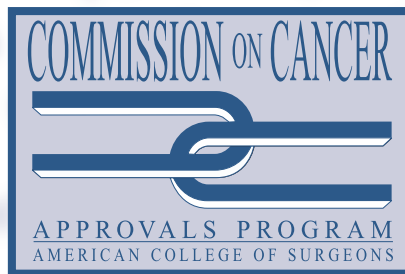


FORDS

FACILITY ONCOLOGY REGISTRY DATA STANDARDS



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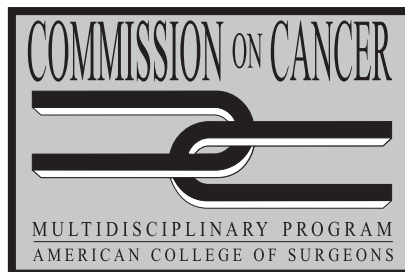


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Preface

Implementation of the *Facility Oncology Registry Data Standards (FORDS)* will be required of all Commission on Cancer (CoC)-approved cancer programs starting with cases diagnosed January 1, 2003. Registry data management is an essential element of each CoC-approved cancer program. *FORDS* has been written to ensure that hospital cancer registry data support the meaningful evaluation of patient diagnosis and treatment and that these data are structured and maintained with standardized quality control mechanisms.

Development of *FORDS*

Beginning in March 2000, an extensive review was conducted of the Commission on Cancer's registry data collection manual, *Standards of the Commission on Cancer Volume II: Registry Operations and Data Standards (ROADS)*. The initial phase of this review focused on the development of a set of discussion points and recommendations that were presented to a workgroup—comprised of clinicians, registrars, and cancer registry software vendors—in February of 2001.

This workgroup established five guidelines that defined the revisions to *ROADS*:

- **Registry support:** Collect data items that are necessary to the maintenance of a quality cancer registry. The CoC, through its Approvals Program, is committed to setting the highest possible standards for hospital cancer registry operations. The data set defined in *FORDS* contains all of the elements necessary to operate a successful cancer registry.
- **Clinical relevance:** Collect data items that improve our clinical understanding of the treatment and outcomes experience of patients. *ROADS*, and its 1998 revision, substantially advanced the CoC's commitment to collecting data that described surgical care. The *FORDS* manual expands the CoC's commitment to better describing the multidisciplinary care of cancer patients.
- **Collectible data:** Ensure the scope of the data that the CoC requires registry professionals to abstract does not reach beyond currently available and commonly utilized abstracting sources. The CoC recognizes the need to balance a data collection scheme that provides maximum information while minimizing the inherent burden associated with expanding the clinical scope of the defined required data set found in *FORDS*.
- **Objective recording:** Eliminate data items that require subjective consideration by registry staff or require the consideration of multiple factors before arriving at a single abstracted code value.
- **Clear presentation:** Ensure that each item that appears in *FORDS* is clearly defined, that there is a rationale for the inclusion of each item in the data standards manual, and that coding instructions for each item are clearly presented and thorough.

The guidelines resulted in the removal, revision, and addition of data items to the *FORDS* manual:

- The removal of 102 data items from the list of CoC-required and recommended items appearing in *ROADS*.
- *FORDS* requires data items:
 - Sixteen data items that are either autocoded or derived and do not have to be abstracted from patient charts or records.
 - Fifty-eight data items that have been retained and remain unchanged from *ROADS*.
 - Forty data items that have been retained from *ROADS*, but have been revised. Twenty-seven data items—most describing first course treatment—have revised code sets and definitions. The remaining

13 items were revised to accommodate updated editions of staging or coding references, or simply involved changes in the item length.

- Nineteen new data items. Two supplemental patient address line items have been added. Six new items describe comorbidities and complications—these have been introduced to facilitate risk adjustment calculations. Eleven new treatment items have been introduced.
- Twenty-four case administration items. Twelve case administration items are autocoded by registry software and the remaining items are override flags. All of these administrative items have been introduced to enable registry staff to manage the quality of their program’s data.

Overview of Changes Introduced with *FORDS*

Each of the data items in *FORDS* satisfies each of the criteria set by the advisory workgroup—that items are necessary to maintain a quality cancer registry, clinically relevant, collectable, objective, and clearly defined. Changes to items retained from *ROADS* and newly introduced items are highlighted below.

- **Case Eligibility:** Case accessioning requirements have been modified to bring CoC requirements into agreement with those of other standard setting organizations.
 - Beginning with tumors diagnosed January 1, 2003, the CoC no longer requires registries of approved programs to accession skin primaries (C44. _) with histology codes 8000-8110, regardless of the stage of disease at diagnosis.
 - A new Class 7 has been defined for use by facilities that collect “pathology only” reportable-by-agreement cases.
- **Unique Patient Identifier Codes:** Modifications were made to two key data items that serve to identify patients within registry data sets.
 - *Accession Number* (NAACCR Item #550) has been allotted additional characters in *FORDS*. The initial characters that signify the year the patient was first seen for a cancer now accommodate a four-character year value rather than the former two-character value. The final characters that signify the order in which the patient was accessioned into the registry have been expanded from four to five characters to handle the expanding size of some registry software caseloads. The change in item length was adopted previously for data exchange, so registry software providers in many facilities may have implemented the expanded code before publication of *FORDS*.
 - The representation of *Sequence Number* (NAACCR Item #560) has been changed substantially. The CoC worked with central registry organizations, particularly the Surveillance, Epidemiology and End Results Program (SEER) and the National Program of Cancer Registries (NPCR), through NAACCR to develop codes and instructions for assigning sequence numbers that could be adopted by all cancer registry standard setting organizations. Two needs were identified. First, the use of codes consisting entirely of numerals is expected to improve the accuracy of data entry and to be easier to manipulate in many analytic settings. Second, the new codes and instructions are designed for applicability across settings that may have differing case eligibility requirements.
- **Patient Address:** Changes have been introduced to the address items in order to make them more adaptable for use with current technology.
 - The instructions for coding the number and street portion of addresses and cities now also incorporate postal service specifications. These changes should improve automatic processing of addresses for mailing and will facilitate address input to automated coding systems that generate Census area, latitude and longitude, or other regional descriptors.

- Two new address data items—*Patient Address (Number and Street) at Diagnosis—Supplemental* (NAACCR Item #2335), and *Patient Address (Number and Street) Current—Supplemental* (NAACCR Item #2355)—have been added for address specifications that may be needed by the registry, but are not of the type specified for number and street. Typically, these lines can be used to name a nursing home, convalescent center or apartment complex, an “in care of” name, or similar address content. In some cases, the line may be used for an apartment or post office box number if the address is too long to fit into the number and street space. The new items can be left blank when not needed.
- Number and street items and city name items are being lengthened to meet postal service recommendations.
- The use of the Federal Information Processing Standards (FIPS) code for counties is now required for *County at Diagnosis* (NAACCR Item #90). This code has been recommended by the CoC for many years. Use of the standard codes is necessary when registry reports are pooled as in central registries; they are more readily administered by registry software providers; and they are in a form that can be linked to Census or similar information for analysis with respect to characteristics of patient environment.
- **Patient Identification:** Patient insurance status was modified and the inclusion of coding for comorbid conditions and complications is now included.
 - The response categories for *Primary Payer at Diagnosis* (NAACCR Item #630) have been revised to eliminate categories that have no bearing on the compensation for services provided (eg, the former welfare category). Health services research and health policy experts indicate the revised categories are an exhaustive representation of current and near future primary payer types. JCAHO requires the patient admission page to record the type of insurance or payment structures that cover the patient while receiving hospital care.
 - The CoC now requires that the registry record include up to six comorbid conditions and/or treatment complications. These can be copied from the face sheet of the patient record using specific ranges of ICD-9-CM codes.
- **Stage of Disease:** Diagnostic and staging procedures have been refined to limit the scope of the procedures described. Previously in *ROADS*, a single data item recorded all diagnostic and palliative surgeries. There are now separate data items for these surgeries in *FORDS*. Additionally, information related to the *AJCC Cancer Staging Manual*, Sixth Edition, has been included.
- **Treatment:** *FORDS* introduces substantial changes in the organization and structure of all treatment items to make the information more clinically relevant, draw on the information most accessible to registrars in the patient record, and provide a more comprehensive picture of the treatment provided to the patient. The instructions and code categories for all treatment items have been updated to improve their clarity and consistency, and the relationships among treatment items is explicitly defined.
 - The CoC now requires that ALL treatment items be abstracted by registries in approved cancer programs.

Surgery Items:

- g The selection, response categories, and instructions for all surgery items have been reviewed for current clinical applicability, clarity of use, and continuity of historic data. In keeping with these principles, some items that had site-specific definitions in the past are now represented by a single set of response categories. Many continued items have new codes and revised coding instructions. Some continued site-specific codes have revised grouping. Some new items have been added. And finally, some items previously defined in *ROADS* do not appear in this

publication. Registrars familiar with the former instructions will need to be especially mindful of the changes introduced.

Radiation Items:

- g The radiation items have been reassessed to describe the full spectrum of radiation oncology therapy available in contemporary clinical practice.

Systemic Therapy Items:

- g The systemic therapy items have been reviewed and redesigned for greater uniformity in their definition while still retaining historic analytic continuity. *Hormone Therapy* (NAACCR Item #1400) and *Immunotherapy* (NAACCR Item #1410) now are limited to describing whether or not agents were administered to a patient. The new item *Hematologic Transplant/Endocrine Procedures* (NAACCR Item #3250) was designed to capture those infrequent instances in which a medical, surgical, or radiation procedure is performed on a patient which has an effect on the hormonal or immunologic balance of the patient.
- g The new, single data item, *Date Systemic Therapy Started* (NAACCR Item #3230), replaces the three data items that formerly recorded start dates for chemotherapy, hormone therapy, and immunotherapy.

Palliative Care:

- g New items used to record pain assessment evaluation and procedures performed to provide symptom palliation. They are designed to help evaluate symptomatic care provided to the cancer patient.
- **Patient Outcomes:** These data items were revised to ensure they provided clinical relevance and that the information is accessible to registrars.
 - *Type of First Recurrence* (NAACCR Item #1880) was restructured to provide more comprehensive information than the two former type of recurrence items and the three former site of distant recurrence items. The revision incorporates the same sites of distant recurrence for tumors with distant recurrence in *one* organ or organ system *only*. The structure of the item discourages coding of recurrence in those sites when it is not truly distant. It separates recurrence in unknown distant sites from recurrence in multiple distant sites, and it separates both from the other categories. The revision provides more detail than the previous items for recording simultaneous recurrence at local, regional, and/or distant locations. It also provides separate recurrence codes for tumors that were originally diagnosed as in situ to accommodate differences in some central registry requirements for submitting in situ cases with a subsequent invasive diagnosis.

Using *FORDS*

Section One, *Case Eligibility, Cancer Identification, and Overview of Coding Principles*, provides a context for abstracting and coding the items defined in Section Two and describes the types of cases that must be abstracted and followed by the registry. It also explains the relationships among data items.

Section Two, *Coding Instructions*, contains detailed instructions and codes for each item. Facility oncology registry data are now routinely collected by the National Cancer Data Base (NCDB) of the CoC, as well as state and regional central registries. The CoC supports those programs, and to facilitate communication among registries, all items in *FORDS* are identified by their unique North American Association of Central Cancer Registries (NAACCR) item numbers.

In addition to *FORDS*, the registrar will need to use other manuals to record some items:

Fritz A, Percy C, et al (eds): *International Classification of Diseases for Oncology*, Third Edition. Geneva. World Health Organization, 2000.

Greene FL, Page DL, et al (eds): *AJCC Cancer Staging Manual*, Sixth Edition. New York, NY, Springer-Verlag, 2002. (Or the most current edition of the AJCC staging manual).

Other recommended references include:

Fritz A, Ries L (eds): *SEER Extent of Disease—1998: Codes and Coding Instructions*, Third Edition. Bethesda, MD, NIH, NCI, 1998.

Hultstrom D (ed): *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 10*, Sixth Edition. Springfield, IL, North American Association for Central Cancer Registries, 2002.

Puckett CD (ed): *The Educational Annotation of ICD-9-CM*, Fourth Edition. Reno, NV, Channel Publishing Ltd., 1996.

Acknowledgments

Editors

Jerri Linn Phillips, MA, CTR
Andrew K. Stewart, MA
Pat Tary, CTR

Developmental Editor

Kelly Poirier

ROADS 2003 Task Force Members

Frank Baker, PhD
Albert Brady, MD, FACP
Ralph Broadwater, MD, FACS
Alfred Cohen, MD, FACS
Vilma Cokkinides, PhD
Carolyn Compton, MD, PhD
Stephen Edge, MD, FACS
Brenda Edwards, PhD
Kenneth Gerlach, CTR
Dianne Hulstrom, CTR
Linda Jund, CTR
Nicholas Lang, MD, FACS
Rosemary McKee, CTR
Mitchell Morris, MD, FACS
Kate O'Brien, MPH
Nicholas Petrelli, MD, FACS
Frances Ross, CTR
Carol Scott-Conner, MD (Chair)
Brenda Shank, MD, PhD, FACR
Theodore Williamson, MD, PhD

CoC Staff Contributors

Asa Carter, CTR
Susan DesHarnais, PhD
Lynda Douglas, CTR
Mary Jo Strebel, RHIT, CTR
JoAnne Sylvester, MA

Special Acknowledgments and Recognition

Susan Capron
Annette Hurlbut, RHIT, CTR
Dianne V. Hultstrom, RHIT, CTR
Lynn G. Reiss, MS
Uniform Data Standards Committee (NAACCR)

SECTION ONE:

Case Eligibility, Cancer Identification, and Overview of Coding Principles

CASE ELIGIBILITY

The American College of Surgeons Commission on Cancer (CoC) requires registries in approved programs to accession, abstract, and conduct follow-up activities for required malignancies diagnosed and/or initially treated at the abstracting facility. The malignancies must meet the criteria for analytic cases (classes of case 0, 1, or 2), and pathologically and clinically diagnosed inpatients and outpatients must be included.

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

Malignancies with an ICD-O-3* behavior code of 2 or 3 are required.

EXCEPTION 1: Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, *is required* and should be recorded as 9421/3 in the registry.

EXCEPTION 2: Malignant primary skin cancers (C44. _) with histology codes 8000–8110 *are not required* by the CoC. Skin primaries with those histologies diagnosed prior to January 1, 2003, were required to be accessioned and followed if the AJCC stage group at diagnosis was II, III, or IV. Those cases should remain in the registry data and continue to be followed.

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

As part of the registry case-finding activities, all pathology reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included.

List of Ambiguous Diagnostic Terms	
Terms That Constitute a Diagnosis	Terms That <i>Do Not</i> Constitute a Diagnosis**
Apparent(ly)	Cannot be ruled out
Appears to	Equivocal
Comparable with	Possible
Compatible with	Potentially malignant
Consistent with	Questionable
Favor(s)	Rule out
Malignant appearing	Suggests
Most likely	Worrisome
Presumed	
Probable	
Suspect	
Suspicious	
Typical of	

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

**Without additional information.

Examples of Diagnostic Terms:

- The inpatient discharge summary documents a chest x-ray *consistent with carcinoma* of the right upper lobe. The patient refused further workup or treatment. *Consistent with carcinoma* is indicative of cancer.
- The mammogram report states *suspicious for malignancy*. *Suspicious for malignancy* is indicative of cancer.

Examples of Nondiagnostic Terms:

- The inpatient discharge summary documents a chest x-ray *consistent with neoplasm* of the right upper lobe. The patient refused further workup or treatment. *Consistent with neoplasm* is not indicative of cancer. While “consistent with” can indicate involvement, “neoplasm” without specification of malignancy is not considered diagnostic.
- Final diagnosis is reported as *possible carcinoma* of the breast. *Possible* is not a diagnostic term for cancer.

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

REPORTABLE-BY-AGREEMENT CASES

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

Examples of Reportable-by-Agreement Cases:

- The cancer committee requests abstracting and follow-up of Class of Case 3 cases.
- The state central registry requests abstracting of benign and borderline intracranial and central nervous system tumors for submission to the state.

CASES NOT REQUIRED BY THE CoC TO BE ACCESSIONED

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

CLASS OF CASE

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

Analytic Cases

Analytic cases (*Class of Case* 0–2) are included in treatment and survival analysis.

Cases diagnosed at the accessioning facility and/or administered any of the first course of treatment there after the registry’s reference date are analytic. A network clinic or outpatient center belonging to the facility is considered part of the facility.

Cases that were not diagnosed, but had a treatment plan developed, at the accessioning facility and the treatment was carried out elsewhere no longer need to be included in the accessioning facility's registry. If these cases are collected as reportable-by-agreement cases, they should be coded as Class 0 if diagnosed at the facility, or coded as Class 2 if the treatment plan is the only portion of the treatment completed at the accessioning facility.

Nonanalytic Cases

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

Class of Case Definitions	
Class	Includes
Analytic Cases	
Class 0	Diagnosis at the accessioning facility and all of the first course of treatment was performed elsewhere or the decision not to treat was made at another facility. <ul style="list-style-type: none"> • Patients diagnosed at the accessioning facility who choose to be treated elsewhere. • Patients diagnosed at the accessioning facility who are referred elsewhere for treatment.
Class 1	Diagnosis at the accessioning facility, and all or part of the first course of treatment was performed at the accessioning facility. <ul style="list-style-type: none"> • Patients diagnosed at the accessioning facility whose treatment plan is either not to treat or watchful waiting. • Patients diagnosed at the accessioning facility who refuse treatment. • Patients diagnosed at the accessioning facility who are not treatable due to age, advanced disease, or other medical conditions. • Patients diagnosed at the accessioning facility for whom it is unknown whether treatment was recommended or administered. • Patients diagnosed at the accessioning facility for whom treatment was recommended, but it is unknown whether it was administered. • Patients diagnosed at a staff physician's office who receive their first course of treatment at the accessioning facility. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility. • Patients diagnosed at the accessioning facility who received all or part of their first course of treatment in a staff physician's office.
Class 2	Diagnosis elsewhere, and all or part of the first course of treatment was performed at the accessioning facility.
Nonanalytic Cases	
Class 3	Diagnosis and all of the first course of treatment was performed elsewhere. Presents at the accessioning facility with recurrence or persistent disease. <ul style="list-style-type: none"> • Patients treated at the accessioning facility for whom no information on first course of treatment is available. • Patients treated for recurrence, or progression for a previously diagnosed malignancy.
Class 4	Diagnosis and/or first course of treatment was performed at the accessioning facility prior to the reference date of the registry. <ul style="list-style-type: none"> • Patients for whom the accessioning facility manages or treats a recurrence or progression of disease after the reference date. • Patients for whom it is unknown whether the accessioning facility delivered the first course of treatment prior to the reference date.
Class 5	Diagnosed at autopsy. <ul style="list-style-type: none"> • Prior to autopsy, there was no suspicion or diagnosis of cancer.

Class of Case Definitions	
Class	Includes
Nonanalytic Cases continued	
Class 6	Diagnosis and all of the first course of treatment was completed by the same staff physician in an office setting. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility.
Class 7	Pathology report only. Patient does not enter the accessioning facility at any time for diagnosis or treatment. This category excludes cases diagnosed at autopsy.
Class 8	Diagnosis was established by death certificate only. <i>Used by central registries only.</i>
Class 9	Unknown. Sufficient detail for determining Class of Case is not stated in patient record. <i>Used by central registries only.</i> <ul style="list-style-type: none"> • Unknown if previously diagnosed. • Unknown if previously treated. • Previously diagnosed, date unknown.

CANCER IDENTIFICATION

UNIQUE PATIENT IDENTIFIER CODES

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

- Accession numbers are never reassigned, even if a patient is removed from the registry.
- The sequence number is the sequence of all tumors over the lifetime of a patient and is counted throughout the patient's lifetime.
- A registry may contain a single abstract for a patient with a sequence number of 02, because the first tumor had been either diagnosed and treated elsewhere or diagnosed and/or treated before the facility's reference date (the CoC does not require registries at approved cancer programs to accession Class of Case 3 or 4 cases). Because of differences in requirements, however, it is still possible for two registries with dissimilar eligibility requirements (for example, a facility registry and a state central registry) to assign different sequence numbers to the same tumor, even though the sequence number codes and instructions applied are the same.

CANCER IDENTIFICATION

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

Primary Site

The instructions for coding primary site are found in the "Topography" section of the ICD-O-3 "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 23–26). Use the alphabetic index in ICD-O-3 to assign the most specific site if only a general location is specified in the record. The following guidelines should be followed for consistent analysis of primary sites for particular histologies.

Lymphoma

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

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

Note: For purposes of analysis:

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

Kaposi Sarcoma

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

Melanoma

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

Laterality

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

List of Paired Organ Sites	
ICD-O-3	Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1–C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)

List of Paired Organ Sites	
ICD-O-3	Site
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C50.0–C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0–C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0–C69.9	Eye and lacrimal gland
C74.0–C74.9	Adrenal gland
C75.4	Carotid body

Morphology (Histology, Behavior, and Grade)

The instructions for coding histology, behavior, and grade are found in the “Morphology” section of the ICD-O-3 “Coding Guidelines for Topography and Morphology” (ICD-O-3 pp. 27–34).

- To code multiple or mixed histologies existing in one primary, use the following guidelines in this priority order:
 - 1) Select a combination code.
 - 2) Code the histology that comprises the majority of the tumor. Phrases such as “predominantly” and “with features of” are often used to identify the principal tumor type.

Note: The terms “with foci of”, “areas of”, or “elements of” do not describe the majority of the tumor. Do not code the histologies described by these terms unless there is a combination code.
 - 3) Code the histology with the highest ICD-O-3 morphology code.

Multiple Primaries

Enter the case into the database as a single or multiple primary as documented by the physician. If a physician determination is absent or unavailable, then use the following guidelines. Primary site, laterality, histologic type, and timing are each considered.

- For lymphomas and leukemias, use the tables in Appendix A of *FORDS* to decide whether differing histologies represent one or more primaries. Primary site and timing are not applicable for determining whether these malignancies represent one or more primaries.
- Use the instructions below under the heading “Site Differences” to decide whether the tumor(s) is one site or multiple sites.
- Follow the instructions below under the heading “Histology Differences” to decide whether tumors other than lymphomas or leukemias represent a single histology or mixed/multiple histologies.
- Follow the instructions below under the heading “Timing” to decide if one or more primaries are involved.

Site Differences

Primary Site (NAACCR Item #400) and *Laterality* (NAACCR Item #410) are used together to determine whether two lesions are considered one or two tumors based on anatomic location. The ICD-O-3 topography code has four characters, the letter C followed by three digits (eg, C61.9). The fourth character is always a subcategory of the first three. In general, the first three characters represent an individual organ and the fourth character is a subsite or a portion of that organ. However, in some instances two or more three-character ICD-O-3 topography codes apply to a single organ. The rules for distinguishing single from multiple sites address (1) whether organs or subsites of organs represent unique tumors, (2) whether a unique organ is represented by one three-character ICD-O-3 topography code or more, and (3) whether a paired site is involved.

Site organs are represented by a single three-character ICD-O-3 code. A difference in the **third** character of the ICD-O-3 topography code designates a separate site for all other primary sites.

Subsites represent unique primaries. A difference in the **fourth** or final character of the ICD-O-3 topography code designates a separate site for the following site groups **only**:

- Colon (C18.0–C18.9) except polyps involving multiple segments (see “Colon and Rectum Polyps” following)
- Anus/anal canal (C21.0–C21.8)
- Pleura (visceral, parietal, NOS) (C38.4)
- Bone (C40.0–C41.9)
- Melanoma of the skin (C44.0–C44.9)
- Peripheral nerves/autonomic nervous system (C47.0–C47.9)
- Connective tissue (C49.0–C49.9)

Colon and Rectum Polyps:

- Simultaneous lesions and polyps in the same segment of the colon are a single primary.
- Polyps may be present in more than one segment of the colon. If the diagnosis reads “adenocarcinoma in multiple polyps,” it is one primary, colon, NOS (C18.9).

- Familial polyposis is a genetic disease characterized by polyps that increase in numbers and may cover the mucosal surface of the colon. The benign disease usually develops into adenocarcinoma in adenomatous polyposis coli or adenocarcinoma in multiple adenomatous polyps.
- Patients with the histologies “adenocarcinoma in adenomatous polyposis coli” (8220/3) and “adenocarcinoma in multiple adenomatous polyps” (8221/3) have a different disease process than those patients with frank adenocarcinomas of the colon or typical colon polyps. If multiple segments of the colon, or the colon and rectosigmoid, or the colon, rectosigmoid and rectum are involved with adenocarcinoma in adenomatous polyposis coli or adenocarcinoma in multiple adenomatous polyps, it is a single primary. Code the primary site to colon, NOS (C18.9).

Site organs may be represented by more than one three-character ICD-O-3 topography code. The following groups of three-character ICD-O-3 topography codes refer to single organs. Lesions within any combination of each group are considered to be the same primary site.

- C01 Base of tongue; C02 Other and unspecified parts of tongue
- C05 Palate; C06 Other and unspecified parts of mouth
- C07 Parotid gland; C08 Other and unspecified major salivary glands
- C09 Tonsil; C10 Oropharynx
- C12 Pyriform sinus; C13 Hypopharynx
- C23 Gallbladder; C24 Other and unspecified parts of biliary tract
- C30 Nasal cavity and middle ear; C31 Accessory sinuses
- C33 Trachea; C34 Bronchus and lung
- C37 Thymus; C38.0 Heart; C38.1–.3 Mediastinum; C38.8 Overlapping lesion of heart, mediastinum, and pleura
- C51 Vulva; C52 Vagina; C57.7 Other specified female genital organs; C57.8–9 Unspecified female genital organs
- C56 Ovary; C57.0 Fallopian tube
- C57.1 Broad ligament; C57.2 Round ligament
- C57.3 Parametrium; C57.4 Uterine adnexa
- C60 Penis; C63 Other and unspecified male genital organs
- C64 Kidney; C65 Renal pelvis; C66 Ureter; C68 Other and unspecified urinary organs
- C74 Adrenal gland; C75 Other endocrine glands and related structures

Paired Organ Sites

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

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

EXCEPTIONS: The following are always single primaries:

- Simultaneous bilateral involvement of the ovaries with a single histology
- Simultaneous bilateral retinoblastomas
- Simultaneous bilateral Wilm tumors

Histology Differences

The ICD-O-3 morphology code has five digits (eg, 8500/3). The **fifth digit** of the ICD-O-3 morphology code is the behavior code. The behavior code is not used to determine multiple primaries. The first four characters are sometimes referred to as the “histology code.” Multiple terms may describe a single histology. Refer to the ICD-O-3 histology code to determine whether two or more lesions represent the same tumor histologically.

- If the first three digits of the ICD-O-3 histology codes are identical, then the histology is the **same**.
- Lesion(s) may have a single histology (the first three digits of the morphology code are the same) with invasive and in situ components. This is a **single histology**. Code the behavior of the invasive component.
- A single lesion is **one** primary even if the lesion crosses site boundaries.
- A single lesion with mixed histologic types is **one** primary.
- If one lesion is invasive and another lesion of the same histologic type is in situ, or if two or more lesions have invasive and in situ components, only one **histologic** primary is represented.
- A difference in the first three digits of the ICD-O-3 histology code indicates a **different** histologic type.

EXCEPTION 1: If one malignancy is stated to be carcinoma, NOS, adenocarcinoma, NOS, sarcoma, NOS, or melanoma, NOS and the second lesion is a more specific term, such as large cell carcinoma, mucinous adenocarcinoma, spindle cell sarcoma, or superficial spreading melanoma, consider this to be a **single** histology.

EXCEPTION 2: For lymphatic and hematopoietic disease, use Appendix A of *FORDS* to determine which histologies represent single or multiple primaries.

EXCEPTION 3: Consider the following as a **single** histology, even though the first three digits of the ICD-O-3 morphology codes differ. Code its histology according to the rules for mixed histologies.

- Transitional cell carcinoma (8120–8131) of the bladder (C67.–)
- Ductal (8500) and lobular (8520) adenocarcinoma of the breast (C50.–)
- Multiple lesions with the **same** histology occurring in different sites are **separate** primaries **unless** a physician says they are metastatic.
- Multiple lesions with **different** histologies occurring in different sites are **separate** primaries **unless** a physician states otherwise.

Timing

Lesions occurring within two months of each other are “simultaneous.”

- If two malignancies of the same histology (following the rules under “Histology Differences”) occur in the same site (following the rules under “Site Differences”, including those for laterality for paired sites) simultaneously (ie, within two months of each other), there is only **one** primary.

EXCEPTION: Each occurrence of melanoma of the skin is a new or **separate** primary **unless** a physician states otherwise.

- Multiple lesions with different histologies in a single site are **separate** primaries, whether they occur simultaneously or at different times.
- If two malignancies of the same histology (following the rules under “Histology Differences”) and in the same site (following the rules under “Site Differences,” including rules for laterality for paired sites) are identified **more** than two months apart, then there are **two** primaries. Complete a separate report for each one.

EXCEPTIONS: The following are recurrences of the original disease without time limits.

- Bladder primaries with morphology codes 8120–8130.
- Invasive adenocarcinomas of the prostate, site code C61.9.
- Kaposi sarcoma (9140) of any site.

Note: Consider Kaposi sarcoma as one primary site. Refer to “Primary Site” for coding rules.

- Lymphoma and leukemia histologies that are determined from Appendix A to refer to the same primary.

Examples of single or multiple primary coding:

- 1) A patient has separate, independent tumors on the lower gum (C03.1) and the anterior floor of the mouth (C04.0). The third characters of the ICD-O-3 topography code are different, so the patient has multiple tumors in multiple primary sites.
- 2) The patient has multiple, separate, simultaneous tumors in the trigone of the bladder (C67.0) and the lateral wall of the bladder (C67.2) of the same histologic type. Code one primary site, bladder, NOS (C67.9).
- 3) The patient has separate, independent tumors in the sigmoid colon (C18.7) and the transverse colon (C18.4). Abstract two primaries.
- 4) A physician detects two lesions in the **same segment** of the colon. The pathology report identifies the lesions as an adenocarcinoma (8140/3) and an adenocarcinoma in an adenomatous polyp (8210/3). This is one primary; code the histology to adenocarcinoma (8140/3). Adenocarcinoma in an adenomatous polyp is an earlier stage of disease than an invasive adenocarcinoma.
- 5) A patient has a colectomy, and the pathology identifies two lesions in the sigmoid colon. The first lesion is an invasive adenocarcinoma (8140/3) and the second is an adenocarcinoma in situ (8140/2). This is a single histology. Code the histology and behavior as adenocarcinoma, NOS (8140/3).
- 6) A stomach biopsy is interpreted as adenocarcinoma, NOS (8140/3). The pathology from the resection identifies the tumor as linitis plastica (8142/3). Record the morphology code for linitis plastica (8142/3).
- 7) The pathology of a breast cancer describes mixed ductal (8500/3) and lobular carcinoma (8520/3). Record the combination code “ductal carcinoma and lobular carcinoma” (8522/3).
- 8) A lung lesion is predominantly adenocarcinoma (8140/3) with focal areas of bronchioalveolar adenocarcinoma (8250/3). A combination code does not exist. Record the predominant histology, adenocarcinoma (8140/3).

- 9) A patient with bladder cancer is diagnosed with a mixed transitional cell carcinoma (8120/3) and epidermoid carcinoma (8070/3). There is no combination code for these histologies, and the pathology report does not identify a predominant histology. Record the higher-numbered morphology code, transitional cell carcinoma (8120/3).

Revising the Original Diagnosis

Data are gathered from multiple sources using the most recent and complete information available. Over time, the patient's records may contain new information such as tests, scans, and consults. Change the primary site, laterality, histology, and stage as the information becomes more complete. If the primary site is changed, it may also be necessary to revise site-specific staging and treatment codes. There is no time limit for making revisions that give better information about the original diagnosis or stage. However, if staging information is updated, it is important to adhere to the timing requirements for the respective staging system. Most cases that require revision are unknown primaries.

Example:

The institution clinically diagnoses a patient with carcinomatosis. The registry enters the case as an unknown primary (C80.9), carcinoma, NOS (8010/3), stage of disease unknown. Nine months later, a paracentesis shows serous cystadenocarcinoma. The physician says that the patient has an ovarian primary. Change the primary site to ovary (C56.9), histology to serous cystadenocarcinoma (8441/3), and diagnostic confirmation to positive cytologic study, no positive histology (code 2). If enough information is available that meets the AJCC timing requirements for staging, change the stage from unknown to the appropriate staging basis, TNM elements, and stage group.

Example:

A physician may decide that a previously clinically diagnosed malignancy is a benign lesion. The patient is referred from a nursing home to the facility. The chest x-ray shows a cavitory lesion in the right lung. The family requests that the patient undergo no additional workup or treatment. Discharge diagnosis is "probable carcinoma of right lung." The registry abstracts a lung primary (C34.9). Two years later a chest x-ray shows an unchanged lesion. The physician documents "lung cancer ruled out." Delete the case from the database. Adjust the sequence number(s) of any other primaries the patient may have. Do not reuse the accession number.

OVERVIEW OF CODING PRINCIPLES

PATIENT ADDRESS AND RESIDENCY RULES

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

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

Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau whenever possible. The registry can resolve residency questions by using the Census Bureau's definition, "the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home." Vital statistic rules may differ from Census rules. Do not record residence from the death certificate. Review each case carefully.

Rules for Persons with Ambiguous Residences

Persons with More Than One Residence (summer and winter homes): Use the address the patient specifies if a usual residence is not apparent.

Persons with No Usual Residence (transients, homeless): Use the address of the place the patient was staying when the cancer was diagnosed. This could be a shelter or the diagnosing facility.

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

Persons in Institutions: The Census Bureau states, "Persons under formally authorized, supervised care or custody," are residents of the institution. This includes the following:

- Incarcerated persons
- Persons in nursing, convalescent, and rest homes
- Persons in homes, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill.
- Long-term residents of other hospitals, such as Veterans Affairs (VA) hospitals.

Persons in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their families. Military personnel may use the installation address or the surrounding community's address.

The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

COMORBIDITIES AND COMPLICATIONS

The CoC requires that the registry record include up to six comorbid conditions and/or treatment complications, to be copied from the patient record. The information is recorded in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code form by hospitals, typically on the face sheet of the billing record.

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

The items describing patient comorbid conditions and complications are:

- Comorbidities and Complications #1* (NAACCR Item #3110)
- Comorbidities and Complications #2* (NAACCR Item #3120)
- Comorbidities and Complications #3* (NAACCR Item #3130)
- Comorbidities and Complications #4* (NAACCR Item #3140)
- Comorbidities and Complications #5* (NAACCR Item #3150)
- Comorbidities and Complications #6* (NAACCR Item #3160)

Comorbidities are preexisting medical conditions or conditions that were present at the time the patient was diagnosed with this cancer.

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

Complications are conditions that occur during the hospital stay, while the patient is being treated for the cancer.

- Only “E” codes describe adverse effects occurring during medical care are collected in this data item. They are represented by ICD-9-CM codes E870–E879.9 (misadventures to patients during surgical and medical care) and E930–E949.9 (drugs and medicinal and biologic substances causing adverse effects in therapeutic use).
- Complications are coded with the leading character “E,” without the decimal point, and trailing zeros. Thus, E930.0 would be coded as E9300.

STAGE OF DISEASE AT INITIAL DIAGNOSIS

Surgical Diagnostic and Staging Procedures

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

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

AJCC TNM Staging

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

- All cases should use the following time guidelines for evaluating stage: through first course of surgery or four months, whichever is longer.*
- All cases should be confirmed microscopically for TNM classification (including clinical information). Rare cases that do not have biopsy or cytology of the tumor can be staged but should be analyzed separately and should not be included in survival analyses.*
- The CoC requires registries in approved cancer programs to record the clinical and pathologic classifications of TNM and stage group.

The CoC requires that clinical and pathologic T, N, and M components must be recorded by the **managing physician(s)** for all analytic cases that have an AJCC coding scheme (Class of Case codes 0, 1, or 2). If all components are available, and no stage group has been recorded, the registrar may enter a stage group based on the component information. The following AJCC staging information should be included in each case record:

- Code the T, N, M elements (clinical and pathologic) as recorded in the medical record by the managing physician(s).
- Code the AJCC Stage Group (clinical and pathologic); if no stage group was recorded by the managing physician(s), the registrar may enter stage group based on the components recorded.
- Code the stage (prefix/suffix) descriptor (clinical and pathologic).
- Code the edition number of the AJCC TNM stage system being used.

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

The AJCC items that must be coded are:

Clinical T (NAACCR Item #2940)
Clinical N (NAACCR Item #2950)
Clinical M (NAACCR Item #2960)
Clinical Stage Group (NAACCR Item #2970)
Staged By (Clinical) (NAACCR Item #2980)
Pathologic T (NAACCR Item #2990)
Pathologic N (NAACCR Item #3000)
Pathologic M (NAACCR Item #3010)
Pathologic Stage Group (NAACCR Item #3020)
Staged By (Pathologic) (NAACCR Item #2980)

- If a patient has multiple primaries, stage each primary independently.
- If the stage group cannot be determined, then record it as unknown.
- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, the physician identifies which primary has metastasized, update the stage(s) as appropriate.

*Greene FL, Page DL, et al (eds): *AJCC Cancer Staging Manual*, Sixth Edition. New York, NY, Springer-Verlag, 2002 (or the most current edition of the *AJCC Cancer Staging Manual*).

Ambiguous Terminology

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

List of Ambiguous Terms Describing Tumor Spread

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

FIRST COURSE OF TREATMENT

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. “No therapy” is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given.

Treatment Plan

A treatment plan describes the type(s) of therapies intended to modify or control the malignancy. 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 CoC-approved program and may contain part or all of the treatment plan.
- An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation.
- If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: “initial treatment must begin within four months of the date of initial diagnosis.”

Time Periods for First Course of Treatment

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

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

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

All Malignancies Except Leukemias

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

Leukemias

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

Surgery

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

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

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

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

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

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

Relationships Among Surgical Items

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

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

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

- *Surgical Procedure of Primary Site* is a site-specific item that describes the most invasive extent of local tumor destruction or surgical resection of the primary site and of surrounding tissues or organs that are removed in continuity with the primary site.
- *Scope of Regional Lymph Node Surgery* describes the removal, biopsy, or aspiration of sentinel nodes and other regional lymph nodes that drain the primary site and may include surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease.
- *Surgical Procedure/Other Site* describes first course resection of distant lymph node(s) and/or regional or distant tissue or organs. That is, it describes procedures that remove tissue or organs beyond the primary site, beyond the tissue removed in continuity with the primary site, and beyond the regional lymph nodes that drain the primary site.
- If surgery of the respective type was performed, the code that best describes the surgical procedure is recorded whether or not any cancer was found in the resected portion. Incidental removal of tissue or organs, when it is not performed as part of cancer treatment (for example, incidental removal of an appendix), does not alter code assignment.

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

- Codes 10 through 18 are site-specific descriptions of tumor-destruction procedures that do not produce a pathologic specimen.
- Codes 20 through 80 are site-specific descriptions of resection procedures.
- Response categories are defined in logical sequence. Within groups of codes (particularly the 20 series), procedures are defined with increasing degrees of descriptive precision. Between groups (eg, 40 vs 50) procedures are defined with increasing extent of the surgical resection.
- To the extent possible, codes and their definitions are the same as those previously assigned in *ROADS* to accommodate analysis in registries that maintain unconverted data. As a result, the code or numeric sequence may deviate from the order in which the descriptions of the surgical procedures are listed. For codes 00 through 79, the descriptions of the surgical procedures are hierarchical. Last-listed responses take precedence over earlier-listed responses (regardless of the code or numeric value). Code 98 takes precedence over code 00.

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

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

- The special code 98 applies to specific tumors that cannot be clearly defined in terms of primary or nonprimary site. *Surgical Procedure of Primary Site* should be coded 98 for any tumor characterized by the specific sites and/or morphologies identified in the site-specific code instructions for *Unknown and Ill-Defined Primary Sites* and *Hematopoietic/Reticuloendothelial/Immunoproliferating/Myeloproliferative Disease*. The item *Surgical Procedure/Other Site* is used to indicate whether surgery was performed for these tumors.

Five items augment the information recorded in *Surgical Procedure of Primary Site*.

- *Date of Most Definitive Surgical Resection, Date of Surgical Discharge, and Readmission to the Same Hospital Within 30 Days of Surgical Discharge* apply to the most definitive (most invasive) first course primary site surgery performed, that is, to the event recorded under *Surgical Procedure of Primary Site*.
- *Scope of Regional Lymph Node Surgery* has been modified so that it more accurately describes current surgical practice and is no longer site-specific. It now consistently distinguishes between sentinel lymph node biopsy and removal of other regional lymph nodes and distinguishes removal of regional lymph nodes during the same surgical procedure as a sentinel node biopsy from subsequent removal.
 - One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment to previously published treatment based on the former codes, or to data still unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. The compromise incorporated in the *Scope of Regional Lymph Node Surgery* codes separates removal of one to three nodes (code 4) from removal of four or more nodes in the response categories (code 5). It is **very important** to note that this distinction is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than four nodes was not reflected in surgery codes. **The distinction between fewer than four nodes and four or more nodes removed is not intended to reflect clinical significance** when applied to a particular surgical procedure.
- *Surgical Margins of the Primary Site* records the pathologist's determination of the presence of microscopic or macroscopic involvement of cancer at the margins of resection following the surgical resection described by *Surgical Procedure of Primary Site*.
- *Surgical Procedure/Other Site* has been simplified and is no longer site-specific with the implementation of *FORDS*. This item describes whether surgery was performed for tumors having unknown or ill-defined primary sites or hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease morphologies. If any surgical treatment was performed on these cancers, *Surgical Procedure/Other Site* is coded 1.
- *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* distinguishes planned from unplanned rehospitalization and is used as a quality of care indicator.
- *Reason for No Surgery* identifies why surgical therapy was not provided to the patient and distinguishes a physician's not recommending surgical therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

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

Radiation

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

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

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

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

Relationships Among Radiation Items

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

- If radiation was the only type of first course treatment performed or was the first of multiple treatment modalities, *Date Radiation Started* is the same as *Date of First Course of Treatment*. Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.
- The special code 88888888 is used for *Date Radiation Started* when radiation is part of the planned first course of treatment, but that treatment has not yet started at the time the case is abstracted.

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

The targeted anatomic region is described by *Radiation Treatment Volume*. The treatment volume may be the same as the primary site of disease; however, the available code values provide descriptions of anatomic regions that may extend beyond the primary site of disease; for example, codes 18–21 serve to describe the radiation therapy delivered to breast cancer patients. The codes listed in *FORDS* have been expanded to include additional anatomic sites not available in *ROADS*.

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

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

- Codes 40 through 43 describe proton radiation (code 40) and specific type of stereotactic radiotherapy (codes 41–43). If stereotactic radiotherapy is delivered to a patient but the exact modality is not recorded, use code 41 (Stereotactic radiosurgery, NOS).
- Codes 50 through 55 are used to record different types of brachytherapy administration, also known as radioactive seed implants. Code 50 should be used to record the application of radioactive materials not otherwise specified.
- Codes 60 through 62 provide codes to describe the administration of specific radioisotopes. Code 60 (Radioisotopes, NOS) should be used when specific details of the radioisotope administration is not available.
- Code 98 is reserved for cases where it is known that radiation therapy was delivered but the modality is not recorded in the patient record.
- The unit of measure for radiologic dosing is the centigray (cGy), which has replaced the use of “rads” to describe radiation dose.

Corresponding data items *Boost Treatment Modality* and *Boost Dose (cGy)* describe supplemental radiation delivered to the patient.

- The boost dose may or may not employ the same treatment modality. For example, external beam radiation may be used for regional treatment and is followed by brachytherapy to provide the boost dose.
- Not all patients who receive radiation therapy receive a boost dose radiation. In these cases, the modality and dose should be coded as 00 and 00000, respectively.

In addition to knowing the duration of treatment and the modalities and doses involved, it is critical to know the number of treatments to be able to gauge the intensity of the dose delivered to the patient. The data item *Number of Treatments to This Volume* describes the total number of therapeutic treatments (regional and boost combined) delivered to the anatomic volume coded in *Radiation Treatment Volume*.

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

- *Radiation/Surgery Sequence* identifies those instances where radiation therapy and the surgical management of the patient are not discrete and overlap with respect to time. Radiation therapy can precede the surgical resection of a tumor and then be continued after the patient’s surgery, or radiation can be administered intraoperatively.
- *Reason for No Radiation* identifies why radiation therapy was not provided to the patient and distinguishes a physician’s not recommending this therapy due to contraindicating conditions from a patient’s refusal of a recommended treatment plan.

Systemic Therapy

Systemic therapy encompasses the treatment modalities captured by the items chemotherapy, hormone therapy, and immunotherapy. The descriptions and relationships among the items have been revised to separate the description of the administration of systemic agents or drugs from medical procedures which affect the hormonal or immunologic balance of the patient.

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

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

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

The following items describe systemic therapy performed at this facility:

Chemotherapy at This Facility (NAACCR Item #700)
Hormone Therapy at This Facility (NAACCR Item #710)
Immunotherapy at This Facility (NAACCR Item #720)

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

Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of chemotherapeutic agents.

Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy drugs. If a patient has an adverse reaction, the managing physician may change one of the agents in a combination regimen. If the replacement agent belongs to the same group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) as the original agent, there is no change in the regimen. However, if the replacement agent is of a different group than the original agent, the new regimen represents the start of subsequent therapy, *only the original agent or regimen is recorded as first course therapy*.

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

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

Relationships Among Systemic Therapy Items

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

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

The data items *Chemotherapy*, *Hormone Therapy*, and *Immunotherapy* describe whether or not each respective class of agent(s) or drug(s) were administered to the patient as part of first course therapy. In the case of chemotherapy, additional distinction is allowed for instances where single or multiagent regimens were administered.

- Each of these three items includes code values that describe the reason a particular class of drugs is not administered to the patient and distinguishes a physician's not recommending systemic therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

Hematologic Transplant/Endocrine Procedures captures those infrequent instances in which a medical, surgical, or radiation procedure is performed on a patient that has an effect on the hormonal or immunologic balance of the patient.

- Hematologic procedures, such as bone marrow transplants or stem cell harvests, are typically employed in conjunction with administration of systemic agent(s), usually chemotherapy.
- Endocrine procedures, either radiologic or surgical, may be administered in combination with systemic agent(s), typically hormonal therapeutic agents.
- As first course therapy, hematologic procedures will rarely be administered in conjunction with endocrine radiation or surgery. The use of code 40 in response to this data item should be reviewed and confirmed with the managing physician(s).

Palliative Procedures

Palliative procedures are performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or pain management therapy. They are not meant to diagnose, stage, or treat the disease and may be provided at any time during the patient's care. These procedures are generally not included in the statistical analysis of treatment. Individual item descriptions in Section Two should be consulted for specific coding instructions.

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

Pain Assessment (NAACCR Item #3260)
Palliative Procedure (NAACCR Item #3270)

The following items describes systemic therapy performed at this facility:

Palliative Procedure at This Facility (NAACCR Item #3280)

Pain Assessment indicates whether a pain assessment is noted in the patient record. *Palliative Procedure* and *Palliative Procedure at This Facility* describe modality(ies) used to provide palliation and whether the procedure was performed to relieve pain and/or alleviate other symptoms.

- If a patient received surgical, radiologic, or systemic treatment, do not code the employed treatment modalities as palliative care.
- For cases of advanced disease, it is possible for a patient to receive one or a combination of treatment modalities in conjunction with palliative care intended to reduce the burden of pain associated with metastatic disease. For example, a patient with metastatic prostate cancer may receive an orchiectomy and systemic hormonal treatment in addition to palliative radiation for bone metastasis.

CASE ADMINISTRATION

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

Administrative Tracking

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

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

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

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

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

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

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

EDITS Overrides

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

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

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

A series of override items designed to work with the EDITS package have been added to *FORDS*. Some of the CoC edits identify rare, but possible, code combinations. For these edits, an override flag can be set if, upon review, the unusual combination is verified as being correct. Once set, the error message will not be repeated on subsequent EDITS passes.

- When no error message is generated by an edit that uses an override item, no action by the registrar is needed.
- If an error message is generated, the problem can often be resolved by checking the accuracy of the entry for each item that contributes to the edit and correcting any problems identified. If correction of data entry errors resolves the problem, no override entry is needed. If the codes reflect the information in the patient record, check for physician notes indicating the unusual combination of circumstances (for example, a colon adenocarcinoma in a child) has been confirmed.
- Enter the override code according to the instructions for the data item. If no comment regarding the unusual circumstances can be found in the record, it may be necessary to check with the managing physician or pathologist to determine whether it is appropriate to override the edit.

Code Versions Used

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

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

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

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

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

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

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

RX Coding System—Current identifies whether the treatment information was recorded using CoC rules or SEER rules and the version of each applied.

- The CoC requires that the *FORDS* manual be followed for all cases diagnosed January 1, 2003, or later (*RX Coding System–Current* = 06).

The *ICD-O-3 Conversion Flag* identifies how conversion from ICD-O-2 to ICD-O-3 was accomplished, and the *ICD-O-2 Conversion Flag* identifies how conversion from ICD-O-1 to ICD-O-2 was accomplished.

- Both should be autocoded at the time of conversion. If the results of either conversion were verified by review for some cases, the conversion flag will need to be updated to indicate that the case was reviewed.

**SECTION TWO:
Coding Instructions**

Patient Identification

ACCESSION NUMBER

Item Length: 9
NAACCR Item #550

Description

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

Rationale

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

Instructions for Coding

- When a patient is deleted from the database, **do not** reuse the accession number for another patient.
- The first four numbers specify the year and the last five numbers are the numeric order in which the patient was entered into the registry database.
- Numeric gaps are allowed in accession numbers.

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

Examples:

Code	Reason
200300033	Patient enters the hospital in 2003, and is diagnosed with breast cancer. The patient is the 33rd patient accessioned in 2003.
200300033	A patient with the accession number 200300033 for a breast primary returns to the hospital with a subsequent colon primary in 2004. The accession number will remain the same. <i>Sequence Number</i> (NAACCR Item #560) will reflect this primary.
200300010	Patient is diagnosed in November 2002, at another facility. Enters the reporting facility in January 2003, and is the tenth case accessioned in 2003.
200300012	Patient is diagnosed in staff physician office in December 2002. Enters the reporting facility in January 2003, and is the 12th case accessioned in 2003.
200300001	First patient diagnosed/treated and entered into the registry database for 2003.
200300999	999th patient diagnosed/treated and entered into the registry database for 2003.
200309999	9999th patient diagnosed/treated and entered into the registry database for 2003.
200401504	1504th patient diagnosed/treated and entered into the registry database for 2004.

SEQUENCE NUMBER

Item Length: 2
 Allowable Values: 00–35,
 60–88, 99
 NAACCR Item #560

Description

Indicates the sequence of all reportable neoplasms over the lifetime of the patient.

Rationale

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

Instructions for Coding

- Codes 00–35 and 99 indicate reportable neoplasms of malignant or in situ behavior, which the CoC requires to be reported (See Case Eligibility, Section One). Codes 60–88 indicate other neoplasms that the state registry or the hospital cancer committee has defined as reportable (cases reportable-by-agreement).
- Code 00 only if the patient has a single reportable primary. If the patient develops a subsequent reportable primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.
- If two or more reportable 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.
- Code 60 only if the patient has a single primary reportable by agreement only. If the patient develops a subsequent primary tumor reportable-by-agreement, change the code for the first tumor from 60 to 61, and assign codes to subsequent tumors reportable-by-agreement sequentially.
- If two or more neoplasms reportable-by-agreement only are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- If a patient has had a tumor that the facility did not accession, but which would have been reportable by CoC requirements or reportable-by-agreement, then its sequence is taken into account for assignment of subsequent tumors.
- Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that would affect the sequence.

CoC-Required

Code	Definition
00	One CoC-required primary only in the patient's lifetime
01	First of two or more CoC-required primaries
02	Second of two or more CoC-required primaries
...	
...	(Actual sequence of this CoC-required primary)
...	
35	Thirty-fifth of thirty-five CoC-required primaries
99	Unspecified CoC-required sequence number or unknown

Reportable-By-Agreement

Code	Definition
60	Only one neoplasm required by the state or the hospital cancer committee but not by the CoC (reportable-by-agreement only)
61	First of two or more neoplasms reportable-by-agreement only
62	Second of two or more neoplasms reportable-by-agreement only
...	
...	(Consecutive number of neoplasms reportable-by-agreement only)
...	
87	Twenty-seventh of twenty-seven primary neoplasms reportable-by-agreement only
88	Unspecified number of neoplasms in this category.

Examples:

Code	Reason
00	A patient with no history of previous cancer is diagnosed with in situ breast carcinoma June 13, 2003.
01	The sequence number is changed when the patient with breast carcinoma diagnosed on June 13, 2003, is diagnosed with a subsequent skin melanoma on August 30, 2003.
02	The sequence number assigned to a skin melanoma diagnosed on August 30, 2003, following a breast carcinoma diagnosed on June 13, 2003.
04	A nursing home patient is admitted to a hospital for first course surgery for a colon adenocarcinoma. The patient had three previous primary cancers that the CoC requires to be accessioned, but was not seen for them at this facility. No sequence numbers 01, 02 or 03 are entered for this patient.
60	The sequence number assigned to a benign brain tumor diagnosed on November 1, 2005, following a breast carcinoma diagnosed on June 13, 2003, and a skin melanoma diagnosed on August 30, 2003.

MEDICAL RECORD NUMBER

Item Length: 11
 Right Justified, Leading Blanks
 NAACCR Item #2300

Description

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

Rationale

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

Instructions for Coding

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

Examples:

Code	Reason
_____000000	If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.
_____RT (Radiology) _____SU (One-day surgery clinic)	Record standard abbreviations for departments that do not use HIM medical record numbers.
_____UNK	The medical record number is unknown.

SOCIAL SECURITY NUMBER

Item Length: 9
NAACCR Item #2320

Description

Records the patient's Social Security number.

Rationale

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

Instructions for Coding

- Code the patient's Social Security number.
- A patient's Medicare claim number may not always be identical to the person's Social Security number.
- Code Social Security numbers that end with "B" or "D" as 999999999. The patient receives benefits under the spouse's number and this is the spouse's Social Security number.

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

MILITARY MEDICAL RECORD NUMBER SUFFIX

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

Description

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

Rationale

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

Instructions for Coding

Record the Family Member Prefix (FMP) codes assigned by individual military medical facilities.

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

LAST NAME

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

Description

Identifies the last name of the patient.

Rationale

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

Instructions for Coding

- Truncate name if more than 25 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do not use punctuation.
- Do not leave blank; code as unknown if the patient's last name is unknown.
- This field may be updated, if the last name changes.

Examples:

Code	Reason
Mc Donald	Recorded with space as Mc Donald.
O'Hara	Recorded with apostrophe as O'Hara.
Smith-Jones	Janet Smith marries Fred Jones and changes her name to Smith-Jones.
UNKNOWN	If the patient's last name is unknown, enter UNKNOWN.

FIRST NAME

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

Description

Identifies the first name of the patient.

Rationale

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

Instructions for Coding

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

Examples:

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

**MIDDLE NAME
(MIDDLE INITIAL)**

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

Description

Identifies the middle name or middle initial of the patient.

Rationale

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

Instructions for Coding

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

Examples:

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

**PATIENT ADDRESS (NUMBER AND STREET)
AT DIAGNOSIS**

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

Description

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

Rationale

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

Instructions for Coding

- Record the number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at <http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf>.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.
- Punctuation is normally limited to periods (ie, 39.2 RD), slashes for fractional addresses (ie, 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (ie, 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (ie, 425 FLOWER BLVD # 72).
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not update this data item if the patient's address changes.
- See "Residency Rules" in Section One for further instructions.

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

**PATIENT ADDRESS (NUMBER AND STREET)
AT DIAGNOSIS–SUPPLEMENTAL**

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

Description

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

Rationale

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

Instructions for Coding

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

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

**CITY/TOWN AT DIAGNOSIS
(CITY OR TOWN)**

Item Length: 20
Upper-case
Left Justified
NAACCR Item #70

Description

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

Rationale

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

Instructions for Coding

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

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

**STATE AT DIAGNOSIS
(STATE)**

Item Length: 2
 Upper-case
 NAACCR Item #80

Description

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

Rationale

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

Instructions for Coding

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

Code	Definition
IL	If the state in which the patient resides at the time of diagnosis and treatment is Illinois, then use the USPS code for the state of Illinois.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is known.
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is unknown.
ZZ	Resident of U.S., NOS (including its territories, commonwealths, or possessions); Canada, NOS; residence unknown.

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

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

The following are abbreviations for Canadian provinces and territories:

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

**POSTAL CODE AT DIAGNOSIS
(ZIP CODE)**

Item Length: 9
 Left Justified
 NAACCR Item #100

Description

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

Rationale

The postal code is part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies.

Instructions for Coding

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

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

COUNTY AT DIAGNOSIS

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

Description

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

Rationale

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

Instructions for Coding

- For U.S. residents, use codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. This publication is available in a reference library or can be accessed on the Internet through the U.S. EPA's Envirofacts Data Warehouse and Applications Web site at <http://www.epa.gov/>.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- If the patient is a non-U.S. resident and is coded XX in *State at Diagnosis* (NAACCR Item #80), then code the patient's country of residence in this space.
- For country codes, see *SEER Extent of Disease–1998: Codes and Coding Instructions*, Third Edition, (<http://seer.cancer.gov/>) or *NAACCR Volume II: Data Standards and Data Dictionary*, Seventh Edition, (<http://www.naacr.org>).*
- Do not update this data item if the patient's county of residence changes.

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

*Fritz A, Ries L, eds. *SEER Extent of Disease–1998: Codes and Coding Instructions*, Third Edition. Bethesda MD, NIH, NCI, 1998.

*Hultstrom D, ed. *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 10*, Seventh Edition. Springfield, IL: North American Association for Central Cancer Registries, March 2002.

**PATIENT ADDRESS (NUMBER AND STREET)–
CURRENT**

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

Description

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

Rationale

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

Instructions for Coding

- Record the number and street address or the rural mailing address of the patient's current usual residence.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at <http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf>.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.
- Punctuation is normally limited to periods (ie, 39.2 RD), slashes for fractional addresses (ie, 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (ie, 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (ie, 425 FLOWER BLVD # 72).
- Update this data item if the patient's address changes.
- See "Residency Rules" in Section One for further instructions.

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

**PATIENT ADDRESS (NUMBER AND STREET)
CURRENT-SUPPLEMENTAL**

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

Description

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

Rationale

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

Instructions for Coding

- Record the place or facility (ie, a nursing home or name of an apartment complex) of the patient's current usual residence.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Update this data item if a patient's address changes.
- See "Residency Rules" in Section One for further instructions.

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

CITY/TOWN–CURRENT

Item Length: 20
 Upper-case
 Left Justified
 NAACCR Item #1810

Description

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

Rationale

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

Instructions for Coding

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- If the patient has multiple malignancies, the current city or town should be the same for all tumors.
- Update this data item if the patient’s city/town of residence changes.
- See “Residency Rules” in Section One for further instructions.

Code	Definition
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.

STATE-CURRENT

Item Length: 2
 Upper-case
 NAACCR Item #1820

Description

Identifies the patient's current state of residence.

Rationale

This item provides a current state of residence used for follow-up purposes. It is different from *State at Diagnosis* (NAACCR Item #80).

Instructions for Coding

- U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory of the patient's current usual residence.
- If the patient has multiple tumors, the current state of residence should be the same for all tumors.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Update this data item if the patient's state of residence changes.

Code	Definition
IL	If the state in which the patient resides at the time of diagnosis and treatment is Illinois, then use the USPS code for the state of Illinois.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is known.
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is unknown.
ZZ	Resident of U.S., NOS (including its territories, commonwealths, or possessions); Canada, NOS; residence unknown.

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

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

The following are abbreviations for Canadian provinces or territories:

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

**POSTAL CODE–CURRENT
(ZIP CODE)**

Item Length: 9
Left Justified
NAACCR Item #1830

Description

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

Rationale

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

Instructions for Coding

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

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

TELEPHONE

Item Length: 10
NAACCR Item #2360

Description

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

Rationale

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

Instructions for Coding

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

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

PLACE OF BIRTH

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

Description

Records the patient's place of birth.

Rationale

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

Instructions for Coding

- Use the most specific code.
- Use the SEER Geocodes for "Place of Birth." These codes include states of the United States as well as foreign countries.
- For SEER Geocodes, see *The SEER Program Code Manual*, Third Edition, (<http://seer.cancer.gov/>) or *NAACCR Volume II: Data Standards and Data Dictionary*, Seventh Edition, (<http://www.naacr.org>).*

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

*Fritz A, Ries L, eds., *The SEER Program Code Manual*, Third Edition. Bethesda MD, NIH, NCI, 1998.

*Hultstrom D, ed. *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 10*, Seventh Edition. Springfield, IL: North American Association for Central Cancer Registries, March 2002.

DATE OF BIRTH

Item Length: 8
NAACCR Item #240

Description

Identifies the date of birth of the patient.

Rationale

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

Instructions for Coding

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

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

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

Examples:

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

AGE AT DIAGNOSIS

Item Length: 3

Allowable Values: 000–120, 999

Right Justified, Zero-filled

NAACCR Item #230

Description

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

Rationale

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

Instructions for Coding

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

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

RACE 1

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

Description

Identifies the primary race of the person.

Rationale

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

Instructions for Coding

- Additional races reported by the person should be coded in Race 2, Race 3, Race 4, and Race 5.
- Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2000.
- “Race” is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If the patient is multiracial, then code all races using *Race 2* (NAACCR Item #161) through *Race 5* (NAACCR Item #164).
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- For cases diagnosed prior to January 1, 2000, Race 2 through Race 5 must be blank **unless** the patient has more than one primary with at least one primary diagnosed after January 1, 2000. In this case, the race codes for all primaries must be the same as the one for the primary diagnosed after January 1, 2000.

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

Examples:

Code	Reason
01	A patient was born in Mexico of Mexican parentage. Code also <i>Spanish/Hispanic Origin</i> (NAACCR Item #190).
02	A black female patient. A specific race code (other than blank or 99) must not occur more than once. For example, do not code “Black” in <i>Race 1</i> for one parent and “Black” in <i>Race 2</i> for the other parent.
05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded to <i>Race 2</i>). If a person’s race is recorded as a combination of white and any other race, code to the appropriate <i>other</i> race in this field and then code Caucasian as “White” in the next race field.
05	A patient’s race is listed as Asian and the birthplace is Japan. Code to birthplace. When the race is recorded as “Oriental,” “Mongolian,” or “Asian,” and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birthplace information.
07	A patient has a Hawaiian father, black mother, Japanese grandfather, and Korean grandmother. If a person’s race is recorded as a combination of Hawaiian and any other race(s), code the person’s primary race as Hawaiian and code the other races in <i>Race 2</i> , <i>Race 3</i> , <i>Race 4</i> , and <i>Race 5</i> as appropriate. In this case, black to <i>Race 2</i> ; Japanese to <i>Race 3</i> ; and Korean to <i>Race 4</i> .
08	A patient is of Korean and Asian ancestry. Do not code “Asian” in a subsequent race field if a specific Asian race(s) has already been coded.
25	A patient with a Polynesian mother, Tahitian father, and Samoan grandparents.
99	A patient’s race is unknown. <i>Race 2</i> through <i>Race 5</i> must also be 99.

RACE 2

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

Description

Identifies the patient's race.

Rationale

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

Instructions for Coding

- “Race” is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- For cases diagnosed prior to January 1, 2000, Race 2 through Race 5 must be blank **unless** the patient has more than one primary with at least one primary diagnosed after January 1, 2000. In this case, the race codes for all primaries must be the same as the one for the primary diagnosed after January 1, 2000.

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

RACE 3

Item Length: 2

Allowable Values: 01–14,
20–22, 25–28, 30–32,
88, 96–99

NAACCR Item #162

Description

Identifies the patient's race.

Rationale

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

Instructions for Coding

- “Race” is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- For cases diagnosed prior to January 1, 2000, Race 2 through Race 5 must be blank **unless** the patient has more than one primary with at least one primary diagnosed after January 1, 2000. In this case, the race codes for all primaries must be the same as the one for the primary diagnosed after January 1, 2000.

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

RACE 4

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

Description

Identifies the patient's race.

Rationale

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

Instructions for Coding

- “Race” is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- For cases diagnosed prior to January 1, 2000, Race 2 through Race 5 must be blank *unless* the patient has more than one primary with at least one primary diagnosed after January 1, 2000. In this case, the race codes for all primaries must be the same as the one for the primary diagnosed after January 1, 2000.

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

RACE 5

Item Length: 2

Allowable Values: 01–14,
20–22, 25–28, 30–32, 88,
96–99

NAACCR Item #164

Description

Identifies the patient's race.

Rationale

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

Instructions for Coding

- “Race” is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- For cases diagnosed prior to January 1, 2000, Race 2 through Race 5 must be blank *unless* the patient has more than one primary with at least one primary diagnosed after January 1, 2000. In this case, the race codes for all primaries must be the same as the one for the primary diagnosed after January 1, 2000.

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

**SPANISH ORIGIN—ALL SOURCES
(SPANISH/HISPANIC ORIGIN)**

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

Description

Identifies persons of Spanish or Hispanic origin.

Rationale

This code is used by hospital and central registries to identify whether or not the person should be classified as “Hispanic” for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White category) of *Race* (NAACCR Item #160).

Instructions for Coding

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

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

SEX

Item Length: 1

Allowable Values: 1–4, 9

NAACCR Item #220

Description

Identifies the sex of the patient.

Rationale

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

Instructions for Coding

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

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

PRIMARY PAYER AT DIAGNOSIS

Item Length: 2
 Allowable Values: 01, 02, 10,
 20, 31, 35, 36, 50–56, 99
 NAACCR Item #630

Description

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

Rationale

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

Instructions for Coding

- Record the type of insurance reported on the patient's admission page.
- If more than one payer or insurance carrier is listed on the patient's admission page record the first.
- If the patient's payer or insurance carrier changes, do not change the initially recorded code.

Code	Label	Definition
01	Not insured	Patient has no insurance and is declared a charity write-off.
02	Not insured, self-pay	Patient has no insurance and is declared responsible for charges.
10	Insurance, NOS	Type of insurance unknown or other than the types listed in codes 20, 31, 35, 36, 50–56.
20	Managed Care, HMO, 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.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than those described in codes 35 and 36.
35	Medicaid administered through a Managed Care plan	State government administered insurance which is administered through a commercial Managed Care plan such as an HMO or PPO for persons who are uninsured, below the poverty level, or covered under entitlement programs.
36	Medicaid with Medicare supplement	State government administered Medicaid insurance with Federal Medicare supplement.
50	Medicare	Federal government funded insurance for persons who are retired or disabled. Not described in codes 51 and 52.
51	Medicare with supplement	Patient has Medicare and another insurance to pay costs not covered by Medicare.
52	Medicare with Medicaid supplement	Federal government Medicare insurance with State Medicaid administered supplement.

Code	Label	Definition
53	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents. Formally CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
54	Military	Military personnel or their dependents who are treated at a military facility.
55	Veterans Affairs	Veterans who are treated in Veterans Affairs facilities.
56	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility or at another facility, and the medical costs are reimbursed by the Indian Health Service. Patient receives care at a Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

Examples:

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

COMORBIDITIES AND COMPLICATIONS #1

Item Length: 5
 Allowable Values:00000,
 00100–13980, 24000–99990,
 E8700–E8799, E9300–E9499
 Left Justified, Zero-filled
 NAACCR Item #3110

Description

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

Rationale

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

Instructions for Coding

- Comorbid conditions and complications must be reported for patients that have inpatient hospitalizations at your facility.
- Comorbid conditions and complications should be reported for patients receiving outpatient care or treated in oncology clinics at your facility when available.
- Report the comorbid conditions and complications associated with the first treatment episode for this cancer. This will often, though not always, be a hospitalization for surgery.
- Consult the patient record for the discharge abstract. Comorbid conditions and complications are found under secondary diagnoses on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
- Code the comorbid conditions and complications in the sequence in which they appear in patient record as secondary diagnoses.
- Comorbidities are preexisting medical conditions or conditions that were present at the time the patient was diagnosed with this cancer, ie, chronic conditions such as COPD, diabetes, and hypertension. Comorbid conditions are identified by ICD-9-CM codes 001–139.8 and 240–999.9.
- **Do not** record any neoplasms (ICD-9-CM codes 140–239.9) listed as secondary diagnoses for this data item.
- Complications are conditions that occur during the hospital stay, while the patient is being treated for the cancer, ie, postoperative urinary tract infection or pneumonia. Complications are identified by the ICD-9-CM “E” codes which classify environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. Only “E” codes which describe adverse effects occurring during medical care are collected in this data item and include ICD-9-CM codes E870–E879.9 (misadventures to patients during surgical and medical care) and E930–E949.9 (drugs and medicinal and biological substances causing adverse effects in therapeutic use).
- **Do not** record other causes of injury and poisoning (ICD-9-CM codes E800–E869.9, E880–E929.9, or E950–E999).
- **Do not** record factors influencing health status and contact with health services (ICD-9-CM codes V01–V82.9).
- If no comorbid conditions or complications were documented, then code 00000 in this data item, and leave the remaining “Comorbidities and Complications” data items blank.
- If fewer than 6 secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining “Comorbidities and Complications” data items blank.
- If fewer than 6 comorbid conditions or complications are listed, then code the diagnoses listed, and leave the remaining “Comorbidities and Complications” data items blank.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 6 comorbid conditions or complications. <i>Note:</i> For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters.
00000	No comorbid conditions or complications documented.

Examples:

Code	Reason
49600	COPD (ICD-9-CM code 496)
25001	Type 1 diabetes mellitus (ICD-9-CM code 250.01)
40100	Hypertension (ICD-9-CM code 401)
E8732	The patient was inadvertently exposed to an overdose of external beam radiation (ICD-9-CM code E873.2)
E8782	The patient with colon cancer underwent surgical resection and subsequently experienced an anastomotic leak (ICD-9-CM code E878.2)
E9300	During hospitalization, the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-9-CM code E930.0)

COMORBIDITIES AND COMPLICATIONS #2

Item Length: 5

Allowable Values:

00100–13980, 24000–99990,
E8700–E8799, E9300–E9499

Left Justified, Zero-filled

NAACCR Item #3120

Description

Records the patient's preexisting medical conditions and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale

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

Instructions for Coding

- If only one comorbid condition or complication is listed, then leave this data item blank.
- If only two comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 6 comorbid conditions or complications. <i>Note:</i> For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. <i>Note:</i> For complications (ICD-9-CM codes E870–E879.9 and E930–E949.9) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than two comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #3

Item Length: 5

Allowable Values:

00100–13980, 24000–99990,

E8700–E8799, E9300–E9499

Left Justified, Zero-filled

NAACCR Item #3130

Description

Records the patient's preexisting medical conditions and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale

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

Instructions for Coding

- If fewer than three comorbid conditions or complications are listed, then leave this data item blank.
- If only three comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 6 comorbid conditions or complications. <i>Note:</i> For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. <i>Note:</i> For complications (ICD-9-CM codes E870–E879.9 and E930–E949.9) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than three comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #4

Item Length: 5

Allowable Values:

00100–13980, 24000–99990

E8700–E8799, E9300–E9499

Left Justified, Zero-filled

NAACCR Item #3140

Description

Records the patient's preexisting medical conditions and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale

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

Instructions for Coding

- If fewer than four comorbid conditions or complications are listed, then leave this data item blank.
- If only four comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 6 comorbid conditions or complications. <i>Note:</i> For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. <i>Note:</i> For complications (ICD-9-CM codes E870–E879.9 and E930–E949.9) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than four comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #5

Item Length: 5
 Allowable Values
 00100–13980, 24000–99990,
 E8700–E8799, E9300–E9499
 Left Justified, Zero-filled
 NAACCR Item #3150

Description

Records the patient’s preexisting medical conditions and/or complications during the patient’s hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale

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

Instructions for Coding

- If fewer than five comorbid conditions or complications are listed, then leave this data item blank.
- If only five comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining “Comorbidities and Complications” items blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 6 comorbid conditions or complications. <i>Note:</i> For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. <i>Note:</i> For complications (ICD-9-CM codes E870–E879.9 and E930–E949.9) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than five comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #6

Item Length: 5

Allowable Values:

00100–13980, 24000–99990,
E8700–E8799, E9300–E9499

Left Justified, Zero-filled

NAACCR Item #3160

Description

Records the patient's preexisting medical conditions and/or complications during the patient's hospital stay for the treatment of this cancer. Both are considered secondary diagnoses.

Rationale

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

Instructions for Coding

- If fewer than six comorbid conditions or complications are listed, then leave this data item blank.
- For further coding instructions, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 6 comorbid conditions or complications. <i>Note:</i> For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. <i>Note:</i> For complications (ICD-9-CM codes E870–E879.9 and E930–E949.9) there is an assumed decimal point between the 4th and 5th characters.
(leave blank)	Fewer than six comorbid conditions and complications documented.

**FOLLOWING PHYSICIAN
(FOLLOW-UP PHYSICIAN)**

Item Length: 8
Left Justified
NAACCR Item #2470

Description

Records the identification number of the person currently responsible for the patient's medical care.

Rationale

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

Instructions for Coding

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

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

PRIMARY SURGEON

Item Length: 8
 Left Justified
 NAACCR Item #2480

Description

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

Rationale

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

Instructions for Coding

- The registry assigns a unique number to the primary surgeon. Many registries use the physician's state medical license number.
- Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.
- Do not update this data item.

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

**PHYSICIAN #3
(OTHER PHYSICIAN)**

Item Length: 8
Left Justified
NAACCR Item #2490

Description

Records the identification number of another physician involved in the care of the patient. The Commission on Cancer recommends that this data item identify the physician who performed the most definitive radiation therapy.

Rationale

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

Instructions for Coding

- The registry assigns a unique number to this data item. Many registries use the physician's state medical license number.
- If this item is used to identify the radiation oncologist, then the following definitions can be used. If the facility chooses to identify another physician, the facility will need to develop and implement definitions for analysis.
- If the registry has designated a primary radiation oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another radiation oncologist.
- Do not update this data item.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
00000000	If the patient did not have radiation therapy or a radiation therapy consult.
88888888	If the physician who performed a radiation therapy procedure was not a radiation oncologist, ie, a diagnostic radiologist or surgeon.
99999999	The primary radiation oncologist is unknown or an identification number is not assigned.

**PHYSICIAN #4
(OTHER PHYSICIAN)**

Item Length: 8
 Left Justified
 NAACCR Item #2500

Description

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

Rationale

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

Instructions for Coding

- The registry assigns a unique number to this data item. Many registries use the physician's state medical license number.
- If this item is used to identify the medical oncologist, then the following definitions can be used. If the facility chooses to identify another physician, the facility will need to develop and implement definitions for analysis.
- If the registry has designated a primary medical oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another medical oncologist.
- Do not update this data item.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
00000000	If the patient did not receive systemic therapy or a medical oncology consult.
88888888	If the physician who gave systemic therapy was not a medical oncologist, ie, radiation oncologist, general practitioner or surgeon.
99999999	The primary medical oncologist is unknown or an identification number is not assigned.

Cancer Identification

CLASS OF CASE

Item Length: 1
 Allowable Values: 0–9
 NAACCR Item #610

Description

Classifies cases recorded in the database.

Rationale

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

Instructions for Coding

- Class of Case has ten categories 0–9. Analytic cases are coded 0–2. Nonanalytic cases are coded 3–9.
- Abstracting for Class of Case 0 and 1 is to be completed within six months of diagnosis.
- Abstracting for Class of Case 2 is to be completed within six months of first contact with the facility.
- The CoC Approvals Program does NOT require hospitals to abstract nonanalytic cases (3–9).

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

Examples:

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

FACILITY REFERRED FROM

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

Description

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

Rationale

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

Instructions for Coding

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

Code	Definition
(fill spaces)	Seven or eight-digit FIN.
000000000	If the patient was not referred to the reporting facility from another facility.
009999999	If the patient was referred, but the referring facility's ID number is unknown.

Examples:

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

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

FACILITY REFERRED TO

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

Description

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

Rationale

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

Instructions for Coding

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

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

Examples:

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

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

DATE OF FIRST CONTACTItem Length: 8
NAACCR Item #580**Description**

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

Rationale

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

Instructions for Coding:

- Date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or treatment of a reportable tumor.
- This may be the date of an outpatient visit for a biopsy, x-ray, or laboratory test, or the date a pathology specimen was collected at the hospital.
- If this is an autopsy-only or death certificate-only case, then use the date of death.

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

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

Examples:

Code	Reason
02122004	If a patient has an outpatient mammography that is suspicious for malignancy on February 12, 2004, and subsequently undergoes an excisional biopsy or radical surgical procedure on February 14, 2004, then record the date of the mammography (February 12, 2004) as the date of first contact/first admission to this facility.
09082003	Patient undergoes a biopsy in a physician's office on September 8, 2003. The pathology specimen was sent to the reporting facility and was read as malignant melanoma. The patient enters that same reporting facility on September 14, 2003 for wide reexcision. The date of first contact is September 8, 2003.
12072004	Patient has an MRI of the brain on December 7, 2004 for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19 removes all gross tumor. The date of first contact is December 7, 2004.
09992005	If the exact date of admission to the reporting facility is not known, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description "Spring," 2003.
07992003	If information is limited to the description "The middle of the year," 2003.
10992003	If information is limited to the description "Fall," 2003.
12992003 or 01992004	If information is limited to the description "Winter." Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

DATE OF INITIAL DIAGNOSIS

Item Length: 8
NAACCR Item #390

Description

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

Rationale

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

Instructions for Coding

- Use the first date of diagnosis whether clinically or histologically confirmed.
- If the physician states that in retrospect the patient had cancer at an earlier date, then use the earlier date as the date of diagnosis.
- Use the date therapy was started as the date of diagnosis if the patient receives a first course of treatment before a definitive diagnosis.
- Refer to the list of “Ambiguous Terms” in Section One for language that represents a diagnosis of cancer.
- The date of death is the date of diagnosis for a Class of Case 5.

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

Month

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

Day

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

Year

Use four-digit year
9999 Year unknown

Examples:

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

PRIMARY SITEItem Length: 4
NAACCR Item #400**Description**

Identifies the primary site.

Rationale

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

Instructions for Coding

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

EXCEPTIONS: Myeloid sarcoma and leukemic reticuloendotheliosis (see ICD-O-3 for coding rules).**Examples:**

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

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

LATERALITY

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

Description

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

Rationale

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

Instructions for Coding

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

Code	Definition
0	Organ is not considered to be a paired site.
1	Origin of primary is right.
2	Origin of primary is left.
3	Only one side involved, right or left origin not specified.
4	Bilateral involvement, side of origin unknown, stated to be a single primary. This includes: <ul style="list-style-type: none"> • Both ovaries simultaneously involved with a single histology • Bilateral retinoblastomas • Bilateral Wilms' tumors
9	Paired site, but lateral origin unknown; midline tumor.

HISTOLOGY

Item Length: 4
NAACCR Item #420

Description

Identifies the microscopic anatomy of cells.

Rationale

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

Instructions for Coding

- Record histology using the ICD-O-3 codes in the Numeric Lists/Morphology section (ICD-O-3, pp. 69–104) and in the Alphabetic Index (ICD-O-3, pp. 105–218).
- ICD-O-3 identifies the morphology codes with an “M” preceding the code number. Do not record the “M.”
- Follow the coding rules outlined on pages 20 through 40 of ICD-O-3.
- Review all pathology reports.
- Code the **final** pathologic diagnosis.

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

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

Examples:

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

BEHAVIOR CODE

Item Length: 1
 Allowable Values: 2, 3
 NAACCR Item #523

Description

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

Rationale

The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or malignant (3). The CoC requires hospital cancer registries to abstract and report to the NCDB tumors with behavior codes 2 and 3.

Instructions for Coding

- Record only tumors with behavior codes of 2 or 3.
- Code 3 if any invasion is present, no matter how limited.
- If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior.

EXCEPTION: The ICD-O-3 behavior code given for juvenile astrocytoma (9421/1) is 1, which is not reportable. To ensure the capture of these historical cases, please code the behavior as 3. Refer to “Case Eligibility” in Section One for information.

Code	Label	Definition
2	In situ and/or carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk.
		Bowen disease.
		Clark level 1 for melanoma (limited to epithelium).
		Comedocarcinoma, noninfiltrating (C50.-).
2	Synonymous with in situ	Confined to epithelium.
		Hutchinson melanotic freckle, NOS (C44.-).
		Intracystic, noninfiltrating.
		Intraductal.
		Intraepidermal, NOS.
		Intraepithelial, NOS.
		Involvement up to, but not including the basement membrane.
		Lentigo maligna (C44.-).
		Lobular neoplasia (C50.-).
		Lobular, noninfiltrating (C50.-).
		Noninfiltrating.
		Noninvasive.
		No stromal involvement.
		Papillary, noninfiltrating or intraductal.
		Precancerous melanosis (C44.-).
Queyrat erythroplasia (C60.-).		

Code	Label	Definition
3	Invasive	Invasive or microinvasive.

Example:

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

GRADE/DIFFERENTIATION

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

Description

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

Rationale

This data item is useful for prognosis.

Instructions for Coding

- Code grade according to ICD-O-3 (pp. 30–31 and 67).
- Code the grade or differentiation as stated in the **final** pathologic diagnosis. If the differentiation is not stated in the final pathologic diagnosis, use the information from the microscopic description or comments.
- When the pathology report(s) lists more than one grade of tumor, code to the highest grade, even if the highest grade is only a focus (Rule G, ICD-O-3, p. 21).
- Code the grade or differentiation from the pathologic examination of the primary tumor, not from metastatic sites.
- When there is no tissue diagnosis, it may be possible to establish grade through magnetic resonance imaging (MRI) or positron emission tomography (PET). When available, code grade based on the recorded findings from these imaging reports.
- If the primary site is unknown, code the grade/differentiation as unknown (9).
- Code the grade for in situ lesions if the information is available.
- **Do not** use “high grade,” “low grade,” or “intermediate grade” descriptions for lymphomas as a basis for differentiation. These terms are categories in the Working Formulation of Lymphoma Diagnoses and do not relate to the grade.
- Codes 5–7 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.

Code	Grade/Cell	Label
1	Grade I	Well differentiated; differentiated, NOS
2	Grade II	Moderately differentiated; moderately well differentiated; intermediate differentiation
3	Grade III	Poorly differentiated
4	Grade IV	Undifferentiated; anaplastic
For Lymphomas and Leukemias		
5		T cell
6		B cell; pre-B; B-precursor
7		Null cell; non T-non B
8		NK (natural killer) cell
For Use in All Histologies		
9		Grade or differentiation not determined, not stated or not applicable; cell type not determined, not stated or not applicable

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

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

Conversion tables used to change a 3-grade system to a 4-grade system.

When described by terminology:

Code	Grade	Terminology
2	I–II	Low grade, partially well differentiated
3	II–III	Medium grade
	III	Moderately undifferentiated, relatively undifferentiated
4	III–IV	High grade

When described in numerical terms:

Code	Documentation
2	I/III or 1/3
3	II/III or 2/3
4	III/III or 3/3

Site specific:

Prostate

Code	Gleason’s Score	Pattern	Grades/Description
1	2, 3, 4	1, 2	I Well differentiated
2	5, 6	3	II Moderately differentiated
3	7, 8, 9, 10	4, 5	III Poorly differentiated

Breast

Code	Bloom-Richardson Grade	Differentiation	Bloom-Richardson Scores
1	Low grade	Well differentiated	3, 4, 5
2	Intermediate grade	Moderately differentiated	6, 7
3	High grade	Poorly differentiated	8, 9

Note: Bloom-Richardson score may also be called modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR grading, BR grading, Elston-Ellis modification of Bloom-Richardson score, the Nottingham modification of Bloom-Richardson score, Nottingham-Tenovus, or Nottingham grade.

AJCC Staging

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

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

DIAGNOSTIC CONFIRMATION

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

Description

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

Rationale

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

Instructions for Coding

- This is a hierarchical schema to identify how the malignancy was determined—from histologic confirmation (1) being most precise to unknown (9) being the least. Code 1 is the highest determination and takes precedence.
- This data item must be changed to the lower code if a more definitive method confirms the diagnosis at any time during the course of the disease.

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

TUMOR SIZE

Item Length: 3

Allowable Values: 000–990, 999

NAACCR Item #780

Description

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

Rationale

Tumor size is an important prognostic factor for cancer.

Instructions for Coding

- Code the exact size of the primary tumor in millimeters (mm).
Converting units of measure:
 - 1 mm is one-tenth of a centimeter (cm), thus, a 20-mm or 2-cm tumor is coded as 020.
- EXCEPTION:**
 - For melanomas of the skin (C44.0–C44.9), vulva (C51.0–C51.9), penis (C60.0–C60.0), scrotum (C63.3), and conjunctiva (C69.0), code the depth of invasion in HUNDREDTHS of millimeters.
 - Code 989 for melanomas of the skin (C44.0–C44.9), vulva (C51.0–C51.9), penis (C60.0–C60.0), scrotum (C63.3), and conjunctiva (C69.0) which are 9.89 mm or greater in depth.
- Code the largest dimension or diameter of the tumor, whether it is from a biopsy specimen or the complete resection of the primary tumor.
- Code the size of the primary tumor, not the size of polyps, ulcers, cysts, or metastases.
- Record the size of the tumor from the pathology report, if available.
- Information on tumor size from imaging/radiographic techniques can be used to code size, but should be taken as low priority, just above physical exam.
- Code 001 for tumors less than 1 mm in size.
- Code the size as stated for purely in situ tumors.
- If both an in situ and an invasive component are present, and each is measured, code the size of the invasive component even if it is smaller.
- Code 998 when following terms describe tumor involvement for these specified sites:
 - Esophagus (C15.0–C15.5, C15.8, C15.9): Entire circumference.
 - Stomach (C16.0–C16.6, C16.8, C16.9): Diffuse, widespread, $\frac{3}{4}$ or more, linitis plastica.
 - Colorectal (C18.0–C20.9 with M-8220/8221 and /2 or /3): Familial/multiple polyposis.
 - Lung and main stem bronchus (C34.0–C34.3, C34.8, C34.9): Diffuse, entire lobe or lung.
 - Breast (C50.0–C50.6, C50.8, C50.9): Inflammatory carcinoma; diffuse, widespread, $\frac{3}{4}$ or more of breast.
- Code 999, unknown, if only one size is given for a mixed *in situ* and invasive tumor.
- Code the size of the residual tumor if an excisional biopsy is performed and residual tumor at time of resection of the primary site is found to be larger than the excisional biopsy.
- **Do not** add pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor.
- Code 999 if the size of the tumor is unknown or the tumor size is not documented in the patient record.
- Code 999 for histologies or sites where size is not applicable:
 - Unknown or ill-defined primary (C76.0–C76.8, C80.9)
 - Hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 and/or M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)
 - Multiple myeloma (9732)
 - Letterer-Siwe disease (9754)

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

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

Examples:

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

REGIONAL LYMPH NODES EXAMINED

Item Length: 2

Allowable Values: 00–90,
95–99

NAACCR Item #830

Description

Records the total number of regional lymph nodes that were examined by the pathologist.

Rationale

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

Instructions for Coding

- Record the total number of regional lymph nodes removed as part of the first course of treatment and examined by the pathologist.
- The number of regional lymph nodes examined **must be** equal to or greater than the number of nodes recorded in *Regional Lymph Nodes Positive* (NAACCR Item #820).
- Code 95 when a lymph node aspiration was performed, but no nodes were removed.
- Code 99 when it is unknown whether lymph nodes were examined.
- Code 99 for histologies or sites where regional lymph node examination is not applicable:
 - Unknown or ill-defined primary (C76.0–76.8, C80.9).
 - Brain and cerebral meninges (C70.0, C71.0–71.9).
 - Lymphomas (M-9590–9596, 9650–9719, 9727–9729) with a lymph node primary site (C77.0–77.9).
 - Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9720, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989).
 - Multiple myeloma (9732).
 - Letterer-Siwe disease (9754).
- Do not record regional lymph nodes removed to establish recurrence of progression of disease.
- Do not code *distant* lymph nodes removed as part of the first course of treatment.
- Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.

Code	Description
00	No nodes were examined.
01–89	1–89 nodes were examined. (Code the exact number of regional lymph nodes examined.)
90	90 or more nodes were examined.
95	No regional nodes were removed, but aspiration of regional nodes was performed.
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated.
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated.
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown.
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record.

REGIONAL LYMPH NODES POSITIVE

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

Description

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases.

Rationale

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

Instructions for Coding

- Record the total number of regional lymph nodes removed as part of the first course of treatment and examined by the pathologist that were reported as containing tumor.
- The number of positive regional lymph nodes **cannot** exceed the number of nodes recorded in *Regional Lymph Nodes Examined* (NAACCR Item #830).
- Code 96 when 96 or more nodes are positive.
- Code 97 when the cytology or histology from a lymph node aspiration is positive for malignant cells.
- Code 97 when nodes were documented by the pathologist as containing tumor, but the number of positive nodes is not specified.
- Code 98 when no nodes were removed or examined.
- Code 99 when it is unknown whether lymph nodes were examined.
- Code 99 for histologies or sites where regional lymph node examination is not applicable:
 - Unknown or ill-defined primary (C76.0–76.8, C80.9).
 - Brain and cerebral meninges (C70.0, C71.0–71.9).
 - Lymphomas (M-9590–9596, 9650–9719, 9727–9729) with a lymph node primary site (C77.0–77.9).
 - Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989).
 - Multiple myeloma (9732).
 - Letterer-Siwe disease (9754).
- Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.

Code	Description
00	All nodes examined are negative.
01–95	1–95 nodes are positive. (Code exact number of nodes positive)
96	96 or more nodes are positive.
97	Positive nodes are documented, but the number is unspecified.
98	No nodes were examined.
99	It is unknown whether nodes are positive; not applicable; not stated in patient record.

Stage of Disease at Diagnosis

**DATE OF SURGICAL DIAGNOSTIC
AND STAGING PROCEDURE**Item Length: 8
NAACCR Item #1280**Description**

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

Rationale

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

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

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

Month	Day	Year
00	00	0000
01	01	Use four-digit year
02	02	9999 Year unknown
03	03	
04	...	
05	...	
06	30	
07	31	
08	99	Day unknown
09		
10		
11		
12		
99		

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

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

Code	Definition
10992003	If information is limited to the description “Fall,” 2003.
12992003 or 01992004	If information is limited to the description “Winter.” Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

**SURGICAL DIAGNOSTIC AND STAGING
PROCEDURE**

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

Description

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

Rationale

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

Instructions for Coding:

- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).
- Do not code surgical procedures which aspirate, biopsy, or remove *regional lymph nodes* in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). See instructions for *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292).
- Do not code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears). These are not considered surgical procedures.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* (NAACCR Item #1290) to code these procedures.
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* (NAACCR Item #3270) to code these procedures.

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

Examples:

Code	Reason
00	A lung cancer primary was diagnosed by CT scan. The patient expired. No surgical diagnostic or staging surgical procedure was performed.
01	A needle biopsy of a liver metastasis in a patient with suspected widespread colon cancer was done. Gross residual tumor is left at the biopsy site.
01	A thoracentesis is performed on a patient with suspected lung primary, and the withdrawn sample is cytologically examined for confirmation of malignant pleural effusion.
02	During a colonoscopy, a biopsy of a primary rectal mass was done. Gross residual tumor is left at the biopsy site.
03	During abdominal exploratory surgery, a gastric lesion and suspicious retroperitoneal lymph nodes were observed. No biopsy or treatment was done.
04	An abdominal exploration of a patient revealed pancreatic carcinoma with extension into surrounding organs and arteries. No attempt to treat. A bypass was performed to alleviate symptoms.
05	An exploratory procedure was performed for primary colon carcinoma with biopsy of suspicious liver lesions.
06	Esophagogastrostomy was performed for infiltrating gastric tumor following a biopsy of the primary site.
07	Stage III lung carcinoma was diagnosed and staged prior to admission.
09	A patient expires in the emergency room with recently diagnosed metastatic melanoma. It is unknown whether a diagnostic or staging procedure was done.

**SURGICAL DIAGNOSTIC AND STAGING
PROCEDURE AT THIS FACILITY**

Item Length: 2
Allowable Values: 00–07, 09
NAACCR Item #740

Description

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

Rationale

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

Instructions for Coding

- Record the type of procedure performed as part of the initial diagnosis and workup at this facility.
- Do not code surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). See instructions for *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292).
- Do not code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears). These are not considered surgical procedures.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* (NAACCR Item #1290) to code these procedures.
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* (NAACCR Item #3270) to code these procedures.

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

CLINICAL T

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

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Code clinical T as recorded in the medical record by the physician(s) managing the patient's care.
- Truncate the least significant subdivision of the category from the right as needed.
- For lung, occult carcinoma is coded TX.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

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

Note: AJCC TNM staging elements assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals do not meet the requirement for physician staging.

CLINICAL N

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

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record clinical N as recorded in the medical record by the physician(s) managing the patient's care.
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

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

Note: AJCC TNM staging elements assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals do not meet the requirement for physician staging.

CLINICAL M

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

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record clinical M as recorded in the medical record by the physician(s) managing the patient's care.
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

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

Note: AJCC TNM staging elements assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals do not meet the requirement for physician staging.

CLINICAL STAGE GROUP

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

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the clinical stage group as recorded in the medical record by the physician(s) managing the patient's care.
- The stage group may be completed by the registrar if the clinical T, N, and M have been recorded by the physician.
- If the value is only one digit, then record to the left and leave the second space blank.
- Truncate the least significant subdivision of the category from the right as needed.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

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

Note: Staging assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.

CLINICAL STAGE (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1

Allowable Values: 0–6, 9

NAACCR Item #980

Description

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

Rationale

Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group. The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the clinical stage (prefix/suffix) descriptor as documented in the medical record by the physician(s) managing the patient's care.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

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

Note: Staging assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.

STAGED BY (CLINICAL STAGE)

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

Description

Identifies the person who recorded the clinical AJCC staging elements and the stage group in the patient's medical record.

Rationale

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

Instructions for Coding

- Record the person who documented the AJCC clinical staging elements and the stage group in the medical record.
- The staging elements (T, N, M) and the stage group must be recorded.
- The CoC Approvals Program requires that all analytic cases must be staged in the medical record by the physician(s) managing the patient's care. A pathologist may contribute to staging by recording the appropriate T and/or N elements following evaluation of a resected specimen. The managing physician, however, must record the M element and the stage group.

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

Note: Staging assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.

PATHOLOGIC T

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

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, to design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record pathologic T as recorded in the medical record by the physician(s) managing the patient's care.
- Truncate the least significant subdivision of the category from the right as needed.
- For lung, occult carcinoma is coded TX.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

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

Note: AJCC TNM staging elements assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals do not meet the requirement for physician staging.

PATHOLOGIC N

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

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record pathologic N as recorded in the medical record by the physician(s) managing the patient's care.
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

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

Note: AJCC TNM staging elements assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals do not meet the requirement for physician staging.

PATHOLOGIC M

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

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record pathologic M as recorded in the medical record by the physician(s) managing the patient's care.
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

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

Note: AJCC TNM staging elements assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals do not meet the requirement for physician staging.

PATHOLOGIC STAGE GROUP

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

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the pathologic stage group as recorded in the medical record by the physician(s) managing the patient's care.
- The stage group may be completed by the registrar if the pathologic T, N, and M have been recorded by the physician.
- If pathologic M (NAACCR Item #900) is coded as either X or blank and clinical M (NAACCR Item #960) is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging elements pT, pN, and cM (NAACCR Item #s 880, 890, 960) may be used to complete the pathologic stage group.
- If the value is only one digit, record to the left and leave the second space blank.
- Truncate the least significant subdivision of the category from the right as needed.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

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

Note: Staging assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.

PATHOLOGIC STAGE (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1

Allowable Values: 0–6, 9

NAACCR Item #920

Description

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

Rationale

Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group. The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the pathologic stage (prefix/suffix) descriptor as documented in the medical record by the physician(s) managing the patient's care.
- Refer to the current *AJCC Cancer Staging Manual* for coding rules.

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

Note: Staging assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.

STAGED BY (PATHOLOGIC STAGE)

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

Description

Identifies the person who recorded the pathologic AJCC staging elements and the stage group in the patient's medical record.

Rationale

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

Instructions for Coding

- Record the person who documented the AJCC staging elements and the stage group in the medical record.
- The staging elements (T, N, M) and the stage group must be recorded.
- The CoC Approvals Program requires that all analytic cases must be staged in the medical record by the physician(s) managing the patient's care. A pathologist may contribute to staging by recording the appropriate T and/or N elements following evaluation of a resected specimen. The managing physician, however, must record the M element and the stage group.

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

Note: Staging assigned by medical students, residents, fellows, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.

SEER SUMMARY STAGE 2000

Item Length: 1

Allowable Values: 0–5, 7, 9

NAACCR Item #759

Description

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

Rationale

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

Instructions for Coding

- Record the SEER Summary Stage 2000 code for all cases that do not have a defined AJCC staging schema.
- Refer to the *SEER Summary Staging Manual 2000* for site-specific coding instructions. This information can be found online at <http://www.seer.cancer.gov/Publications/SummaryStage/>.

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

**NOTE: Insert Collaborative Stage data items here
when they are available in 2003
for implementation January 1, 2004.**

First Course of Treatment

DATE OF FIRST COURSE OF TREATMENTItem Length: 8
NAACCR Item #1270**Description**

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

Rationale

It is important to be able to measure the delay between diagnosis and the onset of treatment. A secondary use for this date is as a starting point for survival statistics (rather than using the diagnosis date). This date cannot be calculated from the respective first course treatment dates if no treatment was given. Therefore, providing information about those instances in which a physician decides not to treat a patient or a patient's family or guardian declines treatment is important.

Instructions for Coding

- Record the earliest of the following dates: *Date of First Surgical Procedure* (NAACCR Item #1200), *Date Radiation Started* (NAACCR Item #1210), *Date Systemic Therapy Started* (NAACCR Item #3230), or *Date Other Treatment Started* (NAACCR Item #1250).
- In cases of nontreatment, in which a physician decides not to treat a patient or a patient's family or guardian declines all treatment, the date of first course of treatment is the date this decision was made.

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

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

Examples:

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

DATE OF FIRST SURGICAL PROCEDURE

Item Length: 8

NAACCR Item #1200

Description

Records the earliest date on which any first course surgical procedure was performed. Formerly called “Date of Cancer-Directed Surgery.”

Rationale

This item can be used to sequence multiple treatment modalities and to evaluate the time intervals between treatments.

Instructions for Coding

- Record the date of the first surgical procedure of the types coded as *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Surgical Procedure/Other Site* (NAACCR Item #1294) performed at this or any facility.
- The date in this item may be the same as that in *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170), if the patient received only one surgical procedure and it was a resection of the primary site.
- If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item *Date of First Course Treatment* (NAACCR Item #1270).

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

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

Examples:

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

**DATE OF MOST DEFINITIVE SURGICAL RESECTION
OF THE PRIMARY SITE**Item Length: 8
NAACCR Item #3170**Description**

Records the date of the most definitive surgical resection of the primary site performed as part of the first course of treatment.

Rationale

This item is used to measure the lag time between diagnosis and the most definitive surgery of the primary site. It is also used in conjunction with *Date of Surgical Discharge* (NAACCR Item #3180) to calculate the duration of hospitalization following the most definitive primary site surgical procedure. This can then be used to evaluate treatment efficacy.

Instructions for Coding

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

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

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

Examples:

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

SURGICAL PROCEDURE OF PRIMARY SITE

Item Length: 2

Allowable Values: 00, 10B80, 90, 98, 99

L/R Justified, Zero-filled

NAACCR Item #1290

Description

Records the surgical procedure(s) performed to the primary site.

Rationale

This data item can be used to compare the efficacy of treatment options.

Instructions for Coding

- Site-specific codes for this data item are found in Appendix B.
- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.
- If registry software allows multiple procedures to be recorded, this item refers to the most invasive surgical procedure of the primary site.
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is unavailable.
- Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in this item.
- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix B.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results.

Code	Label	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10–19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to Appendix B for the correct site-specific code for the procedure.
20–80	Site-specific codes; resection	Refer to Appendix B for the correct site-specific code for the procedure.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific codes; special	Special code. Refer to Appendix B for the correct site-specific code for the procedure.
99	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

**SURGICAL PROCEDURE OF PRIMARY SITE
AT THIS FACILITY**

Item Length: 2
 Allowable Values: 00, 10B80, 90,
 98, 99
 L/R Justified, Zero-filled
 NAACCR Item #670

Description

Records the surgical procedure(s) performed to the primary site at this facility.

Rationale

This data item can be used to compare the efficacy of treatment options.

Instructions for Coding

- Site-specific codes for this data item are found in Appendix B.
- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.
- If registry software allows multiple procedures to be collected, this item refers to the most invasive surgical procedure for the primary site.
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is unavailable.
- Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in this item.
- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results.

Code	Label	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10–19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to Appendix B for the correct site-specific code for the procedure.
20–80	Site-specific codes; resection	Refer to Appendix B for the correct site-specific code for the procedure.
90	Surgery, NOS	A surgical procedure to primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific codes; special	Special code. Refer to Appendix B for the correct site-specific code for the procedure.
99	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

SURGICAL MARGINS OF THE PRIMARY SITE

Item Length: 1

Allowable Values: 0–3, 7–9

NAACCR Item #1320

Description

Records the final status of the surgical margins after resection of the primary tumor.

Rationale

This data item serves as a quality measure for pathology reports and is used for staging, and may be a prognostic factor in recurrence.

Instructions for Coding

- Record the margin status as it appears in the pathology report.
- Codes 0–3 are hierarchical; if two codes describe the margin status, use the numerically higher code.
- If no surgery of the primary site was performed, code 8.
- For lymphomas (M-9590–9596, 9650–9719, 9727–9729) with a lymph node primary site (C77.0–C77.9), code 9.
- For an unknown or ill-defined primary (C76.0–C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4, or M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980-9989), code 9.

Code	Label	Definition
0	No residual tumor	All margins are grossly and microscopically negative.
1	Residual tumor, NOS	Involvement is indicated, but not otherwise specified.
2	Microscopic residual tumor	Cannot be seen by the naked eye.
3	Macroscopic residual tumor	Gross tumor of the primary site which is visible to the naked eye.
7	Margins not evaluable	Cannot be assessed (indeterminate).
8	No primary site surgery	No surgical procedure of the primary site. Diagnosed at autopsy.
9	Unknown or not applicable	It is unknown whether a surgical procedure to the primary site was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

Example:

Code	Reason
3	(C18-Colon) The pathology report from a colon resection describes the proximal margin as grossly involved with tumor (code 3) and the distal margin as microscopically involved (code 2). Code macroscopic involvement (code 3).

SCOPE OF REGIONAL LYMPH NODE SURGERY

Item Length: 1

Allowable Values: 0–7, 9

NAACCR Item #1292

Description

Identifies the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

Rationale

This data item can be used to compare and evaluate the extent of surgical treatment.

Instructions for Coding

- The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
- Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item *Date of First Course of Treatment* (NAACCR Item #1270) and/or *Date of First Surgical Procedure* (NAACCR Item #1200) as appropriate.
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9), code 9.
- For lymphomas (M-9590–9596, 9650–9719, 9727–9729) with a lymph node primary site (C77.0–C77.9), code 9.
- For an unknown or ill-defined primary (C76.0–C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field *Surgical Procedure/Other Site* (NAACCR Item #1294).
- Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.

Code	Label	Definition
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease.
2	Sentinel lymph node biopsy	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel node biopsy.
4	1–3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.

Code	Label	Definition
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

Examples:

Code	Reason
0	There was an attempt at regional lymph node dissection or sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.
1	(C14.0-Pharynx) Aspiration of regional lymph node to confirm histology of widely metastatic disease.
2	(C44.5-Skin of Back) Patient has melanoma of the back. A sentinel lymph node dissection was done with the removal of one lymph node. This node was negative for disease.
3	(C61.9-Prostate) Bilateral pelvic lymph node dissection for prostate cancer.
6	(C50.3-Breast) Sentinel lymph node biopsy of right axilla, followed by right axillary lymph node dissection during the same surgical event.
9	(C34.9-Lung) Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of surgery in patient record.

Note: One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment with previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is *very important* to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 lymph nodes was not reflected in surgery codes. *It is not intended to reflect clinical significance* when applied to a particular surgical procedure. It is important to *avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items.*

SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY

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

Description

Identifies the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at this facility.

Rationale

This item can be used to compare and evaluate the extent of surgical treatment.

Instructions for Coding

- The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
- If a surgical procedure which aspirates, biopsies, or removes regional lymph nodes to diagnose or stage this cancer, record the scope of regional lymph nodes surgery in this data item. Record the date of this surgical procedure in data item *Date of First Course of Treatment* (NAACCR Item #1270) and/or *Date of First Surgical Procedure* (NAACCR Item #1200) as appropriate.
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9), code 9.
- For lymphomas (M-9590–9596, 9650–9719, 9727–9729) with a lymph node primary site (C77.0–C77.9), code 9.
- For all unknown or ill-defined primary (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. They are coded in the data field *Surgical Procedure/Other Site* (NAACCR Item #1294).
- Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.

Code	Label	Definition
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease.
2	Sentinel lymph node biopsy	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel node biopsy.
4	1–3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.

Code	Label	Definition
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

Note: One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment with previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is *very important* to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 lymph nodes was not reflected in surgery codes. *It is not intended to reflect clinical significance* when applied to a particular surgical procedure. It is important *to avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items.*

SURGICAL PROCEDURE/OTHER SITE

Item Length: 1

Allowable Values: 0–5, 9

NAACCR Item #1294

Description

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

Rationale

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

Instructions for Coding

- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s)* and/or regional/distant tissue or organs.
- Incidental removal of tissue or organs is not a “Surgical Procedure/Other Site.”

Code	Label	Definition
0	None	No surgical procedure of nonprimary site was performed. Diagnosed at autopsy.
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	Nonprimary surgical procedure to other regional sites	Resection of regional site.
3	Nonprimary surgical procedure to <i>distant lymph node(s)</i>	Resection of <i>distant lymph node(s)</i> .
4	Nonprimary surgical procedure to distant site	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.

Examples:

Code	Reason
0	(C18.1—Colon) The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon.
1	Surgical biopsy of metastatic lesion from liver; unknown primary.
2	(C18.3—Colon) Surgical ablation of solitary liver metastasis, hepatic flexure primary.
4	(C19.9—Rectosigmoid) Excision of multiple liver metastasis.
4	(C34.9—Lung) Removal of solitary brain metastasis.
5	(C21.0—Anus) Excision of solitary liver metastasis and one large hilar lymph node.

**SURGICAL PROCEDURE/OTHER SITE
AT THIS FACILITY**

Item Length: 1
 Allowable Values: 0–5, 9
 NAACCR Item #674

Description

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

Rationale

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

Instructions for Coding

- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s)* and/or regional/distant tissue or organs.
- Incidental removal of tissue or organs is not a “Surgical Procedure/Other Site.”

Code	Label	Definition
0	None	No nonprimary surgical site resection was performed. Diagnosed at autopsy.
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	Nonprimary surgical procedure to other regional sites	Resection of regional site.
3	Nonprimary surgical procedure to <i>distant lymph node(s)</i>	Resection of <i>distant lymph node(s)</i> .
4	Nonprimary surgical procedure to distant site	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.

DATE OF SURGICAL DISCHARGE

Item Length: 8
NAACCR Item #3180

Description

Records the date the patient was discharged following primary site surgery. The date corresponds to the event recorded in *Surgical Procedure of Primary Site* (NAACCR Item #1290), and *Date of Most Definitive Surgical Resection* (NAACCR Item #3170).

Rationale

Length of stay is an important quality of care and financial measure among hospital administrations, those who fund public and private health care, and public health users. This date, in conjunction with the data item *Date of Most Definitive Surgical Resection* (NAACCR Item #3170), will allow for the calculation of a patient's length of hospitalization associated with primary site surgery.

Instructions for Coding

- Record the date the patient was discharged from the hospital following the event recorded in *Surgical Procedure of Primary Site* (NAACCR Item #1290).
- If the patient died following the event recorded in *Surgical Procedure of Primary Site* (NAACCR Item #1290), but before being discharged from the treating facility, then the *Date of Surgical Discharge* is the same as the date recorded in the data item *Date of Last Contact or Death* (NAACCR Item #1750).
- If the patient received out-patient surgery, then the date of surgical discharge is the same as the date recorded in the data item *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170).

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

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

Examples:

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

**READMISSION TO THE SAME HOSPITAL
WITHIN 30 DAYS OF SURGICAL DISCHARGE**

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

Description

Records a readmission to the same hospital within 30 days of discharge following hospitalization for surgical resection of the primary site.

Rationale

This data item provides information related to the quality of care. A patient may have a readmission related to the primary diagnosis on discharge if the length of stay was too short, and then he/she needed to return due to problems or complications. A patient may also need to be readmitted if discharge planning and/or follow-up instructions were ineffective. It is important to distinguish a planned from an unplanned readmission, since a planned readmission is not an indicator of quality of care problems.

Instructions for Coding

- Consult patient record or information from the billing department to determine if a readmission to the same hospital occurred within 30 days of the date recorded in the item *Date of Surgical Discharge* (NAACCR Item #3180).
- Only record a readmission related to the treatment of this cancer.
- Review the treatment plan to determine whether the readmission was planned.

Code	Definition
0	No surgical procedure of the primary site was performed, or the patient was not readmitted to the same hospital within 30 days of discharge.
1	A patient was surgically treated and was readmitted to the same hospital within 30 days of being discharged. This readmission was unplanned.
2	A patient was surgically treated and was then readmitted to the same hospital within 30 days of being discharged. This readmission was planned (chemotherapy port insertion, revision of colostomy, etc.)
3	A patient was surgically treated and, within 30 days of being discharged, the patient had both a planned and an unplanned readmission to the same hospital.
9	It is unknown whether surgery of the primary site was recommended or performed. It is unknown whether the patient was readmitted to the same hospital within 30 days of discharge. Death certificate only.

Examples:

Code	Reason
0	A patient does not return to the hospital following a local excision for a Stage I breast cancer.
0	A patient was surgically treated and, upon discharge from acute hospital care, was admitted/transferred to an extended care ward of the hospital.
1	A patient is readmitted to the hospital three weeks (21 days) following a colon resection due to unexpected perirectal bleeding.
2	Following surgical resection the patient returns to the hospital for the insertion of a chemotherapy port.

**REASON FOR NO SURGERY
OF PRIMARY SITE**

Item Length: 1
 Allowable Values: 0–2, 5–9
 NAACCR Item #1340

Description

Records the reason that no surgery was performed on the primary site.

Rationale

When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's failure to recommend that treatment, or due to the refusal of the patient, a family member, or the patient's guardian.

Instructions for Coding

- If *Surgical Procedure of Primary Site* (NAACCR Item #1290) is coded 00 or 98, then record the reason based on documentation in the patient record.
- Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include surgery of the primary site, or if the option of "no treatment" was accepted by the patient.
- Code 7 if the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Cases coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any was provided.

Code	Definition
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in patient record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

Examples:

Code	Reason
2	A patient with a primary tumor of the liver is not recommended for surgery due to advanced cirrhosis.
8	A patient is referred to another facility for recommended surgical resection of a gastric carcinoma, but further information from the facility to which the patient was referred is not available.

DATE RADIATION STARTED

Item Length: 8

NAACCR Item #1210

Description

Records the date on which radiation therapy began at any facility that is part of the first course of treatment.

Rationale

It is important to be able to sequence the use of multiple treatment modalities and to evaluate the time intervals between the treatments. For some diseases, the sequence of radiation and surgical therapy is important when determining the analytic utility of pathologic stage information.

Instructions for Coding

- If radiation therapy is the first or only treatment administered to the patient, then the date radiation started should be the same as the date entered into the item *Date of First Course of Treatment* (NAACCR Item #1270).
- The date when treatment started will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- Code 88888888 if radiation therapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.

Code	Description
MMDDCCYY	The month, day, and year (MMDDCCYY) that the first course of radiation therapy began at any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	No radiation therapy administered. Diagnosed at autopsy.
88888888	When radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up. The date should be revised at the next follow-up.
99999999	When it is unknown whether any radiation therapy was administered, the date is unknown, or the case was identified by death certificate only.

Month

00
 01 January
 02 February
 03 March
 04 April
 05 May
 06 June
 07 July
 08 August
 09 September
 10 October
 11 November
 12 December
 88
 99 Month unknown

Day

00
 01
 02
 03
 ...
 ...
 30
 31
 88
 99 Day unknown

Year

0000
 Use four-digit year
 8888
 9999 Year unknown

Examples:

Code	Reason
12152003	A patient has external beam radiation on December 15, 2003.
10122003	A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on October 12, 2003.
06022003	A patient enters the facility for interstitial radiation boost for prostate cancer that is performed on August 6, 2003. Just prior to this, the patient had external beam therapy to the lower pelvis that was started on June 2, 2003 at another facility. Record the first date of radiation, regardless of the location of treatment.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description "Spring," 2003.
07992003	If information is limited to the description "The middle of the year," 2003.
10992003	If information is limited to the description "Fall," 2003.
12992003 or 01992004	If information is limited to the description "Winter." Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

LOCATION OF RADIATION TREATMENT

Item Length: 1

Allowable Values: 0–4, 8, 9

NAACCR Item #1550

Description

Identifies the location of the facility where radiation therapy was administered during the first course of treatment.

Rationale

This data item provides information useful to understanding the referral patterns for radiation therapy services and for assessing the quality and outcome of radiation therapy by delivery site.

Instructions for Coding

Code	Label	Definition
0	No radiation treatment	No radiation therapy was administered to the patient.
1	All radiation treatment at this facility	All radiation therapy was administered at the reporting facility.
2	Regional treatment at this facility, boost elsewhere	Regional treatment was administered at the reporting facility; a boost dose was administered elsewhere.
3	Boost radiation at this facility, regional elsewhere	Regional treatment was administered elsewhere; a boost dose was administered at the reporting facility.
4	All radiation treatment elsewhere	All radiation therapy was administered elsewhere.
8	Other	Radiation therapy was administered, but the pattern does not fit the above categories.
9	Unknown	Radiation therapy was administered, but the location of the treatment facility is unknown or not stated in patient record; it is unknown whether radiation therapy was administered.

Examples:

Code	Reason
2	A patient received radiation therapy to the entire head and neck region at the reporting facility and is then referred to another facility for a high-dose-rate (HDR) intracavitary boost.
3	A patient was diagnosed with breast cancer at another facility and received surgery and regional radiation therapy at that facility before being referred to the reporting facility for boost dose therapy.
8	Regional treatment was initiated at another facility and midway through treatment the patient was transferred to the reporting facility to complete the treatment regime.
9	Patient is known to have received radiation therapy, but records do not define the facility or facility(s) where the treatment was administered.

RADIATION TREATMENT VOLUME

Item Length: 2

Allowable Values: 00–41, 50, 60, 98, 99

NAACCR Item #1540

Description

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

Rationale

This data item provides information describing the anatomical structures targeted by the regional radiation therapy and can be used to determine whether the site of the primary disease was treated with radiation or if other regional or distant sites were targeted. This information is useful in evaluating the patterns of care within a facility (local analysis of physician practices) and on a regional or national basis.

Instructions for Coding

Radiation treatment volume will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact treatment volume may require assistance from the radiation oncologist for consistent coding.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient.
01	Eye/orbit	The radiation therapy target volume is limited to the eye and/or orbit.
02	Pituitary	The target volume is restricted to the pituitary gland and all adjacent volumes are irradiated incidentally.
03	Brain (NOS)	Treatment is directed at tumors lying within the substance of the brain, or its meninges.
04	Brain (limited)	The treatment volume encompasses less than the total brain, or less than all of the meninges.
05	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the oropharyngeal complex, usually encompassing regional lymph nodes.
06	Head and neck (limited)	Limited volume treatment of a head and neck primary with the exception of glottis (code 7), sinuses (code 8), or parotid (code 9).
07	Glottis	Treatment is limited to a volume in the immediate neighborhood of the vocal cords.
08	Sinuses	The primary target is one or both of the maxillary sinuses or the ethmoidal frontal sinuses. In some cases, the adjacent lymph node regions may be irradiated.
09	Parotid	The primary target is one of the parotid glands. There may be secondary regional lymph node irradiation as well.
10	Chest/lung (NOS)	Radiation therapy is directed to some combination of hilar, mediastinal, and/or supraclavicular lymph nodes, and/or peripheral lung structures.
11	Lung (limited)	Radiation therapy is directed at one region of the lung without nodal irradiation.
12	Esophagus	The primary target is some portion of the esophagus. Regional lymph nodes may or may not be included in the treatment. Include tumors of the gastroesophageal junction.

Code	Label	Definition
13	Stomach	The primary malignancy is in the stomach. Radiation is directed to the stomach and possibly adjacent lymph nodes.
14	Liver	The primary target is all or a portion of the liver, for either primary or metastatic disease.
15	Pancreas	The primary tumor is in the pancreas. The treatment field encompasses the pancreas and possibly adjacent lymph node regions.
16	Kidney	The target is primary or metastatic disease in the kidney or the kidney bed after resection of a primary kidney tumor. Adjacent lymph node regions may be included in the field.
17	Abdomen (NOS)	Include all treatment of abdominal contents that do not fit codes 12–16.
18	Breast	The primary target is the intact breast and no attempt has been made to irradiate the regional lymph nodes.
19	Breast/lymph nodes	A deliberate attempt has been made to include regional lymph nodes in the treatment of an intact breast.
20	Chest wall	Treatment encompasses the chest wall (following mastectomy).
21	Chest wall/lymph nodes	Treatment encompasses the chest wall (following mastectomy) plus fields directed at regional lymph nodes.
22	Mantle, Mini-mantle	Treatment consists of a large radiation field designed to encompass all of the regional lymph nodes above the diaphragm, including cervical, supraclavicular, axillary, mediastinal, and hilar nodes (mantle), or most of them (mini-mantle). This code is used exclusively for patients with Hodgkin's or non-Hodgkin's lymphoma.
23	Lower extended field	The target zone includes lymph nodes below the diaphragm along the paraaortic chain. It may include extension to one side of the pelvis. This code includes the "hockey stick" field utilized to treat seminomas.
24	Spine	The primary target relates to the bones of the spine, including the sacrum. Spinal cord malignancies should be coded 40 (Spinal cord).
25	Skull	Treatment is directed at the bones of the skull. Any brain irradiation is a secondary consequence.
26	Ribs	Treatment is directed toward metastatic disease in one or more ribs. Fields may be tangential or direct.
27	Hip	The target includes the proximal femur for metastatic disease. In may cases there may be acetabular disease as well.
28	Pelvic bones	The target includes structures of the bones of the pelvis other than the hip or sacrum.
29	Pelvis (NOS)	Irradiation is directed at soft tissues within the pelvic region and codes 34–36 do not apply.
30	Skin	The primary malignancy originates in the skin and the skin is the primary target. So-called skin metastases are usually subcutaneous and should be coded 31 (Soft tissue).

Code	Label	Definition
31	Soft tissue	All treatment of primary or metastatic soft tissue malignancies not fitting other categories.
32	Hemibody	A single treatment volume encompassing either all structures above the diaphragm, or all structures below the diaphragm. This is almost always administered for palliation of widespread bone metastasis in patients with prostate or breast cancer.
33	Whole body	Entire body included in a single treatment.
34	Bladder and pelvis	The primary malignancy originated in the bladder, all or most of the pelvis is treated as part of the plan, typically with a boost to the bladder.
35	Prostate and pelvis	The primary malignancy originated in the prostate, all or most of the pelvis is treated as part of the plan, typically with a boost to the prostate.
36	Uterus and cervix	Treatment is confined to the uterus and cervix or vaginal cuff, usually by intracavitary or interstitial technique. If entire pelvis is included in a portion of the treatment, then code 29 (Pelvis, NOS).
37	Shoulder	Treatment is directed to the proximal humerus, scapula, clavicle, or other components of the shoulder complex. This is usually administered for control of symptoms for metastases.
38	Extremity bone, NOS	Bones of the arms or legs. This excludes the proximal femur, code 27 (Hip). This excludes the proximal humerus, code 37 (Shoulder).
39	Inverted Y	Treatment has been given to a field that encompasses the paraaortic and bilateral inguinal or inguinofemoral lymph nodes in a single port.
40	Spinal cord	Treatment is directed at the spinal cord or its meninges.
41	Prostate	Treatment is directed at the prostate with or without the seminal vesicles, without regional lymph node treatment.
50	Thyroid	Treatment is directed at the thyroid gland.
60	Lymph node region, NOS	The target is a group of lymph nodes not listed above. Examples include isolated treatment of a cervical, supraclavicular, or inguinofemoral region.
98	Other	Radiation therapy administered, treatment volume other than those previously categorized.
99	Unknown	Radiation therapy administered, treatment volume unknown or not stated in patient record; it is unknown whether radiation therapy was administered.

Examples:

Code	Reason
01	Lymphoma of the orbit treated with 4 cm x 4 cm portals.
02	Pituitary adenomas receiving small opposed field or rotational treatment.
03	The entire brain is treated for metastatic disease.

Code	Reason
04	Limited field irradiation of an oligodendroglioma or glioblastoma.
05	Carcinoma of the left tonsil treated with opposed lateral fields to the neck and an anterior supraclavicular field.
06	Interstitial implant utilized to treat a small carcinoma of the lateral tongue.
07	Small lateral fields utilized to treat a T1 or T2 glottic tumor.
11	Small portal treatment is delivered to the right bronchial/hilar region to stop hemoptysis.
17	Irradiation for hypersplenism due to lymphoma.
19	Tangential fields deliberately arranged in a manner that will encompass internal mammary lymph nodes in a patient with a medial primary; breast tangential fields plus supraclavicular and/or axillary field in a patient with five positive lymph nodes.
20	Following mastectomy, a patient has prophylactic chest wall irradiation to prevent local recurrence; a thoracotomy scar is irradiated because of known contamination with tumor.
24	An inverted "T" field is utilized to treat painful metastases in the lumbar vertebrae and sacrum in a patient with prostate cancer.
25	Patient with myeloma receives total skull irradiation for numerous "punched out" lesions that are causing discomfort.
33	Patient with chronic lymphocytic leukemia receives five treatments of 10 cGy each to reduce adenopathy or lymphocyte count.
36	Patient receives intracavitary therapy alone for a high-grade Stage IA carcinoma of the endometrium.
38	The distal forearm is treated for a metastatic lesion involving the radius.
39	Stage IA Hodgkin's disease presenting in an inguinal lymph node.
40	A portion of the spinal cord is treated for a primary ependymoma.
60	Ovarian carcinoma presenting with left supraclavicular lymphadenopathy as the only documented site of metastatic disease. The supraclavicular region is treated to prevent neurologic complications.
98	Anterior neck is treated for a primary thyroid lymphoma.

REGIONAL TREATMENT MODALITY

Item Length: 2

Allowable Values: 00, 20–32, 40–43,
50–55, 60–62, 98, 99

NAACCR Item #1570

Description

Records the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment.

Rationale

Radiation treatment is frequently delivered in two or more phases which can be summarized as “regional” and “boost” treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Instructions for Coding

- Radiation treatment modality will typically be found in the radiation oncologist’s summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.
- Note that in some circumstances the boost treatment may precede the regional treatment.
- For purposes of this data item, photons and x-rays are equivalent.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt- 60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2–5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.
24	Photons (6–10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.
25	Photons (11–19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.

Code	Label	Definition
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, HDR	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
80*	Combination modality, specified*	Combination of external beam radiation and either radioactive implants or radioisotopes*
85*	Combination modality, NOS*	Combination of radiation treatment modalities not specified in code 80.*
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Examples:

Code	Reason
20	A patient with prostate carcinoma receives pelvic irradiation at the reporting facility, and is then referred to a major medical center for experimental proton therapy boost.
24	A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days. This is followed by 6 MV photon treatment of the entire breast. In this case, the “boost” precedes the regional treatment.
25	In an experimental program, a patient with as Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.
25	Patient receives 15 MV external pelvic treatment to 4,500 cGy for cervical carcinoma, and then receives two Fletcher intracavitary implants.
29	A patient with carcinoma of the parotid receives daily treatments of which 60% are delivered by 15 MV photons and 40% of the dose is delivered by 16 MV electrons.
99	A patient with a head and neck cancer was referred from another facility for an HDR brachytherapy boost. Detailed treatment records from the other facility are not available.

- * **Note:** For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to *Vol. II, ROADS*, and *DAM* rules and **should not** be used to record regional radiation for cases diagnosed on or later than January 1, 2003.

REGIONAL DOSE: cGy

Item Length: 5
 Right Justified, Zero-filled
 NAACCR Item #1510

Description

Records the dominant or most clinically significant total dose of regional radiation therapy delivered to the patient during the first course of treatment. The unit of measure is centiGray (cGy).

Rationale

To evaluate patterns of radiation oncology care, it is necessary to capture information describing the prescribed regional radiation dose. Outcomes are strongly related to the dose delivered.

Instructions for Coding

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the dose as indicated in the summary chart. Determining the exact dose may be highly subjective and require assistance from the radiation oncologist for consistent coding.
- Regional dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the total dose of regional radiation therapy may require assistance from the radiation oncologist for consistent coding.
- Do not include the boost dose, if one was administered.
- Code 88888 when brachytherapy or radioisotopes—codes 50–62 for Regional Treatment Modality (NAACCR Item #1570)—were administered to the patient.
- Note that dose is still occasionally specified in “rads.” One rad is equivalent to one centiGray (cGy).

Code	Definition
(fill spaces)	Record the actual regional dose delivered.
00000	Radiation therapy was not administered.
88888	Not applicable, brachytherapy or radioisotopes administered to the patient.
99999	Regional radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered.

Examples:

Code	Reason
05000	A patient with Stage III prostate carcinoma received pelvic irradiation to 5,000 cGy followed by a prostate boost to 7,000 cGy. Record the regional dose as 5,000 cGy.
06000	A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region. The dose is calculated at a prescribed depth of 3 cm. A secondary calculation shows a D_{max} dose of 6,450 cGy. Record the regional dose reflecting the prescribed dose of 6,000 cGy.
05500	A patient with a Stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the dose of the breast to 5,500 cGy. The supraclavicular lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm, and an interstitial boost in the primary tumor bed delivers an additional 2,500 cGy to a small volume in the breast. Record the primary target of the breast as 5,500 cGy.

BOOST TREATMENT MODALITY

Item Length: 2

Allowable Values: 00, 20–32, 40–43,
50–55, 60–62, 98, 99

NAACCR Item #3200

Description

Records the dominant modality of radiation therapy used to deliver the most clinically significant boost dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or IMRT. External beam boosts may consist of two or more successive phases with progressively smaller fields generally coded as a single entity.

Rationale

Radiation treatment is frequently delivered in two or more phases which can be summarized as “regional” and “boost” treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Instructions for Coding

- Radiation boost treatment modalities will typically be found in the radiation oncologist’s summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- In the event that multiple radiation therapy boost modalities were employed during the treatment of the patient, record only the dominant modality.
- Note that in some circumstances, the boost treatment may precede the regional treatment.
- For purposes of this field, photons and x-rays are equivalent.

Code	Label	Definition
00	No boost treatment	A boost dose was not administered to the patient.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2–5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.
24	Photons (6–10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.
25	Photons (11–19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.

Code	Label	Definition
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, HDR	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Examples:

Code	Reason
29	A patient with carcinoma of the tonsil receives 4,500 cGy to the head and neck region with 6 MV photons. The primary site and involved regional lymph nodes are then boosted, ie, taken to a maximum dose of 7,400 cGy, using a sequence of beam arrangements involving 6 MV photons, 15 MV photons, and 12 MV electrons.

Code	Reason
30	In an experimental program, a patient with Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.
40	A patient with prostate carcinoma receives pelvic irradiation at the reporting facility and is referred to a major medical center for experimental proton therapy boost.
51	A patient receives external pelvic treatment to 4,500 cGy for cervical carcinoma, then receives two Fletcher intracavitary implants as boost treatment.
55	A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days.
99	A patient with a head and neck cancer is referred to another institution for an HDR brachytherapy boost. Detailed treatment records from the other institution are not available.

BOOST DOSE: cGy

Item Length: 5
 Right Justified, Zero-filled
 NAACCR Item #3210

Description

Records the additional dose delivered to that part of the treatment volume encompassed by the boost fields or devices. The unit of measure is centiGray (cGy).

Rationale

To evaluate patterns of radiation oncology care, it is necessary to capture information describing the prescribed boost radiation dose. Outcomes are strongly related to the dose delivered.

Instructions for Coding

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the dose as indicated in the summary chart. Consult the radiation oncologist for the exact dose, if necessary.
- Radiation boost treatment dose will typically be found in the radiation oncologist’s summary letter for the first course of treatment. Determination of the additional boost dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- Do not include the regional dose. In general, the boost dose will be calculated as the difference between the maximum prescribed dose and the regional dose. Many patients will not have a boost.
- Code 88888 when brachytherapy or radioisotopes—codes 50–62 for Boost Treatment Modality (NAACCR Item #3200)—were administered to the patient.
- Note that dose is still occasionally specified in “rads.” One rad is equivalent to one centiGray (cGy).

Code	Definition
(fill spaces)	Record the actual boost dose delivered.
00000	Boost dose therapy was not administered.
88888	Not applicable, brachytherapy or radioisotopes administered to the patient.
99999	Boost radiation therapy was administered, but the dose is unknown.

Examples:

Code	Reason
02000	A patient with Stage III prostate carcinoma receives pelvic irradiation to 5,000 cGy followed by a conformal prostate boost to 7,000 cGy. Record the prescribed (and delivered) boost dose, 2,000 cGy (7,000 cGy minus 5,000 cGy).
00000	A patient with a left supraclavicular metastasis from a gastric carcinoma receives 6,000 cGy to the left supraclavicular region. The dose is calculated at a prescribed depth of 3 cm. A secondary calculation shows a D_{max} dose (dose at depth of maximum dose) of 6,450 cGy. Do not confuse D_{max} doses with boost doses. In this case, there is no planned boost. Record the boost dose as 00000 cGy.
02500	A patient with a Stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the central axis dose in the breast to 5,040 cGy. The supraclavicular lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm, and an interstitial boost in the primary tumor bed delivers an additional 2,500 cGy to a small volume in the breast. Record the boost dose as 2,500 cGy. Note that standards for describing an interstitial or intracavitary treatment with a single number are somewhat variable.

NUMBER OF TREATMENTS TO THIS VOLUME

Item Length: 2
 Allowable Values: 00–99
 Right Justified, Zero-filled
 NAACCR Item #1520

Description

Records the total number of treatment sessions (fractions) administered during the first course of treatment.

Rationale

This data item is used to evaluate patterns of radiation therapy and the treatment schedules.

Instructions for Coding

- The number of treatments or fractions will typically be found in the radiation oncologist’s summary letter for the first course of treatment. Determination of the exact number of treatments or fractions delivered to the patient may require assistance from the radiation oncologist for consistent coding.
- Although a treatment session may include several treatment portals delivered within a relatively confined period of time—usually a few minutes—it is still considered one session.
- The total number of treatment sessions (fractions) is the sum of the number of fractions of regional treatment and the number of fractions of boost treatment.

Code	Label	Definition
00	None	Radiation therapy was not administered to the patient.
01–98	Number of treatments	Total number of treatment sessions administered to the patient.
99	Unknown	Radiation therapy was administered, but the number of treatments is unknown.. Or, it is unknown whether radiation therapy was administered.

Examples:

Code	Reason
25	A patient with breast carcinoma had treatment sessions in which treatment was delivered to the chest wall and separately to the ipsilateral supraclavicular region for a total of three treatment portals. Twenty-five treatment sessions were given. Record 25 treatments.
35	A patient with Stage IIIB bronchogenic carcinoma received 25 treatments to the left hilum and mediastinum, given in 25 daily treatments over five weeks. A left hilar boost was then given in 10 additional treatments. Record 35 treatments.
50	A patient with advanced head and neck cancer was treated using “hyperfractionation.” Three fields were delivered in each session, two sessions were given each day, six hours apart, with each session delivering a total dose of 150 cGy. Treatment was given for a total of 25 days. Record 50 treatments.

RADIATION/SURGERY SEQUENCE

Item Length: 1

Allowable Values: 0, 2–6, 9

NAACCR Item #1380

Description

Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Rationale

The sequence of radiation and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Instructions for Coding

Surgical procedures include *Surgical Procedure of Primary Site* (NAACCR Item #1290); *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292); *Surgical Procedure/Other Site* (NAACCR Item #1294). If all of these procedures are coded 0, then this item should be coded 0.

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery.
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	Radiation therapy both before and after surgery	Radiation therapy given before and after any surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown	Administration of radiation therapy and surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if radiation therapy was administered and/or it is unknown if surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed.

Examples:

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2	A large lung lesion received radiation therapy prior to resection.
3	A patient received a wedge resection of a right breast mass with axillary lymph node dissection followed by radiation to right breast.
4	Preoperative radiation therapy was given to a large, bulky vulvar lesion and was followed by a lymph node dissection. This was then followed by radiation therapy to treat positive lymph nodes.
5	A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma.
6	Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy.
9	An unknown primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. The patient enters for chemotherapy.

DATE RADIATION ENDED

Item Length: 8
NAACCR Item #3220

Description

The date on which the patient completes or receives the last radiation treatment at any facility.

Rationale

The length of time over which radiation therapy is administered to a patient is a factor in tumor control and treatment morbidity. It is useful to evaluate the quality of care and the success of patient support programs designed to maintain continuity of treatment.

Instructions for Coding

The date when treatment ended will typically be found in the radiation oncologist's summary letter for the first course of treatment.

Code	Definition
MMDDCCYY	The month, day, and year (MMDDCCYY) radiation therapy ended at any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	When no radiation was administered. Diagnosed at autopsy.
88888888	When radiation was administered and was still ongoing at the time of most recent follow-up. The date should be revised at the next follow-up.
99999999	When it is unknown whether any radiation therapy was administered, the date is unknown, or the case was identified by death certificate only.

Month

00
01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December
88
99 Month unknown

Day

00
01
02
03
...
...
30
31
88
99 Day unknown

Year

0000
Use four-digit year
8888
9999 Year unknown

Examples:

Code	Reason
01042005	A patient starts regional radiation treatment on December 15, 2004 and treatment continues until January 4, 2005.
04042006	A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on April 4, 2006.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description "Spring," 2003.
07992003	If information is limited to the description "The middle of the year," 2003.
10992003	If information is limited to the description "Fall," 2003.
12992003 or 01992004	If information is limited to the description "Winter." Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

REASON FOR NO RADIATION

Item Length: 1

Allowable Values: 0–2, 5–9

NAACCR Item #1430

Description

Records the reason that no regional radiation therapy was administered to the primary site.

Rationale

When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's failure to recommend that treatment, or due to the refusal of the patient, a family member, or the patient's guardian.

Instructions for Coding

- If *Regional Treatment Modality* (NAACCR Item #1570) is coded 00, then record the reason based on documentation in patient record.
- Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include radiation therapy.
- Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Cases coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple options, but it is unknown which treatment, if any, was provided.

Code	Definition
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, etc.).
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate and autopsy cases only.

Example:

Code	Reason
1	A patient with Stage I prostate cancer is offered either surgery or brachytherapy to treat his disease. The patient elects to be surgically treated.

DATE SYSTEMIC THERAPY STARTEDItem Length: 8
NAACCR Item #3230**Description**

Records the date of initiation for systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals—from diagnosis to treatment and from treatment to recurrence.

Instructions for Coding

- Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes *Chemotherapy* (NAACCR Item #1390), *Hormone Therapy* (NAACCR Item #1400), *Immunotherapy* (NAACCR Item #1410), and *Hematologic Transplant and Endocrine Procedures* (NAACCR Item #3250).
- Code 88888888 if systemic therapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.

Code	Definition
MMDDCCYY	The date systemic therapy started is the month, day, and year that systemic therapy was first administered. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. If the exact date on which systemic therapy was started is not available, then record an approximate date.
00000000	When no systemic therapy was administered. Diagnosed at autopsy.
88888888	When systemic therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up. The date should be revised at the next follow-up.
99999999	When it is unknown if any systemic therapy was administered, the date is unknown, or the case was identified by death certificate only.

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

Examples:

Code	Reason
12152003	A patient with breast cancer begins her regimen of chemotherapy on December 15, 2003, and is subsequently given tamoxifen on January 20, 2004.
06022003	A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2003. The patient is then started on a regime of hormonal agents on June 9, 2003.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description "Spring," 2003.
07992003	If information is limited to the description "The middle of the year," 2003.
10992003	If information is limited to the description "Fall," 2003.
12992003 or 01992004	If information is limited to the description "Winter." Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

CHEMOTHERAPY

Item Length: 2

Allowable Values: 00–03, 82, 85–88, 99

NAACCR Item #1390

Description

Records the type of chemotherapy administered as first course treatment at this and all other facilities. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if chemotherapy was not administered.

Instructions for Coding

- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.
- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and *only the original agent or regimen is recorded as first course therapy*.
- Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of chemotherapeutic agents.

Code	Definition
00	None, chemotherapy was not part of the planned first course of therapy.
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multiagent chemotherapy administered as first course therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

Code	Definition
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples:

Code	Reason
01	A patient with primary liver cancer is known to have received chemotherapy, however, the name(s) of agent(s) administered is not stated in patient record.
02	A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the administration of fluorouracil as single agent chemotherapy, and levamisole as an immunotherapeutic agent.
02	A patient with non-Hodgkin's lymphoma is treated with fludarabine.
03	A patient with early stage breast cancer receives chemotherapy. The patient chart indicates that a regimen containing doxorubicin is to be administered.
86	Following surgical resection of an ovarian mass the following physician recommends chemotherapy. The patient record states that chemotherapy was not subsequently administered to the patient, but the reason why chemotherapy was not administered is not given.

CHEMOTHERAPY AT THIS FACILITY

Item Length: 2

Allowable Values: 00–03, 82, 85–88, 99

NAACCR Item #700

Description

Records the type of chemotherapy administered as first course treatment at this facility. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if chemotherapy was not administered.

Instructions for Coding

- Record only chemotherapy received at this facility. Do not record agents administered at other facilities.
- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and *only the original agent or regimen is recorded as first course therapy*.
- Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs*, Third Edition, for a list of chemotherapeutic agents.

Code	Definition
00	None, chemotherapy was not part of the planned first course of therapy.
01	Chemotherapy administered as first course therapy; but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multiagent chemotherapy administered as first course therapy
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

Code	Definition
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

**HORMONE THERAPY
(HORMONE/STEROID THERAPY)**

Item Length: 2
Allowable Values: 00, 01, 82,
85–88, 99
NAACCR Item #1400

Description

Records the type of hormone therapy administered as first course treatment at this and all other facilities. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if hormone therapy was not administered.

Instructions for Coding

- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of hormonal agents.

Code	Definition
00	None, hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
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.

Code	Definition
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples:

Code	Reason
00	A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormonal therapy.
00	A patient with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. This patient must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy.
00	A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy.
01	A patient with metastatic prostate cancer is administered flutamide (an antiestrogen).
87	A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) and the refusal is noted in the patient record.

**HORMONE THERAPY AT THIS FACILITY
(HORMONE/STEROID THERAPY)**

Item Length: 2
 Allowable Values: 00, 01, 82,
 85–88, 99
 NAACCR Item #710

Description

Records the type of hormone therapy administered as first course treatment at this facility. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if hormone therapy was not administered.

Instructions for Coding

- Record only hormone therapy received at this facility. Do not record procedures done at other facilities.
- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of hormonal agents.

Code	Definition
00	None, hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
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.

Code	Definition
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

IMMUNOTHERAPY

Item Length: 2

Allowable Values: 00, 01, 82, 85–88, 99

NAACCR Item #1410

Description

Records the type of immunotherapy administered as first course treatment at this and all other facilities. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if immunotherapy was not administered.

Instructions for Coding

- Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy.
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of immunotherapeutic agents.

Code	Definition
00	None, immunotherapy was not part of the planned first course of therapy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples:

Code	Reason
01	A patient with malignant melanoma is treated with interferon.
85	Before recommended immunotherapy could be administered, the patient died from cancer.

IMMUNOTHERAPY AT THIS FACILITY

Item Length: 2
 Allowable Values: 00, 01, 82,
 85–88, 99
 NAACCR Item #720

Description

Records the type of immunotherapy administered as first course treatment at this facility. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if immunotherapy was not administered.

Instructions for Coding

- Record only immunotherapy received at this facility. Do not record agents administered at other facilities.
- Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy.
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of immunotherapeutic agents.

Code	Definition
00	None, immunotherapy was not part of the planned first course of therapy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES

Item Length: 2

Allowable Values: 00, 10–12, 20, 30,
40, 82, 85–88, 99

NAACCR Item #3250

Description

Identifies systemic therapeutic *procedures* administered as part of the first course of treatment at this and all other facilities. If none of these *procedures* were administered, then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Rationale

This data item allows the evaluation of patterns of treatment which involve the alteration of the immune system or change the patient's response to tumor cells but does not involve the administration of antineoplastic agents. In addition, when evaluating the quality of care, it is useful to know the reason if these *procedures* were not performed.

Instructions for Coding

- Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.
- Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.
- Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or effect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.
- Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.
- If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 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.

Code	Definition
00	No transplant procedure or endocrine therapy was administered as part of first course therapy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant—autologous.
12	Bone marrow transplant—allogeneic.
20	Stem cell harvest.
30	Endocrine surgery and/or endocrine radiation therapy.

Code	Definition
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20.)
82	Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age).
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

DATE OTHER TREATMENT STARTED

Item Length: 8
NAACCR Item #1250

Description

Records the date on which other treatment began at any facility.

Rationale

Collecting dates for each treatment modality allows for the sequencing of multiple treatments and aids in the evaluation of time intervals—from diagnosis to treatment and from treatment to recurrence.

Instructions for Coding

- Other treatment is that which cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.
- If other treatment is the first or only treatment administered to the patient, then the date other treatment started should be the same as the *Date of First Course of Treatment* (NAACCR Item #1270).

Code	Definition
MMDDCCYY	The month, day, and year other treatment began at any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	When no other treatment was administered. Diagnosed at autopsy.
99999999	When it is unknown if other treatment was administered, the date is unknown, or the case was identified by death certificate only.

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

Examples:

Code	Reason
03162003	A patient with metastatic disease was started on an experimental therapy on March 16, 2003.
06022005	On June 2, 2005, a patient started treatment which cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description "Spring," 2003.
07992003	If information is limited to the description "The middle of the year," 2003.
10992003	If information is limited to the description "Fall," 2003.
12992003 or 01992004	If information is limited to the description "Winter." Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

OTHER TREATMENT

Item Length: 1

Allowable Values: 0–3, 6–9

NAACCR Item #1420

Description

Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

Rationale

Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Instructions for Coding

- A complete description of the treatment plan should be recorded in the text field for “Other Treatment” on the abstract.
- Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment “modifies, controls, removes, or destroys proliferating cancer tissue.” Such treatments include phlebotomy, transfusions, and aspirin (see Notes below), and should be coded 1.

Code	Label	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases (see Notes below).
2	Other—Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other—Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other—Unproven	Cancer treatments administered by nonmedical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient’s physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient’s family member, or the patient’s guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment.

Notes:

- Phlebotomy may be called blood removal, blood letting, or venisection.
- Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.
- Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia. Record ONLY aspirin therapy to thin the blood for symptomatic control of thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:
 - Pain control is approximately 325–1000 mg every 3–4 hours.
 - Cardiovascular protection starts at about 160 mg/day.
 - Aspirin treatment for essential thrombocythemia is low dose, approximately 70–100 mg/day.

OTHER TREATMENT AT THIS FACILITY

Item Length: 1

Allowable Values: 0–3, 6–9

NAACCR Item #730

Description

Identifies other treatment given at this facility that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

Rationale

Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Instructions for Coding

- A complete description of the treatment plan should be recorded in the text field for “Other Treatment” on the abstract.
- Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment “modifies, controls, removes, or destroys proliferating cancer tissue.” Such treatments include phlebotomy, transfusions, and aspirin (see Notes below), and should be coded 1.

Code	Label	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases (see Notes below).
2	Other—Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other—Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other—Unproven	Cancer treatments administered by nonmedical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient’s physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient’s family member, or the patient’s guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment.

Notes:

- Phlebotomy may be called blood removal, blood letting, or venisection.
- Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.
- Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia. Record ONLY aspirin therapy to thin the blood for symptomatic control of thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:
 - Pain control is approximately 325–1000 mg every 3–4 hours.
 - Cardiovascular protection starts at about 160 mg/day.
 - Aspirin treatment for essential thrombocythemia is low dose, approximately 70–100 mg/day.

PAIN ASSESSMENT

Item Length: 1
 Allowable Values: 0–3, 9
 NAACCR Item #3260

Description

Records whether or not a pain assessment was performed to determine the need for palliative care.

Rationale

Information about pain assessment and pain management is necessary in order to evaluate the quality of care given to a patient. Palliative care includes pain and symptom management during active cancer treatment (ie, surgery, radiation, chemotherapy) as well as care given at end of life when active treatment of cancer may have ceased.

Instructions for Coding

The item can be entered or updated at any time following the date of diagnosis.

Code	Definition
0	No pain assessment is noted in patient record.
1	A pain assessment is described in patient record, and the assessment did not indicate a need for palliative care.
2	A pain assessment is described in patient record, and the assessment did indicate a need for palliative care. A referral for palliative care, however, is not noted in patient record.
3	A pain assessment is described in patient record, and the assessment did indicate a need for palliative care. A referral for palliative care is noted in patient record.
9	It is unknown whether a pain assessment was performed. The patient record is unavailable or the patient was accessioned prior to January 1, 2003.

Examples:

Code	Reason
2	A woman with advanced ovarian cancer is assessed for palliative care. The patient record does not indicate a referral for palliative care.
3	A patient with advanced lung cancer is assessed by the following physician for pain control and a referral is made with the recommendation of an opiate prescription.

PALLIATIVE PROCEDURE

Item Length: 1
 Allowable Values: 0–7, 9
 NAACCR Item #3270

Description

Identifies any procedure performed in an effort to palliate or alleviate symptoms. Palliative procedures are performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or other pain management therapy.

Rationale

This data item allows reporting facilities to track the use of procedures that are considered palliative rather than therapeutic, diagnostic, or staging.

Instructions for Coding

- Record the type of palliative procedure administered during the first course of treatment or in lieu of treatment.
- Record the type of palliative procedure either performed at your institution or for which the patient was referred to another facility.
- Palliative procedures are not used in diagnosing, staging, or treating the primary tumor.
- Surgical procedures, radiation therapy, and systemic therapy that are part of first course therapy are coded in their respective fields.

Code	Definition
0	No palliative care provided.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for pain management therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in patient record.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

Examples:

Code	Reason
0	No palliative care was given.
1	A patient with unresectable pancreatic carcinoma receives bypass surgery to alleviate jaundice and pain.
1	A thoracentesis is performed to alleviate pressure on the primary site; no cytology was performed on the withdrawn specimen.
2	A patient is diagnosed with Stage IV prostate cancer. His only symptoms are painful bony metastases in his right hip and lower spine. XRT is given to those areas.

Code	Reason
3	A patient is given palliative chemotherapy for Stage IIIB lung cancer.
4	A 93-year old patient is diagnosed with multiple myeloma and enters a pain management clinic to treat symptoms. No other therapy is planned due to other medical problems.
5	A patient is diagnosed with widely disseminated small cell lung cancer. A resection of solitary brain metastasis is performed followed by XRT to the lower spine for painful bony metastasis. There is no known referral for pain management.
6	A patient diagnosed with colon cancer receives bypass surgery to alleviate symptoms and XRT to the liver for metastasis, and then enters a pain management clinic for treatment for unremitting abdominal pain.
7	A patient enters the facility with a clinical diagnosis of metastatic renal cell carcinoma for noninvasive palliation.
9	A patient enters the facility with a new diagnosis of widely disseminated Stage IV breast cancer, but patient record does not state whether palliative care was provided.

PALLIATIVE PROCEDURE AT THIS FACILITY

Item Length: 1
 Allowable Values: 0–7, 9
 NAACCR Item #3280

Description

Identifies any procedure performed at this facility in an effort to palliate or alleviate symptoms. Palliative procedures are performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or other pain management therapy.

Rationale

This data item allows reporting facilities to track the use of procedures that are considered palliative rather than therapeutic, diagnostic, or staging.

Instructions for Coding

- Record the type of palliative procedure performed at this facility.
- This item can be entered or updated at any time following the date of diagnosis.
- Palliative procedures are not used in diagnosing, staging, or treating the primary tumor.
- Surgical procedures, radiation therapy, and systemic therapy that are part of first course therapy are coded in their respective fields.

Code	Definition
0	No palliative care provided.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for pain management therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in patient record.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

Outcomes

DATE OF FIRST RECURRENCEItem Length: 8
NAACCR Item #1860**Description**

Records the date of the first recurrence.

Rationale

This data item is used to measure the efficacy of the first course of treatment.

Instructions for Coding

Record the date the physician diagnoses metastatic or recurrent cancer.

Code	Definition
MMDDCCYY	The date of first recurrence is the month, day, and year that the first recurrence was diagnosed. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. If the exact date on which the diagnosis was made is not available, then record an approximate date.
00000000	If the patient became disease-free after treatment, never had a recurrence, or if the patient was never disease-free. Diagnosed at autopsy.
99999999	When it is unknown if the patient had a first recurrence or the case was identified by death certificate only.

Month

00
01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December
99 Month unknown

Day

00
01
02
03
...
...
30
31
99 Day unknown

Year

0000
Use four-digit year
9999 Year unknown

Examples:

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

TYPE OF FIRST RECURRENCE

Item Length: 2

Allowable Values: 00, 04, 06, 10,
13–17, 20–22, 25–27, 30, 36, 40,
46, 51–59, 60, 62, 70, 88, 99
NAACCR Item #1880

Description

Identifies the type of first recurrence after a period of documented disease-free intermission or remission.

Rationale

This item is used to evaluate treatment efficacy and as a long-term prognostic factor.

Instructions for Coding

- Code the type of recurrence(s) at the time the first recurrence is identified.
- Codes 00 through 70 are hierarchical. Record the highest-numbered applicable response.
- If the tumor was originally diagnosed as in situ, code recurrence to 06, 16, 17, 26, 27, 36, or 46 only. Do not use those codes for any other tumors. Codes 00, 88, or 99 may apply to any tumor.
- Codes 51–59 (organ or organ system of distant recurrence) apply only if all first occurrences were in a single category. There may be multiple metastases (or “seeding”) within the distant location.
- Code leukemias that are in remission 00. If the patient relapses, then code recurrence status as 59.
- If there is more than one primary tumor and the physician is unable to decide which has recurred, code the recurrent disease for each tumor. If, at a later date, the recurrent primary is identified, revise the codes as appropriate.

Code	Definition
00	Patient became disease-free after treatment and has not had a recurrence.
04	In situ recurrence of an invasive tumor.
06	In situ recurrence of an in situ tumor.
10	Local recurrence, and there is insufficient information available to code to 13–17. Local recurrence includes recurrence confined to the remnant of the organ of origin, to the organ of origin, to the anastomosis, or to scar tissue where the organ previously existed.
13	Local recurrence of an invasive tumor.
14	Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.
15	Both local and trocar recurrence of an invasive tumor (both 13 and 14).
16	Local recurrence of an in situ tumor, NOS
17	Both local and trocar recurrence of an in situ tumor.
20	Regional recurrence, and there is insufficient information available to code to 21–27.
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22	Recurrence of an invasive tumor in regional lymph nodes only.
25	Recurrence of an invasive tumor in adjacent tissue or organ(s) and in regional lymph nodes (both 21 and 22) at the same time.
26	Regional recurrence of an in situ tumor, NOS.
27	Recurrence of an in situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30	Both regional recurrence of an invasive tumor in adjacent tissue or organs(s) and/or regional lymph nodes (20–25) and local and/or trocar recurrence (10, 13, 14, or 15).

Code	Definition
36	Both regional recurrence of an in situ tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) and local and/or trocar recurrence (16 or 17).
40	Distant recurrence, and there is insufficient information available to code to 46–62.
46	Distant recurrence of an in situ tumor.
51	Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
54	Distant recurrence of an invasive tumor in the liver only.
55	Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site.
56	Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but not the external eye.
57	Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58	Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59	Distant systemic recurrence of an invasive tumor only. This includes leukemia, bone marrow metastasis, carcinomatosis, generalized disease.
60	Distant recurrence of an invasive tumor in a single distant site (51–58) and local, trocar and/or regional recurrence (10–15, 20–25, or 30).
62	Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51–59).
70	Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
88	Disease has recurred, but the type of recurrence is unknown.
99	It is unknown whether the disease has recurred or if the patient was ever disease-free.

Examples:

Code	Reason
52	Distant site of recurrence, lung.
62	Multiple distant sites of recurrence, ie, liver and lung.

DATE OF LAST CONTACT OR DEATHItem Length: 8
NAACCR #1750**Description**

Records the date of last contact with the patient or the date of death.

Rationale

This information is used for patient follow-up and outcomes studies.

Instructions for Coding

- Record the last date on which the patient was known to be alive or the date of death.
- If a patient has multiple primaries, all records should have the same date of last contact.

Code	Definition
MMDDCCYY	The date of last contact is the month, day, and year that last contact was made. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. If the exact date on which last contact was made is not available, then record an approximate date.

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

Examples:

Code	Reason
06302004	The patient's date of death was June 30, 2004.
99992003	The medical record contains only the year of death (2003).
01142005	A patient returns his follow-up inquiry with no date information, the envelope is postmarked January 14, 2005.

VITAL STATUS

Item Length: 1
 Allowable Values: 0, 1
 NAACCR Item #1760

Description

Records the vital status of the patient as of the date entered in *Date of Last Contact or Death* (NAACCR Item #1750).

Rationale

This information is used for patient follow-up and outcomes studies.

Instructions for Coding

- This item is collected during the follow-up process with *Date of Last Contact or Death* (NAACCR Item #1750).
- If a patient has multiple primaries, all records should have the same vital status.

Code	Label
0	Dead
1	Alive

Examples:

Code	Reason
0	Death clearance information obtained from a state central registry confirms the death of the patient within the past year.
1	In response to a follow-up letter to a patient's following physician, it is learned the patient is alive.

CANCER STATUS

Item Length: 1
 Allowable Values: 1, 2, 9
 NAACCR Item #1770

Description

Records the presence or absence of clinical evidence of cancer as of the *Date of Last Contact or Death* (NAACCR Item #1750).

Rationale

This information is used for patient follow-up and outcomes studies.

Instructions for Coding

- Cancer status is based on information from the patient's physician or other official source such as a death certificate.
- The patient's cancer status should be changed **only** if new information is received from the patient's physician or other official source. If information is obtained from the patient, a family member, or other nonphysician, then cancer status is not updated.
- Cancer status changes if the patient has a recurrence or relapse.
- If a patient has multiple primaries, each primary could have a different cancer status.

Code	Label
1	No evidence of this cancer
2	Evidence of this cancer
9	Unknown, indeterminate whether this cancer is present; not stated in patient record

Examples:

Code	Reason
1	Patient with hematopoietic disease who is in remission.
1	A patient is seen by the physician on February 2, 2004 with no evidence of this cancer. The patient did not return to the physician. The patient was then called by the registry on August 29, 2005. The <i>Date of Last Contact or Death</i> (NAACCR Item #1750) is updated, but the cancer status is not.
2	A patient with prostate cancer is diagnosed with bone metastasis in April 2003. The registrar finds an obituary documenting the patient's death in a nursing home in June 2003.

FOLLOWING REGISTRY

Item Length: 10
 Right Justified, Zero-filled
 NAACCR Item #2440

Description

Records the facility identification number of the registry responsible for following the patient.

Rationale

This data item is useful when the same patient is recorded in multiple registries.

Instructions for Coding

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

Code	Definition
(fill spaces)	Ten-digit facility identification number.
009999999	If the following registry's identification number is unknown.

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

Note: A written agreement may be drawn up between two registries noting which hospital will be responsible for follow-up.

FOLLOW-UP SOURCE

Item Length: 1
 Allowable Values: 0–5, 7–9
 NAACCR Item #1790

Description

Records the source from which the latest follow-up information was obtained.

Rationale

This data item is used by registries to identify the most recent follow-up source.

Instructions for Coding

Code	Label	Definition
0	Reported hospitalization	Hospitalization at another institution/hospital or first admission to the reporting facility.
1	Readmission	Hospitalization or outpatient visit at the reporting facility.
2	Physician	Information from a physician.
3	Patient	Direct contact with the patient.
4	Department of Motor Vehicles	The Department of Motor Vehicles confirmed the patient has a current license.
5	Medicare/Medicaid file	The Medicare or Medicaid office confirmed the patient is alive.
7	Death certificate	Information from the death certificate only.
8	Other	Friends, relatives, employers, other registries, or any sources not covered by other codes.
9	Unknown; not stated in patient record	The follow-up source is unknown or not stated in patient record.

**NEXT FOLLOW-UP SOURCE
(NEXT FOLLOW-UP METHOD)**

Item Length: 1
Allowable Values: 0–5, 8, 9
NAACCR Item #1800

Description

Identifies the method planned for the next follow-up.

Rationale

This data item is used by registries to identify the method planned for the next follow-up.

Instructions for Coding

Registries in CoC-approved cancer programs are not required to follow foreign residents.

Code	Definition
0	Chart requisition
1	Physician letter
2	Contact letter
3	Phone call
4	Other hospital contact
5	Other, NOS
8	Foreign residents (not followed)
9	Not followed. Other cases for which follow-up is not required.

Case Administration

ABSTRACTED BY

Item Length: 3
Left Justified
NAACCR Item #570

Description

Records the initials or assigned code of the individual abstracting the case.

Rationale

This item can be used for quality control and management in multistaffed registries.

Instructions for Coding

Code the initials of the abstractor.

Code	Definition
(fill spaces)	Initials or code of abstractor.

FACILITY IDENTIFICATION NUMBER (FIN)

Item Length: 10
 Right Justified, Zero-filled
 NAACCR Item #540

Description

Identifies the facility reporting the case.

Rationale

Each facility's identification number (FIN) is unique. The number is essential to the National Cancer Data Base (NCDB) for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Instructions for Coding

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

Examples:

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

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

ARCHIVE FIN

Item Length: 10
 Right Justified, Zero-filled
 NAACCR Item #3100

Description

Identifies the facility that originally abstracted the case.

Rationale

It is essential for hospital registries to have the ability to distinguish cases originally accessioned by each registry of the merged unit. This enables the CoC to manage the receipt of historical data and to appropriately attribute these data.

Instructions for Coding

- *Archive FIN* is automatically coded by the software provider.
- This data item never changes and must be included as part of the patient record when data are submitted to the NCDB.
- For facilities that have not merged, the *Archive FIN* and *FIN* (NAACCR Item #540) will be the same.
- If facilities merged after January 1, 2003, a new *FIN* was assigned to represent the merged facility. This new *FIN* was assigned to all cases in the *merged* registry, but the *Archive FIN* for cases from each registry prior to the merger **does not** change.
- For facilities with seven-digit *FINs* in the range of 6020009–6953290 that were assigned by the CoC before January 1, 2001, the coded *FIN* will consist of three leading zeros followed by the full seven-digit number. The *Archive FIN* must be recorded similarly.
- For facilities with eight-digit *FINs* greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded *FIN* will consist of two leading zeros followed by the full eight-digit number. The *Archive FIN* must be recorded similarly.

Examples:

Code	Reason
0006439999	General Hospital, Anytown, Illinois (FIN: 6439999). Original diagnosis was made at this facility; both the <i>FIN</i> and the <i>Archive FIN</i> are the same.
0006439999 or 0006430000	General Hospital (FIN: 6439999) and Anytown Medical Center (FIN: 6430000) in Anytown IL merged; the two cancer registries were combined and now report as Anytown Medical Center. The new <i>FIN</i> for this reporting facility is 10000099. All cases from the merged General Hospital and Anytown Medical Center registry have the new <i>FIN</i> (0010000099) assigned to them. In addition, either the General Hospital <i>Archive FIN</i> (0006439999) or the Anytown Medical Center <i>Archive FIN</i> (0006430000) is retained in each record depending on which registry originally accessioned the case.

OVERRIDE ACSN/CLASS/SEQ

Item Length: 1
 Allowable Values: 1
 NAACCR Item #1985

Description

Used with CoC Metafile and the EDITS software to override the edit Accession Number, Class of Case, Seq Number (CoC).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit Accession Number, Class of Case, Seq Number (CoC).
- Leave blank and correct the code for any item documented for the edit Accession Number, Class of Case, Seq Number (CoC) if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Accession Number, Class of Case, Seq Number (CoC) confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE HOSPSEQ/DXCONF

Item Length: 1
Allowable Values: 1
NAACCR Item #1986

Description

Used with CoC Metafile and the EDITS software to over-ride the edit Diagnostic Confirm, Seq Num—Hosp (CoC).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit Diagnostic Confirm, Seq Num—Hosp (CoC).
- Leave blank and correct the code for any item documented for the edit Diagnostic Confirm, Seq Num—Hosp (CoC) if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Diagnostic Confirm, Seq Num—Hosp (CoC) confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE COC—SITE/TYPE

Item Length: 1
 Allowable Values: 1
 NAACCR Item #1987

Description

Used with CoC Metafile and the EDITS software to override the edit Primary Site, Morphology-Type Check (CoC) and/or the edit Primary Site, Morphology-Type ICD-O-3 (CoC).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit Primary Site, Morphology-Type Check (CoC) and/or the edit Primary Site, Morphology-Type ICD-O-3 (CoC).
- Leave blank and correct the code for any item documented for the edit Primary Site, Morphology-Type Check (CoC) and/or the edit Primary Site, Morphology-Type ICD-O-3 (CoC) if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Primary Site, Morphology-Type Check (CoC) and/or the edit Primary Site, Morphology-Type ICD-O-3 (CoC) confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE HOSPSEQ/SITE

Item Length: 1
 Allowable Values: 1
 NAACCR Item #1988

Description

Used with CoC Metafile and the EDITS software to override the edit Seq Num—Hosp, Primary Site, Morph (CoC), and/or the edit Seq Num—Hosp, Primary Site, Morph ICD-O-3 (CoC).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit Seq Num—Hosp, Primary Site, Morph (CoC) and/or the edit Seq Num—Hosp, Primary Site, Morph ICD-O-3 (CoC).
- Leave blank and correct the code for any item documented for the edit Seq Num—Hosp, Primary Site, Morph (CoC) and/or the edit Seq Num—Hosp, Primary Site, Morph ICD-O-3 (CoC) if , on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Seq Num—Hosp, Primary Site, Morph (CoC) and/or the edit Seq Num—Hosp, Primary Site, Morph ICD-O-3 (CoC) confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE SITE/TNM-STAGE GROUP

Item Length: 1
 Allowable Values: 1
 NAACCR Item #1989

Description

Used with CoC Metafile and the EDITS software to override the edits Primary Site, AJCC Stage Group, edition 3/4; Primary Site, AJCC Stage Group, edition 5; and Primary Site, AJCC Stage Group, edition 6.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edits Primary Site, AJCC Stage Group, edition 3/4; Primary Site, AJCC Stage Group, edition 5; and Primary Site, AJCC Stage Group, edition 6.
- Leave blank and correct the code for any item documented for the edits Primary Site, AJCC Stage Group, edition 3/4; Primary Site, AJCC Stage Group, edition 5; and Primary Site, AJCC Stage Group, edition 6, if, on review, it is discovered to be incorrect.
- Code 1 for cases diagnosed December 31, 2002 or earlier if a review of all items documented for the edits Primary Site, AJCC Stage Group, edition 3/4, and Primary Site, AJCC Stage Group, edition 5, agree with the information on file.
- Code 1 for cases diagnosed January 1, 2003 and later if communication with the managing physician who staged the case confirms that of the original code assignments for all items documented for the edits Primary Site, AJCC Stage Group, edition 6, were intended.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE AGE/SITE/MORPH

Item Length: 1
 Allowable Values: 1
 NAACCR Item #1990

Description

Used with CoC Metafile and the EDITS software to override the edit Age, Primary Site, Morphology (CoC) and/or the edit Age, Primary Site, Morphology ICD-O-3 (CoC).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit Age, Primary Site, Morphology (CoC) and/or the edit Age, Primary Site, Morphology ICD-O-3 (CoC).
- Leave blank and correct the code for any item documented for the edit Age, Primary Site, Morphology (CoC) and/or the edit Age, Primary Site, Morphology ICD-O-3 (CoC) if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Age, Primary Site, Morphology (CoC) and/or the edit Age, Primary Site, Morphology ICD-O-3 (CoC) confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE SURG/DXCONF

Item Length: 1
 Allowable Values: 1
 NAACCR Item #2020

Description

Used with the EDITS software to override the edit RX Summ—Surg Prim Site, Diag Conf (SEER IF76) and/or the edit RX Summ—Surgery Type, Diag Conf (SEER IF46).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit RX Summ—Surg Prim Site, Diag Conf (SEER IF76) and/or the edit RX Summ—Surgery Type, Diag Conf (SEER IF46).
- Leave blank and correct the code for any item documented for the edit RX Summ—Surg Prim Site, Diag Conf (SEER IF76) and/or the edit RX Summ—Surgery Type, Diag Conf (SEER IF46) if, on review, it is discovered to be incorrect.
- Code 1 if review of all items documented for the edit RX Summ—Surg Prim Site, Diag Conf (SEER IF76) and/or the edit RX Summ—Surgery Type, Diag Conf (SEER IF46) confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE SITE/TYPE

Item Length: 1
 Allowable Values: 1
 NAACCR Item #2030

Description

Used with CoC Metafile and the EDITS software to override the edit Primary Site, Morphology-Type Check (SEER IF25) and/or the edit Primary Site, Morphology-Type ICD-O-3 (SEER IF25).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit Primary Site, Morphology-Type Check (SEER IF25) and/or the edit Primary Site, Morphology-Type ICD-O-3 (SEER IF25).
- Leave blank and correct the code for any item documented for the edit Primary Site, Morphology-Type Check (SEER IF25) and/or the edit Primary Site, Morphology-Type ICD-O-3 (SEER IF25) if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Primary Site, Morphology-Type Check (SEER IF25) and/or the edit Primary Site, Morphology-Type ICD-O-3 (SEER IF25) confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE HISTOLOGY

Item Length: 1

Allowable Values: 1, 2, 3

NAACCR Item #2040

Description

Used with CoC Metafile and the EDITS software to override any of four edits: Diagnostic Confirmation, Behav Code (CoC); Diagnostic Confirmation, Behavior ICD-O-3 (CoC); Morphology—Type&Behavior (CoC); and/or Morphology—Type&Behavior ICD-O-3 (CoC).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edits Diagnostic Confirmation, Behav Code (CoC); Diagnostic Confirmation, Behavior ICD-O-3(CoC); Morphology—Type&Behavior (CoC); or Morphology—Type&Behavior ICD-O-3 (CoC).
- Leave blank and correct the code for any item documented for the edits Diagnostic Confirmation, Behav Code (CoC); Diagnostic Confirmation, Behavior ICD-O-3(CoC); Morphology—Type&Behavior (CoC); or Morphology—Type&Behavior ICD-O-3 (CoC) if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edits Diagnostic Confirmation, Behav Code (CoC); Diagnostic Confirmation, Behavior ICD-O-3(CoC); Morphology—Type&Behavior (CoC); or Morphology—Type&Behavior ICD-O-3 (CoC) confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed: allow flag for edits “Morphology—Type&Behavior (SEER MORPH)” and “Morphology—Type&Behavior (NAACCR MORPH)” in EDITS.
2	Reviewed: allow flag for edits “Diagnostic Confirmation, Behavior Code (SEER IF31)” and “Diagnostic Confirmation, Behav Code (NAACCR IF31)” in EDITS.
3	Reviewed: conditions 1 and 2 above both apply.

OVERRIDE LEUK, LYMPHOMA

Item Length: 1
 Allowable Values: 1
 NAACCR Item #2070

Description

Used with CoC Metafile and the EDITS software to override the edit Diagnostic Confirmation, Histol Typ (CoC) and/or the edit Diagnostic Confirmation, Histol Typ ICD-O-3 (CoC).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit Diagnostic Confirmation, Histol Typ (CoC) and/or the edit Diagnostic Confirmation, Histol Typ ICD-O-3 (CoC).
- Leave blank and correct the code for any item documented for the edit Diagnostic Confirmation, Histol Typ (CoC) and/or the edit Diagnostic Confirmation, Histol Typ ICD-O-3 (CoC) if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Diagnostic Confirmation, Histol Typ (CoC) and/or the edit Diagnostic Confirmation, Histol Typ ICD-O-3 (CoC) confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE SITE/BEHAVIOR

Item Length: 1
 Allowable Values: 1
 NAACCR Item #2071

Description

Used with CoC Metafile and the EDITS software to override the edit Primary Site, Behavior Code (CoC) and/or the edit Primary Site, Behavior Code ICD-O-3 (CoC).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit Primary Site, Behavior Code (CoC) and/or the edit Primary Site, Behavior Code ICD-O-3 (CoC).
- Leave blank and correct the code for any item documented for the edit Primary Site, Behavior Code (CoC) and/or the edit Primary Site, Behavior Code ICD-O-3 (CoC) if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Primary Site, Behavior Code (CoC) and/or the edit Primary Site, Behavior Code ICD-O-3 (CoC) confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

OVERRIDE SITE/LAT/MORPH

Item Length: 1
 Allowable Values: 1
 NAACCR Item #2074

Description

Used with the EDITS software to override the edit Laterality, Primary Site, Morphology (SEER IF42) and/or the edit Laterality, Primary Site, Morph ICD-O-3 (SEER IF42).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the edit Laterality, Primary Site, Morphology (SEER IF42) and/or the edit Laterality, Primary Site, Morph ICD-O-3 (SEER IF42).
- Leave blank and correct the code for any item documented for the edit Laterality, Primary Site, Morphology (SEER IF42) and/or the edit Laterality, Primary Site, Morph ICD-O-3 (SEER IF42) if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Laterality, Primary Site, Morphology (SEER IF42) and/or the edit Laterality, Primary Site, Morph ICD-O-3 (SEER IF42) confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed.
1	Reviewed.

COC CODING SYSTEM—CURRENT

Item Length: 2

Allowable Values: 00–08, 99

NAACCR Item #2140

Description

Indicates the Commission on Cancer coding system currently used in the record.

Rationale

Knowledge of the coding system that describes the meaning of the codes currently stored for each case is necessary for interpretation of the coded data. It is also necessary for correct conversion of the record to a different coding system or to a different registry software system. This item differs from *CoC Coding System—Original* (NAACCR Item #2150) if the record has been converted to a more recent coding system.

Instructions for Coding

- All fields in a case record should be coded according to the same Commission on Cancer coding system following record conversion.
- This code does not apply to patient race, primary site, histology, TNM stage and its components, or cause of death. The original coding systems for these items are recorded in other fields.
- This item should be updated every time the record is converted to another coding system.

Code	Label	Definition
00	None	No CoC coding system used.
01	Pre-1988	Pre-1988 version (Cancer Program Manual Supplement)
02	1988	1988 <i>Data Acquisition Manual</i>
03	1989	1989 <i>Data Acquisition Manual</i>
04	1990	1990 <i>Data Acquisition Manual</i>
05	1994	1994 <i>Data Acquisition Manual</i>
06	1996	<i>Standards of the Commission on Cancer Volume II: Registry Operations and Data Standards (ROADS)</i>
07	1998	<i>Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)</i> 1998 Revisions
08	2003	<i>Facility Oncology Registry Data Standards (FORDS)</i>
99	Unknown	Unknown coding system.

Examples:

Code	Reason
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program and no conversion of the record has occurred since its accession into the registry.
08	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program. In 1989, the registry records were converted to conform to the codes defined in the 1989 <i>Data Acquisition Manual</i> . The registry data were subsequently converted in 1996, 1998, and 2003 with the publication of each manual.

Code	Reason
08	A case accessioned in 1997 was coded according to 1996 <i>Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)</i> , and subsequently converted to correspond to the coding system expressed in <i>Facility Oncology Registry Data Standards (FORDS)</i> .
99	A case was accessioned in 1989, but it is unknown whether the 1988 or 1989 version of the <i>Data Acquisition Manual</i> was used to code the case. The conversion of this record to a more recent coding system is not possible due the uncertainty of its original coding system.

COC CODING SYSTEM—ORIGINAL

Item Length: 2

Allowable Values: 00–08, 99

NAACCR Item #2150

Description

Indicates the Commission on Cancer coding system used to originally code the items.

Rationale

The coding system used when a case is originally coded limits the possible categories that could have been applied to code the case. Because code categories may change over time as new coding systems are developed, this item is used to assist interpretation when cases that may have been coded originally according to multiple coding systems are analyzed.

Instructions for Coding

- All fields in a case record should be coded according to the same Commission on Cancer coding system.
- This code does not apply to patient race, primary site, histology, TNM stage and its components, or cause of death. The original coding systems for these items are recorded in other fields.
- This item must not be changed when the record is converted to another coding system. That information is reflected in the data item *CoC Coding System—Current* (NAACCR Item #2140).
- Code 99 for cases coded prior to 2003 if the correct CoC coding system is not known, or if multiple coding systems were used to code a single case. Ordinarily, it will not be necessary to use code 99 for cases accessioned in 2003 or later.

Code	Label	Definition
00	None	No CoC coding system used.
01	Pre-1988	Pre-1988 version (Cancer Program Manual Supplement)
02	1988	1988 <i>Data Acquisition Manual</i>
03	1989	1989 <i>Data Acquisition Manual</i>
04	1990	1990 <i>Data Acquisition Manual</i>
05	1994	1994 <i>Data Acquisition Manual</i>
06	1996	<i>Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)</i>
07	1998	<i>Standards of the Commission on Cancer Volume II: Registry Operations and Data Standards (ROADS) 1998 Revisions</i>
08	2003	<i>Facility Oncology Registry Data Standards (FORDS)</i>
99	Unknown	Original CoC coding system used is not known.

Examples:

Code	Reason
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program.
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program. In 1989, the registry records were converted to conform to the codes defined in the 1989 <i>Data Acquisition Manual</i> . The registry data were subsequently converted in 1996, 1998, and 2003 with the publication of each manual.
06	A case accessioned in 1997 was coded according to <i>1996 Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)</i> , and subsequently converted to correspond to the coding rules expressed in <i>Facility Oncology Registry Data Standards (FORDS)</i> .
99	A case was accessioned in 1989, but it is unknown whether the 1988 or 1989 version of the <i>Data Acquisition Manual</i> was used to code the case.

RACE CODING SYSTEM—CURRENT

Item Length: 1
 Allowable Values: 1–6, 9
 NAACCR Item #170

Description

Describes how is currently coded. If converted, this field shows the system to which it was converted.

Rationale

Race #1–#5 codes (NAACCR Items #160–164) have changed over time. To accurately group and analyze data, it is necessary to record the system used to record the race codes.

Instructions for Coding

This item is autocoded by the software provider.

Code	Definition
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	SEER <1988 (1-digit)
3	1988 + SEER & CoC (2-digit)
4	1991 + SEER & CoC (added codes 20–97)
5	1994 + SEER & CoC (added code 14)
6	2000 + SEER & CoC (no new codes added, new items <i>Race #2–Race #5</i> added)
9	Other

RACE CODING SYSTEM—ORIGINAL

Item Length: 1
 Allowable Values: 1–6, 9
 NAACCR Item #180

Description

Describes how race was originally coded.

Rationale

Race #1–#5 codes (NAACCR Items #160–164) have changed over time. Identifying both the original and current coding systems used to code race promotes accurate data grouping and analysis.

Instructions for Coding

This item is autocoded by the software provider.

Code	Definition
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	SEER <1988 (1-digit)
3	1988 + SEER & CoC (2-digit)
4	1991 + SEER & CoC (added codes 20–97)
5	1994 + SEER & CoC (added code 14)
6	2000 + SEER & CoC (no new codes added, new items <i>Race #2–Race #5</i> added)
9	Other

SITE CODING SYSTEM—CURRENT

Item Length: 1

Allowable Values: 1–6, 9

NAACCR Item #450

Description

Describes how the primary site is currently coded. If converted, this field shows the system to which it was converted.

Rationale

This information is used for some data analysis and for further item conversions.

Instructions for Coding

This item is autocoded by the software provider.

Code	Definition
1	ICD-8 and Manual of Tumor Nomenclature and Coding (MOTNAC)
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

SITE CODING SYSTEM—ORIGINAL

Item Length: 1
 Allowable Values: 1–6, 9
 NAACCR Item #460

Description

Describes how the primary site was originally coded.

Rationale

This information is used for some data analysis. Converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding

This item is autocoded by the software provider.

Code	Definition
1	ICD-8 and Manual of Tumor Nomenclature and Coding (MOTNAC)
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

MORPHOLOGY CODING SYSTEM—CURRENT

Item Length: 1
 Allowable Values: 1–7, 9
 NAACCR Item #470

Description

Describes how morphology is currently coded. If converted, this field shows the system to which it was converted.

Rationale

This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding

This item is autocoded by the software provider.

Code	Definition
1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
9	Other

MORPHOLOGY CODING SYSTEM—ORIGINAL

Item Length: 1
 Allowable Values: 1–7, 9
 NAACCR Item #480

Description

Describes how morphology was originally coded. If later converted, this field shows the original codes used.

Rationale

This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding

This item is autocoded by the software provider.

Code	Definition
1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
9	Other

ICD-O-2 CONVERSION FLAG

Item Length: 1
 Allowable Values: 0–6
 NAACCR Item #1980

Description

Specifies how the conversion of site and morphology codes from ICD-O-1 and the field trial edition to ICD-O-2 was accomplished. SEER item names include years 1973–1991. However, some registries may have used codes for cases before 1973.

Rationale

This information is used for some data analysis and for further item conversions.

Instructions for Coding

- Codes 0, 1, and 2 are autocoded by the software provider.
- Codes 3 and 4 are manually entered following a review of the automated morphology conversion from ICD-O-1 to ICD-O-2.

Code	Definition
0	Primary site and morphology originally coded in ICD-O-2.
1	Primary site and morphology converted without review.
2	Primary site and morphology converted with review; morphology machine-converted without review.
3	Primary site machine-converted without review; morphology converted with review.
4	Primary site and morphology converted with review.
5	Morphology converted from ICD-O-3 without review.
6	Morphology converted from ICD-O-3 with review.

ICD-O-3 CONVERSION FLAG

Item Length: 1
 Allowable Values: 0, 1, 3
 NAACCR Item #2116

Description

Identifies how the conversion of morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Rationale

This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding

- Code 1 is autocoded by the software provider.
- Code 3 is manually entered following review of the automated morphology conversion from ICD-O-2 to ICD-O-3.

Code	Definition
(leave blank)	Not converted.
1	Morphology (Morph—Type&Behav ICD-O-3, NAACCR Item #521) converted from (Morph—Type&Behav ICD-O-2, NAACCR Item #419) without review.
3	Morphology (Morph—Type&Behav ICD-O-3, NAACCR Item #521) converted from (Morph—Type&Behav ICD-O-2, NAACCR Item #419) with review.
0	Morphology (Morph—Type&Behav ICD-O-3, NAACCR Item #521) originally coded in ICD-O-3.

TNM EDITION NUMBER

Item Length: 2

Allowable Values: 00–06, 88, 99

NAACCR Item #1060

Description

Identifies the edition of the *AJCC Cancer Staging Manual* used to stage the case.

Rationale

AJCC stage and component T, N, and M codes and rules have changed over time. This item enables the analysis of cases grouped by edition number.

Instructions for Coding

Code	Label
00	Not staged (cases that have AJCC staging scheme and staging was not done).
01	First Edition
02	Second Edition
03	Third Edition
04	Fourth Edition
05	Fifth Edition
06	Sixth Edition
88	Not applicable (cases that do not have an AJCC staging scheme).
99	Staged, but the edition is unknown.

RX CODING SYSTEM—CURRENT

Item Length: 2
 Allowable Values: 00–06, 99
 NAACCR Item #1460

Description

Describes how treatment for this case is now coded.

Rationale

This information is used for some data analysis and for further item conversions.

Instructions for Coding

- This item is autocoded by the software provider.
- The *FORDS* manual **must** be used to record treatment for all cases diagnosed January 1, 2003, or later and this item **must** be coded 06.

Code	Definition
00	Treatment data not coded/transmitted, ie, all treatment fields blank.
01	Treatment data coded using 1-digit surgery codes.
02	Treatment data coded according to 1983–1992 SEER manuals and CoC manuals 1983–1995.
03	Treatment data coded according to 1996 ROADS manual.
04	Treatment data coded according to 1998 ROADS supplement.
05	Treatment data coded according to 1998 SEER manual.
06	Treatment data coded according to FORDS.
99	Other coding, including partial or nonstandard coding.

APPENDIX A

Appendix A: Definitions of Single and Subsequent Primaries for Hematologic Malignancies

Based on ICD-O-3 reportable malignancies, effective with diagnoses 01/01/2001 and after

Cancer registrars are often faced with multiple pathology reports in patients with hematologic malignancies, and the diagnoses reported may require different morphology codes. This is due in part to the fact that more intensive diagnostic study may yield a more specific diagnosis, and in part due to the natural histories of hematopoietic diseases, which may progress from one diagnosis into another.

The following chart, provided to aid the registrar in determining single versus subsequent primaries, employs the following guidelines:

1. “Lymphoma” is a general term for hematopoietic solid malignancies of the lymphoid series. “Leukemia” is a general term for liquid malignancies of either the lymphoid or the myeloid series. While it is recognized that some malignancies occur predominantly (or even exclusively) in liquid or solid form, because so many malignancies can potentially arise as either leukemias or lymphomas (or both), all hematopoietic malignancies are assumed to have this potential.
2. Malignancies of the lymphoid series are considered to be different from those of the myeloid series. Therefore, a lymphoid malignancy arising after diagnosis of a myeloid malignancy (or myelodysplastic or myeloproliferative disorder) would be considered a subsequent primary; however, a myeloid malignancy diagnosed after a previous myeloid malignancy would not count as a subsequent primary. Histiocytic malignancies are considered different from both lymphoid and myeloid malignancies.
3. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma (NHL). Among the NHLs, B-cell malignancies are considered different from T-cell/NK cell malignancies. Therefore, a B-cell malignancy arising later in the course of a patient previously diagnosed with a T-cell malignancy would be considered a subsequent primary; however, a T-cell malignancy diagnosed later in the same patient would not be considered a subsequent primary.
4. The sequence of diagnoses affects whether a diagnosis represents a subsequent primary. In some cases, the order of occurrence of the two diagnoses being compared is a factor in the decision whether the second diagnosis is a new primary.

We gratefully acknowledge the assistance of Drs. Charles Lynch, Charles Platz, and Fred Dick of the University of Iowa. Dr. Tim Cote of the SEER Program, Jennifer Seiffert, MLIS, CTR, and Annette Hurlbut, RHIT, CTR for their assistance with this project.

To use the table, assign the ICD-O-3 code to the first diagnosis and find the row containing that code. Assign the ICD-O-3 code for the second diagnosis and find the column containing that code. In the cell at the intersection of the first diagnosis row and second diagnosis column, a “**S**” symbol indicates that the two diagnoses are most likely the **same** disease process (prepare/update a single abstract) and a “**D**” indicates that they are most likely **different** disease processes (prepare more than one abstract).

Note 1: If one of the two diagnoses is an NOS (not otherwise specified) term and the other is more specific and determined to be the same disease process, code the more specific diagnosis regardless of the sequence. For example, if a diagnosis of non-Hodgkin lymphoma, NOS is followed by a diagnosis of follicular lymphoma, assign the morphology code for the follicular lymphoma.

Note 2: The table “Single versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases” (pages X-X) and the “Complete Diagnostic Terms for Table (based on ICD-O-3)” (page X) display only the ICD-O-3 primary (boldfaced) term associated with the code. Refer to the *International Classification of Disease, Third Edition* (ICD-O-3) for a complete list of related terms and synonyms.

Source: SEER Program, NCI E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 1 SECOND DX ACROSS FIRST DX DOWN		1. 9590 Malign lymphoma, NOS	2. 9591 NHL, NOS	3. 9596 Compos HD/NHL	4. 9650-9667 Hodgkin lymphoma	5. 9670-9671 ML, small B lymph	6. 9673 Mantle cell lymph	7. 9675-9684 ML, diff large B-cell	8. 9687 Burkitt lymphoma	9. 9689,9699 Marg zn, B-cl lym	10. 9690-9698 Follicular lymphoma
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	D	D	S	S	S	S	S	S
3. Composite HD/NHL	9596	S	S	S	S	S	S	S	S	S	S
4. Hodgkin lymphoma	9650-9667	S	D	D	S	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	S	D	D	S	D	S	D	D	D
6. Mantle cell lymphoma	9673	S	S	D	D	D	S	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	D	D	S	D	S	S	D	S
8. Burkitt lymphoma	9687	S	S	D	D	D	D	D	S	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	S	S	D	D	D	D	D	D	S	D
10. Follicular lymphoma	9690-9698	S	S	D	D	D	D	S	D	D	S
11. Mycos fung, Sezary disease	9700-9701	S	S	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	S	S	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	S	S	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	S	S	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	S	S	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	S	S	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	D	D	S	D	S	D	D	D
21. Waldenstrom macroglob	9761	S	S	D	D	S	D	S	D	D	D
22. Heavy chain disease, NOS	9762	S	S	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	S	S	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	S	D	D	D	D	D	S	D	D
25. Acute biphenotypic leukem	9805	S	S	D	D	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	D	D	D	D	S	D	S
27. BCLL/SLL	9823	S	S	D	D	S	D	S	D	D	D
28. Burkitt cell leukemia	9826	S	S	D	D	D	D	D	S	D	D
29. Adult T-cell leuk/lymph	9827	S	S	D	D	D	D	D	D	D	D
30. Polym'cyt leuk, NOS	9832	D	D	D	D	S	D	D	D	D	D
31. Polym'cyt leuk, B-cell	9833	D	D	D	D	S	D	D	D	D	D
32. Polym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	S	S	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	S	S	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	S	S	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	S	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 2 SECOND DX ACROSS FIRST DX DOWN		11. 9700-9701 MF, Sezary disease	12. 9702-9719 T/NK-cell lymphoma	13. 9727 Precurs lym'blas lymph NOS	14. 9728 Precurs lym'blas lymph B-cl	15. 9729 Precurs lym'blas lymph T-cl	16. 9731-9734 Plasma cell tumors	17. 9740-9742 Mast cell tumors	18. 9750-9756 Histiocytos; LCH	19. 9757-9758 Dendritic cell sarc	20. 9760 Immunoprolif dis
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	D	D	D	S	S
3. Composite HD/NHL	9596	S	S	S	S	S	D	D	D	D	S
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	S
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	S	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	S	D	D	D	D	D	D	D	S
13. Precurs lym'blas lymph NOS	9727	D	D	S	S	S	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	S	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	S	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	S	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	S	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	S	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	S	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	S	D	D	D	S
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	S
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	S
23. Immun sm intest disease	9764	D	D	D	D	D	S	D	D	D	S
24. Leuk/Acute leuk, NOS	9800-9801	D	S	S	S	S	D	D	D	D	D
25. Acute biphenotypic leukem	9805	S	S	S	S	S	D	D	D	D	D
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	S	S	S	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	S	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	S	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	D	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 3 SECOND DX ACROSS FIRST DX DOWN		21. 9761 Waldenstrom	22. 9762 Heavy chain dis	23. 9764 Imm sm intest dis	24. 9800-9801 Leuk/Acu leuk NOS	25. 9805 Acute biphenotypic leuk	26. 9820 Lym'cyt leuk, NOS	27. 9823 BCLL/SLL	28. 9826 Burkitt leukemia	29. 9827 Adult T-cell leuk/lym	30. 9832 Prolym leuk, NOS
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	S	S	S	S	D
3. Composite HD/NHL	9596	S	S	S	S	D	S	S	S	S	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	S	S	S	D	D	S
6. Mantle cell lymphoma	9673	D	D	D	D	S	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	S	D	S	S	S	D	D	S
8. Burkitt lymphoma	9687	D	D	D	S	S	S	D	S	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	S	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	S	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	S	S	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	S	S	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	S	S	S	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	S	S	S	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	S	S	S	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	S	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	S	D	D	D	D	S	S	D	D	D
22. Heavy chain disease, NOS	9762	D	S	S	D	D	S	S	D	D	D
23. Immun sm intest disease	9764	D	S	S	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	D	S	S	S	D	S	S	D
25. Acute biphenotypic leukem	9805	D	D	D	S	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	S	S	S	S	S	S	S
27. BCLL/SLL	9823	D	D	D	D	S	S	S	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	S	S	S	D	S	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	S	S	D	D	S	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	S	S	D	D	S
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	S	S	D	D	S
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	S	S	D	D	S	S
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	S	S	S	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	S	S	S	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	S	S	S	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	S	S	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	S	S	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	S	S	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	S	S	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	S	S	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	S	S	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	S	S	D	D	D	D	D
43. NK-cell leukemia	9948	D	D	D	S	S	S	D	D	D	D
44. Polycythemia vera	9950	D	D	D	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	S	S	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	S	S	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	S	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	S	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	S	S	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	S	S	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	S	S	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 4 SECOND DX ACROSS FIRST DX DOWN		31. 9833 Prolym leuk, B-cell	32. 9834 Prolym leuk, T-cell	33. 9835 Precurs leuk, NOS	34. 9836 Precurs leuk, B-cell	35. 9837 Precurs leuk, T-cell	36. 9840-9910 Myeloid leukemias	37. 9920 Therapy rel AML	38. 9930 Myeloid sarcoma	39. 9931 Acute panmyelosis	40. 9940 Hairy cell leukemia	41. 9945 Chr myelomono leu
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	D	D	S	S	S	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	S	S	S	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	S	S	S	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	S	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	S	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	S	S	S	S	S	S	D	D	S
25. Acute biphenotypic leukem	9805	S	S	S	S	S	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S	D
27. BCLL/SLL	9823	S	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	S	S	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	S	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	S	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	S	S	S	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	S	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	S	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	S	S	S	S	D	S
37. Therapy related AML	9920	D	D	D	D	D	S	S	S	S	D	S
38. Myeloid sarcoma	9930	D	D	D	D	D	S	S	S	S	D	S
39. Acute panmyelosis	9931	D	D	D	D	D	S	S	S	S	D	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	S	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	S	S	S	S	D	S
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	S	S	S	S	D	S
43. NK-cell leukemia	9948	D	D	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	S	S	S	S	D	S
46. Myelosclerosis	9961	D	D	D	D	D	S	S	S	S	D	S
47. Essen thrombocythem	9962	D	D	D	D	D	S	S	S	S	D	S
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	S	S	S	S	D	S
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	S	S	S	S	D	S
50. Refractory anemias	9980-9986	D	D	D	D	D	S	S	S	S	D	S
51. Therapy related MDS	9987	D	D	D	D	D	S	S	S	S	D	S
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	S	S	S	S	D	S

Codes: S--one primary only; D--presumably a subsequent primary

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 5 SECOND DX ACROSS FIRST DX DOWN		42. 9946 Juv myelomono leu	43. 9948 NK-cell leukemia	44. 9950 Polycythemia vera	45. 9960 Chr myeloprolif dis	46. 9961 Myelosclerosis	47. 9962 Ess thrombocythem	48. 9963 Chr neutrophil leu	49. 9964 Hypereosin syndr	50. 9980-9986 Refract anemias	51. 9987 Therapy rel MDS	52. 9989 Myelodys syn NOS
1. Malignant lymphoma, NOS	9590	S	S	D	D	D	D	D	D	D	D	D
2. NHL, NOS	9591	D	D	D	D	D	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	D	D	D	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	D	D	S	S	D	S	S	D	S	S
25. Acute biphenotypic leukem	9805	S	S	D	S	S	D	D	D	S	S	S
26. Lymphocytic leukem, NOS	9820	D	S	D	D	D	D	D	D	D	D	D
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	S	D	D	S	S	S	S	S	D	S	S
37. Therapy related AML	9920	S	D	D	D	S	D	D	D	D	S	S
38. Myeloid sarcoma	9930	S	D	D	S	S	S	S	D	D	S	S
39. Acute panmyelosis	9931	S	D	D	D	S	D	D	D	D	S	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	S	D	D	S	S	D	S	D	D	S	S
42. Juvenile myelomonocy leuk	9946	S	D	D	D	S	D	D	D	D	S	S
43. NK-cell leukemia	9948	D	S	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	S	S	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	S	S	S	S	D	D	D	D
46. Myelosclerosis	9961	S	D	D	S	S	S	S	D	D	S	S
47. Essen thrombocythem	9962	D	D	D	S	S	S	S	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	S	S	S	D	D	D	D
49. Hypereosinophilic syndrome	9964	S	D	D	S	S	D	D	S	D	D	D
50. Refractory anemias	9980-9986	S	D	D	S	S	D	D	D	S	S	S
51. Therapy related MDS	9987	S	D	D	S	S	D	D	D	S	S	S
52. Myelodysplastic syndr, NOS	9989	S	D	D	S	S	D	D	D	S	S	S

Codes: S--one primary only; D--presumably a subsequent primary

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COMPLETE DIAGNOSTIC TERMS FOR TABLE (BASED ON ICD-O-3)

1	9590 Malignant lymphoma, NOS
2	9591 Malignant lymphoma, non-Hodgkin, NOS
3	9596 Composite Hodgkin and non-Hodgkin lymphoma
4	9650-9667 Hodgkin lymphoma (all subtypes)
5	9670-9671 Malignant lymphoma, small B lymphocytic
6	9673 Mantle cell lymphoma
7	9675-9684 Malignant lymphoma, diffuse large B-cell
8	9687 Burkitt lymphoma
9	9689, 9699 Marginal zone B-cell lymphoma
10	9690-9698 Follicular lymphoma
11	9700-9701 Mycosis fungoides and Sezary syndrome
12	9702-9719 T/NK-cell non-Hodgkin lymphoma
13	9727 Precursor cell lymphoblastic lymphoma, NOS
14	9728 Precursor B-cell lymphoblastic lymphoma
15	9729 Precursor T-cell lymphoblastic lymphoma
16	9731-9734 Plasma cell tumors
17	9740-9742 Mast cell tumors
18	9750-9756 Histiocytosis/Langerhans cell histiocytosis
19	9757-9758 Dendritic cell sarcoma
20	9760 Immunoproliferative disease, NOS
21	9761 Waldenstrom macroglobulinemia
22	9762 Heavy chain disease, NOS
23	9764 Immunoproliferative small intestinal disease
24	9800-9801 Leukemia, NOS/Acute leukemia, NOS
25	9805 Acute biphenotypic leukemia
26	9820 Lymphoid leukemia, NOS
27	9823 B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
28	9826 Burkitt cell leukemia
29	9827 Adult T-cell leukemia/lymphoma (HTLV-1 positive)
30	9832 Prolymphocytic leukemia, NOS
31	9833 Prolymphocytic leukemia, B-cell type
32	9834 Prolymphocytic leukemia, T-cell type
33	9835 Precursor cell lymphoblastic leukemia, NOS
34	9836 Precursor B-cell lymphoblastic leukemia
35	9837 Precursor T-cell lymphoblastic leukemia
36	9840-9910 Myeloid leukemias
37	9920 Therapy related acute myelogenous leukemia
38	9930 Myeloid sarcoma
39	9931 Acute panmyelosis with myelofibrosis
40	9940 Hairy cell leukemia
41	9945 Chronic myelomonocytic leukemia, NOS
42	9946 Juvenile myelomonocytic leukemia
43	9948 Aggressive NK-cell leukemia
44	9950 Polycythemia vera
45	9960 Chronic myeloproliferative disease, NOS
46	9961 Myelosclerosis with myeloid metaplasia
47	9962 Essential thrombocythemia
48	9963 Chronic neutrophilic leukemia
49	9964 Hypereosinophilic syndrome
50	9980-9986 Refractory anemias
51	9987 Therapy related myelodysplastic syndrome, NOS
52	9989 Myelodysplastic syndrome, NOS

Version 1.01. Codes corrected for terms in rows 7 and 9 on pages 2-5.

APPENDIX B:
Site-Specific Surgery Codes

ORAL CAVITY

Lip C00.0–C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0–C02.9, Gum C03.0–C03.9, Floor of Mouth C04.0–C04.9, Palate C05.0–C05.9, Other Parts of Mouth C06.0–C06.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
- No specimen sent to pathology from surgical events 10–14.**
- 20 Local tumor excision, NOS
- 26 Polypectomy
 - 27 Excisional biopsy
- Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
- 25 Laser excision
- Specimen sent to pathology from surgical events 20–27.**
- 30 Wide excision, NOS
- Code 30 includes:**
- Hemiglossectomy
 - Partial glossectomy
- 40 Radical excision of tumor, NOS
- 41 Radical excision of tumor ONLY
 - 42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
 - 43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)
- Codes 40–43 include:**
- Total glossectomy
 - Radical glossectomy
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

PAROTID AND OTHER UNSPECIFIED GLANDS

Parotid Gland C07.9, Major Salivary Glands C08.0–C08.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

 - 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from surgical events 10–14.

 - 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26–27 WITH

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation - 25 Laser excision

Specimen sent to pathology from surgical events 20–27.

 - 30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
 - 31 Facial nerve spared
 - 32 Facial nerve sacrificed - 33 Superficial lobe ONLY
 - 34 Facial nerve spared
 - 35 Facial nerve sacrificed
 - 36 Deep lobe (Total)
 - 37 Facial nerve spared
 - 38 Facial nerve sacrificed
-
- 40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
 - 41 Facial nerve spared
 - 42 Facial nerve sacrificed
-
- 50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
 - 51 WITHOUT removal of temporal bone
 - 52 WITH removal of temporal bone
 - 53 WITH removal of overlying skin (requires graft or flap coverage)
-
- 80 Parotidectomy, NOS
-
- 90 Surgery, NOS
-
- 99 Unknown if surgery performed; death certificate ONLY

PHARYNX**Tonsil C09.0–C09.9, Oropharynx C10.0–C10.9, Nasopharynx C11.0–C11.9
Pyriform Sinus C12.9, Hypopharynx C13.0–C13.9, Pharynx C14.0**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Stripping

No specimen sent to pathology from surgical events 10–15.

- 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26–27 WITH

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
 - 25 Laser excision
 - 28 Stripping

Specimens sent to pathology from surgical events 20–28.

- 30 Pharyngectomy, NOS
 - 31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
 - 32 Total pharyngectomy

- 40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
 - 41 WITH Laryngectomy (laryngopharyngectomy)
 - 42 WITH bone
 - 43 WITH both 41 and 42

- 50 Radical pharyngectomy (includes total mandibular resection), NOS
 - 51 WITHOUT laryngectomy
 - 52 WITH laryngectomy

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

ESOPHAGUS**C15.0–C15.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from surgical events 10–14.

- 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26–27 WITH

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
 - 25 Laser excision

Specimen sent to pathology from surgical events 20–27.

- 30 Partial esophagectomy

- 40 Total esophagectomy, NOS

- 50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
 - 51 WITH laryngectomy
 - 52 WITH gastrectomy, NOS
 - 53 Partial gastrectomy
 - 54 Total gastrectomy
 - 55 Combination of 51 WITH any of 52–54

- 80 Esophagectomy, NOS

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

STOMACH**C16.0–C16.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

Specimen sent to pathology from surgical events 20–27.

30 Gastrectomy, NOS (partial, subtotal, hemi-)

31 Antrectomy, lower (distal-less than 40% of stomach)***

32 Lower (distal) gastrectomy (partial, subtotal, hemi-)

33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:

Partial gastrectomy, including a sleeve resection of the stomach

Billroth I: anastomosis to duodenum (duodenostomy)

Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS

41 Near-total gastrectomy

42 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

50 Gastrectomy, NOS WITH removal of a portion of esophagus

51 Partial or subtotal gastrectomy

52 Near total or total gastrectomy

Codes 50–52 are used for gastrectomy resection when only portions of esophagus are included in procedure.

60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***

61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***

62 Near total or total gastrectomy, in continuity with the resection of other organs***

63 Radical gastrectomy, in continuity with the resection of other organs***

Codes 60–63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

80 Gastrectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

COLON**C18.0–C18.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).**Codes**

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS

27 Excisional biopsy

26 Polypectomy, NOS

28 Polypectomy-endoscopic

29 Polypectomy-surgical excision

Any combination of 20 or 26–29 WITH

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

Specimen sent to pathology from surgical events 20–29.

30 Partial colectomy, segmental resection

32 Plus resection of contiguous organ; example: small bowel, bladder

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)

41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)

51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)

61 Plus resection of contiguous organ; example: small bowel, bladder

70 Colectomy or coloproctectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

80 Colectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

RECTOSIGMOID**C19.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).**Codes**

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser ablation

No specimen sent to pathology from surgical events 10–14.

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

Specimen sent to pathology from surgical events 20–27.

- 30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
 - 31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:

- Anterior resection
- Hartmann operation
- Low anterior resection (LAR)
- Partial colectomy, NOS
- Rectosigmoidectomy, NOS
- Sigmoidectomy

- 40 Pull through WITH sphincter preservation (colo-anal anastomosis)
- 50 Total proctectomy
- 51 Total colectomy
- 55 Total colectomy WITH ileostomy, NOS
 - 56 Ileorectal reconstruction
 - 57 Total colectomy WITH other pouch; example: Koch pouch

- 60 Total proctocolectomy, NOS
- 65 Total proctocolectomy WITH ileostomy, NOS
- 66 Total proctocolectomy WITH ileostomy and pouch
- Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.**
- 70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration
- 80 Colectomy, NOS; Proctectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

RECTUM**C20.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).**Codes**

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
 11 Photodynamic therapy (PDT)
 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 13 Cryosurgery
 14 Laser
No specimen sent to pathology from surgical events 10-14.
- 20 Local tumor excision, NOS
 27 Excisional biopsy
 26 Polypectomy
 Any combination of 20 or 26–27 WITH
 21 Photodynamic therapy (PDT)
 22 Electrocautery
 23 Cryosurgery
 24 Laser ablation
 25 Laser excision
 28 Curette and fulguration
Specimen sent to pathology from surgical events 20–28.
- 30 Wedge or segmental resection; partial proctectomy, NOS
Procedures coded 30 include, but are not limited to:
 Anterior resection
 Hartmann's operation
 Low anterior resection (LAR)
 Transsacral rectosigmoidectomy
- 40 Pull through WITH sphincter preservation (coloanal anastomosis)
- 50 Total proctectomy
Procedure coded 50 includes, but is not limited to:
 Abdominoperineal resection (Miles Procedure)
- 60 Total proctocolectomy, NOS
- 70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration
- 80 Proctectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

ANUS**C21.0–C21.8**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

 - 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Thermal Ablation

No specimen sent to pathology from surgical events 10–15.

 - 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26–27 WITH

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation - 25 Laser excision
- Specimen sent to pathology from surgical events 20–27.**
-
- 60 Abdominal perineal resection, NOS (APR; Miles procedure)
 - 61 APR and sentinel node excision
 - 62 APR and unilateral inguinal lymph node dissection
 - 63 APR and bilateral inguinal lymph node dissection
-
- 90 Surgery, NOS
-
- 99 Unknown if surgery performed; death certificate ONLY

LIVER AND INTRAHEPATIC BILE DUCTS**C22.0–C22.1**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Alcohol (Percutaneous Ethanol Injection-PEI)
 - 16 Heat-Radio-frequency ablation (RFA)
 - 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10–17.
- 20 Wedge or segmental resection, NOS
 - 21 Wedge resection
 - 22 Segmental resection, NOS
 - 23 One
 - 24 Two
 - 25 Three
 - 26 Segmental resection AND local tumor destruction

Specimen sent to pathology from surgical events 20–26.
- 30 Lobectomy, NOS
 - 36 Right lobectomy
 - 37 Left lobectomy
 - 38 Lobectomy AND local tumor destruction
- 50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
 - 51 Right lobectomy
 - 52 Left lobectomy
 - 59 Extended lobectomy AND local tumor destruction
- 60 Hepatectomy, NOS
 - 61 Total hepatectomy and transplant
- 65 Excision of a bile duct (for an intra-hepatic bile duct primary only)
 - 66 Excision of a bile duct PLUS partial hepatectomy
- 75 Bile duct and hepatectomy WITH transplant
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

PANCREAS**C25.0–C25.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 25 Local excision of tumor, NOS
- 30 Partial pancreatectomy, NOS; example: distal
- 35 Local or partial pancreatectomy and duodenectomy
 - 36 WITHOUT distal/partial gastrectomy
 - 37 WITH partial gastrectomy (Whipple)
- 40 Total pancreatectomy
- 60 Total pancreatectomy and subtotal gastrectomy or duodenectomy
- 70 Extended pancreatoduodenectomy
- 80 Pancreatectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

LARYNX
C32.0–C32.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Stripping

No specimen sent to pathology from surgical events 10–15.

- 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26–27 WITH

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
 - 25 Laser excision
 - 28 Stripping

Specimen sent to pathology from surgical events 20–28.

- 30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
 - 31 Vertical laryngectomy
 - 32 Anterior commissure laryngectomy
 - 33 Supraglottic laryngectomy

- 40 Total or radical laryngectomy, NOS
 - 41 Total laryngectomy ONLY
 - 42 Radical laryngectomy ONLY

- 50 Pharyngolaryngectomy

- 80 Laryngectomy, NOS

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

LUNG

C34.0–C34.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
- 15 Local tumor destruction, NOS
 - 12 Laser ablation or cryosurgery
 - 13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)**No specimen sent to pathology from surgical events 12–13 and 15.**
- 20 Excision or resection of less than one lobe, NOS
 - 23 Excision, NOS
 - 24 Laser excision
 - 25 Bronchial sleeve resection ONLY
 - 21 Wedge resection
 - 22 Segmental resection, including lingulectomy**Specimen sent to pathology from surgical events 20–25.**
- 30 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
 - 33 Lobectomy WITH mediastinal lymph node dissection
- 45 Lobe or bilobectomy extended, NOS
 - 46 WITH chest wall
 - 47 WITH pericardium
 - 48 WITH diaphragm
- 55 Pneumonectomy, NOS
 - 56 WITH mediastinal lymph node dissection (radical pneumonectomy)**The mediastinal 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 mediastinal lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292)
- 80 Resection of lung, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

**HEMATOPOIETIC/RETICULOENDOTHELIAL/
IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE**

C42.0, C42.1, C42.3, C42.4 (with any histology)

or

M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989 (with any site)

Code

- 98 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

Surgical procedures for hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

BONES, JOINTS, AND ARTICULAR CARTILAGE C40.0–C41.9
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0–C47.9
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C49.0–C49.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 998–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
- 15 Local tumor destruction
No specimen sent to pathology from surgical event 15.
- 25 Local excision
- 26 Partial resection
Specimen sent to pathology from surgical events 25–26.
- 30 Radical excision or resection of lesion WITH limb salvage
- 40 Amputation of limb
 - 41 Partial amputation of limb
 - 42 Total amputation of limb
- 50 Major amputation, NOS
 - 51 Forequarter, including scapula
 - 52 Hindquarter, including ilium/hip bone
 - 53 Hemipelvectomy, NOS
 - 54 Internal hemipelvectomy
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

SPLEEN**Spleen C42.2**

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction, NOS
No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
- 21 Partial splenectomy
- 22 Total splenectomy
- 80 Splenectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

SKIN**C44.0–C44.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser ablation

No specimen sent to pathology from surgical events 10–14.

- 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26–27 WITH

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation- 25 Laser excision

Specimen sent to pathology from surgical events 20–27.

- 30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
 - 31 Shave biopsy followed by a gross excision of the lesion
 - 32 Punch biopsy followed by a gross excision of the lesion
 - 33 Incisional biopsy followed by a gross excision of the lesion
 - 34 Mohs surgery, NOS
 - 35 Mohs with 1-cm margin or less
 - 36 Mohs with more than 1-cm margin

- 45 Wide excision or reexcision of lesion or minor (local) amputation with margins more than 1 cm, NOS. Margins **MUST** be microscopically negative.
 - 46 WITH margins more than 1 cm and less than 2 cm
 - 47 WITH margins greater than 2 cm

- 60 Major amputation

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

BREAST**C50.0–C50.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction, NOS
No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
- 20 Partial mastectomy, NOS; less than total mastectomy, NOS
 21 Partial mastectomy WITH nipple resection
 22 Lumpectomy or excisional biopsy
 23 Reexcision of the biopsy site for gross or microscopic residual disease
 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)
Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.
- 30 Subcutaneous mastectomy
A subcutaneous mastectomy is the removal of breast tissue without the nipple and areolar complex or overlying skin.
- 40 Total (simple) mastectomy
 41 WITHOUT removal of uninvolved contralateral breast
 43 Reconstruction NOS
 44 Tissue
 45 Implant
 46 Combined (Tissue and Implant)
 42 WITH removal of uninvolved contralateral breast
 47 Reconstruction NOS
 48 Tissue
 49 Implant
 75 Combined (Tissue and Implant)
A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.
For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
If contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.
- 50 Modified radical mastectomy
 51 WITHOUT removal of uninvolved contralateral breast
 53 Reconstruction, NOS
 54 Tissue
 55 Implant
 56 Combined (Tissue and Implant)

- 52 WITH removal of uninvolved contralateral breast
 - 57 Reconstruction, NOS
 - 58 Tissue
 - 59 Implant
 - 63 Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.

If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

- 60 Radical mastectomy, NOS
 - 61 WITHOUT removal of uninvolved contralateral breast
 - 64 Reconstruction, NOS
 - 65 Tissue
 - 66 Implant
 - 67 Combined (Tissue and Implant)
 - 62 WITH removal of uninvolved contralateral breast
 - 68 Reconstruction, NOS
 - 69 Tissue
 - 73 Implant
 - 74 Combined (Tissue and Implant)
- 70 Extended radical mastectomy
 - 71 WITHOUT removal of uninvolved contralateral breast
 - 72 WITH removal of uninvolved contralateral breast
- 80 Mastectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

CERVIX UTERI**C53.0–C53.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Loop Electrocautery Excision Procedure (LEEP)
 - 16 Laser ablation
 - 17 Thermal ablation

No specimen sent to pathology from surgical events 10–17.
- 20 Local tumor excision, NOS
 - 26 Excisional biopsy, NOS
 - 27 Cone biopsy
 - 24 Cone biopsy WITH gross excision of lesion
 - 29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH

 - 21 Electrocautery
 - 22 Cryosurgery
 - 23 Laser ablation or excision
 - 25 Dilatation and curettage; endocervical curettage (for in situ only)
 - 28 Loop electrocautery excision procedure (LEEP)

Specimen sent to pathology from surgical events 20–29.
- 30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.
- 40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.
- 50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
 - 51 Modified radical hysterectomy
 - 52 Extended hysterectomy
 - 53 Radical hysterectomy; Wertheim procedure
 - 54 Extended radical hysterectomy
- 60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
 - 61 WITHOUT removal of tubes and ovaries
 - 62 WITH removal of tubes and ovaries

-
- 70 Pelvic exenteration
71 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 72 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

CORPUS UTERI**C54.0–C55.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Loop Electocautery Excision Procedure (LEEP)
 - 16 Thermal ablation

No specimen sent to pathology from surgical events 10–16.
- 20 Local tumor excision, NOS; simple excision, NOS
 - 24 Excisional biopsy
 - 25 Polypectomy
 - 26 Myomectomy

Any combination of 20 or 24–26 WITH

 - 21 Electrocautery
 - 22 Cryosurgery
 - 23 Laser ablation or excision

Specimen sent to pathology from surgical events 20–26.
- 30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies).
 - 31 WITHOUT tube(s) and ovary(ies)
 - 32 WITH tube(s) and ovary(ies)
- 40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.
- 50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.
- 60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
 - 61 Modified radical hysterectomy
 - 62 Extended hysterectomy
 - 63 Radical hysterectomy; Wertheim procedure
 - 64 Extended radical hysterectomy

-
- 65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
66 WITHOUT removal of tube(s) and ovary(ies)
67 WITH removal of tube(s) and ovary(ies)
- 75 Pelvic exenteration
76 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 77 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 78 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 79 Extended exenteration
Includes pelvic blood vessels or bony pelvis.
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

OVARY**C56.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 17 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 17.
- 25 Total removal of tumor or (single) ovary, NOS
26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
27 WITHOUT hysterectomy
28 WITH hysterectomy
Specimen sent to pathology from surgical events 25–28.
- 35 Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done
36 WITHOUT hysterectomy
37 WITH hysterectomy
- 50 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done
51 WITHOUT hysterectomy
52 WITH hysterectomy
- 55 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
56 WITHOUT hysterectomy
57 WITH hysterectomy
- 60 Debulking; cytoreductive surgery, NOS
61 WITH colon (including appendix) and/or small intestine resection (not incidental)
62 WITH partial resection of urinary tract (not incidental)
63 Combination of 61 and 62
Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.
- 70 Pelvic exenteration, NOS
71 Anterior
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 72 Posterior
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 73 Total
Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

- 74 Extended
Includes pelvic blood vessels or bony pelvis.
- 80 (Salpingo-)oophorectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

PROSTATE**C61.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures* (NAACCR Item #3250).

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 18 Local tumor destruction or excision, NOS
- 19 Transurethral resection (TURP), NOS
Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003).
- 10 Local tumor destruction, NOS
 - 14 Cryoprostatectomy
 - 15 Laser ablation
 - 16 Hyperthermia
 - 17 Other method of local tumor destruction**No specimen sent to pathology from surgical events 10–17.**
- 20 Local tumor excision, NOS
 - 21 Transurethral resection (TURP), NOS
 - 22 TURP—cancer is incidental finding during surgery for benign disease
 - 23 TURP—patient has suspected/known cancer
 Any combination of 20–23 WITH
 - 24 Cryosurgery
 - 25 Laser
 - 26 Hyperthermia**Specimen sent to pathology from surgical events 20–26.**
- 30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact
- 50 Radical prostatectomy, NOS; total prostatectomy, NOS
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.
- 70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.
- 80 Prostatectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

TESTIS**C62.0–C62.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 12 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 12.
- 20 Local or partial excision of testicle
Specimen sent to pathology from surgical event 20.
- 30 Excision of testicle, NOS WITHOUT cord
- 40 Excision of testicle, NOS WITH cord/or cord not mentioned
- 80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER**Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
 11 Photodynamic therapy (PDT)
 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 13 Cryosurgery
 14 Laser
 15 Thermal ablation
No specimen sent to pathology from this surgical event 10–15.
- 20 Local tumor excision, NOS
 26 Polypectomy
 27 Excisional biopsy
 Any combination of 20 or 26–27 WITH
 21 Photodynamic therapy (PDT)
 22 Electrocautery
 23 Cryosurgery
 24 Laser ablation
 25 Laser excision
Specimen sent to pathology from surgical events 20–27.
- 30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)
Procedures coded 30 include, but are not limited to:
 Segmental resection
 Wedge resection
- 40 Complete/total/simple nephrectomy—for kidney parenchyma
 Nephroureterectomy
Includes bladder cuff for renal pelvis or ureter.
- 50 Radical nephrectomy
May include removal of a portion of vena cava, adrenal gland(s), Gerota=s fascia, perinephric fat, or partial/total ureter.
- 70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)
The other organs, such as colon or bladder, may be partially or totally removed.
- 80 Nephrectomy, NOS
 Ureterectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

BLADDER**C67.0–C67.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Intravesical therapy
 - 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy
- No specimen sent to pathology from surgical events 10–16.**
- 20 Local tumor excision, NOS
- 26 Polypectomy
 - 27 Excisional biopsy
- Combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
- 25 Laser excision
- Specimen sent to pathology from surgical events 20–27.**
- 30 Partial cystectomy
- 50 Simple/total/complete cystectomy
- 60 Radical cystectomy (male only)
- 61 Radical cystectomy PLUS ileal conduit
 - 62 Radical cystectomy PLUS continent reservoir or pouch, NOS
 - 63 Radical cystectomy PLUS abdominal pouch (cutaneous)
 - 64 Radical cystectomy PLUS in situ pouch (orthotopic)
- 70 Pelvic exenteration, NOS
- 71 Radical cystectomy (female only); anterior exenteration
- A radical cystectomy in a female includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra.**
- 72 Posterior exenteration
 - 73 Total exenteration
- Includes removal of all pelvic contents and pelvic lymph nodes.**
- 74 Extended exenteration
- Includes pelvic blood vessels or bony pelvis.**
- 80 Cystectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

BRAIN**Meninges C70.0–C70.9, Brain C71.0–C71.9,
Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0–C72.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Do not code laminectomies for spinal cord primaries.

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Tumor destruction, NOS
No specimen sent to pathology from surgical event 10.
Do not record stereotactic radiosurgery as tumor destruction. It should be recorded in the radiation treatment item *Regional Treatment Modality* (NAACCR Item # 1570).
- 20 Biopsy of tumor, lesion, or mass
Specimen sent to pathology from surgical event 20.
- 40 Partial resection
- 55 Gross total resection
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

THYROID GLAND**C73.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 13 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 13.
- 25 Removal of less than a lobe, NOS
 - 26 Local surgical excision
 - 27 Removal of a partial lobe ONLY**Specimen sent to pathology from surgical events 25–27.**
- 20 Lobectomy and/or isthmectomy
 - 21 Lobectomy ONLY
 - 22 Isthmectomy ONLY
 - 23 Lobectomy WITH isthmus
- 30 Removal of a lobe and partial removal of the contralateral lobe
- 40 Subtotal or near total thyroidectomy
- 50 Total thyroidectomy
- 80 Thyroidectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

LYMPH NODES**C77.0–C77.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).
- 15 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 15.
- 25 Local tumor excision, NOS
Less than a full chain, includes a lymph node biopsy.
- 30 Lymph node dissection, NOS
31 One chain
32 Two or more chains
- 40 Lymph node dissection, NOS PLUS splenectomy
41 One chain
42 Two or more chains
- 50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
51 One chain
52 Two or more chains
- 60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy
(Includes staging laparotomy for lymphoma.)
61 One chain
62 Two or more chains
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

ALL OTHER SITES

C14.1–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from surgical events 10–14.

- 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26–27 WITH

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation

25 Laser excision

Specimen sent to pathology from surgical events 20–27.

- 30 Simple/partial surgical removal of primary site

- 40 Total surgical removal of primary site; enucleation
 - 41 Total enucleation (for eye surgery only)

- 50 Surgery stated to be “debulking”

- 60 Radical surgery

Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

UNKNOWN AND ILL-DEFINED PRIMARY SITES**C76.0–C76.8, C80.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Code

98 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

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AMERICAN COLLEGE OF SURGEONS
633 N. SAINT CLAIR ST.
CHICAGO, IL 60611-3211