

Date of Diagnosis

Item Length: 8
 NAACCR Item #: 390
 NAACCR Name: Date of Diagnosis
 XML NAACCR ID: dateOfDiagnosis

The date of diagnosis is the month, day, and year the reportable neoplasm was first identified, clinically or microscopically, by a recognized medical practitioner.

Date of diagnosis must be transmitted in the YYYYMMDD format. Date of diagnosis may be recorded in the transmission format, or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format. Regardless of the format, at least **Year** of diagnosis must be **known or estimated for cases transmitted to SEER**. Year of diagnosis **cannot be blank or unknown for cases transmitted to SEER**.

Transmitting Dates

Transmit date data items in the year, month, day format (YYYYMMDD). Transmit only known or estimated **year** of diagnosis; blanks will not be accepted for year. Leave the month, day and/or year¹ blank when they cannot be estimated or are unknown.

Common Formats

YYYYMMDD	Complete date is known
YYYYMM	Year and month are known/estimated; day is unknown
YYYY	Year is known/estimated; month and day cannot be estimated or are unknown
Blank	Year, ¹ month, and day cannot be estimated or are unknown

Transmit Instructions

1. Transmit date data items in the year, month, day format (YYYYMMDD)
2. Transmit only known or estimated year of diagnosis, blanks will not be accepted
3. Leave the month and/or day blank when they cannot be estimated or are unknown
4. Most SEER registries collect the month, day, and year of diagnosis. When the full date (YYYYMMDD) is transmitted, the seventh and eighth digits (day) will be held confidentially and only used for survival calculations when received by NCI SEER..

Instructions

Cases with an unknown year of diagnosis **cannot** be transmitted to NCI SEER. It is very important to do everything possible to determine the year of diagnosis.

Case transmitted to NCI SEER

1. Follow-back must be done to obtain the date of diagnosis. If no information can be found, follow instruction 2.

¹ Cases NOT transmitted to SEER only

2. Date of diagnosis must be estimated. See the coding instructions below for estimating date of diagnosis.
 - a. For reports dated December or January of a given year, code the month of the report or the month of admission (instruction 9.a.viii.). Coding the month of the report or the month of admission results in a better estimate of the date of diagnosis than coding month as 99 and having the computer assign July as the month of diagnosis, for example.
 - b. When the diagnosis date is stated to be spring, summer, fall, or winter, follow coding instructions 9.a.i., ii., iii., and iv.

Case **NOT** transmitted to NCI SEER

1. Code the date of diagnosis when known, even if the case is not transmitted to SEER for other reasons
2. Code as unknown when there is no information available

Codes for Year

Code the four-digit year of diagnosis

Codes for Month

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

Codes for Day

- 01
- 02
- 03
- ..
- ..
- 31

Coding Instructions

1. Code the month, day and year the tumor was first diagnosed, clinically or microscopically, by a recognized medical practitioner
 - a. When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis

Example: Area of microcalcifications in breast suspicious for malignancy on 02/13/2023. Biopsy positive for ductal carcinoma on 02/28/2023. The date of diagnosis is 02/13/2023.

2. When the **only** information available is a positive pathology or cytology report, code the date the biopsy was **done**, not the date the report was dictated or transcribed
3. Code the date the procedure was done, not the date the specimen was received or read as positive by the pathologist when the date of diagnosis is coded from a pathology report

Example: Biopsy was performed on 05/06/2023. The specimen from the biopsy was received and read by the pathologist as positive for cancer on 05/09/2023. The date of diagnosis is 05/06/2023.

4. The first diagnosis of cancer may be **clinical** (i.e., based on clinical findings or physician's documentation)

Note: Do **not** change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology.

Example 1: On May 15, 2023, physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung in June 3, 2023. The date of diagnosis remains May 15, 2023.

Example 2: Radiologist reports Liver Imaging Reporting and Data System (LI-RADS) Category 5 on imaging. Later biopsy confirms hepatocellular carcinoma (HCC). Record date of diagnosis as date of LI-RADS imaging.

Note: Appendix E in the 2023 SEER Program Manual lists which PI-RADS, BI-RADS, and LI-RADS are reportable versus non-reportable. If reportable, use the date of the imaging procedure as the date of diagnosis when this is the earliest date and there is no information to dispute the imaging findings.

5. Positive **tumor markers** alone are **not** diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

Example 1: 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).

Example 2: The patient has an elevated PSA and the physical examination is negative. The physician documents that he/she suspects that the patient has prostatic cancer and is referring the patient for a needle biopsy. The needle biopsy is positive, confirming the physician's suspicion of cancer. The date of diagnosis is the date the physician documented that he/she **suspects** that the patient has prostatic cancer.

Note: Positive tumor markers alone are never used for case ascertainment.

6. Use the date of suspicious cytology when the diagnosis is proven by subsequent biopsy, excision, or other means

Example: Cytology suspicious for malignancy 01/12/2023. Diagnosis of carcinoma per biopsy on 02/06/2023. Record 01/12/2023 as the date of diagnosis.

Note 1: “Suspicious” cytology means that the diagnosis is preceded by an [ambiguous term](#) such as apparently, appears, compatible with, etc.

Note 2: Do **not** use ambiguous cytology **alone** for case ascertainment.

7. Code the **earlier date** as the date of diagnosis when
 - a. A recognized medical practitioner says that, in **retrospect**, the patient had cancer at an earlier date or
 - b. The original slides are reviewed and the pathologist documents that cancer was present. Code the date of the original procedure as the diagnosis date.

Example: The patient had an excision of a benign fibrous histiocytoma in January 2023. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The physician documents in the chart that the previous tumor must have been malignant. Code the diagnosis date as January 2023.

Note: Do **not** back-date the diagnosis when

- The information on the previous tumor is unclear **AND/OR**
- There is **no review** of previous slides **AND/OR**
- There is **no physician’s statement** that, in retrospect, the previous tumor was malignant

Example: The patient had a total hysterectomy and a bilateral salpingo-oophorectomy (BSO) in June 2023 with pathology diagnosis of papillary cystadenoma of the ovaries. In December 2023, the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2023 are not reviewed and there is no physician statement saying the previous tumor was malignant. The date of diagnosis is December 2023.

8. Code the **date of death** as the date of diagnosis for autopsy only cases
9. Death certificate only (DCO) Cases
 - a. Use information on the death certificate to estimate the date of diagnosis
 - b. Record the date of death as the date of diagnosis when there is not enough information available to estimate the date of diagnosis; for example, the time from onset to the date of death is described as ‘years’
 - c. If no information is available, record the date of death as the date of diagnosis
10. **Estimate the date of diagnosis** if an exact date is not available. Use all information available to calculate the month and year of diagnosis.
 - a. Estimating the **month**
 - i. Code “spring” to April
 - ii. Code “summer” or “middle of the year” to July
 - iii. Code “fall” or “autumn” as October
 - iv. For “winter” 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 of diagnosis.
 - v. Code “early in year” to January
 - vi. Code “late in year” to December
 - vii. Use whatever information is available to calculate the month of diagnosis

Example 1: Admitted October 2023. History states that the patient was diagnosed 7 months ago. Subtract 7 from the month of admission and code date of diagnosis to March 2023.

Example 2: Outpatient bone scan done January 2023 that states history of prostate cancer. The physician says the patient was diagnosed in 2023. Assume bone scan was part of initial work-up and code date of diagnosis to January 2023.

- viii. Code the month of admission when there is no basis for estimation
- ix. Leave month blank (or convert 99 to blank) if there is no basis for approximation
- b. Estimating the **year**
 - i. Code “a couple of years” to two years earlier
 - ii. Code “a few years” to three years earlier
 - iii. Use whatever information is available to calculate the year of diagnosis
 - iv. Code the year of admission when there is no basis for estimation
- 11. If **no information** about the date of diagnosis is available
 - a. Case transmitted to NCI SEER
 - i. Use the date of admission as the date of diagnosis
 - ii. In the absence of an admission date, code the date of first treatment as the date of diagnosis
 - b. Case **NOT** transmitted to NCI SEER
 - i. Code month and year as unknown

Nursing Home and Hospice Residents (Not hospitalized for their cancer; no information other than nursing home or hospice records and/or death certificate)

- 1. Use the **best approximation** for the date of diagnosis when the only information available is that the patient **had cancer while in the nursing home** and it is unknown whether the patient had cancer when admitted
- 2. Code the **date of admission** to the nursing home as the date of diagnosis when
 - a. The **only information available** is that the patient had cancer when admitted to the nursing home
 - b. The **only information available** is that the patient had cancer while in the nursing home, it is unknown whether the patient had cancer when admitted, and there is **no basis for approximation**

Cases Diagnosed Before Birth

Record the actual date of diagnosis for diagnoses made in utero even though this date will precede the date of birth.

Example: Fetal intrahepatic mass consistent with hepatoblastoma diagnosed via ultrasound at 39 weeks gestation (01/30/2023). Live birth by C-section 02/04/2023. Code the date of diagnosis as 01/30/2023.

Note: Prenatal diagnoses are reportable when there is a live birth.