operative report(s)
   b. Pathology report(s)
2. Biopsy
   a. Operative report(s)
   b. Pathology report(s)
3. Resection and/or biopsy performed, but operative report(s) and pathology are not available (minimal information)
   a. Tumor Board
   b. Code from physician's documentation of original diagnosis from operative or pathology report OR
   c. Physician's documentation of primary site in the medical record
4. For cases diagnosed by imaging (no pathology/resection or biopsy) use information from scans in the following priority order:
   a. MRI
   b. CT
   c. PET
   d. Angiogram
5. See (page 14 of STR) Table 2: Reportable Primary Sites to confirm the primary site is reportable.
6. When the primary site is cranial nerve OR peripheral nerve, see (page 20 of STR Table 4: Coding Primary Site for Malignant Tumors of Cranial and Peripheral Nerves to determine whether the portion of the nerve is cranial or peripheral (different site codes).

Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with

  Note: “And” and “with” are used as synonyms when describing multiple histologies within a single tumor.
- Cerebrospinal fluid; CSF
- Dura; meninges
- Extradural; not within the meninges; within the cranium; within the skull but not within the cerebral meninges
- Extramedullary; outside medulla oblongata C700
- Infratentorial; below the tentorium cerebelli; either cerebellum or brainstem
- Intracranial; within the skull, within the cranium
- Intradural; between layers of the cerebral meninges; C700
- Intradural-extramedullary; within the spinal canal but outside of the nerves
- Intraspinal; occurring within the spinal column especially the vertebral canal; spinal nerve roots
- Site; topography
- Supratentorial; above the tentorium cerebelli; cerebrum
  - Cerebrum contains frontal lobe, parietal lobe, occipital lobe, and temporal lobe
- Tentorium cerebelli; cerebellar tentorium
- Tumor; mass; lesion; neoplasm when
  - These terms are used ONLY to determine multiple primaries
  - Do not use these terms for casefinding or determining reportability
- Type; subtype; variant
- WHO Grade 3 and WHO Grade 4; malignant; invasive; /3

Terms that are Not Equivalent or Equal

This is a term that is **not equivalent**. There are no casefinding implications.

- Component is not equivalent to subtype/variant
    - Component is only coded when the pathologist specifies the component as a second carcinoma.

Priority Order for Using Documentation to Identify Histology

- Code the histology diagnosed prior to neoadjuvant treatment.
    - Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
    - Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
- Code the histology assigned by the physician. Do not change histology in order to make the case applicable to staging.

The priority list is used for single primaries (including multiple tumors abstracted as a single primary)

This is a hierarchical list of source documentation.

1. Pathology/tissue from resection of primary tumor
    a. Biomarkers
        - Biomarkers are emerging as an important part of cancer diagnosis and treatment. Some biomarkers are used to determine treatment rather than histologic type. The efficacy of identification of histologic type using biomarkers differs from primary site to primary site. When a histologic type is identified using a biomarker, code the identified histology. Biomarkers do not identify all histologic types.
        - Biomarkers are not listed because they change rapidly.
    b. The addendum and/or comments
    c. Final diagnosis
    d. CAP protocol/summary
2. Pathology/tissue from biopsy of primary tumor
    a. Biomarkers
        - Biomarkers are emerging as an important part of cancer diagnosis and treatment. Some biomarkers are used to determine treatment rather than histologic type. The efficacy of identification of histologic type using biomarkers differs from primary site to primary site. When a histologic type is identified using a biomarker, code the identified histology. Biomarkers do not identify all histologic types.
        - Biomarkers are not listed because they change rapidly
    b. The addendum and/or comments
    c. Final diagnosis

d. CAP protocol/summary

- Addendums and comments are given the highest priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
- The pathologist's diagnosis is always the most reliable, so the final diagnosis is the second priority.
- Do not use the microscopic or gross section of the pathology report for coding.
- The CAP protocol is a checklist which:
  - Provides guidelines for collecting the essential data elements for complete reporting of tumors and optimal patient care.
  - Allows physicians to check multiple histologies
- The synoptic portion of CAP must be documented in one location. Most frequently, in the:
  - Pathology final diagnosis
  - Addendum to the path report

3. Cytology (most frequently cerebrospinal fluid)
4. Tissue/pathology from a metastatic site
   - Code the behavior /3
   - The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan.
5. Scan: The following list is in priority order.
   a. MRI
   b. CT
   c. PET
   d. Angiogram
6. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
   a. Documentation from Tumor Board
   b. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
   c. Physician's reference to type of cancer (histology) in the medical record
   - Code the specific histology when documented.
   - Code the histology to malignant neoplasm NOS 8000 or as stated by the physician when nothing more specific is documented

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

https://apps.naaccr.org/ssdi/schema/brain/?breadcrumbs=(~schema_list~)

Primary Site	Histology	Behavior
C700, C710-C719	8000-8700, 8720-8790, 8802, 8810, 8815, 8850, 8890, 8900, 9064, 9070-9071, 9080, 9084-9085, 9100-9105, 9120, 9133, 9140, 9180, 9220, 9362, 9364, 9380-9540, 9680, 9699, 9700-9714, 9751-9759	*<Any value>*
C700, C710-C719	8710-8714, 8800-8801, 8803-8806, 8811-8814, 8820-8842, 8851-8881, 8891-8898, 8901-9063, 9065, 9072-9073, 9081-9083, 9086-9091, 9110, 9121-9132, 9135-9137, 9141-9175, 9181-9210, 9221-9361, 9363, 9365-9373, 9541-9582	0, 1
C700, C710-C719	9590-9679, 9687-9698, 9716-9742, 9761-9992	0, 1

Site-Specific Data Items (SSDI)/Grade

https://apps.naaccr.org/ssdi/schema/brain/?breadcrumbs=(~schema_list~)

Name	Default Value	Used for Staging	NAACCR Item	Required By
Grade Clinical	9	No	NAACCR #3843	CCCR/Canada COC NPCR SEER
Grade Pathological	9	No	NAACCR #3844	
Brain Molecular Markers	88	No	NAACCR #3816	NPCR SEER

Grade ID 24-Clinical and Pathological Grade Instructions

Grade Coding Instructions and Tables (see page 112 and 113)

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00721	Brain	72	Brain and Spinal Cord
00722	CNS Other	72	Brain and Spinal Cord
00723	Intracranial Gland	72	Brain and Spinal Cord

Surgery Codes

Brain [and other parts of central nervous system] Meninges C700-C709, Brain C710–C719, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C720-C729

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Surgery Codes for the Brain, Meninges, Spinal Cord, Cranial Nerves and Other Parts of the CNS: https://seer.cancer.gov/manuals/2018/AppendixC/Surgery_Codes_Brain_2018.pdf

Additional Resources

- 2018 Solid Tumor Rules for Brain/CNS: https://seer.cancer.gov/tools/solidtumor/Malignant_CNS_STM.pdf
- SSDI Manual for coding Brain/CNS: https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547

Non-Malignant Brain and Central Nervous System

https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Brain_2018.pdf

Site codes

Site Group	Reportable Subsite Terms and Code
Brain	Brain NOS C719 Brain stem C717 Cerebellum NOS C716 Cerebrum C710 Frontal lobe C711 Occipital lobe C714 Overlapping lesion of brain and central nervous system C718 Parietal lobe C713 Temporal lobe C712 Ventricle NOS C715
Cranial Nerves	Abducent (cranial nerve VI) C725 Accessory (cranial nerve XI) C725 Acoustic (cranial nerve VIII) C724 Cranial nerve NOS C725 Facial (cranial nerve VII) C725 Glossopharyngeal (cranial nerve IX) C725 Hypoglossal (cranial nerve XII) C725 Oculomotor (cranial nerve III) C725 Olfactory (cranial nerve I C722) Optic (cranial nerve II) C723 Trigeminal (cranial nerve V) C725 Trochlear (cranial nerve IV) C725 Vagus (cranial nerve X) C725

Site Group	Reportable Subsite Terms and Code
Ill-Defined Sites Central Nervous System	Nervous system NOS C729 Overlapping lesion of brain and central nervous system C728
Intracranial Duct and Glands	Craniopharyngeal duct C752 Pineal gland C753 Pituitary gland C751
Meninges	Cerebral meninges C700 Meninges NOS C709 Spinal meninges C701
Spinal Sites	Cauda equina/conus medullaris/filum terminale C721 Meninges NOS C709 Spinal cord C720 Spinal meninges C701

Priority Order for Using Documentation to Assign Behavior

1. Pathology: Tissue from resection in the following priority order:
    a. Use the pathologist's description of behavior
        i. Never change behavior described by pathologist
    b. Cases are reportable as non-malignant when pathology states a WHO Grade 1
    c. WHO Grade 2 may be either non-malignant or malignant. Use the pathologist's description of behavior (priority #1a)
2. Pathology: Tissue from biopsy
3. Cytology (usually cerebrospinal fluid)
4. Physician's documentation (no pathology report) in the following priority order:
    a. Tumor Board
    b. Documentation of original diagnosis/tumor behavior
    c. Documentation of behavior, no mention of original diagnosis
5. Scans: Use behavior information from imaging in the following priority order:
    a. MRI
    b. CT
    c. PET
    d. Angiogram
6. When above instructions do not apply, use Table 1 (see page 7 of STR) to determine behavior.

Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with

  Note: “And” and “with” are used as synonyms when describing multiple histologies within a single tumor.
- Atypical; uncertain behavior /1
- Cerebrospinal fluid; CSF
- Dermoid; dermoid cyst
- Dura; meninges
- Extradural; not within the meninges; within the cranium; within the skull but not within the cerebral meninges
- Extramedullary; outside medulla oblongata C700
- Intracranial; within the skull, within the cranium
- Intradural; between layers of the cerebral meninges; C700
- Intradural-extramedullary; within the spinal canal but outside of the nerves
- Intraspinal; occurring within the spinal column especially the vertebral canal
- Majority; major; predominantly; greater than 50%
- Non-malignant is synonymous with:
  - /0 Benign
  - /1 Uncertain whether benign or malignant; borderline malignancy; low malignant potential; uncertain malignant potential
- Site; topography
- Subarachnoid space; between the arachnoid mater and the pia mater of spinal meninges
- Type; subtype; variant
- Tumor; mass; tumor mass; lesion; neoplasm
  - The terms tumor, mass, tumor mass, lesion, and neoplasm are not used in a standard manner in clinical diagnoses, scans, or consults. Disregard the terms unless there is a physician’s statement that the term is a non-malignant tumor/neoplasm
  - These terms are used ONLY for determining multiple primaries
  - DO NOT USE these terms for casefinding or determining reportability
- • WHO Grade 1; Non-malignant /0 and /1

Terms that are Not Equivalent or Equal

This is a term that is **not equivalent**. There are no casefinding implications.

- Component is not equivalent to subtype/variant

  Note: Component is only coded when the pathologist specifies the component as a second carcinoma

Priorities for Coding Primary Site

- Always check the operative report(s) which will have information on whether the surgery or biopsy was intracranial (inside the cranium/skull) or intraspinal (within the dura/meninges covering the spinal cord)
- Code the specific primary site. Use an NOS site code only when a specific site is not known.

Use the list below in hierarchical order:

1. Resection
    a. Operative report(s)
    b. Pathology report(s)
2. Biopsy
    a. Operative report(s)
    b. Pathology report(s)
3. Resection and/or biopsy performed, but operative report(s) and pathology are not available (minimal information):
    a. Tumor Board
    b. Code from physician's documentation of original diagnosis from operative or pathology report OR
    c. Physician's documentation of primary site in the medical record
4. For cases diagnosed by imaging (no pathology/resection or biopsy) use information from scans in the following priority order:
    a. MRI
    b. CT
    c. PET
    d. Angiogram
5. See (page 13) Table 2: Reportable Primary Sites to confirm the primary site is reportable.
6. When the primary site is cranial nerve OR cranial nerve meninges, see (page 15) Table 3: Reportability of Non-Malignant Cranial Nerve (CN) Tumors to confirm the site of the tumor is intracranial (reportable) or extracranial (not reportable)

7. See (page 20) Table 4: Non-Reportable Neoplasms for site/histology combinations and histologies that are not reportable.
8. When the primary site is brain or intracranial glands, see (page 21)Table 5: Histologic Types of Non-Malignant Intracranial (Brain and Gland) Tumors to confirm site/histology combinations.

Priority Order for Using Documentation to Identify Histology

- Code the histology diagnosed prior to neoadjuvant treatment.
  - Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
  - Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
- Code the histology assigned by the physician. Do not change histology in order to make the case applicable to staging.

The priority list is used for single primaries (including multiple tumors abstracted as a single primary).

This is a hierarchical list of source documentation:

- Pathology/tissue from resection
  a. Biomarkers
     - Biomarkers do not identify all histologic types.
     - Biomarkers are not listed because they change rapidly.
  b. The addendum and/or comments
  c. Final diagnosis
  d. CAP protocol/summary
- Pathology/tissue from biopsy
  a. Biomarkers
     - Biomarkers do not identify all histologic types.
     - Biomarkers are not listed because they change rapidly.
  b. The addendum and/or comments
  c. Final diagnosis
  d. CAP protocol/summary
     - Addendums and comments are given the highest priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
     - The pathologist's diagnosis is always the most reliable, so the final diagnosis is the second priority.
     - Do not use the microscopic or gross section of the pathology report for coding.
     - The CAP protocol is a checklist which:

- Provides guidelines for collecting the essential data elements for complete reporting of tumors and optimal patient care.
- Allows physicians to check multiple histologies

- The CAP summary must be documented in one locate on. It is usually found in:
  - Pathology final diagnosis OR
  - An addendum to the path report

- Cytology (most frequently spinal fluid)
- Radiography: The following list is in priority order.
  a. MRI
  b. CT
  c. PET
  d. Angiogram
- Clinical Diagnosis: Code the histology documented by the physician when none of the above are available. Priority for using documentation:
  a. Documentation from Tumor Board
  b. References to pathology diagnosis
  c. Physician's reference to type of cancer (histology) in the medical record
  - Code the specific histology when documented.

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

https://apps.naaccr.org/ssdi/schema/brain/?breadcrumbs=(~schema_list~)

Primary Site	Histology	Behavior
C700, C710-C719	8000-8700, 8720-8790, 8802, 8810, 8815, 8850, 8890, 8900, 9064, 9070-9071, 9080, 9084-9085, 9100-9105, 9120, 9133, 9140, 9180, 9220, 9362, 9364, 9380-9540, 9680, 9699, 9700-9714, 9751-9759	***<Any value>***
C700, C710-C719	8710-8714, 8800-8801, 8803-8806, 8811-8814, 8820-8842, 8851-8881, 8891-8898, 8901-9063, 9065, 9072-9073, 9081-9083, 9086-9091, 9110, 9121-9132, 9135-9137, 9141-9175, 9181-9210, 9221-9361, 9363, 9365-9373, 9541-9582	0, 1
C700, C710-C719	9590-9679, 9687-9698, 9716-9742, 9761-9992	0, 1

Name	Default Value	Used for Staging	NAACCR Item	Required By

Grade Clinical Grade Pathological	9 9	No No	NAACCR #3843 NAACCR #3844	CCCR/Canada COC NPCR SEER
Brain Molecular Markers	88	No	NAACCR #3816	NPCR SEER

Grade ID 24-Clinical and Pathological Grade Instructions

https://www.naaccr.org/SSDI/Grade-Manual.pdf (see page 112 and 113)

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00721	Brain	72	Brain and Spinal Cord
00722	CNS Other	72	Brain and Spinal Cord
00723	Intracranial Gland	72	Brain and Spinal Cord

Surgery Codes

Brain [and other parts of central nervous system] Meninges C700-C709, Brain C710–C719, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C720-C729

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Brain, CNS, Meninges, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System: https://seer.cancer.gov/manuals/2018/AppendixC/Surgery_Codes_Brain_2018.pdf

Additional Resources

- 2018 Solid Tumor Rules for Non-Malignant Brain/CNS: https://seer.cancer.gov/tools/solidtumor/Non_Malignant_CNS_STM.pdf
- SSDI Manual for coding Brain/CNS: https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547

B

APPENDIX B:
REPORTING LAW AND RULES

THE LAW

HEALTH AND SAFETY CODE

TITLE 2. HEALTH

SUBTITLE D. PREVENTION, CONTROL, AND REPORTS OF DISEASES

CHAPTER 82. CANCER REGISTRY

Sec. 82.001. SHORT TITLE. This chapter may be cited as the Texas Cancer Incidence Reporting Act.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 33, eff. Sept. 1, 1991.

Sec. 82.002. DEFINITIONS. In this chapter:

(1) "Cancer" includes:

(A) a large group of diseases characterized by uncontrolled growth and spread of abnormal cells;

(B) any condition of tumors having the properties of anaplasia, invasion, and metastasis;

(C) a cellular tumor the natural course of which is fatal, including malignant and benign tumors of the central nervous system; and

(D) malignant neoplasm, other than nonmelanoma skin cancers such as basal and squamous cell carcinomas.

(2) "Clinical laboratory" means an accredited facility in which:

(A) tests are performed identifying findings of anatomical changes; and

(B) specimens are interpreted and pathological diagnoses are made.

(3) "Health care facility " means:

(A) a general or special hospital as defined by Chapter 241 (Texas Hospital Licensing Law);

(B) an ambulatory surgical center licensed under Chapter 243;

(C) an institution licensed under Chapter 242; or

(D) any other facility, including an outpatient clinic, that provides diagnosis or treatment services to patients with cancer.

(4) "Health care practitioner" means:

(A) a physician as defined by Section 151.002, Occupations Code; or

(B) a person who practices dentistry as described by Section 251.003, Occupations Code.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 1, eff. Sept. 1, 2001.

Sec. 82.003. APPLICABILITY OF CHAPTER. This chapter applies to records of cases of cancer, diagnosed on or after January 1, 1979, and to records of all ongoing cancer cases diagnosed before January 1, 1979.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 2, eff. Sept. 1, 2001.

Sec. 82.004. REGISTRY REQUIRED. The department shall maintain a cancer registry for the state.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0252, eff. April 2, 2015.

Sec. 82.005. CONTENT OF REGISTRY. (a) The cancer registry must be a central data bank of accurate, precise, and current information that medical authorities agree serves as an invaluable tool in the early recognition, prevention, cure, and control of cancer.

(b) The cancer registry must include:

(1) a record of the cases of cancer that occur in the state; and

(2) information concerning cancer cases as the executive commissioner considers necessary and appropriate for the recognition, prevention, cure, or control of cancer.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 3, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0253, eff. April 2, 2015.

Sec. 82.006. EXECUTIVE COMMISSIONER AND DEPARTMENT POWERS. (a) To implement this chapter, the executive commissioner may adopt rules that the executive commissioner considers necessary.

(b) To implement this chapter, the department may:

(1) execute contracts considered necessary;

(2) receive the data from medical records of cases of cancer that are in the custody or under the control of clinical laboratories, health care facilities, and health care practitioners to record and analyze the data directly related to those diseases;

(3) compile and publish statistical and other studies derived from the patient data obtained under this chapter to provide, in an accessible form, information that is useful to physicians, other medical personnel, and the general public;

(4) comply with requirements as necessary to obtain federal funds in the maximum amounts and most advantageous proportions possible;

(5) receive and use gifts made for the purpose of this chapter; and

(6) limit cancer reporting activities under this chapter to specified geographic areas of the state to ensure optimal use of funds available for obtaining the data.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 4, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0254, eff. April 2, 2015.

Sec. 82.007. REPORTS. (a) The department shall publish an annual report to the legislature of the information obtained under this chapter.

(b) The department, in cooperation with other cancer reporting organizations and research institutions, may publish reports the department determines are necessary or desirable to carry out the purpose of this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 34, eff. Sept. 1, 1991.

Sec. 82.008. DATA FROM MEDICAL RECORDS. (a) To ensure an accurate and continuing source of data concerning cancer, each health care facility, clinical laboratory, and health care practitioner shall furnish to the department, on request, data the executive commissioner considers necessary and appropriate that is derived from each medical record pertaining to a case of cancer that is in the custody or under the control of the health care facility, clinical laboratory, or health care practitioner. The department may not request data that is more than three years old unless the department is investigating a possible cancer cluster. At the request and with the authorization of the applicable health care facility, clinical laboratory, or health care practitioner, data may be furnished to the department through a health information exchange as defined by Section 182.151.

(b) A health care facility, clinical laboratory, or health care practitioner shall furnish the data requested under Subsection (a) in a reasonable format prescribed by department rule and within six months of the patient's admission, diagnosis, or treatment for cancer unless a different period is prescribed by the United States Department of Health and Human Services.

(c) The data required to be furnished under this section must include patient identification and diagnosis.

(d) The department may access medical records that would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified patient from the following sources:

(1) a health care facility or clinical laboratory providing screening, diagnostic, or therapeutic services to a patient with respect to cancer; or

(2) a health care practitioner diagnosing or providing treatment to a patient with cancer, except as described by Subsection (g).

(e) The executive commissioner shall adopt procedures that ensure adequate notice is given to the health care facility, clinical laboratory, or health care practitioner before the department accesses data under Subsection (d).

(f) A health care facility, clinical laboratory, or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for the costs of accessing and reporting the data. The costs reimbursed under this subsection must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of data under Subsection (d), and may include salary and travel expenses. The department may assess a late fee on an account that is 60 days or more overdue. The late fee may not exceed one and one-half percent of the total amount due on the late account for each month or portion of a month the account is not paid in full. A health care facility, clinical laboratory, or health care practitioner may request that the department conduct a hearing to determine whether reimbursement to the department under this subsection is appropriate.

(g) The department may not require a health care practitioner to furnish data or provide access to records if:

(1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and

(2) the facility reported the same data the practitioner would be required to report.

(h) The data required to be furnished under this section may be shared with cancer registries of health care facilities subject to the confidentiality provisions in Section 82.009.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 35, eff. Sept. 1, 1991; Acts 1997, 75th Leg., ch. 343, Sec. 1, eff. May 27, 1997; Acts 1999, 76th Leg., ch. 1411, Sec. 23.01, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 589, Sec. 5, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0255, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1085 (H.B. 2641), Sec. 5, eff. September 1, 2015.

Sec. 82.009. CONFIDENTIALITY. (a) Reports, records, and information obtained under this chapter are confidential and are not subject to disclosure under Chapter 552, Government Code, are not subject to subpoena, and may not otherwise be released or made public except as provided by this section or Section 82.008(h). The reports, records, and information obtained under this chapter are for the confidential use of the department and the persons or public or private entities that the department determines are necessary to carry out the intent of this chapter.

(b) Medical or epidemiological information may be released:

(1) for statistical purposes in a manner that prevents identification of individuals, health care facilities, clinical laboratories, or health care practitioners;

(2) with the consent of each person identified in the information; or

(3) to promote cancer research, including release of information to other cancer registries and appropriate state and federal agencies, under rules adopted by the executive commissioner to ensure confidentiality as required by state and federal laws.

(c) A state employee may not testify in a civil, criminal, special, or other proceeding as to the existence or contents of records, reports, or information concerning an individual whose medical records have been used in submitting data required under this chapter unless the individual consents in advance.

(d) Data furnished to a cancer registry or a cancer researcher under Subsection (b) or Section 82.008(h) is for the confidential use of the cancer registry or the cancer researcher, as applicable, and is subject to Subsection (a).

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(90), eff. Sept. 1, 1995; Acts 1997, 75th Leg., ch. 343, Sec. 2, eff. May 27, 1997; Acts 1999, 76th Leg., ch. 1411, Sec. 23.02, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 589, Sec. 6, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0256, eff. April 2, 2015.

Sec. 82.010. IMMUNITY FROM LIABILITY. The following persons subject to this chapter that act in compliance with this chapter are not civilly or criminally liable for furnishing the information required under this chapter:

(1) a health care facility or clinical laboratory;

(2) an administrator, officer, or employee of a health care facility or clinical laboratory;

(3) a health care practitioner or employee of a health care practitioner; and

(4) an employee of the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 7, eff. Sept. 1, 2001.

Sec. 82.011. EXAMINATION AND SUPERVISION NOT REQUIRED. This chapter does not require an individual to submit to any medical examination or supervision or to examination or supervision by the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0257, eff. April 2, 2015.

THE RULES

Texas Administrative Code

Title 25. Health Services

Part 1. Department of State Health Services

Chapter 91. Cancer

Subchapter A. Cancer Registry

Effective Date: April 2, 2017

§91.1. Purpose.

This subchapter implements the Texas Cancer Incidence Reporting Act, Health and Safety Code, Chapter 82. This legislation concerns the reporting of cases of cancer for the recognition, prevention, cure or control of those diseases, and to facilitate participation in the national program of cancer registries established by 42 United States Code, §§280e - 280e-4. Nothing in this subchapter shall preempt the authority of facilities or individuals providing diagnostic or treatment services to patients with cancer to maintain their own cancer registries.

§91.2. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--The Texas Cancer Incidence Reporting Act, Texas Health and Safety Code, Chapter 82.

(2) Cancer--Includes a large group of diseases characterized by uncontrolled growth and spread of abnormal cells; any condition of tumors having the properties of anaplasia, invasion, and metastasis; a cellular tumor the natural course of which is fatal, including intracranial and central nervous system malignant, borderline, and benign tumors as required by the national program of cancer registries; and malignant neoplasm, other than non-melanoma skin cancers such as basal and squamous cell carcinomas.

(3) Cancer Reporting Handbook--The Texas Cancer Registry's manual for reporting entities that documents reporting procedures and format.

(4) Clinical laboratory--An accredited facility in which tests are performed identifying findings of anatomical changes; specimens are interpreted and pathological diagnoses are made.

(5) Confidential cancer data--Information that includes items that may identify an individual, and is subject to Health and Safety Code, §82.009.

(6) Department--Department of State Health Services.

(7) Health care facility--A general or special hospital as defined by the Health and Safety Code, Chapter 241; an ambulatory surgical center licensed under the Health and Safety Code, Chapter 243; an institution licensed under the Health and Safety Code, Chapter 242; or any other facility, including an outpatient clinic, that provides diagnostic or treatment services to patients with cancer.

(8) Health care practitioner--A physician as defined by Occupations Code, §151.002 or a person who practices dentistry as described by the Occupations Code, §251.003.

(9) Quality assurance--Operational procedures by which the accuracy, completeness, and timeliness of the information reported to the department can be determined and verified.

(10) Report--Information provided to the department that notifies the appropriate authority of the occupancy of a specific cancer in a person, including all information required to be provided to the department.

(11) Reporting Entity--A reporting entity may include a health care facility, clinical laboratory, health care practitioner, or a health information exchange as defined by Health and Safety Code, §182.151.

(12) Research--A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

(13) Statistical cancer data--Aggregate presentation of individual records on cancer cases excluding patient identifying information.

(14) Texas Cancer Registry--The cancer incidence reporting system administered by the Department of State Health Services.

§91.3. Who Reports and Access to Records.

(a) Each health care facility, clinical laboratory or health care practitioner shall report to the department, by methods specified in §§91.4 - 91.7 of this title (relating to Cancer Registry), required data from each medical record pertaining to a case of cancer in its custody or under its control except for cases to which subsection (d) of this section would apply.

(b) A health care facility or clinical laboratory providing screening, diagnostic or therapeutic services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient.

(c) A health care practitioner providing diagnostic or treatment services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient except for cases to which subsection (d) of this section would apply.

(d) The department may not require a health care practitioner to furnish data or provide access to records if:

(1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and

(2) the facility reported the same data the practitioner would be required to report.

(e) Health care facilities, clinical laboratories, and health care practitioners are subject to federal law known as the Health Insurance Portability and Accountability Act of 1996 found at Title 42 United States Code §1320d et seq.; the federal privacy rules adopted in Title 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164; and applicable state medical records privacy laws. Because state law requires reporting of cancer data, persons subject to this chapter are permitted to provide the data to the department without patient consent or authorization under 45 C.F.R. §164.512(a) relating to uses and disclosures required by law and §164.512(b)(1) relating to disclosures for public health activities. Both of these exceptions to patient consent or authorization are recognized in the state law.

§91.4. What to Report.

(a) Reportable conditions.

(1) The cases of cancer to be reported to the Texas Cancer Registry are as follows:

(A) all neoplasms with a behavior code of two or three in the most current edition of the International Classification on Diseases for Oncology (ICD-O) of the World Health Organization with the exception of those designated by the Texas Cancer Registry as non-reportable in the Cancer Reporting Handbook; and

(B) all benign and borderline intracranial and central nervous system neoplasms as required by the national program of cancer registries.

(2) Codes and taxa of the most current edition of the International Classification of Diseases, Clinical Modification of the World Health Organization which correspond to the Texas Cancer Registry's reportable list are specified in the Cancer Reporting Handbook.

(b) Reportable information.

(1) Except as provided in paragraph (2) of this subsection and health care practitioners in §91.5(c) of this title (relating to When to Report), those data required to be reported for each cancer case shall include:

(A) name, address, zip code, and county of residence;

(B) social security number, date of birth, gender, race and ethnicity, marital status, birthplace, and primary payer at time of diagnosis, to the extent such information is available from the medical record;

(C) information on industrial and occupational history, smoking status, height and weight to the extent such information is available from the medical record;

(D) diagnostic information including the cancer site and laterality, cell type, tumor behavior, markers, grade and size, stage of disease, date of diagnosis, diagnostic confirmation method, sequence number, and other primary tumors;

(E) first course of cancer-related treatment, including dates and types of procedures;

(F) text information to support cancer diagnosis, stage and treatment codes;

(G) health care facility or practitioner related information including reporting institution number, casefinding source, type of reporting source, medical record number, registry number, tumor record number, class of case, date of first contact, date of last contact, vital status, facility referred from, facility referred to, managing physician, follow-up physician, date abstracted, abstractor, and electronic record version; and

(H) clinical laboratory related information including laboratory name and address, pathology case number, pathology report date, pathologist, and referring physician name and address.

(2) The department or its authorized representative may exempt a reporting entity from providing specific reportable data items delineated in paragraph (1) of this subsection to the extent that those data to be exempted are not collected by the reporting entity.

(3) Except as provided in §91.6(b) of this title (relating to How to Report), each report shall:

(A) be electronically readable and contain all data items required in paragraph (1) of this subsection;

(B) be fully coded and in a format prescribed by the Texas Cancer Registry;

(C) meet all quality assurance standards utilized by the Texas Cancer Registry;

(D) in the case of individuals who have more than one form of cancer, be submitted separately for each primary cancer diagnosed;

(E) be submitted to the Texas Cancer Registry electronically; and

(F) be transmitted by secure means at all times to protect the confidentiality of the data.

§91.5. When to Report.

(a) All reports shall be submitted to the department within six months of the patient's admission, initial diagnosis, or treatment for cancer.

(b) Data shall be submitted no less than quarterly by health care facilities with annual caseloads of 400 or less. Monthly submissions are required for all other health care facilities.

(c) Data shall be submitted no less than quarterly by health care practitioners initially diagnosing a patient with cancer and performing the in-house pathological tests for that patient. Otherwise, data shall be submitted within 2 months of the request to a health care practitioner by the department or its authorized representative for a report or subset of a report on a patient diagnosed or treated elsewhere and for whom the same cancer data has not been reported.

(d) Data shall be submitted no less than quarterly by clinical laboratories.

§91.6. How to Report.

(a) Reports of cancer from health care facilities, clinical laboratories and health care practitioners shall be submitted to the Texas Cancer Registry electronically using a secure electronic process as defined by the department. At the request and with the authorization of the applicable health care facility, clinical laboratory, or health care practitioner, data may be furnished to the Texas Cancer Registry through a health information exchange.

(b) The Texas Cancer Registry may accept the submission of paper copies of medical records from a health care facility, pathology reports from a clinical laboratory and reports or subsets of reports from a health care practitioner under the following conditions.

(1) The department, or its authorized representative, shall determine that such paper submissions are more expedient than electronic reporting.

(2) The acceptance of paper submissions from a health care facility, clinical laboratory or health care practitioner shall be approved by the department or its authorized representative.

(3) The department, or its authorized representative, may approve acceptance of paper submissions from defined groups or types of health care facilities, clinical laboratories or health care practitioners.

(4) All records and reports provided to the Texas Cancer Registry pursuant to this subsection must be transmitted by secure means at all times to protect the confidentiality of the data.

§91.7. Where to Report.

Data reports should be submitted to the Texas Cancer Registry as specified in the Cancer Reporting Handbook.

§91.8. Compliance.

(a) Each health care facility, clinical laboratory, or health care practitioner that reports to the department, by methods specified in §§91.4 - 91.7 of this title (relating to Cancer Registry), is considered compliant.

(b) A person will be notified in writing if the person has not reported in compliance with this chapter within 30 days following the end of the required monthly or quarterly reporting timeframe and will be

given an opportunity to take corrective action within 60 days from the date of the notification letter. A second notification letter will be sent 30 days after the date of the original notification letter if no corrective action has been taken.

(c) If a person is non-compliant and takes no corrective action within 60 days of the original notification letter, the department or its authorized representative may access the information from the health care facility, clinical laboratory or health care practitioner as provided in §91.3 of this title (relating to Who Reports, Access to Records) and report it in the appropriate format.

(1) The health care facility, clinical laboratory or health care practitioner shall be notified at least two weeks in advance before a scheduled arrival for collection of the information.

(2) A health care facility, clinical laboratory or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for its cost to access and report the information. The costs must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of the data and may include salary and travel expenses. It is presumed that a health care facility, clinical laboratory or health care practitioner acted knowingly or in bad faith if it failed to take corrective action within 60 days of the date of the original notification letter.

(3) A health care facility, clinical laboratory or health care practitioner may request the department to conduct a hearing under the department's fair hearing rules to determine whether reimbursement to the department is appropriate.

(d) Any health care facility, clinical laboratory or health care practitioner which is required to reimburse the department or its authorized representative for the cost to access and report the information pursuant to subsection (c)(2) of this section shall provide payment to the department or its authorized representative within 60 days of the day this payment is demanded. In the event any health care facility, clinical laboratory or health care practitioner fails to make payment to the department or its authorized representative within 60 days of the day the payment is demanded, the department or its authorized representative may, at its discretion, assess a late fee not to exceed 1-1/2 % per month of the outstanding balance.

§91.9. Confidentiality and Disclosure.

(a) Pursuant to the Act, Chapter 82, §82.009, all data obtained is for the confidential use of the department and the persons or entities, public or private, that the department determines are necessary to carry out the intent of the Act.

(b) Limited release of the data is allowed by the Act, §82.008(h) and §82.009(b).

(c) Any requests for confidential or statistical cancer data shall be made in accordance with §91.11 or §91.12 of this title (relating to Cancer Registry).

(d) The Texas Cancer Registry is subject to state law that requires compliance with portions of the federal law and regulations cited in §91.3(e) of this title (relating to Who Reports, Access to Records).

The department is authorized to use and disclose, for purposes described in the Act, cancer data without patient consent or authorization under 45 C.F.R §164.512(a) relating to uses and disclosures required by law, §164.512(b)(1) and (2) relating to uses and disclosures for public health activities, and §164.512(i) relating to uses and disclosures for research purposes.

§91.10. Quality Assurance.

The department shall cooperate and consult with persons required to comply with this chapter so that such persons may provide timely, complete, and accurate data. The department will provide:

(1) reporting training, technical assistance, on-site case-finding studies, and reabstracting studies;

(2) quality assessment reports to ascertain that the computerized data utilized for statistical information and data compilation is accurate; and

(3) educational information on cancer morbidity and mortality statistics available from the Texas Cancer Registry and the department.

§91.11. Requests for Statistical Cancer Data.

(a) Statistical cancer data previously analyzed are available upon written or oral request to the Texas Cancer Registry. All other requests for statistical cancer data shall be in writing and directed to: Texas Cancer Registry, Mail Code 1928, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347 or CancerData@dshs.state.tx.us.

(b) To ensure that the proper data are provided, the request shall include, but not be limited to, the following information:

(1) name, address, and telephone number of the person requesting the information;

(2) type of data needed and for what years (e.g. lung cancer incidence rates, Brewster County, 1998 - 2002); and

(3) name and address of person(s) to whom data and billings are to be submitted (if applicable).

§91.12. Requests and Release of Confidential Cancer Data.

(a) Data requests for research.

(1) Requests for confidential cancer data shall be in writing and directed to: Texas Cancer Registry, Mail Code 1928, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347 or CancerData@dshs.state.tx.us.

(2) Written requests for confidential cancer data shall meet the submission requirements of the department's Institutional Review Board (IRB) before release.

(3) The Texas Cancer Registry may release confidential cancer data to state, federal, local, and other public agencies and organizations if approved by the IRB.

(4) The Texas Cancer Registry may release confidential cancer data to private agencies, organizations, and associations if approved by the IRB.

(5) The Texas Cancer Registry may release confidential cancer data to any other individual or entities for reasons deemed necessary by the department to carry out the intent of the Act if approved by the IRB.

(b) Data requests for non-research purposes.

(1) The Texas Cancer Registry may provide reports containing confidential cancer data back to the respective reporting entity from records previously submitted to the Texas Cancer Registry from each respective reporting entity for the purposes of case management and administrative studies. These reports will not be released to any other entity.

(2) The Texas Cancer Registry may release confidential cancer data to other areas of the department, provided that the disclosure is required or authorized by law. All communications of this nature shall be clearly labeled "Confidential" and will follow established departmental internal protocols and procedures.

(3) The Texas Cancer Registry may release confidential cancer data to state, federal, local, and other public agencies and organizations in accordance with subsection (a) of this section.

(4) The Texas Cancer Registry may release confidential cancer data to any other individual or entities for reasons deemed necessary to carry out the intent of the Act and in accordance with subsection (a) of this section.

(5) An individual who submits a valid authorization for release of an individual cancer record shall have access to review or obtain copies of the information described in the authorization for release.

- Texas Cancer Incidence Reporting Act and Reporting Rules also available on the web at https://www.dshs.texas.gov/tcr/lawrules.aspx
- The Texas Cancer Registry Rule can be found at the Texas Administrative Code webpage http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=91&rl=4

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APPENDIX C:
FIPS COUNTY CODES

FIPS COUNTY CODES - TEXAS COUNTIES

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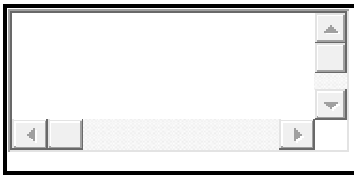	
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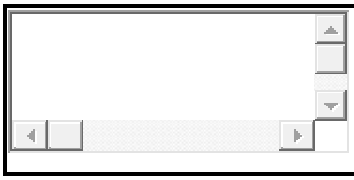	

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AJCCID		
SchemaID		
SchemaDisc1		
SSDI		
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APPENDIX E: COMMON ACCEPTABLE ABBREVIATIONS

Common Acceptable Abbreviations

(In order of Abbreviation)

When abbreviating words in an address, refer to the Address Abbreviations section of the National Zip Code and Post Office Directory, published by the U.S. Postal Service. For short names of antineoplastic drugs, consult SEER*RX Interactive Antineoplastic Drugs Database: https://seer.cancer.gov/seertools/seerrx/.

ABBREVIATION	DESCRIPTION
A	Allergy
A	Annum
A	Anode
A	Anterior
A	Aortic
A	Artery
A	Axial
AA	Aplastic anemia
AB	Abort (miscarry)
AB	About
AB	Antibody
AB	Asthmatic bronchitis
ABD, ABDOM	Abdomen
ABG	Arterial Blood Gas
ABN	Abnormal
ABP	Arterial blood pressure
ABST	Abstract
AC	Adrenal cortex
AC	Air contrast
AC	Anterior chamber
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
ACID P'TASE	Acid phosphatase
A-COLON	Ascending Colon
ACTH	Adrenocorticotrophic hormone
ADENOCA	Adenocarcinoma
ADH	Antidiuretic hormone (vasopressin)
ADJ	Adjacent

ABBREVIATION	DESCRIPTION
ADL	Activities of Daily Living
ADM	Admission
ADM	Admit
ADR	Adverse drug reaction
AFF	Afferent
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Atrial gallop
AG	Antigen
AG	Argentum (silver, chemical symbol for)
AGL	Acute granulocytic leukemia
A/G RATIO	Albumin-globulin ratio
AGNO3	Silver Nitrate
AIDS	Acquired immunodeficiency syndrome
AIL	Angioimmunoblastic lymphadenopathy
AILD	Angioimmunoblastic lymphadenopathy with dysprotinemia
AIN	Anal intraepithelial neoplasia
AK(A)	Above knee (amputation)
AKA	Also known as
ALB	Albumin
ALCL	Anaplastic large cell lymphoma
ALK PHOS	alkaline phosphatase
ALL	Acute lymphocytic leukemia
AMA	Against medical advice
AMB	ambulatory
AMKL	Acute megakaryocytic leukemia
AML	Acute myelogenous leukemia
AMP	Amputation
ANAP	Anaplastic
ANAT	Anatomy
ANO	Axillary node dissection
ANED	Alive no evidence of disease
ANES(TH)	Anesthesia, anesthetic
ANT	Anterior

ABBREVIATION	DESCRIPTION
ANTE	Before
A&P	Auscultation & percussion
AP	Abdominal perineal
AP	Anteroposterior
AP	Anterior pituitary
AP&LAT	Anteroposterior & lateral
ARC	Aids Related Complex
ARMS	Alveolar Rhabdomyosarcoma
APP	Appendix
APPROX	Approximately
ASP	Aspiration
AUT	Autopsy
AV	Arteriovenous
AX	Axilla(ry)
B	Bacillus
B	Black
B	Blue
B	Born
B	Brother
BA	Bachelor of Arts
BA	Barium (chemical symbol for)
BA	Bronchial asthma
BALT	Bronchial-associated lymphoid tissue
BAS	Basal
BASOS	Basophil(s) (granular leukocyte)
BBB	Blood-brain block
BBB	Bundle-branch block
BBT	Basal body temperature
BC	Birth control
BC	Bone conduction
BC	Buccocervical
BCC	Basal cell carcinoma
B-CELLS	Special lymphocytes formed in bone marrow (derived from bursa of Fabricius)
BCG	Bacillus Calmette-Guerin

ABBREVIATION	DESCRIPTION
BD	Bile duct
BE	Barium enema
B/F	Black female
BIO	Twice a day
BIL	Bilateral
BK(A)	Below knee (amputation)
BM	Bone marrow
BM	Bowel movement
B/M	Black male
BMR	Basal metabolic rate
BMT	Bone marrow transplant
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BRB(PR)	Bright Red Blood (per Rectum)
BRM	Biological response modifier
BSC	Bone scan
BSE	Breast self-examination
BS	Bowel Sounds
BS, BRS	Breath Sounds
BSO	Bilateral salpingo-oophorectomy
BT	Brain tumor
BUN	Blood urea nitrogen
BUS	Bartholin's, urethral & Skene's glands
BX	Biopsy
C	Centigrade
Ca	Ca-Journal of the American Cancer Society
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CAT	Computerized axial tomography
CBC	Complete blood count
CBD	Common bile duct
CC	Chief complaint
CC	Cubic centimeter

ABBREVIATION	DESCRIPTION
CHEMO	Chemotherapy
CHF	Congestive heart failure
CHR	Chronic
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIS	Carcinoma-in situ
CLL	Chronic lymphocytic leukemia
CLR	Clear
CM	Centimeter
CM	Costal margin
CML	Chronic myeloid/myelocytic leukemia
CMML	Chronic myelomonocytic leukemia
CMV	Cytomegalovirus
CNS	Central nervous system
C/O	Complaining of
CO2	Carbon dioxide
Co60	Cobalt 60
Cont	Continue
Contra	Contralateral
COR	Heart
CPK	Creatine Phosphokinase
CR	Complete remission
CRF	Chronic renal failure
CS	Cesium
CS	Collaborative Stage
CSF	Cerebrospinal fluid
CSF	Colony-stimulating factor
C-SPINE	Cervical spine
CTCL	Cutaneous T cell lymphoma
CTR	Certified Tumor Registrar
CT SC, CAT Scan	Computerized (axial) tomography scan
CVA	Cerebrovascular accident
CVA	Costovertebral angle
C/W	Consistent with

ABBREVIATION	DESCRIPTION
CX	Cervix
CXR	Chest x-ray
CYSTO	Cystoscopy
CYTO	Cytology
D1, D2 ETC	First dorsal vertebra, second, etc.
D&C	Dilatation and curettage
DC	Discharge
DC	Discontinued
DCIS	Ductal carcinoma in situ
D-Colon	Descending Colon
DECR (or <)	Decreased
DERM	Dermatology
DD	Discharge diagnosis
DDX	Differential diagnosis
DERM	Dermatology
DIAM	Diameter
DIFF	Differentiated, differential
DIS, DISCH	Disease; Discharge
DLS	Date last seen
DNA	Deoxyribonucleic acid
DNR	Do not resuscitate
DO	Doctor of Osteopathy
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of death
DOE	Dyspnea on exertion
DP	Dorsalis Pedis
DR	(Medical) doctor
DRE	Digital Rectal Exam
DS	Discharge
DTR	Deep tendon reflex
DX	Diagnosis
ECF	Extended care facility
ECG, EKG	Electrocardiogram

ABBREVIATION	DESCRIPTION
EEG	Electroencephalogram
EENT	Eyes, ears, nose, & throat
EGD	Esophagogastroduodenoscopy
EMG	Electromyogram
ENL	Enlarged
ENT	Ear, nose & throat
EPA	Erect (standing), posterior, anterior
ER(A)	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography
EST	Electroshock therapy
ETOH	Alcohol
EUA	Exam under anesthesia
EVAL	Evaluation
EXAM	Examination
EXC	Excision
EXP LAP	Exploratory laparotomy
EXT	Extend, extension
EXT	External; Extremity
F	Fahrenheit
FAB	French American and British Classification Scheme for Leukemia
FB	Fingerbreadth
FBS	Fasting blood sugar
FDA	Food and Drug Administration in USA
FIGO	International Federation of Gynecology and Obstetrics
F(M)H	Family (medical) history
FLURO	Fluoroscopy
FNA	Fine Needle Aspiration
FOM	Floor of mouth
FP	Flat plate
FS	Frozen Section
FU	Follow up
FUO	Fever unknown origin
FX	Fracture
FX	Frozen section

ABBREVIATION	DESCRIPTION
GA	Gastric analysis
GB	Gallbladder
GBM	Glioblastoma multiforme
GCT	Germ cell tumor
GE	Gastroenterostomy
GE	Gastroesophageal
GEN	Generalized
GI	Gastrointestinal
GM	Gram
GP	General practitioner
GR	Grade, grain(s)
GU	Genitourinary
GYN	Gynecology
HB	Hemoglobin
HCG	Human Chorionic Gonadotropin
HCL	Hairy cell leukemia
HCT	Hematocrit
HCVD	Hypertensive cardiovascular disease
HD	Heart disease
HD	Heart disease
HEENT	Head, eyes, ears, nose & throat
HGB	Hemoglobin
HIV	Human immunodeficiency virus
HN2	Nitrogen mustard
H2O	Water
H/O	History of
HORM	Hormone
HOSP	Hospital
H&P	History and physical
HPF	High power field
HPI	History of present illness
HPV	Human papilloma virus
HR(S)	Hour(s)
HRT	Hormone Replacement therapy

ABBREVIATION	DESCRIPTION
HTLV-III	Human T-Lymphotrophic virus type III
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I	Iodine
IARC	International Agency for Research on Cancer
ICD-O-1	International Classification of Diseases for Oncology, 1st Ed., 1976
ICD-O-2	International Classification of Diseases, for Oncology, 2nd Ed., 1992
ICD-O-3	International Classification of Diseases, for Oncology, 3rd Ed., 2000
ICF	Intercellular fluid
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IG	Immunoglobulin
IM	Intramuscular
IMA	Internal mammary artery
IMP	Impression
INCL	Includes, including
INCR	Increase
INF	Inferior
INF	Infraction
INF	Infusion
INFILT	Infiltrating
INJ	Injection
INT MED	Internal medicine
INPT, IP	Inpatient
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement
IPPB	Intermittent positive pressure breathing
IPSI	Ipsilateral
IRREG	Irregular
IT	Intrathecal
IV	Intravenous
IVC	Inferior vena cava

ABBREVIATION	DESCRIPTION
IVP	Intravenous pyelogram
IVU	Intravenous Urography
JVD	Jugular venous distention
K	Potassium
KG	Kilogram
KJ	Knee jerk
KK	Knee kick
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L	Left
L	Liter
L	Lower
L1-L5	Lumbar vertebrae
LAD	Lymphadenopathy
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LCIS	Lobular carcinoma in-situ
LCM	Left costal margin
LDH	Lactic dehydrogenase
LE	Lower extremity; Lupus erythematosus
LFT	Liver function test
LG	Large
LIF	Left iliac fossa
LINAC	Linear accelerator
LIQ	Lower inner quadrant (breast)
LKS(B)	Liver, kidney, spleen, (bladder)
LLE	Left lower extremity
LLL	Left lower lobe (lung)
LLQ	Left lower quadrant (abdomen)
LMD	Local medical doctor
LMP	Last menstrual period
LN(S)	Lymph node(s)
LND	Lymph Node Dissection

ABBREVIATION	DESCRIPTION
LOP	Lower outer quadrant (breast)
LP	Lumbar puncture
LPF	Lower power field
LPN	Licensed practical nurse
LS	Lumbosacral
LSK, LKS	Liver, spleen, kidneys
LSO	Left salpingo-oophorectomy
L-SPINE	Lumbar spine
LT	Left
LUE	Left upper extremity
LUL	Left upper lobe (lung)
LUQ	Left upper quadrant (abdomen)
L&W	Living and well
M	Monocytes, meter
MAB	Monoclonal antibody
MAL	Malignant
MALT	mucosal-associated lymphoid tissue
MALIG	Malignant
MAND	Mandible
MAST	Mastectomy
M-CSF	Macrophage Colony-Stimulating Factor
MC	Millicurie
MCH	Mean corpuscular hemoglobin
MCHC	Mean corpuscular hemoglobin count
MCL	Mid clavicular line
MCV	Mean corpuscular volume
MD	Medical doctor
MD	Moderately differentiated
MED	Medicine
MOS	Myelodysplastic syndrome
MET, METS	Metastatic, metastases
MEV	Million electron volts
MH	Marital history
MH	Mental health

ABBREVIATION	DESCRIPTION
MI	Myocardial infarction
MIN	Minimum
MG	Milligram
MICRO	Microscopic
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MOD	Moderate
MOD DIFF	Moderately differentiated
MO	Month
MPNST	Malignant peripheral nerve sheath tumor
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MSL	Mid sternal line
MULT	Multiple
MX	Microscopic
MX	Maxilla(ry), maximum
NA	Not applicable
NBS	Normal bowel sounds
NEC	Not elsewhere classified
NED	No evidence of disease
NEG or -	Negative
NEMD	No Evidence of Metastatic Disease
NERD	No evidence of recurrent disease
NEURO	Neurology
NHL	Non Hodgkin lymphoma
NK	Natural killer
NL	Normal
NOS	Not otherwise specified
NR	Not recorded
NR	Not reportable
NSCLC	Non-small cell lung carcinoma
NSF	N significant findings
NTP	Normal temperature and pressure

ABBREVIATION	DESCRIPTION
N&V	Nausea and vomiting
NVD	neck vein distention
OB	Obstetrics
OBST	Obstructed (ing, ion)
OD	Right eye (oculus dexter)
OH	Occupational history
OP	Operation
OP	Outpatient
OPD	Outpatient clinic; department
OPHTH	Ophthalmology
OP RPT	Operative Report
OR	Operating room
ORTH	Orthopedics
OS	Bone
OS	Left eye (oculus sinister)
OS	Mouth
OS	Opening
OSTEO	Osteomyelitis
OT	Occupational therapy
OTO	Otology
OU	Each eye (oculus uterque)
OV	Office visit
OZ	Ounce
P	Pulse
P&A	Percussion and auscultation
PA	Posteroanterior
PA	Pulmonary artery
PA	Physician assistant
PALP	Palpable, palpated, palpation
PAP	Papanicolaou smear
PAP	Papillary
PAR	Post anesthesia room
PARA	Number of pregnancies resulting in viable infants
PATH	Pathology

ABBREVIATION	DESCRIPTION
PCV	Packed cell volume
PD	Poorly differentiated
PDR	Physician's Desk Reference
PE	Physical examination
PED	Pediatrics
PEG	Pneumoencephalography
PEG	Percutaneous gastrostomy tube
PERC	Percutaneous
PET	Positron emission tomography
PH	Past or personal history
PI	Present illness
PID	Pelvic inflammatory disease
PIN	Prostatic intraepithelial neoplasia
PLT	Platelets
PM	Post mortem (after death)
PMD	Personal (primary) medical doctor
PMH	Past medical history
PND	Postnasal drip
PNET	Peripheral neuroectodermal tumor (bone tumors)
PNET	Primitive neuroectodermal tumor (CNS tumors)
PO, POSTOP	Postoperative(ly)
POD	Postoperative day
POOR DIFF	Poorly differentiated
POS or +	Positive
POSS	Possible
POST	Posterior
POST	Postmortem examination
POSTOP	Postoperative(ly)
PPD	Purified protein derivative (Tuberculin skin test)
PPD	Packs per day
PR	Partial response
PR(A)	Progesterone receptor (assay)
PREOP	Preoperative(ly)
PTA	Prior to Admission

ABBREVIATION	DESCRIPTION
PROB	Probable(ly)
PSA	Prostate specific antigen
PT	Patient
PT	Physiotherapy
PTA	Prior to examination
PUO	Pyrexia of undetermined origin
PULM	Pulmonary
Q	Quadrant
QID	Four times a day
R	Roentgen
R	Respiration
R	Right
RA	Radium
RAD	Radiation
RAD	Radiation Absorbed Dose
RAD	Radical
RAEB (-T)	Refractory anemia with excess blasts (in transformation)
RAIU	Radioactive iodine (I 131) uptake
RARS	Refractory anemia with ringed sideroblasts
RBC	Red blood cells
RCM	Right costal margin
RCS	Reticulum cell sarcoma
REG	Radioencephalogram
RES	Reticuloendothelial system
RESEC	Resection
RESP	Respiratory
RH	Rhesus (monkey) factor in blood
RIA	Radioimmunoassay
RIF	Right iliac fossa
RIQ	Right inner quadrant (abdomen)
RLE	Right lower extremity
RLL	Right lower lobe (lung)
RLQ	Right lower quadrant
RML	Right middle lobe (lung)

ABBREVIATION	DESCRIPTION
RMS	Rhabdomyosarcoma
RN	Registered nurse
RNP	Registered nurse practitioner
RNA	Ribonucleic acid
RO, R/O	Rule out
ROF	Review of outside films
ROM	Range of motions
ROS	Review of slides
ROS	Review of outside slides
ROS	Review of Systems
ROQ	Right outer quadrant (abdomen)
RSO	Right salpingo-oophorectomy
R-S cells	Reed-Sternberg cells
RT	Radiation therapy
RT	Right
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
R-V	Rectovaginal
RX	Treatment
S1S5	Sacral vertebra
SALT	Skin-associated lymphoid tissue
SARC	Sarcoma
SB	Small bowel
SBE	Subacute bacterial endocarditis
SCC	Squamous cell carcinoma
S-COLON	Sigmoid Colon
SEER	Surveillance Epidemiology and End Results
SGOT	Serum glutamic oxaloacetic
SGPT	Serum glutamic pyruvic transaminase
SS	Social Security
SH	Serum hepatitis
SM	Small
SMA	Sequential multiple analysis (Biochem profile)

ABBREVIATION	DESCRIPTION
SML BWL	Small bowel
SNF	Skilled nursing facility
SO	Salpingo-oophorectomy
SOB	Shortness of breath
SOL	Solution
S/P	Status post
SPEC	Specimen
SP GR	Specific gravity
S-Q, SQ	Subcutaneous
SQ, SQUAM	Squamous
SQ CELL CA	Squamous cell carcinoma
SR	Sedimentation rate
S-SPINE	Sacral spine
STAPH	Staphylococcus
STAT	Immediately (statim)
STREP	Streptococcus
STSG	Split thickness skin graft
SUBCU	Subcutaneous
SUB-Q, SUBQ	Subcutaneous
SURG	Surgery, surgical
SUSP	Suspicious/Suspected
SVC	Superior vena cava
SX	Symptoms
SYMP	Symptoms
T	Temperature
T	Thoracic
TA	Toxin-antitoxin
T1-T2	Thoracic vertebra
T&A	Tonsillectomy and adenoidectomy
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy-bilateral salpingo oophorectomy
TB, TBC	Tuberculosis
TCC	Transitional cell carcinoma
T-COLON	Transverse Colon

ABBREVIATION	DESCRIPTION
TD	Tumor dose
TID	Three times a day
TNM	Tumor, Nodes, Metastasis
TP	Total protein
TPN	Total parenteral nutrition
TPR	Temperature, pulse and respiration
TS	Tumor size
TSH	Thyroid stimulating hormone
T-SPINE	Thoracic spine
TUR	Transurethral resection
TURB	Transurethral resection-Bladder
TURP	Transurethral resection-Prostate
TVH	Total vaginal hysterectomy
TX	Treatment
U	Unit
UCHD	Usual childhood diseases
UE	Upper extremity
UGI	Upper gastrointestinal
UIQ	Upper inner quadrant (breast)
ULCC	Undifferentiated large cell carcinoma
UMB	Navel (umbilicus)
UNDIFF	Undifferentiated
UOQ	Upper outer quadrant (abdomen)
UR	Urine
URI	Upper respiratory infection
UROL	Urology
UTI	Urinary tract infection
VAG	Vagina, Vaginal
VAG HYST	Vaginal hysterectomy
VAIN	Vaginal intraepithelial neoplasia
VASC	Vascular
VD	Venereal Disease
VIN	Vulvar intraepithelial neoplasia
VS	Vital signs

ABBREVIATION	DESCRIPTION
W/	With
WBC	White blood cells
W/D	Well developed
WD, WELL DIFF	Well differentiated
W/F	White female
W/M	White male
WN	Well nourished
WNL	Within normal limits
W/O	Without
WT	Weight
W/U	Work-up
XR	X-ray
Y/O	Year old
YR	Year

Symbols

@ At

/ Comparison

< Decrease, Less than

= Equals

> Increase, More than

- Negative

Number*

+ Positive

Pounds**

x Times

*If it appears before a numeral

**If it appears after a numeral

F

APPENDIX F:
COMPARISON OF DATA SETS

Definitions

- **Required Data Set (R):** Commission-approved programs must record the required data set items using the codes and definitions specified in the STORE manual.
- **Supplementary Data Set (S):** The supplementary data set contains additional data items that are important for the efficient operation of a cancer registry.
- **Surveillance, Epidemiology, and End Results Program (SEER):** Required data elements for a central registry affiliated with the National Cancer Institute's SEER Program.
- **National Program of Cancer Registries (NPCR):** Refers to requirements and recommendations of the NPCR regarding data items that should be collected or computed by NPCR state registries.
- **Commission on Cancer (CoC):** Refers to requirements and recommendations of the Commission on Cancer of ACoS.
- **Texas Cancer Registry (TCR):** Refers to the requirements and recommendations of the Texas Cancer Registry.
- **Exchange Elements for Hospital to Central and Central to Central:** Items required for facilities reporting to central registries (labeled Hosp>Central), and items that central registries should use when sending cases to other central registries (labeled Central>Central).

Codes for Recommendations

(If left blank, the data field is not currently collected by the TCR and other entities.)

• No recommendations

C Collect

D Derived

D* Derived, when available

D+ Derived; central registries may collect either SEER Summary Stage 2000 or Collaborative Stage

DH Historically derived and currently transmitted

DH* Historically derived and currently transmitted when available

R Required

R# Required; central registries may code available data using either SEER or CoC data items and associated rules

R#* Required, when available; central registries may code available data using SEER or CoC data items and associated rules

R$ Requirements differ by year

R* Required, when available

R^ Required, these text requirements may be met with one or several text block fields

R+ Required, central registries may collect either SEER Summary Stage 2000 or Collaborative Stage

RC Collected by SEER from CoC-accredited hospitals

RH Historically collected and currently transmitted

RH* Historically collected and currently transmitted when available

RN Collect according to NPCR stage transition schedule

RS Required, site specific

RS# Required, site specific; central registries may code available data using either SEER or CoC data items and associated rules

RS* Required, site specific; when available

Ret. Retired

Rev. Revised

S Supplementary/recommended

T Data is vital to complete exchange record

T* Transmit data if available for any case in exchange record

TH Only certain historical cases may require these fields

TH* Only certain historical cases may require these fields; transmit data if available for any case in exchange record

√ Populated by TCR

The following table is derived from **Chapter VIII: Required Status Table** of the NAACCR *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*, which can be found at http://datadictionary.naaccr.org/?c=8.

Table F.1 Comparison of Data Sets

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	10	Record Type	√	R	•	R	•	R			NAACCR
	20	Patient ID Number	√	R	•	•	R	R			Reporting Registry
	21	Patient System ID-Hosp	•	•	•	•	•	•			NAACCR
	30	Registry Type	•	•	•	•	•	•			NAACCR
	35	FIN Coding System									Retired
	37	Reserved 00									

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	40	Registry ID	R	R	•	•	R	R			NAACCR
	45	NPI--Registry ID	•	•	•	•	R*	•			CMS
	50	NAACCR Record Version	R	R	•	R	R	R			NAACCR
	60	Tumor Record Number	•	•	•	•	S	S			NAACCR
	70	Addr at DX--City	R	R	R	R	R	•			CoC
	80	Addr at DX--State	R	R	R	R	R	R			CoC
New	81	State at DX Geocode 1970/80/90	D	D	•	•	R	R			NAACCR
New	82	State at DX Geocode 2000	D	D	•	•	R	R			NAACCR
New	83	State at DX Geocode 2010	D	D	•	•	R*	R*			NAACCR
New	84	State at DX Geocode 2020	D	D	•	•	•	•			NAACCR
New	89	County at DX Analysis	D	D	•	•	R	R			NAACCR
Rev.	90	County at DX Reported	R	R	R	R	R	R			FIPS/SEER
Rev.	94	County at DX Geocode 1970/80/90	D	D	•	•	D	R			NAACCR
	95	County at DX Geocode2000	D	D	•	•	D	R			NAACCR
	96	County at DX Geocode2010	D	D	•	•	D	R			NAACCR
Rev.	97	County at DX Geocode2020	D	D	•	•	•	•			NAACCR
	100	Addr at DX--Postal Code	R	R	R	R	R	•			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	102	Addr at DX--Country	•	•	R	R	R	•			NAACCR
	110	Census Tract 1970/80/90	DH*	RH*	•	•	RH	RH			SEER
	120	Census Cod Sys 1970/80/90	DH*	RH*	•	•	RH	RH			SEER
New	125	Census Tract 2020	D	D	•	•	R*	R*			NAACCR
	130	Census Tract 2000	RH	RH	•	•	RH	RH			NAACCR
	135	Census Tract 2010	R	R	•	•	R	R			NAACCR
	145	Census Tr Poverty Indictr	R	R	•	•	D	R			NAACCR
	150	Marital Status at DX	•	•	•	•	R	R			SEER
	160	Race 1	R	R	R	R	R	R			SEER/CoC
	161	Race 2	R	R	R	R	R	R			SEER/CoC
	162	Race 3	R	R	R	R	R	R			SEER/CoC
	163	Race 4	R	R	R	R	R	R			SEER/CoC
	164	Race 5	R	R	R	R	R	R			SEER/CoC
	170	Race Coding Sys--Current	•	•	R	R	•	•			NAACCR
	180	Race Coding Sys--Original	•	•	R	R	•	•			NAACCR
	190	Spanish/Hispanic Origin	R	R	R	R	R	R			SEER/CoC
	191	NHIA Derived Hisp Origin	D	D	•	•	D	R			NAACCR
	192	IHS Link	√	R*	•	•	•	R			NPCR
	193	Race--NAPIIA(derived API)	D	R	•	•	D	R			NAACCR
	200	Computed Ethnicity	R	R	•	•	D	R			SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	210	Computed Ethnicity Source	R	R	•	•	R	R			SEER
Rev.	220	Sex	R	R	R	R	R	R			SEER/CoC
	230	Age at Diagnosis	√	R	R	R	R	R			SEER/CoC
Rev.	240	Date of Birth	R	R	R	R	R	R			SEER/CoC
	241	Date of Birth Flag	D	R	R	R	R	R			NAACCR
Rev.	250	Birthplace	RH*	RH*	•	•	•	•			SEER/CoC
Rev.	252	Birthplace--State	R*	R*	R	R	R	R			NAACCR
Rev.	254	Birthplace--Country	R*	R*	R	R	R	R			NAACCR
Ret	260	Religion									
	270	Census Occ Code 1970-2000	√	R*	•	•	•	•			Census/NPCR
	272	Census Ind Code 2010 CDC	R*	R*	•	•	•	•			Census/NPCR
	280	Census Ind Code 1970-2000	√	R*	•	•	•	•			Census/NPCR
	282	Census Occ Code 2010 CDC	R*	R*	•	•	•	•			Census/NPCR
	290	Occupation Source	√	R*	•	•	•	•			NPCR
	300	Industry Source	√	R*	•	•	•	•			NPCR
	310	Text--Usual Occupation	R	R*	•	•	•	•			NPCR
	320	Text--Usual Industry	R	R*	•	•	•	•			NPCR
	330	Census Occ/Ind Sys 70-00	√	R*	•	•	•	•			NPCR
New	339	RUCA 2000		D	•	•	D	R			NAACCR
New	341	RUCA 2010		D	•	•	D	R			NAACCR
New	345	URIC 2000		D	•	•	D	R			NAACCR
New	346	URIC 2010		D	•	•	D	R			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	351	GeoLocationID - 1970/80/90		D	•	•	R	R			NAACCR
New	352	GeoLocationID - 2000		D	•	•	R	R			NAACCR
New	353	GeoLocationID - 2010		D	•	•	R	R			NAACCR
New	354	GeoLocationID - 2020		D	•	•	•	•			NAACCR
New	361	Census Block Group 2020		•	•	•	•	•			Census
	362	Census Block Group 2000	D	•	•	•	S	•			Census
	363	Census Block Group 2010	•	•	•	•	R	•			Census
	364	Census Tr Cert 1970/80/90	D	RH*	•	•	RH	RH			SEER
	365	Census Tr Certainty 2000	D	RH	•	•	RH	RH			NAACCR
	366	GIS Coordinate Quality	R*	R*	•	•	S	•			NAACCR
	367	Census Tr Certainty 2010	D	R	•	•	R	R			NAACCR
Rev.	368	Census Block Grp 1970/80/90	•	•	•	•	S	•			Census
New	369	Census Tract Certainty 2020	D	D	•	•	•	•			NAACCR
	370	Reserved 01									
	380	Sequence Number--Central	R	R	•	•	R	R			SEER
	390	Date of Diagnosis	R	R	R	R	R	R			SEER/CoC
	391	Date of Diagnosis Flag	D	R	•	•	R	R			NAACCR
	400	Primary Site	R	R	R	R	R	R			SEER/CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	410	Laterality	R	R	R	R	R	R			SEER/CoC
	419	Morph--Type&Behav ICD-O-2	•	•	•	•	•	•			
	420	Histology (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH			SEER/CoC
	430	Behavior (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH			SEER/CoC
	439	Date of Mult Tumors Flag	•	•	RH	RH	RH	RH			NAACCR
Rev.	440	Grade	RH	RH	RH	RH	RH	RH			SEER/CoC
	441	Grade Path Value		RH*	RH	RH	RH	RH			AJCC
	442	Ambiguous Terminology DX	•	•	RH	RH	RH	RH			SEER
	443	Date Conclusive DX	•	•	RH	RH	RH	RH			SEER
	444	Mult Tum Rpt as One Prim	•	•	RH	RH	RH	RH			SEER
	445	Date of Mult Tumors	•	•	RH	RH	RH	RH			SEER
	446	Multiplicity Counter	•	•	RH	RH	RH	RH			SEER
	448	Date Conclusive DX Flag	•	•	RH	RH	RH	RH			NAACCR
	449	Grade Path System		RH*	RH	RH	RH	RH			AJCC
	450	Site Coding Sys--Current	R	R	R	R	•	•			NAACCR
	460	Site Coding Sys--Original	•	•	R	R	•	•			NAACCR
Rev.	470	Morph Coding Sys--Current	R	R	R	R	•	•			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	480	Morph Coding Sys--Originl	•	•	R	R	•	•			NAACCR
	490	Diagnostic Confirmation	R	R	R	R	R	R			SEER/CoC
	500	Type of Reporting Source	R	R	•	•	R	R			SEER
	501	Casefinding Source	R*	R*	•	•	•	•			NAACCR
	521	Morph--Type&Behav ICD-O-3	•	•	•	•	•	•			
	522	Histologic Type ICD-O-3	R	R	R	R	R	R			SEER/CoC
	523	Behavior Code ICD-O-3	R	R	R	R	R	R			SEER/CoC
	530	Reserved 02									
	540	Reporting Facility	R	R	R	R	R	•			CoC
	545	NPI--Reporting Facility	D	R*	R	R	R*	•			CMS
	550	Accession Number--Hosp	R	•	R	R	R	•			CoC
	560	Sequence Number--Hospital		•	R	R	R	•			CoC
	570	Abstracted By	R	•	R	R	R	•			CoC
	580	Date of 1st Contact	R	R	R	R	•	•			CoC
	581	Date of 1st Contact Flag	R	R	R	R	•	•			NAACCR
	590	Date of Inpt Adm	•	•	•	•	•	•			NAACCR
	591	Date of Inpt Adm Flag	•	•	•	•	•	•			NAACCR
	600	Date of Inpt Disch	•	•	•	•	•	•			NAACCR
	601	Date of Inpt Disch Flag	•	•	•	•	•	•			NAACCR
	605	Inpatient Status	•	•	•	•	•	•			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	610	Class of Case	R	R	R	R	RC	•			CoC
	630	Primary Payer at DX	R*	R*	R	R	R	R			CoC
	668	RX Hosp--Surg App 2010	•	•	R	R	•	•			CoC
	670	RX Hosp--Surg Prim Site	•	•	R	R	R	•			CoC
	672	RX Hosp--Scope Reg LN Sur	•	•	R	R	R	•			CoC
	674	RX Hosp--Surg Oth Reg/Dis	•	•	R	R	R	•			CoC
	676	RX Hosp--Reg LN Removed	•	•	RH	RH	•				CoC
	680	Reserved 03									
New	682	Date Regional Lymph Node Dissection	•	•	R	R	RC				NAACCR
New	683	Date Regional Lymph Node Dissection Flag	•	•	•	•	RC				NAACCR
	690	RX Hosp--Radiation	•	•	•	•	RH				SEER
	700	RX Hosp--Chemo	•	•	R	R	R				CoC
	710	RX Hosp--Hormone	•	•	R	R	R				CoC
	720	RX Hosp--BRM	•	•	R	R	R				CoC
	730	RX Hosp--Other	•	•	R	R	R				CoC
	740	RX Hosp--DX/Stg Proc	•	•	R	R	•				CoC
	746	RX Hosp--Surg Site 98-02	•	•	RH	RH	RH				CoC
	747	RX Hosp--Scope Reg 98-02	•	•	RH	RH	RH				CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	748	RX Hosp--Surg Oth 98-02	•	•	RH	RH	RH				CoC
	750	Reserved 04	•								
Rev.	752	Tumor Size Clinical	•	•	•	•	R				SEER
Rev.	754	Tumor Size Pathologic	•	•	•	•	R	R			SEER
	756	Tumor Size Summary	R	R	R	R	S	S			NPCR/CoC
Rev.	759	SEER Summary Stage 2000	RH	R	RH	RH	RH	RH			SEER
	760	SEER Summary Stage 1977	RH	RH	RH	RH	•	S			SEER
Rev.	762	Derived Summary Stage 2018	•	RN	•	•	D	R			SEER
Rev.	764	Summary Stage 2018	R	R	R	R	R*	R*			SEER
Rev.	772	EOD Primary Tumor	•	•	•	•	R	R			SEER
Rev	774	EOD Regional Nodes	•	•	•	•	R	R			SEER
Rev.	776	EOD Mets	•	•	•	•	R	R			SEER
Rev.	779	Extent of Disease 10-Dig		RN	•	•	•	•			
Rev.	780	EOD--Tumor Size	RH	RN	RH	RH	RH	RH			SEER/CoC
Rev.	785	Derived EOD 2018 T	•	•	•	•	D	R			SEER
Rev.	790	EOD--Extension	•	•	•	•	RH	RH			SEER
New	795	Derived EOD 2018 M	•	•	•	•	D	R			SEER
Rev.	800	EOD--Extension Prost Path	•	•	•	•	RH	RH			SEER
	810	EOD--Lymph Node Involv	•	•	•	•	RH	RH			SEER
New	815	Derived EOD 2018 N	•	•	•	•	D	R			SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	818	Derived EOD 2018 Stage Group	•	•	•	•	D	R			SEER
	820	Regional Nodes Positive	R	R	R	R	R	R			SEER/CoC
	830	Regional Nodes Examined	R	R	R	R	R	R			SEER/CoC
New	832	Date of Sentinel Lymph Node Biopsy	•	•	RS	RS	R*	R*			CoC
New	833	Date Sentinel Lymph Node Biopsy Flag	•	•	RS	RS	R*	R*			CoC
New	834	Sentinel Lymph Nodes Examined	•	•	RS	RS	R*	R*			CoC
New	835	Sentinel Lymph Nodes Positive	•	•	RS	RS	R*	R*			CoC
	840	EOD--Old 13 Digit	•	•	•	•	RH	RH			SEER
	850	EOD--Old 2 Digit	•	•	•	•	RH	RH			SEER
	860	EOD--Old 4 Digit	•	•	•	•	RH	RH			SEER
	870	Coding System for EOD	•	•	•	•	RH	RH			SEER
Rev.	880	TNM Path T	RH	RH	RH	RH	RH	RH			AJCC
Rev.	890	TNM Path N	RH	RH	RH	RH	RH	RH			AJCC
Rev.	900	TNM Path M	RH	RH	RH	RH	RH	RH			AJCC
Rev.	910	TNM Path Stage Group	RH	RH	RH	RH	RH*	RH*			AJCC
Rev.	920	TNM Path Descriptor	RH	RH	RH	RH	RH	RH			CoC
Rev.	930	TNM Path Staged By	•	•	RH	RH	RH	RH			CoC
Rev.	940	TNM Clin T	RH	RH	RH	RH	RH	RH			AJCC
Rev.	950	TNM Clin N	RH	RH	RH	RH	RH	RH			AJCC
Rev.	960	TNM Clin M	RH	RH	RH	RH	RH	RH			AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	970	TNM Clin Stage Group	RH	RH	RH	RH	RH*	RH*			AJCC
Rev.	980	TNM Clin Descriptor	RH	RH	RH	RH	RH	RH			CoC
Rev.	990	TNM Clin Staged By	•	•	•	RH	RH	RH			CoC
New	995	AJCC ID	D	D	D	R	R*	R*			NAACCR
New	1001	AJCC TNM Clin T	•	•	R	R	R*	R*			AJCC
New	1002	AJCC TNM Clin N	•	•	R	R	R*	R*			AJCC
New	1003	AJCC TNM Clin M	•	•	R	R	R*	R*			AJCC
New	1004	AJCC TNM Clin Stage Group	•	•	R	R	R*	R*			AJCC
New	1011	AJCC TNM Path T	•	•		R	R*	R*			AJCC
New	1012	AJCC TNM Path N	•	•	•	•	R*	R*			AJCC
New	1013	AJCC TNM Path M	•	•	R	R	R*	R*			AJCC
New	1014	AJCC TNM Path Stage Group	•	•	R	R	R*	R*			AJCC
New	1021	AJCC TNM Post Therapy T	•	•	R	R	R*	R*			AJCC
New	1022	AJCC TNM Post Therapy N	•	•	R	R	R*	R*			AJCC
New	1023	AJCC TNM Post Therapy M	•	•	R	R	R*	R*			AJCC
New	1024	AJCC TNM Post Therapy Stage Group	•	•	R	R	R*	R*			AJCC
Ret.	1030	TNM Other Stage Group									Retired
New	1031	AJCC TNM Clin T Suffix	•	•	•	•	R*	R*			AJCC
New	1032	AJCC TNM Path T Suffix	•	•	•	•	R*	R*			AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	1033	AJCC TNM Post Therapy T Suffix	•	•	•	•	R*	R*			AJCC
New	1034	AJCC TNM Clin N Suffix	•	•	•	•	R*	R*			AJCC
New	1035	AJCC TNM Path N Suffix	•	•	•	•	R*	R*			AJCC
New	1036	AJCC TNM Post Therapy N Suffix	•	•	•	•	R*	R*			AJCC
Rev.	1060	TNM Edition Number	RH	RH	RH	RH	RH	RH			CoC
Rev.	1112	Mets at DX-Bone	•	•	R	R	R	R			SEER
Rev.	1113	Mets at DX-Brain	•	•	R	R	R	R			SEER
Rev.	1114	Mets at Dx-Distant LN	•	•	R	R	R	R			SEER
Rev.	1115	Mets at DX-Liver	•	•	R	R	R	R			SEER
Rev.	1116	Mets at DX-Lung	•	•	R	R	R	R			SEER
Rev.	1117	Mets at DX-Other	•	•	R	R	R	R			SEER
	1120	Pediatric Stage	•	•	•	•	•	•			CoC
	1130	Pediatric Staging System	•	•	•	•	•	•			CoC
	1140	Pediatric Staged By	•	•	•	•	•	•			CoC
	1150	Tumor Marker 1	•	•	RH	RH	RH	RH			SEER
	1160	Tumor Marker 2	•	•	RH	RH	RH	RH			SEER
	1170	Tumor Marker 3	•	•	RH	RH	RH	RH			SEER
	1180	Reserved 05	•								
	1182	Lymphovascular Invasion	R	R*	R	R	RS	RS			AJCC
	1190	Reserved 06									
	1200	RX Date Surgery	R	R	R	R	RC	RC			CoC
	1201	RX Date Surgery Flag	R	R	R	R	RC	RC			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1210	RX Date Radiation	R	R	R	R	RC	RC			CoC
	1211	RX Date Radiation Flag	R	R	R	R	RC	RC			NAACCR
	1220	RX Date Chemo	R	R	R	R	RC	RC			CoC
	1221	RX Date Chemo Flag	R	R	R	R	RC	RC			NAACCR
	1230	RX Date Hormone	R	R	R	R	RC	RC			CoC
	1231	RX Date Hormone Flag	R	R	R	R	RC	RC			NAACCR
	1240	RX Date BRM	R	R	R	R	RC	RC			CoC
	1241	RX Date BRM Flag	R	R	R	R	RC	RC			NAACCR
	1250	RX Date Other	R	R	R	R	RC	RC			CoC
	1251	RX Date Other Flag	R	R	R	R	RC	RC			NAACCR
	1260	Date Initial RX SEER	R	R#	•	•	R	R			SEER
	1261	Date Initial RX SEER Flag	D	R#	•	•	R	R			NAACCR
	1270	Date 1st Crs RX CoC	R#	R#	R	R	•	•			CoC
	1271	Date 1st Crs RX CoC Flag	R#	R#	R	R	•	•			NAACCR
	1280	RX Date DX/Stg Proc	•	•	R	R	•	•			CoC
	1281	RX Date DX/Stg Proc Flag	•	•	R	R	•	•			NAACCR
	1285	RX Summ--Treatment Status	R#	R#	R	R	R	R			SEER/CoC
	1290	RX Summ--Surg Prim Site	R	R	R	R	R	R			SEER/CoC
	1292	RX Summ--Scope Reg LN Sur	R	R	R	R	R	R			SEER/CoC
	1294	RX Summ--Surg Oth Reg/Dis	R	R	R	R	R	R			SEER/CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1296	RX Summ--Reg LN Examined	•	•	RH	RH	RH	RH			SEER/CoC
	1300	Reserved 07									
	1310	RX Summ--Surgical Approch		•	RH	RH	•	•			CoC
	1320	RX Summ--Surgical Margins	•	•	R	R	R*	R*			CoC
	1330	RX Summ--Reconstruct 1st	•	•	RH	RH	RH	RH			SEER
	1340	Reason for No Surgery	R	R	R	R	R	R			SEER/CoC
	1350	RX Summ--DX/Stg Proc	•	•	R	R	•	•			CoC
Rev.	1360	RX Summ--Radiation	RH	RH	•	•	RH	RH			SEER
	1370	RX Summ--Rad to CNS	•	•	•	•	RH	RH			SEER/CoC
	1380	RX Summ--Surg/Rad Seq	R	R	R	R	R	R			SEER/CoC
	1390	RX Summ--Chemo	R	R	R	R	R	R			SEER/CoC
	1400	RX Summ--Hormone	R	R	R	R	R	R			SEER/CoC
	1410	RX Summ--BRM	R	R	R	R	R	R			SEER/CoC
	1420	RX Summ--Other	R	R	R	R	R	R			SEER/CoC
	1430	Reason for No Radiation	R	R	R	R	•	•			CoC
	1460	RX Coding System--Current	R	R	R	R	•	RH			NAACCR
New	1501	Phase I Dose per Fraction	•	•	R	R	R*	R*			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	1502	Phase I Radiation External Beam Planning Tech	•	•	R	R	R*	R*			CoC
New	1503	Phase I Number of Fractions	•	•	R	R*	R*				CoC
New	1504	Phase I Radiation Primary Treatment Volume	•	•	R	R*	R*				CoC
New	1505	Phase I Radiation to Draining Lymph Nodes	•	•	R	R*	R*				CoC
New	1506	Phase I Radiation Treatment Modality	R	R	R	R	R	R			CoC
New	1507	Phase I Total Dose	•	•	R	R	R*	R*			CoC
Rev.	1510	Rad--Regional Dose: cGy	•	•	RH	RH	•	•			CoC
New	1511	Phase II Dose per Fraction	•	•	R	R	R*	R*			CoC
New	1512	Phase II Radiation External Beam Planning Tech	•	•	R	R	R*	R*			CoC
New	1513	Phase II Number of Fractions	•	•	R	R	R*	R*			CoC
New	1514	Phase II Radiation Primary Treatment Volume	•	•	R	R	R*	R*			CoC
New	1515	Phase II Radiation to Draining Lymph Nodes	•	•	R	R	R*	R*			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	1516	Phase II Radiation Treatment Modality	•	•	R	R	R	R			CoC
New	1517	Phase II Total Dose	•	•	R	R	R*	R*			CoC
Rev.	1520	Rad--No of Treatment Vol	•	•	RH	RH	•	•			CoC
New	1521	Phase III Dose per Fraction	•	•	R	R	R*	R*			CoC
New	1522	Phase III Radiation External Beam Planning Tech	•	•	R	R	R*	R*			CoC
New	1523	Phase III Number of Fractions	•	•	R	R	R*	R*			CoC
New	1524	Phase III Radiation Primary Treatment Volume	•	•	R	R	R*	R*			CoC
New	1525	Phase III Radiation to Draining Lymph Nodes	•	•	R	R	R*	R*			CoC
New	1526	Phase III Radiation Treatment Modality	•	•	R	R	R	R			CoC
New	1527	Phase III Total Dose	•	•	R	R	R*	R*			CoC
New	1531	Radiation Treatment Discontinued Early	•	•	R	R	R*	R*			CoC
New	1532	Number of Phases of Rad Treatment to this Volume	•	•	R	R	R*	R*			CoC
New	1533	Total Dose	•	•	R	R	R*	R*			CoC
Rev.	1540	Rad--Treatment Volume	•	•	RH	RH	•	•			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	1550	Rad--Location of RX	•	•	RH	RH	•	•			CoC
Rev.	1570	Rad--Regional RX Modality	RH	RH	RH	RH	RH	•			CoC
	1639	RX Summ--Systemic/Sur Seq	R	R	R	R	R	R			CoC
	1640	RX Summ--Surgery Type	•	•	•	•	RH	RH			SEER
	1646	RX Summ--Surg Site 98-02	•	•	RH	RH	RH	RH			SEER/CoC
	1647	RX Summ--Scope Reg 98-02	•	•	RH	RH	RH	RH			SEER/CoC
	1648	RX Summ--Surg Oth 98-02	•	•	RH	RH	RH	RH			SEER/CoC
	1650	Reserved 08	•								
	1660	Subsq RX 2nd Course Date	•	•	•	•	•	•			CoC
	1661	Subsq RX 2ndCrs Date Flag	•	•	•	•	•	•			NAACCR
	1670	Subsq RX 2nd Course Codes	•	•	•	•	•	•			
	1671	Subsq RX 2nd Course Surg	•	•	•	•	•	•			CoC
	1672	Subsq RX 2nd Course Rad	•	•	•	•	•	•			CoC
	1673	Subsq RX 2nd Course Chemo	•	•	•	•	•	•			CoC
	1674	Subsq RX 2nd Course Horm	•	•	•	•	•	•			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1675	Subsq RX 2nd Course BRM	•	•	•	•	•	•			CoC
	1676	Subsq RX 2nd Course Oth	•	•	•	•	•	•			CoC
	1677	Subsq RX 2nd--Scope LN SU	•	•	•	•	•	•			CoC
	1678	Subsq RX 2nd--Surg Oth	•	•	•	•	•	•			CoC
	1679	Subsq RX 2nd--Reg LN Rem	•	•	•	•	•	•			CoC
	1680	Subsq RX 3rd Course Date	•	•	•	•	•	•			CoC
	1681	Subsq RX 3rdCrs Date Flag	•	•	•	•	•	•			NAACCR
	1690	Subsq RX 3rd Course Codes	•	•	•	•	•	•			
	1691	Subsq RX 3rd Course Surg	•	•	•	•	•	•			CoC
	1692	Subsq RX 3rd Course Rad	•	•	•	•	•	•			CoC
	1693	Subsq RX 3rd Course Chemo	•	•	•	•	•	•			CoC
	1694	Subsq RX 3rd Course Horm	•	•	•	•	•	•			CoC
	1695	Subsq RX 3rd Course BRM	•	•	•	•	•	•			CoC
	1696	Subsq RX 3rd Course Oth	•	•	•	•	•	•			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1697	Subsq RX 3rd--Scope LN Su	•	•	•	•	•	•			CoC
	1698	Subsq RX 3rd--Surg Oth	•	•	•	•	•	•			CoC
	1699	Subsq RX 3rd--Reg LN Rem	•	•	•	•	•	•			CoC
	1700	Subsq RX 4th Course Date	•	•	•	•	•	•			CoC
	1701	Subsq RX 4thCrs Date Flag	•	•	•	•	•	•			NAACCR
	1710	Subsq RX 4th Course Codes	•	•	•	•	•	•			
	1711	Subsq RX 4th Course Surg	•	•	•	•	•	•			CoC
	1712	Subsq RX 4th Course Rad	•	•	•	•	•	•			CoC
	1713	Subsq RX 4th Course Chemo	•	•	•	•	•	•			CoC
	1714	Subsq RX 4th Course Horm	•	•	•	•	•	•			CoC
	1715	Subsq RX 4th Course BRM	•	•	•	•	•	•			CoC
	1716	Subsq RX 4th Course Oth	•	•	•	•	•	•			CoC
	1717	Subsq RX 4th--Scope LN Su	•	•	•	•	•	•			CoC
	1718	Subsq RX 4th--Surg Oth	•	•	•	•	•	•			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1719	Subsq RX 4th--Reg LN Rem	•	•	•	•	•	•			CoC
	1740	Reserved 09									
	1741	Subsq RX--Reconstruct Del	•	•	•	•	•	•			CoC
	1750	Date of Last Contact	R	R	R	R	R	R			SEER/CoC
	1751	Date of Last Contact Flag	D	R	R	R	R	R			NAACCR
	1760	Vital Status	R	R	R	R	R	R			SEER/CoC
New	1762	Vital Status Recode	D	D	•	•	D	R			NAACCR
	1770	Cancer Status	•	•	R	R	•	•			CoC
New	1772	Date of Last Cancer (tumor) Status	•	•	R	R	•	•			CoC
New	1773	Date of Last Cancer (tumor) Status Flag			R	R	•	•			CoC
New	1775	Record Number Recode	•	•	•	•	D	R			NAACCR
New	1780	Quality of Survival	•	•	•	•	•	•			CoC
	1782	Surv-Date Active Followup	•	•	•	•	D	R			NAACCR
	1783	Surv-Flag Active Followup	•	•	•	•	D	R			NAACCR
	1784	Surv-Mos Active Followup	•	•	•	•	D	R			NAACCR
Rev.	1785	Surv-Date Presumed Alive	•	D	•	•	D	R			NAACCR
Rev.	1786	Surv-Flag Presumed Alive	•	D	•	•	D	R			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	1787	Surv-Mos Presumed Alive	•	D	•	•	D	R			NAACCR
Rev.	1788	Surv-Date DX Recode	•	D	•	•	D	R			NAACCR
	1790	Follow-Up Source	R*	R*	R	•	•	•			CoC
	1791	Follow-up Source Central	D	R	•	•	•	•			NAACCR
	1800	Next Follow-Up Source	•	•	R	•	•	•			CoC
	1810	Addr Current--City	•	•	R	•	R	•			CoC
	1820	Addr Current--State	•	•	R	•	R	•			CoC
	1830	Addr Current--Postal Code	•	•	R	•	R	•			CoC
	1832	Addr Current--Country	•	•	R	•	R	•			NAACCR
	1835	Reserved 10									
	1840	County--Current	•	•	•	•	•	•			NAACCR
	1842	Follow-Up Contact--City	•	•	•	•	•	•			SEER
	1844	Follow-Up Contact--State	•	•	•	•	•	•			SEER
	1846	Follow-Up Contact--Postal	•	•	•	•	•	•			SEER
	1847	FollowUp Contact--Country	•	•	•	•	•	•			NAACCR
	1850	Unusual Follow-Up Method	•	•	•	•	•	•			NAACCR
	1860	Recurrence Date--1st	•	•	R	R	RC	•			CoC
	1861	Recurrence Date--1st Flag	•	•	R	R	RC	•			NAACCR
	1880	Recurrence Type--1st	•	•	R	R	RC	•			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1900	Reserved 11									
	1910	Cause of Death	√	R	•	•	R	R			SEER
New	1914	SEER Cause Specific COD	•	D	•	•	D	R			SEER
New	1915	SEER Other COD	•	D	•	•	D	R			SEER
	1920	ICD Revision Number	√	R	•	•	R	R			SEER
	1930	Autopsy	•	•	•	•	•	•			NAACCR
	1940	Place of Death		RH	•	•	•	•			NPCR
	1942	Place of Death--State	R	R	•	•	R*	R*			NAACCR
	1944	Place of Death--Country	R*	R*	•	•	R*	R*			NAACCR
	1960	Site (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1970	Morph (73-91) ICD-O-1	•	•	•	•	•	•			
	1971	Histology (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1972	Behavior (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1973	Grade (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1980	ICD-O-2 Conversion Flag	•	•	RH	RH	R	R			SEER
	1981	Over-ride SS/NodesPos	•	•	•	•	R	R			NAACCR
	1982	Over-ride SS/TNM-N	•	•	•	•	R	R			NAACCR
	1983	Over-ride SS/TNM-M	•	•	•	•	R	R			NAACCR
	1985	Over-ride Acsn/Class/Seq	•	•	R	R	•	•			CoC
	1986	Over-ride HospSeq/DxConf	•	•	R	R	•	•			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1987	Over-ride CoC-Site/Type	•	•	R	R	•	•			CoC
	1988	Over-ride HospSeq/Site	•	•	R	R	•	•			CoC
	1989	Over-ride Site/TNM-StgGrp	R	R	R	R	•	•			CoC
	1990	Over-ride Age/Site/Morph	D	R	R	R	R	R			SEER
New	1992	Over-ride TNM Stage	•	RN	•	•	•	•			NAACCR
New	1993	Over-ride TNM Tis	•	RN	•	•	•	•			NAACCR
New	1994	Over-ride TNM 3	•	RN	•	•	•	•			NAACCR
	2000	Over-ride SeqNo/DxConf	D	R	•	•	R	R			SEER
	2010	Over-ride Site/Lat/SeqNo	D	R	•	•	R	R			SEER
	2020	Over-ride Surg/DxConf	D	R	R	R	R	R			SEER
	2030	Over-ride Site/Type	D	R	R	R	R	R			SEER
	2040	Over-ride Histology	D	R	R	R	R	R			SEER
	2050	Over-ride Report Source	D	R	•	•	R	R			SEER
	2060	Over-ride Ill-define Site	D	R	•	•	R	R			SEER
	2070	Over-ride Leuk, Lymphoma	D	R	R	R	R	R			SEER
	2071	Over-ride Site/Behavior	D	R	R	R	R	R			SEER
	2072	Over-ride Site/EOD/DX Dt	D	•	•	•	R	R			SEER
	2073	Over-ride Site/Lat/EOD	D	•	•	•	R	R			SEER
	2074	Over-ride Site/Lat/Morph	D	R	R	R	R	R			SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	2078	Over-ride Name/Sex	•	R	•	•	R	R			NAACCR
	2080	Reserved 13									
	2081	CRC CHECKSUM	•	•	•	•	S	S			NAACCR
	2085	Date Case Initiated	•	•	•	•	•	•			NAACCR
	2090	Date Case Completed	•	•	•	•	•	•			NAACCR
	2092	Date Case Completed--CoC	•	•	D	D	•	•			CoC
	2100	Date Case Last Changed	√	•	D	D	•	•			NAACCR
	2110	Date Case Report Exported	√	R	•	•	•	•			NPCR
	2111	Date Case Report Received	√	R	•	•	•	•			NPCR
	2112	Date Case Report Loaded	√	R	•	•	•	•			NPCR
	2113	Date Tumor Record Availbl	R	R	•	•	•	•			NPCR
	2116	ICD-O-3 Conversion Flag	D	R	•	•	R	R			SEER/CoC
	2120	SEER Coding Sys--Current	•	•	•	•	•	R			NAACCR
	2130	SEER Coding Sys--Original	•	•	•	•	•	R			NAACCR
	2140	CoC Coding Sys--Current	•	•	R	R	•	•			CoC
	2150	CoC Coding Sys--Original	•	•	R	R	•	•			CoC
New	2152	CoC Accredited Flag	D	R	•	•	R*	R*			NPCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	2155	RQRS NCDB Submission Flag	•	•	R	R	•	•			CoC
Ret.	2161	Reserved 18									
Ret.	2162	Reserved 19									
Ret.	2163	Reserved 20									
	2170	Vendor Name	√	•	R	R	•	•			NAACCR
	2180	SEER Type of Follow-Up	•	•	•	•	R	R			SEER
	2190	SEER Record Number	•	•	•	•	•	R			SEER
	2200	Diagnostic Proc 73-87	•	•	•	•	RH	RH			SEER
	2210	Reserved 14	•								
	2220	State/Requestor Items	•	•	•	•	•	•			Varies
	2230	Name--Last	R	R	R	•	R	•			CoC
	2240	Name--First	R	R	R	•	R	•			CoC
	2250	Name--Middle	R	R	R	•	R	•			CoC
	2260	Name--Prefix	•	•	•	•	•	•			NAACCR
	2270	Name--Suffix	•	•	•	•	R	•			NAACCR
	2280	Name--Alias	R	R	•	•	R	•			NAACCR
	2290	Name--Spouse/Parent	•	•	•	•	•	•			NAACCR
	2300	Medical Record Number	R	R	R	•	R	•			CoC
	2310	Military Record No Suffix	•	•	•	•	•	•			CoC
New	2315	Medicare Beneficiary Identifier									NAACCR
	2320	Social Security Number	R	R	R	•	R	•			CoC
	2330	Addr at DX--No & Street	R	R	R	•	R	•			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	2335	Addr at DX--Supplementl	R	R	R*	•	R	•			CoC
	2350	Addr Current--No & Street	•	•	R	•	R	•			CoC
	2352	Latitude	D	R*	•	•	S	•			NAACCR
	2354	Longitude	D	R*	•	•	S	•			NAACCR
	2355	Addr Current--Supplementl	•	•	R*	•	R*	•			CoC
	2360	Telephone	•	•	R	•	R	•			CoC
	2380	DC State File Number	R	R	•	•	R*	•			State
	2390	Name--Maiden	R √	R	•	•	R	•			NAACCR
	2392	Follow-Up Contact--No&St	•	•	•	•	•	•			SEER
	2393	Follow-Up Contact--Suppl	•	•	•	•	•	•			SEER
	2394	Follow-Up Contact--Name	•	•	•	•	•	•			SEER
	2400	Reserved 15									
	2410	Institution Referred From	•	•	•	•	•	•			CoC
	2415	NPI--Inst Referred From	•	•	R	•	•	•			CMS
	2420	Institution Referred To	•	•	•	•	•	•			CoC
	2425	NPI--Inst Referred To	•	•	R	•	•	•			CMS
	2440	Following Registry	•	•	•	•	RH	•			CoC
	2445	NPI--Following Registry	•	•	•	•	RH*	•			CMS
	2450	Reserved 16									

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	2460	Physician--Managing	•	•	•	•	•	•			NAACCR
	2465	NPI--Physician--Managing	•	•	R	•	•	•			CMS
	2470	Physician--Follow-Up	R	•	•	•	R	•			CoC
	2475	NPI--Physician--Follow-Up	•	•	R	•	R*	•			CMS
	2480	Physician--Primary Surg	•	•	•	•	•	•			CoC
	2485	NPI--Physician--Primary Surg	•	•	R	R	•	•			CMS
	2490	Physician 3		•	•	•	•	•			CoC
	2495	NPI--Physician 3	•	•	R	R	•	•			CMS
	2500	Physician 4	•	•	•	•	•	•			CoC
	2505	NPI--Physician 4	•	•	R	R	•	•			CMS
New	2508	EHR Reporting	•	•	•	•	•	•			NAACCR
	2510	Reserved 12	•								
	2520	Text--DX Proc--PE	R^	R^	•	•	R	•			NPCR
	2530	Text--DX Proc--X-ray/Scan	R^	R^	•	•	R	•			NPCR
	2540	Text--DX Proc--Scopes	R^	R^	•	•	R	•			NPCR
	2550	Text--DX Proc--Lab Tests	R^	R^	•	•	R	•			NPCR
	2560	Text--DX Proc--Op	R^	R^	•	•	R	•			NPCR
	2570	Text--DX Proc--Path	R^	R^	•	•	R	•			NPCR
	2580	Text--Primary Site Title	R	R^	•	•	R	•			NPCR
	2590	Text--Histology Title	R	R^	•	•	R	•			NPCR
	2600	Text--Staging	R	R^	•	•	R	•			NPCR
	2610	RX Text--Surgery	R	R^	•	•	R	•			NPCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	2620	RX Text Radiation (Beam)	R	R^	•	•	R	•			NPCR
	2630	RX Text Radiation Other	R	R^	•	•	R	•			NPCR
	2640	RX Text Chemo	R	R^	•	•	R	•			NPCR
	2650	RX Text Hormone	R	R^	•	•	R	•			NPCR
	2660	RX Text--BRM	R	R^	•	•	R	•			NPCR
	2670	RX Text--Other	R	R^	•	•	R	•			NPCR
	2680	Text--Remarks	•	•	•	•	R	•			NPCR
	2690	Text--Place of Diagnosis	•	•	•	•	•	•			NPCR
Ret.	2700	Reserved 17									
Ret.	2730	CS PreRx Tumor Size									
Ret.	2735	CS PreRx Extension									
Ret.	2740	CS PreRx Tum Sz/Ext Eval									
Ret.	2750	CS PreRx Lymph Nodes									
Ret.	2755	CS PreRx Reg Nodes Eval									
Ret.	2760	CS PreRx Mets at DX									
Ret.	2765	CS PreRx Mets Eval									
Ret.	2770	CS PostRx Tumor Size									
Ret.	2775	CS PostRx Extension									
Ret.	2780	CS PostRx Lymph Nodes									
Ret.	2785	CS PostRx Mets at DX									
Rev.	2800	CS Tumor Size	RH*	RH*	RH	RH	RH*	RH*			AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	2810	CS Extension	RH*	RH*	RH	RH	RH*	RH*			AJCC
Rev.	2820	CS Tumor Size/Ext Eval	RH*	RH*	RH	RH	RH*	RH*			AJCC
Rev.	2830	CS Lymph Nodes	RH*	RH*	RH	RH	RH*	RH*			AJCC
Rev.	2840	CS Lymph Nodes Eval	RH*	RH*	RH	RH	RH*	RH*			AJCC
Rev.	2850	CS Mets at DX	RH*	RH*	RH	RH	RH*	RH*			AJCC
Rev.	2851	CS Mets at Dx-Bone	•	•	RH	RH	RH	RH			AJCC
Rev.	2852	CS Mets at Dx-Brain	•	•	RH	RH	RH	RH			AJCC
Rev.	2853	CS Mets at Dx-Liver	•	•	RH	RH	RH	RH			AJCC
Rev.	2854	CS Mets at Dx-Lung	•	•	RH	RH	RH	RH			AJCC
Rev.	2860	CS Mets Eval	RH*	RH*	RH	RH	RH*	RH*			AJCC
Rev.	2861	CS Site-Specific Factor 7	RH*	RH*	RH	RH	RH	RH			AJCC
Rev.	2862	CS Site-Specific Factor 8	RS*	RS*	RH	RH	RH	RH			AJCC
Rev.	2863	CS Site-Specific Factor 9	RS*	RS* RH*	RH	RH	RH	RH			AJCC
Rev.	2864	CS Site-Specific Factor10	RS*	RS* RH*	RH	RH	RH	RH			AJCC
Rev.	2865	CS Site-Specific Factor11	RS*	RS* RH*	RH	RH	RH	RH			AJCC
Rev.	2866	CS Site-Specific Factor12	RH*	RH*	RH	RH	RH	RH			AJCC
Rev.	2867	CS Site-Specific Factor13	RS*	RS* RH*	RH	RH	RH	RH			AJCC
Rev.	2868	CS Site-Specific Factor14	RS*	RS* RH*	RH	RH	RH	RH			AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	2869	CS Site-Specific Factor15	RS*	RS* RH*	RH	RH	RH	RH			AJCC
Rev.	2870	CS Site-Specific Factor16	RS*	RS* RH*	RH	RH	RH	RH			AJCC
Rev.	2871	CS Site-Specific Factor17	RH*	RH*	RH	RH	RH	RH			AJCC
Rev.	2872	CS Site-Specific Factor18	•	•	RH	RH	RH	RH			AJCC
Rev.	2873	CS Site-Specific Factor19	•	•	RH	RH	RH	RH			AJCC
Rev.	2874	CS Site-Specific Factor20	•	•	RH	RH	RH	RH			AJCC
Rev.	2875	CS Site-Specific Factor21	•	•	RH	RH	RH	RH			AJCC
Rev.	2876	CS Site-Specific Factor22	•	•	RH	RH	RH	RH			AJCC
Rev.	2877	CS Site-Specific Factor23	•	•	RS	RS	RH	RH			AJCC
Rev.	2878	CS Site-Specific Factor24	•	•	RH	RH	RH	RH			AJCC
Rev.	2879	CS Site-Specific Factor25	RS*	RS* RH*	RH	RH	RH	RH			AJCC
Rev.	2880	CS Site-Specific Factor 1	RS*	RS* RH*	RH	RH	RH	RH			AJCC
Rev.	2890	CS Site-Specific Factor 2	RS*	RS* RH*	RH	RH	RH	RH			AJCC
Rev.	2900	CS Site-Specific Factor 3	RH*	RH*	RH	RH	RH	RH			AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	2910	CS Site-Specific Factor 4	RH*	RH*	RH	RH	RH	RH			AJCC
Rev.	2920	CS Site-Specific Factor 5	RS*	RS* RH*	RH	RH	RH	RH			AJCC
Rev.	2930	CS Site-Specific Factor 6	RS*	RS* RH*	RH	RH	RH	RH			AJCC
Rev.	2935	CS Version Input Original	D	R*	RH	RH	RH*	RH*			AJCC
Rev.	2936	CS Version Derived	RH*	RH*	DH	DH	D*	DH*			AJCC
Rev.	2937	CS Version Input Current	D	R* RH	RH	RH	RH*	RH*			AJCC
Rev.	2940	Derived AJCC-6 T	•	•	DH	DH	DH	RH			AJCC
Rev.	2950	Derived AJCC-6 T Descript	•	•	DH	DH	DH	RH			AJCC
Rev.	2960	Derived AJCC-6 N	•	•	DH	DH	DH	RH			AJCC
Rev.	2970	Derived AJCC-6 N Descript	•	•	DH	DH	DH	RH			AJCC
Rev.	2980	Derived AJCC-6 M	•	•	DH	DH	DH	RH			AJCC
Rev.	2990	Derived AJCC-6 M Descript	•	•	DH	DH	DH	RH			AJCC
Rev.	3000	Derived AJCC-6 Stage Grp	•	•	DH	DH	DH	RH			AJCC
Rev.	3010	Derived SS1977	D	•	DH	DH	D*	S			AJCC
Rev.	3020	Derived SS2000	D+	RH*	DH	DH	D+	R+			AJCC
Rev.	3030	Derived AJCC--Flag		•	DH	DH	DH	RH			AJCC
	3040	Derived SS1977--Flag	^	•	DH	DH	D*	S			AJCC
Rev.	3050	Derived SS2000--Flag	^	RH*	DH	DH	D*	S			AJCC
	3100	Archive FIN	•	•	R	R	•	•			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	3105	NPI--Archive FIN	•	•	R	R	•	•			CMS
Rev.	3110	Comorbid/Complication 1	•	•	RH	RH	•	•			CoC
Rev.	3120	Comorbid/Complication 2	•	•	RH	RH	•	•			CoC
Rev.	3130	Comorbid/Complication 3	•	•	RH	RH	•	•			CoC
Rev.	3140	Comorbid/Complication 4	•	•	RH	RH	•	•			CoC
Rev.	3150	Comorbid/Complication 5	•	•	RH	RH	•	•			CoC
Rev.	3160	Comorbid/Complication 6	•	•	RH	RH	•	•			CoC
Rev.	3161	Comorbid/Complication 7	•	•	RH	RH	•	•			CoC
Rev.	3162	Comorbid/Complication 8	•	•	RH	RH	•	•			CoC
Rev.	3163	Comorbid/Complication 9	•	•	RH	RH	•	•			CoC
Rev.	3164	Comorbid/Complication 10	•	•	RH	RH	•	•			CoC
	3165	ICD Revision Comorbid	•	•	•	•	•	•			CoC
Rev.	3170	RX Date Mst Defn Srg	R	R	R	R	R*	R*			CoC
Rev.	3171	RX Date Mst Defn Srg Flag	R	R	R	R	R*	R*			NAACCR
	3180	RX Date Surg Disch	•	•	R	R	•	•			CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	3181	RX Date Surg Disch Flag	•	•	R	R	•	•			NAACCR
	3190	Readm Same Hosp 30 Days	•	•	R	R	•	•			CoC
Rev.	3200	Rad--Boost RX Modality	•	•	•	•	•	•			CoC
Rev.	3210	Rad--Boost Dose cGy	•	•	•	•	•	•			CoC
	3220	RX Date Rad Ended	•	•	R	R	•	•			CoC
	3221	RX Date Rad Ended Flag	•	•	R	R	•	•			NAACCR
	3230	RX Date Systemic	•	•	R	R	RC	RC			CoC
	3231	RX Date Systemic Flag	•	•	R	R	RC	RC			NAACCR
	3250	RX Summ--Transplnt/Endocr	R	R	R	R	R	R			CoC
	3270	RX Summ--Palliative Proc	•	•	R	R	•	•			CoC
	3280	RX Hosp--Palliative Proc	•	•	R	R	•	•			CoC
	3300	RuralUrban Continuum 1993	D	D	•	•	•	•			NAACCR
	3310	RuralUrban Continuum 2003	D	D	•	•	•	•			NAACCR
	3312	RuralUrban Continuum 2013	D	D	•	•	D	R			NAACCR
Rev.	3400	Derived AJCC-7 T	RH*	RH*	DH	DH	DH	RH			AJCC
Rev.	3402	Derived AJCC-7 T Descript	RH*	RH*	DH	DH	DH	RH			AJCC
Rev.	3410	Derived AJCC-7 N	RH*	RH*	DH	DH	DH	RH			AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	3412	Derived AJCC-7 N Descript	RH*	RH*	DH	DH	DH	RH			AJCC
Rev.	3420	Derived AJCC-7 M	RH*	RH*	DH	DH	DH	RH			AJCC
Rev.	3422	Derived AJCC-7 M Descript	RH*	RH*	DH	DH	DH	RH			AJCC
Rev.	3430	Derived AJCC-7 Stage Grp	RH*	RH*	DH	DH	DH	RH			AJCC
	3440	Derived PreRx-7 T	•	•	•	•	•	•			AJCC
	3442	Derived PreRx-7 T Descrip	•	•	•	•	•	•			AJCC
	3450	Derived PreRx-7 N	•	•	•	•	•	•			AJCC
	3452	Derived PreRx-7 N Descrip	•	•	•	•	•	•			AJCC
	3460	Derived PreRx-7 M	•	•	•	•	•	•			AJCC
	3462	Derived PreRx-7 M Descrip	•	•	•	•	•	•			AJCC
	3470	Derived PreRx-7 Stage Grp	•	•	•	•	•	•			AJCC
	3480	Derived PostRx-7 T	•	•	•	•	•	•			AJCC
	3482	Derived PostRx-7 N	•	•	•	•	•	•			AJCC
	3490	Derived PostRx-7 M	•	•	•	•	•	•			AJCC
	3492	Derived PostRx-7 Stge Grp	•	•	•	•	•	•			AJCC
	3600	Derived Neoadjuv Rx Flag	•	•	•	•	•	•			AJCC
Rev.	3605	Derived SEER Path Stg Grp	•	•	•	•	DH	RH			SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	3610	Derived SEER Clin Stg Grp	•	•	•	•	DH	RH			SEER
Rev.	3614	Derived SEER Cmb Stg Grp	•	•	•	•	DH	RH			SEER
Rev.	3616	Derived SEER Combined T	•	•	•	•	DH	RH			SEER
Rev.	3618	Derived SEER Combined N	•	•	•	•	DH	RH			SEER
Rev.	3620	Derived SEER Combined M	•	•	•	•	DH	RH			SEER
Rev.	3622	Derived SEER Cmb T Src	•	•	•	•	DH	RH			SEER
Rev.	3624	Derived SEER Cmb N Src	•	•	•	•	DH	RH			SEER
Rev.	3626	Derived SEER Cmb M Src	•	•	•	•	DH	RH			SEER
New	3645	NPCR Derived AJCC 8 TNM Clin Stg Grp	•	•	•	•	•	•			NPCR
New	3646	NPCR Derived AJCC 8 TNM Path Stg Grp	•	•	•	•	•	•			NPCR
New	3647	NPCR Derived AJCC 8 TNM Post Therapy Stg Grp	•	•	•	•	•	•			NPCR
	3650	NPCR Derived Clin Stg Grp	RH	RH	•	•	•	•			NPCR
	3655	NPCR Derived Path Stg Grp	RH	RH	•	•	•	•			NPCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	3700	SEER Site-Specific Fact 1	•	•	•	•	R	R			SEER
	3702	SEER Site-Specific Fact 2	•	•	•	•	•	•			SEER
	3704	SEER Site-Specific Fact 3	•	•	•	•	•	•			SEER
	3706	SEER Site-Specific Fact 4	•	•	•	•	•	•			SEER
	3708	SEER Site-Specific Fact 5	•	•	•	•	•	•			SEER
	3710	SEER Site-Specific Fact 6	•	•	•	•	•	•			SEER
	3720	NPCR Specific Field	R	R	•	•	•	•			NPCR
Rev.	3750	Over-ride CS 1	•	•	RH	RH	•	•			AJCC
Rev.	3751	Over-ride CS 2	•	•	RH	RH	•	•			AJCC
Rev.	3752	Over-ride CS 3	•	•	RH	RH	•	•			AJCC
Rev.	3753	Over-ride CS 4	•	•	RH	RH	•	•			AJCC
Rev.	3754	Over-ride CS 5	•	•	RH	RH	•	•			AJCC
Rev.	3755	Over-ride CS 6	•	•	RH	RH	•	•			AJCC
Rev.	3756	Over-ride CS 7	•	•	RH	RH	•	•			AJCC
Rev.	3757	Over-ride CS 8	•	•	RH	RH	•	•			AJCC
Rev.	3758	Over-ride CS 9	•	•	RH	RH	•	•			AJCC
Rev.	3759	Over-ride CS 10	•	•	RH	RH	•	•			AJCC
Rev.	3760	Over-ride CS 11	•	•	RH	RH	•	•			AJCC
Rev.	3761	Over-ride CS 12	•	•	RH	RH	•	•			AJCC
Rev.	3762	Over-ride CS 13	•	•	RH	RH	•	•			AJCC
Rev.	3763	Over-ride CS 14	•	•	RH	RH	•	•			AJCC
Rev.	3764	Over-ride CS 15	•	•	RH	RH	•	•			AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	3765	Over-ride CS 16	•	•	RH	RH	•	•			AJCC
Rev.	3766	Over-ride CS 17	•	•	RH	RH	•	•			AJCC
Rev.	3767	Over-ride CS 18	•	•	RH	RH	•	•			AJCC
Rev.	3768	Over-ride CS 19	•	•	RH	RH	•	•			AJCC
Rev.	3769	Over-ride CS 20	RH	RH	RH	RH	RH	RH			AJCC/NPCR
Rev.	3780	Secondary Diagnosis 1	•	•	RH	RH	•	•			CoC
Rev.	3782	Secondary Diagnosis 2	•	•	RH	RH	•	•			CoC
Rev.	3784	Secondary Diagnosis 3	•	•	RH	RH	•	•			CoC
Rev.	3786	Secondary Diagnosis 4	•	•	RH	RH	•	•			CoC
Rev.	3788	Secondary Diagnosis 5	•	•	RH	RH	•	•			CoC
Rev.	3790	Secondary Diagnosis 6	•	•	RH	RH	•	•			CoC
Rev.	3792	Secondary Diagnosis 7	•	•	RH	RH	•	•			CoC
Rev.	3794	Secondary Diagnosis 8	•	•	RH	RH	•	•			CoC
Rev.	3796	Secondary Diagnosis 9	•	•	RH	RH	•	•			CoC
Rev.	3798	Secondary Diagnosis 10	•	•	RH	RH	•	•			CoC
New	3800	Schema ID	D	D	D	D	D	R			NAACCR
New	3801	Chromosome 1p: Loss of Heterozygosity (LOH)	•	•	RS	RS	RS	RS			NAACCR
New	3802	Chromosome 19q: Loss of Heterozygosity (LOH)	•	•	RS	RS	RS	RS			NAACCR
New	3803	Adenoid Cystic Basaloid Pattern	•	•	RS	RS	RS	RS			NAACCR
New	3804	Adenopathy	•	•	RS	RS	RS	RS			NAACCR
New	3805	AFP Post-Orchiectomy Lab Value	•	•	RS	RS	RC	RC			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	3806	AFP Post-Orchiectomy Range	•	•	RS	RS	RC	RC			NAACCR
New	3807	AFP Pre-Orchiectomy Lab Value	•	•	RS	RS	RC	RC			NAACCR
New	3808	AFP Pre-Orchiectomy Range	•	•	RS	RS	RC	RC			NAACCR
New	3809	AFP Pretreatment Interpretation	•	•	RS	RS	RC	RC			NAACCR
New	3810	AFP Pretreatment Lab Value	•	•	RS	RS	RC	RC			NAACCR
New	3811	Anemia	•	•	RS	RS	RS	RS			NAACCR
New	3812	B symptoms	•	•	RS	RS	RS	RS			NAACCR
New	3813	Bilirubin Pretreatment Total Lab Value	•	•	RS	RS	RC	RC			NAACCR
New	3814	Bilirubin Pretreatment Unit of Measure	•	•	RS	RS	RC	RC			NAACCR
New	3815	Bone Invasion	•	•	RS	RS	RS	RS			NAACCR
New	3816	Brain Molecular Markers	R	R	•	•	RS	RS			NAACCR
New	3817	Breslow Tumor Thickness	R	R	RS	RS	RS	RS			NAACCR
New	3818	CA-125 Pretreatment Interpretation	•	•	RS	RS	RS	RS			NAACCR
New	3819	CEA Pretreatment Interpretation	•	•	RS	RS	RS	RS			NAACCR
New	3820	CEA Pretreatment Lab Value	•	•	RS	RS	RS	RS			NAACCR
New	3821	Chromosome 3 Status	•	•	RS	RS	RC	RC			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	3822	Chromosome 8q Status	•	•	RS	RS	RC	RC			NAACCR
New	3823	Circumferential Resection Margin (CRM)	•	•	RS	RS	RS	RS			NAACCR
New	3824	Creatinine Pretreatment Lab Value	•	•	RS	RS	RC	RC			NAACCR
New	3825	Creatinine Pretreatment Unit of Measure	•	•	RS	RS	RS	RS			NAACCR
New	3826	Estrogen Receptor Percent Positive or Range	•	•	•	•	RC	RC			NAACCR
New	3827	Estrogen Receptor Summary	R	R	RS	RS	RS	RS			NAACCR
New	3828	Estrogen Receptor Total Allred Score	•	•	RS	RS	RC	RC			NAACCR
New	3829	Esophagus and EGJ Tumor Epicenter	•	•	RS	RS	RS	RS			NAACCR
New	3830	Extranodal Extension Clin (non-Head and Neck)	•	•	RS	RS	RC	RC			NAACCR
New	3831	Extranodal Extension Head and Neck Clinical	•	•	RS	RS	RC	RC			NAACCR
New	3832	Extranodal Extension Head and Neck Pathological	•	•	RS	RS	RS	RS			NAACCR
New	3833	Extranodal Extension Path (non-Head and Neck)	•	•	RS	RS	RC	RC			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	3834	Extravascular Matrix Patterns	•	•	RS	RS	RC	RC			NAACCR
New	3835	Fibrosis Score	R	R	RS	RS	RC	RC			NAACCR
New	3836	FIGO Stage	•	•	RS	RS	RS	RS			NAACCR
New	3837	Gestational Trophoblastic Prognostic Scoring Index	•	•	RS	RS	RS	RS			NAACCR
New	3838	Gleason Patterns Clinical	•	•	RS	RS	RS	RS			NAACCR
New	3839	Gleason Patterns Pathological	•	•	RS	RS	RS	RS			NAACCR
New	3840	Gleason Score Clinical	•	•	RS	RS	RC	RC			NAACCR
New	3841	Gleason Score Pathological	•	•	RS	RS	RC	RC			NAACCR
New	3842	Gleason Tertiary Pattern	•	•	RS	RS	RC	RC			NAACCR
New	3843	Grade Clinical	R	R	R	R	R	R			NAACCR
New	3844	Grade Pathological	RN	RN	R	R	R	R			NAACCR
New	3845	Grade Post Therapy	RN	• RN	R	R	RS	RS			NAACCR
New	3846	hCG Post-Orchiectomy Lab Value	•	•	RS	RS	RC	RC			NAACCR
New	3847	hCG Post-Orchiectomy Range	•	•	RS	RS	RS	RS			NAACCR
New	3848	hCG Pre-Orchiectomy Lab Value	•	•	RS	RS	RC	RC			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	3849	hCG Pre-Orchiectomy Range	•	•	RS	RS	RS	RS			NAACCR
New	3850	HER2 IHC Summary	•	•	RS	RS	RS*	RS*			NAACCR
New	3851	HER2 ISH Dual Probe Copy Number	•	•	RS	RS	RS*	RS*			NAACCR
New	3852	HER2 ISH Dual Probe Ratio	•	•	RS	RS	RS*	RS*			NAACCR
New	3853	HER2 ISH Single Probe Copy Number	•	•	RS	RS	RS*	RS*			NAACCR
New	3854	HER2 ISH Summary	•	•	RS	RS	RS*	RS*			NAACCR
New	3855	HER2 Overall Summary	R	R	RS	RS	RS	RS			NAACCR
New	3856	Heritable Trait	•	•	RS	RS	RS	RS			NAACCR
New	3857	High Risk Cytogenetics	•	•	RS	RS	RS	RS			NAACCR
New	3858	High Risk Histologic Features	•	•	RS	RS	RS	RS			NAACCR
New	3859	HIV Status	•	•	RS	RS	RS	RS			NAACCR
New	3860	International Normalized Ratio Prothrombin Time	•	•	RS	RS	RC	RC			NAACCR
New	3861	Ipsilateral Adrenal Gland Involvement	•	•	RS	RS	RS	RS			NAACCR
New	3862	JAK2	•	•	RS	RS	RS	RS			NAACCR
New	3863	Ki-67	•	•	RS	RS	RC	RC			NAACCR
New	3864	Invasion Beyond Capsule	•	•	RS	RS	RS	RS			NAACCR
New	3865	KIT Gene Immunohistochemistry	•	•	RS	RS	RC	RC			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	3866	KRAS	•	•	RS	RS	RS	RS			NAACCR
New	3867	LDH Post-Orchiectomy Range	•	•	RS	RS	RS	RS			NAACCR
New	3868	LDH Pre-Orchiectomy Range	•	•	RS	RS	RS	RS			NAACCR
New	3869	LDH Pretreatment Level	•	•	RS	RS	RS	RS			NAACCR
New	3870	LDH Upper Limits of Normal	•	•	RS	RS	RC	RC			NAACCR
New	3871	LN Assessment Method Femoral-Inguinal	•	•	RS	RS	RC	RC			NAACCR
New	3872	LN Assessment Method Para-Aortic	•	•	RS	RS	RC	RC			NAACCR
New	3873	LN Assessment Method Pelvic	•	•	RS	RS	RC	RC			NAACCR
New	3874	LN Distant Assessment Method	•	•	RS	RS	RC	RC			NAACCR
New	3875	LN Distant: Mediastinal, Scalene	•	•	RS	RS	RC	RC			NAACCR
New	3876	LN Head and Neck Levels I-III	•	•	RS	RS	RS	RS			NAACCR
New	3877	LN Head and Neck Levels IV-V	•	•	RS	RS	RS	RS			NAACCR
New	3878	LN Head and Neck Levels VI-VII	•	•	RS	RS	RS	RS			NAACCR
New	3879	LN Head and Neck Other	•	•	RS	RS	RS	RS			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	3880	LN Isolated Tumor Cells (ITC)	•	•	RS	RS	RS	RS			NAACCR
New	3881	LN Laterality	•	•	RS	RS	RS	RS			NAACCR
New	3882	LN Positive Axillary Level I-II	•	•	RS	RS	RS	RS			NAACCR
New	3883	LN Size	•	•	RS	RS	RS	RS			NAACCR
New	3884	LN Status Femoral-Inguinal, Para-Aortic, Pelvic	•	•	RS	RS	RS	RS			NAACCR
New	3885	Lymphocytosis	•	•	RS	RS	RS	RS			NAACCR
New	3886	Major Vein Involvement	•	•	RS	RS	RS	RS			NAACCR
New	3887	Measured Basal Diameter	•	•	RS	RS	RS	RS			NAACCR
New	3888	Measured Thickness	•	•	RS	RS	RS	RS			NAACCR
New	3889	Methylation of O6-Methylguanine-Methyltransferase	•	•	RS	RS	RS	RS			NAACCR
New	3890	Microsatellite Instability (MSI)	RS*	RS*	RS	RS	RS	RS			NAACCR
New	3891	Microvascular Density	•	•	RS	RS	RC	RC			NAACCR
New	3892	Mitotic Count Uveal Melanoma	•	•	RS	RS	RC	RC			NAACCR
New	3893	Mitotic Rate Melanoma	•	•	RS	RS	RS	RS			NAACCR
New	3894	Multigene Signature Method	•	•	RS	RS	RS	RS			NAACCR
New	3895	Multigene Signature Results	•	RN	RS	RS	RS	RS			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	3896	NCCN International Prognostic Index (IPI)	•	•	RS	RS	RS	RS			NAACCR
New	3897	Number of Cores Examined	•	•	RS	RS	RS	RS			NAACCR
New	3898	Number of Cores Positive	•	•	RS	RS	RS	RS			NAACCR
New	3899	Number of Examined Para-Aortic Nodes	•	•	RS	RS	RC	RC			NAACCR
New	3900	Number of Examined Pelvic Nodes	•	•	RS	RS	RC	RC			NAACCR
New	3901	Number of Positive Para-Aortic Nodes	•	•	RS	RS	RC	RC			NAACCR
New	3902	Number of Positive Pelvic Nodes	•	•	RS	RS	RC	RC			NAACCR
New	3903	Oncotype Dx Recurrence Score-DCIS	•	•	RS	RS	RC	RC			NAACCR
New	3904	Oncotype Dx Recurrence Score-Invasive	RN	RN •	RS	RS	RS	RS			NAACCR
New	3905	Oncotype Dx Risk Level-DCIS	•	•	RS	RS	RC	RC			NAACCR
New	3906	Oncotype Dx Risk Level-Invasive	•	•	RS	RS	RC	RC			NAACCR
New	3907	Organomegaly	•	•	RS	RS	RS	RS			NAACCR
New	3908	Percent Necrosis Post Neoadjuvant	•	•	RS	RS	RC	RC			NAACCR
New	3909	Perineural Invasion	•	•	RS	RS	RS	RS			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	3910	Peripheral Blood Involvement	•	•	RS	RS	RS	RS			NAACCR
New	3911	Peritoneal Cytology	R	•	RS	RS	RS	RS			NAACCR
New	3913	Pleural Effusion	•	•	RS	RS	RS	RS			NAACCR
New	3914	Progesterone Receptor Percent Positive or Range	•	•	RS	RS	RC	RC			NAACCR
New	3915	Progesterone Receptor Summary	R	R	RS	RS	RS	RS			NAACCR
New	3916	Progesterone Receptor Total Allred Score	•	•	RS	RS	RC	RC			NAACCR
New	3917	Primary Sclerosing Cholangitis	•	•	RS	RS	RC	RC			NAACCR
New	3918	Profound Immune Suppression	•	•	RS	RS	RS	RS			NAACCR
New	3919	Prostate Pathological Extension	•	•	RS	RS	RS	RS			NAACCR
New	3920	PSA (Prostatic Specific Antigen) Lab Value	R	R	RS	RS	RS	RS			NAACCR
New	3921	Residual Tumor Volume Post Cytoreduction	•	•	RS	RS	RS	RS			NAACCR
New	3922	Response to Neoadjuvant Therapy	•	•	RS	RS	RC	RC			NAACCR
New	3923	S Category Clinical	•	•	RS	RS	RS	RS			NAACCR
New	3924	S Category Pathological	•	•	RS	RS	RS	RS			NAACCR
New	3925	Sarcomatoid Features	•	•	RS	RS	RS	RS			NAACCR
New	3926	Schema Discriminator 1	R	R	RS	RS	RS	RS			NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	3927	Schema Discriminator 2	•	•	RS	RS	RS	RS			NAACCR
New	3928	Schema Discriminator 3	•	•	RS	RS	RS	RS			NAACCR
New	3929	Separate Tumor Nodules	•	•	RS	RS	RS	RS			NAACCR
New	3930	Serum Albumin Pretreatment Level	•	•	RS	RS	RS	RS			NAACCR
New	3931	Serum Beta-2 Microglobulin Pretreatment Level	•	•	RS	RS	RS	RS			NAACCR
New	3932	LDH Pretreatment Lab Value	R	R	RS	RS	RS	RS			NAACCR
New	3933	Thrombocytopenia	•	•	RS	RS	RS	RS			NAACCR
New	3934	Tumor Deposits	•	•	RS	RS	RS	RS			NAACCR
New	3935	Tumor Growth Pattern	•	•	RS	RS	RS	RS			NAACCR
New	3936	Ulceration	•	•	RS	RS	RS	RS			NAACCR
New	3937	Visceral and Parietal Pleural Invasion	•	•	RS	RS	RS	RS			NAACCR
	7010	Path Reporting Fac ID 1	•	•	•	•	•	•			HL7
	7011	Path Reporting Fac ID 2	•	•	•	•	•	•			HL7
	7012	Path Reporting Fac ID 3	•	•	•	•	•	•			HL7
	7013	Path Reporting Fac ID 4	•	•	•	•	•	•			HL7
	7014	Path Reporting Fac ID 5	•	•	•	•	•	•			HL7
	7090	Path Report Number 1	•	•	•	•	•	•			HL7
	7091	Path Report Number 2	•	•	•	•	•	•			HL7
	7092	Path Report Number 3	•	•	•	•	•	•			HL7
	7093	Path Report Number 4	•	•	•	•	•	•			HL7
	7094	Path Report Number 5	•	•	•	•	•	•			HL7

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	7100	Path Order Phys Lic No 1	•	•	•	•	•	•			HL7
	7101	Path Order Phys Lic No 2	•	•	•	•	•	•			HL7
	7102	Path Order Phys Lic No 3	•	•	•	•	•	•			HL7
	7103	Path Order Phys Lic No 4	•	•	•	•	•	•			HL7
	7104	Path Order Phys Lic No 5	•	•	•	•	•	•			HL7
	7190	Path Ordering Fac No 1	•	•	•	•	•	•			HL7
	7191	Path Ordering Fac No 2	•	•	•	•	•	•			HL7
	7192	Path Ordering Fac No 3	•	•	•	•	•	•			HL7
	7193	Path Ordering Fac No 4	•	•	•	•	•	•			HL7
	7194	Path Ordering Fac No 5	•	•	•	•	•	•			HL7
	7320	Path Date Spec Collect 1	•	•	•	•	•	•			HL7
	7321	Path Date Spec Collect 2	•	•	•	•	•	•			HL7
	7322	Path Date Spec Collect 3	•	•	•	•	•	•			HL7
	7323	Path Date Spec Collect 4	•	•	•	•	•	•			HL7
	7324	Path Date Spec Collect 5	•	•	•	•	•	•			HL7
	7480	Path Report Type 1	•	•	•	•	•	•			HL7
	7481	Path Report Type 2	•	•	•	•	•	•			HL7
	7482	Path Report Type 3	•	•	•	•	•	•			HL7

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					COLLECT	TRANSMIT	COLLECT	TRANSMIT	HOSP > CENTRAL	CENTRAL > CENTRAL	
	7483	Path Report Type 4	•	•	•	•	•	•			HL7
	7484	Path Report Type 5	•	•	•	•	•	•			HL7

G

APPENDIX G: REPORTABLE LIST

This listing provides documentation of all conditions the TCR considers reportable. Note the following changes:

The 2018 ICD-O-3 Update Guidelines includes comprehensive tables listing all changes to ICD-O-3

effective for cases diagnosed 1/1/2018 forward. For coding instructions for these new terms refer to the 2018 Implementation Guidelines. Please see Coding tables in .pdf and Excel format for 2018 ICD-O-3 New Codes, Behaviors, and Terms-Updated 8/22/18.

Reportable conditions from both the *International Classification of Diseases for Oncology, Second Edition (ICD-O-2)* and the *Third Edition (ICD-O-3)* are included in the listing.

- Reportable conditions and terms with behavior changed from /1 (borderline) in *ICD-O-2* to /3 (malignant) in *ICD-O-3 are included*. These conditions are reportable only when diagnosed on or after January 1, 2001.
- Several terms changed behavior from /3 (malignant) in *ICD-O-2* to /1 (borderline) in *ICD-O-3*. These conditions are reportable only when diagnosed prior to January 1, 2001, and are identified in *[brackets and italics]*.
- New terms and synonyms for existing ICD-O codes were added.
- Terms **bolded** and followed by an asterisk (*) indicate new terms in ICD-O-3 effective for January 1, 2015.
- Terms followed by asterisks (**) indicate that the terms are reportable for benign and borderline behaviors (0 and 1) only when the primary site is listed in the table Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors on page 24 in the Casefinding Section of the Cancer Reporting Handbook 2016. If the behavior is malignant (2 or 3) the terms are reportable for any site.
- Terms followed by asterisks (***) indicate new terms in ICD-O-3 effective for January 1, 2016 after discontinuation of Collaborative Stage. For these new terms refer to the list below.

Adamantinoma (long bones, malignant, tibial only)

Adenoacanthoma

Adenocarcinofibroma

Adenocarcinoma

Adenocarcinoma, pancreatobilliary-type***

Adenofibroma (malignant endometrioid only)

Adenoma**

Adenoma (carcinoid bronchial and cylindroid bronchial only)

Adenosarcoma

AIN III (anal intraepithelial neoplasia, grade III)

ALK positive large B-cell lymphoma

Ameloblastoma (malignant only)

Androblastoma (malignant only)

Anemia, refractory

Angioendotheliomatosis

Angiolipoma**

Angiomyosarcoma

Angiosarcoma

Argentaffinoma (malignant only)

Arrhenoblastoma (malignant only)

Astroblastoma

Astrocytoma**

Astroglioma

B lymphoblastic leukemia/lymphoma,

Blastoma

Cancer

Carcinoid, malignant (stromal, argentaffin tumor NOS, enterochromaffin-like cell NOS, and tubular)

Carcinofibroma

Carcinoma

Carcinomatosis

Carcinosarcoma

CASTLE (Carcinoma showing thymus-like element)

Chloroma

Cholangiocarcinoma

Chondroblastoma

Chondrosarcoma

Chordoma

Choriocarcinoma

Chorioepithelioma

Chorionepithelioma

Chronic lymphoproliferative disorder of NK-cells

Class IV cytology

Class V cytology

Combined large cell neuroendocrine carcinoma

Comedocarcinoma

CPNET (central primitive neuroectodermal, NOS)

Craniopharyngioma**

Cylindroma (exclude eccrine dermal, and skin)

Cyst (dermoid with malignant transformation only or dermoid with secondary tumor)

Cystadenocarcinofibroma

Cystadenocarcinoma

Cystadenofibroma (malignant endometrioid only)

[Cystadenoma (diagnosis date prior to January 1, 2001);

mucinous, borderline malignancy

papillary, borderline malignancy

papillary mucinous, borderline malignancy

papillary pseudomucinous, borderline malignancy

papillary serous, borderline malignancy

pseudomucinous, borderline malignancy

serous, borderline malignancy]

Cystic pancreatic endocrine neoplasm (CPEN)*

Cystosarcoma phyllodes (malignant only)

Cytopenia, refractory with multilineage dysplasia

Dermatofibrosarcoma

Diktyoma (exclude benign)

DIN III (ductal intraepithelial neoplasia, grade III)

Disease (include only):

alpha heavy chain

Bowen

Chronic myeloproliferative

Di Guglielmo

Franklin

Gamma heavy chain

Heavy chain NOS

Hodgkin

immunoproliferative [NOS and small

intestinal only]
Letterer-Siwe
Mast cell, systemic tissue
Mu heavy chain
Myeloproliferative, chronic, NOS
Paget [exclude of bone]
Sezary
Disorder, myeloproliferative, chronic
Disorder, primary cutaneous CD30+ T-cell lymphoproliferative
Dysgerminoma
Ectomesenchymoma
Endometriosis, stromal
Ependymoblastoma
Ependymoma**
Epithelioma (NOS, basal cell, malignant, and squamous cell only)
Erythremia (acute and chronic only)
Erythroleukemia
Erythroplasia, Queyrat
Esthesioneuroblastoma
Esthesioneurocytoma
Esthesioneuroepithelioma
Fibroblastic reticular cell tumor
Fibrochondrosarcoma
Fibrodentinosarcoma
Fibroepithelioma, of Pinkus type or NOS
Fibrolipoma**
Fibroliposarcoma
Fibroma, NOS**
Fibromyxosarcoma
Fibro-odontosarcoma
Fibrosarcoma
Fibroxanthoma (malignant only)

Gangliocytoma**

Ganglioglioma**

Ganglioneuroblastoma

Ganglioneuroma**

Gastrinoma (malignant only)

Gemistocytoma

Germinoma

GIST-Gastrointestinal stromal tumor (malignant only)

Glioblastoma

Gliofibroma**

Glioma**

Gliomatosis cerebri

Gliosarcoma

Glomangiosarcoma

Glucagonoma (malignant)*

Granuloma (Hodgkin only)

Hemangioblastoma**

Hemangioendothelioma**

Hemangioma**

Hemangiopericytoma**

Hemangiosarcoma

Hepatoblastoma

Hepatocarcinoma

Hepatocholangiocarcinoma

Hepatoma (exclude benign)

Hidradenocarcinoma

Hidradenoma (malignant only)

Histiocytoma (malignant fibrous only)

Histiocytosis (malignant, and acute progressive X only)

Histiocytosis, Langerhans cell, disseminated or generalized

Hutchinson melanotic freckle (melanoma in situ only)

Hydroa vaccinforme-like lymphoma

Hypernephroma

Immunocytoma

Insulinoma (malignant only)

Intravascular large B-cell lymphoma

Langerhans cell histiocytosis, NOS

Langerhans cell histiocytosis, multifocal

Langerhans cell histiocytosis, unifocal

Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease

LCIS, NOS (lobular carcinoma in situ)

Leiomyoma (NOS)**

Leiomyomatosis (NOS)**

Leiomyosarcoma

Lentigo maligna

Leukemia

LIN III

Linitis plastica

Lipoma (atypical or NOS)**

Liposarcoma (exclude well differentiated liposarcoma, superficial)

LN2 (of breast also called lobular neoplasia, grade 2 only)

Lymphangioendothelioma (malignant only)

Lymphangiosarcoma

Lymphoblastoma

Lymphoepithelioma

Lymphoma

Lymphosarcoma

Macroglobulinemia, Waldenstrom

Malignancy

Malignant

Malignant Poorly Differentiated neuroendocrine tumors

Mastocytoma (malignant only)

Mastocytosis (malignant only)

Medulloblastoma

Medulloepithelioma

Medullomyoblastoma

Melanocytoma, meningeal

Melanoma (exclude juvenile)

Melanocytoma, meningial**

Melanocytosis, diffuse**

Melanomatosis, meningeal

Melanosis (precancerous only)

Meningioma**

Meningiomatosis**

Mesenchymoma (malignant only)

Mesonephroma (exclude benign)

Mesothelioma (exclude benign and cystic)

Metaplasia, agnogenic myeloid

Microglioma

Micropapillary carcinoma, NOS***

Midline carcinoma of children and young adults with NUT rearrangement

Mixed acinar ductal carcinoma***

Mixed phenotype acute leukemia

MPNST, NOS (malignant peripheral nerve sheath tumor)

Multiple neurofibromatosis

Mycosis Fungoides

Myeloid and lymphoid neoplasms

Myelodysplastic/Myeloproliferative neoplasm

Myelofibrosis (acute, chronic idiopathic, with myeloid metaplasia or as a result of myeloproliferative disease only)

Myeloma

Myelomatosis

Myelosclerosis (megakaryocytic, acute, malignant or with myeloid metaplasia)

Myelosis

Myoblastoma (malignant granular cell only)

Myoepithelioma (malignant only)

Myosarcoma

Myosis, stromal NOS or endolymphatic stromal

Myxoliposarcoma

Myxosarcoma

Neoplasia, ductal intraepithelial, grade 3 (of breast, also called DIN III)

Neoplasia, intratubular germ cell

Neoplasia, lobular, grade 2 of breast only (also called LN2)

Neoplasia, squamous intraepithelial, grade 3 (of anus, vulva and vagina only- also called, AIN III, VIN III and VAIN III)

Neoplasm (malignant only)

Neoplasm**

Nephroblastoma

Nephroma (exclude mesoblastic)

Neurilemmoma**

Neurilemmosarcoma

Neuroblastoma

Neurocytoma**, olfactory

Neuroepithelioma

Neurofibroma**

Neurofibromatosis (NOS)**

Neurofibrosarcoma

Neuroma (NOS)**

Neurosarcoma

Neurothekeoma**

Nevus (malignant blue only)

Non-invasive mucinous cystic neoplasm (MCN) of the páncreas with high-grade displasia*

NUT carcinoma

Odontosarcoma

Oligoastrocytoma, mixed

Oligodendroblastoma

Oligodendroglioma

Orchioblastoma

Osteochondrosarcoma

Osteoclastoma (malignant only)

Osteofibrosarcoma

Osteosarcoma

Pancreatoblastoma

Pancreatobilliary-type carcinoma***

Panmyelosis, acute only

Papillary tumor of the pineal region***

Papilloma**

Paraganglioma **

Paragranuloma, Hodgkin

Perineural MPNST

Perineurioma**

Pheochromoblastoma

Pheochromocytoma (malignant only)

Pilomatrixoma (malignant only)

Pilomyxoid astrocytoma***

Pinealoma (NOS)**

Pineoblastoma

Pineocytoma**

Pituitary Adenoma

Plasmacytoma

Plasmablastic lymphoma

PNET (primitive neuroectodermal tumor)

Pneumoblastoma

Polycythemia (proliferative, rubra vera, or vera)

Polyembryoma

Polymorphic PTLD

Polyposis (malignant lymphomatous only)

Porocarcinoma

Poroma, eccrine (malignant only)

PPNET (peripheral primitive neuroectodermal tumor)

Preleukemia

Primary cutaneous follicle centre lymphoma

Primary cutaneous gamma-delta T-cell lymphoma

Prolactinoma**

Pseudomyxoma peritonei

Queyrat erythroplasia

Rathke Pouch Tumor

Refractory neutropenia

Refractory thrombocytopenia

Reticuloendotheliosis

Reticulosarcoma

Reticulosis (histiocytic medullary, malignant, pagetoid, and polymorphic only)

Retinoblastoma

Rhabdomyoma (NOS)**

Rhabdomyosarcoma

Rhabdosarcoma

Sarcoma (exclude well differentiated liposarcoma, superficial)

Sarcomatosis (meningeal only)

Schwannoma

Secondary Neuroendocrine tumors

Seminoma

Serrated adenocarcinoma*

SETTLE (spindle epithelial tumor with thymus-like element)

Solid pseudopapillary neoplasm of the pancreas *

Somatostatinoma (malignant only)

Spermatocytoma

Spiradenoma (malignant only)

Spongioblastoma

Spongioneuroblastoma

Stromatosis, endometrial

Struma (malignant ovarii and Wuchernde Langhans only)

Subependymoma**
Subependymoma-ependymoma, mixed
Sympathicoblastoma
Syndrome,
- 5q deletion with Myelodysplastic (5q-) syndrome
- Hypereosinophilic
- Myelodysplastic
  - NOS
  - with 5q deletion syndrome
  - therapy-related, NOS
  - therapy-related, alkylating agent related
  - therapy-related, epidopophyllotoxin related
- Preleukemic
- Sezary

Synovioma (NOS and malignant only)
Syringoma chondroid, (malignant only)
Systemic EBV positive T-cell Lymphoproliferative disease of childhood
T-cell/histiocyte rich large B-cell lymphoma
T-cell large granular lymphocytic leukemia
T lymphoblastic leukemia/lymphoma
Teratoblastoma, malignant
Teratocarcinoma
Teratoma**
Thecoma (malignant only)
Thrombocythemia (essential, essentialhemorrhagic, idiopathic, or idiopathic hemorrhagic)
Thymoma (malignant or type C only)
Tumor (include only):
- adenocarcinoid
- adrenal cortical (malignant only)
- alpha cell (malignant only)
- Askin
- Bednar

beta cell (malignant only)
Brenner (malignant only)
Burkitt
carcinoid, NOS (except of appendix)
carcinoid (malignant only)
cells**
desmoplastic small round cell
dysembryoplastic neuroepithelial**
embolus
endodermal sinus
epithelial**
Ewing
fibrous, solitary**
follicular dendritic cell
fusiform cell type (malignant only)
G cell (malignant only)
gastrin cell (malignant only)
gastrointestinal stromal (malignant only)
germ cell
giant cell (malignant only)
glomus (malignant only)
granular cell**
granulosa cell (malignant or sarcomatoid only)
Grawitz
interstitial cell (malignant only)
intravascular bronchial alveolar
Klatskin
Krukenberg
Leydig cell (malignant only)
malignant (any type)
mast cell (malignant only)
Merkel cell

mesenchymal (malignant only)

mesodermal, mixed

metastatic

mixed pineal

mixed salivary gland type (malignant only)

[mucinous, of low malignant potential; *diagnosis date prior to January 1, 2001]*

mucocarcinoid

Mullerian mixed

neuroectodermal (exclude melanotic)

nonencapsulating sclerosing

odontogenic (malignant only)

olfactory, neurogenic

Pancoast

[papillary mucinous, of low malignant potential; diagnosis date prior to January 1, 2001]

[papillary serous, of low malignant potential; diagnosis date prior to January 1, 2001]

peripheral neuroectodermal or peripheral primitive neuroectodermal, NOS

peripheral nerve sheath (malignant only)

phyllodes (malignant only)

pineal parenchymal of intermediate differentiation

Pinkus

plasma cell

polyvesicular vitelline

primitive neuroectodermal

rhabdoid, NOS

rhabdoid/teratoid, atypical

round cell, desmoplastic, small

Schminke

Secondary

[serous, NOS, of low malignant potential serous, papillary, of low malignant potential diagnosis date prior to January 1, 2001]

Sellar region granular cell tumor

Sertoli-Leydig cell (poorly differentiated, with heterologous elements, sarcomatoid (malignant only)

sinus, endodermal
small cell type (malignant only)
smooth muscle (NOS)**
soft tissue**
spindle cell type (malignant only)
spindle epithelial with thymus-like element or thymus-like differentiation
steroid cell (malignant only)
sweat gland (malignant only)
teratoid/rhabdoid, atypical
transitional pineal
Triton, malignant
trophoblastic, epithelioid
vitelline, polyvesicular
Wilms
yolk sac or yolk sac, hepatoid

Ulcer, rodent

Urachal carcinoma

VAIN III (vaginal intraepithelial neoplasia, grade 3)

VIN III (vulvar intraepithelial neoplasia, grade 3)

Vipoma (malignant only)

Xanthoastrocytoma, pleomorphic

Resource: Jean-Baptiste R, Gebhard IK (eds.). Series IV: Cancer Case Ascertainment. Procedure Guidelines for Cancer Registries. Springfield, IL: North American Association of Central Cancer Registries, February 2002.

H

APPENDIX H:
QUICK REFERENCE

Data Fields Quick Reference

The Sample Abstract Form can be found in Appendix D in the 2018-2019 CRH.

Data Field 540: Reporting Facility Number

See page 64

Enter 3 digit code assigned by TCR. If you do not know your facility number, contact your regional office or call 1-800-252-8059.

Data Field 500: Reporting Source

See page 64

Enter code for the source documents and/or facility used to abstract the case.

1 - Hospital inpatient; Managed health plans with comprehensive, unified medical records

2 - Radiation Treatment Centers or Medical Oncology Centers (Facility or Private)

3 - Laboratory Only (Facility or Private)

4 - Physician's Office/Private Medical Practitioner

5 - Nursing/Convalescent Home, Hospice

6 - Autopsy Only

7 - Death Certificate Only

8 – Other hospital outpatient units/surgery centers

Note: *Assign codes in priority order: 1, 2, 8, 4, 3, 5, 6 and 7 (if more than one source is used)*

Data Field 580: Date Of Admit/First Contact/Admit (YYYYMMDD)

See page 66

Enter year, month and day of the patient's first admission to your facility for diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.

Data Field 550: Registry Number

See page 68

The first four digits identify the calendar year the patient was first seen at the facility with a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year's accession/registry number will start with **00001**.

Data Field 2300: MEDICAL RECORD NUMBER

See page 68

Enter the medical record number (MRN) used for the patient's first admission with a DX of cancer. MRN's less than 11 digits and alpha characters are acceptable. If the MRN is not available (for example, outpatient clinic charts) enter "OP" in this field.

Special Codes:

RT: Radiation Therapy department patient without a medical record number

SU: One-day surgery clinic patient without a medical record number

UNK: Medical Record Number Unknown

Data Field 610: Class Of Case

See page 69

Divides data into analytical and non-analytical categories.

Data Field 2230: Patient Last Name

See page 74

Enter the name of the patient in CAPITAL LETTERS. Hyphens, apostrophes, and spaces are allowed. **Do not leave blank.**

Data Field 2240: Patient First Name

See page 74

Enter first name of patient in CAPITAL LETTERS. Hyphens, apostrophes, and spaces are allowed. **Do not leave blank.**

Data Field 2250: Patient Middle Name

See page 75

Enter the middle name of the patient in CAPITAL LETTERS. Blanks, hyphens, spaces, and apostrophes are allowed. Enter middle initial if full name is unknown. Leave blank if unknown.

Data Field 2390: Patient Maiden Name

See page 75

Enter the maiden name of female patients who are or have been married. Blanks, hyphens, spaces, and apostrophes are allowed. Leave blank if unknown.

Data Field 2280: Name-Alias

See page 76

Enter an alternative name or "AKA" used by the patient, if known. If unknown, leave blank.

Data Field 2330: Street Address

See page 77

Enter the number and street of the patient's residence at the time the cancer is diagnosed in 60 characters or less. If address is not known, enter "NO ADDRESS" or "UNKNOWN". **DO NOT LEAVE BLANK**. Punctuation marks are not allowed in this field. Abbreviate, as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service or on the website at https://www.usps.com/.

Data Field 2335: Address at DX Supplemental

See page 79

If the name of a facility is provided instead of an address enter the facility name here. If this space is not needed **leave it blank**.

Data Field 70: Patient City

See page 80

Enter the city of residence at the time the cancer is diagnosed. If no address is known, record "Unknown". **Do not leave blank.**

Data Field 80: Patient State

See page 80

Enter the two letter abbreviation for state of residence at time of diagnosis. Record US for resident of United States, NOS. If resident of foreign country, other than Mexico (MX) or Canada (CD), record either XX if the country is known or YY if the country is unknown. If no address is known, enter "ZZ".

Data Field 100: Patient Zip Code

See page 83

Enter patient's zip code at time of diagnosis. If known, enter nine digit extended zip code. If unavailable, refer to National Zip Code Directory or the USPS website: https://zip4.usps.com/zip4/welcome.jsp. If resident of foreign country, code all "8's." If address is not available enter "99999".

Data Field 90: FIPS County Code

See page 84 & APPENDIX C

Enter the three digit Federal Information Processing Standards code found in Appendix C. Code "998" for out-of-state or foreign residents. If address is not available enter "999".

Data Field 102: Address at DX-Country

See page 85

Enter the appropriate alpha-3-digit code for the country of residence. Use codes issued by the United States Postal Service. Use USA for United States.

Data Field 2320: Patient SSN

See page 86

Every resource should be exhausted to obtain social security number. If not available, code all "9's" **as a last resort only**. Take caution to enter the patient's number and not the spouse's number. Dashes and slashes are not allowed in this field.

Data Field 240: Patient Date Of Birth (YYYYMMDD)

See page 87

DOB must be coded. Enter year, month and day of patient's birth. **Unknown date of birth will not be accepted**

Data Field 252: Place Of Birth-State

See page 88

Record the patient's state of birth (if available) using the US Postal Service. If the state of birth is unknown, code to ZZ.

Data Field 254: Place Of Birth-Country

See page 88

Record the patient's country of birth (if available) using the US Postal Service. If the country of birth is unknown, code to ZZU.

Data Field 160: Race Codes 1 – 5

See page 89

Enter the 2 digit code to identify the primary race of the patient.

CODE	DESCRIPTION	CODE	DESCRIPTION
01	White	17	Pakistani
02	Black	20	Micronesian, NOS
03	American Indian, Aleutian, Eskimo (includes all indigenous populations of the Western hemisphere)	21	Chamorro/Chamoru
04	Chinese	22	Guamanian, NOS
05	Japanese	25	Polynesian, NOS

CODE	DESCRIPTION	CODE	DESCRIPTION
06	Filipino	26	Tahitian
07	Hawaiian	27	Samoan
08	Korean	28	Tongan
10	Vietnamese	30	Melanesian, NOS
11	Laotian	31	Fiji Islander
12	Hmong	32	New Guinean
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS	98	Other
16	Asian Indian	99	Unknown
88	No additional races (races 2-5)		

Data Field 161, 162, 163 & 164: Race 2, Race 3, Race 4, & Race 5

See page 93

If the patient is multi-racial, code all the races using items (RACE 2) through (RACE 5) Use code “88" for no further race documented.

Data Field 190: Spanish/Hispanic Origin

See page 95

This code identifies persons of Spanish or Hispanic origin. The information may be coded from the medical record or may be based on Spanish/Hispanic names. Persons of Spanish or Hispanic origin may be of any race. A list of Spanish/Hispanic surnames is available on the TCR website online appendices: https://www.dshs.texas.gov/tcr/training/handbook/Appendix-Spanish-Hispanic-Surnames.pdf

CODE	DESCRIPTION
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic (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 other information the person is not Hispanic. Ordinarily for central registry use only.

CODE	DESCRIPTION
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not; not stated in patient record

Data Field 220: Patient Sex Codes

See page 97

Enter the code to identify the gender of the patient.

CODE	DESCRIPTION
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not Stated/Unknown

Data Field 320: Text Usual Industry

See page 98

Document the patient's usual industry to the extent that the information is available in the medical record.

Data Field 310: Text Usual Occupation

See page 99

Document the patient's usual occupation to the extent that the information is available in the medical record.

Data Field 2680: Other Pertinent Information

See page 100

Document other pertinent information for which adequate or appropriate space has not been provided on the reporting form. Such information may include additional staging or treatment information, history of disease or comments regarding lack of documentation in the medical record. Document the name of the facility that referred the patient or the name of the facility that the patient was referred to in this field. Document age and race of the patient in this field.

Data Field 2470: Physician Follow Up

See page 101

Record the state license number of the physician currently responsible for following the patient. Physician license numbers for Texas can be found at the following website: http://www.tmb.state.tx.us/page/look-up-a-license.

Data Field 560: Sequence Number

See page 101

Indicates the chronological sequence of this reportable neoplasm IN THE PATIENT'S LIFETIME. Each PRIMARY tumor is assigned a different number.

Sequence Number: Malignant Neoplasms

ONE PRIMARY	MORE THAN ONE PRIMARY	SEQUENCE
00 One primary only	01 First of two or more primaries	99 Unspecified
	02 Second of two or more primaries	
	03 Third of three or more primaries	

Sequence Number: Non-Malignant Neoplasms

ONE PRIMARY	MORE THAN ONE PRIMARY	SEQUENCE
60 One primary only	61 First of two or more primaries	88 Unspecified
	62 Second of two or more primaries	
	63 Third of three or more primaries	

Data Field 2220: Other Primary Tumors (Site, Morphology, And Date)

See page 103

Complete **if the patient has other reportable tumors during their lifetime.** Record the site, morphology, and date of any other primaries. DO NOT INCLUDE SECONDARY/METASTATIC LESIONS.

Data Field 630: Primary Payer At Dx

See page 104

Record patient's insurance.

CODE	DESCRIPTION
01	Not insured
02	Not insured, self-pay
10	Insurance, NOS

CODE	DESCRIPTION
20	Private Insurance: Managed Care, HMO, or PPO
21	Private Insurance: Fee-for-Service
31	Medicaid
35	Medicaid-Administered through a Managed Care plan
60	Medicare without supplement, Medicare, NOS
61	Medicare with supplement, NOS
62	Medicare-Administered through a Managed Care plan
63	Medicare with private supplement
64	Medicare with Medicaid eligibility
65	TRICARE
66	Military
67	Veterans Affairs
68	Indian/Public Health Services
99	Insurance status unknown

Data Field 9960: Height

See page 106

Enter height as a 2 digit number measured in inches. Round all inches values to the nearest whole number; values with decimal place x.5 and greater should be rounded up (code 62.5 inches as 63 inches). **Do not leave this field blank. If the information is not available use code 99 (Unknown).**

Data Field 9961: Weight

See page 107

Enter the weight as a 3 digit number measured in pounds. Round values to the nearest whole number. Values with decimal place x.5 should be rounded up (Code 155.5 pounds as 156). Code a weight of less than 100 pounds with a leading 0 (Code 95 pounds as 095) **Do not leave this field blank. If the information is not available use code 999 (Unknown).**

Non-NAACCR Data Fields 9965 (Tobacco Use Cigarettes), 9966 (Tobacco Use Other Smoke), 9967 (Tobacco Use Smokeless), And 9968 (Tobacco Use Nos)

See pages 107-110

Record the patient's past or current use of tobacco. Record from sections such as Nursing Interview Guide, Vital Stats, or Nursing Assessment section.

CODE	DESCRIPTION
0	Never used
1	Current user (as of Date of diagnosis)
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated/no smoking specifics provided

Data Field 39: Date Of Initial Diagnosis (YYYYMMDD)

See page 112

Enter the date of initial diagnosis of this cancer by a recognized medical practitioner **by any method** (for example, a positive finding from a radiology report); regardless of whether the diagnosis was made at this facility or elsewhere. The date of diagnosis for "Death Certificate Only" or "Autopsy Only" is the date of death. For vague dates, estimate month and year. For cases with unknown date of diagnosis code month and year of date of first contact (for June 2018 code 201806) and document "Date of dx unknown" in Other Pertinent Information Text Field. This should be used as a last resort after exhausting all available resources. Every effort must be made to obtain date of diagnosis.

Data Field 420, 430: Morphology ICD-O-2: Type and Behavior

See page 115

The International Classification of Diseases for Oncology, (ICD-O) 2nd Edition, is to be used for coding and reporting the morphology and behavior of tumors diagnosed before January 1, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Data Field 522 & 523: Morphology ICD-O-3: Type and Behavior

See page 115

The International Classification of Diseases for Oncology, (ICD-O) 3rd Edition is to be used for coding and reporting the morphology and behavior of tumors diagnosed on or after January 1, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form to support coding. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Note: *Refer to the Solid Tumor Rules for cases diagnosed on or after 1/1/2018: https://seer.cancer.gov/tools/solidtumor/*

Refer to the SEER website for hematopoietic and lymphoid malignancies. Click on the following link for the Database and Manual: https://seer.cancer.gov/tools/heme/

Data Field 400: Primary Site

See page 120

Record the specific topography code from ICD-O-3. **Adequate documentation must be provided** in the **FINAL DIAGNOSIS** (Data Fields 2590 and 2580) section of the reporting form to support coding.

Data Field 3843: Grade Clinical, 3844

See pages 129

This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant).
For cases diagnosed January 1, 2018, and later, this data item, replaces NAACCR Data Item Grade [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the clinical stage group. For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC Chapter. The AJCC Chapter-specific grading systems (codes 1-5) take priority over the generic grade definitions (codes A-E, L, H, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Codes (Refer to the most recent version of the SSDI Manual for additional site-specific instructions)

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank. Leave blank for cases diagnosed prior to 2018.

Data Field 3844: Grade Pathological

See page 130

This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup.

For cases diagnosed January 1, 2018 and later, this data item, along with Grade Clinical and Grade Post Therapy, replaces the data item Grade [NAACCR Item #440] as well as site specific. If AJCC staging is being assigned the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup.

For cases diagnosed January 1, 2018 and later, this data item, along with Grade Clinical and Grade Post Therapy, replaces the data item Grade [NAACCR Item #440] as well as site specific instructions.

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

Codes (Refer to the most recent version of the SSDI Manual for additional site-specific instructions)

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank. Leave blank for cases diagnosed prior to 2018.

Data Field 410: Laterality

See page 130

Enter the code to identify the laterality of a paired site.

CODE	DESCRIPTION
0	Not a paired site
1	Right origin of primary
2	Left origin of primary
3	Only one side involved, right or left origin of primary not indicated
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or: Both ovaries simultaneously involved with a single histology, Bilateral retinoblastomas, and Bilateral Wilms' tumors. **Note**: If both lungs have nodules or tumors and the lung of origin is not known, assign code 4
5	Paired site: midline tumor
9	Unknown site; paired site, lateral origin unknown

Data Field 2580 & 2590: Final Diagnosis- Morphology/Behavior, Grade, Primary Site, and Laterality Documentation

See page 135

Record the morphology/behavior, grade, primary site, and laterality descriptions.

Data Field 1182: Lymphovascular Invasion

See page 135

Indicates presence or absence of tumor cells in lymphatic channels.

CODE	DESCRIPTION
0	Lymphovascular invasion not present (absent)/Not identified
1	Lymphovascular invasion present/Identified
8	Not applicable
9	Unknown if lymphovascular invasion present Indeterminate

Data Field 490: Diagnostic Confirmation

See page 137

The best method of confirmation throughout the entire course of the disease. All diagnostic reports in the medical record must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer. Different coding instructions are given for solid tumors (page 136) and hematopoietic and lymphoid neoplasms (page 139).

Table H.10 DIAGNOSTIC CONFIRMATION FOR SOLID TUMORS

CODE	DESCRIPTION	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Histological confirmation (tissue microscopically examined). In situ behavior must be microscopically confirmed.
2	Positive cytology	Cytological confirmation (no tissue microscopically examined; fluid cells microscopically examined). Includes pap smears, bronchial brushings, FNA and peritoneal fluid, cervical and vaginal smears, diagnoses based on paraffin block specimens from concentrated spinal, pleural or peritoneal fluid.
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.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies that are clinically diagnostic for cancer but there is no histologic confirmation. This includes alpha-fetoprotein for liver cancer. Elevated PSA is non-diagnostic of cancer. However if the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, code to 5. (STORE 2018 Manual).
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical/endoscopic procedure only with no tissue resected for microscopic exam.
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 physician documented the tumor in the medical record. **Note:** Refer to the *Ambiguous Terminology List* in the MP/H Rules for cases diagnosed on or after 1/1/2007.

CODE	DESCRIPTION	DEFINITION
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate only cases.

Table H.11 DIAGNOSTIC CONFIRMATION FOR HEMATOPOIETIC OR LYMPHOID TUMORS (9590-9992)

CODE	DESCRIPTION	DEFINITION
MICROSCOPICALLY CONFIRMED		
	Positive histology	Tissue from lymph node(s), organ(s) or other tissue specimens from biopsy, frozen section, surgery or autopsy; Bone marrow specimens (aspiration and biopsy); Peripheral blood smear can be used as histological diagnoses for all hematopoietic histologies (9590/3-9992/3) For **leukemia** only (9800/3-9948/3), positive histology also includes • Complete blood count (CBC) • White blood count (WBC) Neoplasm microscopically confirmed **AND** • Immunophenotyping, genetic testing or JAK2 **not** done **OR** • Immunophenotyping, genetic testing or JAK2 done but **negative** (non-diagnostic) for the neoplasm being abstracted **OR** • Immunophenotyping, genetic testing or JAK2 done but **not listed** in the Definitive Diagnostic Methods in the Heme DB ○ In situations like this, the immunophenotyping, genetic testing, or JAK2 may have been done to **rule out** other neoplasms that are clonally similar to the neoplasm being abstracted. Usually the provisional diagnosis will include two or more neoplasms **Example**: Bone marrow positive for myeloproliferative neoplasm, probable essential thrombocythemia. JAK2 done and is negative. The JAK2 did not confirm the essential thrombocythemia. Code the myeloproliferative neoplasm (9975/3) with diagnostic confirmation code 1 (positive bone marrow biopsy only). **Example:** Acute Myeolomonocytic Leukemia (9867/3) CD 10 (+). CD 10 (+) is not listed under Immunophenotyping for this histology, diagnostic confirmation shlud be 1 Use for historical cases not already in the database if information states that there was histologic confirmation.

CODE	DESCRIPTION	DEFINITION
2	Positive cytology, no positive histology	This code is rarely used for Hematopoietic and Lymphoid neoplasms. This code includes examination of fluid such as spinal fluid, peritoneal fluid, or pleural fluid. This code also includes paraffin block specimens from concentrated spinal fluid, peritoneal fluid, or pleural fluid. When a small-gauge needle (fine needle aspirations or FNA), or other method is used to obtain a specimen and there is not enough tissue to do a histologic examination the report will be a cytology report rather than a pathology report.
3	Positive histology PLUS: • Positive immunophenotyping AND/OR • Positive genetic studies (**Effective for cases diagnosed 1/1/2010 and later**)	This code can only be used when there is histologic confirmation (including ambiguous terminology and provisional diagnosis) (Code 1) **and** • Immunophenotyping, genetic testing, or JAK2 is listed in the **Definitive Diagnostic Methods** in the Heme DB **AND** a) Immunophenotyping, genetic testing, or JAK2 is **positive** for the neoplasm being abstracted ***(confirms disease)*** **OR** b) Immunophenotyping, genetic testing, or JAK2 identified a ***more specific histology*** (not preceded by ambiguous terminology) **Note:** ***Do not use*** code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when preceding by ambiguous terminology. ***Example (identifying a more specific histology:*** Bone Marrow biopsy (+) for Acute Myeloid Leukemia (9861/3). Genetic testing (+) for AML with inv (16) (p13.1q22) (9871/3) code diagnostic confirmation code 3, positive histology and positive genetic testing.
4	Positive microscopic confirmation, method not specified	This code is rarely used for Hematopoietic Lymphoid neoplasms The diagnosis is stated to be microscopically confirmed but the method is not specified or unknown.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker study	This code is rarely used for Hematopoietic and Lymphoid neoplasms. If there no provisional diagnosis or clinical suspicion of cancer, immunophenotyping or genetic testing would not be done. **Example**: CT scan consistent with multiple myeloma (9732/3). Twenty-four hour urine protein elevated with the presence of Bence-Jones kappa. Code 5 for diagnosis based on the positive Bence-Jones, which is listed as one of the diagnostic confirmation methods in the Heme DB and is also a lab test. Code 1 and 3 do not apply because there is no histologic confirmation and positive immunophenotyping and or genetic studies in this example.

CODE	DESCRIPTION	DEFINITION
6	Direct visualization without microscopic confirmation	This code is rarely used for hematopoietic and lymphoid neoplasms. The operative report may state that the patient had lymphoma but no biopsy or cytology was done or the the diagnosis is determined by gross autopsy findings (no tissue or cytologic confirmation).
7	Radiography and other imaging techniques without microscopic confirmation	This code is rarely used for Hematopoietic and Lymphoid neoplasms. Assign code 7 when the diagnosis is confirmed by radiology or other imaging techniques only.
8	Clinical diagnosis only (other than 5, 6, or 7)	While clinical diagnosis is seldom used for solid tumors, it is a valid diagnostic method for certain hematopoietic neoplasms. The Heme DB will list Clinical Diagnosis as the definitive diagnostic method for certain hematopoietic neoplasms. For these neoplasms, the biopsy, immunophenotyping, and genetic testing do not confirm the neoplasm. The diagnosis is determined based on the physician's clinical expertise, combined with the information from the biopsy, equivocal or negative tests, and the clinical symptoms. This is called a "diagnosis of exclusion" because the physician's judgment and the work-up literally exclude all other possible diagnoses, leaving one diagnosis. **Example**: Bone marrow biopsy shows anemia NOS; physician notes states the patient's overall clinical presentation of hypercalcemia, fever, and anemia is consistent with Myelodysplastic Syndrome, NOS (9989/3). Code Diagnostic Confirmation 8, clinical diagnosis only.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate only cases.

Data Field 2600: Summary Stage Documentation

See page 150

Text field for documentation of extent of disease to support coding. Include findings from radiology and pathology reports and descriptions of observations from history and physical and operative reports. Include dates and types of procedures and exams. Document information such as lymph node involvement, extent of invasion, extension to adjacent organs, and metastatic spread of disease. Both positive and negative findings that are pertinent to describing the spread of the tumor from the primary site should be recorded. Stage documentation should include all information available through completion of surgery(ies) in the first course of treatment or within **4 months** of diagnosis in the absence of disease progression, whichever is longer. These findings may be obtained from diagnostic

reports of radiology, endoscopy, surgery, and laboratory tests prior to treatment. Document both the date and the source of the staging information.

Data Fields 2520, 2530, 2540, 2550, 2560, 2570: Documentation of Cancer Diagnosis, Extent of Disease, and Treatment

See page 245

Text information to support cancer diagnosis, stage, and treatment codes **MUST BE PROVIDED BY ALL FACILITIES**. Document all types of the **first course** of definitive treatment administered, regardless of where the treatment was received, in chronological order.

Data Field 756: Tumor Size Summary

See page 154

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen. Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Tumor size code 999 is used when size is unknown or not applicable. Sites/morphologies where tumor size is not applicable:

- Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms (histology codes 9590-9992)
- Kaposi Sarcoma
- Melanoma Choroid
- Melanoma Ciliary Body
- Melanoma Iris
- Unknown Primary

Data Field 820: Regional Lymph Nodes Positive

See page 183

Record the total number of regional lymph nodes pathologically examined and found to be positive. 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.

Use code 99 for sites or morphologies for which information about the field is unknown or not applicable:

Examples:

- Brain
- Intracranial Gland
- Reticuloendotheliosis

- Placenta
- Leukemia, Lymphoma
- Myeloma and Plasma Cell Disorder
- Other and Ill-Defined Primaries, Unknown Primaries

Data Field 830: Regional Lymph Nodes Examined

See page 187

Record the total number of regional lymph nodes removed. The number of regional lymph nodes removed is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment. If no regional lymph nodes are identified in the pathology report, code 00.

Use code 99 for sites or morphologies for which information about the field is unknown or not applicable:

Examples:

- Brain
- Intracranial Gland
- Reticuloendotheliosis
- Placenta
- Leukemia, Lymphoma
- Myeloma and Plasma Cell Disorder
- Other and Ill-Defined Primaries, Unknown Primaries

Documentation in the Summary Stage text field is required to support coding.

Data Fields SSDI's

See page 159

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank. SEER has developed a staging tool referred to as **SEER*RSA** that provides information (primary site/histology/other factors defined) about each cancer schema. See tables lists of the site-specific schema discriminators and SSDIs that are new and are required for collection in 2018, page 186.

Page 186 - The **first table lists** schema discriminators with the corresponding NAACCR item number and description. The **second table** lists SSDIs required for staging. For additional required data items, see **NAACCR Version 18 Required Status Table** and the **SSDI Manual**. Refer to **SEER*RSA** and the SSDI manual for codes and coding instructions.

Documentation in the Summary Stage text field is required to support coding.

Data Field 760: Summary Stage 1977

To be used with cases diagnosed/admitted prior to 2001. Summary Stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

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
8	Not applicable
9	Unstaged

Note: Do not use Code "8" for Summary Stage.

Data Field 764: Summary Stage 2018

See page 158

To be used with cases diagnosed/admitted January 1, 2001 and after. Summary Stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

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
8	Not applicable
9	Unstaged

Note: Do not use Code "8" for Summary Stage.

Data Field 1001: TNM Clinical T

See page 163

Description

Detailed site-specific codes for the clinical tumor (T) as defined by the current AJCC edition.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1002: TNM Clinical N

See page 163

Description

Detailed site-specific codes for the clinical nodes (N) as defined by the current AJCC edition.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1003: TNM Clinical M

See page 164

Description

Detailed site-specific codes for the clinical metastases (M) as defined by the current AJCC edition.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1004: TNM Clinical Stage Group

See page 165

Description

Detailed site-specific codes for the clinical stage group as defined by the current AJCC edition.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1011: TNM Pathologic T

See page 165

Description

Detailed site-specific codes for the pathologic tumor (T) as defined by the current AJCC edition.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1012: TNM Pathologic N

See page 166

Description

Detailed site-specific codes for the pathologic nodes (N) as defined by the current AJCC edition.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules. **Documentation in the Summary Stage Text field is required to support coding.**

Data Field 1013: TNM Pathologic M

See page 167

Description

Detailed site-specific codes for the clinical path (M) as defined by the current AJCC edition.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules

Data Field 1014: TNM Pathologic Stage Group

See page 168

Description

Detailed site-specific codes for the pathologic stage group as defined by the current AJCC edition.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1260: Date of Initial Treatment (YYYYMMDD)

See page 175

Enter the date the first course of treatment (surgery, radiation, systemic or other) started at any facility.
Note: This field will no longer be derived.

Data Field 1261: Date of Initial RX Flag

See page 177

This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if therapy was administered).
11	No proper value is applicable in this context (no treatment given or autopsy only).
12	A proper value is applicable but not known.
(blank)	A valid date value is provided in item Date of Initial Treatment (NAACCR Item #1260).

Data Field 1292: Scope Of Reg LN Surgery

See page 178

Enter the code that defines the removal of regional lymph nodes. If no cancer-directed procedure was performed code (0).

Data Field 1200: RX Date-Surgery (YYYYMMDD)

See page 189

Document and enter the date of the **first** definitive cancer-directed surgery performed at any facility. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery. If surgery was done but the date is unknown record the year and month of diagnosis and leave the day blank.

Data Field 1201: RX Date Surgery Flag

See page 191

This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item Date of First Surgical Procedure (NAACCR Item #1200).

Data Field 3170: RX Date Most Definitive Surgery (YYYYMMDD)

See page 191

Document and enter the date of the most definitive surgery of the primary site performed at any facility as part of first course treatment.

Data Field 3171: RX Date Mst Defn Srg Flag

See page 192

This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item Date of First Surgical Procedure (NAACCR Item #3170).

Data Field 1290 Surgery RX Code

See page 193

Document and code the most definitive first course cancer-directed surgery at any facility. Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is not considered cancer-directed surgery. Brushings, washings and aspiration of cells are not surgical procedures.

Data Field 1340: Reason for no Surgery

See page 195

If no cancer directed surgery to the primary site was performed record the reason.

CODE	DESCRIPTION
0	Surgery of the primary site was performed
1	Not part of the planned first course
2	Not recommended due to patient risk factors
5	Patient died prior to planned or recommended surgery
6	Surgery recommended and unknown why not performed
7	Patient or family refused surgery
8	Surgery recommended, unknown if performed
9	Unknown if surgery recommended or performed

Data Field 1294: RX Summ-Surg.Oth Reg/Dist RX Code

See page 197

Document and code the highest numbered code that describes the surgical resection of Regional/Distant Sites and Distant lymph nodes.

Data Fields 2610, 2630, 2640, 2650, 2660, 2670: Treatment Documentation

See page 199

Text field used to support codes in the treatment fields. Document all planned treatment even if it is unknown if treatment was given. List dates and types of all treatment given, even if it was done at another facility.

Data Field 1210: Date Radiation Started (YYYYMMDD)

See page 200

Document and enter the date radiation began at any facility as part of the first course of treatment.

Data Field 1211: Date Radiation Flag

See page 201

This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if radiation given).
11	No proper value is applicable in this context (no radiation given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (radiation therapy is planned as part of first course of therapy, but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item Date Radiation Started (NAACCR Item #1210).

Data Field 1506: Phase I Radiation Treatment Modality

See page 201

Phase I Radiation Treatment Modality

STORE 2018 pages 285-286

Radiation Treatment Modality--Phase I is new for 2018. This data item identifies the radiation modality administered during the first phase of radiation treatment delivered during the first course of treatment. **The TCR only requires NAACCR item # 1506 Phase I Radiation Treatment Modality for cases diagnosed in 2018.**

Description

Identifies the radiation modality administered during first phase of radiation treatment delivered during the first course treatment. This data item is required for CoC-accredited facilities as of 1/1/2018 and it is required by the TCR.

Code	Description
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	04 External beam, electrons
05	05 External beam, neutrons
06	06 External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Treatment radiation modality unknown; Unknown if radiation treatment administered

*For more detailed coding instructions please see STORE 2018 Manual beginning on page 304

Data Field 1380: RX Summ-Surg/Rad Seq

See page 204

Code the sequence of radiation and surgical procedures given as part of the first course of treatment.

CODE	DESCRIPTION
0	No radiation therapy and/or surgical procedures
2	Radiation therapy before surgery
3	Radiation therapy after surgery
4	Radiation therapy both before and after surgery
5	Intraoperative radiation therapy
6	Intraoperative radiation therapy with other therapy administered before or after surgery

7	Surgery both before and after radiation
9	Sequence unknown, but both surgery and radiation were given

Data Field 1430: Reason No Radiation

See page 206

Code the reason no regional radiation therapy was administered to the patient.

CODE	DESCRIPTION
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.
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.

Data Field 1220: Chemotherapy Date Started (YYYYMMDD)

See page 208

Record the first or earliest date of chemotherapy. If no chemotherapy was given or it is unknown if chemotherapy was given, leave the field blank.

Data Field 1221: Chemotherapy Date Started Flag

See page 209

This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if chemotherapy was given).
11	No proper value is applicable in this context (no chemotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy was given but the date is unknown).

15	Information is not available at this time, but it is expected that it will be available later (chemotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item Date Chemotherapy Started (NAACCR Item #1220). Case was diagnosed between 2003 and 2009 and the facility did not record Date Chemotherapy Started (NAACCR Item #1220) at that time.

Data Field 1390: Chemotherapy Code

See page 209

Document and code the type of chemotherapy the patient received as part of the first course of treatment at any facility. Chemotherapy may involve the delivery of one or a combination of chemotherapeutic agents. Code 88 if the only information available is that the patient was referred to an oncologist. Code 00 if chemotherapy was not delivered

Data Field 1230: Date Hormone Therapy Started (YYYYMMDD)

See page 216

Record the first or earliest date on which hormone therapy was given as part of first course of treatment. If no hormone therapy was given or it is unknown if hormone therapy was given, leave this field blank.

Data Field 1231: RX Date Hormone Flag

See page 217

This flag explains why there is no appropriate value in the corresponding date field

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if any hormone therapy was given).
11	No proper value is applicable in the context (no hormone therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (hormone therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
15	Information is not available at this time, but it is expected that it will be available later (hormone therapy is planned as part of first course treatment, but had not yet started at the last follow-up).
(blank)	A valid date is provided in item Date Hormone Therapy Started (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record Date Hormone Therapy Started (NAACCR Item #1230) at that time.

Data Field 1400 RX Summ-Hormone

See page 218

Document and code the type of hormone therapy the patient received as part of the first course of treatment at any facility. Hormonal therapy may involve the delivery of one or a combination of agents. Code 88 when the only information available is the patient was referred to an oncologist. Code 00 if hormone therapy was not delivered

Table RX Date-Hormone Flag Codes

CODE	DESCRIPTION
00	None; hormone therapy was not part of the planned first course of therapy; not usually administered for this type and/or stage of cancer; Diagnosed at autopsy only
01	Hormone therapy was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. 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.

Data Field 1240: Immunotherapy Date Started (YYYYMMDD)

See page 222

Record the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of therapy. If no immunotherapy was given or it is unknown if immunotherapy was given, leave this field blank.

Data Field 1241: Immunotherapy Date Started Flag

See page 223

This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if immunotherapy was given).
11	No proper value is applicable in this context (no immunotherapy given).

CODE	DESCRIPTION
12	A proper value is applicable but not known. This event occurred, but the date is unknown (immunotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
15	Information is not available at this time, but it is expected that it will be available later (immunotherapy is planned as part of first course treatment, but had not yet been started at the time of the last follow-up).
(blank)	A valid date is provided in item Date Immunotherapy Started (NAACCR Item #1240). Case was diagnosed between 2003 and 2009 and the facility did not record Date Immunotherapy started (NAACCR Item #1240) at that time.

Data Field 1410: Immunotherapy Code

See page 224

Document and code the type of Immunotherapy the patient received as part of the first course of treatment at any facility. Code to 88 when the only information is that the patient was referred to an oncologist. Code 00 if Immunotherapy was not delivered.

RX Date-Immunotherapy Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if immunotherapy was given).
11	No proper value is applicable in this context (no immunotherapy given)
12	A proper value is applicable but not known. This event occurred, but date is unknown (that is, immunotherapy was given but the date is unknown and cannot be estimated).
15	Information is not available at this time, but it is expected that it will be available later (immunotherapy is planned as part of first course treatment, but had not yet been started at the time of the last follow-up)
(blank)	A valid date is provided in item *Date Immunotherapy Started* (NAACCR Item #1240). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Immunotherapy Started* (NAACCR Item #1240) at that time.

Data Field 3250: Transplant/Endocrine Code

See page 227

Code the type of hematologic transplant and/or endocrine procedures the patient received as part of the first course of treatment at any facility. Code 88 if the only information is that the patient was referred to a specialist for hematologic transplant or endocrine procedures. Code 00 if a transplant or endocrine procedure was not done.

RX Summ– Transplant/Endocrine Codes

CODE	DESCRIPTION
00	No transplant procedure or endocrine therapy was administered as part of first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only
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 (Stem cell transplant) and infusion.
30	Endocrine surgery and/or endocrine radiation therapy as first course of therapy
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20) as first course of therapy.
82	Transplant procedure and/or endocrine therapy was not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of disease prior to administration).
85	Transplant procedure and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy.
86	Transplant procedure and/or endocrine surgery/radiation were not administered. It was recommended by the patient's physician, but was not administered as part of first course therapy. No reason was noted in the planned or recommended therapy.
87	Transplant procedure and/or endocrine surgery/radiation were 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	Transplant procedure and/or endocrine therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether transplant procedure or endocrine therapy was recommended or administered because it is not documented in the medical record. Death certificate only.

Data Field 1639: RX Summ—Systemic Surg Seq

See page 230

Code the administration of systemic therapy in sequence with the first surgery performed, described in the data item **Date of First Surgical Procedure.**

CODE	DESCRIPTION
0	No systemic therapy and/or surgical procedures
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before or after surgery
7	Surgery both before and after systemic therapy

9	Sequence unknown

Data Field 1250: Date Other Treatment Started (YYYYMMDD)

See page 233

Enter the date other treatment is delivered that is not included in surgery, radiation therapy, and systemic treatment. If no other treatment was given or it is unknown if other treatment was given, leave the field blank.

Data Field 1251: RX Date Other

CODE	TYPE	DESCRIPTION
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases. *See **Examples**
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-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 non-medical 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 patient record.
8	Recommended; unknown if done	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.

Data Field: 1251 RX Date Other Flag

See page 234

This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if any Other Treatment was given).

11	No proper value is applicable in this context (no other treatment given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (other treatment was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (radiation therapy is planned as part of first course of therapy, but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item Date Other Treatment Started (NAACCR Item #1250).

Data Field 1420: Other Treatment Code

See page 234

Document and code the type of "other treatment" the patient received as part of the first course of treatment at any facility. "Other treatment" is designed to modify or control the cancer cells, but is not included in surgery, radiation, or systemic therapy.

Data Field 1285: RX Summ-Treatment Status

See page 238

Code whether or not first course treatment was given.

CODE	DESCRIPTION
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

Data Field 1750: Date Of Last Contact Or Death (YYYYMMDD)

See page 239

Enter the date the patient was last seen at your facility, date of last contact, or date of death. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the "Other Pertinent Information" text area, document the patient is deceased and the date of death is not available.

Data Field 1760: Vital Status

See page 240

Patient's vital status as of the date recorded in the "Date of last contact/death" field.

CODE	DESCRIPTION
0	Dead
1	Alive

Data Field 1942: Place Of Death - State

See page 241

See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes: https://seer.cancer.gov/tools/codingmanuals/index.html

Data Field 1944: Place Of Death-Country

See page 241

Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes.

CODE	DESCRIPTION
USA	United States
ZZN	North America NOS
ZZC	Central America NOS
ZZX	Non-US NOS
ZZU	Unknown

Data Field 2090: Date Abstracted (YYYYMMDD)

See page 241

Record year, month, and day reporting form is completed.

Data Field 570: Abstractor Initials

See page 242

Record the initials of the abstractor.

Data Field 1060: TNM Edition Number

See page 242

TNM Edition Number indicates the edition of the AJCC manual that was used to manually code the TNM values for the patient.

CASEFINDING QUICK REFERENCE

Casefinding and Reportable List (Detailed instructions on pages 29-62)

1. Every inpatient and outpatient case with active disease and/or receiving cancer-directed therapy **must** be reported to the Department of State Health Services, Texas Cancer Registry (TCR) regardless of the state or country of residence.
2. Cases of cancer to be reported to the TCR include:
    a. All neoplasms with a behavior code of two or three in the International Classification of Diseases for Oncology (ICD-O) 3rd edition (with certain exceptions); and
    b. All benign and borderline neoplasms of the central nervous system with a morphology term and code listed in ICD-O-3 (includes brain and other CNS neoplasms)

    Note: Benign and borderline CNS cases diagnosed prior to 2004 are no longer required to be submitted to the TCR.
3. Obtain disease indices including both inpatient and outpatient admissions after medical records are completed and coded (monthly or quarterly).
4. Check the indices against a list of cases previously reported to the TCR to identify new cases.
5. Complete an abstract for patients found on the disease index with a reportable diagnosis not previously submitted to the TCR. Patients who have been previously reported to the TCR need to be checked for possible multiple primaries. Refer to the *Multiple Primaries/Histology Rules* (MP/H) and to the *2015 Hematopoietic and Lymphoid Neoplasm Coding Manual* for assistance.
6. To prevent reporting a primary for a patient twice, compare the patient name and primary cancer site from your registry database (accession list) to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.
7. Other department logs/records (radiation therapy logs, emergency department logs, oncology unit records, surgery logs, etc.) are to be reviewed in the same method as the disease index to insure all reportable cases are submitted to the TCR.
8. Pathology reports, including all histology, cytology, hematology and autopsy reports, should be reviewed to identify all reportable neoplasms. These should also be reviewed against a list of records submitted to the TCR.

The following lists are intended to aid the appropriate personnel in creating a disease index with the required reportable neoplasms and ICD-10-CM codes. **A DI with the reportable ICD-10-CM codes will require a 100% review.**

REPORTABLE ICD-10-CM CODES

Table H. 29 Reportable ICD-10-CM Codes

ICD-10-CM CODE (100% Review Required)	DESCRIPTION
C00.0- C43.9 C4A.0-C4A.9, C45.- C96.9	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies NEW for FY2018: C96.20 Malignant mast cell neoplasm, unspecified C96.21 Aggressive systemic mastocytosis C96.22 Mast cell sarcoma C96.29 Other malignant cell neoplasm
C49.A_	Gastrointestinal Stromal Tumors (GIST) Note: GIST is only reportable when it is malignant (/3). GIST, NOS (not stated whether malignant or benign) is a /1 and is not reportable.
D00.00 - D05.92 D07.0-D09.9	In-situ neoplasms (*Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*).
D18.02	Hemangioma of intracranial structures and any site
D18.1	Lymphangioma, any site (*Note: Includes Lymphangiomas of Brain, Other parts of nervus system and endocrine glands, which are reportable*)
D32.0-D32.9	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.0 – D33.9	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.0, D43.09	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46-D46.9	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)

ICD-10-CM CODE (100% Review Required)	DESCRIPTION
D47.02	Systemic mastocytosis *Note:* Effective 10/1/2017
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3)
D47.4	Osteomyelofibrosis (9961/3)
D47.Z1-D47.Z9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9931/3)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

^ International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2017

Source: *https://seer.cancer.gov/tools/casefinding/case2016-icd10cm.html*

SUPPLEMENTARY ICD-10CM CODES

Table 3.5 Supplementary ICD-10-CM Code List Effective 10/0110/1/2017-9/30/2018

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
B20	Human immunodeficiency virus [HIV] disease with other diseases
B97.33, B97.34, B97.35	Human T-cell lymphotrophic virus,(type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomavirus as the cause of diseases classified elsewhere

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
D10.0 - D31.92, D34, D35.0, D35.1, D35.5_ D35.9, D36.0-D36.9	Benign neoplasms (see "must collect" list for reportable benign neoplasms) ***Note:*** *Screen for incorrectly coded malignancies or reportable by agreement tumors* ***Note****: Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.*
D3A.0-D3A.8 D3A.00-D3A.098	Benign carcinoid tumors
D37.0 - D41.9	Neoplasms of uncertain or unknown behavior (see "must collect" list for reportable neoplasms of uncertain or unknown behavior) ***Note:*** *Screen for incorrectly coded malignancies or reportable by agreement tumors*
D44.0 - D44.2, D44.6-D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands (see "must collect" list for D44.3-D44.5) ***Note:*** *Screen for incorrectly coded malignancies or reportable by agreement tumors*
D47.01	Cutaneous mastocytosis (9740/1) *Note: Effective 10/1/2017*
D47.09	Other mast cell neoplasms of uncertain behavior *Note: Effective 10/1/2017*
D47.2	Monoclonalgammopathy ***Note:*** *Screen for incorrectly coded Waldenstrom's macroglobulinemia*
D47.Z2	Castleman disease
D48.0-D48.9	Neoplasm of uncertain behavior of other and unspecified sites
D49.0 - D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)
D61.1	Drug-induced aplastic anemia (also known as “aplastic anemia due to antineoplastic chemotherapy”) ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
D61.810	Antineoplastic chemotherapy induced pancytopenia
D61.82	Myelophthisis *ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50. _)*
D63.0	Anemia in neoplastic disease
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia *Note: Screen for incorrectly coded thrombocythemia*
D70.1	Agranulocytosis secondary to cancer chemotherapy
D72.1	Eosinophilia (*Note: Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosonophilic syndrome."*)
D75.81	Myelofibrosis (note: this is not primary myelofibrosis [9961/3] ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)
D76.1-D76.3	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified *Note: Review for miscodes*
D89.40-D89.49	Mast cell activation syndrome and related disorders *Note: Effective 10/1/2016*
E08	Diabetes mellitus due to underlying condition *ICD-10-CM Coding instruction note: Code first the underlying condition, such as: malignant neoplasm (C00-C96)*
E31.20-E31.9	Multiple endocrine neoplasia [MEN] syndromes *ICD-10-CM Coding instruction: Code also any associated malignancies and other conditions associated with the syndromes*
E34.0	Carcinoid syndrome
E83.52	Hypercalcemia

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G13.0	Paraneoplastic neuromyopathy and neuropathy ICD-10-CM Coding instruction note:: Code first underlying neoplasm (C00-D49)
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease *ICD-10-CM Coding instruction note:: Code first underlying neoplasm (C00-D49)*
G32.8-G32.81	Other specified degenerative disorders of nervous system in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: cerebral degeneration (due to) neoplasm (C00-D49)
G53	Cranial nerve disorders in diseases classified elsewhere *Note: Code first underlying neoplasm (C00-D49)*
G55	Nerve root and plexus compressions in diseases classified elsewhere *ICD-10-CM Coding instruction note: code also underlying disease, such as neoplasm (C00-D49)*
G63	Polyneuropathy in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: neoplasm (C00-D49)
G73.1	Lambert-Eaton syndrome in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)*
G89.3	Neoplasm related pain (acute)(chronic)
G99.2	Myelopathy in diseases classified elsewhere *ICD-10-CM Coding instruction: Code first underlying disease, such as: neoplasm (C00-D49)*
H47.42	Disorders of optic chiasm in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
H47.521-H47	Disorders of visual pathways in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*
H47.63-	Disorders of visual cortex in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
J34.81	Nasal mucositis (ulcerative)
J91.0	Malignant pleural effusion ICD-10-CM Coding instruction: Code first underlying neoplasm

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
J93.12	Secondary spontaneous pneumothorax *ICD-10-CM Coding instruction: Code first underlying condition, such as:* *Malignant neoplasm of bronchus and lung (C34._)* *Secondary malignant neoplasm of lung (C78.0_)*
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.33	Oral mucositis (ulcerative) due to radiation
K22.711	Barrett's esophagus with high grade dysplasia
K62.7	Radiation proctitis
K62.82	Dysplasia of anus (AIN I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
M36.0	Dermato(poly)myositis in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)
M36.1	Arthropathy in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm, such as: Leukemia (C91-C95), malignant histiocytosis (C96.A), multiple myeloma (C90.0)
M84.50-M84.576	Pathologic fracture in neoplastic disease ICD-10-CM Coding instruction: Code also underlying neoplasm (C00-D49)
M90.60-M90.69	Osteitis deformans in neoplastic disease *ICD-10-CM Coding instruction: Code first the neoplasm (C40._, C41._)*
N42.3	Dysplasia of prostate (PIN I and PIN II)
N76.81	Mucositis (ulcerative) of vagina and vulva
N87._	Dysplasia of cervix uteri (CIN I and CIN II)
N89.0,N89.1, N89.3	Vaginal dysplasia (VIN I and VIN II)
N90.0,N90.1, N90.3	Vulvar dysplasia (VAIN I and VAIN II)

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
O01.-	Hydatidiform mole *Note: Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00- C97 range*
O9A.13	Malignant neoplasm complicating pregnancy, childbirth and the puerperium (conditions in C00-C96) *ICD-10-CM Coding instruction: Use additional code to identify neoplasm*
Q85.0-	Neurofibromatosis (nonmalignant) (9540/1) *Note: Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable*
R18.0	Malignant ascites *ICD-10-CM Coding instruction: Code first malignancy, such as:* *Malignant neoplasm of ovary (C56._), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)*
R53.0	Neoplastic (malignant) related fatigue *ICD-10-CM Coding instruction: Code first associated neoplasm*
R59.-	Enlarged lymph nodes
R85.6-	Abnormal findings on cytological and histological examination of digestive organs. ***Note:*** *see "must collect" list for R85.614*
R87.61-, R87.62-	Abnormal findings on cytological/histological examination of female genital organs. ***Note:*** *see "must collect" list for R87.614 and R87.624*
R92.-	Abnormal findings on diagnostic imaging of breast
R97.-	Abnormal tumor markers
T38.6-	Poisoning by antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified
T38.8-, T38.996	Poisoning by hormones and their synthetic substitutes
T45.1-	Poisoning by, adverse effect of and under dosing of antineoplastic and immunosuppressive drugs
T45.8-, T45.96	Poisoning by primary systemic and hematological agent, unspecified
T66	Unspecified effects of radiation

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
T80.2-	Infections following infusion, transfusion and therapeutic injection
T80.810	Extravasation of vesicant antineoplastic chemotherapy
T80.818	Extravasation of other vesicant agent
T86.0	Complications of bone marrow transplant ICD-10-CM Coding instruction: Use addition code to identify other transplant complications, such as: malignancy associated with organ transplant (C80.2) or post-transplant lymphoproliferative disorders (PTLD) (D47.Z1)
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z12.-_	Encounter for screening for malignant neoplasms
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z15.0	Genetic susceptibility to malignant neoplasm ICD-10-CM Coding instruction: Code first, if applicable, any current malignant neoplasm (C00-C75, C81-C96); Use additional code, if applicable, for any personal *history of malignant neoplasm (Z85._)*
Z17.0, Z17.1	Estrogen receptor positive and negative status
Z19.1	Hormone sensitive malignancy status
Z19.2	Hormone resistant malignancy status
Z40.0_	Encounter for prophylactic surgery for risk factors related to malignant neoplasms
Z42.1	Encounter for breast reconstruction following mastectomy
Z48.290	Encounter for aftercare following bone marrow transplant

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1-	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare
Z85._	Personal history of malignant neoplasm
Z86.0_, Z86.01_, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior
Z92.21, Z92.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z94.81, Z94.84	Bone marrow and stem cell transplant status

^International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2017

Table H.31 The following are exclusions and do not need to be reported to the TCR:

ICD-O-3 MORPHOLOGY CODES	DIAGNOSIS/TERMINOLOGY
8000–8005	Neoplasms, malignant, NOS of the skin
8010/2	Carcinoma in-situ of cervix (CIN) **beginning with 1996 cases**
8010–8046	Epithelial carcinomas of the skin
8050–8084	Papillary and squamous cell carcinomas of the skin **except genital sites**
8077/2	Squamous Intraepithelial Neoplasia, grade III of cervix **beginning with 1996 cases; CIN**
8090–8110	Basal cell carcinomas of the skin **except genital sites**
8148/2	Prostatic Intraepithelial Neoplasia (PIN)

Ambiguous Terminology

The following terms are diagnostic of cancer: Apparent(ly), Appears, Comparable with, Compatible with, Consistent with, Favor(s), Malignant appearing, Most likely, Neoplasm (beginning with 2004 diagnosis and only for C700-C729, C751-C753), Presumed, Probable, Suspect(ed), Suspicious(for), Tumor (beginning with 2004 diagnosis and only for C700-C729, C751-C753), Typical (of).

Note: Do not substitute synonyms such as “supposed” for presumed, or “equal” for comparable. Do not substitute “likely” for most likely.

Exception: If cytology is reported as "suspicious" do not interpret this as a diagnosis of cancer. Report the case only if there is either a positive biopsy, a physician's clinical diagnosis of cancer supporting the cytology findings, or cancer directed therapy is administered.

Note: This list should be used only for determining case reportability. Do not use this list to determine the appropriate histology or stage.

Cases To Report Only If Cancer-Directed Therapy Is Planned Or Given

- Cases diagnosed and/or treated for cancer prior to admission should be reported if there is evidence of active disease, whether or not diagnostic or therapeutic procedures were performed.
- Cases diagnosed at autopsy, with no suspicion prior to death that the cancer existed, should be reported.
- Abstract cases using the medical record from the first admission (inpatient or outpatient) to your facility with a reportable diagnosis. Use information from subsequent admissions to include all first course treatment information and to supplement documentation.
- Do not report cases diagnosed prior to 1995
- Do not complete a report for each admission; submit one report per primary tumor.

Example 1. A patient is diagnosed with prostate cancer and has several admissions for treatment of the prostate cancer. Only one abstract should be completed.

Example 2. A patient is diagnosed with two separate primary tumors, such as adenocarcinoma of the prostate and squamous cell carcinoma of the lung. Complete one abstract for the prostate primary and another for the lung.

Helpful Hints

- Report all cases of *active* cancer regardless of state of residence.
- Report all inpatients and outpatients.
- Do not report basal or squamous cell carcinomas of the skin, except skin of genital sites.
- To ensure case ascertainment, review the disease indexes; pathology, cytology, hematology, and autopsy reports.
- Do not complete an abstract for each admission.
- Report all benign and borderline tumors of the central nervous system.
- Cases in which the disease is no longer active (such as leukemia in remission) should only be reported if the patient is still receiving cancer-directed therapy.
- Do not report carcinoma in situ of cervix (any histology).
- Do not report intraepithelial neoplasia of the prostate (PIN III).

TREATMENT STANDARD TABLES

Table H.32 Scope of Regional Lymph Node Surgery Codes

CODE	DESCRIPTION
0	None
1	Biopsy or aspiration of regional lymph nodes, NOS
2	Sentinel lymph node biopsy (only)
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS
4	1–3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

Note: For specific instructions on coding this data field see page 185 of this manual or go to: http://www.facs.org/cancer/ncdb/scope-regional-lymph-node-surgery.pdf

Table H.33 Surgery Codes

CODE	DESCRIPTION
00	None
10-19	Site-specific codes; tumor destruction
20-80	Site-specific codes; resection
90	Surgery, NOS
98	Site-specific surgery codes; special
99	Unknown

Table H.35 Phase I Radiation Treatment Modality Codes

CODE	DESCRIPTION
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS

CODE	DESCRIPTION
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Treatment radiation modality unknown; Unknown if radiation treatment administered

Note: For specific instructions on coding this data field see page 201 of this manual.

Table H.37 Chemotherapy Codes

CODE	DESCRIPTION
00	None; chemotherapy was not part of the first course of therapy
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., 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 the patient record.
87	Chemotherapy was not delivered. 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.

Note: For specific instructions on coding this data field see page 212 of this manual

Table H.38 Hormone Therapy Codes

CODE	DESCRIPTION

00	None; hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. 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	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.

Note: For specific instructions on coding this data field see page 220 of this manual.

Table H.39 Immunotherapy Codes

CODE	DESCRIPTION
00	None, immunotherapy was not part of the first course of therapy.
01	Immunotherapy administered as first course of therapy
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., 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 treatment. 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 immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: For specific instructions on coding this data field see page 226 of this manual.

Table H.40 Hematologicv Transplant and Endocrine Procedures

CODE	DESCRIPTION

00	No transplant procedure or endocrine therapy was administered as part of the first course of therapy.
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 were not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hematologic transplant and/or endocrine surgery/radiation were 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 therapy. No reason was stated in patient's record.
87	Hematologic transplant and/or endocrine surgery/radiation were 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 were recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation were recommended or administered because it is not documented in the medical record. Death certificate only.

Note: For specific instructions on coding this data field see page 229 of this manual.

Table H.41 Other Treatment Codes

CODES	DESCRIPTION
0	None
1	Other
2	Other-Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended; unknown if administered
9	Unknown

Note: For specific instructions on coding this data field see page 236 of this manual.

Table H.42 Regional Nodes Positive Standard Table

CODE	DESCRIPTION
00	All nodes examined are negative
01-89	1 to 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.

Note: For specific instructions on coding this data field see page 156 of this manual.

Table H.43 Regional Nodes Examined Standard Table

CODE	DESCRIPTION
00	No nodes were examined
01-89	1 to 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.
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 record

Note: For specific instructions on coding this data field see page 160 of this manual.

Data Items Currently or Previously Collected

The Texas Cancer Registry adheres to reporting requirements mandated by the National Program of Cancer Registries. Additional data items are required to meet requests from our data users.

Table H.44 Data Items Currently or Previously Collected

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Date of Admission/First Contact	580	1995 - present
Date of Admission/First Contact Flag *	581	2010 – present
Registry/Accession Number	550	1995 - present
Reporting Facility	540	1995 - present
NPI Reporting Facility (Derived)	545	2009 - present
Types of Reporting Source	500	1995 - present
Medical Record #	2300	1995 - present
Class of Case	610	1998 - present
Last Name	2230	1995 - present
First Name	2240	1995 - present
Middle Name	2250	1995 - present
Maiden Name	2390	1995 - present
Alias	2280	1995 - 2002 2006 - present
Street Address	2330	1995 - present
Address at Dx Supplemental	2335	2006 - present
City	70	1995 - present
State	80	1995 - present
Zip Code	100	1995 - present
FIPS County Code at DX	90	1995 - present
Address at Dx-Country	102	2013 - present
Social Security Number	2320	1995 - present
Date of Birth	240	1995 - present
Date of Birth Flag *	241	2010 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Place of Birth	250	1998 - 2013
Birthplace-State	252	2013 - present
Birthplace-Country	254	2013 -present
Race 1	160	1995 - present
Race 2	161	2001 - present
Race 3	162	2001 - present
Race 4	163	2001 - present
Race 5	164	2001 - present
Spanish/Hispanic Origin	190	1995 - present
Sex	220	1995 - present
Text Usual Occupation	310	2010 - present
Text Usual Industry	320	2010 - present
Other Pertinent Information	2680	1995 - present
Physician Managing	2460	2006 - 2010
Physician Follow Up	2470	2006 - present
Facility Referred From	2410	2001 - 2010
Facility Referred To	2420	2001 - 2010
Sequence Number Hospital	560	1995 - present
Sequence Number Central	380	2011 - present
Other Primary Tumors	2200	1995 - present
Primary Payer at DX	630	2007 - present
Comorbidity/Secondary Diagnosis #1	3110	2011 - 2017
Comorbidity/Secondary Diagnosis #2	3120	2011 - 2017
Comorbidity/Secondary Diagnosis #3	3130	2011 - 2017
Comorbidity/Secondary Diagnosis #4	3140	2011 - 2017
Comorbidity/Secondary Diagnosis #5	3150	2011 - 2017
Comorbidity/Secondary Diagnosis #6	3160	2011 - 2017

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Comorbidity/Secondary Diagnosis #7	3161	2011 - 2017
Comorbidity/Secondary Diagnosis #8	3162	2011 - 2017
Comorbidity/Secondary Diagnosis #9	3163	2011 - 2017
Comorbidity/Secondary Diagnosis #10	3164	2011 - 2017
Source Comorbidity/Secondary Diagnosis	Non-NAACCR 9970	2011 - 2017
Date of Initial Diagnosis	390	1995 - present
Date of Diagnosis Flag	391	2010 - present
ICD-O-2 Morph Prior to 2001	420	1995 - 2001
Behavior prior to 2001	430	1995 - 2001
ICD-O-3 2001 and forward	522	2001 - present
Behavior 2001 and forward	523	2001 - present
Primary Site	400	1995 - present
Grade of Tumor	440	1995 - 2017
Grade Path Value	441	2011 - 2013
Grade Path System	449	2011 - 2013
Grade Clinical	3843	2018 – present
Grade Pathological	3844	2018 - present
Laterality	410	1995 - present
Final DX Morph/Beh/Grade	2590	1995 - present
Final DX Primary Site and Laterality	2580	1995 - present
Lymph - Vascular Invasion	1182	2011 - present
Diagnostic Confirmation	490	1995 - present
Tumor Size Summary	756	2016
Tumor Size Prior to 2004	780	1998 – 2003
Summary Stage 1977 for appropriate years	760	1995 - 2000
Summary Stage 2000 for appropriate years	759	2001 – 2004, 2014-present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
CS Tumor Size 2004 and forward	2800	2004 - 2015
CS Extension	2810	2004 - 2015
CS Tumor Size/EXT Eval	2820	2008 - 2015
CS Lymph Nodes	2830	2004 - 2015
CS Lymph Nodes Eval	2840	2011 - 2015
Regional Nodes Positive	820	1998 - present
Regional Nodes Examined	830	1998 - present
CS Mets at DX	2850	2004 - 2015
CS Mets Eval	2860	2011 - 2015
CS Site Specific Factor 1 NPCR required only	2880	2004 - 2017
CS Site Specific Factor 2 NPCR required only	2890	2010 - 2017
CS Site Specific Factor 3 NPCR required only	2900	2004 - 2015
CS Site Specific Factor 4 NPCR required only	2910	2011 - 2015
CS Site Specific Factor 5 NPCR required only	2920	2011 - 2017
CS Site Specific Factor 6 NPCR required only	2930	2011 - 2017
CS Site Specific Factor 7 NPCR required only	2861	2011 - 2015
CS Site Specific Factor 8 NPCR required only	2862	2010 - 2017
CS Site Specific Factor 9 NPCR required only	2863	2010 - 2017
CS Site Specific Factor 10 NPCR required only	2864	2010 - 2017
CS Site Specific Factor 11 NPCR required only	2865	2010 - 2017
CS Site Specific Factor 12 NPCR required only	2866	2010 - 2015
CS Site Specific Factor 13 NPCR required only	2867	2010 - 2017
CS Site Specific Factor 14 NPCR required only	2868	2010 - 2017

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
CS Site Specific Factor 15 NPCR required only	2869	2011 - 2017
CS Site Specific Factor 16 NPCR required only	2870	2011 - 2017
CS Site Specific Factor 17 NPCR required only	2871	2011 - 2015
CS Site Specific Factor 25 NPCR required only	2879	2010 - 2017
Brain Molecular Markers	3816	2018 – present
Breslow Tumor Thickness	3817	2018 – present
Estrogen Receptor Summary	3827	2018 – present
Fibrosis Score	3835	2018 – present
HER2 Overall Summary	3855	2018 – present
LDH Pretreatment Lab Value	3932	2018 – present
Microsatellite Instability (MSI)	3890	2018 – present
Progesterone Receptor Summary	3915	2018 – present
PSA (Prostatic Specific Antigen) Lab Value	3920	2018 – present
Schema Discriminator 1	3926	2018 - present
Schema Discriminator 2	3927	2018 - present
Summary Stage Documentation	2600	1995 - present
TNM Clinical T	940	2015 – 2017
AJCC TNM Clin T	1001	2018 - present
TNM Clinical N	950	2015 – 2017
AJCC TNM Clin N	1002	2018 – present
TNM Clinical M	960	2015 – 2017
AJCC TNM Clin M	1003	2018- present
TNM Clinical Stage (Prefix/Suffix) Descriptor	980	2015 - 2017
TNM Clinical Stage Group	970	2015 - 2017
AJCC TNM Clin Stage Group	1004	2018 – present
TNM Pathologic T	880	2015 – 2017

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
AJCC TNM Path T	1011	2018 – present
TNM Pathologic N	890	2015 - 2017
AJCC TNM Path N	1012	2018- present
TNM Pathologic M	900	2015 -
AJCC TNM Path M	1013	2018 – present
TNM Pathologic Stage (Prefix/Suffix) Descriptor	920	2015 – 2017
TNM Pathologic Stage Group	910	2015 -
AJCC TNM Path Stage Group	1014	2018-
RX Summary - Reg LN Examined	1296	2001 - 2005
RX Summary - Scope of Reg LN Surgery	1292	2001 - present
Date of Initial Treatment	1260	2010 - present
Date of Initial Treatment Flag	1261	2010 - present
RX Date Surgery	1200	1995 - present
RX Date Surgery Flag	1201	2010 - present
Surgery RX Code	1290	1995 - present
RX Date Mst Defn Srg	3170	2015 - present
RX Date Mst Defn Srg Flag	3171	2015 - present
Reason for No Surgery	1340	1998 - 2002 2006 - present
RX Summary - Surgery Other/Dist RX Code	1294	1998 - present
RX Text Surgery	2610	2004 - present
Date Radiation Started	1210	1995 - present
RX Date Radiation Flag	1211	2010 - present
RX Summary - Radiation	1360	1998 - 2002 2012 - 2017
Radiation Regional RX Modality Code	1570	2003 - 2017
Phase I Radiation Treatment Modality	1506	2018 – present
Reason for no Radiation	1430	1998 - 2002 2011 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
RX Text - Radiation	2620, 2630	2004 - present
RX Summary - Surgery/Radiation Sequence	1380	2004 - present
RX Date - Systemic	3230	2004 - 2010
Date Chemotherapy Started	1220	2010 - present
RX Date Chemotherapy Flag	1221	2010 - present
Chemotherapy Code	1390	1995 - present
Reason for no Chemotherapy	1440	1998 - 2002
RX Text - Chemotherapy	2640	2004 - present
Date Hormone Therapy Started	1230	2010 - present
RX Date Hormone Flag	1231	2010 - present
Hormone Code	1400	1995 - present
Reason for no Hormone	1450	1998 - 2002
RX Text - Hormone	2650	2004 - present
Date Immunotherapy Started	1240	2010 - present
RX Date Immunotherapy Flag	1241	2010 - present
Immunotherapy Code	1410	1995 - present
RX Summary Transplant/Endocrine	3250	2003 - present
RX Text - Immunotherapy	2660	2004 - present
RX Summary - Systemic/Surgery Sequence	1639	2006 - present
Date other Treatment Started	1250	1995 - present
RX Date Other Flag	1251	2010 - present
Other Treatment Code	1420	1995 - present
RX Text - Other	2670	2004 - present
RX - Summary Treatment Status	1285	2010 - present
Date of Last Contact or Death	1750	1995 - present
Date of Last Contact Flag	1751	2010 - present
Vital Status	1760	1998 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Place of Death-State	1942	2013 - present
Place of Death-Country	1944	2013 - present
Follow Up Source (Derived)	1790	2009 - present
Date Abstracted	2090	1995 - present
Abstractor Initials	570	1995 - present
NAACCR Record Version	50	2003 - present
AJCC Edition Number	1060	2015 - present
Height	Non - NAACCR 9960	2011 - present
Weight	Non - NAACCR 9961	2011 - present
Tobacco Use	Non - NAACCR 9965 - 9968	- present

The TCR does not allow blanks for the following items:

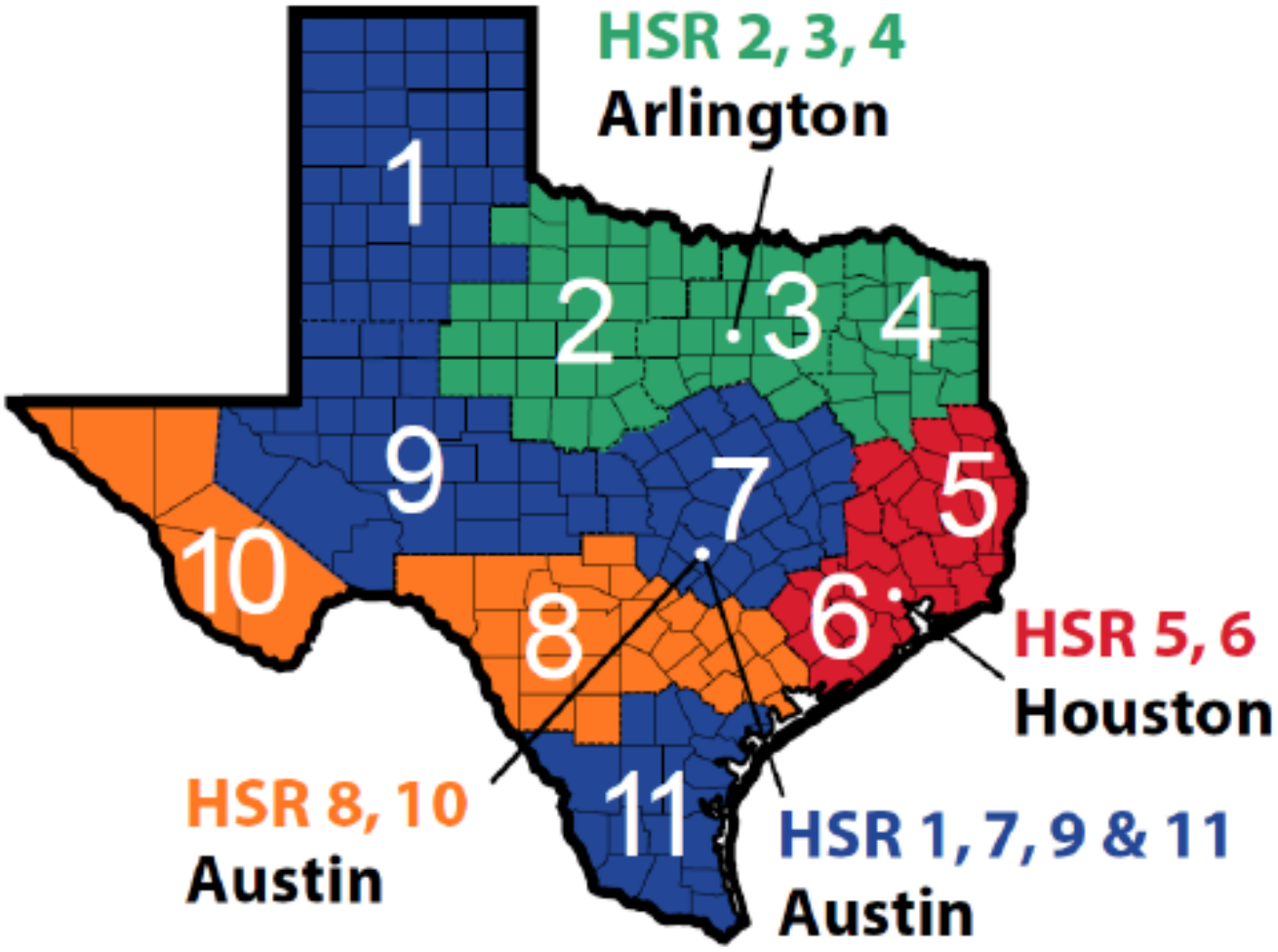
- Date of Admission/First Contact, NAACCR #580
- Date of Date of Birth, NAACCR #240

I

APPENDIX I:
HEALTH SERVICES REGIONS

Health Service Region Map

https://www.dshs.texas.gov/tcr/training/handbook/Appendix-Health-Service-Regions.pdf



J

APPENDIX J:
SPANISH/HISPANIC SURNAMES

Available on the TCR website at

https://www.dshs.texas.gov/tcr/training/handbook/Appendix-Spanish-Hispanic-Surnames.pdf

2018-2019 Cancer Reporting Handbook

Texas Cancer Registry

Publication No. E10-10677

Released May 2019