ILLINOIS STATE CANCER REGISTRY

Standards For Data Reporting and Data Dictionary

Effective January 1, 2016

Compatible with NAACCR Record Layout Version 16

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

In 1984, the ILLINOIS HEALTH AND HAZARDOUS SUBSTANCES REGISTRY ACT (IHHSR) (410 ILCS 525/1 et seq) established the Illinois State Cancer Registry (ISCR) within the State Department of Public Health to collect cancer incidence information for residents of Illinois, to monitor trends, to detect potential public health problems, to predict risks and to assist in investigating cancer clusters.

Section 840.100 Entities Required to Submit Information

1) Hospitals;

2) Hospital-affiliated and free standing or independent laboratories;

3) Ambulatory Surgical Treatment Centers;

4) Independent Radiation Therapy Centers;

5) Independent and reference pathology laboratories;

6) Nursing homes;

7) Physicians' offices; and

8) Other Illinois facilities diagnosing and treating cancer.

Section 840.115 Methods of Reporting Cancer Registry Information:

All patients identified at a reporting facility, whether as an inpatient or outpatient, who meet one of the three following criteria **are reportable** to the Registry:

1) Patients with a newly diagnosed cancer who have, within six months after diagnosis, received cancer-directed treatment or refused treatment.
2) Patient with cancer diagnosed through autopsy.
3) Patient diagnosed and receiving all first course treatment elsewhere and now receiving cancer-directed treatment at the reporting facility.

A facility required to report shall submit cancer specific information as outlined below. (Information from the Act has been modified to reflect the variables currently being collected).

1) Reporting Information – type of report being submitted, abstractor identification code and the date the abstract was submitted.

2) Patient Data and Resident Address – patient's full name (including maiden name, when applicable and available), Social Security number, telephone number, and residential address, including street address, city, county, state, and postal code.

3) Personal Data – patient's birth date, age, sex, race, ethnicity, birthplace, history of occupation and industry, and health insurance status.

4) Diagnosis Data – initial diagnosis date, diagnostic information, method of diagnosis, primary site, laterality, histology and behavior code, grade, stage of disease, including clinical and pathological extent of disease information, existence of other reportable primary diseases and date of diagnosis, first course cancer-directed therapy, and supporting text information for all diagnostic procedures, histology, primary site, staging and treatment.

5) Facility Data – facility identification number provided by the Department of Public Health, the medical record number, date of admission, type of reporting source, accession number (if available), case identification type, vital status, class of case.

6) Follow-Up Data – date of last follow-up or death.

7) Text Documentation – description of the primary site, histology, diagnostic test results, staging, pathology results and treatment information.

April 14, 2003 was the effective date for the privacy requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and the Standards for Privacy of Individually Identifiable Health Information (the HIPAA Privacy Rule), 45 CFR Parts 160 and 164. The HIPAA Privacy Rule affords comprehensive Federal protection for the privacy of individual health information. The Illinois Department of Public Health (Department) fully supports the goals of the HIPAA Privacy Rule.

The HIPAA Privacy Rule recognizes access by the public health system must continue in order to ensure public health and safety. In fact, the HIPAA Privacy Rule explicitly allows covered entities to make uses and disclosures of protected health information without the individual's consent or authorization if: (1) required by law; (2) for public health activities; (3) for health oversight activities; (4) to avert a serious

threat to health or safety; or (5) for disaster relief purposes. 45 CFR 164.512(a), (b), and (d), (j), and 45 CFR 164.510(b)(4). Examples of these types of permitted disclosures include, but are not limited to:

> Registry Reporting. Statutorily created registries should continue to receive information from covered entities without disruption. These include, but are not limited to, the Illinois State Cancer Registry, the Illinois Head and Spinal Cord Injury Registry, the Trauma Registry, the Hazardous Substances Registry, the Adult Blood Lead Registry, the Adverse Pregnancy Outcomes Reporting System. 45 CFR 164.512(a), (b)(1)(i).

ISCR is bound by the Act to protect any information made confidential or privileged under law. "The identity, or any group of facts that tends to lead to the identity of any person whose condition or treatment is submitted to the IHHSR, is confidential and shall not be open to public inspection or dissemination . . ." (IHHSR Act 525/4d). All public data reports issued by ISCR are aggregated to make it impossible to identify any patient or reporting facility unless permitted by the reporting facility.

ISCR must maintain a standard of high quality data to ensure the usefulness of the cancer information. The following processes have been implemented to maintain this standard:

- computer EDITS checks;
- assessment of timeliness of data submissions;
- evaluation of completeness of abstracts;
- casefinding and reabstracting audits at reporting facilities;
- reliability studies.

ISCR follows the most recent data collection standards published in the North American Association of Central Cancer Registries (NAACCR) Standards for Cancer Registries, Volume II Data Standards and Data Dictionary. These standards are developed through a collaborative effort of national standard-setting organizations that include the Centers for Disease Control and Prevention National Program of Cancer Registries, National Cancer Institute Surveillance Epidemiology & End Results Program, the American College of Surgeons Commission on Cancer and the Canadian Council of Cancer Registries.

CHAPTER 2: CASEFINDING

All reporting facilities are responsible for complete casefinding. Procedures for implementing casefinding must be adopted by each reporting facility. To ensure complete case ascertainment the following sources should be reviewed as they apply:

- Medical Record Disease Index (ICD-9-CM) **OR** CPT Coding Index
- Pathology Reports, Cytology Reports, Autopsy Reports
- Surgery logs
- Clinic logs and appointment books
- Diagnostic x-rays, nuclear medicine reports, and/or other imaging techniques

CASEFINDING LIST FOR REPORTABLE TUMORS

Casefinding lists are intended for searching a variety of cases so as not to miss any reportable cases. A casefinding list is not the same as a reportable list. See Chapter 3 to identify reportable and non-reportable neoplasms.

Cancer registrars and cancer reporters should use the Surveillance Epidemiology and End Results (SEER) casefinding lists to identify potentially reportable cases. Review of these codes should ensure that all reportable neoplasms are identified. The SEER casefinding lists are more extensive than the list currently found in the Illinois Health and Hazardous Substances Registry Act Rules and Regulations.

The most current SEER casefinding lists are posted at http://seer.cancer.gov/tools/casefinding/.

CHAPTER 3: REPORTABLE CASES

REPORTABLE CASES

A patient is considered to have a reportable neoplasm when a recognized medical practitioner indicates - either histologically or clinically - that the patient has a reportable neoplasm. All diagnostic reports should be reviewed to confirm whether a case is required to be reported.

All patients (inpatient or outpatient/Illinois and out-of-State residents) diagnosed or treated at a reporting facility on or after January 1, 1985 meeting any of the following criteria are reportable.

- All reportable neoplasms clinically and/or histologically diagnosed and/or treated **are reportable**.
- Patients seen for initial histologic confirmation of malignancy **are reportable**, even if they have a previous clinical diagnosis of malignancy.
- Patients with a newly diagnosed cancer who have received first course cancer directed treatment **are reportable**.
- Patients with a newly diagnosed cancer who refuse treatment **are reportable**.
- Patients diagnosed and received all first course treatment elsewhere and now receiving cancer directed treatment at the reporting facility **are reportable.**
  Exception: Patients who are seen at your facility for diagnosis of recurrent or residual disease (after completion of the first course of therapy) but who do not receive treatment at your facility are **not reportable**.
- Patients without a histologic or cytologic confirmation of a reportable neoplasm **are reportable** based on a **clinical diagnosis** (when a recognized medical practitioner says a patient has a reportable neoplasm). A clinical diagnosis may be recorded in the final diagnosis on the face sheet, operative report, endoscopy report, radiology report, or other parts of the medical record.
- All patients diagnosed by autopsy only **are reportable**.
- **NOTE: The Class of Case variable is not used to determine reportability**.

REPORTABLE NEOPLASMS LIST BY CATEGORY OF BEHAVIOR

HEMATOPOIETIC PRIMARIES

Follow the Reportability Instructions in the <u>Hematopoetic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual</u> for all lymphomas, leukemias, and other hematopoietic primaries.

SOLID PRIMARIES

Primary cancer sites and cancer morphologies codes are found in the International Classification of Diseases for Oncology (ICD-O). It should be noted that there are three editions in print.

ICD-O-1 is used for cases diagnosed prior to January 1, 1992.
ICD-O-2 is used for cases diagnosed between January 1, 1992 and December 31, 2000.
ICD-O-3 is used for cases diagnosed on or after January 1, 2001 through December 31, 2013.

Note: The <u>NAACCR Guidelines for ICD-O-3 Update Implementation</u> (published December 2013) included a table of new ICD-O-3 codes and terms effective for 2015; however, the use of the new codes was postponed due to issues with adding these codes to the CSv2 software. For diagnosis year 2016, all standard setters have agreed to postpone these codes once again, and to use the alternate codes published in Table 2 of the <u>NAACCR Guidelines for ICD-O-3 Update Implementation</u>. It is anticipated that these codes will be implemented in 2017 when the AJCC-TNM 8th Edition goes into effect.

BEHAVIOR CODES /0 AND /1 (BENIGN AND UNCERTAIN OR UNKNOWN BEHAVIOR)

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

Dermoid cyst (9084/0) of the brain is reportable.

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

Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. ISCR does not require facilities to report these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted.

NOTE: The following histologies listed in ICD-O-3 with a behavior code of /1 are reportable, but must be reported with a behavior code of /3.

9421/3 juvenile/pilocytic astrocytoma

9751/3 Langerhans cell histiocytosis NOS, cases diagnosed on or after 1/1/2010

9831/3 T-cell large granular lymphocytic leukemia/Chronic lymphoproliferative disorder of NK-cells, cases diagnosed on or after 1/1/2010

9975/3 Myeloproliferative neoplasm, unclassifiable/Myelodysplastic/Myelo-proliferative neoplasm, unclassifiable, cases diagnosed on or after 1/1/2010

8240/3 Carcinoid tumor, NOS of appendix (C18.1), cases diagnosed on or after 1/1/2015.

BEHAVIOR CODE /2 (IN-SITU)

All in situ cancer cases, except in situ of the cervix, are reportable. These tumors also may be described as:

Adenocarcinoma in an adenomatous polyp with no invasion of stalk

AIN III (anal intraepithelial neoplasia)

Clark level I for melanoma (limited to epithelium)

Comedocarcinoma, noninfiltrating

Confined to epithelium

Hutchinson melanotic freckle, NOS

Intracystic noninfiltrating

Intraductal

Intraepidermal, NOS

Intraepithelial, NOS

Involvement up to, but not including the basement membrane

Laryngeal intraepithelial neoplasia, grade III (LIN III), C320-C329

Lentigo maligna

Lobular, noninfiltrating

Lobular neoplasia

Noninfiltrating

Noninvasive

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

No stromal invasion

Papillary, noninfiltrating and intraductal

Precancerous melanosis

Queyrat erythroplasia

Squamous intraepithelial neoplasia, grade III (SIN III), except cervix and skin

VAIN III (vaginal intraepithelial neoplasia)

VIN III (vulvar intraepithelial neoplasia)

BEHAVIOR CODE /3 (MALIGNANT)

Morphologies listed in the ICD-O with a 5th digit behavior code of /3 are reportable.

Histologies listed in Appendix D (tables D1a and D1b) of the Hematopoietic and Lymphoid Neoplasm Coding Manual are **not** listed in the ICD-0-3 manual, but **are** reportable neoplasms for cases diagnosed on or after 1/1/2010. The following web site provides information on the changes in collection and reporting of hematopoietic and lymphoid neoplasms: http://seer.cancer.gov/tools/heme/

Gastrointestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they must be abstracted and assigned a Behavior Code ICD-0-3 of 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.[1]

Carcinoid tumors, NOS of the appendix diagnosed on or after 1/1/2015 should be reported with a behavior code of /3.

Mature teratoma of the testes in adults is malignant and reportable as 9080/3, but continues to be non-reportable in pre-pubescent children (9080/0). The following provides additional guidance:
- Adult is defined as post puberty.
- Pubescence can take place over a number of years.
- Do not rely solely on age to indicate pre or post puberty status. Review all information (physical history, etc.) for documentation of pubertal status. When testicular teratomas occur in adult males, pubescent status is likely to be stated in the medical record because it is an important factor of the diagnosis.
- Do not report if unknown whether patient is pre or post pubescence. When testicular teratoma occurs in a male and there is no mention of pubescence, it is likely that the patient is a child, or pre-pubescent, and the tumor is benign.

Cystic pancreatic endocrine neoplasm (CPEN) is considered malignant and is reportable, until proven otherwise. Most CPEN cases are non-functioning and are reportable using histology code 8150/3, unless the tumor is specified as a neuroendocrine tumor, Grade 1 (assign code 8240/3) or neuroendocrine grade 2 (assign code 8249/3).

Solid pseudopapillary neoplasm of the pancreas is reportable as 8452/3. Solid pseudopapillary neoplasm of pancreas is synonymous with solid pseudopaillary carcinoma (C25._)

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).

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.

Exclusions:

Skin cancers (C44._) with histologies 8000-8005, 8010-8046, 8050-8084, 8090-8110 are not reportable.

Cancers with histologies 8000-8005, 8010-8046, 8050-8084, 8090-8110 arising in non-skin sites (site codes other than C44._) **are** reportable.

Notes:

Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. ISCR does not require facilities to report these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted.

Squamous cell carcinoma with a behavior code of /2 or /3 originating in mucoepidermoid sites must be reported. These sites include lip (C00.1-00.9), anus (C21.0), labia (C51.0-51.1), clitoris (C51.2), vulva (C51.9), vagina (C52.9), prepuce (C60.0), penis (C60.1-60.9) and scrotum (C63.2).

As a general guideline, if the pathology report indicates squamous cell carcinoma of skin of the lip, do not report. If the pathology report indicates a malignant squamous cell carcinoma lip lesion, without mention of the skin, report as C00.1-C00.9.

Basal cell carcinomas arise from skin cells, not mucous membranes. Basal cell carcinomas of the lip, NOS are coded to C44.0 (skin of lip) and are not reportable. Basal cell carcinomas arising in the vermilion border (lipstick portion) of the lip are coded C00._ and are reportable.

NON-REPORTABLE CASES

Patients who are seen at your facility for diagnosis of recurrent or residual disease (after completion of the first course of therapy) but who do not receive treatment at your facility are **not reportable**.

Patients seen in **consultation only.** A consult may be done to confirm a diagnosis or develop a treatment plan. The reporting institution may provide services not available at the diagnosing or treating facility, such as Computerized Tomography (CT) scans, Magnetic Resonance Imaging (MRI) scans, or placement of venous access devices.

Patients receiving **transient care** at the reporting institution to prevent interruption of the first course of treatment. A patient may be vacationing or visiting in the area, or equipment failure at the primary treating institution may require the patient to temporarily receive treatment elsewhere.

Patients admitted for **terminal supportive care** only; for example, pain management.

Patients with active cancer **admitted for an unrelated medical condition.**

Patients with a past history of cancer who currently have **no evidence of the disease.**

Patients with a **precancerous condition.**

Patients admitted to a designated **hospice unit or home care service.**

Do not report a case based ONLY on suspicious cytology (any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable in this manual).

Benign **and borderline tumors diagnosed prior to January 1, 2004,** are not reportable. Benign and borderline tumors are tumors with the 5th digit morphology code of /0 or /1.

Skin cancers (C44._) with histologies 8000-8005, 8010-8046, 8050-8084, and 8090-8110.

Patients with **carcinoma in situ of the cervix (CIS).**

Patients with **cervical intraepithelial neoplasia (CIN I, CIN II, or CIN III, M-8077/2).**

Patients with **prostatic intraepithelial neoplasia (PIN III, M-8148/2).**

Carcinoid tumorlets in the lung.

Cases designated "BIRADS 4" or "BIRADS 5" without any additional information.

> The American College of Radiology defines BIRADS Category 4 as "Suspicious abnormality." This is **not** reportable terminology – abnormality is **not** a reportable term.

> BIRADS Category 5 is defined as "Highly suggestive of malignancy." ("Highly suggestive" is **not** reportable ambiguous terminology).

Low-grade appendiceal mucinous neoplasm (LAMN). (The WHO classification designates LAMN as /1 with uncertain malignant potential.)

Diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (DIPNECH). 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.

Lentiginous melanocytic lesion.

Lobular intraepithelial neoplasia grade I.

Intraductal papillary mucinous neoplasms with low or moderate grade dysplasia, also called IPMN adenomas.

Noninvasive mucinous cystic neoplasm (MCN) of the pancreas with low or intermediate grade dysplasia.

Subdural hygroma. Subdural hygroma is a collection of cerebrospinal fluid in the subdural space, not a neoplasm. It may be related to a head injury.

HGSIL (high grade squamous intraepithelial lesion) of the vulva or vagina.

Do not report mature teratoma of the testis when diagnosed before puberty (benign, 9080/0).

Do not report mature teratoma when it is not known whether the patient is pre- or post-pubescent.

Pubescence can take place over a number of years; review history and physical information and do not rely only on age.

For ovary: Mature teratoma is benign (9080/0); therefore, it is not a reportable neoplasm.

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).

Do not report liver cases based only on an LI-RADS category of LR-4.

Lung: Do **not** use the ACR Lung Imaging Reporting and Data System (Lung-RADS™) to determine reportability. Look for reportable terminology from the managing physician or other sources.

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.
"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 0/1.

AMBIGUOUS TERMS THAT CONSTITUTE A DIAGNOSIS

This list of terms considered diagnostic of cancer have been developed and agreed upon by the CoC, NPCR, SEER and CCCR.

The list below should be used only for determining case reportability. Do not use this list to determine the appropriate histology or stage.

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

*additional terms for nonmalignant primary intracranial and central nervous system tumors only (C70.0-C72.9, C75.1-75.3) beginning with 2004 diagnoses.

** Do not substitute synonyms such as "supposed" for presumed or "equal" for comparable terms. Do not substitute "likely" for "most likely".

USING AMBIGUOUS TERMINOLOGY TO DETERMINE CASE REPORTABILITY FOR CYTOLOGY SPECIMENS

Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears; usually a function of the pathology department.

Do **not** report 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.

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

USING AMBIGUOUS TERMINOLOGY TO DETERMINE CASE REPORTABILITY FOR HEMATOPOIETIC TUMORS

Follow the Reportability Instructions in the Hematopoietic and Lymphoid Neoplasm Coding Manual.

USING AMBIGUOUS TERMINOLOGY TO DETERMINE CASE REPORTABILITY FOR SOLID TUMORS

In most circumstances, the diagnosis of cancer, as recorded in the patient's medical record, clearly is synonymous with reportable cancer. However, in those situations where the physician is not certain of the diagnosis, the associated terminology in the medical record can reflect that uncertainty and is often ambiguous.

Reliance on ambiguous terms to determine reportability should not be final; if presented with such a case, the facility abstractor must review the final discharge diagnosis and all pertinent laboratory and radiology (e.g. X-Rays or CT scans) findings that will help determine reportability of the case.

If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included.

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

Exception 1: If cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Exception 2: Do not abstract the case if the initial impression involves an ambiguous reportable term and resection, excision, biopsy, cytology or physician's **statement proves the case is not reportable**.

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

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

Example: Abdominal CT reveals a 1 cm 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." Report the case. "Consistent with" is a reportable ambiguous term. Accept "consistent with" over the non-reportable term "possibly."

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

> **Example 1:** Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not report 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 is available. Do not report 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 report the case. The needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven to be false.

> **Example 4:** Esophageal biopsy with diagnosis of "focal areas suspicious for adenocarcinoma in situ." Diagnosis on partial esophagectomy specimen "with foci of high grade dysplasia; no invasive carcinoma identified." Do not report the case. The esophagectomy proved that the suspicious biopsy result was false.

CHAPTER 4: MULTIPLE PRIMARY TUMORS

The following table includes links to the various web sites that contain information on interpreting and coding multiple primary tumors. Use the appropriate link for the corresponding type of tumor and year of diagnosis.

Effective Dates:	Sources of Information:
Solid Tumors	
1/1/1988 Revised 1989 Revised 1990 Revised 1992 3rd edition, eff. 1/1/1998- 2003	http://seer.cancer.gov/tools/codingmanuals/historical.html http://seer.cancer.gov/tools/codingmanuals/historical.html
2004 Rev. 1 1/1/2004 – 12/31/2006	http://seer.cancer.gov/tools/codingmanuals/historical.html
2007 – current	http://seer.cancer.gov/tools/mphrules/download.html
Benign and Borderline Primary Intra-cranial and CNS Tumors	
2004 – 2006	http://seer.cancer.gov/tools/codingmanuals/historical.html **pages 18-19**
2007 – current	http://seer.cancer.gov/tools/mphrules/download.html
Hematopoietic and Lymphoid Neoplasms	
3rd Edition, 1998 Diagnosed prior to 2001	http://seer.cancer.gov/tools/codingmanuals/historical.html **pages 14-37**
2001 – current	http://seer.cancer.gov/tools/heme/

CHAPTER 5: REPORTING

DATA SUBMISSION

Monthly submissions of reportable cases are required.

All facilities must submit abstracts electronically via vendor-provided software or ISCR- provided software (Abstract Plus or Web Plus). Abstract Plus and Web Plus are provided at no cost. Please contact Brenda Wanless at 217/524-9351 or at brenda.wanless@illinois.gov for information on how to obtain Abstract Plus or Web Plus.

The following GENERAL GUIDELINES must be followed before the electronically-submitted cancer abstracts will be accepted by ISCR:

The format and contents of records submitted to ISCR in electronic format MUST conform to the data exchange standards established by the North American Association of Central Cancer Registries (NAACCR) for RECORD TYPE A (Full case Abstract). Refer to the most recent version of North American Association of Central Cancer Registries, Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, for further information on the required record layout.

Submitting facilities are required to use the most recent Illinois version of the EDITS metafile prior to submission of data.

Electronic submissions should be sent to ISCR through the MoveIT Program or by on-line entry using WebPlus. Contact Brenda Wanless at 217/524-9351 or at brenda.wanless@illinois.gov for instructions on how to register for Web Portal access and the MoveIT Program.

Electronic case files are to be named in the following format: facility ID #, number of cases, and month, day, year to avoid the possibility of duplication or overwriting of files.

Example: 9999.106.02012014.dat or 9999.106.02012014.cas

REQUESTS TO UPDATE OR DELETE RECORDS

Cases should be abstracted when the complete medical record is available for abstracting the required information, but no more than six months after the initial diagnosis date. Data are gathered from multiple sources using the most recent and complete information available. Information may be missing in the medical record at the time a case is abstracted. Over time, the patient's records may contain new information which may change the diagnosis date, primary site, laterality, histology, grade, stage, treatment, etc.

Notify ISCR of changes to cases updated with more definitive information. Changes to cases and requests to delete records **MUST be submitted electronically** through the IDPH Web Portal at www.idphnet.illinois.gov using the change/delete form.

If the primary site or histology is changed, it may also be necessary to revise site-specific staging and treatment codes.

There is no time limit for making revisions that give better information about the original diagnosis or stage. However, if staging information is updated, it is important to adhere to the timing requirements for the respective staging system.

Do not resubmit a case with changes unless instructed to do so by ISCR staff. ISCR software will not load the resubmitted case and the submitted changes will be lost.

FACILITY UPDATES

If your facility has a change in personnel, address, telephone, etc., please notify ISCR.

You may submit the changes electronically through the IDPH Web Portal at http://www.idphnet.illinois.gov.

REPORTING/ABSTRACTING QUESTIONS

Questions about Multiple Primary and Histology Rules, the Hematopoietic Coding and Multiple Primary Rules, and ICD-O should be researched at SEER Inquiry. If you cannot find an answer to your question after searching on SEER Inquiry, you may submit a question to Ask A SEER Registrar .

Questions about AJCC TNM Staging, Collaborative Staging, FORDS, and CoC Cancer Program Standards can be researched at or directed to the CAnswer Forum (http://cancerbulletin.facs.org/forums/).

If you have a question that is not answered by using the above resources, please send an email to dph.iscrrep@illinois.gov or call 217/785-1873.

CHAPTER 6: ABSTRACTING PRINCIPLES

INFORMATION ON DATE FORMAT

Beginning January 1, 2010 the format for date field transmission changed from MMDDYYYY to YYYYMMDD and new date field flags were added to handle the unknown values and codes that have meanings other than dates.

The date format as viewed by the reporting facility may vary by vendor since the display does not affect the transmission format. However, only valid portions of the date will be transmitted.

Below are the common formats to handle the situation where only certain components of date are known.

YYYYMMDD	when complete date is known and valid
YYYYMM	when year and month are known and valid, and day is unknown
YYYY	when year is known and valid, and month and day are unknown
Blank	when no known date applies

The field is fixed-length and left-justified. Any **missing component should be replaced by spaces**. If there are no known date components, the fixed-length variable will be completely blank. For unknown values and codes that have meanings other than dates the HL7 Flavors of Null Table has been adopted for flagging each non-system-generated missing date as a way to eliminate the ambiguity of missing values. A date flag field, to serve as a flag or indicator, is used for each date field for which an unknown or not applicable value is appropriate. This item would be blank if a valid date is transmitted in its associated date item. The only date fields that would not have a flag are system-generated dates.

INFORMATION ON AMBIGUOUS TERMINOLOGY

AMBIGUOUS TERMINOLOGY FOR STAGING

Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. Sometimes the clinician is hesitant to commit to a definite statement that a particular organ or tissue is involved by the cancer and uses what data collectors refer to as "ambiguous terminology." The following lists can generally be used to interpret the intent of the clinician if there is no specific statement of involvement in the medical record. However, if individual clinicians use these terms differently, the clinician's definitions and choice of therapy should be recognized. If a term used in a diagnostic statement is not listed below, consult the clinician to determine the intent of the statement.

Collaborative Stage Note: Some Collaborative Stage schemas interpret certain words as involvement, such as 'encasing' the carotid artery for a head and neck site. Terminology in the schema takes priority over this list**.**

Considered as Involvement

Adherent	Fixation to a structure other than primary**	Invasion to into, onto, out onto
Apparent(ly)	Fixed to another structure**	Most likely
Appears to	Impending perforation of	Onto*
Comparable with	Impinging upon	Overstep
Compatible with	Impose/imposing on	Presumed
Consistent with	Incipient invasion	Probable
Contiguous/continuous with	Induration	Protruding into (unless encapsulated)
Encroaching upon*	Infringe/infringing	Suspected
Extension to, into, onto, out onto	Into*	Suspicious
Features of	Intrude	To*
		Up to

* interpreted as involvement whether the description is clinical or operative/pathological
** interpreted as involvement of other organ or tissue

DO NOT Consider as Involvement

Abuts	Encompass(ed)	Questionable
Approaching	Entrapped	Reaching
Approximates	Equivocal	Rule out
Attached	Extension to without invasion/involvement of	Suggests
Cannot be excluded/ruled out	Kiss/kissing	Very close to
Efface/effacing/effacement	Matted (except for lymph nodes)	Worrisome
Encased/encasing	Possible	

Note: This is not the same list published in Section One of the Facility Oncology Registry Data Standards (FORDS) manual to be used for determining reportability. This is not the same list of ambiguous terminology provided for the Multiple Primary and Histology Coding Rules published and maintained by the SEER Program (http://www.seer.cancer.gov/tools/mphrules/).

Ambiguous Terms Used to Code Histology

Solid Tumors

When any of the ambiguous terms are used to describe a more specific histology, code the more specific histology. Use the current MP/H rules under histology to determine histology coding rules.

Ambiguous terms that are characteristic (used to code histology)

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

Example: Non-small cell carcinoma, most likely adenocarcinoma. Code adenocarcinoma.

Hematopoietic Tumors

Ambiguous terminology is not used to code histology for hematopoietic and lymphoid cases. In most cases, the ambiguous terms mean there is not a final diagnosis; tests may be pending or the tumor just doesn't have enough characteristics to pin down the exact histology.

Diagnoses based on ambiguous terminology require follow back to see if the diagnosis has been confirmed or proven to be incorrect if not confirmed.

See the Hematopoietic and Lymphoid Neoplasm Coding Manual for details.

FIRST COURSE OF TREATMENT [1]

ISCR Note: This section applies to all neoplasms (including benign and borderline intracranial and CNS tumors) except hematopoietic and lymphoid neoplasms. For information regarding first course of therapy for hematopoietic and lymphoid neoplasms, refer to the NCI SEER Hematopoietic and Lymphoid Neoplasm Coding Manual.

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 new Rx Summ–Treatment Status (NAACCR Item #1285) 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.

Treatment Plan

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

- All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient.

- A discharge plan must be part of the patient's record in a JCAHO-accredited hospital and may contain part or the entire treatment plan.

- An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation.

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

Time Periods for First Course of Treatment

If first course treatment was provided, the Date 1st Crs Rx CoC (NAACCR Item #1270) is the earliest of Rx Date Surgery (NAACCR Item #1200), Rx Date Radiation (NAACCR Item #1210), Rx Date Systemic (NAACCR Item #3230), or Rx Date Other (NAACCR Item #1250).

- If no treatment is given, record the date of the decision not to treat, the date of patient refusal, or the date the patient expired if the patient died before treatment could be given.

- If active surveillance ("watchful waiting") was selected, record the date of that decision.

- Additional data items further define the parameters for specific treatments and treatment modalities, as described in the following sections.

A new item, Rx Summ–Treatment Status (NAACCR Item #1285), implemented in 2010, summarizes whether the patient received any first course treatment, no treatment, or is being managed by active surveillance.

All Malignancies except Hematopoietic and Lymphoid Neoplasms

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

Hematopoietic and Lymphoid Neoplasms

Registrars should consult with the hematopoietic references including the manual and database.

Leukemias

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

Surgery

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

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

> Rx Summ-- Surg Prim St (NAACCR Item #1290)
> Rx Summ --Surg/Rad Seq (NAACCR Item #1380)
> Rx Summ -- Scope Reg LN Surg (NAACCR Item #1292)
> Rx Summ --Surg Oth Reg/Dis (NAACCR Item #1294)
> Reason for No Surgery (NAACCR Item #1340)
> Rx Date Surgery (NAACCR Item #1200)
> Rx Date Surgery Flag (NAACCR Item #1201)
> Rx Date Mst Defn Srg (NAACCR Item #3170)
> Rx Date Mst Defn Surg Flag (NAACCR Item #3171)

The paragraphs below describe how the surgery items fit together.

Relationships among Surgical Items

Rx Date Surgery (NAACCR Item #1200) is the date that the first Rx Summ - Surg Prim Site (NAACCR Item #1290), Rx Summ- Scope Reg Ln Sur (NAACCR Item #1292), or Rx Summ – Surg Oth Reg/Dis (NAACCR Item #1294) is performed as part of first course treatment.

- If surgery was the only type of first course treatment performed or was the first of multiple treatment modalities, Rx Date Surgery (NAACCR Item #1200) is the same as Date 1st CRS Rx COC (NAACCR Item #1270). Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.

Rx Summ - Surg Prim Site (NAACCR Item #1290), Rx Summ- Scope Reg Ln Sur (NAACCR Item #1292), and Rx Summ – Surg Oth Reg/Dis (NAACCR Item #1294), record three distinct aspects of first course therapeutic surgical procedures that may be performed during one or multiple surgical events. If multiple primaries are treated by a single surgical event, code the appropriate surgical items separately for each primary.

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

- Rx Summ – Surg Prim Site (NAACCR Item #1290) is a site-specific item that describes the most invasive extent of local tumor destruction or surgical resection of the primary site and of surrounding tissues or organs that are removed in continuity with the primary site.

- Rx Summ – Scope Reg Ln Sur (NAACCR Item #1292) describes the removal, biopsy, or aspiration of sentinel nodes and other regional lymph nodes that drain the primary site and may include surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease as well as removal of nodes for treatment of the disease.

- Rx Summ-Surg Other Reg/Dis (NAACCR Item #1294) describes first course resection of distant lymph node(s) and/or regional or distant tissue or organs beyond the Rx Summ – Surg Prim Site (NAACCR Item #1290) range.

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

The code ranges and corresponding descriptions for site-specific Rx Summ – Surg Prim Site (NAACCR Item #1290) code are grouped according to the general nature of the procedure:

- Codes 10 through 19 are site-specific descriptions of tumor-destruction procedures that do not produce a pathologic specimen.

- Codes 20 through 80 are site-specific descriptions of resection procedures.

- The special code 98 applies to specific tumors that cannot be clearly defined in terms of primary nonprimary site. Rx Summ – Surg Prim Site (NAACCR Item #1290) should be coded 98 for any tumor characterized by the specific sites and/or morphologies identified in the site-specific code instructions for Unknown and Ill-Defined Primary Sites and Hematopoietic/Reticuloendothelial/Immunoproliferating/Myeloproliferative Disease. The item Rx Summ-Surg Other Reg/Dis (NAACCR Item #1294) is used to indicate whether surgery was performed for these tumors.

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

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

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

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

Rx Summ – Scope Reg Ln Sur (NAACCR Item #1292) distinguishes between sentinel lymph node biopsy and removal of other regional lymph nodes and distinguishes removal of regional lymph nodes during the same surgical procedure as a sentinel node biopsy from subsequent removal.

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

Rx Summ-Surg Other Reg/Dis (NAACCR Item #1294) describes surgery performed on tissue or organs other than the primary site or regional lymph nodes. It is also used to describe whether surgery was performed for tumors having unknown or ill-defined primary sites or hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease morphologies. If any surgical treatment was performed on these cancers, Rx Summ-Surg Other Reg/Dis (NAACCR Item #1294) is coded 1.

Rx Date Mst Defn Srg (NAACCR Item # 3170) is the date on which the specific procedure recorded in Rx Summ – Surg Prim Site (NAACCR Item #1290) was performed. If only one first course surgical procedure was performed, then the date will be the same as that for Rx Date Surgery (NAACCR Item#1200).

Reason for No Surgery (NAACCR Item# 1340) identifies why surgical therapy was not provided to the patient and distinguishes a physician's not recommending surgical therapy due to contraindication conditions from a patient's refusal of recommended treatment plan.

Radiation

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

> Rx Date Radiation (NAACCR Item #1210)
>
> Rx Date Radiation Flag (NAACCR Item #1211)
>
> Rad – Regional Rx Modality (NAACCR Item #1570)
>
> Rad – Boost Rx Modality (NAACCR Item #3200)
>
> Rx Summ – Surg/Rad Seq (NAACCR Item #1380)
>
> Reason for No Radiation (NAACCR Item #1430)

Relationships among Radiation Items

Rx Date Radiation (NAACCR Item #1210) is the date that the first radiation therapy was delivered to the patient as part or all of the first course of therapy.

The type of regional dose therapy is captured by the item Rad – Regional Rx Modality (NAACCR Item #1570). [2]

- Codes 20 through 32 of Rad – Regional Rx Modality (NAACCR Item #1570) apply to the delivery of **beam** radiation. If the patient record does not specify the specific modality employed, then code the most general description of the modality, code 20.
- Codes 40 through 43 describe proton radiation (code 40) and specific type of stereotactic radiotherapy (codes 41–43). If stereotactic radiotherapy is delivered to a patient but the exact modality is not recorded, use code 41 (Stereotactic radiosurgery, NOS).
- Codes 50 through 55 are used to record different types of brachytherapy administration, also known as radioactive seed implants. Code 50 should be used to record the application of radioactive materials not otherwise specified.
- Codes 60 through 62 provide codes to describe the administration of specific radioisotopes. Code 60 (Radioisotopes, NOS) should be used when specific details of the radioisotope administration is not available.
- Code 98 is reserved for cases where it is known that radiation therapy was delivered but the modality is not recorded in the patient record (beam, IMRT, etc.,)
- The unit of measure for radiologic dosing is the centigray (cGy), which has replaced the use of "rads" to describe radiation dose.
- If only one radiation treatment modality is delivered to a patient and it is not specified as either regional or boost treatment, assume it is regional treatment and code the Rad – Regional Rx Modality (NAACCR Item #1570) accordingly.
- A boost treatment is provided to a smaller field within the same volume as regional radiation in order to enhance the effect of the regional treatment.
    - The boost dose may or may not employ the same treatment modality. For example, external beam radiation may be used for regional treatment and be followed by brachytherapy to provide the boost dose.
    - Not all patients who receive radiation therapy receive a boost dose radiation. For these cases, boost modality should be coded as 00.

Two items augment the information recorded in the radiation modality.

Rx Summ – Surg/Rad Seq (NAACCR Item #1380) identifies those instances where radiation therapy and the surgical management of the patient are not discrete and overlap with respect to time. Radiation therapy can precede the surgical resection of a tumor and then be continued after the patient's surgery, or radiation can be administered intraoperatively.

Reason for No Radiation (NAACCR Item #1430) identifies why radiation therapy was not provided to the patient and distinguishes a physician's not recommending this therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

Systemic Therapy

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

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

Rx Date Systemic (NAACCR Item #3230)
Rx Date Systemic Flag (NAACCR Item #3231)
Rx Date Chemo (NAACCR Item #1220)
Rx Date Chemo Flag (NAACCR Item #1221)
Rx Date Hormone (NAACCR Item #1230)
Rx Date Hormone Flag (NAACCR Item #1231)
Rx Date BRM (NAACCR Item #1240)
Rx Date BRM Flag (NAACCR Item #1241)
Rx Summ – Systemic/Surg Seq (NAACCR Item #1639)
Rx Summ-Chemo (NAACCR Item #1390)
Rx Summ-Hormone (NAACCR Item #1400)
Rx Summ-BRM (NAACCR Item #1410)
Rx Summ-Transplnt/Endocr (NAACCR Item #3250)

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

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

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

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

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

Method	Administration
Intrathecal	Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (for example, Ommaya reservoir).
Pleural/pericardial	Injected directly into pleural or pericardial space to control malignant effusions.
Intraperitoneal	Injected into the peritoneal cavity.
Hepatic artery	Injected into a catheter inserted into the artery that supplies blood to the liver.

Relationships among Systemic Therapy Items

The data item Rx Date Systemic (NAACCR Item #3230) describes the first date on which any first course systemic treatment was administered to the patient. Nine out of 10 patients treated with systemic therapy receive only a single class of drugs (chemotherapy, hormone therapy, or immunotherapy). Of the remaining patients who receive a combined regimen of systemic therapies, two-thirds begin these combined regimens simultaneously. For the purposes of clinical surveillance, the collection of multiple dates to describe the sequence of systemic therapy administration is not necessary.

The data items Rx Summ-Chemo (NAACCR Item #1390), Rx Summ-Hormone (NAACCR Item #1400), and Rx Summ-BRM (NAACCR Item #1410) describe whether or not each respective class of agent(s) or drug(s) were administered to the patient as part of first course therapy, based on SEER*Rx. In the case of chemotherapy, additional distinction is allowed for instances where single or multiagent regimens were administered. Each of these three items includes code values that describe the reason a particular class of drugs is not administered to the patient and distinguishes a physician's not recommending systemic therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

Rx Summ-Transplnt/Endocr (NAACCR Item #3250) captures those infrequent instances in which a medical, surgical, or radiation procedure is performed on a patient that has an effect on the hormonal or immunologic balance of the patient. Hematologic procedures, such as bone marrow transplants or stem cell harvests, are typically employed in conjunction with administration of systemic agent(s), usually chemotherapy.

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

Other Treatment

Rx Summ--Other (NAACCR Item #1420) encompasses first course treatment that cannot be described as surgery, radiation, or systemic therapy according to the defined data items found in this manual.

This item is also used for supportive care treatment for reportable hematopoietic diseases that do not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Treatments such as phlebotomy, transfusions, and aspirin are recorded in Rx Summ--Other (NAACCR Item #1420) data item for certain hematopoietic diseases, and should be coded 1. Consult the most recent version of the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** for instructions for coding care of specific hematopoietic neoplasms in this item.

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

> Rx Summ – Other (NAACCR Item #1420)
> Rx Date Other (NAACCR Item #1250)
> Rx Date Other Flag (NAACCR Item #1251)

Treatment, Palliative and Prophylactic Care

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

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

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

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

Embolization

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

Chemoembolization is a procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This procedure permits a higher concentration of drug to be in contact with the tumor for a longer period of time. Code chemoembolization as Rx Summ-Chemo (NAACCR Item #1390) when the embolizing agent(s) is a chemotherapeutic drug(s) or when the term chemoembolization is used with no reference to the agent. Use SEER* Rx Interactive Antineoplastic Drugs Database (http://seer.cancer.gov/tools/seerrx) to determine whether the drugs used are classified as chemotherapeutic agents. Also code as Rx Summ-Chemo (NAACCR Item #1390) when the patient has primary or metastatic cancer in the liver and the only information about embolization is a statement that the patient had chemoembolization, tumor embolization or embolization of the tumor in the liver. However, if alcohol is specified as the embolizing agent, even in the liver, code the treatment as Rx Summ – Other (NAACCR Item #1420).

Radioembolization is embolization combined with injection of small radioactive beads or coils into an organ or tumor. Code Rad – Regional Rx Modality (NAACCR Item #1570) as brachytherapy when tumor embolization is performed using a radioactive agent or radioactive seeds.

Embolization is coded as Rx Summ – Other (NAACCR Item #1420) (code 1) if the embolizing agent is alcohol, or if the embolized site is other than the liver and the only information in the record is that the patient was given "embolization" with no reference to the agent.

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

CHAPTER 7: DATA DICTIONARY

ABSTRACTED BY

Alternate name	Item #	Length	Source of Standard	Column #
	570	3	CoC	742-744

Description:

An alphanumeric code assigned by the reporting facility that identifies the individual abstracting the case.

Coding Instructions:

- Code the initials or code of the abstractor.

ADDR AT DX--CITY

Alternate name	Item #	Length	Source of Standard	Column #
City or Town (pre-96 CoC) City/ Town at Diagnosis (CoC)	70	50	CoC	95-144

Description:

Name of the city or town in which the patient resides at the time the reportable tumor is diagnosed. If the patient resides in a rural area, record the name of the city used in the mailing address. If the patient has multiple primaries, the city of residence may be different for each primary.

Coding Instructions:

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.

- If the patient has multiple primaries, the city of residence may be different for each primary.

- Township names should be converted to city names.

- Do not update this data item if the patient's city or town of residence changes. [1]

- If the city of residence at diagnosis is not available, record the city reported on the chart or medical record.

- **College students** are residents of the school area. Boarding school children below college level are residents of their parents' home. [1]

- If a patient is **staying with relatives** while receiving treatment, the home address of the patient should be recorded.

- For persons with **more than one residence** (summer and winter homes), use the address the patient specifies if a usual residence is not apparent. [1]

- Information regarding **homeless residents** should be entered in relation to where they were diagnosed. Use the address of the place they were staying when the cancer was diagnosed. This could be a shelter or the diagnosing facility. [1]

- Persons **in institutions** are residents of the institution. This includes: [1]
  - incarcerated persons
  - persons in nursing, convalescent and rest homes
  - persons in homes, schools, hospitals or wards for the physically disabled, mentally handicapped or mentally ill
  - long term residents of other hospitals, such as Veterans Affairs hospitals

- Persons in the **Armed Forces and on Maritime ships** are residents of the installation area. Use the stated address for military personnel and their family. Military personnel may use the installation address or the surrounding community address. The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and Maritime ships. Refer to Census Bureau publications for the detailed rules.[1]

Codes (in addition to valid City):

UNKNOWN   City at diagnosis unknown

ADDR AT DX--NO & STREET

Alternate name	Item #	Length	Source of Standard	Column #
Patient Address (Number and Street) at Diagnosis (CoC) Number and Street (pre-96 CoC)	2330	60	CoC	3628-3687

Description:

The number and street address or the rural mailing address of the patient's residence at the time the reportable tumor was diagnosed. If the patient has multiple tumors, address at diagnosis may be different for each tumor. Additional address information such as facility, nursing home, or name of apartment complex should be entered in Addr at DX-Supplementl (NAACCR Item #2335). Do not update this item if patient moves after diagnosis.

Coding Instructions:

- Record the **complete** address, including the street number, street direction, street name, street type, street location**, apartment numbers, fractional addresses, etc.**
  - (e.g., 501 W COTTAGE GRV E APT 3)

- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards can be found at http://pe.usps.gov/text/pub28/welcome.htm.

- See Table 7.1 for a list of common standard street abbreviations.

- Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning.
  - Punctuation normally is limited to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 ½ MAIN ST), and hyphens when the hyphen carries meaning (e.g., 289-01 MONTGOMERY AVE).
  - Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 FLOWER BLVD # 72).

- Additional address information such as facility, nursing home or name of apartment complex should be entered in Addr at Dx-Supplementl (NAACCR Item #2335).

- If the patient has multiple primaries, the address at diagnosis may be different for each primary.

- If there is no address available, UNKNOWN should be entered in this field.

- If the only known address is a Rural Route Number (e.g., Rural Route 6) insert RR 6 in this field.

- If the name of the street is NORTH, the entire word should be spelled out and should not be abbreviated. However, if north is a direction use N (e.g., N NORTH ST).

- If SAINT is part of the street name, the entire word should be spelled out and should not be abbreviated (e.g., SAINT LOUIS ST).

- Do not update this data item if the patient's address changes.

- If the address at diagnosis is not available, record the address reported on the chart or medical record.

- **College students** are residents of the school area. Boarding school children below college level are residents of their parents' home.[1]

- If a patient is **staying with relatives** while receiving treatment, the home address of the patient should be recorded.

- Information regarding **homeless residents** should be entered in relation to where they were diagnosed. Use the address of the place they were staying when the cancer was diagnosed. This could be a shelter or the diagnosing institution.[1]

- **Trailer or Mobile Home Court** should have the street address. The name of the court should be entered in Addr at DX-Supplementl (NAACCR Item #2335).

- Persons in the **Armed Forces and on Maritime ships** are residents of the installation area. Use the stated address for military personnel and their family. Military personnel may use the installation address or the surrounding community address.[1]

- For persons with **more than one residence** (summer and winter homes), use the address the patient specifies if a usual residence is not apparent.[1]

- Persons **in institutions** are residents of the institution. The address of the institution should be recorded. The name of the institution should be entered in Addr at DX-Supplementl (NAACCR Item #2335). This includes:[1]
    - incarcerated persons
    - persons in nursing, convalescent and rest homes
    - persons in homes, schools, hospitals or wards for the physically disabled, mentally handicapped or mentally ill
    - long term residents of other hospitals, such as Veterans Affairs hospitals

Codes (in addition to valid street address):

UNKNOWN   Patient's address is unknown

Table 7.1 STANDARD USPS ADDRESSING ABBREVIATIONS

Street type	Standard Abbreviation	Street Type	Standard Abbreviation
Alley	ALY	Manor	MNR
Annex	ANX	Meadows	MDWS
Arcade	ARC	Mews	MEWS
Avenue or Avenida	AVE	Motorway	MTWY
Bend	BND	Oval	OVAL
Bluff	BLF	Overpass	OVPS
Boulevard	BLVD	Park	PARK
Branch	BR	Parkway	PKWY
Bridge	BRG	Pass	PASS
Brook	BRK	Path	PATH
Bypass	BYP	Pike	PIKE
Calle	C	Place	PL
Causeway	CSWY	Plaza	PLZ
Center	CTR	Point	PT
Circle	CIR	Ramp	RAMP
Club	CLB	Ridge	RDG
Common	COM	River	RIV
Court	CT	Road	RD
Cove	CV	Row	ROW
Crescent	CRES	Rue	RUE
Crossing	XING	Skyway	SKWY
Drive	DR	Square	SQ
Estates	EST	Station	STA
Expressway	EXPY	Street	ST
Falls	FLS	Summit	SMT
Forest	FRST	Terrace	TER
Freeway	FWY	Throughway	THWY
Gardens	GDNS	Trace	TRCE
Grove	GRV	Trafficway	TFWY
Heights	HTS	Trail	TRL
Highways	HWY	Tunnel	TUNL
Hills	HLS	Turnpike	TPKE
Junction	JCT	Underpass	UNP
Landing	LDG	View	VW
Lane	LN	Vista	VIS
Loop	LOOP	Walk	WALK
Mall	MALL	Wall	WALL
		Way	WAY

For additional street suffix abbreviations go to http://pe.usps.com/text/pub28/28apc_002.htm

ADDR AT DX--POSTAL CODE

Alternate name	Item #	Length	Source of Standard	Column #
Zip Code (pre-CoC) Postal Code (CCCR) Postal Code at Diagnosis (CoC)	100	9	CoC	147-155

Description:

Postal code for the address of the patient's residence at the time the reportable tumor is diagnosed. If the patient has multiple tumors, the postal code may be different for each tumor. For U.S. residents, use either the 5-digit or the extended 9-digit ZIP code. Blanks follow the 5-digit code if the 4-digit extension is not collected.

Coding Instructions:

- A zip code lookup can be found at www.usps.com.

- To record US zip codes, use either the 5-digit or 9-digit extended zip code. Blanks follow the 5-digit zip code if 9-digit zip code is not available.

- If the patient has multiple primaries, the postal code may be different for each primary.

- Do not update this data item if the patient's postal code changes.

- If the postal code of residence at diagnosis is not available, record the postal code reported on the chart or medical record.

Codes (in addition to known US and Canadian or other postal codes):

888888888   Resident of country other than the United States, U.S. possessions or territories, or Canada **AND** the postal code is unknown

999999999   Resident of the United States or U.S. possessions, territories, or Canada **AND** the postal code is unknown; **OR** Residence is unknown

999999   Resident of Canada and postal code is unknown

ADDR AT DX--STATE

Alternate name	Item #	Length	Source of Standard	Column #
State at Diagnosis (CoC) State (pre-96 CoC)	80	2	CoC	145-146

Description:

USPS abbreviation for the state, territory, commonwealth, U.S. possession, or CanadaPost abbreviation for the Canadian province/territory in which the patient resides at the time the reportable tumor is diagnosed. If the patient has multiple primaries, the state of residence may be different for each tumor.

A list of state abbreviations is in Table 7.2 of this manual.

Coding Instructions:[1]

- Use U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory in which the patient resides at the time the tumor is diagnosed and treated.

- If the patient has multiple tumors, the state of residence may be different for subsequent primaries.

- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.

- Do not update this data item if the patient's state of residence changes.

Codes (in addition to USPS abbreviations):

CD   Resident of Canada, NOS (province/territory unknown)

US   Resident of United States, NOS (state/commonwealth/territory/possession unknown)

XX   Resident of country other than the United States (Including its territories, commonwealths, or possessions) or Canada, and country is known

YY   Resident of country other than United States (Including its territories, commonwealths or possessions) or Canada, and country is unknown

ZZ   Residence unknown

TABLE 7.2   US POSTAL SERVICE ABBREVIATIONS FOR STATES AND TERRITORIES

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

The following are abbreviations for Canadian provinces or territories:

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

ADDR AT DX--SUPPLEMENTL

Alternate name	Item #	Length	Source of Standard	Column #
Patient Address (Number and Street) at Diagnosis – Supplemental (CoC)	2335	60	CoC	3688-3747

Description:

This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex. Do not use this item for information stored in other address items such as Addr at DX-NO & Street (NAACCR Item #2330).

Coding Instructions:

- If the patient has multiple primaries, the address may be different for each primary.

- Do not update this data item if the patient's address information changes.

- If this address space is not needed, then leave blank.

- If the address at diagnosis is not available, record the address reported on the chart or medical record.

- If the address contains information such as apartment numbers, it should be entered in Addr at DX-NO & Street (NAACCR Item #2330).

AMBIGUOUS TERMINOLOGY DX

Alternate name	Item #	Length	Source of Standard	Column #
Ambiguous Terminology Ambiguous Terminology as Basis for Diagnosis	442	1	SEER	566-566

Description:

Identifies all cases, including death certificate only and autopsy only, for which an ambiguous term is the most definitive word or phrase used to establish a cancer diagnosis (i.e., to determine whether or not the case is reportable). Ambiguous terminology may originate from any source document, such as pathology report, radiology report, or from a clinical report. This data item is used only when ambiguous terminology is used to establish diagnosis. It is not used when ambiguous terminology is used to clarify a primary site, specific histology, histologic group, or stage of disease.

Coding Instructions:

- **Code this data item for cases diagnosed January 1, 2007 through December 31, 2012. For all other cases leave this data item blank.**

- Refer to Chapter 3 of this manual for a list of ambiguous terms that constitute a diagnosis of cancer.

- Facilities are not required to report cases that contain ambiguous terms describing a cytology diagnosis.

- Refer to the 2007 Multiple Primary and Histology Coding Rules at http://www.seer.cancer.gov/tools/mphrules/download.html for detailed coding instructions. (Go to the bookmark "Data Items" for coding instructions.)

Codes:

0   Conclusive term

1   Ambiguous term only

2   Ambiguous term followed by conclusive term

9   Unknown term

Blank   Information not collected for this diagnosis date

BEHAVIOR CODE ICD-O-3

Alternate name	Item #	Length	Source of Standard	Column #
Behavior Code (CoC)	523	1	SEER/CoC	554-554
ICD-O-3 Behaviour (CCCR)				

Description:

Code for the behavior of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for tumors diagnosed beginning January 1, 2001 and later; it is recommended that prior cases be converted from ICD-O-2.

Coding Instructions:

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

- Code 3 if any malignant invasion is present, no matter how limited.[1]

- Code 3 if any malignant metastasis to nodes or tissue beyond the primary is present.[1]

- If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior.[1]

  Note: The following histologies listed in ICD-O-3 with a behavior code of /1 are reportable, but must be reported with a behavior code of /3.
    o 9421/3 juvenile/pilocytic astrocytoma for cases diagnosed on or after 1/1/2001 only
    o 9751/3 Langerhans cell histiocytosis, NOS for cases diagnosed on or after 1/1/2010 only
    o 9831/3 T-cell large granular lymphocytic leukemia/Chronic lymphoproliferative disorder of NK-cells for cases diagnosed on or after 1/1/2010 only
    o 9975/3 Myeloproliferative neoplasm, unclassifiable/Myelodysplastic/Myeloproliferative neoplasm, undassifiable for cases diagnosed on or after 1/1/2010 only
    o Gastrointestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they must be abstracted and assigned a Behavior Code ICD-0-3 of 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.[1]
    o 8240/3 Carcinoid tumor, NOS of appendix, for cases diagnosed on or after 1/1/2015.

Codes:[1]

Code	Label	Definition
0	Benign	Benign
1	Borderline	Uncertain whether benign or malignant
		Borderline malignancy
		Low malignant potential
		Uncertain malignant potential
2	In situ and synonymous with in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Bowen disease (not reportable for C44._)
		Clark level 1 for melanoma (limited to epithelium)
		Comedocarcinoma, noninfiltrating (C50._)
		Confined to epithelium
		Hutchinson melanotic freckle, NOS (C44._)
		Intracystic, noninfiltrating (carcinoma)
		Intraductal (carcinoma)
		Intraepidermal, NOS (carcinoma)
		Intraepithelial, NOS (carcinoma)
		Involvement up to, but not including the basement membrane
		Lentigo maligna (C44._)
		Lobular neoplasia (C50._)
		Lobular, noninfiltrating (C50._) (carcinoma)
		Noninfiltrating (carcinoma)
		Noninvasive (carcinoma only)
		No stromal invasion or involvement
		Papillary, noninfiltrating or intraductal (carcinoma)
		Precancerous melanosis (C44._)
		Queyrat erythroplasia (C60.)
3	Invasive	Invasive or microinvasive

BIRTHPLACE--COUNTRY

Alternate name	Item #	Length	Source of Standard	Column #
	254	3	NAACCR	444-446

Description:

Code for the country in which the patient was born. If the patient has multiple tumors, all records should contain the same code. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Birthplace--State (NAACCR Item #252). These two data items are intended to replace the use of Birthplace (NAACCR Item #250).

Codes:

- See Appendix A of this manual for a list of state codes and their respective country codes.

BIRTHPLACE--STATE

Alternate name	Item #	Length	Source of Standard	Column #
	252	2	NAACCR	442-443

Description:

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. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Birthplace--Country (NAACCR Item #254). These two data items are intended to replace the item Birthplace (NAACCR Item #250).

Codes:

- See Appendix A of this manual for a list of state codes and their respective country codes.

CLASS OF CASE

Alternate name	Item #	Length	Source of Standard	Column #
	610	2	CoC	776-777

Description:

The Class of Case data item **is not to be used in determining reportability** of a tumor/neoplasm to ISCR. Whether the case is to be reported must be determined independently. Refer to Chapter 3 of this manual to determine case reportability.

Class of Case divides cases into two groups. Analytic cases (codes 00-22) are grouped according to the location of diagnosis and treatment. Nonanalytic cases (codes 30–49 and 99) are abstracted by the facility to meet ISCR reporting requirements. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.[1]

Coding Instructions:[1]

- Code the Class of Case that most precisely describes the patient's relationship to the facility.

- Code 00 applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code Class of Case as 10.

- It is possible that information for coding Class of Case will change during the patient's first course of care. If that occurs, change the code accordingly.

- Physicians who are not employed by the hospital but are under contract with it or have routine admitting privileges there are described in codes 10-12 and 41 as physicians with admitting privileges. Treatment provided in the office of a physician with admitting privileges is provided "elsewhere". That is because care given in the physician's office is not within the hospital's realm of responsibility.

- If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved are staff physicians or not, as with any other physician.

- "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. If these cases are abstracted, they are Class of Case 31. **Monitoring of oral medication started elsewhere is coded Class of Case 31.** If a patient begins first course radiation or chemotherapy **infusion** elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (Class of Case 21).

Codes:[1] **(Continue on next page)**

Initial diagnosis at reporting facility

00   Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere.

10   Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS.

11   Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility.

12   Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility.

13   Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of the first course treatment was done elsewhere.

14   Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility.

Initial diagnosis elsewhere, facility involved in first course treatment

20   Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS.

21   Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.

22   Initial diagnosis elsewhere AND all first course treatment was done at the reporting facility.

Patient appears in person at reporting facility

30   Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere).

31   Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement).

32   Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease).

33   Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active).

34   Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility.

35   Case diagnosed before the program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility.

36   Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility.

37	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility.
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death.

Patient does not appear in person at reporting facility

40	Diagnosis AND all first course treatment given at the same staff physician's office.
41	Diagnosis and all first course treatment given in two or more different offices of physicians with admitting privileges.
42	Nonstaff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility).
43	Pathology or other lab specimens only.
49	Death certificate only **(for ISCR use only).**
99	Nonanalytic case of unknown relationship to facility.

Examples

Code   Reason

00	Leukemia was diagnosed at the facility, and all care was given in an office of a physician with practice privileges
11	Patient was diagnosed by a physician with practice privileges, received neoadjuvant radiation at another facility, then underwent surgical resection at the reporting facility
42	Patients from an unaffiliated, free-standing clinic across the street that hospital abstracts its cases because many physicians work both at the clinic and the hospital

COUNTY AT DX

Alternate name	Item #	Length	Source of Standard	Column #
County (pre-96 SEER/COC)County at Diagnosis (CoC)	90	3	FIPS/SEER	156-158

Description:

Code for the county of the patient's residence at the time the tumor was diagnosed. For U.S. residents, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas." If the patient has multiple tumors, the county codes may be different for each tumor.

Detailed standards have not been set for Canadian provinces/territories. Use code 998 for Canadian residents.

Coding Instructions:

- The county for a specific Illinois address can be found by doing a lookup online at www.usps.com.

- See Table 7.3 of this manual for the Illinois County Code List.

- Assign code 998 for non-Illinois residents.

- If the patient has multiple tumors, the county codes may be different for each tumor.

- Do not update this data item if the patient's county of residence changes.

- For patient whose initial diagnosis and treatment was done before the admission for which this abstract is being prepared, if the county of residence at diagnosis is not available, record the county on the chart or medical record.

Codes (in addition to FIPS and Geocodes):

998   Known town, city, state, or country of residence, but county code not known AND a resident outside of the state of reporting institution (must meet all criteria)

999   County unknown.

Table 7.3 ILLINOIS COUNTY FIPS CODES

Code	County Name	Code	County Name	Code	County Name
001	Adams	071	Henderson	141	Ogle
003	Alexander	073	Henry	143	Peoria
005	Bond	075	Iroquois	145	Perry
007	Boone	077	Jackson	147	Piatt
009	Brown	079	Jasper	149	Pike
011	Bureau	081	Jefferson	151	Pope
013	Calhoun	083	Jersey	153	Pulaski
015	Carroll	085	Jo Daviess	155	Putnam
017	Cass	087	Johnson	157	Randolph
019	Champaign	089	Kane	159	Richland
021	Christian	091	Kankakee	161	Rock island
023	Clark	093	Kendall	163	St Clair
025	Clay	095	Knox	165	Saline
027	Clinton	097	Lake	167	Sangamon
029	Coles	099	La Salle	169	Schuyler
031	Cook	101	Lawrence	171	Scott
033	Crawford	103	Lee	173	Shelby
035	Cumberland	105	Livingston	175	Stark
037	De Kalb	107	Logan	177	Stephenson
039	De Witt	109	McDonough	179	Tazewell
041	Douglas	111	McHenry	181	Union
043	Du Page	113	McLean	183	Vermillion
045	Edgar	115	Macon	185	Wabash
047	Edwards	117	Macoupin	187	Warren
049	Effingham	119	Madison	189	Washington
051	Fayette	121	Marion	191	Wayne
053	Ford	123	Marshall	193	White
055	Franklin	125	Mason	195	Whiteside
057	Fulton	127	Massac	197	Will
059	Gallatin	129	Menard	199	Williamson
061	Greene	131	Mercer	201	Winnebago
063	Grundy	133	Monroe	203	Woodford
065	Hamilton	135	Montgomery		
067	Hancock	137	Morgan	998	Outside of
069	Hardin	139	Moultrie		Illinois

CS EXTENSION

Alternate name	Item #	Length	Source of Standard	Column #
	2810	3	AJCC	988-990

Description:

Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in CS Extension (NAACCR Item #2810).

Coding Instructions:

- **For cases diagnosed January 1, 2004 through December 31, 2015, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for general information on coding CS Extension. http://cancerstaging.org/cstage/Pages/default.aspx

- Refer to the Collaborative Stage Data Collection System User Coding Instructions Site Specific Schemas for CS Extension coding instructions for individual primary sites. http://cancerstaging.org/cstage/Pages/default.aspx

CS LYMPH NODES

Alternate name	Item #	Length	Source of Standard	Column #
CS Lymph Nodes (SEER EOD)	2830	3	AJCC	992-994

Description:

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

Coding Instructions:

- **For cases diagnosed January 1, 2004 through December 31, 2015, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for general information on coding CS Lymph Nodes. http://cancerstaging.org/cstage/Pages/default.aspx

- Refer to the Collaborative Stage Data Collection System Coding Instructions Site Specific Schemas for CS Lymph Nodes coding instructions for individual primary sites. http://cancerstaging.org/cstage/Pages/default.aspx

CS LYMPH NODES EVAL

Alternate name	Item #	Length	Source of Standard	Column #
CS Regional Nodes Evaluation CS Reg Nodes Eval	2840	1	AJCC	995-995

Description:

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

Coding Instructions:

- **For cases diagnosed January 1, 2004 through December 31, 2015, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for general information on coding CS Lymph Nodes Eval. http://cancerstaging.org/cstage/Pages/default.aspx

- Refer to the Collaborative Stage Data Collection System Coding Instructions Site Specific Schemas for CS Lymph Nodes Eval coding instructions for individual primary sites. http://cancerstaging.org/cstage/Pages/default.aspx

CS METS AT DX

Alternate name	Item #	Length	Source of Standard	Column #
CS Metastasis at Diagnosis	2850	2	AJCC	996-997

Description:

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

Coding Instructions:

- **For cases diagnosed January 1, 2004 through December 31, 2015, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for general information on coding CS Mets at Dx. http://cancerstaging.org/cstage/Pages/default.aspx

- Refer to the Collaborative Stage Data Collection System Coding Instructions Site Specific Schemas for CS Mets at Dx coding instructions for individual primary sites. http://cancerstaging.org/cstage/Pages/default.aspx

CS METS AT DX-BONE

Alternate name	Item #	Length	Source of Standard	Column #
	2851	1	AJCC	999-999

Description:

Identifies the presence of distant metastatic involvement of bone at time of diagnosis. This includes only the bone, not the bone marrow.

Coding Instructions:

- **For cases diagnosed January 1, 2010 through December 31, 2015, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for information on coding CS Mets at Dx - Bone. http://cancerstaging.org/cstage/Pages/default.aspx

CS METS AT DX-BRAIN

Alternate name	Item #	Length	Source of Standard	Column #
	2852	1	AJCC	1000-1000

Description:

This data item identifies the presence of distant metastatic involvement of the brain at time of diagnosis. This includes only the brain, not spinal cord or other parts of the central nervous system.

Coding Instructions:

- **For cases diagnosed January 1, 2010 through December 31, 2015, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for information on coding CS Mets at Dx - Brain. http://cancerstaging.org/cstage/Pages/default.aspx

CS METS AT DX-LIVER

Alternate name	Item #	Length	Source of Standard	Column #
	2853	1	AJCC	1001-1001

Description:

Identifies the presence of distant metastatic involvement of the liver at time of diagnosis.

Coding Instructions:

- **For cases diagnosed January 1, 2010 through December 31, 2015, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for information on coding CS Mets at Dx - Liver. http://cancerstaging.org/cstage/Pages/default.aspx

CS METS AT DX-LUNG

Alternate name	Item #	Length	Source of Standard	Column #
	2854	1	AJCC	1002-1002

Description:

Identifies the presence of distant metastatic involvement of the lung at time of diagnosis. This includes only the lung, not pleura or pleural fluid.

Coding Instructions:

- **For cases diagnosed January 1, 2010 through December 31, 2015, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for information on coding CS Mets at Dx – Lung. http://cancerstaging.org/cstage/Pages/default.aspx

CS METS EVAL

Alternate name	Item #	Length	Source of Standard	Column #
CS Metastasis Evaluation	2860	1	AJCC	998-998

Description:

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

Coding Instructions:

- **For cases diagnosed January 1, 2004 through December 31, 2015, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for general information on coding CS Mets Eval. http://cancerstaging.org/cstage/Pages/default.aspx

- Refer to the Collaborative Stage Data Collection System Coding Instructions Site Specific Schemas for CS Mets Eval coding instructions for individual primary sites. http://cancerstaging.org/cstage/Pages/default.aspx

CS SITE-SPECIFIC FACTOR 1

Alternate name	Item #	Length	Source of Standard	Column #
	2880	3	AJCC	1003-1005

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004 code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF1 for the following schemas only:**

Brain	Hypopharynx	Mycosis Fungoides	Retinoblastoma
Breast	Intracranial Gland	Nasal Cavity	Retroperitoneum
Buccal Mucosa	Larynx Glottic	Nasopharynx	Salivary Gland Other
CNS Other	Larynx Other	NET Stomach	Sinus Ethmoid
Conjunctiva	Larynx Subglottic	Oropharynx	Sinus Maxillary
Epiglottis Anterior	Larynx Supraglottic	Palate Hard	Soft Tissue
Esophagus	Lip Lower	Palate Soft	Stomach
Esophagus GE junction	Lip Other	Parotid Gland	Submandibular Gland
Floor of Mouth	Lip Upper	Peritoneum	Tongue Anterior
Gum Lower	Lung	Pharyngeal Tonsil	Tongue Base
Gum Other	Melanoma Conjunctiva	Placenta	
Gum Upper	Melanoma Skin	Pleura	
Heart Mediastinum	Mouth Other	Prostate	

CS SITE-SPECIFIC FACTOR 2

Alternate name	Item #	Length	Source of Standard	Column #
	2890	3	AJCC	1006-1008

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF2 for the following schemas only:**

Appendix	Corpus adenosarcoma	Melanoma choroid	NET rectum
Bladder	Corpus carcinoma	Melanoma ciliary body	Rectum
Breast	Corpus sarcoma	Melanoma conjunctiva	Small Intestine
Carcinoid appendix	Lymphoma	Melanoma skin	
Colon	Lymphoma ocular adnexa	NET colon	

CS SITE-SPECIFIC FACTOR 3

Alternate name	Item #	Length	Source of Standard	Column #
	2900	3	AJCC	1009-1011

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF3 for the following schemas only:**

Breast	Melanoma skin	Merkel cell skin
Melanoma choroid	Merkel cell penis	Merkel cell vulva
Melanoma ciliary body	Merkel cell scrotum	Prostate

CS SITE-SPECIFIC FACTOR 4

Alternate name	Item #	Length	Source of Standard	Column #
	2910	3	AJCC	1012-1014

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF4 for the following schemas only:**

Breast	Melanoma iris
Melanoma choroid	Melanoma skin
Melanoma ciliary body	Testis

CS SITE-SPECIFIC FACTOR 5

Alternate name	Item #	Length	Source of Standard	Column #
	2920	3	AJCC	1015-1017

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF5 for the following schemas only:**

Breast	GIST Peritoneum	Testis

CS SITE-SPECIFIC FACTOR 6

Alternate name	Item #	Length	Source of Standard	Column #
	2930	3	AJCC	1018-1020

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF6 for the following schemas only:**

GIST esophagus	GIST stomach
GIST small intestine	Skin eyelid

CS SITE-SPECIFIC FACTOR 7

Alternate name	Item #	Length	Source of Standard	Column #
	2861	3	AJCC	1021-1023

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF7 for the following schemas only:**

Melanoma skin

CS SITE-SPECIFIC FACTOR 8

Alternate name	Item #	Length	Source of Standard	Column #
	2862	3	AJCC	1024-1026

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF8 for the following schemas only:**

Breast	Prostate

CS SITE-SPECIFIC FACTOR 9

Alternate name	Item #	Length	Source of Standard	Column #
	2863	3	AJCC	1027-1029

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004 code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF9 for the following schemas only:**

Breast

CS SITE-SPECIFIC FACTOR10

Alternate name	Item #	Length	Source of Standard	Column #
	2864	3	AJCC	1030-1032

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF10 for the following schemas only:**

Bile Ducts IntraHepatic	GIST peritoneum	Prostate

CS SITE-SPECIFIC FACTOR11

Alternate name	Item #	Length	Source of Standard	Column #
	2865	3	AJCC	1033-1035

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases, leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF11 for the following schemas only:**

Appendix	GIST appendix	GIST rectum	Vulva
Breast	GIST colon	Merkel cell vulva	

CS SITE-SPECIFIC FACTOR12

Alternate name	Item #	Length	Source of Standard	Column #
	2866	3	AJCC	1036-1038

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF12 for the following schemas only:**

Scrotum	Skin

CS SITE-SPECIFIC FACTOR13

Alternate name	Item #	Length	Source of Standard	Column #
	2867	3	AJCC	1039-1041

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF13 for the following schema only:**

Breast	Testis

CS SITE-SPECIFIC FACTOR 14

Alternate name	Item #	Length	Source of Standard	Column #
	2868	3	AJCC	1042-1044

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF14 for the following schema only:**

Breast

CS SITE-SPECIFIC FACTOR15

Alternate name	Item #	Length	Source of Standard	Column #
	2869	3	AJCC	1045-1047

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF15 for the following schemas only:**

Breast	Testis

CS SITE-SPECIFIC FACTOR16

Alternate name	Item #	Length	Source of Standard	Column #
	2870	3	AJCC	1048-1050

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF16 for the following schemas only:**

Breast	Scrotum	Skin	Testis

CS SITE-SPECIFIC FACTOR17

Alternate name	Item #	Length	Source of Standard	Column #
	2871	3	AJCC	1051-1053

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF17 for the following schema only:**

Penis

CS SITE-SPECIFIC FACTOR25

Alternate name	Item #	Length	Source of Standard	Column #
	2879	3	AJCC	1075-1077

Description:

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

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- **Code CS SSF25 for the following schema only:**

Bile Ducts Distal	Lacrimal Sac	Peritoneum
Bile Ducts Perihilar	Melanoma Ciliary Body	Peritoneum Female Genital
Cystic Duct	Melanoma Iris	Pharyngeal Tonsil
Esophagus GE junction	Nasopharynx	Stomach
Lacrimal Gland		

CS TUMOR SIZE

CASES DIAGNOSED JANUARY 1, 2004 – DECEMBER 31, 2015

Alternate name	Item #	Length	Source of Standard	Column #
	2800	3	AJCC	985-987

Description:

Records the largest dimension or diameter of the **primary tumor** in millimeters. To convert centimeters to millimeters multiply the dimension by 10. If tumor size is given in tenths of millimeters, record size as 001 if largest dimension or diameter of tumor is between 0.1 and 0.9 mm.

Coding Instructions:

- **For cases diagnosed January 1, 2004 through December 31, 2015, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for general information on coding CS Tumor Size. http://cancerstaging.org/cstage/Pages/default.aspx

- Refer to the Collaborative Stage Data Collection System Coding Instructions Site Specific Schemas for CS Tumor Size coding instructions for individual primary sites. http://cancerstaging.org/cstage/Pages/default.aspx

ILLINOIS STATE CANCER REGISTRY STANDARDS FOR DATA REPORTING

Effective January 1, 2016
Page | 88

CS TUMOR SIZE/EXT EVAL

Alternate name	Item #	Length	Source of Standard	Column #
CS Tumor Size/Extension Evaluation CS TS/Ext-Eval	2820	1	AJCC	991-991

Description:

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

Coding Instructions:

- **For cases diagnosed January 1, 2004 through December 31, 2015, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for general information on coding CS Tumor Size/Ext Eval. http://cancerstaging.org/cstage/Pages/default.aspx

- Refer to the Collaborative Stage Data Collection System Coding Instructions Site Specific Schemas for CS Tumor Size/Ext Eval coding instructions for individual primary sites. http://cancerstaging.org/cstage/Pages/default.aspx

DATE 1ST CRS RX COC

Alternate name	Item #	Length	Source of Standard	Column #
Date of First Course of Treatment (CoC) Date Started (pre 96 CoC) Date of 1st Crs RX--CoC	1270	8	CoC	1446-1453

Description:

Records the date on which treatment (surgery, radiation, systemic, or other therapy) of the patient began at any facility.[1]

Coding Instructions:[1]

- Record the earliest of the following dates: Rx Date Surgery (NAACCR Item #1200), Rx Date Radiation (NAACCR Item #1210), Rx Date Systemic (NAACCR Item #3230), or Rx Date Other (NAACCR Item #1250).

- If active surveillance or watchful waiting is selected as the first course of treatment (Rx Summ–Treatment Status [NAACCR Item #1285] = 2) record the date this decision is made.

- In cases of non-treatment (Rx Summ–Treatment Status [NAACCR Item #1285] = 0), in which a physician decides not to treat a patient or a patient's family or guardian declines all treatment, the date of first course of treatment is the date this decision was made.

- Leave this item blank if the cancer was diagnosed at autopsy and not suspected prior to that.

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

DATE 1ST CRS RX COC FLAG

Alternate name	Item #	Length	Source of Standard	Column #
Date of 1st Crs RX Flag	1271	2	NAACCR	1454-1455

Description:

This flag explains why no appropriate value is in the field Date of 1st Crs Rx COC (NAACCR Item #1270).

Coding Instructions:[1]

- Leave this item blank if Date 1st Crs Rx CoC (NAACCR Item #1270) has a full or partial date recorded.

- Code 10 if it is unknown whether any treatment was administered.

- Code 11 if the initial diagnosis was at autopsy.

- Code 12 if the Date 1st Crs Rx CoC (NAACCR Item #1270) cannot be determined at all, but the patient did receive first course treatment.

- Code 12 If a decision not to treat was made, but the date is totally unknown.

- Code 12 if a decision to use active surveillance was made, but the date is totally unknown.

DATE CONCLUSIVE DX

Alternate name	Item #	Length	Source of Standard	Column #
Date of Conclusive Diagnosis Date of Conclusive Terminology Date of Conclusive Dx	443	8	SEER	567-574

Description:

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

Coding Instructions:

- **Code this data item for cases diagnosed between January 1, 2007 and December 31, 2012. For all other cases leave this data item blank.**

- Refer to the 2007 Multiple Primary and Histology Coding Rules at http://www.seer.cancer.gov/tools/mphrules/download.html for detailed coding instructions. (Go to the bookmark "Data Items" for coding instructions.)

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

DATE CONCLUSIVE DX FLAG

Alternate name	Item #	Length	Source of Standard	Column #
	448	2	NAACCR	575-576

Description:

This flag explains why no appropriate value is in the corresponding date field, Date Conclusive Dx (NAACCR Item #443). Effective January 1, 2010 through December 31, 2012.

Coding Instructions:

- **Code this data item for cases diagnosed between January 1, 2007 and December 31, 2012. For all other cases leave this data item blank.**

- Refer to the 2007 Multiple Primary and Histology Coding Rules at http://www.seer.cancer.gov/tools/mphrules/download.html for detailed coding instructions. (Go to the bookmark "Data Items" for coding instructions.)

Code:

10 No information whatsoever can be inferred from this exceptional (non-date) value (e.g., unknown if the diagnosis was initially based on ambiguous terminology).

11 No proper value is applicable in this context (e.g., not applicable, initial diagnosis made by unambiguous terminology (Code 0 in data item Ambiguous Terminology Dx [NAACCR Item #442]).

12 A proper value is applicable but not known (e.g., the initial ambiguous diagnosis was followed by a conclusive term, but the date of the conclusive term is unknown).

15 Information is not available at this time, but it is expected that it will be available later (e.g., accessioned based on ambiguous terminology only (Code 1 in data item Ambiguous Terminology DX [NAACCR Item #442]).

Blank   A valid date value is provided in item Date Conclusive Dx (NAACCR Item #443). Case was diagnosed prior to January 1, 2007 or after December 31, 2012.

DATE OF 1ST CONTACT

Alternate name	Item #	Length	Source of Standard	Column #
Date of Adm/First Contact	580	8	CoC	745-752

Description:

Date of first patient contact, as inpatient or outpatient, with the reporting facility for diagnosis and/or treatment of the tumor.

Coding Instructions:

- Record the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, x- ray, or laboratory test, or the date a pathology specimen was collected at the hospital.[1]

- Record the date of death for autopsy-only or death certificate-only cases.

- When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.[1]

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

DATE OF 1ST CONTACT FLAG

Alternate name	Item #	Length	Source of Standard	Column #
Date of First Contact Flag	581	2	NAACCR	753-754

Description:

This flag explains why no appropriate value is in the field Date of 1st Contact (NAACCR Item #580).

Coding Instructions:[1]

- Leave this item blank if Date of First Contact (NAACCR Item #580) has a full or partial date recorded

- Code 12 if the Date of First Contact (NAACCR Item #580) cannot be determined at all.

DATE OF BIRTH

Alternate name	Item #	Length	Source of Standard	Column #
Birth Date (SEER/CoC/CCCR)	240	8	SEER/CoC	196-203

Description:

Date of birth of the patient. If age at diagnosis and year of diagnosis are known, but year of birth is unknown, then year of birth should be calculated and so coded. Only the year should be entered, left-justified. Estimate date of birth when information is not available. It is better to estimate than to leave birth date unknown.

Coding Instructions:[1]

- Record the patient's date of birth as indicated in the patient record. For single-digit day or month, record with a lead 0 (for example, September is 09). Use the full four-digit year for year.

- For in utero diagnosis and treatment, record the actual date of birth.

- If only the patient age is available, calculate the year of birth from age and the year of diagnosis and leave day and month of birth as unknown (for example, a 60-year-old patient diagnosed in 2010 is calculated to have been born in 1950).

- If month is unknown, the day is coded as unknown. If the year cannot be determined, the day and month are both coded as unknown.

- If the date of birth cannot be determined at all, record the reason in Date of Birth Flag (NAACCR Item #241).

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

DATE OF BIRTH FLAG

Alternate name	Item #	Length	Source of Standard	Column #
	241	2	NAACCR	204-205

Description:

This flag explains why no appropriate value is in the field, Date of Birth (NAACCR Item #240).

Coding Instructions:[1]

- Leave this item blank if Date of Birth (NAACCR Item #240) has a full or partial date recorded.

- Code 12 if the Date of Birth (NAACCR Item #240) cannot be determined at all.

DATE OF DIAGNOSIS

Alternate name	Item #	Length	Source of Standard	Column #
Date of Initial Diagnosis (CoC)	390	8	SEER/CoC	530-537

Description:

Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed.

Rule:

- At a minimum, the year of diagnosis is required for a case to be reportable to ISCR. For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

Coding Instructions:

- Use the first date of diagnosis whether clinically or histologically established.[1] Do not change the date of diagnosis when a later biopsy or cytology provides confirmation of a clinical diagnosis.

  - **Example:** On May 15, 2013, physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung on June 3, 2013. The date of diagnosis remains May 15, 2013.

- 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.

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

- Do **not** use cytology as a basis for diagnosis when **ambiguous terms** are used.
  - "Ambiguous" cytology means that the diagnosis is preceded by an ambiguous term such as apparently, appears, compatible with, etc.
  - **Ambiguous cytology** is **not** diagnostic of cancer. Do not use the date of ambiguous cytology as the date of diagnosis. Use the date of clinical, histologic, or **positive** cytologic confirmation as the date of diagnosis.
  - Refer to the list of ambiguous terminology in Chapter 3 of this manual for language that represents a diagnosis of cancer.
  - **Example:** Cytology suspicious for malignancy 1/12/2015. Diagnosis of carcinoma per biopsy on 2/6/2015. Record 2/5/2015 as the date of diagnosis.

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

- o 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.
- o **Example:** The patient had an excision of a benign fibrous histiocytoma in January 2013. 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 2013.
- o **Example:** The patient had a total hysterectomy and bilateral salpingo-oophorectomy (BSO) in June 2013 with pathology diagnosis of papillary cystadenoma of the ovaries. In December 2013 the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2013 are not reviewed and there is no physician statement saying the previous tumor was malignant. The date of diagnosis is December 2013.

- Use the date treatment was started as the date of diagnosis if the patient receives a first course of treatment before a diagnosis is documented.[1]

- The date of diagnosis for "Autopsy Only" cases is the date of death.

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

- When the year of initial diagnosis cannot be identified it must be approximated. ISCR does not accept cases submitted with an unknown diagnosis year.

Estimating Dates

Estimating the **month**

1. Code "spring of" to April
2. Code "summer" or "middle of the year" to July
3. Code "fall" or "autumn" as October
4. 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.
5. Code "early in year" to January
6. Code "late in year" to December
7. Use whatever information is available to calculate the month
8. Code the month of admission when there is no basis for estimation
9. Leave month blank if there is no basis for approximation

Estimating the **year**

1. Code "a couple of years" to two years earlier
2. Code "a few years" to three years earlier
3. Use whatever information is available to calculate the year
4. Code the year of admission when there is no basis for estimation

DATE OF LAST CONTACT

Alternate name	Item #	Length	Source of Standard	Column #
Date of Last Contact or Death (CoC) Date of Last Follow-up or of Death (SEER)	1750	8	SEER/CoC	2116-2123

Description:

Date of last contact with the patient or date of death. If the patient has multiple tumors, Date of Last Contact should be the same for all tumors.

Coding Instructions:[1]

- Record the last date on which the patient was known to be alive or the date of death.

- If a patient has multiple primaries, all records should have the same date of last contact.

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

DATE OF LAST CONTACT FLAG

Alternate name	Item #	Length	Source of Standard	Column #
	1751	2	NAACCR	2124-2125

Description:

This flag explains why no appropriate value is in the field, Date of Last Contact (NAACCR Item #1750).

Coding Instructions:[1]

- Leave this item blank if Date of Last Contact or Death (NAACCR Item #1750) has a full or partial date recorded.

- Code 12 if the Date of Last Contact or Death (NAACCR Item #1750) cannot be determined.

DATE OF MULT TUMORS

CASES DIAGNOSED JANUARY 1, 2007 THROUGH DECEMBER 31, 2012

Alternate name	Item #	Length	Source of Standard	Column #
Date of Multiple Tumors	445	8	SEER	579-586

Description:

This data item is used to identify the month, day and year the patient is diagnosed with multiple tumors **reported as a single primary** using the SEER multiple primary rules. Use the multiple primary rules for that specific site to determine whether the tumors are a single primary or multiple primaries. Use Date of Mult Tumors Flag (NAACCR Item#439) if there is no appropriate or known date for this item.

Coding Instructions:

- **Code this data item for cases diagnosed between January 1, 2007 and December 31, 2012. For all other cases leave this data item blank.**

- Refer to the 2007 Multiple Primary and Histology Coding Rules at http://www.seer.cancer.gov/tools/mphrules/download.html for detailed coding instructions. (Go to the bookmark "Data Items" for coding instructions.)

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

DATE OF MULT TUMORS FLAG

Alternate name	Item #	Length	Source of Standard	Column #
	439	2	NAACCR	587-588

Description:

This flag explains why no appropriate value is in the field, Date of Mult Tumors (NAACCR Item #445).

Coding Instructions:

- **Code this data item for cases diagnosed between January 1, 2007 and December 31, 2012. For all other cases leave this data item blank.**
- Refer to the 2007 Multiple Primary and Histology Coding Rules at http://www.seer.cancer.gov/tools/mphrules/download.html for detailed coding instructions. (Go to the bookmark "Data Items" for coding instructions.)

Codes:

11   No proper value is applicable in this context (e.g., information on multiple tumors not collected/not applicable for this site).

12   A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., patient was diagnosed with multiple tumors and the date is unknown).

15   Information is not available at this time, but it is expected that it will be available later (e.g., single tumor).

Blank   A valid date value is provided in item Date of Mult Tumors (NAACCR Item #445) or the date was not expected to have been transmitted. Case was diagnosed prior to January 1, 2007 or after December 31, 2012.

DIAGNOSTIC CONFIRMATION

Alternate name	Item #	Length	Source of Standard	Column #
	490	1	SEER/CoC	562-562

Description:

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

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

- These instructions apply to "Codes for Solid Tumors". See the section following this one for Coding Hematopoietic or Lymphoid Tumors (9590-9992). [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. This data item must be changed to the lower (higher priority) code if a more definitive method confirms the diagnosis at any time during the course of the disease. [1]

- Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or D&C or from aspiration of biopsy of bone marrow specimens. [1]

- Assign code 2 when the microscopic diagnosis is based on cytologic examination of cells such as sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. [1] ISCR does not require programs to abstract cases that contain ambiguous terminology regarding a cytologic diagnosis.

- Assign code 4 when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.

- Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer.

  Example: If 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, code the diagnostic confirmation to 5.

  Note: For tests and tumor markers that may be used to help diagnose cancer, see http://www.cancer.gov/cancertopics/factsheet/detection

  http://www.cancer.gov/cancertopics/factsheet/detection/tumor-markers

- Code 6 when the diagnosis is based only on the surgeon's operative report from a surgical exploration or endoscopy or from gross autopsy findings in the absence of tissue or cytological findings. [1]

- 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.

- Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.[1]

Codes for Solid Tumors:[1]

Code	Label	Description
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver primaries. Elevated PSA is not diagnostic of cancer. However, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiology and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually non-analytic).

Coding Instructions Hematopoietic or Lymphoid Tumors (9590-9992):

- These instructions apply to "Codes for Hematopoietic or Lymphoid Tumors". See the preceding section for coding instructions for solid tumors.[1]

- There is no priority hierarchy for coding Diagnostic Confirmation for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing See the Hematopoietic Database (DB) (http://seer.cancer.gov/tools/heme/) for information on the definitive diagnostic confirmation for specific types of tumors.[1]

- Code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.[1]

- Peripheral blood smear can be counted as a histologic diagnosis (Code 1) for all hematopoietic malignancies (9590/3-9992/3).

- For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.[1]

- Use code 2 when the microscopic diagnosis is based on cytologic examination of cells (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.[1]

- Assign code 3 when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. **Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.**[1]

- Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but no positive histologic confirmation.[1]

- Assign code 6 when the diagnosis is based only on the surgeon's report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.[1]

- Assign code 8 when the case was diagnosed by any clinical method that cannot be coded as 6 or 7. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.[1]

Codes for Hematopoietic and Lymphoid Tumors: [1]

Code	Label	Description
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
3	Positive histology PLUS • Positive immunophenotyping AND/OR • Positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia. (9861/3) Genetic testing shows AML with inv(16)(p13.1q22) (9871/3). **Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.**
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only other than 5, 6, or 7	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually non-analytic).

GRADE

Alternate name	Item #	Length	Source of Standard	Column #
Grade, Differentiation or Cell Lineage Indicator (SEER/CCCR) Grade/Differentiation (CoC)	440	1	SEER/CoC	555-555

Description:
Code for the grade or degree of differentiation of the reportable tumor. For lymphomas and leukemias, the field also is used to indicate T-, B-, Null-, or NK-cell origin.

Note: Code 8 was adopted for use with lymphoma cases diagnosed in 1995 and later.

ISCR Notes:
- Do **not** code FIGO grade for gynecologic malignancies in Grade. The conversion from a three-grade system to a four-grade system does not work for FIGO grade three. Since FIGO G3 includes both poorly differentiated and undifferentiated, it cannot be converted.
- Do **not** record WHO grade for brain and CNS neoplasms in Grade.
- Code grade from the time of the initial diagnosis. Do not code grade from recurrence or progression.

Special Note:
The coding instructions for Grade (NAACCR Item#440) have become complicated over time by the introduction of specialized site-specific grading systems. In addition, the coding instructions listed in the FORDS Manual and the SEER Coding Manual differed. Therefore, the CoC-SEER-NPCR Technical Working Group drafted a new set of coding instructions to be used by **everyone** for **cases diagnosed on or after January 1, 2014**.

The new 2014 coding instructions do **NOT** apply to cases diagnosed prior to 2014. Follow the links below to find the correct coding instructions based on the date of diagnosis:

Coding Instructions for Cases Diagnosed on or after January 1, 2014

Coding Instructions for Cases Diagnosed prior to 2014

CODING INSTRUCTIONS FOR CASES DIAGNOSED ON OR AFTER JANUARY 1, 2014

Use these coding instructions ONLY for cases diagnosed on or after January 1, 2014. For cases diagnosed prior to 2014, use the <u>Coding Instructions for Cases Diagnosed prior to 2014</u>.

Hematopoietic and Lymphoid Neoplasms

Cell Indicator (Codes 5, 6, 7, 8, 9)

Cell Indicator (Codes 5, 6, 7, 8) describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used only for hematopoietic and lymphoid neoplasms. Code 9 indicates cell type not determined, not stated, or not applicable.

Coding Grade for Hematopoietic and Lymphoid Neoplasms

1. Determine the histology based on the current Hematopoietic and Lymphoid Neoplasm Manual [http://seer.cancer.gov/tools/heme].

2. Determine the Cell Indicator by applying the "Grade of Tumor Rules" within the current Hematopoietic and Lymphoid Neoplasm Manual [http://seer.cancer.gov/tools/heme] to code the grade.

Grade codes for hematopoietic and lymphoid neoplasms

Terminology	Grade Code
T-cell; T-precursor	5
B-Cell; Pre-B; B-precursor	6
Null cell; Non T-non B	7
NK cell (natural killer cell)	8
Grade unknown, not stated, nor not applicable	9

Solid tumors

Grade, Differentiation (Codes 1, 2, 3, 4, 9)

Pathologic examination determines the grade, or degree of differentiation, of the tumor. For these cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). Well-differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little (poorly differentiated) or no (undifferentiated) resemblance to the tissue from the organ of origin. These similarities/differences may be based on pattern (architecture), cytology, nuclear (or nucleolar) features, or a combination of these elements, depending upon the grading system that is used. Some grading systems use only pattern, for example Gleason grading in prostate. Others use only a nuclear grade (usually size, amount of chromatin, degree of irregularity, and mitotic activity). Fuhrman's grade for kidney is based only on nuclear features. Most systems use a combination of pattern and cytologic and nuclear features; for example Nottingham's for breast combines numbers for pattern, nuclear size

and shape, and mitotic activity. The information from this data item is useful for determining prognosis and treatment.

Pathologists describe the tumor grade using three systems or formats:
1. Two levels of similarity; also called a two-grade system
2. Three levels of similarity; also called a three-grade system (code according to "Coding for solid tumors."
    a. Grade I, well
    b. Grade II, moderately
    c. Grade III, poorly (undifferentiated carcinoma is usually separated from this system, since "poorly" bears some, albeit little, similarity to the host tissue, while "undifferentiated" has none, e.g. Undifferentiated carcinoma).
3. Four levels of similarity; also called a four-grade system. The four-grade system describes the tumor as
    a. Grade I; also called well-differentiated
    b. Grade II; also called moderately differentiated
    c. Grade III; also called poorly differentiated
    d. Grade IV; also called undifferentiated or anaplastic

Breast and prostate grades may convert differently than other sites. These exceptions are noted in "Coding for Solid Tumors", #7-8 below.

Coding for Solid Tumors

1. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code grade based on information prior to neoadjuvant therapy even if grade is unknown.

2. Code the grade from the primary tumor only.
    a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.
    b. If primary site is unknown, code grade to 9.

3. Code the grade shown below (6th digit) for specific histologic terms that imply a grade.
    Carcinoma, undifferentiated (8020/3<u>4</u>)
    Carcinoma, anaplastic (8021/3<u>4</u>)
    Follicular adenocarcinoma, well differentiated (8331/3<u>1</u>)
    Thymic carcinoma, well differentiated (8585/3<u>1</u>)
    Sertoli-Leydig cell tumor, poorly differentiated (8631/3<u>3</u>)
    Sertoli-Leydig cell tumor, poorly differentiated with heterologous
        elements (8634/3<u>3</u>)
    Undifferentiated sarcoma (8805/3<u>4</u>)
    Liposarcoma, well differentiated (8851/3<u>1</u>)
    Seminoma, anaplastic (9062/3<u>4</u>)
    Malignant teratoma, undifferentiated (9082/3<u>4</u>)
    Malignant teratoma, intermediate type (9083/3<u>2</u>)
    Intraosseous osteosarcoma, well differentiated (9187/3<u>1</u>)
    Astrocytoma, anaplastic (9401/3<u>4</u>)
    Oligodendroglioma, anaplastic (9451/3<u>4</u>)

Retinoblastoma, differentiated (9511/3<u>1</u>)
Retinoblastoma, undifferentiated (9512/3<u>4</u>)

4. In situ and/or combined in situ/invasive components:
   a. If a grade is given for an in situ tumor, code it. Do NOT code grade for dysplasia such as high grade dysplasia.
   b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.

5. If there is more than one grade, code the highest grade within the applicable system. Code the highest grade even if it is only a focus. Code grade in the following priority order using the first applicable system:
   a. special grade systems for the sites listed in Coding for Solid Tumors #6
   b. differentiation: use Coding for Solid Tumors #7: 2-, 3-, or 4- grade system
   c. nuclear grade: use Coding for Solid Tumors #7: 2-, 3-, or 4- grade system
   d. If it isn't clear whether it is a differentiation or nuclear grade and a 2-, 3-, or 4- grade system was used, code it.
   e. Terminology (use Coding for Solid Tumors #8)

6. Use the information from the special grade systems first. If no special grade can be coded, continue with Coding for Solid Tumors #7-9.

Special grade systems for solid tumors

Grade information based on CS Site-specific factors for breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma is used to code grade. See **Special Grade System Rules** section below for details on how to use this information to code grade.

CS Schema	Special grade system
Breast	Nottingham or Bloom-Richardson (BR) Score/Grade (SSF 7)
Prostate	Gleason's Score on Needle Core Biopsy/Transurethral Resection of Prostate (TURP) (SSF 8)
Prostate	Gleason's Score on Prostatectomy/Autopsy (SSF 10)
Heart, Mediastinum	Grade for Sarcomas (SSF 1)
Peritoneum	Grade for Sarcomas (SSF 1)
Retroperitoneum	Grade for Sarcomas (SSF 1)
Soft Tissue	Grade for Sarcomas (SSF 1)
Kidney Parenchyma	Fuhrman Nuclear Grade (SSF 6)

Do not use these tables to code grade for any other groups including WHO (CNS tumors), WHO/ISUP (bladder, renal pelvis), or FIGO (female gynecologic sites) grades.

7. Use the Two-, Three- or Four-grade system information

a. Two-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/2, I/II	Low grade	2	1
2/2, II/II	High grade	4	3

In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the two-grade system.

b. Three-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/3	Low grade	2	1
2/3	Intermediate grade	3	2
3/3	High grade	4	3

c. Four-grade system: Any four-grade system including Edmondson and Steiner grade for liver.

Term	Description	Grade Code
1/4	Grade I; Well differentiated	1
2/4	Grade II; Moderately differentiated	2
3/4	Grade III; Poorly differentiated	3
4/4	Grade IV; Undifferentiated	4

8. Terminology: use the 'Description' column or the 'Grade' column to code grade. Breast & Prostate use the same grade code with a few noted exceptions.

Description	Grade	Assign Grade Code	Exception for Breast and Prostate Grade Code
Differentiated, NOS	I	1	
Well differentiated	I	1	
Only stated as 'Grade I'	I	1	
Fairly well differentiated	II	2	
Intermediate differentiation	II	2	
Low grade	I-II	2	1
Mid differentiated	II	2	
Moderately differentiated	II	2	
Moderately well differentiated	II	2	
Partially differentiated	II	2	
Partially well differentiated	I-II	2	1
Relatively or generally well differentiated	II	2	
Only stated as 'Grade II'	II	2	
Medium grade, intermediate grade	II-III	3	2
Moderately poorly differentiated	III	3	
Moderately undifferentiated	III	3	
Poorly differentiated	III	3	
Relatively poorly differentiated	III	3	
Relatively undifferentiated	III	3	
Slightly differentiated	III	3	
Dedifferentiated	III	3	
Only stated as 'Grade III'	III	3	
High grade	III-IV	4	3
Undifferentiated, anaplastic, not differentiated	IV	4	
Only stated as 'Grade IV'	IV	4	
Non-high grade		9	

9. If no description fits or grade is unknown prior to neoadjuvant therapy, code as a 9 (unknown).

SPECIAL GRADE SYSTEMS RULES

Breast (site: breast excluding lymphomas; CS schema: breast)

Use Bloom Richardson (BR) or Nottingham score/grade to code grade based on CSv2 site-specific factor 7 (SSF) as stated below. If your registry does not collect this SSF, use the description in the table below to determine grade. If you collect this SSF, codes 030-130 could be automatically converted into the grade field.

BR could also be referred to as: Bloom-Richardson, modified Bloom-Richardson, BR, BR grading, Scarff-Bloom-Richardson, SBR grading, Elston-Ellis modification of Bloom-Richardson score, Nottingham modification of Bloom-Richardson score, Nottingham modification of Scarff-Bloom-Richardson, Nottingham-Tenovus grade, or Nottingham grade.

Code the tumor grade using the following priority order
  a. BR scores 3-9
  b. BR grade (low, intermediate, high)

BR score may be expressed as a range, 3-9. The score is based on three morphologic features: degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism/nuclear grade of tumor cells. If a report uses words such as low, intermediate, or high rather than numbers, use the table below to code grade.

If only a grade of 1 through 4 is given with no information on the score and it is unclear if it is a Nottingham or BR Grade, do not use the table below. Continue with the next priority according to "Coding for Solid Tumors" #7 above.

Code the highest score if multiple scores are reported (exclude scores from tests after neoadjuvant therapy began). Examples: different scores may be reported on multiple pathology reports for the same primary cancer; different scores may be reported for multiple tumors assigned to the same primary cancer.

CS Site-Specific Factor 7
Nottingham or Bloom-Richardson (BR) Score/Grade

Description	CS Code	Grade Code
Score of 3	030	1
Score of 4	040	1
Score of 5	050	1
Score of 6	060	2
Score of 7	070	2
Score of 8	080	3
Score of 9	090	3
Low Grade, Bloom-Richardson (BR) grade 1, score not given	110	1
Medium (Intermediate) Grade, BR grade 2, score not given	120	2
High Grade, BR grade 3, score not given	130	3

Kidney Parenchyma (Site: kidney parenchyma excluding lymphomas; CS schema: KidneyParenchyma): Fuhrman Nuclear Grade

The Fuhrman Nuclear Grade should be used to code grade for kidney parenchyma only based on CSv2 SSF 6 as stated below. Do not use for kidney renal pelvis. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-040. Fuhrman nuclear grade is a four-grade system based on nuclear diameter and shape, the prominence of nucleoli, and the presence of chromatin dumping in the highest grade.

Description	CS Code	Grade Code
Grade 1	010	1
Grade 2	020	2
Grade 3	030	3
Grade 4	040	4

SoftTissue (sites excluding lymphomas: soft tissue, heart, mediastinum, peritoneum, and retroperitoneum; for CS users: SoftTissue, HeartMediastinum, Peritoneum, Retroperitoneum schemas): Grade for Sarcomas

The Grade for Sarcomas should be used to code grade based on CSv2 SSF 1 as stated below. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-200. The grading system of the French Federation of Cancer Centers Sarcoma Group (FNCLCC) is the preferred system.

Record the grade from any three-grade sarcoma grading system the pathologist uses. For terms such as "well differentiated" or "poorly differentiated," go to Coding for Solid Tumors #8.

In some cases, especially for needle biopsies, grade may be specified only as "low grade" or "high grade." The numeric grade takes precedence over "low grade" or "high grade."

Description	CS Code	Grade Code
Specified as Grade 1 [of 3]	010	2
Specified as Grade 2 [of 3]	020	3
Specified as Grade 3 [of 3]	030	4
Grade stated as low grade, NOS	100	2
Grade stated as high grade, NOS	200	4

Prostate (site: prostate excluding lymphomas; CS schema: prostate)

Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy. Use a known value over an unknown value. Exclude results from tests performed after neoadjuvant therapy began.

This information is collected in CSv2 SSF 8 (Gleason score from biopsy/TURP) and SSF 10 (Gleason score from prostatectomy/autopsy) as stated below. Use the table below to determine grade even if your registry does not collect these SSFs. If you collect these SSFs, the information could be converted into the grade field automatically.

Usually prostate cancers are graded using Gleason score or pattern. Gleason grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score. If only one number is given on a particular test and it is less than or equal to 5 and not specified as a score, do not use the information because it could refer to either a score or a grade. If only one number is given and it is greater than 5, assume that it is a score and use it. If the pathology report specifies a specific number out of a total of 10, the first number given is the score. Example: The pathology report says Gleason 3/10. The Gleason score would be 3.

Historic Perspective

Gleason score	Description					
	CS Code	Grade Code	AJCC 7th	SEER 2003-2013	AJCC 6th	SEER prior 2003
2	002	1	G1	G1	G1	G1
3	003	1	G1	G1	G1	G1
4	004	1	G1	G1	G1	G1
5	005	1	G1	G2	G2	G2
6	006	1	G1	G2	G2	G2
7	007	2	G2	G3	G3	G2
8	008	3	G3	G3	G3	G3
9	009	3	G3	G3	G3	G3
10	010	3	G3	G3	G3	G3

Historical perspective on long term trends in prostate grade: The relationship of Gleason score to grade changed for 1/1/2014+ diagnoses in order to have the grade field in sync with AJCC 7th ed. Analysis of prostate grade before 2014 based solely on the grade field is not recommended. In Collaborative Stage (CS), Gleason score was originally coded in CSv1 in one field (SSF 6) and then it was split into two fields in CSv2 based on the tissue used for the test: needle biopsy/TURP (SSF 8) and prostatectomy/autopsy (SSF 10). For trends using data back to 2004, if one collected the various CS Gleason scores, one could design a recode to have the same criteria as the data collected 2014+. The original grade field would NOT be changed, but for analyses this recode could be based on the CS SSFs and the original grade code.

Computer algorithm to derive grade for prostate based on SSF 8 and SSF 10: if SSF 8 or SSF 10 has known values for Gleason's, the information could be used to automatically derive the grade field.

SSF 8 Code	SSF 10 Grade Code											
	002	003	004	005	006	007	008	009	010	988	998	999
002	1	1	1	1	1	2	3	3	3	*	1	1
003	1	1	1	1	1	2	3	3	3	*	1	1
004	1	1	1	1	1	2	3	3	3	*	1	1
005	1	1	1	1	1	2	3	3	3	*	1	1
006	1	1	1	1	1	2	3	3	3	*	1	1
007	2	2	2	2	2	2	3	3	3	*	2	2
008	3	3	3	3	3	3	3	3	3	*	3	3
009	3	3	3	3	3	3	3	3	3	*	3	3
010	3	3	3	3	3	3	3	3	3	*	3	3
988	*	*	*	*	*	*	*	*	*	*	*	*
998	1	1	1	1	1	2	3	3	3	*	*	*
999	1	1	1	1	1	2	3	3	3	*	*	*

* Grade can't be automatically calculated based on SSF 8 and SSF 10; Go to Step 7

CODING INSTRUCTIONS FOR CASES DIAGNOSED PRIOR TO 2014

Use these coding instructions ONLY for cases diagnosed prior to January 1, 2014.   For cases diagnosed on or after January 1, 2014, use the Coding Instructions for Cases Diagnosed on or after January 1, 2014.

- Code grade according to ICD-O-3 (pp. 30–31 and 67).[2]
- Code the grade or differentiation as stated in the **final** pathologic diagnosis. If grade is not stated in the final pathologic diagnosis, use the information from the microscopic description or comments.[2]
- When the pathology report(s) lists more than one grade of tumor, code to the highest grade, even if the highest grade is only a focus (Rule G, ICD-O-3, p. 21).[2]
- Code the grade or differentiation from the pathologic examination of the primary tumor, not from metastatic sites.[2]
- Record the tumor grade from the pathology or cytology report **prior** to neoadjuvant treatment.
    - Code grade as 9 when no grade is specified on the pathology report from cytology or tissue assessment prior to neoadjuvant treatment OR the pathology report from cytology or tissue assessment prior to neoadjuvant treatment is not available.
- When there is a variation in the usual terms for degree of differentiation, code to the higher grade as specified:

Term	Grade	Code
Low grade	I-II	2
Medium grade; intermediate grade	II-III	3
High grade	III-IV	4
Partially well differentiated	I-II	2
Moderately undifferentiated	III	3
Relatively undifferentiated	III	3

- When there is no tissue diagnosis, it may be possible to establish grade through magnetic resonance imaging (MRI) or positron emission tomography (PET). When available, code grade based on the recorded findings from these imaging reports.[2]
- If the primary site is unknown, code Grade as 9 (Unknown).[2]
- Code the grade for in situ lesions if the information is available. If the lesion is both invasive and in situ, code only the invasive portion. If the invasive component grade is unknown, then code 9.[2]
- **Do not** use "high grade," "low grade," or "intermediate grade" descriptions for lymphomas as a basis for differentiation. These terms are categories in the Working Formulation of Lymphoma Diagnoses and do not relate to Grade.[2]
- Codes 5–8 define T-cell or B-cell origin for leukemias and lymphomas. T-cell, B-cell, or null cell classifications have precedence over grading or differentiation.[2] Consult the most current version of the Hematopoietic and Lymphoid Neoplasm and Coding Manual (http://seer.cancer.gov/tools/heme/) for specific coding instructions for cases diagnosed on or after January 1, 2010.
- For primary tumors of the brain and spinal cord (C71.0–C72.9) do not record the WHO grade as the tumor Grade (NAACCR Item #440); record the WHO grade in the data item CS Site-Specific

Factor 1 (NAACCR Item #2880). Grade astrocytomas (M-9383, 9484, 9400, 9401, 9410-9412, 9420, 9421) according to ICD-O-3 rules: I (well differentiated), Code 1; II (intermediate differentiation), Code 2; III (poorly differentiated), Code 3; IV (anaplastic), Code 4. Do not automatically code glioblastoma multiforme as Grade IV if no grade is given, code 9 (Unknown).[2]

- Some terms in ICD-O-3 carry an implied statement of grade. The following histologies must be reported with the correct grade as stated below:

8020/34	Carcinoma, undifferentiated
8021/34	Carcinoma, anaplastic
8331/31	Follicular adenocarinoma, well differentiated
9082/34	Malignant teratoma, undifferentiated
9401/34	Astrocytoma, anaplastic
9451/34	Oligodendroglioma, anaplastic
9511/31	Retinoblastoma, differentiated
9512/34	Retinoblastoma, undifferentiated

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

Some primary sites are routinely assigned a grade other than Grade (NAACCR Item #440) that is defined by **ICD-O-3**. For the Grade (NAACCR Item #440), it is necessary to convert from these systems to Grade (NAACCR Item #440) as described in the following sections.[2]

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

CODE	TERMINOLOGY	HISTOLOGIC GRADE
2	Low grade	1/2
4	High grade	2/2

Coding Three-Grade Systems[2]

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

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

Note: Do not use this table for breast primaries

Breast (C50. 0-C50.9)[2]

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

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

Kidney (C64.9)[2]

For kidney cancers, code the tumor grade using the following priority rules: (1) Fuhrman Grade, (2) Nuclear Grade, (3) Terminology (well differentiated, moderately differentiated), (4) Histologic Grade. These prioritization rules do not apply to Wilms tumor (M-8960).

Prostate (C61.9)[2]

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

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

Codes:

1   Grade I; grade 1; well differentiated; differentiated, NOS

2   Grade II; grade 2; moderately differentiated, moderately well differentiated; intermediate differentiation

3   Grade III; grade 3; poorly differentiated; dedifferentiated

4   Grade IV; grade 4; undifferentiated; anaplastic

5   T-cell; T-precursor

6   B-cell; pre-B; B-precursor

7   Null cell; non T-non B

8   NK cell (natural killer cell) (effective with diagnosis 1/1/1995 and after)

9   Grade/differentiation unknown, not stated, or not applicable

GRADE PATH SYSTEM

Alternate name	Item #	Length	Source of Standard	Column #
	449	1	AJCC	557-557

Description:

Indicates whether a two, three or four grade system is used.

Coding Instructions:

- **Code this data item for cases diagnosed between January 1, 2011 and December 31, 2013. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for instructions on coding Grade Path System.
  http://cancerstaging.org/cstage/Pages/default.aspx

Codes:

2   Two-Grade System

3   Three-Grade System

4   Four-Grade System

Blank   Not a two, three or four grade system; unknown; information not collected for this diagnosis date

GRADE PATH VALUE

Alternate name	Item #	Length	Source of Standard	Column #
	441	1	AJCC	556-556

Description:

Describes the actual grade according to the grading system in Grade Path System (NAACCR Item #449).

Coding Instructions:

- **Code this data item for cases diagnosed between January 1, 2011 and December 31, 2013. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for instructions on coding Grade Path Value.
  http://cancerstaging.org/cstage/Pages/default.aspx

Codes:

1   Recorded as Grade I or 1

2   Recorded as Grade II or 2

3   Recorded as Grade III or 3

4   Recorded as Grade IV or 4

Blank   No Two, Three or Four System Grade is available; unknown; information not collected for this diagnosis date

HISTOLOGIC TYPE ICD-O-3

Alternate name	Item #	Length	Source of Standard	Column #
ICD-O-3 Histology (CCCR)	522	4	SEER/CoC	550-553

Description:

Codes for the histologic type of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for tumors diagnosed January 1, 2001 and later, and recommended that prior tumors be converted from ICD-O-2. Effective with 2010 diagnoses, this item also includes histology codes as per the 2008 WHO Hematopoietic/Lymphoid publication 39, which are listed on pages 3-5 of the NAACCR 2010 Implementation Guidelines. http://www.naaccr.org/StandardsandRegistryOperations/ImplementationGuidelines.aspx.

Clarification of Required Status:

This data item is required by all standard-setting organizations for tumors diagnosed on or after January 1, 2001, and recommended (by conversion from ICD-O-2 codes when conversion algorithms and tables are available) for tumors diagnosed before 2001.

When the histologic type is coded according to ICD-O-3, the histology code must be reported in Histologic Type ICD-O-3 (NAACCR Item #522), with behavior coded in Behavior Code ICD-O-3 (NAACCR Item #523).

For information on required status for related data items for histologic type and behavior when coded according to ICD-O-2, see Histology (92-00) ICD-O-2 (NAACCR Item #420) and Behavior (92-00) ICD-O-2 (NAACCR Item #430).

ICD-O-3 Updates:

Note: The NAACCR Guidelines for ICD-O-3 Update Implementation (published December 2013) included a table of new ICD-O-3 codes and terms effective for 2015; however, the use of the new codes was postponed due to issues with adding these codes to the CSv2 software. For diagnosis year 2016, all standard setters have agreed to postpone these codes once again, and to use the alternate codes published in Table 2 of the NAACCR Guidelines for ICD-O-3 Update Implementation. It is anticipated that these codes will be implemented in 2017 when the AJCC-TNM 8th Edition goes into effect.

- Effective with cases diagnosed on or after January 1, 2015, code 8240/1 for Carcinoid tumor, NOS of appendix (C18.1) becomes obsolete. Carcinoid tumors of the appendix (C18.1) must be coded to 8240/3.

- Effective with cases diagnosed on or after January 1, 2015, code 8157/3, malignant enteroglucagonoma becomes obsolete.   Malignant enteroglucagonoma must be coded to 8152/3.

Coding Instructions:[1]

- ICD-O-3 identifies the morphology codes with an "M" preceding the code number. Do not record the "M."

- Record histology using the ICD-O-3 codes in the Numeric Lists/Morphology section (ICD-O-3, pp. 69–104) and in the Alphabetic Index (ICD-O-3, pp. 105–218).

- Follow the coding rules outlined on pages 20 through 40 of the ICD-O-3 manual.

- Use the current Multiple Primary and Histology Coding Rules when coding the histology for all reportable solid tumors diagnosed January 1, 2007 or later. Do not use these rules to abstract cases prior to January 1, 2007.

- Review all pathology reports.

- Code the **final** pathologic diagnosis for solid tumors.

- For lymphomas, leukemias and other hematopoietic tumors, follow the instructions in Hematopoietic and Lymphoid Neoplasm Coding Manual and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB) for cases diagnosed on or after January 1, 2010.

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

LATERALITY

Alternate name	Item #	Length	Source of Standard	Column #
Laterality at Diagnosis (SEER)	410	1	SEER/CoC	544-544

Description:

Code for the side of a paired organ or side of the body on which the reportable tumor originated. This applies to the primary site only.   Refer to list of sites that are considered paired organs and require specific laterality (e.g. other than "0, not a paired site").

Coding Instructions:

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

- Do not code metastatic sites as a bilateral involvement.[1]

- Code all non-paired sites '0'.

- Code 4 is seldom used EXCEPT for the following
    - Both ovaries involved simultaneously with a single epithelial histology or multiple epithelial histologies in the range 8000-8799
    - Diffuse bilateral lung nodules
    - Bilateral retinoblastomas
    - Bilateral Wilms tumors

- Where the right and left sides of paired sites are contiguous (come into contact) and the lesion is at the point of contact of the right and left sides, use code 5, midline. NOTE that "midline of the right breast" is coded 1 for right; midline in this usage indicates the primary site is C50.8 (overlapping sites).[1]

- Assign code 5 when the tumor originates in the midline of sites C700, C710-C714, C722-C725, C443, or C445.
    - Do not assign code 5 to sites **not** listed above.
    - **Example 1:** Patient has an excision of a melanoma located just above the umbilicus (C445, laterality 5)
    - **Example 2:** Patient has a midline meningioma of the cerebral meninges (C700, laterality 5)

- Code '9' when the primary is a paired site but no information concerning laterality is known and there is no statement that only one side of the paired organ is involved.

Codes:

0   Not a paired site

1   Right: origin of primary

2   Left: origin of primary

3   Only one side involved; right or left origin unspecified

4   Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; diffuse bilateral lung nodules; bilateral retinoblastomas; bilateral Wilms' tumors

5   Paired site; midline tumor

9   Paired site, but no information concerning laterality

C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage, nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb, scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib, clavicle (excluding sternum)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of the lower limb and hip
C49.1	Connective, subcutaneous and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous and other soft tissues of lower limb and hip
C50.0-50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS **(effective for cases diagnosed on or after January 1, 2004)**
C71.0-71.4	Cerebrum, frontal lobe, temporal lobe, parietal lobe, occipital lobe **(effective for cases diagnosed on or after January 1, 2004)**
C72.2-72.5	Olfactory nerve, optic nerve, acoustic nerve, cranial nerve, NOS **(effective for cases diagnosed on or after January 1, 2004)**
C74.0-74.9	Adrenal/Suprarenal gland (adrenal)
C75.4	Carotid body

LYMPH-VASCULAR INVASION

CASES DIAGNOSED ON OR AFTER JANUARY 1, 2010

Alternate name	Item #	Length	Source of Standard	Column #
	1182	1	AJCC	984-984

Description:

This field records the absence or presence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. The presence of lymph-vascular invasion may affect the patient's prognosis.

Lymph-vascular invasion is defined as the presence of tumor cells found inside small blood vessels or lymphatic channels within the tumor and surrounding tissues in the primary site. The tumor cells have broken free of the primary tumor and now have the capability to float throughout the body. Other names for lymph-vascular invasion are LVI, lymphovascular invasion, vascular invasion, blood vessel invasion, and lymphatic invasion. Vascular invasion is not the same as direct tumor extension from the primary tumor into adjacent blood vessels; LVI cells are not attached to or growing into the wall of the blood vessel. Lymphatic invasion is not the same as involvement of regional lymph nodes. Lymph-vascular invasion does not include perineural invasion.

Coding Instructions:

- **Code this data item for all cases diagnosed on or after January 1, 2010. For all other cases leave this data item blank.**

- Code from pathology report(s). Code the absence or presence of lymph-vascular invasion as described in the medical record.
    - The primary sources of information about lymph-vascular 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.
    - Do not code perineural invasion in this field.
    - Information to code this field can be taken from any specimen from the primary tumor (biopsy or resection).
    - If lymph-vascular invasion is identified in any specimen, it should be coded as present/identified.
    - For cases with benign or borderline behavior, code the lymph-vascular invasion documented (negative or positive) and, if not documented, code unknown.

- For cases treated with neoadjuvant therapy, refer to table below in order to code this field. However, if documentation in the medical record indicates information that conflicts with this table, code lymph-vascular invasion with the documentation in the medical record.

-

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

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

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

- 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 lymph-vascular invasion is present
  - the pathologist indicates the specimen is insufficient to determine lymph-vascular invasion
  - lymph-vascular invasion is not mentioned in the pathology report

Codes:

0   Lymph-vascular Invasion stated as Not Present

1   Lymph-vascular Invasion Present/ Identified

8   Not Applicable

9   Unknown/Indeterminate/not mentioned in path report

Blank   Information not collected for this diagnosis year

MEDICAL RECORD NUMBER

Alternate name	Item #	Length	Source of Standard	Column #
	2300	11	CoC	3606-3616

Description:

Records the medical record number used by the facility to identify the patient.

Coding Instructions:

- Record up to eleven characters of the patient's medical record number.

- If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.[1]

- For facilities without assigned medical record numbers: Use any patient identifier assigned by your facility to retrieve the patient's record. SSN may be used in this field.

Codes (in addition to the medical record number):

UNK   Medical record number unknown

RT   Radiation therapy department patient without HIM number

SU   1-day surgery clinic patient without HIM number

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

METS AT DX-BONE

Alternate name	Item #	Length	Source of Standard	Column #
	1112	1	SEER	838-838

Description:

This field identifies whether bone is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Coding Instructions:

- **Code this data item for cases diagnosed on or after January 1, 2016. For all other cases leave this field blank.**

- **Code information about bone metastases only** (discontinuous or distant metastases to bone) identified at the time of diagnosis. This data item should not be coded for bone marrow involvement.
  - Bone involvement may be single or multiple
  - Information about bone involvement may be clinical or pathologic
  - Code this field for bone metastases even if the patient had any neoadjuvant (preoperative) systemic therapy
  - This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary sites

- **Use of codes.** Assign the code that best describes whether the case has bone metastases at diagnosis.

  - Use code 0 when the medical record
    - indicates that there are no distant (discontinuous) metastases at all
    - includes a clinical or pathologic statement that there are no bone metastases
    - includes imaging reports that are negative for bone metastases
    - indicates that the patient has distant (discontinuous) metastases but bone is not mentioned as an involved site.
    Example: use code 0 when the patient has lung and liver metastases but not bone

o Use code 1 when the medical record
  ▪ indicates that the patient has distant (discontinuous) metastases and bone is mentioned as an involved site
  ▪ indicates that bone is the primary site and there are metastases in a different bone or bones
    • do not assign 1 for a bone primary with multifocal bone involvement of the same bone
  ▪ indicates that the patient is diagnosed as an unknown primary (C809) and bone is mentioned as a distant metastatic site

o Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

o Use code 9 when it cannot be determined from the medical record whether the patient specifically has bone metastases; for example, when there is documentation of carcinomatosis but bone is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include bone.

Codes:

0   None; no bone metastases

1   Yes; distant bone metastases

8   Not applicable

9   Unknown whether bone is an involved metastatic site. Not documented in patient record.

METS AT DX-BRAIN

Alternate name	Item #	Length	Source of Standard	Column #
	1113	1	SEER	839-839

Description:

This field identifies whether brain is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Coding Instructions:[1]

- **Code this data item for cases diagnosed on or after January 1, 2016. For all other cases leave this field blank.**

- **Code information about brain metastases only** (discontinuous or distant metastases to brain) identified at the time of diagnosis. This data item should not be coded for involvement of spinal cord or other parts of the central nervous system.
  - Brain involvement may be single or multiple
  - Information about brain involvement may be clinical or pathologic
  - Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy
  - This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary sites

- **Use of codes.**   Assign the code that best describes whether the case has brain metastases at diagnosis.
  - Use code 0 when the medical record
    - indicates that there are no distant (discontinuous) metastases at all
    - includes a clinical or pathologic statement that there are no brain metastases
    - includes imaging reports that are negative for brain metastases
    - indicates that the patient has distant (discontinuous) metastases but brain is not mentioned as an involved site.
    Example: use code 0 when the patient has lung and liver metastases but not brain
  - Use code 1 when the medical record
    - indicates that the patient has distant (discontinuous) metastases and brain is mentioned as an involved site
    - indicates that the patient is diagnosed as an unknown primary (C809) and brain is mentioned as a distant metastatic site

o Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

o Use code 9 when it cannot be determined from the medical record whether the patient specifically has brain metastases; for example when there is documentation of carcinomatosis but brain is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include brain.

Codes:

0   None; no brain metastases

1   Yes; distant brain metastases

8   Not applicable

9   Unknown whether brain is involved metastatic site. Not documented in patient record.

METS AT DX-DISTANT LN

Alternate name	Item #	Length	Source of Standard	Column #
	1114	1	SEER	840-840

Description:

This field identifies whether distant lymph node(s) are an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Coding Instructions:[1]

- **Code this data item for cases diagnosed on or after January 1, 2016. For all other cases leave this field blank.**

- **Code information about distant lymph node(s) metastases only** (metastases to distant lymph nodes) identified at the time of diagnosis.
    - Distant lymph node involvement may be single or multiple
    - Information about distant lymph node involvement may be clinical or pathologic
    - Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy
    - This field should not be coded for regional lymph node involvement with the exception of lymph nodes for placenta which are M1
    - This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary sites
    - Lymph nodes not listed as regional lymph nodes are to be classified as distant lymph nodes using the TNM definitions.
    - For unknown primaries, unless involved lymph nodes are stated to be distant lymph nodes assign code 9 for unknown.

- **Use of codes.** Assign the code that best describes whether the case has distant lymph node metastases at diagnosis.

    - Use code 0 when the medical record
        - indicates that there are no distant (discontinuous) metastases at all
        - includes a clinical or pathologic statement that there are no distant lymph node metastases
        - includes imaging reports that are negative for distant lymph node metastases
        - indicates that the patient has distant (discontinuous) metastases but distant lymph node(s) are not mentioned as an involved site.
        Example: use code 0 when the patient has lung and liver metastases but not distant lymph node(s)

- Use code 1 when the medical record
  - indicates that the patient has distant (discontinuous) metastases and distant lymph node(s) are mentioned as an involved site
  - indicates that the patient is diagnosed as an unknown primary (C80.9) and distant lymph node(s) are mentioned as a distant metastatic site
- Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

- Use code 9 when it cannot be determined from the medical record whether the patient specifically has distant lymph node metastases; for example when there is documentation of carcinomatosis but distant lymph node(s) are not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include distant lymph node(s).

Codes:

0   None; no distant lymph node metastases

1   Yes; distant lymph node metastases

8   Not applicable

9   Unknown whether distant lymph node(s) are involved metastatic site. Not documented in patient record.

METS AT DX-LIVER

Alternate name	Item #	Length	Source of Standard	Column #
	1115	1	SEER	841-841

Description:

This field identifies whether liver is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Coding Instructions:[1]

- **Code this data item for cases diagnosed on or after January 1, 2016. For all other cases leave this field blank.**

- **Code information about liver metastases only** (discontinuous or distant metastases to liver) identified at the time of diagnosis.
    - o Liver involvement may be single or multiple
    - o Information about liver involvement may be clinical or pathologic
    - o Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy
    - o This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary sites

- **Use of codes.** Assign the code that best describes whether the case has liver metastases at diagnosis.

    - o Use code 0 when the medical record
        - ▪ indicates that there are no distant (discontinuous) metastases at all
        - ▪ includes a clinical or pathologic statement that there are no liver metastases
        - ▪ includes imaging reports that are negative for liver metastases
        - ▪ indicates that the patient has distant (discontinuous) metastases but liver is not mentioned as an involved site.
        Example: use code 0 when the patient has lung and brain metastases but not liver

    - o Use code 1 when the medical record
        - ▪ indicates that the patient has distant (discontinuous) metastases and liver is mentioned as an involved site
        - ▪ indicates that the patient is diagnosed as an unknown primary (C809) and liver is mentioned as a distant metastatic site.

o   Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

o   Use code 9 when it cannot be determined from the medical record whether the patient specifically has liver metastases; for example when there is documentation of carcinomatosis but liver is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include liver.

Codes:

0   None; no liver metastases

1   Yes; distant liver metastases

8   Not applicable

9   Unknown whether liver is involved metastatic site. Not documented in patient record.

METS AT DX-LUNG

Alternate name	Item #	Length	Source of Standard	Column #
	1116	1	SEER	842-842

Description:

This field identifies whether lung is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Coding Instructions:[1]

- **Code this data item for cases diagnosed on or after January 1, 2016. For all other cases leave this field blank.**

- **Code information about lung metastases only** (discontinuous or distant metastases to lung) identified at the time of diagnosis. This data item should not be coded for pleural or pleural fluid involvement.
    - Lung involvement may be single or multiple
    - Information about lung involvement may be clinical or pathologic
    - Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy
    - This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary sites

- **Use of codes.**   Assign the code that best describes whether the case has lung metastases at diagnosis.
    - Use code 0 when the medical record
        - indicates that there are no distant (discontinuous) metastases at all
        - includes a clinical or pathologic statement that there are no lung metastases
        - includes imaging reports that are negative for lung metastases
        - indicates that the patient has distant (discontinuous) metastases but lung is not mentioned as an involved site.
        Example: use code 0 when the patient has liver and brain metastases but not lung
    - Use code 1 when the medical record
        - indicates that the patient has distant (discontinuous) metastases and lung is mentioned as an involved site
        - indicates that lung is the primary site and there are metastases in the contralateral lung

- do not assign code 1 for a lung primary with multifocal involvement of the same lung
    - indicates that the patient is diagnosed with an unknown primary (C809) and lung is mentioned as a distant metastatic site
- Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

- Use code 9 when it cannot be determined from the medical record whether the patient specifically has lung metastases; for example when there is documentation of carcinomatosis but lung is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include lung.

Codes:

0   None; no lung metastases

1   Yes; distant lung metastases

8   Not applicable

9   Unknown whether lung is involved metastatic site. Not documented in patient record.

METS AT DX-OTHER

Alternate name	Item #	Length	Source of Standard	Column #
	1117	1	SEER	843-843

Description:

This field identifies whether other metastatic involvement, other than bone, brain, liver, lung or distant lymph nodes exists. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Coding Instructions:[1]

- **Code this data item for cases diagnosed on or after January 1, 2016. For all other cases leave this field blank.**

- **Code information about other metastases only** (discontinuous or distant metastases) identified at the time of diagnosis. This data item should not be coded for bone, brain, liver, lung, or distant lymph node metastases.
    - Other involvement may be single or multiple
    - Information about other involvement may be clinical or pathologic
    - Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy
    - This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary sites

- **Use of codes.** Assign the code that best describes whether the case has other metastases at diagnosis.
    - Use code 0 when the medical record
        - indicates that there are no distant (discontinuous) metastases at all
        - includes a clinical or pathologic statement that there are no other metastases
        - includes imaging reports that are negative for lung metastases
        - indicates that the patient has distant (discontinuous) metastases but other sites not mentioned as an involved site.
        Example: use code 0 when the patient has lung and liver metastases only

- o Use code 1 when the medical record
  - indicates that the patient has distant (discontinuous) metastases in any site(s) other than bone, brain, liver, lung, or distant lymph node(s)
  - includes but not limited to the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum, and skin
- o Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

- o Use code 9 when it cannot be determined from the medical record whether the patient has metastases other than bone, brain, liver, lung, and distant lymph node(s).

Codes:

0   None; no other metastases

1   Yes; distant metastases in known site(s) other than bone, brain, liver, lung or distant lymph nodes

8   Not applicable

9   Unknown whether any other metastatic site. Not documented in patient record.

MULT TUM RPT AS ONE PRIM

Alternate name	Item #	Length	Source of Standard	Column #
Multiple Tumors Reported as Single Primary Type of Multiple Tumors Reported as One Primary	444	2	SEER	577-578

Description:

This data item identifies cases with multiple tumors that are abstracted as a single primary using the multiple primary rules. Multiple tumors may individually exhibit in situ, invasive, or any combination of in situ and invasive behaviors. Multiple intracranial and central nervous system tumors may individually exhibit benign, borderline, malignant, or any combination of these behaviors. Multiple tumors found in the same organ or in a single primary site may occur at the time of initial diagnosis or later within the time specified by the 2007 Multiple Primary and Histology Coding Rules at www.seer.cancer.gov/tools/mphrules/.

Coding Instructions:

- **Code this data item for cases diagnosed January 1, 2007 through December 31, 2012. For all other cases leave this data item blank.**

- Refer to the 2007 Multiple Primary and Histology Coding Rules at http://www.seer.cancer.gov/tools/mphrules/download.html for detailed coding instructions. (Go to the bookmark "Data Items" for coding instructions.)

Codes: (Continue next page)

00   Single tumor. Includes single tumor with both in situ and invasive components.

10   At least two benign tumors in the same organ or primary site (Behavior = 0).

11   At least two borderline tumors in the same organ/primary site (Behavior = 1).

12   At least one benign AND at least one borderline tumors in the same organ/primary site.

20   At least two in situ tumors in the same organ/primary site (Behavior = 2).

30   One or more in situ tumor(s) AND one or more invasive tumor(s) in the same organ/primary site.

31   One or more polyps with either in situ carcinoma or invasive carcinoma AND one or more frank adenocarcinoma(s) in the same segment of colon, rectosigmoid, and/or rectum.

32   Diagnosis of Familial Polyposis (FAP) AND carcinoma (in situ or invasive) is present in at least one of the polyps.

40   At least two invasive tumors in the same organ, may also have one or more in situ tumors.

80   Multiple tumors present in the same organ/primary site, unknown if in situ or invasive.

88   Information on multiple tumors is not applicable for this site.

99   Unknown if multiple tumors, death certificate only cases.

Blank   Information not collected for this diagnosis date (e.g. all cases diagnosed prior to 2007 or after December 31, 2012)

MULTIPLICITY COUNTER

Alternate name	Item #	Length	Source of Standard	Column #
	446	2	SEER	589-590

Description:

This data item is used to count the number of tumors (multiplicity) reported as a single primary. Do not count metastatic tumors. Use the Multiple Primary and Histology Coding Rules manual, multiple primary rules, for the specific site to determine whether the tumors are a single primary or multiple primaries.

Coding Instructions:

- **Code this data item for cases diagnosed January 1, 2007 through December 31, 2012. For all other cases leave this data item blank.**

- Refer to the 2007 Multiple Primary and Histology Coding Rules at http://www.seer.cancer.gov/tools/mphrules/download.html for detailed coding instructions. (Go to the bookmark "Data Items" for coding instructions.)

Codes:

00   No primary tumor identified (effective for cases diagnosed 1/1/2011 and forward)

01   One tumor only

02   Two tumors present; bilateral ovaries involved with cystic carcinoma

03   Three tumors present

88   Information on multiple tumors not collected/not applicable for this site

89   Multicentric, multifocal, number unknown (effective for cases diagnosed 1/1/2011 and forward)

99   Unknown if multiple tumors; not documented

Blank   Information not collected for this diagnosis date (e.g. all cases diagnosed prior to 2007 or after December 31, 2012)

Note: Codes 00 and 89 were added effective for 2011.

NAME--ALIAS

Alternate name	Item #	Length	Source of Standard	Column #
Alias (CoC)	2280	40	NAACCR	3466-3505

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 (NAACCR Item #2390).

Coding Instructions:

- Record the alternate name or "AKA" used by the patient, if known.

- The name should be left justified.

- Blanks, spaces, hyphens and apostrophes are allowed. Do not use other punctuation.

- This field may be blank.

- Record last name and first name separated by a space.

    Example 1: Ralph Williams uses the name Bud Williams. Record Williams Bud as an alias.

    Example 2: Samuel Clemens uses the name Mark Twain. Record Twain Mark as an alias.

NAME--FIRST

Alternate name	Item #	Length	Source of Standard	Column #
First Name (CoC)	2240	40	CoC	3380-3419

Description:

First name of the patient.

Coding Instructions:

- Do not leave blank; code as UNKNOWN if the patient's first name is not known.

- Truncate name if more than 40 letters long.[1]

- Blank spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.[1]

- This field may be updated if the name changes.[1]

- Do not record prefixes (MR, MS, SR, DR, etc) with the first name. For example, record Mary not SR Mary.

NAME--LAST

Alternate name	Item #	Length	Source of Standard	Column #
Last Name (CoC)	2230	40	CoC	3340-3379

Description:

Last name of the patient.

Coding Instructions:

- The last name must be left justified with trailing blanks.
- Blank spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.[1]
- Do not leave blank; code as UNKNOWN if the patient's last name is unknown.[1]
- This field may be updated if the last name changes.[1]
- Do not record prefixes (MR, MS, DR, etc) or suffixes (JR, MD, DDS, etc) with the last name. For example record Smith not Smith JR.

NAME--MAIDEN

Alternate name	Item #	Length	Source of Standard	Column #
Maiden Name (CoC)	2390	40	NAACCR	3506-3545

Description:

Maiden name of female patients who are or have been married. This is used to link reports on a woman who has changed her name between reports.

Coding Instructions:

- The name should be left justified.

- Blanks, spaces, hyphens and apostrophes are allowed. Do not use other punctuations.

- This field may be blank.

NAME--MIDDLE

Alternate name	Item #	Length	Source of Standard	Column #
Middle Name (CoC)	2250	40	CoC	3420-3459
Middle Initial (pre-96 CoC)				

Description:

Middle name or, if middle name is unavailable, middle initial of the patient.

Coding Instructions:

- Record the middle name or middle initial of the patient. Use alpha characters only.

- The name should be left justified.

- Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.[1]

- This field may be blank.

OVER-RIDE AGE/SITE/MORPH

Alternate name	Item #	Length	Source of Standard	Column #
Age/Site/Histology Interfield Review (Interfield Edit 15) (SEER #3)	1990	1	SEER	1896-1896

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Age, Birth Date, Date of Diagnosis (NAACCR IF13)
Age, Primary Site, Morphology ICDO2 (SEER IF15)
Age, Primary Site, Morphology ICDO3 (SEER IF15)
Age, Primary Site, Morph ICDO3--Adult (SEER)
Age, Primary Site, Morph ICDO3--Pediatric (NPCR)
Date of Birth, Date of Diagnosis (NAACCR IF47)

Over-ride Flag as Used in the EDITS Software Package

Some cancers occur almost exclusively in certain age groups.

Edits of the type Age, Primary Site, Morphology require review if a site/morphology combination occurs in an age group for which it is extremely rare. The edit Age, Primary Site, Morph ICDO3--Adult (SEER) edits cases with an Age at Diagnosis of 15 and older. The edit Age, Primary Site, Morph ICDO3--Pediatric (NPCR) edits cases with an Age at Diagnosis of less than 15. The edits Age, Primary Site, Morphology ICDO2 (SEER IF15) and Age, Primary Site, Morphology ICDO3 (SEER IF15) contain logic for all ages.

Coding Instructions:

1. Leave blank if the program does not generate an error message (and if the case was not diagnosed in utero) for the edits of the type Age, Primary Site, Morphology.

   - Correct any errors for the case if an item is discovered to be incorrect.
   - Code 1 or 3 as indicated if review of items in the error or warning message confirms that all are correct.

Codes :

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed that age/site/histology combination is correct as reported

2   Reviewed and confirmed that case was diagnosed in utero

3   Reviewed and confirmed that conditions 1 and 2 both apply

OVER-RIDE HISTOLOGY

Alternate name	Item #	Length	Source of Standard	Column #
Histology/Behavior Interfield Review (Field Item Edit Morph)	2040	1	SEER	1901-1901

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Diagnostic Confirmation, Behavior ICDO2 (SEER IF31)

Diagnostic Confirmation, Behavior ICDO3 (SEER IF31)

Morphology--Type/Behavior ICDO2 (SEER MORPH)

Morphology--Type/Behavior ICDO3 (COC)

Morphology--Type/Behavior ICDO3 (SEER MORPH)

Over-ride Flags as Used in the EDITS Software Package

Edits of the type Diagnostic Confirmation, Behavior differ in the use of ICD-O-2 or ICD-O-3 and check that, for in situ cases (Behavior = 2), Diagnostic Confirmation specifies microscopic confirmation (1, 2, or 4).

The distinction between in situ and invasive is very important to a registry, since prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissues, i.e., in situ, is made microscopically, cases coded in situ in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or in situ without microscopic evidence.

If an edit of the type, Diagnostic Confirmation, Behavior, gives an error message or warning, check that Behavior and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

Edits of the type, Morphology--Type/Behavior, perform the following check:
1. Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is in situ or malignant. This edit forces review of these rare cases to verify that they are indeed in situ or malignant.
2. The following histologies are generally not accepted as in situ: ICD-O-2 histologies 8000-8004, 8020, 8021, 8331, 8332, 8800-9054, 9062, 9082, 9083, 9110-9491, 9501-9989,

ICD-O-3 histologies 8000-8005, 8020, 8021, 8331, 8332, 8800-9055, 9062, 9082, 9083, 9110-9493, 9501-9989. This edit forces review of these cases.

3. If a Morphology-Type/Behavior edit produces an error or warning message and the case is one in which the 4-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, or the case is one in which the 4-digit morphology code is not generally accepted with a behavior code of 2, verify the coding of morphology and that the behavior should be coded malignant or in situ. The registrar may need to consult a pathologist or medical advisor in problem cases.

   Exceptions:

   If year of Date of Diagnosis > 2000, then a behavior code of 1 is valid for the following ICD-O-2 histologies and no over-ride flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, and 9989. Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472, and 8473. If year of Date of Diagnosis > 2003, the following ICD-O-3 benign histologies will pass without review: 8146, 8271, 8861, 8897, 9121, 9122, 9131, 9161, 9350, 9351, 9352, 9360, 9361, 9383, 9384, 9394, 9412, 9413, 9444, 9492, 9493, 9506, 9531, 9532, 9533, 9534, 9537, 9541, 9550, 9562, and 9570.

4. Grade 5-8 with histologies not in the range of 9590-9948 is impossible.

5. Some terms in ICD-O-2 and ICD-O-3 carry an implied statement of grade. These histologies must be reported with the correct grade as stated below. An error of this type cannot be over-ridden.

   ICD-O-2
   8020/34 Carcinoma, undifferentiated
   8021/34 Carcinoma, anaplastic
   8331/31 Follicular adenocarcinoma, well differentiated
   8851/31 Liposarcoma, well differentiated
   9062/34 Seminoma, anaplastic
   9082/34 Malignant teratoma, undifferentiated
   9083/32 Malignant teratoma, intermediate type
   9401/34 Astrocytoma, anaplastic
   9451/34 Oligodendroglioma, anaplastic
   9511/31 Retinoblastoma, differentiated
   9512/34 Retinoblastoma, undifferentiated

   ICD-O-3
   8020/34 Carcinoma, undifferentiated
   8021/34 Carcinoma, anaplastic
   8331/31 Follicular adenocarcinoma, well differentiated
   9082/34 Malignant teratoma, undifferentiated
   9083/32 Malignant teratoma, intermediate type

9401/34 Astrocytoma, anaplastic

9451/34 Oligodendroglioma, anaplastic

9511/31 Retinoblastoma, differentiated

9512/34 Retinoblastoma, undifferentiated

Coding Instructions:

- Leave blank if the program does not generate an error message for the edits of the types, Diagnostic Confirmation, Behav Code or Morphology--Type/Behavior.

- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1, 2, or 3 as indicated if review of all items in the error or warning message confirms that all are correct.

Codes:

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed that the pathologist states the primary to be "in situ" or "malignant" although the behavior code of the histology is designated as "benign" or "uncertain" in ICD-O-2 or ICD-O-3

2   Reviewed and confirmed that the behavior code is "in situ," but the case is not microscopically confirmed

3   Reviewed and confirmed that conditions 1 and 2 both apply

OVER-RIDE HOSPSEQ/DXCONF

Alternate name	Item #	Length	Source of Standard	Column #
Over-ride Hospital Sequence/Diagnostic Confirmation	1986	1	CoC	1892-1892

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:
   Diagnostic Confirm, Seq Num--Hosp (CoC)

Over-ride Flag as Used in the EDITS Software Package

The edit, Diagnostic Confirm, Seq Num--Hosp (CoC), does the following:

1. If any case is one of multiple primaries and is not microscopically confirmed or lacks a positive lab test/marker study, i.e., Diagnostic Confirmation > 5 and Sequence Number--Hospital > 00 (more than one primary), review is required.
2. If Primary Site specifies an ill-defined or unknown primary (C760-C768, C809), no further checking is done.
3. If Sequence Number--Hospital is in the range of 60-88, this edit is skipped.

It is important to verify that the non-microscopically confirmed case is indeed a separate primary from any others that may have been reported. This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study.

1. If the suspect case is confirmed accurate as coded and if the number of primaries is correct, set the Over-ride HospSeq/DxConf (NAACCR Item #1986) to 1. Do not set the over-ride flag on the patient's other primary cancers.
2. If it turns out that the non-microscopically confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary. Also check for other data items on the remaining cases that may need to be changed as a result of the corrections, such as stage and treatment.

Coding Instructions:

-   Leave blank if the program does not generate an error message for the edit Diagnostic Confirm, Seq Num--Hosp (CoC).

-   Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if review of all items in the error or warning message confirms that all are correct.

Codes :

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed as reported

OVER-RIDE HOSPSEQ/SITE

Alternate name	Item #	Length	Source of Standard	Column #
Over-ride Hospital Sequence/Site	1988	1	CoC	1894-1894

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Seq Num--Hosp, Primary Site, Morph ICDO2 (CoC)
Seq Num--Hosp, Primary Site, Morph ICDO3 (CoC)

Over-ride Flag as Used in the EDITS Software Package

Edits of the type Seq Num--Hosp, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site.

1. If Sequence Number--Hospital indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:
   - C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.
   - C770-C779 (lymph nodes) and ICD-O-2 histology not in range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C420-C424 and ICD-O-2 histology not in range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.
   - Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.
2. If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Coding Instructions:

- Leave blank if the program does not generate an error message for an edit of the type Seq Num--Hosp, Primary Site, Morph.

- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if review of all items in the error or warning message confirms that hospital sequence number and site are both correct.

Codes:

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed as reported

OVER-RIDE LEUK, LYMPHOMA

Alternate name	Item #	Length	Source of Standard	Column #
Leukemia or Lymphoma/Diagnostic Confirmation Interfield Review (Interfield Edit 48)	2070	1	SEER	1904-1904

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

    Diagnostic Confirmation, Histology ICDO2 (SEER IF48)
    Diagnostic Confirmation, Histology ICDO3 (SEER IF48)

Over-ride Flag as Used in the EDITS Software Package

Edits of the type Diagnostic Confirmation, Histology differ in use of ICD-O-2 or ICD-O-3 and check the following:

1. Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation of direct visualization or clinical, and any leukemia with a diagnostic confirmation of direct visualization.
2. If histology = 9590-9717 for ICD-O-2 or 9590-9729 for ICD-O-3 (lymphoma) then Diagnostic Confirmation cannot be 6 (direct visualization) or 8 (clinical).
3. If histology = 9720-9941 for ICD-O-2 or 9731-9948 for ICD-O-3 (leukemia and other) then Diagnostic Confirmation cannot be 6 (direct visualization).

Coding Instructions:

- Leave blank if the program does not generate an error message for the edits of the type Diagnostic Confirmation, Histology.

- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

If the edit produces an error or warning message, verify that the ICD-O-2 or ICD-O-3 histology and diagnostic confirmation are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in Diagnostic Confirmation) for leukemia. Code 1 indicates that a review has taken place and histologic type and diagnostic confirmation are correctly coded.

Codes:

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed as reported

OVER-RIDE SITE/BEHAVIOR

Alternate name	Item #	Length	Source of Standard	Column #
Over-ride Flag for Site/Behavior (IF39)	2071	1	SEER	1905-1905

Description:
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, Behavior Code ICDO2 (SEER IF39)
Primary Site, Behavior Code ICDO3 (SEER IF39)

Over-ride Flag as Used in the EDITS Software Package
Edits of the type, Primary Site, Behavior Code, require review of the following primary sites with a behavior of in situ (ICD-O-2 or ICD-O-3 behavior = 2):

C269	Gastrointestinal tract, NOS
C399	Ill-defined sites within respiratory system
C559	Uterus, NOS
C579	Female genital tract, NOS
C639	Male genital organs, NOS
C689	Urinary system, NOS
C729	Nervous system, NOS
C759	Endocrine gland, NOS
C760-C768	Ill-defined sites
C809	Unknown primary site

Since the designation of in situ is very specific and almost always requires microscopic confirmation, ordinarily specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being in situ is reliable.

If an in situ diagnosis is stated, try to obtain a more specific primary site. A primary site within an organ system can sometimes be identified based on the diagnostic procedure or treatment given or on the histologic type. If no more specific site can be determined, it is usually preferable to code a behavior code of 3. In the exceedingly rare situation in which it is certain that the behavior is in situ and no more specific site code is applicable, set Over-ride Site/Behavior to 1.

Coding Instructions:

- Leave blank if the program does not generate an error message for the edit Primary Site, Behavior Code ICDO2 (SEER IF39) and/or the edit Primary Site, Behavior Code ICDO3 (SEER IF39).

- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if review of site and behavior verifies that the patient has an in situ cancer of a nonspecific site and no further information about the primary site is available.

Codes:

Blank   Not reviewed or reviewed and corrected

 1   Reviewed and confirmed as reported

Note: The IF39 edit does not allow in situ cases of nonspecific sites, such as gastrointestinal tract, NOS; uterus, NOS; female genital tract, NOS; male genital organs, NOS; and others. The over-ride indicates that the conflict has been reviewed.

OVER-RIDE SITE/LAT/MORPH

Alternate name	Item #	Length	Source of Standard	Column #
Over-ride Flag for Site/Laterality/Morphology (IF42)	2074	1	SEER	1908-1908

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Laterality, Primary Site, Morph ICDO2 (SEER IF42)
Laterality, Primary Site, Morph ICDO3 (SEER IF42)

Over-ride Flag as Used in the EDITS Software Package

Edits of the type Laterality, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology and do the following:

1. If the Primary Site is a paired organ and ICD-O-2 or ICD-O-3 behavior is in situ (2), then laterality must be 1, 2, or 3.
2. If diagnosis year less than 1988 and ICD-O-2 or ICD-O-3 histology = 9590, no further editing is performed.
3. If diagnosis year greater than 1987 and ICD-O-2 or ICD-O-3 histology = 9140, 9700, 9701, 9590-9980, no further editing is performed.

The intent of this edit is to force review of in situ cases for which laterality is coded 4 (bilateral) or 9 (unknown laterality) as to origin. In rare instances when the tumor is truly midline (9) or the rare combination is otherwise confirmed correct, enter a code 1 for Override Site/Lat/Morph.

Coding Instructions:

- Leave blank if the program does not generate an error message for the edit Laterality, Primary site, Morph ICDO2 (SEER IF 42) and/or the edit Laterality, Primary site, Morph ICDO3 (SEER IF42).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of site, laterality and morphology verifies that the case had behavior code of "in situ" and laterality is not stated as "right: origin of primary;" "left: origin of primary;" or "only one side involved, right or left origin not specified".

Codes:

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed as reported

OVER-RIDE SITE/TNM-STGGRP

Alternate name	Item #	Length	Source of Standard	Column #
	1989	1	CoC	1895-1895

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:

> Primary Site, AJCC Stage Group - Ed 6, (NAACCR)
> Primary Site, AJCC Stage Group - Ed 6, ICDO3 (COC)
> Primary Site, AJCC Stage Group - Ed 7, (COC)
> Primary Site, AJCC Stage Group - Ed 7, (NPCR)
> Primary Site, AJCC Stage Group - Ed 7, ICDO3(SEER)
> Primary Site, AJCC Stage Group 2016 - Ed7(COC)
> Primary Site, Stage Group 2016 - Ed 7(NPCR)

Over-ride Flag as Used in the EDITS Software Package

Edits of the type Primary Site, AJCC Stage Group - Ed 6 and Primary Site, AJCC Stage Group - Ed 7 check that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the AJCC Cancer Staging Manual Sixth Edition and AJCC Cancer Staging Manual Seventh Edition, using the codes described for the items TNM Clin Stage Group [970] and TNM Path Stage Group [910]. Combinations of site and histology not represented in any AJCC schema must be coded 88. Unknown stage groups must be coded 99. Blanks are not permitted.

Since pediatric cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, Override Site/TNM-Stage Group is used to indicate pediatric cases not coded according to the AJCC manual. Pediatric Stage groups should not be recorded in the TNM Clin Stage Group or TNM Path Stage Group items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any components of either is used to stage a pediatric case, follow the instructions for coding AJCC items and leave Override Site/TNM-Stage Group blank.

Coding Instructions:

- Leave blank if the program does not generate an error message for the edits of the type Primary Site, AJCC Stage Group - Ed 6 and Primary Site, AJCC Stage Group - Ed 7.

- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if the case is confirmed to be a pediatric case that was coded using a pediatric coding system.

Codes:

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed as reported

OVER-RIDE SITE/TYPE

Alternate name	Item #	Length	Source of Standard	Column #
Site/Type Interfield Review (Interfield Edit 25)	2030	1	SEER	1900-1900

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, Heme Morph, DateDX, Override(SEER)
Primary Site, Morphology-Type ICDO2 (CoC)
Primary Site, Morphology-Type ICDO3 (CoC)
Primary Site, Morphology-Type ICDO2 (SEER IF25)
Primary Site, Morphology-Type, Beh ICDO3 (SEER IF25)
Primary Site, Morphology-Type, Beh ICDO3 (CoC)

Over-ride Flag as Used in the EDITS Software Package

Multiple versions of edits of the type Primary site, Morphology-Type check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different over-ride flag. The CoC version of the edit will accept Over-ride CoC-Site/Type (NAACCR Item #1987) or Over-ride Site/Type (NAACCR Item #2030) as equivalent.

1. The Site/Histology validation list (available on the SEER web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations not listed.

2. Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if Primary Site is in the range C440-C449 (skin), and ICD-O-2 histology is in the range 8000-8004 (neoplasms, malignant, NOS), 8010-8045 (epithelial carcinomas), 8050-8082 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), or ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No over-ride is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether a) the combination is biologically implausible, or b) there are cancer registry coding conventions that would dictate different codes for the diagnosis.

Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Coding Instructions:

- Leave blank if the program does not generate an error message for the edits of the type Primary Site, Morphology-Type.

- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if the case has been reviewed and both the site and histology are correct.

Codes:

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed as reported

OVER-RIDE SS/NODESPOS

Alternate name	Item #	Length	Source of Standard	Column #
Over-ride Summary Stage/Nodes Positive	1981	1	NAACCR	1888-1888

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Summary Stage 1977, Regional Nodes Pos (NAACCR)
Summary Stage 2000, Regional Nodes Pos (NAACCR)

Over-ride Flag as Used in the EDITS Software Package

The edit Summary Stage 1977, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 1977 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items. The edit Summary Stage 2000, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 2000 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items.

Coding Instructions:

- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, Regional Nodes Pos (NAACCR) or the edit Summary Stage 2000, Regional Nodes Pos (NAACCR).

- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if the case has been reviewed and it has been verified that the case has both SEER Summary Stage 1977 and Nodes Positive coded correctly or SEER Summary Stage 2000 and Nodes Positive coded correctly.

Codes:

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed as reported

OVER-RIDE SS/TNM-M

Alternate name	Item #	Length	Source of Standard	Column #
Over-ride Summary Stage/TNM-M	1983	1	NAACCR	1890-1890

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

    SS1977, TNM M c,p pre2016(NAACCR)
    SS2000, TNM M c,p pre2016(NAACCR)
    Summary Stage 1977, TNM-M (NAACCR)
    Summary Stage 2000, TNM-M (NAACCR)

Over-ride Flag as Used in the EDITS Software Package

The edit Summary Stage 1977, TNM-M (NAACCR) checks the SEER Summary Stage 1977 against the TNM-M and generates a warning if the SEER Summary Stage 1977 is 'distant' and the TNM-M is '0'. (TNM-M is derived from TNM Path M and TNM Clin M, with TNM Path M having precedence.) It also checks if the SEER Summary Stage 1977 is not 'distant' and the TNM-M is greater than or equal to '1' and generates an error or a warning. The edit Summary Stage 2000, TNM-M (NAACCR) checks the SEER Summary Stage 2000 against the TNM-M and generates a warning if the SEER Summary Stage 2000 is 'distant' and the TNM-M is '0'. It also checks if the SEER Summary Stage 2000 is not 'distant' and the TNM-M is greater than or equal to '1' and generates an error or a warning.

Coding Instructions:

- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, TNM-M (NAACCR) or the edit Summary Stage 2000, TNM-M (NAACCR).

- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if the case has been reviewed and it has been verified that both SEER Summary Stage 1977 and TNM-M have been coded correctly or that SEER Summary Stage 2000 and TNM-M have been coded correctly.

Codes:

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed as reported

OVER-RIDE SS/TNM-N

Alternate name	Item #	Length	Source of Standard	Column #
Over-ride Summary Stage/TNM-N	1982	1	NAACCR	1889-1889

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

SS1977, TNM N c,p pre2016 (NAACCR)

SS2000, TNM N c,p pre2016 (NAACCR)

Summary Stage 1977, TNM-N (NAACCR)

Summary Stage 1977, TNM-N (NAACCR)

Over-ride Flag as Used in the EDITS Software Package

The edit Summary Stage 1977, TNM-N (NAACCR) checks SEER Summary Stage 1977 against the TNM-N and generates an error if the SEER Summary Stage 1977 indicates regional nodal involvement and the TNM-N does not. (TNM-N is derived from TNM Path N and TNM Clin N, with TNM Path N having precedence.) It also generates an error if the SEER Summary Stage 1977 is 'in situ' or 'localized' and the TNM-N is greater than or equal to '1'. The edit Summary Stage 2000, TNM-N (NAACCR) checks SEER Summary Stage 2000 against the TNM-N and generates an error if the SEER Summary Stage 2000 indicates regional nodal involvement and the TNM-N does not. It also generates an error if the SEER Summary Stage 2000 is 'in situ' or 'localized' and the TNM-N is greater than or equal to '1'.

Coding Instructions:

- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, TNM-N (NAACCR) or the edit Summary Stage 2000, TNM-N (NAACCR).

- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if the case has been reviewed and it has been verified that both SEER Summary Stage 1977 and TNM-N or both SEER Summary Stage 2000 and TNM-N have been coded correctly.

Codes

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed as reported

OVER-RIDE SURG/DXCONF

Alternate name	Item #	Length	Source of Standard	Column #
Surgery/Diagnostic Confirmation Interfield Review (Interfield Edit 46)	2020	1	SEER	1899-1899

Description:

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

RX Summ--Surg Prim Site, Diag Conf (SEER IF76)

RX Summ--Surg Site 98-02, Diag Conf (SEER IF106)

RX Summ--Surgery Type, Diag Conf (SEER IF46)

Over-ride Flag as Used in the EDITS Software Package

Edits of the type RX Summ--Surg Prim Site, Diag Conf check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed. If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer. Verify the surgery and diagnostic confirmation codes, and correct any errors. Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery; for example, the tissue removed may be inadequate for evaluation.

Coding Instructions:

- Leave blank if the program does not generate an error message for edits of the type, RX Summ--Surg Prim Site, Diag Conf.

- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if review confirms that they are correct. The patient had surgery, but the tissue removed was not sufficient for microscopic confirmation.

Codes:

Blank   Not reviewed or reviewed and corrected

1   Reviewed and confirmed as reported

PLACE OF DEATH--COUNTRY

Alternate name	Item #	Length	Source of Standard	Column #
	1944	3	NAACCR	452-454

Description:

Code for the country in which the patient died and where certificate of death is filed. If the patient has multiple tumors, all records should contain the same code. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Place of Death--State (NAACCR Item #1942). It replaces the use of Place of Death (NAACCR Item # 1940).

Coding Instructions:

- See Appendix A of this manual for a list of state codes and their respective country codes.

Codes:

Blank   Not applicable, patient alive

PLACE OF DEATH--STATE

Alternate name	Item #	Length	Source of Standard	Column #
	1942	2	NAACCR	450-451

Description:

State or Province where the patient died and where certificate of death is filed. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Place of Death--Country (NAACCR Item #1944). It replaces the use of Place of Death (NAACCR Item #1940).

Coding Instructions:

- See Appendix A of this manual for a list of state codes and their respective country codes.

Codes:

Blank   Not applicable, patient alive

PRIMARY PAYER AT DX

Alternate name	Item #	Length	Source of Standard	Column #
Primary Payer at Diagnosis (CoC)	630	2	CoC	778-779

Description:

Primary payer/insurance carrier at the time of initial diagnosis and/or treatment at the reporting facility.

Coding Instructions:[1]

- If the patient is diagnosed at the reporting facility, record the payer at the time of diagnosis.

- If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known record the payer when the patient is initially admitted for treatment.

- Record the type of insurance reported on the patient's admission page.

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

- If more than one payer or insurance carrier is listed on the patient's admission page record the first.

- If the patient's payer or insurance carrier changes, do not change the initially recorded code.

Codes:[1]　　　　**(Continue on next page)**

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 the types listed in codes 20, 21, 31, 35, 60-68.
20	Private Insurance: Managed Care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types; a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance.
21	Private Insurance: Fee-for-Service	An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than described in code 35.

35	Medicaid administered through a Managed Care plan	Patient is enrolled in Medicaid through a Managed Care program (for example, HMO or PPO). The Managed Care plan pays for all incurred costs.
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 65 years of age or older, or are chronically disabled (Social Security insurance eligible). Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.
62	Medicare administered through a Managed Care plan	Patient is enrolled in Medicare through a Managed Care plan (for example, HMO or PPO). The Managed Care plan pays for all incurred costs.
63	Medicare with private Supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare.
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement.
65	TRICARE	Department of Defense program providing civilian – sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents.

Formally CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). |
| 66 | Military | Military personnel or their dependents who are treated at a military facility. |
| 67 | Veterans Affairs | Veterans treated in Veterans Affairs facilities. |
| 68 | Indian/Public Health Services | Patient receives care at an Indian Health Service facility or at another facility, and the medical costs are reimbursed by the Indian Health Services.

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 | Patient's medical record does not indicate whether or not the patient is insured. |

PRIMARY SITE

Alternate name	Item #	Length	Source of Standard	Column #
ICD-O-2/3 Topography (CCCR)	400	4	SEER/CoC	540-543

Description:

This data item identifies the site of **origin** of a tumor. It is the anatomic location where the tumor first began. If the tumor spreads to other organs, these organs are considered metastatic sites, not the primary site.

Coding Instructions:

- Record the ICD-O-3 topography code for the site of origin.[1]

- Topography codes are indicated by a "C" preceding the three-digit code number. Do not record the decimal point.[1]

- Follow the instructions in Hematopoietic and Lymphoid Neoplasm Coding Manual and the Hematopoietic and Lymphoid Neoplasm Database (Hematopoietic DB) for assigning site for lymphomas, leukemia and other hematopoietic neoplasms.[1]

- Follow the Instructions for Coding in ICD-O-3, pages 20–40 and in the current SEER Multiple Primary and Histology Coding Rules to assign site for solid tumors.[1]

- Use all information available, prior admissions (at your facility or elsewhere), the present admission or any other source, including any subsequent information available.

- Information identifying the primary site may be found on the pathology report, operative report, discharge summary, or face sheet.

- Code the site in which the primary tumor originated, even if it extends onto/into an adjacent subsite.

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

- 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.

- 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.

- 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).

- 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.

- Some histology/behavior terms in ICD-O-3 have a related site code in parentheses; for example: Hepatoma (C220).

  - Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a 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 (C50_) as suggested by the ICD-O-3.

  - 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, and no information is available about the primary site. Code the primary site to liver (C220) as suggest by ICD-O-3.
    - **Example 2:** An excision of the right axillary nodes reveals metastatic infiltrating duct carcinoma. The right breast is negative. The ICD-O-3 shows infiltrating duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).
  - 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:** 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.

- When the medical record does not contain enough information to assign a primary site:
  - Consult a physician advisor to assign the site code.
  - Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site.
  - Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category.
  - 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 a text field
  - Assign C148 when there is an unknown head and neck primary

- **Example:** Lymph node biopsy with diagnosis of squamous cell carcinoma deemed to be a head and neck primary and no specific head and neck primary site identified.
- Assignment of C148 is based on a note in ICD-O-3 indicating it should be used when a code between C000 and C142 cannot be assigned. This code is more specific then C760.

- In cases where no specific primary can be assigned clinically, the pathologist's appraisal of the tumor may enable an organ system such as "Gastrointestinal tract, NOS," C26.9, or "Connective tissue, NOS," C49.9, to be used.

- The default code for sarcomas of unknown primary site is C499 rather than C809.

  - Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. Code the primary site to the organ or origin.
    - **Example:** The pathology identifies a carcinosarcoma of the uterine corpus. Code the primary site to corpus uteri (C549).

- When no information regarding the origin of the primary is available for a patient with "metastatic malignant melanoma", the primary site is coded to C44.9, "Skin, NOS."

- Kaposi Sarcoma (KS) should be coded to the site in which it arises. If no site is noted, code to the skin (C44). If KS arises in the skin and another site simultaneously, code to skin (C44). KS (M9140/3) should be reported only once.

- Code C422 (spleen) as the primary site for angiosarcoma of spleen with metastasis to bone marrow.

- 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

- Code primary site to C311 for rhabdomyosarcoma of the ethmoid sinus.

- In the **absence of any additional information**, assign the codes listed for these primary sites (list continues on next page).

Primary site	Code
Anal margin	C445
Angle of the stomach	C162
Book-leaf lesion (mouth)	C068
Colored/lipstick portion of 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

- When coding colon primaries, if a colon subsite is not stated but a measurement from the anal verge is known, use the following link to assign the subsite based on the distance from the anal verge. http://training.seer.cancer.gov/colorectal/anatomy/figure/figure1.html

- Primary site should be corrected when better information becomes available during the course of the patient's disease. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

RACE 1-5

Name	Item #	Length	Source of Standard	Column #
Race 1	160	2	SEER/CoC	177-178
Race 2	161	2	SEER/CoC	179-180
Race 3	162	2	SEER/COC	181-182
Race 4	163	2	SEER/COC	183-184
Race 5	164	2	SEER/COC	185-186

Description:

Code the patient's race. Race is coded separately from Spanish/Hispanic Origin (NAACCR Item #190). All tumors for the same patient should have the same race code. Additional races reported by the person should be coded in Race 2, Race 3, Race 4 and Race 5.[1]

Priorities for Coding Multiple Races

- 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).

- Codes **02-32, 96-98** take priority over code **01**.

- Code only the specific race when both a specific race code and a non-specific race code apply.
  - Codes 05-17 take priority over code 96.
  - Codes 16-17 take priority over code 15.
  - Codes 20-32 take priority over code 97.
  - Codes 02-32 and 96-97 take priority over code 98.
  - Code 98 takes priority over code 99.

Coding Instructions:

- Record the patient's race, not the patient's ethnicity.

- 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.

  Sources in Priority order
  a. The patient's self-declared identification.
  b. Documentation in the medical record.
  c. Death certificate

- Assign the same race code(s) for all tumors for one patient.

- Code the race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5.
    - Code **88** for the remaining race fields (Race 2 – Race 5) when at least one race, but fewer than five races, are reported.

- Use the associated text field to document
    - Why a particular race code was chosen when there are discrepancies in race information

    Example: The patient is identified as Black in nursing notes and White in a dictated physical exam. Use a text field to document why one race was coded rather than the other.
    - That no race information is available.

- Code as **01** (White) when
    - The race is described as White or Caucasian regardless of place of birth.
    - There is a statement that the patient is Hispanic or Latino(a) and no further information is available

        Example: Sabrina Fitzsimmons is a Latina. Code race as 01 (White).
        Note: Do not code 98 (Other) in this situation.

        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.

- Code race as **02** (Black) when the stated race is African-American, Black, or Negro.

- Assign code **03** for any person stated to be
    - Native American (western hemisphere)
    OR
    - Indian, whether from North, Central, South, or Latin America.

- Assign a specific code when a specific Asian race is stated. Do not use code 96 when a specific race is known.
    Example: Patient is described as Asian in a consult note and as a second generation Korean-American in the history. Code Race 1 as 08 (Korean) and Race 2 through Race 5 as 88.
    Note: Do not code 96 (Other Asian including Asian, NOS and Oriental, NOS) in a subsequent race field when a specific Asian race has been coded.

- 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) because it is more specific than 96.

    Example 2: The person describes himself as an Asian-American born in Laos. Code race as 11 (Laotian) because it is more specific than 96.

- Use the appropriate non-specific code 96 (Other Asian including Asian, NOS and Oriental, NOS), 97 (Pacific Islander, NOS) or 98 (Other) when there is no race code for a specific race.
  Note: Document the specified race in a text field.

- Do not use code 96, 97, or 98 for "multi-racial." See coding examples below.

- All race fields must be coded 99 (Unknown) when Race 1 is coded 99 (Unknown).
  Note: Assign code 99 in race 2-5 only when Race 1 is coded 99.

- Do **not ONLY** use patient name as the basis for coding race.

- Refer to SEER Program Coding and Staging Manual Appendix D, "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" http://seer.cancer.gov/tools/codingmanuals/ when race is unknown or not stated in the medical record and birth place is recorded.

    o In some cases, race may be inferred from the nationality. Use SEER Program Coding and Staging Manual "Appendix D, Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" to identify nationalities from which race codes may be inferred.

    Example 1: Record states: "this native of Portugal…" Code race as 01 (White) per the Appendix.

    Example 2: Record states: "this patient was Nigerian…" Code race as 02 (Black) per the Appendix.

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

        Example 1: Patient's name is Siddhartha Rao and birthplace is listed as England. Code Race 1 through Race 5 as 99 (Unknown).

        Example 2: Patient's name is Ping Chen and birth place is Ethiopia. Code Race 1 through Race 5 as 99 (Unknown).

- 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.

- 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 misclassification of race.

Coding Examples

    Example 1: Patient is stated to be Japanese. Code as 05 (Japanese).

    Example 2: Patient is stated to be German-Irish. Code as 01 (White).

    Example 3: Patient is described as Arabian. Code as 01 (White).

    Example 4: Patient is described as a black female. Code as 02 (Black).

    Example 5: Patient states she has a Polynesian mother and a Tahitian father. Code race 1 as 25 (Polynesian), Race 2 as 26 (Tahitian) and Race 3 through Race 5 as 88.

    Example 6: Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code Race 1 as 02 (Black) and Race 2 through Race 5 as 88.

    Example 7: The patient is described as Asian-American with Korean parents. Code race as 08 (Korean) because it is more specific than 96 (Asian) [-American]

    Example 8: Race 1 through Race 5 in the cancer record are coded as 99 (Unknown). The death certificate states race as black. Change cancer record for Race 1 to 02 (Black) and Race 2 through Race 5 to 88.

    Example 9: Race 1 is coded in the cancer record as 96 (Asian). Death certificate gives birthplace as China. Change Race 1 in the cancer record to 04 (Chinese) and code Race 2 through Race 5 as 88.

    Example 10: Patient is stated to be Chinese and Black. Code Race 1 as 04 (Chinese), code Race 2 as 02 (Black). Code the order stated when no other priority applies.

History

- Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2000.

- Race codes must be identical on each record when the patient has multiple tumors.
    - For cases with all diagnoses prior to January 1, 2000, Race 2 through Race 5 must be blank.
    - For cases that have multiple tumors with at least one primary diagnosed **on or after January 1, 2000**, race codes in Race 1, Race 2, Race 3, Race 4 and Race 5 must be identical on all records.

- Codes **08-13** became effective with diagnoses on or after January 1, 1988.

- Code **09** was **retired** effective with diagnoses on or after January 1, 2010.

- Code **14** became effective with diagnoses on or after January 1, 1994.

- Codes **15**, **16** and **17** became effective with diagnoses on or after January 1, 2010.

- Codes **20-97** became effective with diagnoses on or after January 1, 1991.

Codes:

01   White

02   Black

03   American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)

04   Chinese

05   Japanese

06   Filipino

07   Hawaiian

08   Korean

10   Vietnamese

11   Laotian

12   Hmong

13   Kampuchean

14   Thai

15   Asian Indian or Pakistani, NOS (effective with diagnoses on or after January 1, 2010)

16   Asian Indian (effective with diagnoses on or after January 1, 2010)

17   Pakistani (effective with diagnoses on or after January 1, 2010)

20   Micronesian, NOS

21   Chamorro/Chamoru

22   Guamanian, NOS

25   Polynesian, NOS

26   Tahitian

27   Samoan

28   Tongan

30   Melanesian, NOS

31   Fiji Islander

32   New Guinean

88   No additional races (Race 2 – Race 5)

96   Other Asian, including Asian, NOS and Oriental, NOS

97   Pacific Islander, NOS

98   Other

99   Unknown

RAD--BOOST RX MODALITY

Alternate name	Item #	Length	Source of Standard	Column #
Boost Radiation Treatment Modality	3200	2	CoC	1609-1610

Description:

Records the dominant modality of radiation therapy used to deliver the most clinically significant boost dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or intensity-modulated radiation therapy. External beam boosts may consist of two or more successive phases with progressively smaller fields generally coded as a single entity. This field is used with Rad – Regional Rx Modality (NAACCR Item #1570).

Coding Instructions:

- Radiation boost treatment modalities will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.[1]

- A boost treatment is provided to a smaller field within the same volume as regional radiation in order to enhance the effect of the regional treatment.[1]
  - o The boost dose may or may not employ the same treatment modality. For example, external beam radiation may be used for regional treatment and be followed by brachytherapy to provide the boost dose.
  - o Not all patients who receive radiation therapy receive a boost dose radiation. For these cases, boost modality should be coded as 00.

- In the event that multiple radiation therapy boost modalities were employed during the treatment of the patient, record only the dominant modality.[1]

- Note that in some circumstances, the boost treatment may precede the regional treatment.[1]

- For purposes of this field, photons and x-rays are equivalent. [1]

- Code radioembolization as brachytherapy.[1]

- Codes 20 through 32 of Rad – Boost Rx Modality (NAACCR Item #3200) apply to the delivery of beam radiation. If the patient record does not specify the specific modality employed, then code the most general description of the modality, code 20. [2]

- Codes 40 through 43 describe proton radiation (code 40) and specific type of stereotactic radiotherapy (codes 41–43). If stereotactic radiotherapy is delivered to a patient but the exact modality is not recorded, use code 41 (Stereotactic radiosurgery, NOS).[2]

- Codes 50 through 55 are used to record different types of brachytherapy administration, also known as radioactive seed implants. Code 50 should be used to record the application of radioactive materials not otherwise specified. [2]

- Codes 60 through 62 provide codes to describe the administration of specific radioisotopes. Code 60 (Radioisotopes, NOS) should be used when specific details of the radioisotope administration is not available. [2]

- Assign code 60 for 90-Yttrium and for 131-Iodine when given with Rituxan as treatment for lymphoma. (Code Rituxan as immunotherapy.)

- Code 98 is reserved for cases where it is known that radiation therapy was delivered but the modality is not recorded in the patient record. [2]

- The unit of measure for radiologic dosing is the centigray (cGy), which has replaced the use of "rads" to describe radiation dose. [2]

- If only one radiation treatment modality is delivered to a patient and it is not specified as either regional or boost treatment, assume it is regional treatment and code the Rad – Regional Rx Modality (NAACCR Item #1570) accordingly. [2]

- **ISCR Note: If there is no radiation therapy given at your facility and it is unknown if it was given elsewhere, ISCR prefers the use of code 00 for this data item.**

Codes:[1]   **(Continue on next page)**

Code	Label	Description
00	No boost treatment	A boost dose was not administered to the patient. Diagnosed at autopsy.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons Mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.

42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, Low Dose Rate (LDR)	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, High Dose Rate (HDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, Low Dose Rate (LDR)	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, High Dose Rate (HDR)	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
98	Other, NOS: treatment modality not specified or unknown	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Examples :[1]   **(Continue on next page)**

Code	Reason
29	A patient with carcinoma of the tonsil receives 4,500 cGy to the head and neck region with 6 MV photons. The primary site and involved regional lymph nodes are then boosted, i.e., taken to a maximum does of 7,400 cGy, using a sequence of beam arrangements involving 6 MV photons, 15 MV photons, and 12 MV electrons.
30	In an experimental program, a patient with Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.
40	A patient with prostate carcinoma receives pelvic irradiation at the reporting facility and is referred to a major medical center for experimental proton therapy boost.

51	A patient receives external pelvic treatment to 4,500 cGy for cervical carcinoma, then receives two Fletcher intracavitary implants as boost treatment.
55	A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days.
99	A patient with a head and neck cancer is referred to another institution for an HDR brachytherapy boost. Detailed treatment records from the other institution are not available.

RAD--REGIONAL RX MODALITY

Alternate name	Item #	Length	Source of Standard	Column #
Regional Treatment Modality (CoC)	1570	2	CoC	1607-1608

Description:

Records the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment.

Coding Instructions:

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.[1]

- In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.[1]

- Note that in some circumstances the boost treatment may precede the regional treatment.[1]

- For purposes of this data item, photons and x-rays are equivalent.[1]

- Code IMRT or conformal 3D whenever either is explicitly mentioned.[1]

- Code radioembolization as brachytherapy.[1]

- Note: do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.[1]

- Codes 20 through 32 of Rad – Regional Rx Modality (NAACCR Item #1570) apply to the delivery of beam radiation. If the patient record does not specify the specific modality employed, then code the most general description of the modality, code 20.[2]

- Codes 40 through 43 describe proton radiation (code 40) and specific type of stereotactic radiotherapy (codes 41–43). If stereotactic radiotherapy is delivered to a patient but the exact modality is not recorded, use code 41 (Stereotactic radiosurgery, NOS).[2]

- Codes 50 through 55 are used to record different types of brachytherapy administration, also known as radioactive seed implants. Code 50 should be used to record the application of radioactive materials not otherwise specified.[2]

- Codes 60 through 62 provide codes to describe the administration of specific radioisotopes. Code 60 (Radioisotopes, NOS) should be used when specific details of the radioisotope administration is not available.[2]

- Assign code 60 for 90-Yttrium and for 131-Iodine when given with Rituxan as treatment for lymphoma. (Code Rituxan as immunotherapy.)

- Code 98 is reserved for cases where it is known that radiation therapy was delivered but the modality is not recorded in the patient record. [2]

- The unit of measure for radiologic dosing is the centigray (cGy), which has replaced the use of "rads" to describe radiation dose. [2]

- If only one radiation treatment modality is delivered to a patient and it is not specified as either regional or boost treatment, assume it is regional treatment and code the Rad – Regional Rx Modality (NAACCR Item #1570) accordingly. [2]

- **ISCR Note: If there is no radiation therapy given at your facility and it is unknown if it was given elsewhere, ISCR prefers the use of code 00 for this data item.**

Codes: [1]

(Continue on next page)

Code	Label	Description
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.

32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, Low Dose Rate (LDR)	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, High Dose Rate (HDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, Low Dose Rate (LDR)	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, High Dose Rate (HDR)	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
80*	Combination modality, specified*	Combination of external beam radiation and either radioactive implants or radioisotopes*
85*	Combination modality, NOS*	Combination of radiation treatment modalities not specified in code 80*
98	Other, NOS: treatment modality not specified or unknown	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

*Note: For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to Vol. II, ROADS, and DAM rules and **should not** be used to record regional radiation for cases diagnosed on or later than January 1, 2003.

Examples:[1]

Code	Reason
00	A patient was treated for melanoma with PUVA (psoralen and long-wave ultraviolet radiation). Code this treatment as Rx Summ – Other (NAACCR Item #1420), code 1.
20	A patient with prostate carcinoma receives pelvic irradiation at the reporting facility, and is then referred to a major medical center for experimental proton therapy boost.
24	A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days. This is followed by 6 MV photon treatment of the entire breast. In this case, the "boost" precedes the regional treatment.
25	In an experimental program, a patient with a Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.
25	Patient receives 15 MV external pelvic treatments to 4,500 cGy for cervical carcinoma, and then receives two Fletcher intracavitary implants.
29	A patient with carcinoma of the parotid receives daily treatments of which 60% are delivered by 15 MV photons and 40% of the dose is delivered by 16 MV electrons.
53	A prostate cancer patient is treated with I-125 seeds. I-125 is low dose brachytherapy.
98	A patient with a head and neck cancer underwent regional radiation treatment elsewhere and was referred to reported facility for an HDR brachytherapy boost. Detailed treatment records from the other facility are not available.

REASON FOR NO RADIATION

Alternate name	Item #	Length	Source of Standard	Column #
Reason for No Regional Radiation Therapy	1430	1	CoC	1592-1592

Description:

Code the reason the patient did not receive radiation treatment as part of first course of therapy. See also RAD--Regional RX Modality [NAACCR Item #1570].

Coding Instructions:[1]

- If RAD-- Regional Rx Modality (NAACCR Item #1570) is coded 00, then record the reason based on documentation in patient record.

- Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include radiation therapy.

- Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

- Code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.

- Cases coded 8 should be updated to a more definitive code when further information becomes available. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

- Code 9 if the treatment plan offered multiple options, but it is unknown which treatment, if any, was provided.

Codes:[1] **(Continue next page)**

Code	Definition
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, etc.).
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.

6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in the patient's 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 the patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate cases only.

Example :[1]

Code   **Reason**

1   A patient with Stage I prostate cancer is offered either surgery or brachytherapy to treat his disease. The patient elects to be surgically treated.

REASON FOR NO SURGERY

Alternate name	Item #	Length	Source of Standard	Column #
Reason for No Cancer-Directed Surgery (SEER) Reason for No CA Dir Surgery (CoC) Reason for No Surgery to Primary Site	1340	1	SEER/CoC	1576-1576

Description:

Records the reason that no surgery was performed on the primary site.

Coding Instructions:

- If Rx Summ – Surg Prim Site (NAACCR Item #1290) is coded 00, then record the reason based on documentation in the patient record.[1]

- Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include surgery of the primary site, or if the option of "no treatment" was accepted by the patient.[1]

- Assign code 1 when there is no information in the patient's medical record about surgery AND
    - It is known that surgery is not usually performed for this type and/or state of cancer

        OR

    - There is no reason to suspect that the patient would have had surgery of primary site.

- Code 1 if Rx Summ – Surg Prim Site (NAACCR Item #1290) is coded 98.[1]

- Code 7 if the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.[1]

- Code 8 if it is known that a physician recommended primary site surgery, but no further documentation is available yet to determine whether surgery was performed.[1] Referral to a surgeon is equivalent to a recommendation for surgery.

- Cases coded 8 should be updated to a more definitive code when further information becomes available.[1] **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

- Code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any was provided.[1]

Codes:[1]

Code	Definition
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment. Diagnosed at autopsy.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned surgery etc.).
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in the patient's 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 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 if surgery of the primary site was recommended or performed. Death certificate only.

REGIONAL NODES EXAMINED

Alternate name	Item #	Length	Source of Standard	Column #
Number of Regional Lymph Nodes Examined (SEER) Regional Lymph Nodes Examined Pathologic Review of Regional Lymph Nodes (SEER)	830	2	SEER/CoC	916-917

Description:

Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system.

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for general information on coding Regional Nodes Examined. http://cancerstaging.org/cstage/Pages/default.aspx

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- When there is a discrepancy in the definition of regional lymph nodes as described in the AJCC Cancer Staging Manual and the SEER Summary Staging Manual, use the definition in the AJCC Cancer Staging Manual.

REGIONAL NODES POSITIVE

Alternate name	Item #	Length	Source of Standard	Column #
Number of Positive Regional Lymph Nodes (SEER) Regional Lymph Nodes Positive Pathologic Review of Regional Lymph Nodes (SEER)	820	2	SEER/CoC	914-915

Description:

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system. For tumors diagnosed from 1988 through 2003, this item was part of the 10-digit EOD (NAACCR Item# 779), detailed site-specific codes for anatomic EOD.

Coding Instructions:

- **For cases diagnosed on or after January 1, 2004, code this data item using the most current version of the Collaborative Stage Data Collection System. For all other cases leave this data item blank.**

- Refer to the Collaborative Stage Data Collection System Coding Instructions Part 1 – Section 1: General Instructions for general information on coding Regional Nodes Positive. http://cancerstaging.org/cstage/Pages/default.aspx

- See the most current version of the Collaborative Stage Data Collection System Coding Instructions at http://cancerstaging.org/cstage/Pages/default.aspx for rules and site-specific codes and coding structures.

- When there is a discrepancy in the definition of regional lymph nodes as described in the AJCC Cancer Staging Manual and the SEER Summary Staging Manual, use the definition in the AJCC Cancer Staging Manual.

REPORTING FACILITY

Alternate name	Item #	Length	Source of Standard	Column #
Facility Identification Number (CoC) Reporting Hospital Institution ID Number (CoC)	540	10	CoC	701-710

Description:

This data item records the Illinois State Cancer Registry specific code for the facility reporting the tumor.

RX DATE BRM

Alternate name	Item #	Length	Source of Standard	Column #
Date Immunotherapy Started (CoC) RX Date -- BRM	1240	8	CoC	1536-1543

Description

Date of initiation for immunotherapy (a.k.a. biological response modifier) that is part of the first course of treatment. See also Rx Summ—BRM (NAACCR Item #1410).

Coding Instructions:

- Record the first or earliest date on which immunotherapy or a biologic response modifier was administered by any facility. This date corresponds to administration of the agents coded in Rx Summ-BRM (NAACCR Item #1410). [1]

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

RX DATE BRM FLAG

Alternate name	Item #	Length	Source of Standard	Column #
RX Date – BRM Flag	1241	2	NAACCR	1544-1545

Description:

This flag explains why no appropriate value is in the field, Rx Date BRM (NAACCR Item #1240).

Coding Instructions:

- Leave this item blank if Rx Date BRM (NAACCR Item #1240) has a full or partial date recorded.[1]

- Code 10 if it is unknown whether any immunotherapy or a biologic response modifier was given.[1]

- Code 11 if no immunotherapy or biologic response modifier is planned or given.[1]

- Code 12 if the Rx Date BRM (NAACCR Item #1240) cannot be determined, but the patient did receive first course immunotherapy or a biologic response modifier.[1]

- Code 15 if immunotherapy or a biologic response modifier is planned, but not yet started.[1]

- When further information becomes available, cases coded 15 should be updated to the date immunotherapy or a biologic response modifier was given or be assigned a more definitive code. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

RX DATE CHEMO

Alternate name	Item #	Length	Source of Standard	Column #
Date Chemotherapy Started (CoC) RX Date -- Chemo	1220	8	CoC	1516-1523

Description:

Date of initiation of chemotherapy that is part of the first course of treatment. See also Rx Summ—Chemo (NAACCR Item #1390).

Coding Instructions:

- Record the first or earliest date on which chemotherapy was administered by any facility. This date corresponds to administration of the agents coded in Rx Summ—Chemo (NAACCR Item #1390). [1]

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

RX DATE CHEMO FLAG

Alternate name	Item #	Length	Source of Standard	Column #
RX Date -- Chemo Flag	1221	2	NAACCR	1524-1525

Description:

This flag explains why no appropriate value is in the field, Rx Date Chemo (NAACCR Item #1220).

Coding Instructions:

- Leave this item blank if Rx Date Chemo (NAACCR Item #1220) has a full or partial date recorded.[1]

- Code 10 if it is unknown whether any chemotherapy was given.[1]

- Code 11 if no chemotherapy is planned or given.[1]

- Code 12 if the Rx Date Chemo (NAACCR Item #1220) cannot be determined, but the patient did receive first course chemotherapy.[1]

- Code 15 if chemotherapy is planned, but not yet started.[1]

- When further information becomes available, cases coded 15 should be updated to the date chemotherapy was given or be assigned a more definitive code. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

RX DATE DX/STG PROC

Alternate name	Item #	Length	Source of Standard	Column #
Date of Non Cancer-Directed Surgery (CoC) Date of Diagnostic, Staging or Palliative Procedures (1996-2002) Date of Surgical Diagnostic and Staging Procedure (CoC) RX Date—DX/Stg/Pall Proc RX Date – DX/Stg Proc	1280	8	CoC	1556-1563

Description:

Records the date on which the surgical diagnostic and/or staging procedure was performed. See Rx Summ – Dx/Stg Proc (NAACCR Item #1350).

Coding Instructions:

- Record the date on which the surgical diagnostic and/or staging procedure described in Rx Summ – Dx/Stg Proc (NAACCR Item #1350) was performed at this or any facility.[1]

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

RX DATE DX/STG PROC FLAG

Alternate name	Item #	Length	Source of Standard	Column #
RX Date--Dx/Stg Proc Flag	1281	2	NAACCR	1564-1565

Description:

This flag explains why no appropriate value is in the field, Rx Date Dx/Stg Proc (NAACCR Item #1280).

Coding Instructions:

- Leave this item blank if Rx Date Dx/Stg Proc (NAACCR Item #1280) has a full or partial date recorded.[1]

- Code 10 if it is unknown whether a surgical diagnostic or staging procedure was performed.[1]

- Code 11 if no surgical diagnostic or staging procedure was performed.[1]

- Code 12 if the Rx Date Dx/Stg Proc (NAACCR Item #1280) cannot be determined, but a surgical diagnostic or staging procedure was performed for the patient.[1]

RX DATE HORMONE

Alternate name	Item #	Length	Source of Standard	Column #
Date Hormone Therapy Started (CoC) RX Date--Hormone	1230	8	CoC	1526-1533

Description:

Date of initiation for hormone therapy that is part of the first course of treatment. See also Rx Summ—Hormone (NAACCR Item #1400).

Coding Instructions:

- Record the first or earliest date on which hormone therapy was administered by any facility. This date corresponds to administration of the agents coded in Rx Summ – Hormone (NAACCR Item #1400).[1]

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

RX DATE HORMONE FLAG

Alternate name	Item #	Length	Source of Standard	Column #
RX Date--Hormone Flag	1231	2	NAACCR	1534-1535

Description:

This flag explains why no appropriate value is in the field, Rx Date Hormone (NAACCR Item #1230).

Coding Instructions:

- Leave this item blank if Rx Date Hormone (NAACCR Item #1230) has a full or partial date recorded.[1]

- Code 10 if it is unknown whether any hormone therapy was given.[1]

- Code 11 if no hormone therapy is planned or given.[1]

- Code 12 if the Rx Date Hormone (NAACCR Item #1230) cannot be determined, but the patient did receive first course hormone therapy.[1]

- Code 15 if hormone therapy is planned, but not yet started.[1]

- When further information becomes available, cases coded 15 should be updated to the date hormone therapy was given or be assigned a more definitive code. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

RX DATE MST DEFN SRG

Alternate name	Item #	Length	Source of Standard	Column #
Date of Most Definitive Surgical Resection of the Primary Site RX Date--Most Defin Surg	3170	8	CoC	1466-1473

Description:

Date of most definitive surgical resection of the primary site performed as part of the first course of treatment. Use Rx Date Mst Defn Srg Flag (NAACCR Item #3171) if there is no appropriate or known date for this item.

Coding Instructions: [1]

- **Code this data item for cases diagnosed on or after January 1, 2015. For all other cases leave this data item blank.**

- Record the date on which the surgery described by Rx Summ--Surg Prim Site (NAACCR Item#1290) was performed. [1]

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

RX DATE MST DEFN SRG FLAG

Alternate name	Item #	Length	Source of Standard	Column #
	3171	2	NAACCR	1474-1475

Description:

This flag explains why no appropriate value is in the field, RX Date Mst Defn Srg (NAACCR Item #3170).

Coding Instructions:[1]

- **Code this data item for cases diagnosed on or after January 1, 2015. For all other cases leave this data item blank.**

- Leave this item blank if Rx Date Mst Defn Surg (NAACCR Item #3170) has a full or partial date recorded.

- Code 10 if it is unknown whether any surgery was performed.

- Code 11 if no surgical procedure was performed.

- Code 12 if the Rx Date Mst Defn Surg cannot be determined, but the patient did receive first course surgery.

RX DATE OTHER

Alternate name	Item #	Length	Source of Standard	Column #
Date Other Treatment Started (CoC) RX Date--Other	1250	8	CoC	1546-1553

Description:

Date of initiation for other treatment that is part of the first course of treatment at any facility. See Rx Summ—Other (NAACCR Item #1420).

Coding Instructions:[1]

- Record date on which the care coded as Rx Summ—Other (NAACCR item # 1420) was initiated.

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

RX DATE OTHER FLAG

Alternate name	Item #	Length	Source of Standard	Column #
RX Date--Other Flag	1251	2	NAACCR	1554-1555

Description:

This flag explains why no appropriate value is in the field, Rx Date Other (NAACCR Item #1250).

Coding Instructions:

- Leave this item blank if Rx Date Other (NAACCR Item #1250) has a full or partial date recorded[1].

- Code 10 if it is unknown whether any other treatment was given (Rx Summ-Other [NAACCR Item #1420] is 9). [1]

- Code 11 if no other treatment is planned or given (Rx Summ-Other [NAACCR Item #1420] is 0, 7 or 8). [1]

- Code 12 if the Rx Date Other (NAACCR Item #1250) cannot be determined, but the patient did receive first course other treatment.[1]

- Code 15 if other therapy is planned as part of the first course of treatment, but had not been started at the time of the most recent follow-up.

- When further information becomes available, cases coded 15 should be updated to the date therapy reported in Rx Summ--Other (NAACCR Item # 1420) was given or be assigned a more definitive code. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information.**

RX DATE RADIATION

Alternate name	Item #	Length	Source of Standard	Column #
Date Radiation Started (CoC)	1210	8	CoC	1486-1493
RX Date--Radiation				

Description:

Records the date on which radiation therapy began at any facility that is part of the first course of treatment. Use Rx Date Radiation Flag [NAACCR Item #1211] if there is no appropriate or known date for this item.

Coding Instructions:

- Record the earliest date radiation therapy began at any facility.

- If the exact date radiation started is not available, recording an approximate date is preferred.

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

RX DATE RADIATION FLAG

Alternate name	Item #	Length	Source of Standard	Column #
RX Date--Radiation Flag	1211	2	NAACCR	1494-1495

Description:

This flag explains why no appropriate value is in the field, Rx Date Radiation (NAACCR Item #1210).

Coding Instructions:[1]

- Leave this item blank if Rx Date Radiation (NAACCR Item #1210) has a full or partial date recorded.

- Code 10 if it is unknown whether any radiation was given.

- Code 11 if no radiation is planned or given.

- Code 12 if the Rx Date Radiation (NAACCR Item #1210) cannot be determined, but the patient did receive first course radiation.

- Code 15 if radiation is planned, but has not yet started and the start date is not yet available.

- When further information becomes available, cases coded 15 should be updated to the date radiation therapy was given or be assigned a more definitive code. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

RX DATE SURGERY

Alternate name	Item #	Length	Source of Standard	Column #
Date of Cancer-Directed Surgery (CoC) Date of Surgery Date of First Surgical Procedure (CoC) RX Date--Surgery	1200	8	CoC	1456-1463

Description:

Date the first surgery of the type described under Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes was performed. See also Rx Summ--Surg Prim Site (NAACCR Item #1290), Rx Summ--Scope Reg LN Sur (NAACCR Item #1292), and Rx Summ Surg--Other Reg/Dis (NAACCR Item #1294).

Coding Instructions:

- Record the date of the first surgical procedure of the types coded as Rx Summ-Surg Prim Site (NAACCR Item #1290), Rx Summ-Scope Reg LN Surgery (NAACCR Item #1292) or Rx Summ-Surg Other Reg/Dis (NAACCR Item #1294) performed at this or any facility.[1]

- The date in this item may be the same as that in RX Date Mst Defn Srg (NAACCR Item #3170), if the patient received only one surgical procedure and it was a resection of the primary site.[1]

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

RX DATE SURGERY FLAG

Alternate name	Item #	Length	Source of Standard	Column #
RX Date--Surgery Flag	1201	2	NAACCR	1464-1465

Description:

This flag explains why no appropriate value is in the field, Rx Date Surgery (NAACCR Item #1200).

Coding Instructions:

- Leave this item blank if Rx Date Surgery (NAACCR Item #1200) has a full or partial date recorded.[1]

- Code 10 if it is unknown whether any surgery was performed.[1]

- Code 11 if no surgical procedure was performed.[1]

- Code 12 if the Rx Date Surgery (NAACCR Item #1200) cannot be determined, but the patient did receive first course surgery.[1]

RX DATE SYSTEMIC

Alternate name	Item #	Length	Source of Standard	Column #
Date Systemic Therapy Started RX Date--Systemic	3230	8	CoC	1506-1513

Description:

Date of initiation of systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormone agents, biological response modifiers (immunotherapy), bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy. Use Rx Date Systemic Flag (NAACCR Item#3231) if there is no appropriate or known date for this item.

Coding Instructions:

- Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes Rx Summ-Chemo (NAACCR Item #1390), Rx Summ-Hormone (NAACCR Item #1400), Rx Summ-BRM (NAACCR Item #1410), and Rx Summ-Transplnt/Endocr (NAACCR Item #3250) [1].

- For further instructions on coding date fields see Information on Date Format in Chapter 6 of this manual.

RX DATE SYSTEMIC FLAG

Alternate name	Item #	Length	Source of Standard	Column #
	3231	2	NAACCR	1514-1515

Description:

This flag explains why no appropriate value is in the field, Rx Date Systemic (NAACCR Item #3230).

Coding Instructions:[1]

- Leave this item blank if Rx Date Systemic (NAACCR Item #3230) has a full or partial date recorded.

- Code 10 if it is unknown whether any systemic therapy was given.

- Code 11 if no systemic therapy is planned or given.

- Code 12 if the Rx Date Systemic (NAACCR Item #3230) cannot be determined, but the patient did receive first course systemic therapy.

- Code 15 if systemic therapy is planned, but not yet started.

- When further information becomes available, cases coded 15 should be updated to the date systemic therapy was given or be assigned a more definitive code. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

RX SUMM--BRM

Alternate name	Item #	Length	Source of Standard	Column #
Biological Response Modifiers (pre-96 SEER) Immunotherapy (SEER/CoC)	1410	2	SEER/CoC	1589-1590

Description:

Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at all facilities or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Note: Prior to 2013, targeted therapies that invoke an immune response, such as Herceptin, had been coded as chemotherapy. Effective with cases diagnosed January 1, 2013, and forward these therapies are classified as biological response modifiers. Coding instructions for these changes have been added to the remarks field for the applicable drugs in the SEER*RX Interactive Antineoplastic Drug Database (http://seer.cancer.gov/tools/seerrx/).

Coding Instructions:

- For definition of first course treatment, refer to Chapter 6 of this manual.

- Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.[1]

- Code 00 if the treatment plan offered multiple options and the patient selected treatment that did not include immunotherapy or if the option of "no treatment" was accepted by the patient.[1]

- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.[1]

- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.[1]

- Code 88 if it is known that a physician recommended immunotherapy but no further documentation is available yet to confirm its administration.[1]

- Code 88 to indicate a referral was made to a medical oncologist about immunotherapy.[1]

- Cases coded 88 should be updated to a more definitive code when further information becomes available. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

- Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered; death certificate only.[1]

- **ISCR Note:** If there is no immunotherapy given at your facility and it is unknown if it was given elsewhere, ISCR prefers the use of code 00 for this data item.

- Refer to the SEER* Rx Interactive Antineoplastic Drugs Database (http://seer.cancer.gov/tools/seerrx) for a list of immunotherapeutic agents.[1]

Codes:[1]

00	None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended or administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to admission, etc.).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

RX SUMM--CHEMO

Alternate name	Item #	Length	Source of Standard	Column #
Chemotherapy (SEER/CoC)	1390	2	SEER/CoC	1585-1586

Description:

Codes for chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Includes treatment given at all facilities as part of the first course.

Note: Prior to 2013, targeted therapies that invoke an immune response, such as Herceptin, had been coded as chemotherapy. Effective with cases diagnosed January 1, 2013, and forward these therapies are classified as biological response modifiers. Coding instructions for these changes have been added to the remarks field for the applicable drugs in the SEER*RX Interactive Antineoplastic Drug Database (http://seer.cancer.gov/tools/seerrx/).

Coding Instructions:

- For definition of first course treatment, refer to Chapter 6 of this manual.

- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.[1]

- Code 00 if the treatment plan offered multiple options and the patient selected treatment that did not include chemotherapy or if the option of "no treatment" was accepted by the patient.[1]

- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.[1]

- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.[1]

- Code 88 if it is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration.[1]

- Code 88 to indicate referral was made to a medical oncologist.[1]

- Code 88 when the only information available is the insertion of a port-a-cath.

- Cases coded 88 should be updated to a more definitive code when further information becomes available. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.[1]

- Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.[1]

- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolities, natural products, or other miscellaneous) than original agent, the new regimen represents the state of subsequent therapy, and only the original agent or regimen is recorded as first course therapy.[1] Use SEER*Rx and compare the subcategory of each chemotherapy agent to determine whether or not they belong to the same group (subcategory).

- 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.**

- **ISCR Note:** If there is no chemotherapy given at your facility and it is unknown if it was given elsewhere, ISCR prefers the use of code 00 for this data item.

- Refer to the SEER* Rx Interactive Antineoplastic Drugs Database (http://seer.cancer.gov/tools/seerrx) for a list of chemotherapeutic agents.[1]

Codes:[1] (Continue next page)

00   None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.

01   Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.

02   Single-agent chemotherapy administered as first course therapy.

03   Multi-agent chemotherapy administered as first course therapy.

82   Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).

85   Chemotherapy was not administered because the patient died prior to planned or recommended therapy.

86   Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.

87   Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

88   Chemotherapy was recommended, but it is unknown if it was administered.

99   It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

RX SUMM--DX/STG PROC

Alternate name	Item #	Length	Source of Standard	Column #
RX Summ--DX/Stag/Pall Proc Surgical Diagnostic and Staging Procedure (1996-2002) Non Cancer-Directed Surgery (CoC)	1350	2	CoC	1577-1578

Description:

Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage disease. Some examples of exploratory surgery include but are not limited to: celiotomy; laparotomy; cystotomy; nephrotomy; gastrotomy; thoracotomy.

Coding Instructions:[1]

- For definition of first course treatment, refer to Chapter 6 of this manual.

- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is at your institution or another facility.

- Only record positive procedures. For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.

- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).

- If a lymph node is biopsied or removed to diagnose or stage lymphoma, and that node is NOT the only node involved with lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item Rx Summ--Surg Prim Site (NAACCR Item #1290) to code these procedures.

- Do not code surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease in this data item. Use the data item Rx Summ--Scope Reg LN Sur (NAACCR Item #1292) to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item Rx Date Dx/Stg Proc (NAACCR Item #1280). See instructions for Rx Summ--Scope Reg Ln Sur (NAACCR Item #1292).

- Code brushings, washings, aspiration of cells, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item Diagnostic Confirmation (NAACCR Item #490). These are not considered surgical procedures and should not be coded in this data item.

- Do not code excisional biopsy with clear or microscopic margins in this data item. Use the data item in Rx Summ--Surg Prim Site (NAACCR Item #1290) to code these procedures.

- If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery no tumor remains, DO NOT consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the Rx Summ--Dx/Stg Proc (NAACCR Item #1350) data item and the excisional biopsy or more extensive surgery in the Rx Summ--Surg Prim Site data item (NAACCR Item#1290).

- Do not code palliative surgical procedures in this data item.

- **ISCR Note:** If there is no surgical diagnostic/staging procedure performed at your facility and it is unknown if one was performed elsewhere, ISCR prefers the use of code 00 for this data item.

Codes:

00   No surgical diagnostic or staging procedure was performed.

01   A biopsy (incisional, needle, or aspiration) was done to a site other than the primary. No exploratory procedure was done.

02   A biopsy (incisional, needle, or aspiration) was done to the primary site.

03   A surgical exploration only. The patient was not biopsied or treated.

04   A surgical procedure with a bypass was performed, but no biopsy was done.

05   An exploratory procedure was performed, and a biopsy of either the primary site or another site was done. **ISCR NOTE:** Endoscopic exams are not exploratory procedures. Do not use this code for endoscopic biopsies.

06   A bypass procedure was performed, and a biopsy of either the primary site or another site was done.

07   A procedure was done, but the type of procedure is unknown.

09   No information of whether a diagnostic or staging procedure was performed.

RX SUMM--HORMONE

Alternate name	Item #	Length	Source of Standard	Column #
Hormone Therapy (SEER/CoC) Endocrine (Hormone/Steroid) Therapy (pre-96 SEER)	1400	2	SEER/CoC	1587-1588

Description:

Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Coding Instructions:[1]

- For definition of first course treatment, refer to Chapter 6 of this manual.

- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.

- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.

- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.

- Code 00 if the treatment plan offered multiple options and the patient selected treatment that did not include hormone therapy or if the option of "no treatment" was accepted by the patient.

- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.

- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

- Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.

- Code 88 to indicate the patient was referred to a medical oncologist.

- Cases coded 88 should be updated to a more definitive code when further information becomes available. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered; death certificate only.

- **ISCR Note:** If there is no hormone therapy given at your facility and it is unknown if it was given elsewhere, ISCR prefers the used of code 00 for this data item.

- Refer to the SEER*Rx Interactive Antineoplastic Drugs Database (http://seer.cancer.gov/tools/seerrx) for a list of hormonal agents.[1]

Codes:[1]

00   None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.

01   Hormone therapy administered as first course therapy.

82   Hormone therapy was not recommended or administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).

85   Hormone therapy was not administered because the patient died prior to planned or recommended therapy.

86   Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.

87   Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

88   Hormone therapy was recommended, but it is unknown if it was administered.

99   It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Coding Examples:

Example 1: Endometrial cancer may be treated with progesterone. Code all administration of progesterone to patients with endometrial cancer in this field. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer.

Example 2: **Follicular** and **papillary** cancers of the **thyroid** are often treated with thyroid hormone to suppress serum thyroid-stimulating hormone (TSH). If a patient with papillary and/or follicular cancer of the thyroid is given a thyroid hormone, code the treatment in this field.

Example 3: Bromocriptine suppresses the production of prolactin, which causes growth in pituitary adenoma. Code Bromocriptine as hormone treatment for pituitary adenoma.

Example 4: Lupron is a hormonal treatment for prostate cancer. Code as hormonal treatment when Lupron is given for prostate cancer.

RX SUMM--OTHER

Alternate name	Item #	Length	Source of Standard	Column #
Other Treatment (CoC) Other Cancer – Directed Therapy (SEER/pre-96 COC)	1420	1	SEER/CoC	1591-1591

Description:

Identifies other treatment given at all facilities that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

Coding Instructions:

- For definition of first course treatment, refer to Chapter 6 of this manual.

- The principal treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that "modifies, controls, removes, or destroys" proliferating cancer tissue. Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as Rx Summ - Other (NAACCR Item #1420), code 1 for certain hematopoietic diseases ONLY. Consult the most recent version of the Hematopoietic and Lymphoid Neoplasm Coding Manual for instructions for coding care of specific hematopoietic neoplasms in this item.[1]

- Code 0 if the treatment plan offered multiple options and the patient selected treatment that did not include other therapy or if the option of "no treatment" was accepted by the patient.

- Code 1 for embolization using alcohol as an embolizing agent.[1]

- Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.[1]

- Code 1 for PUVA (psoralen and long-wave ultraviolet radiation).[1]

- Code 1 for photophoresis. This treatment is used ONLY for thin melanoma or cutaneous T-cell lymphoma (mycosis fungoides).

- Assign code 2 for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy.

- 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.

- Assign code 6 for
  - Cancer treatment administered by nonmedical personnel
  - Unconventional methods whether they are the only therapy or are given in combination with conventional therapy
  - Alternative therapy ONLY if the patient receives no other type of treatment
  - Complementary medicine means it is used along with standard medicine, also called conventional medicine. Alternative medicine is used in place of standard treatments. Complementary and alternative medicine treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation.

- Do not code presurgical embolization given to shrink the tumor.

- Code 8 if it is known that a physician recommended treatment coded as Other Treatment, and no further documentation is available yet to confirm its administration.[1]

- Cases coded 8 should be updated to a more definitive code when further information becomes available. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

- **ISCR Note:** If there is no treatment that would be coded in this data item given at your facility and it is unknown if it was given elsewhere, ISCR prefers the used of code 0 for this data item.

Codes:[1]

0	None - All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
1	Other - Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases.
2	Other Experimental - This code is not defined. It may be used to record participation in institutional-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 treatment administered by nonmedical personnel.
7	Refusal - Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered - Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown - It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

RX SUMM--SCOPE REG LN SUR

Alternate name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery (SEER/CoC)	1292	1	SEER/CoC	1569-1569

Description:

Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities.

Coding Instructions:[1]

- For definition of first course treatment, refer to Chapter 6 of this manual.

- The scope of regional lymph node surgery is collected for each surgical event, even if surgery of the primary site was not performed.

- Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item Date 1st Crs Rx CoC (NAACCR Item #1270) and/or Rx Date Surgery (NAACCR Item #1200) if applicable.

- Codes 0-7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.

- If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the cumulative effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7. **Do not rely on registry software to determine the cumulative code.**

- For intracranial and central nervous system primaries (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9, C75.1–C75.3), code 9.

- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0-C77.9), code 9.

- For an unknown or ill-defined primary site (C76.0–C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), code 9.

- Do not code distant lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field Rx Summ-Surg Other Reg/Dis (NAACCR Item #1294).

- Refer to the current AJCC Cancer Staging Manual for site-specific identification of regional lymph nodes.

  Note: One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment with previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate

surgeries in which four or more regional lymph nodes are removed is desirable. However, it is very important to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 lymph nodes was not reflected in surgery codes. It is not intended to reflect clinical significance when applied to a particular surgical procedure. It is important to avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items.

ISCR Note: If there is no regional lymph node procedure performed at your facility and it is unknown if it was performed elsewhere, ISCR prefers the used of code 0 for this data item for cases that are not required to be coded 9.

Codes:[1]

The following instructions should be applied to all surgically treated cases for all types of cancers. The treatment of breast and skin cancer is where the distinction between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered. For all other sites, non-sentinel regional node dissections are typical, and codes 2, 6 and 7 are infrequently used.

(Continue on next several pages)

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50)
		Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node	Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), an axillary node dissection (ALND), or a combination of both SLNBx and ALND. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically

		dissection.	examined as the sole means of distinguishing between a SLNBx and ALND.
0	No regional lymph nodes removed or aspirated	No regional lymph node surgery	
1	Biopsy or aspiration of regional lymph node.	Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed. If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.
2	Sentinel lymph node biopsy	The operative report states that a SLN Bx was performed. Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination. When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes 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 (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.	If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND). Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed or 6 when ALND was

			performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items Regional Lymph Nodes Examined (NAACCR Item #830) and Regional Lymph Nodes Positive (NAACCR Item #820).
3	Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS.	The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure). Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7). Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only. Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes 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 was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate procedure (code 6 or 7). Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label	Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).
4	1 to 3 regional lymph nodes removed.		
5	4 or more regional lymph nodes removed.		

		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 node biopsy and code 3, 4, or 5 at same time or timing not noted	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. | Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However it is possible for these procedures to harvest fewer (or more) nodes.

If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed. |
| 7 | Sentinel node biopsy and code 3, 4, or 5 at different times | 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.

If relatively few nodes are pathologically examined, review the | Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes.

 If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a |

		operative report to confirm whether the procedure was limited to a SLNBx only	SLNBx plus an ALND was performed.
9	Unknown or not applicable	The status of regional lymph node evaluation should be known for surgically treated cases (i.e., cases coded 19-90 in the data item Surgery of Primary Site [NAACCR Item #1290]). Review surgically treated cases coded 9 in Scope of Regional Lymph Node Surgery to confirm the code.	

Examples:

Code	Reason
0	No effort was made to locate sentinel lymph nodes, and no nodes were found in pathologic analysis.
2	**(C50.1-Breast)** There was an attempt at sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.
1	**(C14.0-Pharynx)** Aspiration of regional lymph node to confirm histology of widely metastatic disease.
2	**(C44.5-Skin of Back)** Patient has melanoma of the back. A sentinel lymph node dissection was done with the removal of one lymph node. This node was negative for disease.
3	**(C61.9-Prostate)** Bilateral pelvic lymph node dissection for prostate cancer.
6	**(C50.3-Breast)** Sentinel lymph node biopsy (SLNBx) of right axilla, followed by right axillary lymph node dissection (ALND) during the same surgical event.
7	**(C50.4-Breast)** Sentinel lymph node biopsy (SLNBx) of left axilla, followed in a second procedure 5 days later by a left axillary lymph node dissection (ALND).
9	**(C34.9-Lung)** Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of lymph node surgery in patient record.

RX SUMM--SURG OTH REG/DIS

Alternate name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes (SEER/CoC) Surgical Procedure/Other Site	1294	1	SEER/CoC	1570-1570

Description:

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

Coding Instructions:

- For definition of first course treatment, refer to Chapter 6 of this manual.
- Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.[1]
- If other tissue or organs are removed during primary site surgery that are not specifically defined by the site specific Rx Summ-Surg Prim Site (NAACCR Item #1290) code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.[1]
- Assign the highest numbered code that describes the surgical resection of distant lymph node(s).[1]
- Do not code tissue or organs such as an appendix that were removed incidentally, and the organ was not involved with cancer.
  - o **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.
- If multiple first course surgical procedures coded in this item are performed for a single primary, the code should represent the cumulative effect of those surgeries. Do not rely on registry software to perform this task for you.[1]
- Rx Summ—Surg Oth Reg/Dis (NAACCR Item #1294) is collected for each surgical event even if surgery of the primary site was not performed.[1]
- Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992).[1]
- Assign code 1 when the **involved** contralateral breast is removed for a single breast primary.
- **ISCR Note:** When there is no non-primary surgical procedure performed at your facility and it is unknown if it was performed elsewhere, ISCR prefers the use of code 0 for this data item.

Codes:

0   None. Diagnosed at autopsy.

1   Non-primary surgical procedure performed.

2   Non-primary surgical procedure to other regional sites.

3   Non-primary surgical procedure to distant lymph node(s).

4   Non-primary surgical procedure to distant site.

5   Any combination of codes 2, 3, or 4.

9   Unknown. Death certificate only.

RX SUMM--SURG PRIM SITE

Alternate name	Item #	Length	Source of Standard	Column #
Surgery of Primary Site (SEER/CoC) Cancer-Directed Surgery (pre-96 CoC)	1290	2	SEER/CoC	1567-1568

Description:

Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment.

Coding Instructions:

- See Appendix D for site-specific codes.

- For definition of first course treatment, refer to Chapter 6 of this manual.

- 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. The codes in the range of 00-80 are listed in hierarchical but not necessarily numerical order. When more than one surgical procedure is performed, code the procedure listed furthest down the list within the codes 10-80.
  - **Example:** Patient has a needle biopsy of prostate that is positive for adenocarcinoma. The patient chooses to have a radical prostatectomy. The pathologic examination of the prostatectomy specimen shows no residual tumor. Code the radical prostatectomy.

- If registry software allows multiple procedures to be collected, this item refers to the most invasive surgical procedure for the primary site.[1]

- For codes 00 through 79, the codes are hierarchical. Last listed codes take precedence over codes listed above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is unavailable.[1]

- Code an excisional biopsy, even when documented as incisional, when: all disease is removed (margins free) OR all gross disease is removed and there is only microscopic residual at the margin.
  - **Note:** Do not code an excisional biopsy when there is macroscopic residual disease.

- If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery no tumor remains, DO NOT consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the Rx Summ--Dx/Stg Proc (NAACCR Item #1350) data item and the excisional biopsy or more extensive surgery in the Rx Summ--Surg Prim Site data item (NAACCR Item#1290).

- Code the removal of regional or distant tissue/organs when they are resected in continuity with the primary site (en bloc). Specimens from an en bloc resection may be submitted to pathology separately.

- o **Example:** Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.[1]

- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results. Do not rely on registry software to perform this task for you.[1]

- Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme (not lymph node scheme) for the primary site.

- Assign the surgery code(s) the best represent 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.

- Code **98** for the following sites unless the case is death certificate only:
    - Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease
        - Primary sites: C420, C421, C423, or C424 (all histologies)
        - Histologies: 9727, 9733, 9740-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992 (all sites)
    - Unknown or ill-defined sites (C760-C768, C809) (all histologies)

- **ISCR Note:** If there is no surgical procedure to the primary site performed at your facility and it is unknown if it was performed elsewhere ISCR prefers the use of code 00 for all cases that are not required to be coded 98.

Codes:[1] **(Continue next page)**

Code	Label	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10-19	Site-specific codes; tumor destruction	Tumor destructions, no pathologic specimen produced. Refer to Appendix D for the correct site-specific code for the procedure.
20-80	Site-specific codes; resection	Refer to Appendix D for the correct site-specific code for the procedure.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific codes; special	Special code. Refer to Appendix D for the correct site-specific code for the procedure.

| 99 | Unknown | Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only. |

RX SUMM--SURG/RAD SEQ

Alternate name	Item #	Length	Source of Standard	Column #
Radiation Sequence with Surgery (pre-96 SEER/CoC) Radiation/Surgery Sequence (CoC)	1380	1	SEER/CoC	1582-1582

Description:

Codes for the sequencing of radiation and surgery given as part of the first course of treatment. See also Rx Summ--Surg Prim Site (NAACCR Item#1290), Rx Summ--Scope LN Surg (NAACCR Item#1292), Rx Summ--Surg Oth Reg/Dis (NAACCR Item#1294), and Rx Summ--Radiation (NAACCR Item #1360).

Coding Instructions:[1]

- Surgical procedures include Rx Summ--Surg Prim Site (NAACCR Item #1290); Rx Summ--Scope Reg LN Sur (NAACCR Item #1292); Rx Summ--Surg Other Reg/Dis (NAACCR Item #1294). If all of these procedures are coded 0, or it is not known whether the patient received both surgery and radiation, then this item should be coded 0.

- If the patient received both radiation therapy and any one or a combination of the following surgical procedures: Rx Summ--Surg Prim Site (NAACCR Item #1290); Rx Summ--Scope Reg LN Sur (NAACCR Item #1292); Rx Summ--Surg Other Reg/Dis (NAACCR Item #1294), then code this item 2–9, as appropriate.

- If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

Codes:[1]

(Continue on next page)

Code	Label	Description
0	No radiation therapy and/or surgical procedures; unknown if surgery and/or radiation given	No radiation therapy given or unknown if radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s) or it is unknown whether any surgery given.
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).

3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	Radiation therapy both before and after surgery	At least two courses of radiation therapy are given before and at least two more after surgery to the primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before and/or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
7	Surgery both before and after radiation	Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown, but both surgery and radiation therapy 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.

RX SUMM--SYSTEMIC/SURG SEQ

Alternate name	Item #	Length	Source of Standard	Column #
Systemic/Surgery Sequence	1639	1	CoC	1616-1616

Description:

Records the sequencing of systemic therapy (Rx Summ-Chemo [NAACCR Item#1390], Rx Summ-Hormone [NAACCR Item#1400], Rx Summ-BRM [NAACCR Item#1410], and Rx Summ-Transplnt/Endocr [NAACCR Item#3250]) and surgical procedures given as part of the first course of treatment. See also Rx Summ--Surg Prim Site (NAACCR Item#1290), Rx Summ--Scope LN Surg (NAACCR Item#1292), and Rx Summ--Surg Oth Reg/Dis (NAACCR Item#1294).

Coding Instructions:[1]

- **Code this data item for all cases diagnosed on or after January 1, 2006. For all other cases leave this data item blank**

- Rx Summ – Systemic/Sur Seq (NAACCR Item #1639) is to be used for patients diagnosed on or after January 1, 2006.

- Code the administration of systemic therapy in sequence with the first surgery performed, described in the item Rx Date Surgery (NAACCR Item #1200).

- If none of the following surgical procedures was performed: Rx Summ—Surg Prim Site (NAACCR Item #1290), Rx Summ-Scope Reg LN Sur (NAACCR Item #1292), Rx Summ-Surg Other Reg/Dis (NAACCR Item #1294), then this item should be coded 0.

- If the patient received both systemic therapy and any one or a combination of the following surgical procedures: Rx Summ—Surg Prim Site (NAACCR Item #1290), Rx Summ-Scope Reg LN Sur (NAACCR Item #1292), or Rx Summ-Surg Other Reg/Dis (NAACCR Item #1294), then code this item 2–9, as appropriate.

- If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies. For example: the sequence, chemo then surgery then hormone therapy then surgery is coded 4 for "chemo then surgery then hormone".

Codes:[1]

Code:	Label:	Description:
0	No systemic therapy and/or surgical procedures	No systemic therapy was given; and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed. It is unknown whether both surgery and systemic treatment were provided.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	At least two courses of systemic therapy were given before and at least two more after a surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other systemic therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
7	Surgery both before and after systemic therapy	Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional sites(s), distant site(s), or distant lymph node(s).
9	Sequence unknown	Both surgery and systemic therapy were provided, but the sequence is unknown.

RX SUMM--TRANSPLNT/ENDOCR

Alternate name	Item #	Length	Source of Standard	Column #
Hematologic Transplant and Endocrine Procedures	3250	2	CoC	1583-1584

Description:

Identifies systemic therapeutic procedures administered as part of the first course of treatment at this and all other facilities. If none of these procedures were administered, then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

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.

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 (destroy) the bone marrow. These are not recorded as therapeutic agents.

Peripheral Blood Stem Cell Transplantation (PBSCT): Rescue that uses peripheral blood stem cells to replace stem cells after conditioning.

Rescue: Rescue is the actual BMT or PBSCT done after conditioning.

Stem cells: Immature cells found in bone marrow, blood stream, placenta, 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, PBSCT, 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

Coding Instructions:[1]

- For definition of first course treatment, refer to Chapter 6 of this manual.

- Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient, including haploidentical or half-matched transplants). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.

- Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.

- Endocrine irradiation and/or endocrine surgery are procedures which suppress the natural occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualify as endocrine surgery or endocrine radiation.

- Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer.

- Code 00 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include a transplant or endocrine procedure or if the option of "no treatment" was accepted by the patient.

- If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

- Code 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

- Code 88 if it known that a physician recommended a hematologic transplant or endocrine procedure, but no further documentation is available yet to confirm its administration.

- Code 88 to indicate referral to a specialist for hematologic transplant or endocrine procedures.

- Use code 88 if a bone marrow or stem cell harvest was undertaken, but was not followed by a rescue or reinfusion as part of first course treatment.

- Cases coded 88 should be updated to a more definitive code when further information becomes available. **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

- Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered; death certificate only.

- **ISCR Note:** If there is no transplant or endocrine procedure performed at your facility and it is unknown if one was performed elsewhere, ISCR prefers the used of code 00 for this data item.

Codes:[1]   **(Continue on next page)**

00   No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy.

10   A bone marrow transplant procedure was administered, but the type was not specified.

11   Bone marrow transplant - autologous.

12   Bone marrow transplant - allogeneic.

20   Stem cell harvest and infusion. Umbilical cord stem cell transplant with blood from one or multiple umbilical cords.

30   Endocrine surgery and/or endocrine radiation therapy.

40   Combination of endocrine surgery and/or radiation with a transplant procedure (Combination of codes 30 and 10, 11, 12, or 20).

82   Hematologic transplant and/or endocrine surgery/radiation were not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of disease prior to administration, etc).

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 were not administered as part of the first course of therapy. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.

87   Hematologic transplant and/or endocrine surgery/radiation 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 was recommended, but it is unknown if it was administered.

99   It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

RX SUMM--TREATMENT STATUS

Alternate name	Item #	Length	Source of Standard	Column #
	1285	1	SEER/CoC	1566-1566

Description:

This data item is a summary of the status for all treatment modalities. It is used in conjunction with Date 1st Crs Rx CoC (NAACCR Item #1270) and each modality of treatment with their respective date field to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date. Also indicates active surveillance (watchful waiting). This data item is effective for cases January 1, 2010+ diagnoses.

Coding Instructions:

- This item may be left blank for cases diagnosed prior to 2010. [1]

- Treatment given after a period of active surveillance is considered subsequent treatment and is not coded in this item. [1]

- Use code 0 when treatment is refused or the physician decides not to treat for any reason such as the presence of comorbidities. [1]

- Assign code 1 when the patient receives treatment collected in any of the following fields.

    RX SUMM-SURG PRIM SITE
    RX SUMM-SCOPE REG LN SUR
    RX SUMM-SURG OTH REG/DIS
    RAD-BOOST RX MODALITY
    RAD-REGIONAL RX MODALITY
    RX SUMM-CHEMO
    RX SUMM-HORMONE
    RX SUMM-BRM
    RX SUMM-TRANSPLNT/ENDOCR
    RX SUMM-OTHER

Codes:

0   No treatment given

1   Treatment given

2   Active surveillance (watchful waiting)

9   Unknown if treatment was given

Blank   Information not collected for this diagnosis date

RX TEXT--BRM

Alternate name	Item #	Length	Source of Standard	Column #
	2660	1000	NPCR	17765-18764

Description:

Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Date treatment began.
- Where treatment was given, e.g., at this facility; at another facility.
- Type of BRM agent, e.g., Interferon, BCG.
- BRM procedures, e.g., bone marrow transplant, stem cell transplant.
- Other treatment information, e.g., treatment cycle incomplete; unknown if BRM was given.

Data Item(s) to be verified/validated using the text entered in this field:

- Date of 1ˢᵗ Crs Rx--CoC
- Rx Date Systemic
- RX Summ--Transplnt/Endocr
- RX Summ--BRM
- RX Date--BRM
- RX Summ --Systemic/Sur Seq

RX TEXT--CHEMO

Alternate name	Item #	Length	Source of Standard	Column #
	2640	1000	NPCR	15765-16764

Description:

Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Date chemotherapy began.
- Where treatment was given e.g., at this facility, at another facility.
- Type of chemotherapy, e.g., name of agent(s) or protocol.
- Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given.

Data Item(s) to be verified/validated using the text entered in this field:

- Date of 1st Crs RX --CoC
- RX Summ—Chemo
- RX Summ—Transplnt/Endocr
- RX Date--Systemic
- RX Date--Chemo
- RX Summ--Systemic/Sur Seq

RX TEXT--HORMONE

Alternate name	Item #	Length	Source of Standard	Column #
	2650	1000	NPCR	16765-17764

Description:

Text area for information about hormonal treatment.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Date treatment was started.

- Where treatment was given, e.g., at this facility, at another facility.

- Type of hormone or antihormone, e.g., Tamoxifen.

- Type of endocrine surgery or radiation, e.g., orchiectomy.

- Other treatment information, e.g., treatment cycle incomplete, unknown if hormone was given.

Data Item(s) to be verified/validated using the text entered in this field:

- Date of 1st Crs RX --CoC

- RX Date--Hormone

- RX Date—Systemic

- RX Summ—Transplnt/Endocr

- RX Summ—Hormone

- RX Summ--Systemic/Sur Seq

RX TEXT--OTHER

Alternate name	Item #	Length	Source of Standard	Column #
	2670	1000	NPCR	18765-19764

Description:

Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Date treatment was started.

- Where treatment was given, e.g., at this facility, at another facility.

- Type of other treatment, e.g., blinded clinical trial, hyperthermia.

- Other treatment information, e.g., treatment cycle incomplete, unknown if other treatment is given.

Data Item(s) to be verified/validated using the text entered in this field:

- Date of 1st Crs RX --CoC

- RX Summ--Other

- RX Date--Other

RX TEXT--RADIATION (BEAM)

Alternate name	Item #	Length	Source of Standard	Column #
	2620	1000	NPCR	13765-14764

Description:

Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Date radiation treatment began.

- Where treatment was given, e.g., at this facility, at another facility.

- Type(s) of beam radiation, e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities.

- Other treatment information, e.g., patient discontinued after five treatments; unknown if radiation was given.

Data Item(s) to be verified/validated using the text entered in this field:

- Date of 1st Crs RX --CoC

- RX Summ--Radiation

- RX Summ--Surg/Rad Seq

- Reason For No Radiation

- RX Date Radiation

- Rad Regional Rx Modality

- Rad Boost RX Modality

RX TEXT--RADIATION OTHER

Alternate name	Item #	Length	Source of Standard	Column #
	2630	1000	NPCR	14765-15764

Description:

Text area for manual documentation of information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Date treatment was started.

- Where treatment was given, e.g., at this facility, at another facility.

- Type(s) of non-beam radiation, e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131).

- Other treatment information, e.g., unknown if radiation was given.

Data Item(s) to be verified/validated using the text entered in this field: (Continue next page)

- Date of 1st Crs RX --CoC

- RX Summ--Radiation

- RX Summ--Surg/Rad Seq

- Reason For No Radiation

- Rx Date Radiation

- Rad Regional Rx Modality

- Rad Boost RX Modality

RX TEXT--SURGERY

Alternate name	Item #	Length	Source of Standard	Column #
	2610	1000	NPCR	12765-13764

Description:

Text area for information describing all surgical procedures performed as part of treatment.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Date of each procedure.

- Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites.

- Lymph nodes removed.

- Regional tissues removed.

- Metastatic sites.

- Facility where each procedure was performed.

- Record positive and negative findings. Record positive findings first.

- Other treatment information, e.g., planned procedure aborted; unknown if surgery performed.

Data Item(s) to be verified/validated using the text entered in this field:

- Date of 1st Crs RX –CoC

- Rx Date Surgery

- RX Summ--Surg Prim Site

- RX Summ--Scope Reg LN Sur

- RX Summ--Surg Oth Reg/Dis

- Reason for No Surgery

- RX Summ --Surg/Rad Seq

- RX Summ--Systemic/Sur Seq

SEER SUMMARY STAGE 1977

Alternate name	Item #	Length	Source of Standard	Column #
General Summary Stage (SEER/COC)	760	1	SEER	905-905

Description:

Code for summary stage at the initial diagnosis or treatment of the reportable tumor. SEER Summary Stage 1977 is limited to information available within 2 months of the date of diagnosis. Tumors diagnosed before January 1, 2001, should be assigned a summary stage according to SEER Summary Staging Guide April 1977. Data must be entered manually for this data item.

Coding Instructions:

- **Code this data item for cases diagnosed prior to January 1, 2001. For all other case leave this field blank.**

- Refer to the SEER Summary Staging Guide (April 1977) for site specific coding instructions. http://seer.cancer.gov/tools/codingmanuals/historical.html

- Information used for determining the general summary stage is limited to all information available within **two months** of diagnosis with the exception for carcinoma of the prostate diagnosed 1995 and forward, the time limit for determining summary stage is extended to four months.

- Of stage codes 1, 2, and 3, the highest stage among multiple reporting facilities for a given primary of a given patient will be considered to be the stage at initial diagnosis when falling within the two month time frame. The best available information, whether pathologic, operative or clinical, is used in assigning a stage code. This may be the pathology report in cases in which a total resection is done, or it may be a combination of the operative, pathology, and radiology reports and other clinical studies. When no surgery is performed, radiologic and other diagnostic procedures are used in the determination of stage. Reports such as a liver or bone scan are often the sources of information on any metastatic involvement. If enough information is available to rule out or confirm, either, local, regional or distant disease spread in a non-surgically treated case, this information can be used to stage the tumor.

- Unknown primary cases and cases where the stage at initial diagnosis is unknown should be coded as 9 (unknown).

- The category "in situ" is used only when a histologic report confirms this limited involvement. Clinical evidence alone cannot justify a stage of in situ (0).

- When "micro-invasion" is described by the pathologist, the disease must be staged localized even though all other involvement is in situ.

- Leukemia, Multiple Myeloma, Reticuloendotheliosis and Letterer-Siwe disease will always be staged as distant/systemic (code 7).

- Cell washings (from paracentesis and thoracentesis) that are positive for malignant cells should be staged distant/systemic (code 7).

- Lymphomas coded to C77.0 - C77.9 should have a summary stage of 1, 5, 7, or 9.

Codes:

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

9   Unstaged

Blank   Information not collected for this diagnosis date

SEER SUMMARY STAGE 2000

Alternate name	Item #	Length	Source of Standard	Column #
	759	1	SEER	904-904

Description:

Code for summary stage at the initial diagnosis or treatment of the reportable tumor. Information used to code SEER Summary Stage 2000 is limited to all information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.

Coding Instructions:

- **Code this data item for cases diagnosed on or after January 1, 2001. For all other cases, leave this field blank.**

- Refer to the SEER Summary Staging Manual 2000 for site-specific coding instructions. http://seer.cancer.gov/tools/codingmanuals/historical.html

- Unknown primary cases and cases where the stage at initial diagnosis is unknown should be coded as 9 (unknown).

- The category "in situ" is used only when a histologic report confirms this limited involvement. Clinical evidence alone cannot justify a stage of in situ (0).

- When "micro-invasion" is described by the pathologist, the disease must be staged localized even though all other involvement is in situ.

- Leukemia, Multiple Myeloma, Reticuloendotheliosis and Letterer-Siwe disease will always be staged as distant/systemic (code 7).

- Cell washings (from paracentesis and thoracentesis) that are positive for malignant cells should be staged distant/systemic (code 7).

- Use code 8 for benign and borderline brain/CNS cases.

- Lymphomas coded to C77.0 - C77.9 should have a summary stage of 1, 5, 7, or 9.

Codes:

0   In situ

1   Localized

2   Regional, direction 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

Blank   Information not collected for this diagnosis date

SEQUENCE NUMBER--HOSP

Alternate name	Item #	Length	Source of Standard	Column #
Sequence Number (CoC)	560	2	CoC	740-741

Description:

Item indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient. Sequence Number 00 indicates that the person has only one malignant neoplasm in his lifetime (regardless of hospital registry reference date). Sequence Number 01 indicates the first of two or more malignant neoplasms, while 02 indicates the second of two or more malignant neoplasms, and so on. Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the hospital registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the hospital registry's reference date. Similarly, Sequence Number 60 indicates the patient has only one non-malignant neoplasm, and Sequence Number 61 represents the first of multiple non-malignant neoplasms.

Sequence numbers should be reassigned if the facility subsequently learns of an unaccessioned tumor that affects sequencing.

Timing Rule: If two or more malignant tumors are diagnosed at the same time, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. Likewise, if two or more non-malignant tumors are diagnosed at the same time, the lowest sequence number is assigned to the diagnosis with the worse prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Coding Instructions[1]:

- Codes 00–59 and 99 indicate neoplasms of malignant (in situ or invasive) behavior (Behavior Code ICD-0-3 [NAACCR Item#523] equals 2 or 3). Codes 60–88 indicate neoplasms of non-malignant behavior (Behavior Code ICD-0-3 [NAACCR Item#523] equals 0 or 1).

- Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent malignant or in situ primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.

- Code 60 only if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant primaries sequentially.

- If two or more malignant or in situ neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

- Any tumor in the patient's past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes non-reportable later.

- Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

Codes:[1]

Malignant or In Situ Primaries

00   One malignant or in situ primary only in the patient's lifetime

01   First of two or more independent malignant or in situ primaries

02   Second of two or more independent malignant or in situ primaries

…

…   Actual sequence of this malignant or in situ primary

…

59   Fifty-ninth of 59 or more independent malignant or in situ primaries

99   Unspecified number of malignant or in situ primaries

Non-Malignant Primaries

60   One non-malignant primary only in the patient's lifetime

61   First of two or more independent non-malignant primaries

62   Second of two or more non-malignant primaries

…

…   Actual sequence of this nonmalignant primary

…

87   Twenty-seventh of 27 or more independent non-malignant primaries

88   Unspecified number of independent non-malignant tumors (when a patient has multiple unspecified neoplasms in this category, code 88 should only be used once.)

SEX

Alternate name	Item #	Length	Source of Standard	Column #
	220	1	SEER/CoC	192-192

Description:

Code for the sex of the patient.

Coding Instructions:

- Assign code 3 for intersexed (persons with sex chromosome abnormalities) or hermaphrodite.

- Codes 5 and 6 may be used for cases diagnosed prior to 2015.

- Assign code 5 for transsexuals who are natally male or transsexuals with primary site of C600-C639.

- Assign code 6 for transsexuals who are natally female or transsexuals with primary site of C510-C589.

- Assign code 4 for transsexuals with unknown natal sex and primary site is not C510-C589 or C600-C639.

  - When the patient's gender is not known

  - Assign code 1 when the primary site is C600-C639.

  - Assign code 2 when the primary site is C510-C589.

  - Assign code 9 for primary sites not included above.

Codes:

1   Male

2   Female

3   Other (intersex, disorders of sexual development/DSD). The word hermaphrodite formerly classified under this code is an outdated term.

4   Transsexual, NOS

5   Transsexual, natal male

6   Transsexual, natal female

9   Not stated/Unknown

SOCIAL SECURITY NUMBER

Alternate name	Item #	Length	Source of Standard	Column #
	2320	9	CoC	3619-3627

Description:

Records patient's social security number. The number is entered without dashes and without any letter suffix. This is not always identical to the Medicare claim number.

Coding Instructions:

- Code the patient's Social Security number.[1]

- If a patient has multiple tumors, all records should contain the same social security number.

- Code 999999999 when the patient does not have a social security number, or the information is not available.[1]

- A patient's Medicare claim number may not always be identical to the person's Social Security Number.

- Code Social Security numbers that end with "B" or "D" as 999999999. The patient receives benefits under the spouse's number and this is the spouse's Social Security Number.[1]

- Blanks and zeros are not acceptable in this field.

Codes (in addition to valid social security number):

999999999   Unknown

SPANISH/HISPANIC ORIGIN

Alternate name	Item #	Length	Source of Standard	Column #
Spanish Origin--All Sources (96 CoC) Spanish Surname or Origin (SEER)	190	1	SEER/CoC	189-189

Description:

Code identifying persons of Spanish or Hispanic origin.

Coding Instructions:

- If the patient has multiple tumors, all records should have the same code.

- Use all information to determine the Spanish/Hispanic Origin including
    - The ethnicity stated in the medical record
    - Hispanic origin stated on the death certificate
    - Birthplace
    - Information about life history and/or language spoken
    - A last name or maiden name found on a list of Hispanic/Spanish surnames

- Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.

- Portuguese, Brazilians and Filipinos are not presumed to be Spanish or non-Spanish.
    - Assign code 7 when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list
    - Assign code 0 when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list.

- If the medical record does not say whether the patient is Hispanic, use the surname list provided in Appendix B to compare the name on the medical record to the names on the list. If the name appears on the list, mark the Hispanic origin as Spanish Surname Only (7).

- For all cases where Hispanic origin is not noted on the medical record and the name (last, married or maiden) does not appear on the surname list provided in Appendix B, code Hispanic origin as non-Spanish, non-Hispanic (0).

- **For female patients only**, if the medical record does not say whether the patient is Hispanic, use the surname list provided in Appendix B to compare the maiden name on the medical record to the names on the list. If the maiden name appears on the list, mark Hispanic origin as Spanish Surname Only (7).

- For female patients with no recorded maiden name, if the medical record does not say whether the patient is Hispanic, use the surname list provided in Appendix B to compare the married name on the medical record to the list. If the married name appears on the list, mark Hispanic origin as Spanish Surname Only (7).

Codes:

0   Non-Spanish; non-Hispanic

1   Mexican (includes Chicano)

2   Puerto Rican

3   Cuban

4   South or Central American (except Brazil)

5   Other specified Spanish-Hispanic origin (includes European; excludes Dominican Republic)

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

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

8   Dominican Republic (for use with patients diagnosed January 1, 2005 and later)

9   Unknown whether Spanish or not; not stated in patient's medical record

TELEPHONE

Alternate name	Item #	Length	Source of Standard	Column #
	2360	10	CoC	3868-3877

Description:

Current telephone number with area code for the patient. Number is entered without dashes.

Coding Instructions:

- Record area code and telephone number without dashes.

Codes (in addition to valid telephone number):

0000000000   Patient does not have a telephone

9999999999   Telephone number unavailable or unknown

TEXT--DX PROC--LAB TESTS

Alternate name	Item #	Length	Source of Standard	Column #
	2550	1000	NPCR	8565-9564

Description:

Text area for manual documentation of information from laboratory examinations other than cytology or histopathology.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Type of lab test/tissue specimen(s)

- Record both positive and negative findings. Record positive test results first.

- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.

- Date(s) of lab test(s)

- Where test was done, e.g., at this facility; at another facility.

- Tumor markers include, but are not limited to:

   o Breast Cancer - Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu.

   o Prostate Cancer - Prostatic Specific Antigen (PSA)

   o Testicular Cancer - Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

Data Item(s) to be verified/validated using the text entered in this field:

- Primary Site

- Grade

- Diagnostic Confirmation

- Collaborative Stage variables

- Date of Diagnosis

TEXT--DX PROC--OP

Alternate name	Item #	Length	Source of Standard	Column #
	2560	1000	NPCR	9565-10564

Description:

Text area for manual documentation of all surgical procedures that provide information for staging.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived

- Where procedure was performed, e.g., at this facility; at another facility.

- 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

Data Item(s) to be verified/validated using the text entered in this field:

- Date of Diagnosis

- RX Summ--Dx/Stg Proc

- Diagnostic Confirmation

- Primary Site

- RX Summ--Surg Prim Site

- Collaborative Stage variables

- SEER Summary Stage 1977

- SEER Summary Stage 2000

- Reason for No Surgery

TEXT--DX PROC--PATH

Alternate name	Item #	Length	Source of Standard	Column #
	2570	1000	NPCR	10565-11564

Description:

Text area for manual documentation of information from cytology and histopathology reports.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Date(s) of procedure(s)

- Where procedure was done, e.g., at this facility; at another facility

- Anatomic source of specimen

- Type of tissue specimen(s)

- Tumor type and grade (include all modifying adjectives, e.g., 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 if pathology report is a slide review or a second opinion from an outside source, e.g., AFIP, Mayo, etc.

- Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored.

Data Item(s) to be verified/validated using the text entered in this field:

- Date of Diagnosis

- Primary Site

- Laterality

- Histologic Type ICD-O-3

- Grade

- Collaborative Stage variables

- Diagnostic Confirmation

- Rx Summ--Surg Prim Site

- RX Summ--Scope Reg LN Sur

- Rx Summ--Surg Oth Reg/Dis

- SEER Summary Stage 2000

- SEER Summary Stage 1977

- Regional Nodes Positive

- Regional Nodes Examined

- RX Date--Surgery

- Reason for No Surgery

- RX Summ--Surg/Rad Seq

- RX Summ--Systemic/Sur Seq

TEXT--DX PROC--PE

Alternate name	Item #	Length	Source of Standard	Column #
	2520	1000	NPCR	5565-6564

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 documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

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

Data Item(s) to be verified/validated using the text entered in this field:

- Date of 1st Contact

- Date of Diagnosis

- Age at Diagnosis

- Race 1-5

- Spanish Hispanic Origin

- Sex

- Primary Site

- Laterality

- Histologic Type ICD-O-3

- Sequence Number--Hospital

- Collaborative Stage variables

- SEER Summary Stage 1977

- SEER Summary Stage 2000

TEXT--DX PROC--SCOPES

Alternate name	Item #	Length	Source of Standard	Column #
	2540	1000	NPCR	7565-8564

Description:

Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Date(s) of endoscopic exam(s)

- Where endoscopic exam was performed, e.g., at this facility; at another facility

- 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.

Data Item(s) to be verified/validated using the text entered in this field:

- Date of Diagnosis

- RX Summ--Dx/Stg Proc

- Diagnostic Confirmation

- Primary Site

- Laterality

- Histology ICD-O-3

- Collaborative Stage variables

- SEER Summary Stage 1977

- SEER Summary Stage 2000

TEXT--DX PROC--X-RAY/SCAN

Alternate name	Item #	Length	Source of Standard	Column #
	2530	1000	NPCR	6565-7564

Description:

Text area for manual documentation from all X-rays, scans, and/or other imaging examinations that provide information about staging.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Date(s) and type(s) of X-ray/Scan(s)

- Where X-ray/scan was performed, e.g., at this facility; at another facility

- 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

Data Item(s) to be verified/validated using the text entered in this field:

- Date of Diagnosis

- RXSumm--Dx/Stg Proc

- Primary Site

- Laterality

- Histology ICD-O-3

- Collaborative Stage variables

- SEER Summary Stage 1977

- SEER Summary Stage 2000

TEXT--HISTOLOGY TITLE

Alternate name	Item #	Length	Source of Standard	Column #
	2590	100	NPCR	11665-11764

Description:

Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Information on histologic type and behavior

- Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc.

Data Item(s) to be verified/validated using the text entered in this field:

- Histologic Type ICD-O-3

- Behavior Code ICD-O-3

- Grade

TEXT--PRIMARY SITE TITLE

Alternate name	Item #	Length	Source of Standard	Column #
	2580	100	NPCR	11565-11664

Description:

Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- State the specific location of the primary site, including subsite.

- Include available information on tumor laterality

Data Item(s) to be verified/validated using the text entered in this field:

- Primary Site

- Laterality

TEXT--REMARKS

Alternate name	Item #	Length	Source of Standard	Column #
	2680	1000	NPCR	19765-20764

Description:

Text area for information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data can also be placed here. Problematic coding issues can also be discussed in this section.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- [NAACCR-approved abbreviations](#) should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Smoking history

- Family and personal history of cancer

- Comorbidities

- Information on sequence numbers if a person was diagnosed with another out-of-state or before the registry's reference date

- Place of birth

- Justification of over-ride flags

- Information clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields as "unknown."

TEXT--STAGING

Alternate name	Item #	Length	Source of Standard	Column #
	2600	1000	NPCR	11765-12764

Description:

Additional text area for staging information not already entered in other Text fields.

Text documentation is an essential component of a complete electronic report 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 reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions:

- Prioritize entered information in the order of the fields listed below.

- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized.

- Do not repeat information from other text fields.

- 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.

- If information is missing from the record, state that it is missing.

- Do not include irrelevant information.

- Do not include information that the registry is not authorized to collect.

Suggestions for Text:

- Date(s) of procedure(s), including clinical procedures that 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

Data Item(s) to be verified/validated using the text entered in this field:

- Rx Date--DX/Stg Proc

- Collaborative Stage variables

- SEER Summary Stage 1977

- SEER Summary Stage 2000

- Regional Nodes Positive

- Regional Nodes Examined

- RX Summ--Surg Prim St

- Rx Summ--Scope Reg LN Sur

- Rx Summ--Surg Oth Reg/Dis

- Mult Tum Rpt as One Prim

- Laterality

TEXT--USUAL INDUSTRY

Alternate name	Item #	Length	Source of Standard	Column #
	320	100	NPCR	317-416

Description:

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

Coding Instructions:

- Refer to A Cancer Registrar's Guide to Collecting Industry and Occupation for detailed coding instructions. http://www.cdc.gov/niosh/docs/2011-173/

- Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components.

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

- As noted in the Text--Usual Occupation (NAACCR Item#310) section, in those situations where the usual occupation is not available or is unknown, the patient's current or most recent occupation is recorded, if available. 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 later documentation in the patient's record provides an industry that is more likely to be the usual industry than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

- There should be an entry for Text--Usual Industry if any occupation is recorded. If no information is available regarding the industry in which the reported occupation was carried out, record "unknown." If the patient was not a student or homemaker and had never worked, record "never worked" as the usual industry. This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TEXT--USUAL OCCUPATION

Alternate name	Item #	Length	Source of Standard	Column #
	310	100	NPCR	217-316

Description:

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

Coding Instructions:

- Refer to A Cancer Registrar's Guide to Collecting Industry and Occupation for detailed coding instructions. http://www.cdc.gov/niosh/docs/2011-173/

- Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do not record "retired." If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation.

- If later documentation in the patient's record provides an occupation that is more likely to be the usual occupation than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with occupation information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

- If the patient was a homemaker and also worked outside the home during most of his/her adult life, record the usual occupation outside the home; if the patient was a homemaker and did not work outside the home for most of his/her adult life, record "homemaker." If the patient was not a student or homemaker and had never worked, record "never worked" as the usual occupation.

- If no information is available, record "unknown."

- This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TNM CLIN DESCRIPTOR

Alternate name	Item #	Length	Source of Standard	Column #
Clinical Stage (Prefix/Suffix) Descriptor (CoC)	980	1	CoC	974-974

Description:

Identifies the AJCC clinical stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

Coding Instructions:[1]

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015. Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016. For all other cases leave this data item blank.**

- Record the clinical stage (prefix/suffix) descriptor as documented by the first treating physician or the managing physician in the medical record.

- If the managing physician has not recorded the descriptor, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.

- If the tumor is not staged according to the AJCC manual, leave this data item blank.

- Refer to the current AJCC Cancer Staging Manual for staging rules.

Codes:[1]

Code	Label	Description
0	None	There are no prefix or suffix descriptors that would be used for this case.
1	E-Extranodal, lymphomas only	A lymphoma case involving an extranodal site.
2	S-Spleen, lymphomas only	A lymphoma case involving the spleen.
3	M-Multiple primary tumors in a single site	This is one primary with multiple tumors in the primary site at the time of diagnosis.
5	E&S-Extranodal and spleen, lymphomas only	A lymphoma case with involvement of both an extranodal site and the spleen.
9	Unknown; not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

TNM CLIN M

Alternate name	Item #	Length	Source of Standard	Column #
Clinical M (CoC)	960	4	AJCC	966-969

Description:

Detailed site-specific codes for the clinical metastases (M) as defined by AJCC and recorded by the physician. See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. The AJCC Cancer Staging Manual provides general rules for the assignment of TNM stage as well as specific staging instructions based on primary site and histology.

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.

AJCC TNM staging is based on the evaluation of the T, N, and M components and the assignment of a stage grouping. The T element describes the size and extent of invasion of the primary tumor. The N component describes the presence or absence of tumor in regional lymph nodes. The M component describes the presence or absence of distant metastasis, including involvement of non-regional lymph nodes. Stage groups are used to describe the stage of disease, guide treatment, and predict outcome.

The staging basis is determined by the point of evaluation. Clinical staging is assigned after the staging workup is completed but before any definitive treatment has begun. The clinical staging basis is defined for each site in the AJCC Cancer Staging Manual. Rules applicable to one site do not necessarily apply to another. The clinical staging (or classification) timeframe includes information obtained from the time of diagnosis throughout the diagnostic workup and ends at the initiation of definitive treatment. Within the clinical staging timeframe, criteria include physical exam, imaging, endoscopies, and diagnostic biopsies. It is important to emphasize that the mere existence of a pathology report that includes microscopic assessment does not exclude it from the clinical staging criteria. If the assessment was a part of the diagnostic workup, it has occurred within the clinical timeframe and can be used for clinical staging.

Coding Instructions:

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015.**
  Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016.
  For all other cases leave this data item blank.

- Refer to the current AJCC Cancer Staging Manual for staging rules.[1]

- If a patient has multiple primaries, stage each primary independently.[1]

- Each component of the AJCC stage is important. Even if complete AJCC TNM information is not available in the record, any piece of staging information should be collected and reported. For example, if the T and N are available but no information is available on M, the T and N should be reported.

- Record clinical M as documented by the first treating physician or managing physician in the medical record.[1]

    - If the stage assigned by the physician is inconsistent with the documentation in the medical record, the registrar should assign the stage and record the registrar-assigned stage in the registry database. The registrar should verify the case information with the physician, as he or she may have additional information that would aid in the assignment of stage. However, it is outside the realm of the responsibility of the registrar to educate the physician.[1]

- If the managing physician has not recorded clinical M, registrars will code this item based on the best available information, not necessarily requiring additional contact with the physician.[1]

- If a site/histology combination is not defined in the AJCC Manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- For in situ tumors that are not staged according to the AJCC manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathologic T, N, and M as well as stage group. If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes and do not code 88.[1]

- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, the physician identifies which primary has metastasized, update the stage(s) as appropriate.[1] **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

- Beginning in 2016, new T, N, and M categories were implemented that include 'c' and 'p' designations to enable registrars to comply with AJCC clinical and pathologic stage/classification timeframe rules.[1]

Codes:[1]

Code	Definition	Code	Definition
(blank)	Not recorded	c1E	cM1e
c0	cM0	p1	pM1
c0I$^+$	cM0(i$^+$)	p1A	pM1a
c1	cM1	p1B	pM1b
c1A	cM1a	p1C	pM1c
c1B	cM1b	p1D	pM1d
c1C	cM1c	p1E	pM1e
c1D	cM1d	88	not applicable

TNM CLIN N

Alternate name	Item #	Length	Source of Standard	Column #
Clinical N (CoC)	950	4	AJCC	962-965

Description:

Detailed site-specific codes for the clinical nodes (N) as defined by AJCC and recorded by the physician. See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. The AJCC Cancer Staging Manual provides general rules for the assignment of TNM stage as well as specific staging instructions based on primary site and histology.

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.

AJCC TNM staging is based on the evaluation of the T, N, and M components and the assignment of a stage grouping. The T element describes the size and extent of invasion of the primary tumor. The N component describes the presence or absence of tumor in regional lymph nodes. The M component describes the presence or absence of distant metastasis, including involvement of non-regional lymph nodes. Stage groups are used to describe the stage of disease, guide treatment, and predict outcome.

The staging basis is determined by the point of evaluation. Clinical staging is assigned after the staging workup is completed but before any definitive treatment has begun. The clinical staging basis is defined for each site in the AJCC Cancer Staging Manual. Rules applicable to one site do not necessarily apply to another. The clinical staging (or classification) timeframe includes information obtained from the time of diagnosis throughout the diagnostic workup and ends at the initiation of definitive treatment. Within the clinical staging timeframe, criteria include physical exam, imaging, endoscopies, and diagnostic biopsies. It is important to emphasize that the mere existence of a pathology report that includes microscopic assessment does not exclude it from the clinical staging criteria. If the assessment was a part of the diagnostic workup, it has occurred within the clinical timeframe and can be used for clinical staging.

Coding Instructions:

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015. Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016. For all other cases leave this data item blank.**

- Refer to the current AJCC Cancer Staging Manual for staging rules.[1]

- Each component of the AJCC stage is important. Even if complete AJCC TNM information is not available in the record, any piece of staging information should be collected and reported. For example, if the T and N are available but no information is available on M, the T and N should be reported.

- If a patient has multiple primaries, stage each primary independently.[1]

- Record clinical N as documented by the first treating physician or the managing physician in the medical record.[1]

  - If the stage assigned by the physician is inconsistent with the documentation in the medical record, the registrar should assign the stage and record the registrar-assigned stage in the registry database. The registrar should verify the case information with the physician, as he or she may have additional information that would aid in the assignment of stage. However, it is outside the realm of the responsibility of the registrar to educate the physician.[1]

- If the managing physician has not recorded clinical N, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.[1]

- If a site/histology combination is not defined in the AJCC Manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- For in situ tumors that are not staged according to the AJCC manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathologic T, N, and M as well as stage group. If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes and do not code 88.[1]

- Beginning in 2016, new T, N, and M categories were implemented that include 'c' and 'p' designations to enable registrars to comply with AJCC clinical and pathologic stage/classification timeframe rules.[1]

Codes:[1]

Code	Definition
(blank)	Not recorded
cX	cNX
c0	cN0
c0A	cN0a
c0B	cN0b
c1	cN1
c1A	cN1a
c1B	cN1b
c1C	cN1c
c2	cN2

Code	Definition
c2A	cN2a
c2B	cN2b
c2C	cN2c
c3	cN3
c3A	cN3a
c3B	cN3b
c3C	cN3c
c4	cN4
88	Not applicable

TNM CLIN STAGE GROUP

Alternate name	Item #	Length	Source of Standard	Column #
Clinical Stage Group (CoC)	970	4	AJCC	970-973

Description:

Detailed site-specific codes for the clinical stage group as defined by AJCC and recorded by the physician. See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. The AJCC Cancer Staging Manual provides general rules for the assignment of TNM stage as well as specific staging instructions based on primary site and histology.

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.

AJCC TNM staging is based on the evaluation of the T, N, and M components and the assignment of a stage grouping. The T element describes the size and extent of invasion of the primary tumor. The N component describes the presence or absence of tumor in regional lymph nodes. The M component describes the presence or absence of distant metastasis, including involvement of non-regional lymph nodes. Stage groups are used to describe the stage of disease, guide treatment, and predict outcome.

The staging basis is determined by the point of evaluation. Clinical staging is assigned after the staging workup is completed but before any definitive treatment has begun. The clinical staging basis is defined for each site in the AJCC Cancer Staging Manual. Rules applicable to one site do not necessarily apply to another. The clinical staging (or classification) timeframe includes information obtained from the time of diagnosis throughout the diagnostic workup and ends at the initiation of definitive treatment. Within the clinical staging timeframe, criteria include physical exam, imaging, endoscopies, and diagnostic biopsies. It is important to emphasize that the mere existence of a pathology report that includes microscopic assessment does not exclude it from the clinical staging criteria. If the assessment was a part of the diagnostic workup, it has occurred within the clinical timeframe and can be used for clinical staging.

Coding Instructions:

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015.
  Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016.
  For all other cases leave this data item blank.**

- Refer to the current AJCC Cancer Staging Manual for staging rules.[1]

- Each component of the AJCC stage is important. Even if complete AJCC TNM information is not available in the record, any piece of staging information should be collected and reported. For example, if the T and N are available but no information is available on M, the T and N should be reported.

- If a patient has multiple primaries, stage each primary independently.[1]

- Convert all Roman numerals to Arabic numerals and use upper-case (capital) letters only.[1]

- If the value does not fill all 4 characters, then record the value to the left and leave the remaining spaces blank.[1]

- Record the clinical stage group as documented by the first treating physician or the managing physician in the medical record.[1]

  o If the stage assigned by the physician is inconsistent with the documentation in the medical record, the registrar should assign the stage and record the registrar-assigned stage in the registry database. The registrar should verify the case information with the physician, as he or she may have additional information that would aid in the assignment of stage. However, it is outside the realm of the responsibility of the registrar to educate the physician.[1]

- If the managing physician has not recorded the clinical stage, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.[1]

- If a site/histology combination is not defined in the AJCC Manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- For in situ tumors that are not staged according to the AJCC manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathologic T, N, and M as well as stage group. If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes and do not code 88.[1]

- To assign stage group when some, but not all, T, N and/or M components can be determined, interpret missing components as "X".[1]

- If a stage group cannot be determined from the recorded components, then record it as unknown[1], code 99.

- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, the physician identifies

which primary has metastasized, update the stage(s) as appropriate.[1] **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**. **Codes:[1]**

Codes:[1]

Code	Definition	Code	Definition	Code	Definition
0	Stage 0	1S	Stage IS	3C1	Stage IIIC1
0A	Stage 0A	2	Stage II	3C2	Stage IIIC2
0IS	Stage 0is	2A	Stage IIA	4	Stage IV
1	Stage I	2A1	Stage IIA1	4A	Stage IVA
1A	Stage IA	2A2	Stage IIA2	4A1	Stage IVA1
1A1	Stage IA1	2B	Stage IIB	4A2	Stage IVA2
1A2	Stage IA2	2C	Stage IIC	4B	Stage IVB
1B	Stage IB	3	Stage III	4C	Stage IVC
1B1	Stage IB1	3A	Stage IIIA	OC	Occult
1B2	Stage IB2	3B	Stage IIIB	88	Not applicable
1C	Stage IC	3C	Stage IIIC	99	Unknown

TNM CLIN STAGED BY

Alternate Name	Item #	Length	Source of Standard	Column #
Staged By (Clinical Stage) (CoC)	990	2	CoC	836-837

Description:

Identifies the person who recorded the clinical AJCC staging elements and the stage group in the patient's medical record.

Coding Instructions:[1]

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015. Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016. For all other cases leave this data item blank.**

- Record the role of the person who documented the clinical AJCC staging items and the Stage Group.

- If code 10-20 is used, then all of the staging elements (T, N, and M) and Stage Group must be assigned by the same person.

- If the tumor was not staged, or stage is unknown, use code 00.

- If the physician who assigned the stage cannot be identified as a surgeon, radiation oncologist, or medical oncologist, use code 10. Examples include: dentist, gynecologist, urologist.

- If it is clear from the treatment provided that the physician providing the stage information is a surgeon use code 11. Example: Urologist provides stage information from surgical resection of tumor – code as surgeon – 11.

- If a pathologist assigns T and/or N, and the registrar determines M and determines the stage group from other portions of the record use code 30.

- If staging was obtained from outside the facility, code the role of the person who staged it if known (codes 10-40); otherwise use code 50.

- If applicable, the Staging Elements (T, N, M) and the Stage Group must be recorded.
    - Exception: Lymphoma does not have TNM elements – only assigning Stage Group is applicable

- The staging source may be different for clinical vs. pathologic stage.

Codes:[1]

Code	Label	Definition
00	Not staged	Clinical staging was not assigned; no information was found in the medical record to assign clinical stage
10	Physician, NOS, or physician type not specified in codes 11-15	Clinical staging assigned by a physician not described under codes 11-15 (i.e. cancer committee chair, cancer liaison physician or registry physician advisor
11	Surgeon	Clinical staging assigned by the surgeon only.
12	Radiation Oncologist	Clinical staging assigned by the radiation oncologist only.
13	Medical Oncologist	Clinical staging assigned by the medical oncologist only.
14	Pathologist	Clinical staging assigned by the pathologist only.
15	Multiple Physicians; tumor board, etc.	Clinical staging assigned by multiple physicians such as during a tumor board meeting.
20	Cancer registrar	Clinical staging assigned by the cancer registrar only.
30	Cancer registrar and physician	Clinical staging assigned by the cancer registrar and any of the physicians specified in codes 10-15. This would include the cancer registrar assigning the stage and a physician approving it.
40	Nurse, physician assistant, or other non-physician medical staff	Clinical staging assigned by medical non-physician staff such as a nurse or physician assistant (PA).
50	Staging assigned at another facility	Clinical staging assigned at another facility, person's role unknown
60	Staging by Central Registry including consolidation of multiple sources	Clinical staging assigned by Central Registry personnel based on information from one facility or multiple facilities
88	Case is not eligible for staging	The site/histology combination is not defined in the AJCC Manual
99	Staged but unknown who assigned stage	A stage was found in the medical record but it is unknown who assigned it.

Examples: [1]

10	Initial staging is assigned by the Primary Care General Practitioner
15	During tumor conference after discussion among pathologist, radiologist and surgeon the facilitator announces the final TNM and stage group.
30	Only information on staging in medical record states, T1, nodes negative, registrar enters the listed T, N0 and adds the M and stage group in the abstract.
40	Nurse practitioner documents all staging elements.
40	Staging is entered into the medical record by a physician assistant (PA).
50	Patient transfers to your facility, there is a completed staging form in the chart copies received from the transferring facility, but the staging form is not signed.
60	Uploaded data to central registry from two facilities; there is no documentation listing staging just a comment saying the patient has a late stage cancer. The central registry enters the TNM and stage group based on the consolidated records from the two facilities.
88	A child is diagnosed with Neuroblastoma.

TNM CLIN T

Alternate name	Item #	Length	Source of Standard	Column #
Clinical T (CoC)	940	4	AJCC	958-961

Description:

Detailed site-specific codes for the clinical tumor (T) as defined by AJCC and recorded by the physician. See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. The AJCC Cancer Staging Manual provides general rules for the assignment of TNM stage as well as specific staging instructions based on primary site and histology.

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.

AJCC TNM staging is based on the evaluation of the T, N, and M components and the assignment of a stage grouping. The T element describes the size and extent of invasion of the primary tumor. The N component describes the presence or absence of tumor in regional lymph nodes. The M component describes the presence or absence of distant metastasis, including involvement of non-regional lymph nodes. Stage groups are used to describe the stage of disease, guide treatment, and predict outcome.

The staging basis is determined by the point of evaluation. Clinical staging is assigned after the staging workup is completed but before any definitive treatment has begun. The clinical staging basis is defined for each site in the AJCC Cancer Staging Manual. Rules applicable to one site do not necessarily apply to another. The clinical staging (or classification) timeframe includes information obtained from the time of diagnosis throughout the diagnostic workup and ends at the initiation of definitive treatment. Within the clinical staging timeframe, criteria include physical exam, imaging, endoscopies, and diagnostic biopsies. It is important to emphasize that the mere existence of a pathology report that includes microscopic assessment does not exclude it from the clinical staging criteria. If the assessment was a part of the diagnostic workup, it has occurred within the clinical timeframe and can be used for clinical staging.

Coding Instructions:

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015. Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016. For all other cases leave this data item blank.**

- Refer to the current AJCC Cancer Staging Manual for staging rules.[1]

- Each component of the AJCC stage is important. Even if complete AJCC TNM information is not available in the record, any piece of staging information should be collected and reported. For example, if the T and N are available but no information is available on M, the T and N should be reported.

- If a patient has multiple primaries, stage each primary independently.[1]

- Record clinical T as documented by the first treating physician or the managing physician in the medical record.[1]

  - If the stage assigned by the physician is inconsistent with the documentation in the medical record, the registrar should assign the stage and record the registrar-assigned stage in the registry database. The registrar should verify the case information with the physician, as he or she may have additional information that would aid in the assignment of stage. However, it is outside the realm of the responsibility of the registrar to educate the physician.[1]

- If the managing physician has not recorded clinical T, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.[1]

- If a site/histology combination is not defined in the AJCC Manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- For in situ tumors that are that are not staged according to the AJCC manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathologic T, N, and M as well as stage group. If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes and do not code 88.[1]

- For lung, occult carcinoma is coded cTX.[1]

- Beginning in 2016, new T, N, and M categories were implemented that include 'c' and 'p' designations to enable registrars to comply with AJCC clinical and pathologic stage/classification timeframe rules.[1]

Codes:[1]

Code	Definition	Code	Definition	Code	Definition
(blank)	Not recorded	c1B	cT1b	c3	cT3
cX	cTX	c1B1	cT1b1	c3A	cT3a
c0	cT0	c1B2	cT1b2	c3B	cT3b
pA	pTa	c1C	cT1c	c3C	cT3c
pIS	pTis	c1D	cT1d	c3D	cT3d
pISU	pTispu	c2	cT2	c4	cT4
pISD	pTispd	c2A	cT2a	c4A	cT4a
c1M1	cT1mi, cT1mic	c2A1	cT2a1	c4B	cT4b
c1	cT1	c2A2	cT2a2	c4C	cT4c
c1A	cT1a	c2B	cT2b	c4D	cT4d
c1A1	cT1a1	c2C	cT2c	c4E	cT4e
c1A2	cT1a2	c2D	cT2d	88	not applicable

TNM EDITION NUMBER

Alternate name	Item #	Length	Source of Standard	Column #
	1060	2	COC	938-939

Description:

A code that indicates the edition of the AJCC manual used to stage the case. This applies to the manually coded AJCC fields. It does not apply to the Derived AJCC T, N, M and AJCC Stage Group fields (NAACCR Item #s 2940, 2960, 2980, and 3000).

Coding Instructions:

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015.**
  Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016.
  For all other cases leave this data item blank.

Codes:

00   Not staged (cases that 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), recommended for use with cases diagnosed 1993 - 1997

05   Fifth Edition (published 1997), recommended for use for cases diagnosed 1998 - 2002

06   Sixth Edition (published 2002), recommended for use for cases diagnosed 2003 - 2009

07   Seventh Edition (published 2009), recommended for use with cased diagnosed 2010+

88   Not applicable (cases that do not have an AJCC staging scheme)

99   Edition unknown

TNM PATH DESCRIPTOR

Alternate name	Item #	Length	Source of Standard	Column #
Pathologic Stage (Prefix/Suffix) Descriptor (CoC)	920	1	CoC	956-956

Description:

Identified the AJCC pathologic stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

Coding Instructions:[1]

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015. Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016. For all other cases leave this data item blank.**

- Refer to the current AJCC Cancer Staging Manual for staging rules.

- Record the pathologic stage (prefix/suffix) descriptor as documented by the treating physician(s) or the managing physician in the medical record.

- If the managing physician has not recorded the descriptor, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician(s).

- If the tumor is not staged using AJCC rules, leave this data item blank.

Codes: [1] (Continue next page)

Code	Label	Definition
0	None	There are no prefix or suffix descriptors that would be used for this case.
1	E-Extranodal, lymphomas only	A lymphoma case involving an extranodal site.
2	S-Spleen, lymphomas only	A lymphoma case involving the spleen.
3	M-Multiple primary tumors in a single site	There is one primary with multiple tumors in the organ of origin **at the time of diagnosis.**
4	Y-Classification during or after initial multimodality therapy	Neoadjuvant treatment given before staging.

5	E&S-Extranodal and spleen, lymphomas only	A lymphoma case with involvement of both an extranodal site and the spleen.
6	M&Y-Multiple primary tumors and initial multimodality therapy	A case meeting the parameters of both codes 3 (multiple primary tumors in a single site) and 4 (classification during or after initial multimodality therapy).
9	Unknown; not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

TNM PATH M

Alternate name	Item #	Length	Source of Standard	Column #
Pathologic M (CoC)	900	4	AJCC	948-951

Description:

Detailed site-specific codes for the pathologic metastases (M) as defined by AJCC and recorded by the physician. See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. The AJCC Cancer Staging Manual provides general rules for the assignment of TNM stage as well as specific staging instructions based on primary site and histology.

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.

AJCC TNM staging is based on the evaluation of the T, N, and M components and the assignment of a stage grouping. The T element describes the size and extent of invasion of the primary tumor. The N component describes the presence or absence of tumor in regional lymph nodes. The M component describes the presence or absence of distant metastasis, including involvement of non-regional lymph nodes. Stage groups are used to describe the stage of disease, guide treatment, and predict outcome.

The staging basis is determined by the point of evaluation. Clinical staging is assigned after the staging workup is completed but before any definitive treatment has begun. The clinical staging basis is defined for each site in the AJCC Cancer Staging Manual. Rules applicable to one site do not necessarily apply to another. The pathologic staging/classification timeframe includes information obtained from the moment of diagnosis and throughout the diagnostic workup (i.e., all information from clinical classification), the operative findings and pathology report from the definitive surgery. Within the pathologic staging timeframe, criteria include all of the clinical staging criteria, operative findings from the surgeon, and the pathology report for the resected specimen. Observations from the surgeon in the operative findings that are not accompanied by a biopsy are included in the pathologic staging criteria (e.g., observation of extension without a tissue sample for pathologic review). Similarly, involvement found on imaging is considered in the pathologic staging criteria even in the absence of tissue biopsy.

Coding Instructions:

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015. Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016. For all other cases leave this data item blank.**

- Refer to the current AJCC Cancer Staging Manual for staging rules.[1]

- Each component of the AJCC stage is important. Even if complete AJCC TNM information is not available in the record, any piece of staging information should be collected and reported. For example, if the T and N are available but no information is available on M, the T and N should be reported.

- If a patient has multiple primaries, stage each primary independently.[1]

- Code pathologic M as documented by the first treating physician(s) or the managing physician in the medical record.[1]

  o If the stage assigned by the physician is inconsistent with the documentation in the medical record, the registrar should assign the stage and record the registrar-assigned stage in the registry database. The registrar should verify the case information with the physician, as he or she may have additional information that would aid in the assignment of stage. However, it is outside the realm of the responsibility of the registrar to educate the physician.[1]

- If the managing physician has not recorded pathologic M, registrars will code this item based on the best available information, not necessarily requiring additional contact with the physician.[1]

- If a site/histology combination is not defined in the AJCC Manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- For in situ tumors that are considered as "impossible diagnoses" in the AJCC manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathologic T, N, and M as well as stage group. If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes and do not code 88.[1]

- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, the physician identifies which primary has metastasized, update the stage(s) as appropriate.[1] **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

- Beginning in 2016, new T, N, and M categories were implemented that include 'c' and 'p' designations to enable registrars to comply with AJCC clinical and pathologic stage/classification timeframe rules.[1]

Codes:[1]

Code	Definition
(blank)	Not recorded
c0	cM0
c0I+	cM0(i+)
p1	pM1
p1A	pM1a
p1B	pM1b

Code	Definition
p1C	pM1c
p1D	pM1d
p1E	pM1e
c1	cM1
c1A	cM1a
c1B	cM1b

Code	Definition
c1C	cM1c
c1D	cM1d
c1E	cM1e
88	Not applicable

TNM PATH N

Alternate name	Item #	Length	Source of Standard	Column #
Pathologic N (CoC)	890	4	AJCC	944-947

Description:

Detailed site-specific codes for the pathologic nodes (N) as defined by AJCC and recorded by the physician. See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. The AJCC Cancer Staging Manual provides general rules for the assignment of TNM stage as well as specific staging instructions based on primary site and histology.

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.

AJCC TNM staging is based on the evaluation of the T, N, and M components and the assignment of a stage grouping. The T element describes the size and extent of invasion of the primary tumor. The N component describes the presence or absence of tumor in regional lymph nodes. The M component describes the presence or absence of distant metastasis, including involvement of non-regional lymph nodes. Stage groups are used to describe the stage of disease, guide treatment, and predict outcome.

The staging basis is determined by the point of evaluation. Clinical staging is assigned after the staging workup is completed but before any definitive treatment has begun. The clinical staging basis is defined for each site in the AJCC Cancer Staging Manual. Rules applicable to one site do not necessarily apply to another. The pathologic staging/classification timeframe includes information obtained from the moment of diagnosis and throughout the diagnostic workup (i.e., all information from clinical classification), the operative findings and pathology report from the definitive surgery. Within the pathologic staging timeframe, criteria include all of the clinical staging criteria, operative findings from the surgeon, and the pathology report for the resected specimen. Observations from the surgeon in the operative findings that are not accompanied by a biopsy are included in the pathologic staging criteria (e.g., observation of extension without a tissue sample for pathologic review). Similarly, involvement found on imaging is considered in the pathologic staging criteria even in the absence of tissue biopsy.

Coding Instructions:

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015. Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016. For all other cases leave this data item blank.**

- Refer to the current AJCC Cancer Staging Manual for staging rules.[1]

- Each component of the AJCC stage is important. Even if complete AJCC TNM information is not available in the record, any piece of staging information should be collected and reported. For example, if the T and N are available but no information is available on M, the T and N should be reported.

- If a patient has multiple primaries, stage each primary independently.[1]

- Code pathologic N as documented by the first treating physician(s) or the managing physician in the medical record.[1]

    o If the stage assigned by the physician is inconsistent with the documentation in the medical record, the registrar should assign the stage and record the registrar-assigned stage in the registry database. The registrar should verify the case information with the physician, as he or she may have additional information that would aid in the assignment of stage. However, it is outside the realm of the responsibility of the registrar to educate the physician.[1]

- If the managing physician has not recorded pathologic N, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.[1]

- If a site/histology combination is not defined in the AJCC Manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- For in situ tumors that are considered as "impossible diagnoses" in the AJCC manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathologic T, N, and M as well as stage group. If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes and do not code 88.[1]

- Use of the new category of cN0 for this data item is limited to in situ tumors only in 2016.[1]

- Beginning in 2016, new T, N, and M categories were implemented that include 'c' and 'p' designations to enable registrars to comply with AJCC clinical and pathologic stage/classification timeframe rules.[1]

Codes:[1]

Code	Definition	Code	Definition	Code	Definition
(blank)	Not recorded	p0A	pN0a	p2C	pN2c
pX	pNX	p0B	pN0b	p3	pN3
c0	cN0	p1	pN1	p3A	pN3a
p0	pN0	p1A	pN1a	p3B	pN3b
p0I-	pN0i-	p1B	pN1b	p3C	pN3c
p0I+	pN0i+	p1C	pN1c	p4	pN4
p0M-	pN0m-	p2	pN2	88	Not applicable
p0M+	pN0m+	p2A	pN2a		
p1MI	pN1mi	p2B	pN2b		

TNM PATH STAGE GROUP

Alternate name	Item #	Length	Source of Standard	Column #
Pathologic Stage Group (CoC)	910	4	AJCC	952-955

Description:

Detailed site-specific codes for the pathologic stage group as defined by AJCC and recorded by the physician. See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. The AJCC Cancer Staging Manual provides general rules for the assignment of TNM stage as well as specific staging instructions based on primary site and histology.

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.

AJCC TNM staging is based on the evaluation of the T, N, and M components and the assignment of a stage grouping. The T element describes the size and extent of invasion of the primary tumor. The N component describes the presence or absence of tumor in regional lymph nodes. The M component describes the presence or absence of distant metastasis, including involvement of non-regional lymph nodes. Stage groups are used to describe the stage of disease, guide treatment, and predict outcome.

The staging basis is determined by the point of evaluation. Clinical staging is assigned after the staging workup is completed but before any definitive treatment has begun. The clinical staging basis is defined for each site in the AJCC Cancer Staging Manual. Rules applicable to one site do not necessarily apply to another. The pathologic staging/classification timeframe includes information obtained from the moment of diagnosis and throughout the diagnostic workup (i.e., all information from clinical classification), the operative findings and pathology report from the definitive surgery. Within the pathologic staging timeframe, criteria include all of the clinical staging criteria, operative findings from the surgeon, and the pathology report for the resected specimen. Observations from the surgeon in the operative findings that are not accompanied by a biopsy are included in the pathologic staging criteria (e.g., observation of extension without a tissue sample for pathologic review). Similarly, involvement found on imaging is considered in the pathologic staging criteria even in the absence of tissue biopsy.

Coding Instructions:

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015. Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016. For all other cases leave this data item blank.**

- Refer to the current AJCC Cancer Staging Manual for staging rules.[1]

- Each component of the AJCC stage is important. Even if complete AJCC TNM information is not available in the record, any piece of staging information should be collected and reported. For example, if the T and N are available but no information is available on M, the T and N should be reported.

- If a patient has multiple primaries, stage each primary independently.[1]

- If the value does not fill all 4 characters, then record the value to the left and leave the remaining spaces blank.[1]

- Convert all Roman numerals to Arabic numerals and use upper-case (capital) letters only.[1]

- Record the pathologic stage group as documented by the first treating physician(s) or the managing physician in the medical record.[1]

  - If the stage assigned by the physician is inconsistent with the documentation in the medical record, the registrar should assign the stage and record the registrar-assigned stage in the registry database. The registrar should verify the case information with the physician, as he or she may have additional information that would aid in the assignment of stage. However, it is outside the realm of the responsibility of the registrar to educate the physician.[1]

- If the managing physician has not recorded pathologic stage, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician(s).[1]

- If a site/histology combination is not defined in the AJCC Manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- For in situ tumors that are not staged according to the AJCC manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathologic T, N, and M as well as stage group. If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes and do not code 88.[1]

- To assign stage group when some, but not all, T, N and/or M components can be determined, interpret missing components as "X".[1]

- If pathologic M (NAACCR Item# 900) is coded either X or blank and clinical M (NAACCR Item #960) is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging data items pT, pN, and cM (NAACCR Item#880, 890, 960) may be used to complete the pathologic stage group.

- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is

unable to condude which primary has metastasized. If, at a later time, the physician identifies which primary has metastasized, update the stage(s) as appropriate.[1] **Use the ISCR electronic change/delete form at www.idphnet.illinois.gov to submit the updated information**.

- If a stage group cannot be determined from the recorded components, then record it as unknown[1], code 99.

Codes:[1]

Code	Definition	Code	Definition	Code	Definition
0	Stage 0	1S	Stage IS	3C1	Stage IIIC1
0A	Stage 0A	2	Stage II	3C2	Stage IIIC2
0IS	Stage 0is	2A	Stage IIA	4	Stage IV
1	Stage I	2A1	Stage IIA1	4A	Stage IVA
1A	Stage IA	2A2	Stage IIA2	4A1	Stage IVA1
1A1	Stage IA1	2B	Stage IIB	4A2	Stage IVA2
1A2	Stage IA2	2C	Stage IIC	4B	Stage IVB
1B	Stage IB	3	Stage III	4C	Stage IVC
1B1	Stage IB1	3A	Stage IIIA	OC	Occult
1B2	Stage IB2	3B	Stage IIIB	88	Not applicable
1C	Stage IC	3C	Stage IIIC	99	Unknown

TNM PATH STAGED BY

Alternate Name	Item #	Length	Source of Standard	Column #
Staged By (Pathologic Stage) (CoC)	930	2	CoC	834-835

Description:

Identifies the person who recorded the pathologic AJCC staging elements and the stage group in the patient's medical record.

Coding Instructions:[1]

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015. Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016. For all other cases leave this data item blank.**

- Record the role of the person who documented the clinical AJCC stage items and the Stage Group.

- If the case does not meet the criteria for pathologic staging, the tumor was not staged, or stage is unknown, use code 00.

- If code 10-20 is used, then all of the staging elements (T, N, and M) and Stage Group must be assigned by the same person.

- If the physician who assigned the stage cannot be identified as a surgeon, radiation, oncologist, or medical oncologist, use code 10. Examples include: dentist, gynecologist, urologist.

- If it is clear from the treatment provided that the physician providing the stage information is a surgeon use code 11. Example: Urologist provides stage information from surgical resection of tumor – code as surgeon – 11.

- If a pathologist assigns T and/or N, and the registrar determines M and determines the stage group from other portions of the record use code 30.

- If staging was obtained from outside the facility, code the role of the person who stage it if known (codes 10-40); otherwise use code 50.

- If applicable, the Staging Elements (T, N, M) and the Stage Group must be recorded.
  - Exception: Lymphoma does not have TNM elements – only assigning Stage Group is applicable

- The staging source may be different for clinical vs. pathologic stage.

Codes:[1]

Code	Label	Definition
00	Not staged	Clinical staging was not assigned; no information was found in the medical record to assign clinical stage
10	Physician, NOS, or physician type not specified in codes 11-15	Clinical staging assigned by a physician not described under codes 11-15 (i.e. cancer committee chair, cancer liaison physician or registry physician advisor
11	Surgeon	Clinical staging assigned by the surgeon only.
12	Radiation Oncologist	Clinical staging assigned by the radiation oncologist only.
13	Medical Oncologist	Clinical staging assigned by the medical oncologist only.
14	Pathologist	Clinical staging assigned by the pathologist only.
15	Multiple Physicians; tumor board, etc.	Clinical staging assigned by multiple physicians such as during a tumor board meeting.
20	Cancer registrar	Clinical staging assigned by the cancer registrar only.
30	Cancer registrar and physician	Clinical staging assigned by the cancer registrar and any of the physicians specified in codes 10-15. This would include the cancer registrar assigning the stage and a physician approving it.
40	Nurse, physician assistant, or other non-physician medical staff	Clinical staging assigned by medical non-physician staff such as a nurse or physician assistant (PA).
50	Staging assigned at another facility	Clinical staging assigned at another facility, person's role unknown
60	Staging by Central Registry including consolidation of multiple sources	Clinical staging assigned by Central Registry personnel based on information from one facility or multiple facilities
88	Case is not eligible for staging	The site/histology combination is not defined in the AJCC Manual
99	Staged but unknown who assigned stage	A stage was found in the medical record but it is unknown who assigned it.

TNM PATH T

Alternate name	Item #	Length	Source of Standard	Column #
Pathologic T (CoC)	880	4	AJCC	940-943

Description:

Detailed site-specific codes for the pathologic tumor (T) as defined by AJCC and recorded by the physician. See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. The AJCC Cancer Staging Manual provides general rules for the assignment of TNM stage as well as specific staging instructions based on primary site and histology.

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.

AJCC TNM staging is based on the evaluation of the T, N, and M components and the assignment of a stage grouping. The T element describes the size and extent of invasion of the primary tumor. The N component describes the presence or absence of tumor in regional lymph nodes. The M component describes the presence or absence of distant metastasis, including involvement of non-regional lymph nodes. Stage groups are used to describe the stage of disease, guide treatment, and predict outcome.

The staging basis is determined by the point of evaluation. Clinical staging is assigned after the staging workup is completed but before any definitive treatment has begun. The clinical staging basis is defined for each site in the AJCC Cancer Staging Manual. Rules applicable to one site do not necessarily apply to another. The pathologic staging/classification timeframe includes information obtained from the moment of diagnosis and throughout the diagnostic workup (i.e., all information from clinical classification), the operative findings and pathology report from the definitive surgery. Within the pathologic staging timeframe, criteria include all of the clinical staging criteria, operative findings from the surgeon, and the pathology report for the resected specimen. Observations from the surgeon in the operative findings that are not accompanied by a biopsy are included in the pathologic staging criteria (e.g., observation of extension without a tissue sample for pathologic review). Similarly, involvement found on imaging is considered in the pathologic staging criteria even in the absence of tissue biopsy.

Coding Instructions:

- **CoC facilities must code this data item for cases diagnosed on or after January 1, 2015.**
  Non-CoC facilities must code this data item for all cases diagnosed on or after January 1, 2016.
  For all other cases leave this data item blank

- Refer to the current AJCC Cancer Staging Manual for staging rules.[1]

- Each component of the AJCC stage is important. Even if complete AJCC TNM information is not available in the record, any piece of staging information should be collected and reported. For example, if the T and N are available but no information is available on M, the T and N should be reported.

- Code pathologic T as documented by the first treating physician(s) or the managing physician in the medical record.[1]

  o If the stage assigned by the physician is inconsistent with the documentation in the medical record, the registrar should assign the stage and record the registrar-assigned stage in the registry database. The registrar should verify the case information with the physician, as he or she may have additional information that would aid in the assignment of stage. However, it is outside the realm of the responsibility of the registrar to educate the physician.[1]

- If the managing physician has not recorded pathologic T, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.[1]

- If a site/histology combination is not defined in the AJCC Manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- For in situ tumors that are not staged according to the AJCC manual code 88 for clinical and pathologic T, N, and M as well as stage group.[1]

- Truncate the least significant subdivision of the category from the right as needed.[1]

- For lung, occult carcinoma is coded cTX.[1]

- If a patient has multiple primaries, stage each primary independently.[1]

- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathologic T, N, and M as well as stage group. If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes and do not code 88.[1]

- Beginning in 2016, new T, N, and M categories were implemented that include 'c' and 'p' designations to enable registrars to comply with AJCC clinical and pathologic stage/classification timeframe rules.[1]

Codes:[1]

Code	Definition	Code	Definition	Code	Definition
(blank)	Not recorded	p1B	pT1b	p3	pT3
pX	pTX	p1B1	pT1b1	p3A	pT3a
p0	pT0	p1B2	pT1b2	p3B	pT3b
pA	pTa	p1C	pT1c	p3C	pT3c
pIS	pTis	p1D	pT1d	p3D	pT3d
pISU	pTispu	p2	pT2	p4	pT4
pISD	pTispd	p2A	pT2a	p4A	pT4a
p1M1	pT1mi, pT1mic	p2A1	pT2a1	p4B	pT4b
p1	pT1	p2A2	pT2a2	p4C	pT4c
p1A	pT1a	p2B	pT2b	p4D	pT4d
p1A1	pT1a1	p2C	pT2c	p4E	pT4e
p1A2	pT1a2	p2D	pT2d	88	not applicable

TUMOR SIZE SUMMARY

Alternate Name	Item #	Length	Source of Standard	Column #
	756	3	NPCR/CoC	850-852

Description:

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

Coding Instructions:[1]

Code this data item for cases diagnosed on or after January 1, 2016. For all other cases, leave this field blank.

NOTE: All measurements should be in millimeters (mm).

Record size in specified order:

1. Size measured on the surgical resection specimen, when **surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.**

    a. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report checklist). If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.

    Example: Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).

    Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).

2. If neoadjuvant therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.

    Example: Patient has a 2.2 cm mass in the oropharynx; 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 largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment (See Coding Rules below).

4. If 1, 2, and 3 do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Coding Rules:

ISCR NOTE: Record the tumor size to the nearest whole millimeter.

- Tumor size is the **diameter** of the tumor, **not the depth or thickness** of the tumor.

- **Recording less than/greater than Tumor Size:**

  o If tumor size is reported as less than X mm or less than X cm, the reported tumor size should be 1mm less; for example if size is <10mm, code size as 009. Often these are given in cm such as, < 1cm which is coded as 009, <2cm 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 1mm, use code 001.

  o If tumor size is reported as more than X mm or more than X cm, code size as 1mm more; for example if size is >10 mm, size should be coded as 011. Often these are given in cm such as >1cm, which is coded as 011, >2 cm is coded as 021, >3cm is coded as 031, >4cm is coded as 041, >5cm is coded as 051. If described as anything greater than 989 mm (98.9 cm) code as 989.

  o 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).

- **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 the 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).

  Examples:

  - Breast cancer described as 6.5 millimeters in size. Round up Tumor Size as 007.
  - Cancer in a polyp described as 2.3 millimeters in size. Round down Tumor Size as 002.
  - Focus of cancer described as 1.4 mm in size. Round down as 001.
  - 5.2mm breast cancer. Round down to 5mm and code as 005.

- **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.

- **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.

- **Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis.** However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

- **Record the size of the invasive component, if given.**

  o 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).

  o If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.
    - Example: A breast tumor with infiltrating duct carcinoma with extensive in situ component: total size 2.3 cm. Record tumor size as 023 (23 mm).
    - Example: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).

- **Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.**
  o Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).

- **Record the size as stated for purely in situ lesions.**

- **Disregard microscopic residual or positive surgical margins when coding tumor size.** Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data item.

- **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

- **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.

- **Tumor size code 999 is used when size is unknown or not applicable.** Sites/morphologies where the tumor size is not applicable are listed here.
  - Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: histology codes 9590-9992
  - Kaposi Sarcoma
  - Melanoma Choroid
  - Melanoma Ciliary Body
  - Melanoma Iris

- **Document the information to support coded tumor size in the appropriate text data item of the abstract.**

Codes:

000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2mm-988mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	SITE-SPECIFIC CODES Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9) **If no size is documented:** Circumferential: Esophagus (C15.0-C15.5, C15.8-C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9) Diffuse: Breast (C50.0-C50.6, C50.8-C50.9)
999	Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable

TYPE OF REPORTING SOURCE

Alternate name	Item #	Length	Source of Standard	Column #
	500	1	SEER	563-563

Description:

This variable codes the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original case finding (for example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician's office, code this item 4).

Coding Instructions:

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

- When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source 1, 2, 8, 4, 3, 5, 6, 7.
  - **Note:** Beginning with cases diagnosed 1/1/2006, the definitions for this field have been expanded. Codes 2 and 8 were added to identify outpatient sources that were previously grouped under code 1. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

- Nursing/Convalescent Home/Hospice, is used when the patient is diagnosed in a long-term care facility.

- Autopsy only (6) means the cancer was not diagnosed, even as a clinical diagnosis, while the patient was alive.

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 a 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 of such facilities:** HMOs or other health plan 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 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:** If the facility cannot perform surgical procedures under general anesthesia, code as physician's office.

Codes:

(Continue on next page)

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 freestanding laboratory, surgery, radiation or oncology clinic Includes outpatient services of HMOs and large multi-specialty physician group practices with unified records	1

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 a 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 (For ISCR use only.)	Death certificate 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, 5 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

VITAL STATUS

Alternate name	Item #	Length	Source of Standard	Column #
	1760	1	SEER/CoC	2126-2126

Description:

Vital status of the patient as of the date entered in Date of Last Contact (NAACCR Item #1750).

Coding Instructions:

- If a patient has multiple primary tumors, vital status should be the same for all tumors.

Codes:

0   Dead

1   Alive

REFERENCES

1. FORDS Facility Oncology Registry Data Standards, Revised for 2016 (American College of Surgeons, Chicago, IL, 2016).   Available from
    : http://www.facs.org/cancer/coc/fordsmanual.html

2. FORDS Facility Oncology Registry Data Standards, Revised for 2010 (American College of Surgeons, Chicago, IL, 2002).   Available from
    : https://www.facs.org/~/media/files/quality%20programs/cancer/coc/fords/fords_for_2010d_05012010.ashx

APPENDIX A: COUNTRY AND STATE CODES

Table of Contents

Appendix B: Country and State Codes

Appendix B1
Alphabetic Code List by Country/State

Name of Country/State	ISO Country Code	USPS State Code
Afghanistan	AFG	XX
Africa, NOS[1]	ZZF	YY
Alabama	USA	AL
Aland Islands	ALA	XX
Alaska	USA	AK
Albania	ALB	XX
Alberta	CAN	AB
Algeria	DZA	XX
American Samoa	ASM	AS
Andorra	AND	XX
Angola	AGO	XX
Anguilla	AIA	XX
Antarctica	ATA	XX
Antigua and Barbuda	ATG	XX
Argentina	ARG	XX
Arizona	USA	AZ
Arkansas	USA	AR
Armed Forces Americas	USA	AA
Armed Forces Canada, Europe, Middle East, Africa	USA	AE
Armed Forces Pacific	USA	AP
Armenia	ARM	XX
Aruba	ABW	XX
Asia, NOS[1]	ZZA	YY
Australia	AUS	XX
Austria	AUT	XX
Azerbaijan	AZE	XX
Bahamas	BHS	XX
Bahrain	BHR	XX
Bangladesh	BGD	XX
Barbados	BRB	XX
Belarus	BLR	XX
Belgium	BEL	XX
Belize	BLZ	XX
Benin	BEN	XX
Bermuda	BMU	XX
Bhutan	BTN	XX
Bolivia	BOL	XX
Bonaire, Saint Eustatius and Saba	BES	XX
Bosnia and Herzogovina	BIH	XX
Botswana	BWA	XX
Bouvet Island	BVT	XX
Brazil	BRA	XX
British Columbia	CAN	BC
British Indian Ocean Territory	IOT	XX

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
British Virgin Islands	VGB	XX
Brunei	BRN	XX
Bulgaria	BGR	XX
Burkina Faso	BFA	XX
Burundi	BDI	XX
California	USA	CA
Cambodia	KHM	XX
Cameroon	CMR	XX
Canada	CAN	CD
Cape Verde	CPV	XX
Cayman Islands	CYM	XX
Central African Republic	CAF	XX
Central America, NOS[1]	ZZC	YY
Chad	TCD	XX
Chile	CHL	XX
China	CHN	XX
Christmas Island	CXR	XX
Cocos (Keeling) Islands	CCK	XX
Colombia	COL	XX
Colorado	USA	CO
Comoros	COM	XX
Congo	COG	XX
Congo, Democratic Republic of the	COD	XX
Connecticut	USA	CT
Cook Islands	COK	XX
Costa Rica	CRI	XX
Cote d'Ivoire	CIV	XX
Croatia	HRV	XX
Cuba	CUB	XX
Curacao	CUW	XX
Cyprus	CYP	XX
Czech Republic	CZE	XX
Czechoslovakia[1]	CSK	YY
Delaware	USA	DE
Denmark	DNK	XX
District of Columbia	USA	DC
Djibouti	DJI	XX
Dominica	DMA	XX
Dominican Republic	DOM	XX
Ecuador	ECU	XX
Egypt	EGY	XX
El Salvador	SLV	XX
England	ENG	XX
Equatorial Guinea	GNQ	XX
Eritrea	ERI	XX
Estonia	EST	XX
Ethiopia	ETH	XX
Europe, NOS[1]	ZZE	YY

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
Falkland Islands	FLK	XX
Faroe Islands	FRO	XX
Fiji	FJI	XX
Finland	FIN	XX
Florida	USA	FL
France	FRA	XX
French Guiana	GUF	XX
French Polynesia	PYF	XX
French Southern Territories	ATF	XX
Gabon	GAB	XX
Gambia	GMB	XX
Georgia	USA	GA
Georgia	GEO	XX
Germany	DEU	XX
Ghana	GHA	XX
Gibraltar	GIB	XX
Greece	GRC	XX
Greenland	GRL	XX
Grenada	GRD	XX
Guadeloupe	GLP	XX
Guam	GUM	GU
Guatemala	GTM	XX
Guernsey	GGY	XX
Guinea	GIN	XX
Guinea Bissau	GNB	XX
Guyana	GUY	XX
Haiti	HTI	XX
Hawaii	USA	HI
Heard Island and McDonald Islands	HMD	XX
Honduras	HND	XX
Hong Kong	HKG	XX
Hungary	HUN	XX
Iceland	ISL	XX
Idaho	USA	ID
Illinois	USA	IL
India	IND	XX
Indiana	USA	IN
Indonesia	IDN	XX
Iowa	USA	IA
Iran	IRN	XX
Iraq	IRQ	XX
Ireland	IRL	XX
Isle of Man	IMN	XX
Israel	ISR	XX
Italy	ITA	XX
Jamaica	JAM	XX
Japan	JPN	XX
Jersey	JEY	XX

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
Jordan	JOR	XX
Kansas	USA	KS
Kazakhstan	KAZ	XX
Kentucky	USA	KY
Kenya	KEN	XX
Kiribati	KIR	XX
Korea, NOS	KOR	XX
Kuwait	KWT	XX
Kyrgyzstan	KGZ	XX
Laos	LAO	XX
Latvia	LVA	XX
Lebanon	LBN	XX
Lesotho	LSO	XX
Liberia	LBR	XX
Libya	LBY	XX
Liechtenstein	LIE	XX
Lithuania	LTU	XX
Louisiana	USA	LA
Luxembourg	LUX	XX
Macao	MAC	XX
Macedonia	MKD	XX
Madagascar	MDG	XX
Maine	USA	ME
Malawi	MWI	XX
Malaysia	MYS	XX
Maldives	MDV	XX
Mali	MLI	XX
Malta	MLT	XX
Manitoba	CAN	MB
Marshall Islands	MHL	MH
Martinique	MTQ	XX
Maryland	USA	MD
Massachusetts	USA	MA
Mauritania	MRT	XX
Mauritius	MUS	XX
Mayotte	MYT	XX
Mexico	MEX	XX
Michigan	USA	MI
Micronesia	FSM	FM
Minnesota	USA	MN
Mississippi	USA	MS
Missouri	USA	MO
Moldova	MDA	XX
Monaco	MCO	XX
Mongolia	MNG	XX
Montana	USA	MT
Montenegro	MNE	XX
Montserrat	MSR	XX

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
Morocco	MAR	XX
Mozambique	MOZ	XX
Myanmar	MMR	XX
Namibia	NAM	XX
Nauru	NRU	XX
Nebraska	USA	NE
Nepal	NPL	XX
Netherlands	NLD	XX
Nevada	USA	NV
New Brunswick	CAN	NB
New Caledonia	NCL	XX
New Hampshire	USA	NH
New Jersey	USA	NJ
New Mexico	USA	NM
New York	USA	NY
New Zealand	NZL	XX
Newfoundland and Labrador	CAN	NL
Nicaragua	NIC	XX
Niger	NER	XX
Nigeria	NGA	XX
Niue	NIU	XX
Non-US/Canada NOS[1]	ZZX	YY
Norfolk Island	NFK	XX
North America, NOS[1]	ZZN	YY
North Carolina	USA	NC
North Dakota	USA	ND
North Korea	PRK	XX
Northern Ireland	NIR	XX
Northern Mariana Islands	MNP	MP
Northwest Territories	CAN	NT
Norway	NOR	XX
Nova Scotia	CAN	NS
Nunavut	CAN	NU
Ohio	USA	OH
Oklahoma	USA	OK
Oman	OMN	XX
Ontario	CAN	ON
Oregon	USA	OR
Pacific, NOS[1]	ZZP	YY
Pakistan	PAK	XX
Palau	PLW	PW
Palestine	PSE	XX
Panama	PAN	XX
Papua New Guinea	PNG	XX
Paraguay	PRY	XX
Pennsylvania	USA	PA
Peru	PER	XX
Philippines	PHL	XX

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
Pitcairn Islands	PCN	XX
Poland	POL	XX
Portugal	PRT	XX
Prince Edward Island	CAN	PE
Puerto Rico	PRI	PR
Qatar	QAT	XX
Quebec	CAN	QC
Republic of South Africa	ZAF	XX
Réunion	REU	XX
Rhode Island	USA	RI
Romania	ROU	XX
Russia	RUS	XX
Rwanda	RWA	XX
Saint-Martin (French part)	MAF	XX
Samoa	WSM	XX
San Marino	SMR	XX
Sao Tome and Principe	STP	XX
Saskatchewan	CAN	SK
Saudi Arabia	SAU	XX
Scotland	SCT	XX
Senegal	SEN	XX
Serbia	SRB	XX
Seychelles	SYC	XX
Sierra Leone	SLE	XX
Singapore	SGP	XX
Sint-Maarten	SXM	XX
Slovakia	SVK	XX
Slovenia	SVN	XX
Solomon Islands	SLB	XX
Somalia	SOM	XX
South America, NOS[1]	ZZS	YY
South Carolina	USA	SC
South Dakota	USA	SD
South Georgia and the South Sandwich Islands	SGS	XX
South Korea	KOR	XX
South Sudan	SSD	XX
Spain	ESP	XX
Sri Lanka	LKA	XX
St Pierre and Miquelon	SPM	XX
St. Barthelemy	BLM	XX
St. Helena	SHN	XX
St. Kitts and Nevis	KNA	XX
St. Lucia	LCA	XX
St. Vincent and the Grenadines	VCT	XX
Sudan	SDN	XX
Suriname	SUR	XX
Svalbard and Jan Mayen	SJM	XX
Swaziland	SWZ	XX

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
Sweden	SWE	XX
Switzerland	CHE	XX
Syria	SYR	XX
Taiwan	TWN	XX
Tajikistan	TJK	XX
Tanzania	TZA	XX
Tennessee	USA	TN
Texas	USA	TX
Thailand	THA	XX
Timor-Leste	TLS	XX
Togo	TGO	XX
Tokelau Islands	TKL	XX
Tonga	TON	XX
Trinidad and Tobago	TTO	XX
Tunisia	TUN	XX
Turkey	TUR	XX
Turkmenistan	TKM	XX
Turks and Caicos	TCA	XX
Tuvalu	TUV	XX
U.S. Minor Outlying Islands	UMI	UM
U.S. Virgin Islands	VIR	VI
Uganda	UGA	XX
Ukraine	UKR	XX
United Arab Emirates	ARE	XX
United Kingdom	GBR	XX
United States	USA	US
Unknown[1]	ZZU	ZZ
Uruguay	URY	XX
Utah	USA	UT
Uzbekistan	UZB	XX
Vanuatu	VUT	XX
Vatican City	VAT	XX
Venezuela	VEN	XX
Vermont	USA	VT
Vietnam	VNM	XX
Virginia	USA	VA
Wales	WLS	XX
Wallis and Fotuna	WLF	XX
Washington	USA	WA
West Virginia	USA	WV
Western Sahara	ESH	XX
Wisconsin	USA	WI
Wyoming	USA	WY
Yemen	YEM	XX
Yugoslavia[1]	YUG	YY
Yukon Territory	CAN	YT
Zambia	ZMB	XX
Zimbabwe	ZWE	XX

[1] Custom codes for both historic and future use

Appendix B2
Alphabetic List by Code

ISO Country Code	USPS State Code	Name of Country/State
ABW	XX	Aruba
AFG	XX	Afghanistan
AGO	XX	Angola
AIA	XX	Anguilla
ALA	XX	Aland Islands
ALB	XX	Albania
AND	XX	Andorra
ARE	XX	United Arab Emirates
ARG	XX	Argentina
ARM	XX	Armenia
ASM	AS	American Samoa
ATA	XX	Antarctica
ATF	XX	French Southern Territories
ATG	XX	Antigua and Barbuda
AUS	XX	Australia
AUT	XX	Austria
AZE	XX	Azerbaijan
BDI	XX	Burundi
BEL	XX	Belgium
BEN	XX	Benin
BES	XX	Bonaire, Saint Eustatius and Saba
BFA	XX	Burkina Faso
BGD	XX	Bangladesh
BGR	XX	Bulgaria
BHR	XX	Bahrain
BHS	XX	Bahamas
BIH	XX	Bosnia and Herzogovina
BLM	XX	St. Barthelemy
BLR	XX	Belarus
BLZ	XX	Belize
BMU	XX	Bermuda
BOL	XX	Bolivia
BRA	XX	Brazil
BRB	XX	Barbados
BRN	XX	Brunei
BTN	XX	Bhutan
BVT	XX	Bouvet Island
BWA	XX	Botswana
CAF	XX	Central African Republic
CAN	AB	Alberta
CAN	BC	British Columbia
CAN	CD	Canada
CAN	MB	Manitoba
CAN	NB	New Brunswick

[1] Custom codes for both historic and future use

ISO Country Code	USPS State Code	Name of Country/State
CAN	NL	Newfoundland and Labrador
CAN	NS	Nova Scotia
CAN	NT	Northwest Territories
CAN	NU	Nunavut
CAN	ON	Ontario
CAN	PE	Prince Edward Island
CAN	QC	Quebec
CAN	SK	Saskatchewan
CAN	YT	Yukon Territory
CCK	XX	Cocos (Keeling) Islands
CHE	XX	Switzerland
CHL	XX	Chile
CHN	XX	China
CIV	XX	Cote d'Ivoire
CMR	XX	Cameroon
COD	XX	Congo, Democratic Republic of the
COG	XX	Congo
COK	XX	Cook Islands
COL	XX	Colombia
COM	XX	Comoros
CPV	XX	Cape Verde
CRI	XX	Costa Rica
CSK[1]	YY	Czechoslovakia
CUB	XX	Cuba
CUW	XX	Curacao
CXR	XX	Christmas Island
CYM	XX	Cayman Islands
CYP	XX	Cyprus
CZE	XX	Czech Republic
DEU	XX	Germany
DJI	XX	Djibouti
DMA	XX	Dominica
DNK	XX	Denmark
DOM	XX	Dominican Republic
DZA	XX	Algeria
ECU	XX	Ecuador
EGY	XX	Egypt
ENG	XX	England
ERI	XX	Eritrea
ESH	XX	Western Sahara
ESP	XX	Spain
EST	XX	Estonia
ETH	XX	Ethiopia
FIN	XX	Finland
FJI	XX	Fiji
FLK	XX	Falkland Islands
FRA	XX	France
FRO	XX	Faroe Islands

[1] Custom codes for both historic and future use

ISO Country Code	USPS State Code	Name of Country/State
FSM	FM	Micronesia
GAB	XX	Gabon
GBR	XX	United Kingdom
GEO	XX	Georgia
GGY	XX	Guernsey
GHA	XX	Ghana
GIB	XX	Gibraltar
GIN	XX	Guinea
GLP	XX	Guadeloupe
GMB	XX	Gambia
GNB	XX	Guinea Bissau
GNQ	XX	Equatorial Guinea
GRC	XX	Greece
GRD	XX	Grenada
GRL	XX	Greenland
GTM	XX	Guatemala
GUF	XX	French Guiana
GUM	GU	Guam
GUY	XX	Guyana
HKG	XX	Hong Kong
HMD	XX	Heard Island and McDonald Islands
HND	XX	Honduras
HRV	XX	Croatia
HTI	XX	Haiti
HUN	XX	Hungary
IDN	XX	Indonesia
IMN	XX	Isle of Man
IND	XX	India
IOT	XX	British Indian Ocean Territory
IRL	XX	Ireland
IRN	XX	Iran
IRQ	XX	Iraq
ISL	XX	Iceland
ISR	XX	Israel
ITA	XX	Italy
JAM	XX	Jamaica
JEY	XX	Jersey
JOR	XX	Jordan
JPN	XX	Japan
KAZ	XX	Kazakhstan
KEN	XX	Kenya
KGZ	XX	Kyrgyzstan
KHM	XX	Cambodia
KIR	XX	Kiribati
KNA	XX	St. Kitts and Nevis
KOR	XX	Korea, NOS
KOR	XX	South Korea
KWT	XX	Kuwait

[1] Custom codes for both historic and future use

ISO Country Code	USPS State Code	Name of Country/State
LAO	XX	Laos
LBN	XX	Lebanon
LBR	XX	Liberia
LBY	XX	Libya
LCA	XX	St. Lucia
LIE	XX	Liechtenstein
LKA	XX	Sri Lanka
LSO	XX	Lesotho
LTU	XX	Lithuania
LUX	XX	Luxembourg
LVA	XX	Latvia
MAC	XX	Macao
MAF	XX	Saint-Martin (French part)
MAR	XX	Morocco
MCO	XX	Monaco
MDA	XX	Moldova
MDG	XX	Madagascar
MDV	XX	Maldives
MEX	XX	Mexico
MHL	MH	Marshall Islands
MKD	XX	Macedonia
MLI	XX	Mali
MLT	XX	Malta
MMR	XX	Myanmar
MNE	XX	Montenegro
MNG	XX	Mongolia
MNP	MP	Northern Mariana Islands
MOZ	XX	Mozambique
MRT	XX	Mauritania
MSR	XX	Montserrat
MTQ	XX	Martinique
MUS	XX	Mauritius
MWI	XX	Malawi
MYS	XX	Malaysia
MYT	XX	Mayotte
NAM	XX	Namibia
NCL	XX	New Caledonia
NER	XX	Niger
NFK	XX	Norfolk Island
NGA	XX	Nigeria
NIC	XX	Nicaragua
NIR	XX	Northern Ireland
NIU	XX	Niue
NLD	XX	Netherlands
NOR	XX	Norway
NPL	XX	Nepal
NRU	XX	Nauru
NZL	XX	New Zealand

[1] Custom codes for both historic and future use

ISO Country Code	USPS State Code	Name of Country/State
OMN	XX	Oman
PAK	XX	Pakistan
PAN	XX	Panama
PCN	XX	Pitcairn Islands
PER	XX	Peru
PHL	XX	Philippines
PLW	PW	Palau
PNG	XX	Papua New Guinea
POL	XX	Poland
PRI	PR	Puerto Rico
PRK	XX	North Korea
PRT	XX	Portugal
PRY	XX	Paraguay
PSE	XX	Palestine
PYF	XX	French Polynesia
QAT	XX	Qatar
REU	XX	Réunion
ROU	XX	Romania
RUS	XX	Russia
RWA	XX	Rwanda
SAU	XX	Saudi Arabia
SCT	XX	Scotland
SDN	XX	Sudan
SEN	XX	Senegal
SGP	XX	Singapore
SGS	XX	South Georgia and the South Sandwich Islands
SHN	XX	St. Helena
SJM	XX	Svalbard and Jan Mayen
SLB	XX	Solomon Islands
SLE	XX	Sierra Leone
SLV	XX	El Salvador
SMR	XX	San Marino
SOM	XX	Somalia
SPM	XX	St Pierre and Miquelon
SRB	XX	Serbia
SSD	XX	South Sudan
STP	XX	Sao Tome and Principe
SUR	XX	Suriname
SVK	XX	Slovakia
SVN	XX	Slovenia
SWE	XX	Sweden
SWZ	XX	Swaziland
SXM	XX	Sint-Maarten
SYC	XX	Seychelles
SYR	XX	Syria
TCA	XX	Turks and Caicos
TCD	XX	Chad
TGO	XX	Togo

[1] Custom codes for both historic and future use

ISO Country Code	USPS State Code	Name of Country/State
THA	XX	Thailand
TJK	XX	Tajikistan
TKL	XX	Tokelau Islands
TKM	XX	Turkmenistan
TLS	XX	Timor-Leste
TON	XX	Tonga
TTO	XX	Trinidad and Tobago
TUN	XX	Tunisia
TUR	XX	Turkey
TUV	XX	Tuvalu
TWN	XX	Taiwan
TZA	XX	Tanzania
UGA	XX	Uganda
UKR	XX	Ukraine
UMI	UM	U.S. Minor Outlying Islands
URY	XX	Uruguay
USA	AA	Armed Forces Americas
USA	AE	Armed Forces Canada, Europe, Middle East, Africa
USA	AK	Alaska
USA	AL	Alabama
USA	AP	Armed Forces Pacific
USA	AR	Arkansas
USA	AZ	Arizona
USA	CA	California
USA	CO	Colorado
USA	CT	Connecticut
USA	DC	District of Columbia
USA	DE	Delaware
USA	FL	Florida
USA	GA	Georgia
USA	HI	Hawaii
USA	IA	Iowa
USA	ID	Idaho
USA	IL	Illinois
USA	IN	Indiana
USA	KS	Kansas
USA	KY	Kentucky
USA	LA	Louisiana
USA	MA	Massachusetts
USA	MD	Maryland
USA	ME	Maine
USA	MI	Michigan
USA	MN	Minnesota
USA	MO	Missouri
USA	MS	Mississippi
USA	MT	Montana
USA	NC	North Carolina
USA	ND	North Dakota

[1] Custom codes for both historic and future use

ISO Country Code	USPS State Code	Name of Country/State
USA	NE	Nebraska
USA	NH	New Hampshire
USA	NJ	New Jersey
USA	NM	New Mexico
USA	NV	Nevada
USA	NY	New York
USA	OH	Ohio
USA	OK	Oklahoma
USA	OR	Oregon
USA	PA	Pennsylvania
USA	RI	Rhode Island
USA	SC	South Carolina
USA	SD	South Dakota
USA	TN	Tennessee
USA	TX	Texas
USA	US	United States
USA	UT	Utah
USA	VA	Virginia
USA	VT	Vermont
USA	WA	Washington
USA	WI	Wisconsin
USA	WV	West Virginia
USA	WY	Wyoming
UZB	XX	Uzbekistan
VAT	XX	Vatican City
VCT	XX	St. Vincent and the Grenadines
VEN	XX	Venezuela
VGB	XX	British Virgin Islands
VIR	VI	U.S. Virgin Islands
VNM	XX	Vietnam
VUT	XX	Vanuatu
WLF	XX	Wallis and Fotuna
WLS	XX	Wales
WSM	XX	Samoa
YEM	XX	Yemen
YUG[1]	YY	Yugoslavia
ZAF	XX	Republic of South Africa
ZMB	XX	Zambia
ZWE	XX	Zimbabwe
ZZA[1]	YY	Asia, NOS
ZZC[1]	YY	Central America, NOS
ZZE[1]	YY	Europe, NOS
ZZF[1]	YY	Africa, NOS
ZZN[1]	YY	North America, NOS
ZZP[1]	YY	Pacific, NOS
ZZS[1]	YY	South America, NOS
ZZU[1]	ZZ	Unknown
ZZX[1]	YY	Non-US/Canada NOS

[1] Custom codes for both historic and future use

Appendix B3
Geographic Code List

Name of Country/State	ISO Country Code	USPS State Code
North America, NOS[1]	ZZN	YY
United States	USA	US
Maine	USA	ME
New Hampshire	USA	NH
Vermont	USA	VT
Massachusetts	USA	MA
Rhode Island	USA	RI
Connecticut	USA	CT
New Jersey	USA	NJ
New York	USA	NY
Pennsylvania	USA	PA
Delaware	USA	DE
Maryland	USA	MD
District of Columbia	USA	DC
Virginia	USA	VA
West Virginia	USA	WV
North Carolina	USA	NC
South Carolina	USA	SC
Tennessee	USA	TN
Georgia	USA	GA
Florida	USA	FL
Alabama	USA	AL
Mississippi	USA	MS
Michigan	USA	MI
Ohio	USA	OH
Indiana	USA	IN
Kentucky	USA	KY
Wisconsin	USA	WI
Minnesota	USA	MN
Iowa	USA	IA
North Dakota	USA	ND
South Dakota	USA	SD
Montana	USA	MT
Illinois	USA	IL
Missouri	USA	MO
Kansas	USA	KS
Nebraska	USA	NE
Arkansas	USA	AR
Louisiana	USA	LA
Oklahoma	USA	OK
Texas	USA	TX
Idaho	USA	ID
Wyoming	USA	WY
Colorado	USA	CO

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
Utah	USA	UT
Nevada	USA	NV
New Mexico	USA	NM
Arizona	USA	AZ
Alaska	USA	AK
Washington	USA	WA
Oregon	USA	OR
California	USA	CA
Hawaii	USA	HI
Armed Forces Americas	USA	AA
Armed Forces Canada, Europe, Middle East, Africa	USA	AE
Armed Forces Pacific	USA	AP
Greenland	GRL	XX
Canada	CAN	CD
New Brunswick	CAN	NB
Newfoundland and Labrador	CAN	NL
Nova Scotia	CAN	NS
Prince Edward Island	CAN	PE
Quebec	CAN	QC
Ontario	CAN	ON
Alberta	CAN	AB
Manitoba	CAN	MB
Saskatchewan	CAN	SK
Northwest Territories	CAN	NT
Yukon Territory	CAN	YT
British Columbia	CAN	BC
Nunavut	CAN	NU
Mexico	MEX	XX
Puerto Rico	PRI	PR
U.S. Virgin Islands	VIR	VI
Cuba	CUB	XX
Haiti	HTI	XX
Dominican Republic	DOM	XX
Jamaica	JAM	XX
Anguilla	AIA	XX
Antigua and Barbuda	ATG	XX
Aruba	ABW	XX
Barbados	BRB	XX
Bonaire, Saint Eustatius and Saba	BES	XX
British Virgin Islands	VGB	XX
Cayman Islands	CYM	XX
Curacao	CUW	XX
Dominica	DMA	XX
Grenada	GRD	XX
Guadeloupe	GLP	XX
Martinique	MTQ	XX
Montserrat	MSR	XX
St. Barthelemy	BLM	XX

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
St. Kitts and Nevis	KNA	XX
St. Lucia	LCA	XX
Saint-Maarten	SXM	XX
Saint-Martin (French part)	MAF	XX
St. Vincent and the Grenadines	VCT	XX
Trinidad and Tobago	TTO	XX
Turks and Caicos	TCA	XX
Bermuda	BMU	XX
Bahamas	BHS	XX
St Pierre and Miquelon	SPM	XX
Central America, NOS[1]	ZZC	YY
Guatemala	GTM	XX
Belize	BLZ	XX
Honduras	HND	XX
El Salvador	SLV	XX
Nicaragua	NIC	XX
Costa Rica	CRI	XX
Panama	PAN	XX
South America, NOS[1]	ZZS	YY
Colombia	COL	XX
Venezuela	VEN	XX
Guyana	GUY	XX
Suriname	SUR	XX
French Guiana	GUF	XX
Brazil	BRA	XX
Ecuador	ECU	XX
Peru	PER	XX
Bolivia	BOL	XX
Chile	CHL	XX
Argentina	ARG	XX
Paraguay	PRY	XX
Uruguay	URY	XX
Falkland Islands	FLK	XX
Europe, NOS[1]	ZZE	YY
United Kingdom	GBR	XX
England	ENG	XX
Guernsey	GGY	XX
Isle of Man	IMN	XX
Jersey	JEY	XX
Wales	WLS	XX
Scotland	SCT	XX
Northern Ireland	NIR	XX
Ireland	IRL	XX
Iceland	ISL	XX
Norway	NOR	XX
Svalbard and Jan Mayen	SJM	XX
Denmark	DNK	XX
Faroe Islands	FRO	XX

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
Sweden	SWE	XX
Finland	FIN	XX
Aland Islands	ALA	XX
Germany	DEU	XX
Netherlands	NLD	XX
Belgium	BEL	XX
Luxembourg	LUX	XX
Switzerland	CHE	XX
Austria	AUT	XX
Liechtenstein	LIE	XX
France	FRA	XX
Monaco	MCO	XX
Spain	ESP	XX
Andorra	AND	XX
Portugal	PRT	XX
Italy	ITA	XX
San Marino	SMR	XX
Vatican City	VAT	XX
Romania	ROU	XX
Poland	POL	XX
Czech Republic	CZE	XX
Czechoslovakia[1]	CSK	YY
Slovakia	SVK	XX
Bosnia and Herzogovina	BIH	XX
Croatia	HRV	XX
Macedonia	MKD	XX
Montenegro	MNE	XX
Serbia	SRB	XX
Slovenia	SVN	XX
Yugoslavia[1]	YUG	YY
Bulgaria	BGR	XX
Russia	RUS	XX
Ukraine	UKR	XX
Moldova	MDA	XX
Belarus	BLR	XX
Estonia	EST	XX
Latvia	LVA	XX
Lithuania	LTU	XX
Greece	GRC	XX
Hungary	HUN	XX
Albania	ALB	XX
Gibraltar	GIB	XX
Malta	MLT	XX
Cyprus	CYP	XX
Africa, NOS[1]	ZZF	YY
Morocco	MAR	XX
Algeria	DZA	XX
Tunisia	TUN	XX

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
Libya	LBY	XX
Egypt	EGY	XX
Burkina Faso	BFA	XX
Chad	TCD	XX
Mali	MLI	XX
Mauritania	MRT	XX
Niger	NER	XX
Sudan	SDN	XX
South Sudan	SSD	XX
Western Sahara	ESH	XX
Nigeria	NGA	XX
Benin	BEN	XX
Cameroon	CMR	XX
Cape Verde	CPV	XX
Central African Republic	CAF	XX
Cote d'Ivoire	CIV	XX
Congo	COG	XX
Equatorial Guinea	GNQ	XX
Gambia	GMB	XX
Gabon	GAB	XX
Ghana	GHA	XX
Guinea	GIN	XX
Guinea Bissau	GNB	XX
Liberia	LBR	XX
Senegal	SEN	XX
Sierra Leone	SLE	XX
Togo	TGO	XX
Congo, Democratic Republic of the	COD	XX
Angola	AGO	XX
Sao Tome and Principe	STP	XX
Republic of South Africa	ZAF	XX
Botswana	BWA	XX
Lesotho	LSO	XX
Namibia	NAM	XX
Swaziland	SWZ	XX
Zimbabwe	ZWE	XX
Zambia	ZMB	XX
Malawi	MWI	XX
Mozambique	MOZ	XX
Madagascar	MDG	XX
Tanzania	TZA	XX
Uganda	UGA	XX
Kenya	KEN	XX
Rwanda	RWA	XX
Burundi	BDI	XX
Somalia	SOM	XX
Djibouti	DJI	XX
Ethiopia	ETH	XX

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
Eritrea	ERI	XX
Comoros	COM	XX
Mauritius	MUS	XX
Mayotte	MYT	XX
Réunion	REU	XX
St. Helena	SHN	XX
Seychelles	SYC	XX
Asia, NOS[1]	ZZA	YY
Turkey	TUR	XX
Syria	SYR	XX
Lebanon	LBN	XX
Jordan	JOR	XX
Iraq	IRQ	XX
Bahrain	BHR	XX
Kuwait	KWT	XX
Oman	OMN	XX
Qatar	QAT	XX
Saudi Arabia	SAU	XX
United Arab Emirates	ARE	XX
Yemen	YEM	XX
Israel	ISR	XX
Palestine	PSE	XX
Armenia	ARM	XX
Azerbaijan	AZE	XX
Georgia	GEO	XX
Kazakhstan	KAZ	XX
Kyrgyzstan	KGZ	XX
Tajikistan	TJK	XX
Turkmenistan	TKM	XX
Uzbekistan	UZB	XX
Iran	IRN	XX
Afghanistan	AFG	XX
Pakistan	PAK	XX
Maldives	MDV	XX
British Indian Ocean Territory	IOT	XX
India	IND	XX
Nepal	NPL	XX
Bhutan	BTN	XX
Bangladesh	BGD	XX
Sri Lanka	LKA	XX
Myanmar	MMR	XX
Thailand	THA	XX
Laos	LAO	XX
Cambodia	KHM	XX
Vietnam	VNM	XX
Malaysia	MYS	XX
Singapore	SGP	XX
Brunei	BRN	XX

[1] Custom codes for both historic and future use

Name of Country/State	ISO Country Code	USPS State Code
Indonesia	IDN	XX
Timor-Leste	TLS	XX
Philippines	PHL	XX
China	CHN	XX
Hong Kong	HKG	XX
Taiwan	TWN	XX
Macao	MAC	XX
Mongolia	MNG	XX
Japan	JPN	XX
Korea, NOS	KOR	XX
South Korea	KOR	XX
North Korea	PRK	XX
Christmas Island	CXR	XX
Cocos (Keeling) Islands	CCK	XX
Pacific, NOS[1]	ZZP	YY
Australia	AUS	XX
New Zealand	NZL	XX
U.S. Minor Outlying Islands	UMI	UM
Fiji	FJI	XX
New Caledonia	NCL	XX
Papua New Guinea	PNG	XX
Solomon Islands	SLB	XX
Vanuatu	VUT	XX
Wallis and Fotuna	WLF	XX
Micronesia	FSM	FM
Guam	GUM	GU
Kiribati	KIR	XX
Marshall Islands	MHL	MH
Northern Mariana Islands	MNP	MP
Nauru	NRU	XX
Palau	PLW	PW
American Samoa	ASM	AS
Cook Islands	COK	XX
Norfolk Island	NFK	XX
Niue	NIU	XX
Pitcairn Islands	PCN	XX
French Polynesia	PYF	XX
Tokelau Islands	TKL	XX
Tonga	TON	XX
Tuvalu	TUV	XX
Samoa	WSM	XX
Bouvet Island	BVT	XX
French Southern Territories	ATF	XX
Heard Island and McDonald Islands	HMD	XX
South Georgia and the South Sandwich Islands	SGS	XX
Antarctica	ATA	XX
Non-US/Canada NOS[1]	ZZX	YY
Unknown[1]	ZZU	ZZ

[1] Custom codes for both historic and future use

Appendix B4
Custom Codes for Historic Use Only

Name of Country/State	ISO Country Code	USPS State Code
Maritime Provinces (New Bruns, Newfound, Nova Scotia, PE)	CAN	MM
Prairie Provinces (Alberta, Manitoba, Saskatchewan)	CAN	PP
Northwest Territories, Yukon Territory	CAN	YN
New England and New Jersey	USA	NN
Arabian Peninsula	XAP	YY
Other Caribbean Islands	XCB	YY
China, NOS	XCH	YY
Caucasian Republics of the USSR	XCR	YY
East Africa	XEF	YY
England, Channel Islands, Isle of Man	XEN	XX
Ethiopia (Abyssinia), Eritrea	XET	YY
Germanic Countries	XGR	YY
African Coastal Islands (previously in South Africa, NOS)	XIF	YY
Israel and former Jewish Palestine	XIS	YY
Micronesian Islands	XMC	YY
Melanesian Islands, Solomon Islands	XML	YY
Malaysia, Singapore, Brunei	XMS	YY
North Africa	XNF	YY
North American Islands	XNI	YY
Other Asian Republics of the USSR	XOR	YY
Polynesian Islands	XPL	YY
Scandinavia	XSC	YY
Sudanese Countries	XSD	YY
Southeast Asia	XSE	YY
South Africa, NOS	XSF	YY
Slavic Countries	XSL	YY
Ukraine and Moldavia	XUM	YY
West Africa, NOS (French Africa, NOS)	XWF	YY

APPENDIX B: HEAVILY HISPANIC SURNAMES

US Census Bureau, March 1996

Abeyta	Baca	Carrion	Dominguez	Guardado
Abrego	Badillo	Carvajal	Dominquez	Guerra
Abreu	Baez	Casanova	Duarte	Guerrero
Acevedo	Baeza	Casares	Duenas	Guevara
Acosta	Bahena	Casarez	Duran	Guillen
Acuna	Balderas	Casas	Echevarria	Gurule
Adame	Ballesteros	Casillas	Elizondo	Gutierrez
Adorno	Banda	Castaneda	Enriquez	Guzman
Agosto	Banuelos	Castellanos	Escalante	Haro
Aguayo	Barajas	Castillo	Escamilla	Henriquez
Aguilar	Barela	Castro	Escobar	Heredia
Aguilera	Barragan	Cavazos	Escobedo	Hernadez
Aguirre	Barraza	Cazares	Esparza	Hernandes
Alanis	Barrera	Ceballos	Espinal	Hernandez
Alaniz	Barreto	Cedillo	Espino	Herrera
Alarcon	Barrientos	Ceja	Espinosa	Hidalgo
Alba	Barrios	Centeno	Espinoza	Hinojosa
Alcala	Batista	Cepeda	Esquibel	Holguin
Alcantar	Becerra	Cerda	Esquivel	Huerta
Alcaraz	Beltran	Cervantes	Estevez	Hurtado
Alejandro	Benavides	Cervantez	Estrada	Ibarra
Aleman	Benavidez	Chacon	Fajardo	Iglesias
Alfaro	Benitez	Chapa	Farias	Irizarry
Alicea	Bermudez	Chavarria	Feliciano	Jaime
Almanza	Bernal	Chavez	Fernandez	Jaimes
Almaraz	Berrios	Cintron	Ferrer	Jaquez
Almonte	Betancourt	Cisneros	Fierro	Jaramillo
Alonso	Blanco	Collado	Figueroa	Jasso
Alonzo	Bonilla	Collazo	Flores	Jimenez
Altamirano	Borrego	Colon	Florez	Jiminez
Alva	Botello	Colunga	Fonseca	Juarez
Alvarado	Bravo	Concepcion	Franco	Jurado
Alvarez	Briones	Contreras	Frias	Laboy
Amador	Briseno	Cordero	Fuentes	Lara
Amaya	Brito	Cordova	Gaitan	Laureano
Anaya	Bueno	Cornejo	Galarza	Leal
Anguiano	Burgos	Corona	Galindo	Lebron
Angulo	Bustamante	Coronado	Gallardo	Ledesma
Aparicio	Bustos	Corral	Gallegos	Leiva
Apodaca	Caballero	Corrales	Galvan	Lemus
Aponte	Caban	Correa	Galvez	Leon
Aragon	Cabrera	Cortes	Gamboa	Lerma
Arana	Cadena	Cortez	Gamez	Leyva
Aranda	Caldera	Cotto	Gaona	Limon
Arce	Calderon	Covarrubias	Garay	Linares
Archuleta	Calvillo	Crespo	Garcia	Lira
Arellano	Camacho	Cruz	Garibay	Llamas
Arenas	Camarillo	Cuellar	Garica	Loera
Arevalo	Campos	Curiel	Garrido	Lomeli
Arguello	Canales	Davila	Garza	Longoria
Arias	Candelaria	Deanda	Gastelum	Lopez
Armas	Cano	Dejesus	Gaytan	Lovato
Armendariz	Cantu	Delacruz	Gil	Loya
Armenta	Caraballo	Delafuente	Giron	Lozada
Armijo	Carbajal	Delagarza	Godinez	Lozano
Arredondo	Cardenas	Delao	Godoy	Lucero
Arreola	Cardona	Delapaz	Gomez	Lucio
Arriaga	Carmona	Delarosa	Gonzales	Luevano
Arroyo	Carranza	Delatorre	Gonzalez	Lugo
Arteaga	Carrasco	Deleon	Gracia	Lujan
Atencio	Carrasquillo	Delgadillo	Granado	Luna
Avalos	Carreon	Delgado	Granados	Macias
Avila	Carrera	Delrio	Griego	Madera
Aviles	Carrero	Delvalle	Grijalva	Madrid
Ayala	Carrillo	Diaz	Guajardo	Madrigal

US Census Bureau, March 1996

Maestas	Nazario	Posada	Salcedo	Vaca
Magana	Negrete	Prado	Salcido	Valadez
Malave	Negron	Preciado	Saldana	Valdes
Maldonado	Nevarez	Prieto	Saldivar	Valdez
Manzanares	Nieto	Puente	Salgado	Valdivia
Mares	Nieves	Puga	Salinas	Valencia
Marin	Nino	Pulido	Samaniego	Valentin
Marquez	Noriega	Quesada	Sanabria	Valenzuela
Marrero	Nunez	Quezada	Sanches	Valladares
Marroquin	Ocampo	Quinones	Sanchez	Valle
Martinez	Ocasio	Quinonez	Sandoval	Vallejo
Mascarenas	Ochoa	Quintana	Santacruz	Valles
Mata	Ojeda	Quintanilla	Santana	Valverde
Mateo	Olivares	Quintero	Santiago	Vanegas
Matias	Olivarez	Quiroz	Santillan	Varela
Matos	Olivas	Rael	Sarabia	Vargas
Maya	Olivera	Ramirez	Sauceda	Vasquez
Mayorga	Olivo	Ramon	Saucedo	Vazquez
Medina	Olmos	Ramos	Sedillo	Vega
Medrano	Olvera	Rangel	Segovia	Vela
Mejia	Ontiveros	Rascon	Segura	Velasco
Melendez	Oquendo	Raya	Sepulveda	Velasquez
Melgar	Ordonez	Razo	Serna	Velazquez
Mena	Orellana	Regalado	Serrano	Velez
Menchaca	Ornelas	Rendon	Serrato	Veliz
Mendez	Orosco	Renteria	Sevilla	Venegas
Mendoza	Orozco	Resendez	Sierra	Vera
Menendez	Orta	Reyes	Sisneros	Verdugo
Meraz	Ortega	Reyna	Solano	Verduzco
Mercado	Ortiz	Reynoso	Solis	Vergara
Merino	Osorio	Rico	Soliz	Viera
Mesa	Otero	Rincon	Solorio	Vigil
Meza	Ozuna	Riojas	Solorzano	Villa
Miramontes	Pabon	Rios	Soria	Villagomez
Miranda	Pacheco	Rivas	Sosa	Villalobos
Mireles	Padilla	Rivera	Sotelo	Villalpando
Mojica	Padron	Rivero	Soto	Villanueva
Molina	Paez	Robledo	Suarez	Villareal
Mondragon	Pagan	Robles	Tafoya	Villarreal
Monroy	Palacios	Rocha	Tamayo	Villasenor
Montalvo	Palomino	Rodarte	Tamez	Villegas
Montanez	Palomo	Rodrigez	Tapia	Yanez
Montano	Pantoja	Rodriguez	Tejada	Ybarra
Montemayor	Paredes	Rodriquez	Tejeda	Zambrano
Montenegro	Parra	Rojas	Tellez	Zamora
Montero	Partida	Rojo	Tello	Zamudio
Montes	Patino	Roldan	Teran	Zapata
Montez	Paz	Rolon	Terrazas	Zaragoza
Montoya	Pedraza	Romero	Tijerina	Zarate
Mora	Pedroza	Romo	Tirado	Zavala
Morales	Pelayo	Roque	Toledo	Zayas
Moreno	Pena	Rosado	Toro	Zelaya
Mota	Perales	Rosales	Torres	Zepeda
Moya	Peralta	Rosario	Torrez	Zuniga
Munguia	Perea	Rosas	Tovar	
Muniz	Peres	Roybal	Trejo	
Munoz	Perez	Rubio	Trevino	
Murillo	Pichardo	Ruelas	Trujillo	
Muro	Pina	Ruiz	Ulibarri	
Najera	Pineda	Ruvalcaba	Ulloa	
Naranjo	Pizarro	Saavedra	Urbina	
Narvaez	Polanco	Saenz	Urena	
Nava	Ponce	Saiz	Urias	
Navarrete	Porras	Salas	Uribe	
Navarro	Portillo	Salazar	Urrutia	

APPENDIX C: ABSTRACTING RESOURCES

2007 Multiple Primary and Histology Coding Rules
http://www.seer.cancer.gov/tools/mphrules/download.html

AJCC Cancer Staging Manual
- Manual: https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx
- Cancer Staging Posters:
  https://cancerstaging.org/references-tools/quickreferences/Pages/default.aspx

A Cancer Registrar's Guide to Collecting Occupation and Industry
http://www.cdc.gov/niosh/docs/2011-173/pdfs/2011-173.pdf

Collaborative Stage Data Collection System User Documentation and Coding Instructions
https://cancerstaging.org/cstage/Pages/default.aspx

FORDS Facility Oncology Registry Data Standards, Revised for 2016
http://www.facs.org/cancer/coc/fordsmanual.html

Hematopoietic & Lymphoid Database and Manual
http://www.seer.cancer.gov/tools/heme/

International Classification of Diseases for Oncology, Third Edition, World Health Organization, Geneva, 2000, April Fritz, et. al. (Eds.).

An online version of *International Classification of Diseases for Oncology, Third Edition(ICD-O-3)* is available on the International Agency for Research on Cancer website: http://codes.iarc.fr/ . This useful online tool should be used with the following important notes:

- For solid tumors, only use the original publication, ICD-O-3 (2000). Do not use the ICD-O-3.1 (2011) codes, as the new codes have not been approved for implementation in the United States and/or Canada.
- For non-solid tumors, use the histology rules in the Hematopoietic and Lymphoid Database.
- Refer to the NAACCR Guidelines for ICD-O-3 Update Implementation for the list of ICD-O-3 code changes effective 1/1/2015.
- Use the histology rules in the MP/H manual for solid tumors.

Illinois State Cancer Registry
  Questions may be directed to dph.iscrrep@illinois.gov or 217/785-1873.

NAACCR Edits Detail Report
    Follow the link below to download a PDF document with descriptions of all edits.
    http://www.naaccr.org/StandardsandRegistryOperations/VolumeIV.aspx

NAACCR Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary, Version 16
http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx

SEER*Rx - Interactive Antineoplastic Drugs Database
http://www.seer.cancer.gov/tools/seerrx/

SEER Program Coding and Staging Manual, Appendix C - Site Specific Coding Modules
http://seer.cancer.gov/tools/codingmanuals/index.html

Summary Stage Guide 1977
http://www.seer.cancer.gov/tools/codingmanuals/historical.html

Summary Staging Manual 2000
http://www.seer.cancer.gov/tools/codingmanuals/historical.html

USPS Postal Addressing Standards, Pub 28, January 2013
http://pe.usps.gov/text/pub28/welcome.htm

APPENDIX D: SURGERY CODES

Surgery Codes

Oral Cavity
Lip C000–C009, Base of Tongue C019, Other Parts of Tongue C020–C029, Gum C030–C039, Floor of Mouth C040–C049, Palate C050–C059, Other Parts of Mouth C060–C069

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
        11   Photodynamic therapy (PDT)
        12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
        13   Cryosurgery
        14   Laser
No specimen sent to pathology from surgical events 10–14

20   Local tumor excision, NOS
        26   Polypectomy
        27   Excisional biopsy

        Any combination of 20 or 26–27 WITH
             21   Photodynamic therapy (PDT)
             22   Electrocautery
             23   Cryosurgery
             24   Laser ablation
        25   Laser excision
[*SEER Note*: Codes 20-27 include shave and wedge resection]

30   Wide excision, NOS
     Code 30 includes:
        Hemiglossectomy
        Partial glossectomy

40   Radical excision of tumor, NOS
        41   Radical excision of tumor ONLY
        42   Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
        43   Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)
[*SEER Note*: "In continuity with" or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Codes 40–43 include:
    Total glossectomy
    Radical glossectomy

Specimen sent to pathology from surgical events 20-43

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Parotid and Other Unspecified Glands
Parotid Gland C079, Major Salivary Glands C080–C089

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
        11   Photodynamic therapy (PDT)
        12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
        13   Cryosurgery
        14   Laser
No specimen sent to pathology from surgical events 10–14

20   Local tumor excision, NOS
        26   Polypectomy
        27   Excisional biopsy

        Any combination of 20 or 26–27 WITH
            21   Photodynamic therapy (PDT)
            22   Electrocautery
            23   Cryosurgery
            24   Laser ablation
        25   Laser excision

[***SEER Note:*** Codes 30-80 include major salivary gland, NOS]

30   Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
          31   Facial nerve spared
          32   Facial nerve sacrificed
        33   Superficial lobe ONLY
          34   Facial nerve spared
           35   Facial nerve sacrificed
        36   Deep lobe (Total)
[***SEER Note:*** Codes 30-36 are with or without superficial lobe]
          37   Facial nerve spared
           38   Facial nerve sacrificed

[***SEER Note:*** Codes 40-80 may include submandibulectomy and submaxillectomy]

40   Total parotidectomy, NOS; total removal of major salivary gland, NOS
        41   Facial nerve spared
        42   Facial nerve sacrificed

50   Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
       51   WITHOUT removal of temporal bone
       52   WITH removal of temporal bone
       53   WITH removal of overlying skin (requires graft or flap coverage)

80   Parotidectomy, NOS

Specimen sent to pathology from surgical events 20-80

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Pharynx
Tonsil C090–C099, Oropharynx C100–C109, Nasopharynx C110–C119
Pyriform Sinus C129, Hypopharynx C130–C139, Pharynx C140

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
    11   Photodynamic therapy (PDT)
    12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
    13   Cryosurgery
    14   Laser
    15   Stripping
No specimen sent to pathology from surgical events 10–15

20   Local tumor excision, NOS
    26   Polypectomy
    27   Excisional biopsy

    Any combination of 20 or 26–27 WITH
        21   Photodynamic therapy (PDT)
        22   Electrocautery
        23   Cryosurgery
        24   Laser ablation
    25   Laser excision
    28   Stripping

30   Pharyngectomy, NOS
    31   Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
    32   Total pharyngectomy

40   Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS
    (does NOT include total mandibular resection)
[*SEER Note:* Code 40 includes mandibulectomy (marginal, segmental, hemi-, and/or laryngectomy) NOS. Contiguous bone tissue refers to the mandible.]
    41   WITH laryngectomy (laryngopharyngectomy)
    42   WITH bone [mandibulectomy]
    43   WITH both 41 and 42
[*SEER Note:* Use **code 40** when the patient had a pharyngectomy and maybe some sort of mandibulectomy and/or maybe a laryngectomy, but the exact procedures are not clear. Use **code 41** when the patient had pharyngectomy and laryngectomy but no mandibulectomy. Use **code 42** when the patient had pharyngectomy and mandibulectomy but no laryngectomy. Use **code 43** when it is known that the patient had both a mandibulectomy and laryngectomy in addition to the pharyngectomy.]

50   Radical pharyngectomy (includes total mandibular resection), NOS
    51   WITHOUT laryngectomy
    52   WITH laryngectomy

Specimen sent to pathology from surgical events 20-52.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Esophagus
C150–C159

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
        11   Photodynamic therapy (PDT)
        12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
        13   Cryosurgery
        14   Laser
No specimen sent to pathology from surgical events 10–14

20   Local tumor excision, NOS
        26   Polypectomy
        27   Excisional biopsy

        Any combination of 20 or 26–27 WITH
            21   Photodynamic therapy (PDT)
            22   Electrocautery
            23   Cryosurgery
            24   Laser ablation
        25   Laser excision

30   Partial esophagectomy

40   Total esophagectomy, NOS

50   Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
[**SEER Note:** Codes 50-55 include partial esophagectomy, total esophagectomy, or esophagectomy, NOS.]
        51   WITH laryngectomy
        52   WITH gastrectomy, NOS
        53   Partial gastrectomy
        54   Total gastrectomy
        55   Combination of 51 WITH any of 52–54

80   Esophagectomy, NOS

Specimen sent to pathology from surgical events 20-80

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Stomach
C160–C169

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
         11   Photodynamic therapy (PDT)
         12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
         13   Cryosurgery
         14   Laser

No specimen sent to pathology from surgical events 10–14

20   Local tumor excision, NOS
         26   Polypectomy
         27   Excisional biopsy

Any combination of 20 or 26–27 WITH
         21   Photodynamic therapy (PDT)
         22   Electrocautery
         23   Cryosurgery
         24   Laser ablation
     25   Laser excision

30   Gastrectomy, NOS (partial, subtotal, hemi-)
         31   Antrectomy, lower (distal-less than 40% of stomach)***
         32   Lower (distal) gastrectomy (partial, subtotal, hemi-)
         33   Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:
     Partial gastrectomy, including a sleeve resection of the stomach
     Billroth I: anastomosis to duodenum (duodenostomy)
     Billroth II: anastomosis to jejunum (jejunostomy)

40   Near-total or total gastrectomy, NOS
         41   Near-total gastrectomy
         42   Total gastrectomy
     A total gastrectomy may follow a previous partial resection of the stomach

50   Gastrectomy, NOS WITH removal of a portion of esophagus
      51   Partial or subtotal gastrectomy
      52   Near total or total gastrectomy

Codes 50–52 are used for gastrectomy resection when only portions of esophagus are included in procedure

60   Gastrectomy with a resection in continuity with the resection of other organs, NOS[***]
      61   Partial or subtotal gastrectomy, in continuity with the resection of other organs[***]
      62   Near total or total gastrectomy, in continuity with the resection of other organs[***]
      63   Radical gastrectomy, in continuity with the resection of other organs[***]

Codes 60–63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.
[**SEER Note:** Codes 60-63 may include omentectomy among the organs/tissues removed. "In continuity with" or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80   Gastrectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

[***]Incidental splenectomy NOT included.

Surgery Codes

Colon
C180–C189

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
       11   Photodynamic therapy (PDT)
       12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
       13   Cryosurgery
       14   Laser
No specimen sent to pathology from surgical events 10–14

20   Local tumor excision, NOS
       27   Excisional biopsy
       26   Polypectomy, NOS
       28   Polypectomy-endoscopic
       29   Polypectomy-surgical excision

       Any combination of 20 or 26–29 WITH
          21   Photodynamic therapy (PDT)
          22   Electrocautery
          23   Cryosurgery
          24   Laser ablation
[***SEER Note:*** Codes 21 to 24 above combine 20 Local tumor excision, 27 Excisional biopsy, 26 Polypectomy, NOS, 28 Polypectomy-endoscopic or 29 Polypectomy-surgical excision WITH 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]
       25   Laser excision

30   Partial colectomy [but less than hemicolectomy] segmental resection
       32   Plus resection of contiguous organ; example: small bowel, bladder
[***SEER Note:*** Code 30 includes but is not limited to the following procedures: Appendectomy (for an appendix primary only), enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures, and segmental resection (such as cecectomy or sigmoidectomy). Note that the removal of a short portion of the distal ileum is **not** "removal of a contiguous organ".]

40   Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
       41   Plus resection of contiguous organ; example: small bowel, bladder
[***SEER Note:*** Code 40 includes extended (but less than total) right or left colectomy. Note that the removal of a short portion of the distal ileum is **not** "removal of a contiguous organ".]

50   Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)

      51   Plus resection of contiguous organ; example: small bowel, bladder

[**SEER Note:** Removal of a short portion of the distal ileum is **not** "removal of a contiguous organ"]

60   Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)

[**SEER Note:** Commonly used for familial polyposis or polyposis coli]

      61   Plus resection of contiguous organ; example: small bowel, bladder

[**SEER Note:** Removal of a short portion of the distal ileum is **not** "removal of a contiguous organ"]

70   Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

      Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

[**SEER Note:** "In continuity with" or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80   Colectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Rectosigmoid
C199

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
       11   Photodynamic therapy (PDT)
       12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
       13   Cryosurgery
       14   Laser ablation
No specimen sent to pathology from surgical events 10–14

20   Local tumor excision, NOS
       27   Excisional biopsy
       26   Polypectomy

       Combination of 20 or 26–27 WITH
           21   Photodynamic therapy (PDT)
           22   Electrocautery
           23   Cryosurgery
           24   Laser ablation
       25   Laser excision

30   Wedge or segmental resection; partial proctosigmoidectomy, NOS
       31   Plus resection of contiguous organs; example: small bowel, bladder

       Procedures coded 30 include, but are not limited to:
           Anterior resection
           Hartmann operation
           Low anterior resection (LAR)
           Partial colectomy, NOS
           Rectosigmoidectomy, NOS
           Sigmoidectomy

40   Pull through WITH sphincter preservation (colo-anal anastomosis)
[*SEER Note:* Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation]

50   Total proctectomy
[***SEER Note:*** Procedures coded 50 include but are not limited to: Abdominoperineal resection (A & P resection), anterior/posterior resection (A/P resection)/Miles' operation, Rankin's operation]

51   Total colectomy
[***SEER Note:*** Removal of the colon from cecum to rectosigmoid or portion of rectum]

55   Total colectomy WITH ileostomy, NOS
       56   Ileorectal reconstruction
       57   Total colectomy WITH other pouch; example: Koch pouch

60   Total proctocolectomy, NOS [***SEER Note:*** Combination of 50 and 51]
       65   Total proctocolectomy WITH ileostomy, NOS
       66   Total proctocolectomy WITH ileostomy and pouch
       Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.

70   Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration
[***SEER Note***: Procedures that may be part of an en bloc resection include, but are not limited to: an oophorectomy and a rectal mucosectomy. Code 70 includes any colectomy (partial, hemicolectomy or total) with an en bloc resection of any other organs. The "other organs" may be partially or totally resected. "In continuity with" or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen.]

80   Colectomy, NOS; Proctectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Rectum
C209

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
     11   Photodynamic therapy (PDT)
     12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
     13   Cryosurgery
     14   Laser
No specimen sent to pathology from surgical events 10-14

20   Local tumor excision, NOS
     27   Excisional biopsy
     26   Polypectomy

     Any combination of 20 or 26–27 WITH
          21   Photodynamic therapy (PDT)
          22   Electrocautery
          23   Cryosurgery
          24   Laser ablation
     25   Laser excision
     28   Curette and fulguration

30   Wedge or segmental resection; partial proctectomy, NOS
     Procedures coded 30 include, but are not limited to:
          Anterior resection
          Hartmann's operation
          Low anterior resection (LAR)
          Transsacral rectosigmoidectomy
          Total mesorectal excision (TME)

40   Pull through WITH sphincter preservation (colo-anal anastomosis)
[***SEER Note:*** Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation]

50   Total proctectomy
      Procedure coded 50 includes, but is not limited to:
              Abdominoperineal resection (Miles Procedure)
[**SEER Note**: Also called A & P resection, anterior/posterior (A/P) resection/Miles' operation, Rankin's operation]

60   Total proctocolectomy, NOS

70   Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration
[**SEER Note**: In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80   Proctectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Anus
C210–C218

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

[*SEER Note:* Do not code infrared coagulation as treatment.]

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
    11   Photodynamic therapy (PDT)
    12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
    13   Cryosurgery
    14   Laser
    15   Thermal ablation
No specimen sent to pathology from surgical events 10–15

20   Local tumor excision, NOS
    26   Polypectomy
    27   Excisional biopsy

    Any combination of 20 or 26–27 WITH
        21   Photodynamic therapy (PDT)
        22   Electrocautery
        23   Cryosurgery
        24   Laser ablation
    25   Laser excision

[*SEER Note:* Margins of resection may have microscopic involvement]

60   Abdominal perineal resection, NOS (APR; Miles procedure)
    61   APR and sentinel node excision
    62   APR and unilateral inguinal lymph node dissection
    63   APR and bilateral inguinal lymph node dissection
    The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*
(NAACCR Item # 1292).

Specimen sent to pathology from surgical events 20-63.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Liver and Intrahepatic Bile Ducts
C220–C221

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
    11   Photodynamic therapy (PDT)
    12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
    13   Cryosurgery
    14   Laser
    15   Alcohol (Percutaneous Ethanol Injection-PEI)
    [*SEER Note:* Code 15 (Alcohol (Percutaneous Ethanol Injection-PEI)) can also be described as an "intratumoral injection of alcohol" or "alcohol ablation"]
    16   Heat-Radio-Frequency ablation (RFA)
    17   Other (ultrasound, acetic acid)
No specimen sent to pathology from surgical events 10–17

20   Wedge or segmental resection, NOS
    21   Wedge resection
    22   Segmental resection, NOS
        23   One
        24   Two
        25   Three
        [*SEER Note:* Codes 23-25 mean one, two or three wedges or segments of the liver were removed.]
        26   Segmental resection AND local tumor destruction

30   Lobectomy, NOS
    36   Right lobectomy
    37   Left lobectomy
    38   Lobectomy AND local tumor destruction
[*SEER Note:* Code 30 also referred to as simple lobectomy]

50   Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
    51   Right lobectomy
    52   Left lobectomy
    59   Extended lobectomy AND local tumor destruction

60   Hepatectomy, NOS
    61   Total hepatectomy and transplant

65 Excision of a bile duct (for an intrahepatic bile duct primary only)
  66 Excision of a bile duct PLUS partial hepatectomy

75 Bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events 20-75.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

Pancreas
C250–C259

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

25   Local excision of tumor, NOS

30   Partial pancreatectomy, NOS; example: distal

35   Local or partial pancreatectomy and duodenectomy
       36   **WITHOUT** distal/partial gastrectomy
       37   **WITH** partial gastrectomy (Whipple)

40   Total pancreatectomy

60   Total pancreatectomy and subtotal gastrectomy or duodenectomy

70   Extended pancreatoduodenectomy

80   Pancreatectomy, NOS

90   Surgery, NOS

[*SEER Note:* Assign code 90 for NanoKnife, or irreversible electroporation (IRE)]

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Larynx
C320–C329

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
    11   Photodynamic therapy (PDT)
    12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
    13   Cryosurgery
    14   Laser
    15   Stripping
No specimen sent to pathology from surgical events 10–15

20   Local tumor excision, NOS
    26   Polypectomy
    27   Excisional biopsy

    Any combination of 20 or 26–27 WITH
        21   Photodynamic therapy (PDT)
        22   Electrocautery
        23   Cryosurgery
        24   Laser ablation
    25   Laser excision
    28   Stripping

30   Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
    31   Vertical laryngectomy
    32   Anterior commissure laryngectomy
    33   Supraglottic laryngectomy

    [*SEER Note:* **Vertical laryngectomy:** Removal of involved true vocal cord, ipsilateral false vocal cord, intervening ventricle, and/or ipsilateral thyroid and may include removal of the arytenoids.

    Supraglottic laryngectomy: Conservative surgery intended to preserve the laryngeal function. Standard procedure involves removal of epiglottis, false vocal cords, aryepiglottic folds, arytenoid cartilages, ventricle, upper one third of thyroid cartilage, and/or thyroid membrane. The true vocal cords and arytenoids remain in place to allow vocalization and deglutition.]

40   Total or radical laryngectomy, NOS
     41   Total laryngectomy ONLY
     42   Radical laryngectomy ONLY

[*SEER Note:* Radical laryngectomy: Includes removal of adjacent sites. Do not code the removal of adjacent sites in Surgical Procedure of Other Site.]

50   Pharyngolaryngectomy

80   Laryngectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Lung
C340–C349

**(Except for M9727, 9732, 9741-9742, 9762-9809, 9832,
9840-9931, 9945-9946, 9950-9967, 9975-9992)**

Codes

00   None; no surgery of primary site; autopsy ONLY

19   Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (used principally for cases diagnosed prior to January 1, 2003)

15   Local tumor destruction, NOS
     12   Laser ablation or cryosurgery
     13   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
No specimen sent to pathology from surgical events 12-13 and 15

[*SEER Note:* Assign code 15 for radiofrequency ablation (RFA).]

20   Excision or resection of less than one lobe, NOS
     23   Excision, NOS
     24   Laser excision
     25   Bronchial sleeve resection ONLY
     21   Wedge resection
     22   Segmental resection, including lingulectomy
Specimen sent to pathology from surgical events 20–25

30   Resection of [at least one] lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
     33   Lobectomy WITH mediastinal lymph node dissection
     The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292).

[*SEER Note:* Assign code 30 when lymph node dissection is not performed, but lymph nodes are obtained as part of the lobectomy specimen.]

45   Lobe or bilobectomy extended, NOS
     46   WITH chest wall
     47   WITH pericardium
     48   WITH diaphragm

55   Pneumonectomy, NOS
[***SEER Note:*** Code 55 includes the following procedures: complete pneumonectomy, sleeve pneumonectomy, standard pneumonectomy, total pneumonectomy, resection of whole lung]

      56   WITH mediastinal lymph node dissection (radical pneumonectomy)
      The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292).

65   Extended pneumonectomy
      66   Extended pneumonectomy plus pleura or diaphragm

70   Extended radical pneumonectomy
      The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292).
[***SEER Note:*** An extended radical pneumonectomy is a radical pneumonectomy (including removal of mediastinal nodes) and the removal of other tissues or nodes]

80   Resection of lung, NOS

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Hematopoietic/Reticuloendothelial/
Immunoproliferative/Myeloproliferative Disease
C420, C421, C423, C424 (with any histology)
or
M9727, 9732, 9741-9742, 9762-9809, 9832,
9840-9931, 9945-9946, 9950-9967, 9975-9992

Codes

98   All hematopoietic /reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment

       Surgical procedures for hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item # 1294).

[***SEER Note:*** 99 Death certificate only]

Surgery Codes

Bones, Joints, And Articular Cartilage C400–C419
Peripheral Nerves And Autonomic Nervous System C470–C479
Connective, Subcutaneous, And Other Soft Tissues C490–C499

**(Except for M9727, 9732, 9741-9742, 9762-9809, 9832,
9840-9931, 9945-9946, 9950-9967, 9975-9992)**

Codes

00   None; no surgery of primary site; autopsy ONLY

19   Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003)

15   Local tumor destruction
No specimen sent to pathology from surgical event 15

25   Local excision

26   Partial resection

30   Radical excision or resection of lesion WITH limb salvage

40   Amputation of limb
        41   Partial amputation of limb
        42   Total amputation of limb

50   Major amputation, NOS
        51   Forequarter, including scapula
        52   Hindquarter, including ilium/hip bone
        53   Hemipelvectomy**, NOS**
        54   Internal hemipelvectomy

Specimen sent to pathology from surgical events 25-54

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Spleen
C42.2

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

19   Local tumor destruction, NOS

Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).

21   Partial splenectomy

22   Total splenectomy

80   Splenectomy, NOS

Specimen sent to pathology for surgical events 21-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Skin
C440–C449

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
      11   Photodynamic therapy (PDT)
      12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
      13   Cryosurgery
      14   Laser ablation
No specimen sent to pathology from surgical events 10–14

20   Local tumor excision, NOS
      26   Polypectomy
      27   Excisional biopsy

      Any combination of 20 or 26–27 WITH
           21   Photodynamic therapy (PDT)
           22   Electrocautery
           23   Cryosurgery
           24   Laser ablation
      25   Laser excision

[*SEER Note:* Assign code 11 if there is no pathology specimen. Assign code 21 if there is a pathology specimen. Codes 20-27 include shave and wedge resection]

30   Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
      31   Shave biopsy followed by a gross excision of the lesion
      32   Punch biopsy followed by a gross excision of the lesion
      33   Incisional biopsy followed by a gross excision of the lesion
      34   Mohs surgery, NOS
           [*SEER Note:* Assign code 34 for shave biopsy followed by MOHS surgery for melanoma of the skin.]
      35   Mohs with 1-cm margin or less
      36   Mohs with more than 1-cm margin

[***SEER Note:*** Codes 30 to 35 include less than a wide excision, less than or equal to 1-cm margin, or status of margin is unknown. If it is stated to be a **wide excision** or **reexcision**, but the **margins are unknown**, code to 30.
>   Assign a surgery code from the 30-35 range when any margin is less than 1 cm.
>   *Example*: Melanoma: with surgical margins greater than 1 cm for length and width but less than 1 cm for depth. Assign a surgery code in the 30-35 range. Since tumor thickness is an important prognostic factor for cutaneous melanoma, the deep margin is of particular importance.
>   Use code 45 when there is a wide excision AND it is known that the margins of excision are greater than 1 cm.]

45   Wide excision or reexcision of lesion or minor (local) amputation with margins more than 1 cm, NOS. Margins MUST be microscopically negative.
>   46   WITH margins more than 1 cm and less than or equal to 2 cm
>   47   WITH margins greater than 2 cm

If the excision or reexcision has microscopically negative margins less than 1 cm OR the margins are more than 1 cm but are <u>not</u> microscopically confirmed; use the appropriate code, 20-36.
>   [***SEER Note:*** Assign code 47 for amputation of finger.
>   *Example*: Amputation of finger for subungual melanoma.]

60   Major amputation

Specimen sent to pathology from surgical events 20-60.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Breast
C500–C509

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

19   Local tumor destruction, NOS
No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003)

20   Partial mastectomy, NOS; less than total mastectomy, NOS
    21   Partial mastectomy WITH nipple resection
    22   Lumpectomy or excisional biopsy
    23   Reexcision of the biopsy site for gross or microscopic residual disease
    24   Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)
    Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or -preserving surgery). There may be microscopic residual tumor.

[***SEER Note:*** When a patient has a procedure (e.g., lumpectomy) with reconstruction, code only the procedure (e.g., lumpectomy , code 22) as the surgery.].

30   Subcutaneous mastectomy
    A subcutaneous mastectomy, also called nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.

40   Total (simple) mastectomy, NOS
    41   WITHOUT removal of uninvolved contralateral breast
        43   Reconstruction, NOS
            44   Tissue
            45   Implant
            46   Combined (tissue and implant)
    42   WITH removal of uninvolved contralateral breast
        47   Reconstruction, NOS
            48   Tissue
            49   Implant
            75   Combined (tissue and implant)

[***SEER Note:*** "Tissue" for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment.]

A total (simple) mastectomy removes all breast tissue, the nipple, and the areolar complex. An axillary dissection is not done.

For **single** primaries only, code removal of involved contralateral breast under the data item **Surgical Procedure/Other Site** (NAACCR Item # 1294).

[**SEER Note:** Example of single primary with removal of involved contralateral breast--Inflammatory carcinoma involving both breasts. Bilateral simple mastectomies. Code Surgery of Primary Site 41 and code Surgical Procedure of Other Site 1.]

If **contralateral breast** reveals a **second primary**, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

[**SEER Note:** Placement of a tissue expander at the time of original surgery means that reconstruction is planned as part of the first course of treatment. When an expander is placed, code the mastectomy and reconstruction.]

Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, regardless of whether it is done at the time of mastectomy or later.

[**SEER Note:** Reconstruction may be done at the same time as the mastectomy or may be done later. Code 43-49, or 75 if the operative report or medical record states reconstruction will be done later, or if a tissue expander is inserted during the mastectomy procedure. Tissue expander insertion precedes reconstruction.]

76   Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

50   Modified radical mastectomy
        51   WITHOUT removal of uninvolved contralateral breast
                53   Reconstruction, NOS
                        54   Tissue
                        55   Implant
                        56   Combined (tissue and implant)
        52   WITH removal of uninvolved contralateral breast
                57   Reconstruction, NOS
                        58   Tissue
                        59   Implant
                        63   Combined (tissue and implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.

[**SEER Note:** "In continuity with" or "en bloc" means that all the tissues were removed during the same procedure, but not necessarily in a single specimen. "Tissue" for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment. Assign code 51 or 52 if a patient has an excisional biopsy and axillary dissection followed by a simple mastectomy during the first course of therapy. Code the

cumulative result of the surgeries, which is a modified radical mastectomy in this case. Code the most invasive, extensive or definitive surgery in Surgery of Primary Site.]

If **contralateral breast** reveals a **second primary**, each breast is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For **single** primaries only, code removal of involved contralateral breast under the data item **Surgical Procedure/Other Site** (NAACCR Item # 1294).

60   Radical mastectomy, NOS
    61   WITHOUT removal of uninvolved contralateral breast
        64   Reconstruction, NOS
            65   Tissue
            66   Implant
            67   Combined (tissue and implant)
    62   WITH removal of uninvolved contralateral breast
        68   Reconstruction, NOS
            69   Tissue
            73   Implant
            74   Combined (tissue and implant)

[**SEER Note:** Involves removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, and/or pectoralis major, as well as en bloc axillary dissection. "Tissue" for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment.]

70   Extended radical mastectomy
    71   WITHOUT removal of uninvolved contralateral breast
    72   WITH removal of uninvolved contralateral breast

[**SEER Note:** Involves removal of breast tissue, nipple, areolar complex, variable amounts of skin, pectoralis minor, and/or pectoralis major, as well as removal of internal mammary nodes and en bloc axillary dissection.]

80   Mastectomy, NOS

Specimen sent to pathology for surgical events coded 20-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Cervix Uteri
C530–C539

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

[***SEER Note:*** **Do not code** dilation and curettage (D&C) as Surgery of Primary Site **for invasive cancers**]

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
    11   Photodynamic therapy (PDT)
    12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
    13   Cryosurgery
    14   Laser
    15   Loop Electrocautery Excision Procedure (LEEP)
    16   Laser ablation
    17   Thermal ablation
No specimen sent to pathology from surgical events 10–17

20   Local tumor excision, NOS
[***SEER Note:*** Margins of resection may have microscopic involvement. Procedures in code 20 include but are not limited to: cryosurgery, electrocautery, excisional biopsy, laser ablation, or thermal ablation.]
    26   Excisional biopsy, NOS
    27   Cone biopsy
    24   Cone biopsy WITH gross excision of lesion
    29   Trachelectomy; removal of cervical stump; cervicectomy

    Any combination of 20, 24, 26, 27 or 29 WITH
        21   Electrocautery
        22   Cryosurgery
        23   Laser ablation or excision
    25   Dilatation and curettage; endocervical curettage (for in situ only)
    28   Loop electrocautery excision procedure (LEEP)

30   Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
    Total hysterectomy removes both the corpus and the cervix uteri and may also include a portion of vaginal cuff

40   Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
    Total hysterectomy removes both the corpus and the cervix uteri and may also include a portion of vaginal cuff

50   Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
      51   Modified radical hysterectomy
      52   Extended hysterectomy
      53   Radical hysterectomy; Wertheim procedure
      54   Extended radical hysterectomy

60   Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
      61   WITHOUT removal of tubes and ovaries
      62   WITH removal of tubes and ovaries

70   Pelvic exenteration
      71   Anterior exenteration
             Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

[**_SEER Note:_** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]
      72   Posterior exenteration
             Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

[**_SEER Note:_** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]
      73   Total exenteration
             Includes removal of all pelvic contents and pelvic lymph nodes.

[**_SEER Note:_** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]
      74   Extended exenteration
             Includes pelvic blood vessels or bony pelvis

Specimen sent to pathology from surgical events 20-74.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Corpus Uteri
C540–C559

**(Except for M9727, 9732, 9741-9742, 9762-9809, 9832,
9840-9931, 9945-9946, 9950-9967, 9975-9992)**

[*SEER Note:* **Do not code** dilation and curettage (D&C) as Surgery of Primary Site **for invasive
cancers**]

Codes

00   None; no surgery of primary site; autopsy ONLY

19   Local tumor destruction or excision, NOS
**Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for
cases diagnosed prior to January 1, 2003)**

10   Local tumor destruction, NOS
    11   Photodynamic therapy (PDT)
    12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
    13   Cryosurgery
    14   Laser
    15   Loop Electrocautery Excision Procedure (LEEP)
    16   Thermal ablation
No specimen sent to pathology from surgical events 10–16

20   Local tumor excision, NOS; simple excision, NOS
    24   Excisional biopsy
    25   Polypectomy
    26   Myomectomy

    Any combination of 20 or 24–26 WITH
        21   Electrocautery
        22   Cryosurgery
        23   Laser ablation or excision
[*SEER Note:* Margins of resection may have microscopic involvement]

30   Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of
    tube(s) and ovary(ies)
    31   WITHOUT tube(s) and ovary(ies)
    32   WITH tube(s) and ovary(ies)
[*SEER Note:* For these procedures, the cervix is left in place]

40   Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
    Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50   Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
        Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60   Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
        61   Modified radical hysterectomy
        62   Extended hysterectomy
        63   Radical hysterectomy; Wertheim procedure
                [**SEER Note:** Use code 63 for "Type III" hysterectomy]
        64   Extended radical hysterectomy

65   Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
        66   WITHOUT removal of tube(s) and ovary(ies)
        67   WITH removal of tube(s) and ovary(ies)

75   Pelvic exenteration
        76   Anterior exenteration
                Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and
                pelvic lymph nodes.
                [**SEER Note:** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other
                Site]
        77   Posterior exenteration
                Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
                [**SEER Note:** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other
                Site]
        78   Total exenteration
                Includes removal of all pelvic contents and pelvic lymph nodes.
                [**SEER Note:** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other
                Site]
        79   Extended exenteration
                Includes pelvic blood vessels or bony pelvis

Specimen sent to pathology from surgical events 20-79.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Ovary
C569

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

17   Local tumor destruction, NOS
No specimen sent to pathology from surgical event 17

25   Total removal of tumor or (single) ovary, NOS
    26   Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
    27   WITHOUT hysterectomy
    28   WITH hysterectomy
[**SEER Note***:* Use code 28 for current unilateral (salpingo-) oophorectomy with previous history of hysterectomy.]

35   Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done
    36   WITHOUT hysterectomy
    37   WITH hysterectomy
       [**SEER Note***:* Use code 37 for current unilateral (salpingo-) oophorectomy with previous history of hysterectomy.]

50   Bilateral (salpingo-) oophorectomy; unknown if hysterectomy done
    51   WITHOUT hysterectomy
    52   WITH hysterectomy
       [**SEER Note***:* Use code 52 for current bilateral (salpingo-) oophorectomy with previous history of hysterectomy.]

55   Unilateral or bilateral (salpingo-) oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
    56   WITHOUT hysterectomy
    57   WITH hysterectomy
[**SEER Note***:* Use code 57 for current unilateral (salpingo-) oophorectomy with previous history of hysterectomy.]

60   Debulking; cytoreductive surgery, NOS
    61   WITH colon (including appendix) and/or small intestine resection (not incidental)
    62   WITH partial resection of urinary tract (not incidental)
    63   Combination of 61 and 62
Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or

may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.

[**SEER Note:** Debulking or cytoreductive surgery is implied by the following phrases in the operative report, pathology report, discharge summary, or consultation. (This is not intended to be a complete list. Other phrases may also imply debulking).

    Adjuvant treatment pending surgical reduction of tumor

    Ovaries, tubes buried in tumor

    Tumor burden

    Tumor cakes

    Very large tumor mass

Do not code debulking or cytoreductive surgery based on: multiple biopsies alone, the mention of "multiple tissue fragments" or "removal of multiple implants." Multiple biopsies and multiple specimens confirm the presence or absence of metastasis.]

70   Pelvic exenteration, NOS

    71   Anterior exenteration
    Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
    [**SEER Note**: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.]

    72   Posterior exenteration
    Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
    [**SEER Note**: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.]

    73   Total exenteration
    Includes removal of all pelvic contents and pelvic lymph nodes.
    [**SEER Note:** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.]

    74   Extended exenteration
    Includes pelvic blood vessels or bony pelvis

80   (Salpingo-) oophorectomy, NOS

Specimen sent to pathology from surgical events 25-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Prostate
C619

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item "Hematologic Transplant and Endocrine Procedures" (NAACCR Item # 3250).

Codes

00　　None; no surgery of primary site; autopsy ONLY

18　　Local tumor destruction or excision, NOS

19　　Transurethral resection (TURP), NOS
Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003)

10　　Local tumor destruction [or excision], NOS
　　　14　　Cryoprostatectomy
　　　15　　Laser ablation
　　　16　　Hyperthermia
　　　17　　Other method of local tumor destruction
No specimen sent to pathology from surgical events 10–17
[**SEER Note:** Assign **code 15** for Niagara laser photovaporization of the prostate. Assign **code 16** for Transurethral Microwave Thermotherapy (TUMT). Assign **code 17** for High Intensity Focused Ultrasonography (HIFU) and for Transurethral Needle Ablation (TUNA).]

20　　Local tumor excision, NOS
　　　21　　Transurethral resection (TURP), NOS
　　　22　　TURP—cancer is incidental finding during surgery for benign disease
　　　23　　TURP—patient has suspected/known cancer

　　　Any combination of 20–23 WITH
　　　　　24　　Cryosurgery
　　　　　25　　Laser
　　　　　26　　Hyperthermia

30　　Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact
[**SEER Note:** May include suprapubic prostatectomy.]

50　　Radical prostatectomy, NOS; total prostatectomy, NOS
Includes excision of the prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s); and may include a narrow cuff of bladder neck.

70   Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to cystoprostatectomy, radical cystectomy, and prostatectomy.
[**SEER Note:** "In continuity with" or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80   Prostatectomy, NOS

Specimen sent to pathology from surgical events 20-80.
90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Testis
C620–C629

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

12   Local tumor destruction, NOS
     No specimen sent to pathology from surgical event 12

20   Local or partial excision of testicle

30   Excision of testicle, WITHOUT cord
     [*SEER Note*: Orchiectomy not including spermatic cord]

40   Excision of testicle WITH cord or cord not mentioned (radical orchiectomy)
     [*SEER Note*: Orchiectomy with or without spermatic cord]

80   Orchiectomy, NOS (unspecified whether partial or total testicle removed)

Specimen sent to pathology from surgical events 20-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate only

Surgery Codes

Kidney, Renal Pelvis, and Ureter
Kidney C649, Renal Pelvis C659, Ureter C669

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
    11   Photodynamic therapy (PDT)
    12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
    13   Cryosurgery
    14   Laser
    15   Thermal ablation
No specimen sent to pathology from this surgical event 10–15

20   Local tumor excision, NOS
    26   Polypectomy
    27   Excisional biopsy

    Any combination of 20 or 26–27 WITH
        21   Photodynamic therapy (PDT)
        22   Electrocautery
        23   Cryosurgery
        24   Laser ablation
    25   Laser excision

30   Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)
    Procedures coded 30 include, but are not limited to:
        Segmental resection
        Wedge resection

40   Complete/total/simple nephrectomy—for kidney parenchyma
    Nephroureterectomy
    Includes bladder cuff for renal pelvis or ureter

50   Radical nephrectomy
    May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter

70   Any nephrectomy (simple, subtotal, complete, partial, total, radical) in continuity with the resection of other organ(s) (colon, bladder)
    The other organs, such as colon or bladder, may be partially or totally removed
    [***SEER Note:*** "In continuity with" or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80   Nephrectomy, NOS
      Ureterectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Bladder
C670–C679

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
        11   Photodynamic therapy (PDT)
        12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
        13   Cryosurgery
        14   Laser
        15   Intravesical therapy
        16   Bacillus Calmette-Guerin (BCG) or other immunotherapy
            [*SEER Note:* Code BCG as both surgery and immunotherapy]
Also code the introduction of immunotherapy in the immunotherapy items. If immunotherapy is followed by surgery of the type coded 20-80, code that surgery instead and code the immunotherapy only as immunotherapy.
No specimen sent to pathology from surgical events 10–16

20   Local tumor excision, NOS
        26   Polypectomy
        27   Excisional biopsy
            [*SEER Note:* Code TURB as 27]

        Combination of 20 or 26–27 WITH
            21   Photodynamic therapy (PDT)
            22   Electrocautery
            23   Cryosurgery
        24   Laser ablation
        25   Laser excision

30   Partial cystectomy

50   Simple/total/complete cystectomy

60   Complete cystectomy with reconstruction
    [*SEER Note:* Use code 71 for cystoprostatectomy.]
        61   Radical cystectomy PLUS ileal conduit
        62   Radical cystectomy PLUS continent reservoir or pouch, NOS
        63   Radical cystectomy PLUS abdominal pouch (cutaneous)
        64   Radical cystectomy PLUS in situ pouch (orthotopic)
When the procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

70   Pelvic exenteration, NOS

     71   Radical cystectomy including anterior exenteration
           [***SEER Note:*** Use code 71 for cystoprostatectomy.]

For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

     72   Posterior exenteration

For females, also includes removal of vagina, rectum and anus. For males, also includes prostate, rectum and anus.

     73   Total exenteration

Includes all tissue and organs removed for an anterior and posterior exenteration.
           [***SEER Note:*** Includes removal of all pelvic contents and pelvic lymph nodes. The lymph
           node dissection should also be coded under *Scope of Regional Lymph Node Surgery*
           (NAACCR item # 1292).]

     74   Extended exenteration
Includes pelvic blood vessels and/or bony pelvis

80   Cystectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

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)

Do not code laminectomies for spinal cord primaries

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Tumor destruction, NOS
        [**SEER Note:** Local tumor destruction, NOS; laser interstitial thermal therapy (LITT) - code 10 if
        no specimen sent to pathology]
No specimen sent to pathology from surgical event 10

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as
surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.

20   Local excision of tumor, lesion, or mass, excisional biopsy
        21   Subtotal resection of tumor, lesion or mass in brain
        22   Resection of tumor in spinal cord or nerve
[**SEER Note:** Assign code 20 for stereotactic biopsy of brain tumor]

30   Radical, total, gross resection of tumor, lesion or mass in brain

40   Partial resection of lobe of brain, when the surgery cannot be coded as 20-30

55   Gross total resection of lobe of brain (lobectomy)

Codes 30-55 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events 20-55.

90   Surgery, NOS
[**SEER Note:** Laser interstitial thermal therapy (:LITT) - code 90 if specimen sent to pathology]

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Thyroid Gland
C739

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

13   Local tumor destruction, NOS
No specimen sent to pathology from surgical event 13

25   Removal of less than a lobe, NOS
    26   Local surgical excision
    27   Removal of a partial lobe ONLY

20   Lobectomy and/or isthmectomy
    21   Lobectomy ONLY
    22   Isthmectomy ONLY
    23   Lobectomy WITH isthmus

30   Removal of a lobe and partial removal of the contralateral lobe

40   Subtotal or near total thyroidectomy

50   Total thyroidectomy

80   Thyroidectomy, NOS

Specimen sent to pathology from surgical events 25-80.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Lymph Nodes
C770–C779

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

19   Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003)

15   Local tumor destruction, NOS
No specimen sent to pathology from surgical event 15

25   Local tumor excision, NOS
      Less than a full chain, includes an excisional biopsy of a single lymph node.
      [*SEER Note*: The use of code 25 in RX SUMM—SURG PRIM SITE [1290] is for a primary in one and only one lymph node. The single involved lymph node is removed by an excisional biopsy only. CDC-NPCR, CoC, and SEER are in agreement on the wording of code 25.]

30   Lymph node dissection, NOS
      31   One chain
      32   Two or more chains

40   Lymph node dissection, NOS PLUS splenectomy
      41   One chain
      42   Two or more chains

50   Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
      51   One chain
      52   Two or more chains

60   Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy
      (Includes staging laparotomy for lymphoma)
      61   One chain
      62   Two or more chains

Specimen sent to pathology for surgical events 25-62.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00   None; no surgery of primary site; autopsy ONLY

10   Local tumor destruction, NOS
    11   Photodynamic therapy (PDT)
    12   Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
    13   Cryosurgery
    14   Laser
    [*SEER Note:* Assign code 14 for laser hyperthermia of eye for retinoblastoma]
No specimen sent to pathology from surgical events 10–14

20   Local tumor excision, NOS
    26   Polypectomy
    27   Excisional biopsy

    Any combination of 20 or 26–27 WITH
        21   Photodynamic therapy (PDT)
    22   Electrocautery
    23   Cryosurgery
    24   Laser ablation
    25   Laser excision

30   Simple/partial surgical removal of primary site

40   Total surgical removal of primary site; enucleation
    41   Total enucleation (for eye surgery only)

50   Surgery stated to be "debulking"

60   Radical surgery
    Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs
    [*SEER Note:* In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Specimen sent to pathology from surgical events 20-60.

90   Surgery, NOS

99   Unknown if surgery performed; death certificate ONLY

Surgery Codes

Unknown and Ill-Defined Primary Sites
C760–C768, C809

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

98   **All** unknown and ill-defined disease sites, **WITH** or **WITHOUT surgical treatment**
Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item
Surgical Procedure/Other Site (NAACCR Item #1294)

[*SEER NOTE:* 99 Death certificate only]