STANDARDS
of the Commission on Cancer

VOLUME II: REGISTRY OPERATIONS AND DATA STANDARDS ***(ROADS)***

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Section One: Registry Operations

GENERAL PRINCIPLES

The cancer registry is a system to monitor all types of reportable malignancies diagnosed or treated in an institution. The registry is vital for programmatic and administrative planning and for monitoring patient outcome. It is a valuable resource for research investigations.

The data base includes case identification and a description of the patient and the cancer.

Registry responsibilities include lifetime clinical follow-up of the cancer patient. Follow-up is necessary to evaluate treatment outcome.

The registry staff must be knowledgeable and should include at least one Certified Tumor Registrar (CTR).

REFERENCE DATE

The reference date is the start date after which all eligible cases must be included in the registry. This date is a reference point for many standards and activities of the Approvals Program. A program must establish a reference date as of January 1 of a given year.

To be eligible for survey and approval, a program must have one year of documented clinical program activity and two years of data with one year of successful follow-up.

Approved programs are encouraged to maintain their original reference date and data base whenever possible. Occasionally, circumstances may cause a registry to petition for a change in reference date. Each request is given individual consideration on the basis of whether the program had changes in the population or census, flaws or lapses in data collection, changes in data acquisition methods, or a high lost-to-follow-up rate due to the longevity of the registry. The registry must maintain a five-year data base (reference date) and cannot reapply for a change of reference date for five years.

REPORTABLE LIST

The reportable list identifies diagnoses that will be included in the registry data base. Additional tumors may be included at the discretion of the cancer committee.

Reportable Diagnoses

After their reference date, registries in approved programs must include all reportable malignancies that meet the following criteria:

- Patients diagnosed or received cancer-directed care in the institution's inpatient or outpatient department or ambulatory care center.[1] Patients diagnosed at a staff physician's office and receiving any part of their first course of treatment at the reporting institution.
- Patients diagnosed and treated only in a staff physician's office[2].
- Patients diagnosed with a behavior code of 2[3] or higher as defined in the *International Classification of Diseases for Oncology,* Second Edition (ICD-O-2).
- Patients diagnosed with basal and squamous cell cancers originating in mucoepidermoid sites; lip (C00.0-C00.9); anus (C21.0); vulva (C51.0-C51.9); vagina (C52.9); penis (C60.0-C60.9); scrotum (C63.2).

[1] If the medical record is the property of the reporting institution, the case must be included in the data base.

[2] Class of case 6 not required until 1998.

[3] Certain exceptions apply. See exclusion section.

- Patients diagnosed with skin cancer (C44.-) must be included if the histology is 8000-8004, 8010-8045, 8050-8076, 8081-8082, 8090-8110 and at diagnosis the AJCC stage group is II (T3), III, or IV (see General Principles in Coding, Case Eligibility).
- Patients whose diagnoses are not histologically confirmed. Ambiguous terms are:
  - Compatible with
  - Consistent with
  - Most likely
  - Probable
  - Suspect
  - Suspicious

Exclusions

Registries are not required to accession, abstract, or conduct follow-up for cases that meet the following criteria:

- Patients seen in consultation only. A consult may be done to confirm a diagnosis or treatment plan. The reporting institution may provide services not available at the diagnosing or treating facility, such as Computerized Tomography (CT) scans, Magnetic Resonance Imaging (MRI) scans, or placement of venous access devices.
- Patients receiving transient care at the reporting institution to prevent interruption of the first course of treatment. The patient may be vacationing or visiting in the area, or equipment failure at the primary treating institution may require the patient to temporarily receive treatment elsewhere.
- Patients with active, previously diagnosed cancer who are admitted to the reporting institution for unrelated medical conditions.
- Patients with precancerous conditions or benign tumors.[4]
- Patients with carcinoma-in-situ of the cervix (CIS).
- Patients with an intraepithelial neoplasia. Diagnoses include:
  - Cervical intraepithelial neoplasia
  - Prostatic intraepithelial neoplasia
  - Vaginal intraepithelial neoplasia
  - Vulvar intraepithelial neoplasia
- Patients with skin cancers, (C44.-) who do not meet the conditions specified in the reportable diagnosis list.
- Patients with a history of malignancy who are clinically free of disease.
- Patients admitted for terminal supportive care, including home care service.
- Patients who are admitted to a designated hospice.
- Patients who are diagnosed at a staff physicians's office and treated in another facility.

Other Case Eligibility Criteria

Approved programs must accession, index, abstract, and follow all analytic cases (classes of case 0, 1, and 2). These cases must appear in the patient index. A case may be excluded from the follow-up requirement if the patient resides in a foreign country at the time of diagnosis or follow-up. If the patient is not a US citizen but lives in the United States or a US possession, the registry is required to follow the patient.

[4] These cases may be reportable-by-agreement.

Non-analytic cases (classes of case 3, 4, 5, 8, and 9) do not have to be accessioned, indexed, abstracted, or followed. (see Table 1).

Table 1

Registry Functions by Type of Case*				
	Accession	Patient Index	Abstract	Follow-Up
Analytic (classes of case 0, 1, 2, or 6)	X	X	X	X
Non-analytic (classes of case 3, 4, 5, 8, 9)				
Carcinoma-in-situ of the cervix (CIS)				
Basal or squamous cell carcinoma of a mucoepidermoid site	X	X	X	X
Skin cancer[5]	X	X	X	X
Foreign residents	X	X	X	X[6]

* X identifies required functions.

Reportable-by-Agreement

The cancer committee may choose to collect information on diagnoses not required by the Commission. These reportable-by-agreement diagnoses are added to the reportable list and may include behavior codes of 0 or 1 (benign or uncertain) as defined by the *ICD-O-2* or any of the cases described under the exclusion section. An example of a reportable-by-agreement diagnosis would be a benign neoplasm of the central nervous system such as the pituitary gland.

The cancer committee may also determine if nonanalytic cases will be accessioned, indexed, abstracted, or followed.

CASEFINDING

Casefinding is a systematic method of locating all eligible cases. The method of casefinding must include all points of service from which a patient may enter the health care delivery system for diagnostic or therapeutic services for the management of cancer. Casefinding will identify both new cases and cases already entered into the registry. Readmissions may be a source of follow-up information.

The reporting institution's casefinding procedures must be documented in the procedure manual. Multiple sources must be used to identify the eligible cases. Casefinding sources include:

- Health Information Management Department (HIM). This department maintains the medical records and a disease index that identifies the patient, date of service, and the diagnosis.

[5] Patients diagnosed with skin cancer (C44.-) must be included if the histology is 8000-8004, 8010-8045, 8050- 8076, 8081-8082, 8090-8110 and at the time of diagnosis the AJCC stage group is II (T3), III, or IV. For details, see General Prinicples in Coding, Case Eligibility.

[6] Follow-up is not required if the patient resides in a foreign country at the time of diagnosis or follow-up.

- Pathology and Cytology Departments. The histology, cytology, bone marrow, and autopsy reports are source documents for identifying eligible cases.
- Oncology-related services. Radiation and medical oncology treatment areas are sources of casefinding.
- Staff physician's office. The physician's office is a source of casefinding.

SUSPENSE SYSTEM

A suspense system identifies cases that have not been completely abstracted. The cases should be sorted and listed by the date of diagnosis. Cases should be processed in chronological order. Periodically, administrative reports should be produced to assess timeliness of the abstracting process. The abstracting currency must be six months or less from the date of diagnosis. If a registry serves multiple institutions, the register must include an institution identifier.

A suspense list must contain the patient's name, patient identifier, date of diagnosis, and primary site.

ACCESSION REGISTER

The accession register is an annual, sequential listing of all reportable cancers included in the registry. It may be presented either on-screen or in hard-copy and must be readily accessible. The register must include the accession and sequence numbers, patient name, primary site, and date of initial diagnosis. If a registry serves multiple institutions, the register must include an institution identifier. The accession register is used to audit other registry files, monitor casefinding, assess the workload, and verify patient identification. Reportable-by-agreement cases may also be included in the register.

Detailed information on the assignment of accession and sequence numbers appears in Section Four.

PATIENT INDEX

The patient index is an alphabetical list of each patient entered into the registry since the reference date. The list must contain the patient's name, sex, date of birth, primary site(s), laterality, histology(ies), date(s) of diagnosis, accession number, sequence number(s), medical record number, and date of death.

For patients with multiple primaries, the patient index must include the primary site, laterality, histologic type, date of diagnosis, and sequence number of each primary.

ABSTRACT

An abstract must be completed for all analytic cases that meet the criteria for inclusion in the registry. The abstract is a summary of pertinent information about the patient, the cancer, the treatment, and outcome. Components include patient identification, cancer identification, stage of disease at initial diagnosis, first course of treatment, recurrence, treatment for recurrence or progression, and follow-up. The abstract must contain the items in the required data set. Patient name, race, sex, primary site, histology, laterality of disease, first course of treatment, and patient status at last contact must be in natural language.

If a patient has multiple primary malignancies, an abstract must be prepared for each reportable primary diagnosed or treated at the reporting institution after the reference date. Abstracts should be filed in a manner that permits easy retrieval. Abstracting must be completed within six months from the date of initial diagnosis.

The cancer committee must review and approve the abstract form and content. The supplementary data set contains information that will increase the usefulness of the registry. The Commission recommends collection of these data items.

QUALITY CONTROL

Accuracy and consistency are essential. The cancer committee must supervise the registry for quality and timeliness. A physician member of the cancer committee must be designated to serve as physician advisor to the registry staff. The physician advisor and cancer committee members should be informational resources for the registrar.

The Commission requires a random review by a physician member of the cancer committee of at least 10 percent of all annual analytic accessions. The review should minimally include comparison with source documentation[7] and encompass class of case, primary site, histology, stage of disease, and first course of treatment. Review procedures may also include visual review of abstracts, review of accession register and abstracts, and periodic reabstracting of cases. Computerized data edits are required in computerized registries. Quality control procedures must be reviewed and approved by the cancer committee and documented in the procedure manual. An annual status report of quality control method(s) used, sites reviewed, number of cases reviewed, and the source of quality assessment, such as a physician, a registrar, or central registry personnel, must be reviewed by the cancer committee. The target rate for unknown stage should be less than 10 percent for each site. If the program has more than 10 percent unknown stage in any site, the cancer committee should investigate and resolve the problem as a part of the oncology quality control program.

FOLLOW-UP

Systematic annual follow-up of patients is an important cancer registry function. Follow-up is based on the date of last contact and is delinquent (lost) if no contact has been made within 15 months after the date of last follow-up-information. Cases that are lost (delinquent) should remain in the follow-up process until information is obtained.

A 90 percent follow-up rate of all living and deceased patients is required. The required rate of follow-up for living patients is 80 percent. Non-analytic cases, foreign residents, benign or borderline malignancies, and localized basal and squamous skin cancers are not included in follow-up calculation. Patients who are delinquent or lost to follow-up and whose age exceeds 100 years may be excluded from follow-up calculations.

Follow-up data must include the date(s) and type(s) of treatment for cancer, the site(s) of distant metastasis, the site and histology(ies) of any subsequent primary(ies), the date of last contact, and the status of the patient and the cancer.

[7] Medical record, outpatient files, physician charts, or other documents.

CONFIDENTIALITY AND RELEASE OF INFORMATION

The release of information involves accommodating general, case, and patient-specific data requests. Release of information must be closely supervised by the cancer committee and the cancer registry staff.

Information may be requested by staff physicians, other cancer registries, or by national organizations. Some of the requests will be for general information that does not include patient identification. The cancer committee may authorize the release of general information to specific groups. The registry staff could routinely respond to these requests for information and report the following details to the committee and record in the request log: the request date, requestor's name or organization, information requested, intended use of the data, and the date the information was sent to the requestor.

Other requests may be for information that would specifically identify the patient, the physician, or another individual. These types of requests, as well as those received from groups not covered under the cancer committee's authorization, must be presented to the committee for individual consideration and recorded in the request log. Committee decisions for release of information should be in accordance with the documented policies and procedures of the institution. Each facility should coordinate with appropriate committees to develop and document policies and procedures that address the following:

- Data release criteria
- Patient rights
- Informed consent
- Authorization

REPORTING

Analysis and use of registry data are important end products of data collection. The cancer committee and registry staff should encourage frequent use of the data. Information should be used for cancer conferences and independent studies. Studies should provide the institution with projections and data comparisons.

The data analysis should include comparison of the institution's experience with regional and national data. A critique of the data should identify trends and serve as the basis for quality management and planning.

To assess the use of data and compliance with reporting requirements, a request log or file must be maintained that includes the date of the request, topic, study period, source of the request, and the intent and final use of the data.

RETENTION OF DOCUMENTS

Retention of the following documentation is required: registry data and files (indefinite); minutes for cancer committee meetings and cancer conference(s) (five years); annual and special reports (five years); and research activities (term of retention determined by the institution).

PROCEDURE MANUAL

Registries in approved cancer programs are required to maintain a complete, up-to-date procedure manual that documents each phase of its operations. A procedure manual is a valuable and necessary tool used to organize and maintain an effective, efficient program. A complete procedure manual details the overall structure of the cancer program and the day-to-day operations of the registry. Cancer programs differ in policies, procedures, budgets, and other matters. These activities should be documented in the procedure manual under the direction of the cancer committee. When adhered to, this manual will ensure a smooth operation with consistent and accurate abstracting, systematic and continuous follow-up, and good reporting. The manual is also invaluable for training new registry personnel.

The procedure manual must contain the following: the objectives of the cancer program, including the registry; job descriptions and specifications of registry positions; case eligibility criteria; the reportable list; procedures for casefinding, maintaining and using the suspense file, and accessioning cases into the registry; a description of the registry filing systems; documentation of data collection methods, including principles of abstracting, detailed definitions for each data item, references used for coding systems, if applicable, and staging systems used in the registry; follow-up procedures, including institution and registry policies for contacting patients and samples of committee-approved follow-up letters; documentation of quality control procedures; a description of reporting mechanisms; procedures governing cancer conferences and meetings of the cancer committee; description of the quality management and improvement system; policy statements about confidentiality and the release of information; and documentation of the date(s) of implementation or changes in policies or registry operations.

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Section Two: General Principles in Coding

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CASE ELIGIBILITY

Cases Required

The Commission requires registries in approved programs to include reportable malignancies diagnosed and/or initially treated at the reporting institution, and which meet the criteria for analytic cases (classes of case 0, 1, 2, or 6). Inpatients, outpatients, and clinically diagnosed patients (not histologically confirmed) must be included.

Reportable malignancies have an *ICD-O-2* behavior code of 2[8] or 3.

Basal or squamous cell carcinoma originating in the following sites must be included. These sites are:

Lip	C00.0 - C00.9
Anus	C21.0
Vulva	C51.0-C51.9
Vagina	C52.9
Penis	C60.0 - C60.9
Scrotum	C63.2

Patients diagnosed with skin cancer (C44.-) must be included if the histology is 8000-8004, 8010-8045, 8050-8076, 8081-8082, 8090-8110 and they meet at least one of the following three conditions **at the time of diagnosis:**

- American Joint Committee on Cancer (AJCC) stage group II
  - T3 N0 M0 (primary tumor more than 5 centimeters in greatest dimension)
- AJCC stage group III
  - T4 N0 M0 (primary tumor that has invaded deep extradermal structures such as cartilage, skeletal muscle, or bone)
  - Any T N1 M0 (primary tumor with regional node metastases)
- AJCC stage group IV
  - Any T Any N M1 (primary tumor that has metastasized to distant sites)

Cases <u>Not</u> Required

- Non-analytic classes of case 3, 4, 5, 8, and 9.
- Patients seen only in consultation to establish or confirm a diagnosis or treatment plan.

[8] Certain exceptions apply. See exclusion section.

Examples: A biopsy is done elsewhere. The reporting institution establishes the diagnosis by interpreting the pathology report.

An outpatient CT scan of the chest reads: probable carcinoma of the right lung. The patient does not return to the reporting institution for diagnostic confirmation or treatment. The diagnosis is confirmed, or treatment is delivered at another institution.

Patient comes to the reporting institution for a second opinion. Staff physicians order diagnostic tests and support the original treatment plan. Patient returns to the referring institution for treatment.

- Patients who receive transient care to avoid interrupting a course of therapy started elsewhere.

  Examples: A patient from out of state is visiting relatives in the area. The oncology department at the reporting facility administers the scheduled chemotherapy.

  Due to equipment failure, an institution refers a patient to the reporting facility for treatment. The reporting institution administers radiation therapy until the equipment is repaired.

- Patients with active, previously diagnosed cancer who are admitted to the hospital for an unrelated medical condition.

  Example: A patient with active, previously diagnosed prostate cancer enters the cardiac care unit of the reporting institution.

- Patients with a precancerous condition or a benign tumor[9].
- Patients with carcinoma-in-situ of the cervix (CIS).
- Patients with intraepithelial neoplasia (CIN, PIN, VIN, VAIN).
- Patients with skin cancer (C44.-) that do not meet the histology and stage requirements listed under cases required.
- Patients with a history of malignancy who are clinically free of disease.
- Patients admitted for terminal supportive care, including home care services.
- Patients admitted to a designated hospice.

Reportable-By-Agreement Cases

The cancer committee may request the collection of selected benign or borderline tumors (behavior codes 0 and 1) because of their site of origin or disease course. In addition, the institution may be required to report these cases to a central registry.

Examples: A hospital specializes in neurosurgery. The cancer committee elects to include benign meningiomas (9530/0, 9530/1, 9531/0, 9532/0, 9533/0, 9534/0, 9535/0, 9536/0, 9537/0, 9538/1).

The state registry requires the hospital to report endometrioid adenomas with borderline malignancy (8380/1). The cancer committee adds the adenomas to their reportable-by-agreement list and decides to accession and abstract these cases to comply with state requirements.

[9] Case may be reportable-by-agreement.

The cancer committee may also decide to collect malignant tumors not required by the Commission.

Examples: The committee chooses to collect carcinoma-in-situ of the cervix.

The central registry requires reporting malignant "pathology-only" cases. (Biopsies are done elsewhere and the specimen is sent to the reporting institution's pathology department. The patient never enters the institution.) The cancer committee adds these cases to the reportable-by-agreement list and decides to accession and abstract the cases to comply with the central registry's requirements.

Periodically, the cancer committee should review the reportable-by-agreement list to evaluate the relevancy, use, and continued interest in the collection of these cases.

AMBIGUOUS TERMINOLOGY

Diagnosis

Terms That Constitute a Diagnosis

Interpret the following terms as a diagnosis of cancer. The data base must include patients who have a diagnosis using one or more of these terms.

- Compatible with
- Consistent with
- Most likely
- Probable
- Suspect
- Suspicious

Example: The inpatient discharge summary documents that the patient had a chest x-ray consistent with a carcinoma of the right upper lobe. The patient refused further work-up or treatment.

Exception: If the 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.

Terms That <u>Do Not</u> Constitute a Diagnosis

Do not interpret the following terms as a diagnosis of malignancy. Do not include patients who have a diagnosis consisting only of these terms.

- Equivocal
- Possible
- Questionable
- Suggests
- Worrisome

Example: Final diagnosis is reported as possible carcinoma of the breast.

Staging

Terms That Constitute Tumor Involvement/Extension

In the absence of cytologic or histologic confirmation, interpret the following terms as evidence of tumor involvement. The description may be taken from the clinical, operative, or pathologic documentation.

- Adherent
- Apparent
- Compatible with
- Consistent with
- Encroaching upon
- Fixation, fixed
- Induration
- Into
- Onto
- Out onto
- Probable
- Suspect
- Suspicious
- To

Terms That <u>Do Not</u> Constitute Tumor Involvement/Extension

The following terms are <u>NOT</u> interpreted as tumor involvement:

- Approaching
- Equivocal
- Possible
- Questionable
- Suggests
- Very close to

REVISING THE ORIGINAL DIAGNOSIS OR STAGE

Data are gathered from multiple sources using the most recent and complete information available. Over time, the patient's records may contain new information (tests, scans, consults, etc.). Change the primary site, histology, and stage as the information becomes more complete. There is no time limit for making revisions that give better information about the original diagnosis or stage. 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, change the stage from unknown to the appropriate staging basis; T, N, and M elements; and stage group.

Exception: Do not use information from tests done after the first definitive therapy begins to change the AJCC stage.

Example: A patient has a modified radical mastectomy for breast cancer January 1996. A bone scan done February 1996 reveals bony metastasis.

Example: A physician may decide that a previously clinically diagnosed malignancy is a benign lesion. A patient is referred from a nursing home to the institution. The chest x-ray shows a cavitary lesion in the right lung. The family requests that the patient undergo no additional workup or treatment. Discharge diagnosis is "probable carcinoma of the 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 data base. Adjust the sequence number(s) of any other primaries the patient may have.

DETERMINING MULTIPLE PRIMARIES

General Principles

Guidelines have been defined for coding single and multiple primaries and are based on the ICD-O-2. For selected cases it may be necessary to consult a physician to decide if the case is a single or multiple primary.

Site Differences

The site groups shown in Appendix A are reported as one site.

A difference in the second and/or third character of the ICD-O-2 topography code designates a separate site.

Example: The lower gum (C03.1) and the anterior floor of the mouth (C04.0) are separate sites.

A difference in the fourth character of the ICD-O-2 topography code designates a subsite of the same organ.

Example: The trigone of the bladder (C67.0) and the lateral wall of the bladder (C67.2) are subsites of the bladder and are treated as one site, either overlapping lesion of subsites of the bladder (C67.8) or bladder, NOS (C67.9).

Exception: A difference in the fourth character of the ICD-O-2 topography codes designates a separate site for the following site groups.

Colon	C18.0 - C18.9
Anus/anal canal	C21.0 - C21.8
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

Example: The sigmoid colon (C18.7) and the transverse colon (C18.4) are separate sites.

Exception: 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 may develop 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 adenocarcinomas of the colon or typical colon polyps. If multiple segments of the colon 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).

Histology Coding Rules

Same Histology

When a number of adjectives describe a single histology, record the higher numeric code.

Example: In the diagnosis "transitional cell epidermoid carcinoma," transitional cell (8120/3) and epidermoid (8070/3) are both adjectives describing carcinoma. Record transitional cell (8120/3).

Note: If the diagnosis states "transitional cell and epidermoid carcinoma," "transitional cell with areas of epidermoid carcinoma," or "transitional cell with a focus of epidermoid carcinoma," the diagnosis would be interpreted as one of mixed or multiple histologies.

Another example of single histology occurs when the first three digits of the ICD-O-2 morphology codes are identical.

Example: 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).

Lesion(s) may have a single histology with invasive and in situ components. This is a single primary. Code the behavior of the invasive component.

Note: This rule is also used when multiple lesions are present. One lesion may be invasive and another lesion in situ, or each of the lesions may have invasive and in situ components.

Examples: Pathology of a breast mass shows infiltrating ductal carcinoma (8500/3) with a large intraductal component (8500/2). Code the histology as infiltrating ductal (8500) and the behavior as /3.

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 lesion is an adenocarcinoma in situ (8140/2). Code the histology and behavior as adenocarcinoma, NOS (8140/3).

Mixed or Multiple Histologies

A difference in the first three digits of the ICD-O-2 morphology code indicates a different histology.

Exceptions: Lymphatic and hematopoietic disease. (See Appendix B.)

To code multiple or mixed histologies existing in one primary, use the following guidelines in this priority order:

(1) Select a combination code

Example: 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).

(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 histology.

Example: A lung lesion is predominantly adenocarcinoma (8140/3) with focal areas of bronchioloalveolar adenocarcinoma (8250/3). A combination code does not exist. Record the predominant histology, adenocarcinoma (8140/3).

Note: The terms "with foci of," "areas of," or "elements of" describe minor areas of involvement. Do not code the histologies described by these terms unless there is a combination code.

(3) Code the histology with the highest ICD-O-2 morphology code.

Example: A patient with breast cancer is diagnosed with mixed infiltrating ductal carcinoma (8500/3) and medullary carcinoma (8510/3). There is no combination code for these histologies, and the pathology report does not identify a predominant histology. Record the higher numeric code, medullary carcinoma (8510/3).

Lymphatic and Hematopoietic Disease

Appendix B provides guidelines for determining multiple primaries in lymphatic and hematopoietic diseases.

Simultaneous/Synchronous Diagnoses

Simultaneous or synchronous diagnoses occur either at the same time or within two months of each other.

Single Primary

Same Histology

- A single lesion is one primary even if the lesion crosses site boundaries.

  Example: A patient has a large maxillary sinus tumor that extends into the sphenoid sinus. This is one primary, maxillary sinus (C31.0).

- Lesions with the same histology that recur at the site of an earlier malignancy would be:

  b The same primary if diagnosed within two months.

  Example: A patient has a colectomy in August 1996 for an adenocarcinoma (8140/3). The physician biopsies the anastomotic site in September 1996. The pathologic examination confirms adenocarcinoma. This is a recurrence of the original tumor.

  - A new primary tumor if diagnosed after two months, unless a physician states that the lesion is recurrent or metastatic from the original.

    Example: A patient has an operation for squamous cell carcinoma (8070/3) of the hard palate (C05.0) in January 1996. The physician biopsies another lesion of the hard palate in April 1996. The pathology report confirms squamous cell carcinoma. There is no physician statement identifying the disease as recurrent or metastatic. This is a new primary.

    Exceptions: These sites/histologies are single primaries. Any reappearance of the original disease is documented as a recurrence.

    - Bladder primaries with morphology codes 8120-8130.
    - Kaposi's sarcoma (9140/3).

    Note: Refer to Section Four, Cancer Identification and Primary Site for coding rules.

  b Bowen's disease of the skin/Bowen's type intraepidermal squamous cell carcinoma of the skin, basal, basosquamous, and squamous cell carcinoma of the skin.

  Note: Each occurrence of melanoma of the skin is a new/separate primary UNLESS a physician states otherwise.

- Simultaneous multiple lesions with the same histology in the same site are a single primary. If one lesion is in situ and another invasive, record as a single primary with invasive behavior, code 3.

Paired Organs

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 histologic type, 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, code laterality as "4" and prepare a single abstract.

Exceptions: The following are always single primaries:

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

Adenocarcinoma in a Polyp

Simultaneous lesions and polyps in one segment of the colon are a single primary.

Example: 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). Code the histology to adenocarcinoma (8140/3). Adenocarcinoma in an adenomatous polyp is an earlier stage of disease than an invasive adenocarcinoma.

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). See "General Principles in Coding: Determining Multiple Primaries" for a detailed explanation.

Mixed or Multiple Histologies

- A single lesion with mixed histologies is one primary.

  Example: A patient has a mixed ductal and lobular breast carcinoma in the upper-outer quadrant. Code ductal and lobular carcinoma (8522/3) of the breast, upper-outer quadrant (C50.4).

Multiple Primaries

Same Histology

- Multiple lesions with the same histology occurring in different sites are individual primaries UNLESS a physician states that one of the sites is metastatic.

  Example: The patient has a mass in the esophagus and in the lung. The pathology report identifies both lesions as squamous cell carcinoma, NOS (8070/3). The pathology report does not identify either lesion as metastatic. There are two primaries, lung (C34.9) and esophagus (C15.9).

Mixed or Multiple Histologies

- Multiple lesions with different histologies in a single site are separate primaries, whether they occur simultaneously or at different times.

  Example: A patient has an infiltrating ductal carcinoma (8500/3) in the upper-outer quadrant of the right breast and a medullary carcinoma (8510/3) in the lower-inner quadrant of the right breast. The patient has two primaries.

Exception: Combinations of ductal and lobular carcinoma occurring within two months of each other in the same breast are a single primary.

- Multiple lesions with different histologies occurring in different sites are separate primaries, UNLESS a physician says otherwise.

  Example: A patient is diagnosed with squamous cell carcinoma (8070/3) of the soft palate (C05.1) and an adenocarcinoma (8140/3) in a Barrett's esophagus (C15.9). The patient has two primaries.

STAGE OF DISEASE AT INITIAL DIAGNOSIS

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. Sometimes a complete removal of the malignant tissue is not possible. Operative reports with detailed gross observations at surgery are very important in these cases.

In Commission-approved programs, the managing physician must stage all analytic cases according to the staging system of the American Joint Committee on Cancer (AJCC).

The following data must be recorded for all analytic cases (classes of case codes 0, 1, 2, or 6):

- Staging basis (either clinical or pathologic)
- T, N, M elements (either clinical or pathologic)
- AJCC Stage Group (either clinical or pathologic)

The Commission requires General Summary Stage for cases that cannot be staged according to the AJCC. These cases may be excluded because of site or histology.

Examples: Fallopian tube (site not included in AJCC schemes)

Sarcoma of the lung (lung scheme is only for carcinomas)

Exception: Pediatric cancers are excluded from the Commission's AJCC staging requirement. Childhood cancers must be staged according to the guidelines of the Children's Cancer Group (CCG) or the Pediatric Oncology Group (POG).

Information for stage is based on the history and physical, diagnostic imaging, tests, operative note, and pathology reports.

If the pathologic T or N elements cannot be assessed, record the clinical stage.

Example: The patient's metastatic workup and palpation of the axilla are reported as negative for involvement. The mammogram indicates a 1 cm mass. The pathology report from an excisional biopsy reveals a 1 cm medullary carcinoma. The patient has no further treatment. Pathologic stage is pT1b, pNX, pM0, stage group unknown. Instead of using the unknown stage, clinically stage this case. The clinical stage is cT1b, N0, M0, stage group I.

Stage each primary independently. If you cannot determine the stage group, record unknown.

When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. In the absence of histologic or cytologic confirmation, consult a physician to decide which primary has metastasized. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, a physician identifies which primary has metastasized, update the stage(s) as appropriate.

Data Items (See Section Four)

The data items involved in or related to the staging process include the following:

- Staging basis (clinical, pathologic, other)[10]
- T, N, M elements
- AJCC stage group
- Prefix/suffix descriptor
- TNM edition number
- Size of tumor
- Regional nodes positive
- Regional nodes examined
- Site of distant metastasis
- Staged by
- General Summary Stage
- Extension
- Lymph nodes
- Type of staging system (pediatric)
- Pediatric stage
- Other staging system

Time Periods

AJCC Stage

Clinical classification is based on evidence acquired before treatment. It is based on the physical examination, imaging, endoscopy, biopsy, surgical exploration, and other relevant findings. Clinical classification is appropriate for sites accessible for clinical examination. Clinical classification is also used when a pathologic evaluation is not possible or not known.

Pathologic classification is based on evidence acquired before treatment, supplemented with additional information from surgery and pathologic examination of the resected specimen.

General Summary Stage, Surveillance, Epidemiology, and End Results Program (SEER)

General Summary Stage is limited to all information available within two months of diagnosis.

Exception: General Summary Stage for prostate primaries is limited to all information available within four months of diagnosis for cases diagnosed on or after January 1, 1995.

Exclude metastasis or disease progression that develops after the original diagnosis.

General Summary Stage for all sites is based on pathologic, operative, and clinical assessments. The priority for using these reports is as follows:

- Pathologic
- Operative (particularly important when the surgical procedure does not remove all malignant tissue)
- Clinical

Apply the same rules when autopsy reports are used to stage the disease.

FIRST COURSE OF TREATMENT

First course of treatment includes all methods of therapy recorded in the treatment plan and administered to the patient.

No therapy is a treatment option (the patient refused therapy, the family/guardian refused therapy, the patient expired before therapy started, or the physician recommended no therapy). Therefore, first course of treat-

[10]Incorporated into the T, N, and M data items.

ment may be no treatment. Enter the date the decision was made not to treat into the field "Date of Initial Treatment."

Data Items

Several items document the first course of tumor-directed treatment. Section Four consists of definitions, codes, and instructions on collecting this information.

- Date of first course treatment
- Date of non cancer-directed surgery
- Non cancer-directed surgery
- Non cancer-directed surgery at this facility
- Date of cancer-directed surgery
- Cancer-directed surgery
- Cancer-directed surgery at this facility
- Surgical approach
- Residual primary tumor following cancer-directed surgery
- Reconstructive surgery
- Reason for no surgery
- Date radiation started
- Radiation
- Radiation at this facility
- Regional dose: cGy
- Number of treatments to this volume
- Radiation elapsed treatment time (days)
- Radiation treatment volume
- Location of radiation treatment
- Intent of treatment (radiation)
- Regional treatment modality
- Radiation therapy to CNS
- Radiation/surgery sequence
- Radiation treatment completion status
- Radiation therapy local control status
- Reason no radiation
- Date chemotherapy started
- Chemotherapy
- Chemotherapy at this facility
- Chemotherapy-related field #1
- Chemotherapy-related field #2
- Chemotherapy-related field #3
- Reason no chemotherapy
- Date hormone therapy started
- Hormone therapy
- Hormone therapy at this facility
- Reason no hormone therapy
- Date immunotherapy started
- Immunotherapy
- Immunotherapy at this facility
- Date other treatment started
- Other treatment
- Other treatment at this facility
- Protocol eligibility status
- Protocol participation

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 fragmented. It is frequently found in several different sources, for example: medical or clinic record, consultation reports, and outpatient records. All cancer-directed therapies specified in the physician(s) treatment plan are a part of the first course of treatment.

A discharge plan must be part of the patient's record in a Commission-approved program and may contain part or all of the treatment plan.

A treatment plan may specify one or more modalities of therapy (that is: surgery, radiation, chemotherapy, hormone therapy, immunotherapy, or other therapy). A treatment "regimen" may include combinations of

concurrent or adjuvant therapies. In treatment analyses, use only therapies actually administered to the patient.

Example: A patient had a transurethral resection for a bladder lesion with a positive histology. Resection was followed by radiation, ileal loop diversion, and a complete cystectomy with node dissection. Code the procedures as follows:

DATA ITEM	TREATMENT CODES
Surgery	50 - Complete cystectomy with node dissection
Radiation	1 - Beam radiation
Chemotherapy	0 - None
Hormone therapy	0 - None
Immunotherapy	0 - No immunotherapy
Other treatment	0 - No other cancer-directed therapy

Time Periods

All Malignancies Except Leukemias

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

If the therapy is a part of an established protocol or administered within accepted management guidelines for the disease, it is first course of treatment. When a treatment plan is not available or is unclear, consult the physician advisor.

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."

Treatment failure or disease progression may prompt the physician to stop therapy before the full course has been completed. Record any therapy administered after the discontinuation of first course as secondary or subsequent treatment.

Leukemias

First course of treatment includes all cancer-directed therapies planned and administered by the physician(s) during or after the first diagnosis of leukemia. Record all remission-inducing or remission-maintaining cancer-directed therapy as first course of treatment. Treatment regimens may include multiple modes of therapy. The administration of these therapies can span a year or more.

Example: Certain pediatric leukemia protocols span two years or more from induction to the end of maintenance. Induction, consolidation, and maintenance are all first course of treatment.

If the therapy is a part of an established protocol or administered within accepted management guidelines for the disease, it is first course of treatment. When a treatment plan is not available or is unclear, consult the physician advisor.

A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment.

Treatment

Non Cancer-Directed Treatment

Non cancer-directed treatments prolong the patient's life, alleviate pain, make the patient comfortable, or prepare the patient for cancer-directed therapy. They are not meant to destroy or control the tumor or delay the spread of disease. Non cancer-directed procedures include diagnostic tests and supportive care (treatments designed to relieve symptoms and minimize the effects of the cancer). Non cancer-directed therapies are generally not included in statistical analysis of treatment.

Examples: Closure of a colostomy following resection for cancer of the bowel would be a non cancer-directed treatment.

Diagnostic procedures:

Incisional biopsies

Exploratory procedures with or without biopsies

Supportive care/relieving symptoms:

Pain medication

Oxygen

Antibiotics administered for an associated infection

Transfusions

Intravenous therapy to maintain fluid or nutritional balance

Laser therapy directed at relieving symptoms

Megestrol Acetate is hormone therapy designed to improve nutritional status.

Cancer-Directed Treatment

Cancer-directed treatment is tumor directed, and its purpose is to modify, control, remove, or destroy primary or metastatic cancer tissue. Physicians administer the therapy(ies) to remove or minimize the size of tumor or to delay the spread of disease. Record all cancer-directed therapy administered to the patient. For complete treatment information, record therapies given in other institutions and failed treatments (the patient did not respond).

Examples: Patient is diagnosed with stage IV small cell carcinoma of the lung. The treatment plan recommends radiation to shrink the metastatic tumor and alleviate the pain caused by rib metastases. The reporting institution delivers the radiation. The field "Radiation" is coded 1, beam radiation.

A patient with breast cancer enters the reporting institution for a lumpectomy and axillary node dissection. The physician's treatment plan specifies radiation therapy to the intact breast following surgery. The patient is lost to follow-up. It is unknown if the patient had radiation. Code the field "Surgery" to a partial or less than total mastectomy with axillary node dissection

(20). Record the field "Reason no radiation" as radiation recommended, unknown if done (8) and the field "Radiation" as none (0). When follow-up information becomes available, change the field "Radiation" to the appropriate code, that is, if follow-up reveals that the patient received radiation at another institution, change to the appropriate radiation code (1-5), and change the field "Reason no radiation" to radiation treatment performed (0).

A patient enters the reporting institution with acute leukemia. The treatment plan specifies combination chemotherapy. The patient receives two weeks of chemotherapy and the physician documents, "The patient has failed treatment. We will now start a different course of chemotherapy." Record chemotherapy, multiple agents (3) as first course of treatment. The second chemotherapy regimen is subsequent treatment.

TREATMENT FOR RECURRENCE OR PROGRESSION

Treatment for recurrence or progression of disease (formerly referred to as subsequent therapy) includes all cancer-directed therapies administered after the first course of treatment is complete.

If the patient does not respond or if the disease progresses, a physician may stop the first course of treatment before it is complete. Therapy administered after the first course is stopped is recorded as subsequent treatment.

Section Three: Comparison of Data Sets

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DEFINITIONS

Required Data Set (R)

Commission-approved programs must record the required data set items.

Supplementary Data Set (S)

The supplementary data set contains additional data items that are important for the efficient operation of a cancer registry. The Commission recommends that the supplementary data set be collected.

Optional Data Set (O)

The optional data set includes items that may be of interest to specific institutions or groups.

Surveillance, Epidemiology, and End Results Program (SEER)

Required data elements for a central registry affiliated with the National Cancer Institute's SEER Program.

National Program of Cancer Registries (NPCR)

Required and recommended data elements for state cancer registries participating in the National Program of Cancer Registries of the Centers for Disease Control and Prevention.

COMPARISON OF DATA SETS

An (x) indicates that the item is part of the data set.

ITEM	COC			SEER	NPCR
	R	S	O		
Patient Identification					
Institution ID number (required for participants in multiple-hospital registries)	x				
Accession number	x			x	x
Sequence number	x			x	x
Year first seen for this primary	x				
Medical record number	x				x
Social Security number	x				x
Military medical record number suffix		x			x
Name prefix			x		
Name suffix		x			
Last name	x				x
First name	x				x
Middle name	x				x
Maiden name		x			x
Alias		x			x
Marital status at diagnosis			x	x	x

ITEM	COC			SEER	NPCR
	R	S	O		
Patient address (number and street) at diagnosis	x				x
City/town at diagnosis	x				x
State at diagnosis	x				x
Postal code at diagnosis	x				x
County at diagnosis	x			x	x
Patient address (number and street) - current	x				
City/town - current	x				
State - current	x				
Postal code - current	x				
County - current			x		
Census tract			x	x	x
Census coding system			x	x	x
Telephone	x				
Place of birth			x	x	x
Date of birth	x			x	x
Age at diagnosis		x		x	x
Race	x			x	x
Spanish origin	x			x	x
Sex	x			x	x
Following physician	x				
Managing physician		x			
Primary surgeon	x				
Physician #3		x			
Physician #4		x			
Primary payer at diagnosis	x				
Usual occupation			x		x
Usual industry			x		x
Family history of cancer			x		
Tobacco history			x		
Alcohol history			x		
Type of reporting source			x	x	x
Abstracted by	x				

ITEM	COC			SEER	NPCR
	R	S	O		
Cancer Identification					
Class of case	x				x
Institution referred from		x			
Institution referred to		x			
Date of inpatient admission		x			
Date of inpatient discharge		x			
Inpatient/outpatient status			x		
Screening date			x		
Screening result			x		
Date of initial diagnosis	x			x	x
Primary site	x			x	x
Laterality	x			x	x
Histology	x			x	x
Behavior code	x			x	x
Grade/differentiation	x			x	x
Diagnostic confirmation	x			x	x
Tumor marker #1		x		x	
Tumor marker #2		x		x	
Presentation at cancer conference		x			
Date of cancer conference			x		
Referral to support services		x			
Stage of Disease at Diagnosis					
Size of tumor	x			x	x
Extension (SEER EOD)		x		x	
Lymph nodes (SEER EOD)		x		x	
Regional nodes examined	x			x	
Regional nodes positive	x			x	
Site of distant metastasis #1		x			
Site of distant metastasis #2		x			
Site of distant metastasis #3		x			
General Summary Stage (SEER) (required only in the absence of AJCC classification)	x				x
Clinical T	x				

ITEM	COC			SEER	NPCR
	R	S	O		
Clinical N	x				
Clinical M	x				
Clinical stage group	x				
Clinical stage (prefix/suffix) descriptor		x			
Staged by (clinical stage)	x				
Pathologic T	x				
Pathologic N	x				
Pathologic M	x				
Pathologic stage group	x				
Pathologic stage (prefix/suffix) descriptor		x			
Staged by (pathologic stage)	x				
Other T		x			
Other N		x			
Other M		x			
Other stage group		x			
Other stage (prefix/suffix) descriptor		x			
Staged by (other stage)	x				
Other staging system			x		
Type of staging system (pediatric)	x				
Pediatric stage	x				
Staged by (pediatric stage)	x				
TNM edition number	x				
Date of first positive biopsy			x		
First Course of Treatment					
Date of first course treatment	x			x	x
Date of non cancer-directed surgery	x				
Non cancer-directed surgery	x				
Non cancer-directed surgery at this facility		x			
Date of cancer-directed surgery	x				x
Cancer-directed surgery	x			x	x
Cancer-directed surgery at this facility		x			
Surgical approach	x				

ITEM	COC			SEER	NPCR
	R	S	O		
Residual primary tumor following cancer-directed surgery	x				
Reconstructive surgery		x			
Reason for no surgery		x		x	x
Date radiation started	x				x
Radiation	x			x	x
Radiation at this facility		x			
Regional dose: cGy			x		
Number of treatments to this volume			x		
Radiation elapsed treatment time (days)			x		
Radiation treatment volume			x		
Location of radiation treatment			x		
Intent of treatment (radiation)			x		
Regional treatment modality			x		
Radiation therapy to CNS			x	x	x
Radiation/surgery sequence			x	x	x
Radiation treatment completion status			x		
Radiation therapy local control status			x		
Reason for no radiation		x			
Date chemotherapy started	x				x
Chemotherapy	x			x	x
Chemotherapy at this facility		x			
Chemotherapy field #1			x		
Chemotherapy field #2			x		
Chemotherapy field #3			x		
Chemotherapy field #4			x		
Reason for no chemotherapy		x			
Date hormone therapy started	x				x
Hormone therapy	x			x	x
Hormone therapy at this facility		x			
Reason for no hormone therapy		x			
Date immunotherapy started	x				x
Immunotherapy	x			x	x

ITEM	COC			SEER	NPCR
	R	S	O		
Immunotherapy at this facility		x			
Date other treatment started	x				x
Other treatment	x			x	x
Other treatment at this facility		x			
Protocol eligibility status		x			
Protocol participation		x			
Recurrence					
Date of first recurrence	x				
Type of first recurrence	x				
Other type of first recurrence		x			
Date(s) of subsequent treatments for recurrence or progression		x			
Type(s) of subsequent treatments for recurrence or progression		x			
Recurrence site(s)			x		
Follow-Up					
Date of last contact or death	x			x	x
Vital status	x			x	x
Cancer status	x				
Quality of survival			x		
Following registry			x		
Follow-up source		x			
Next follow-up source		x			
Unusual follow-up method			x		
Cause of death			x	x	x
ICD revision number			x	x	x
Autopsy			x		
Commission on Cancer coding system - current	x				

Section Four: Coding Instructions

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PATIENT IDENTIFICATION

INSTITUTION ID NUMBER **Item Length: 6**

Data Type: Numeric

Required Data Set (participants in multiple hospital registries)

Use the institution ID number assigned by the Cancer Department of the American College of Surgeons. Each institution's identification number is unique. It appears on the Commission's mailing labels and survey form. If you need a single hospital ID number, call the American College of Surgeons Cancer Department at (312) 664-4050, ext. 209. If you need a list of Hospital ID numbers for your state or region, it is available on disk or hard copy from the Cancer Department (see Appendix E).

This is a required data item for cancer programs that share a single registry. Each institution participating in a shared registry is assigned a unique number.

Record only the last six digits. Over time some institutions may have been assigned a number that is preceded by an "H" and "6." These two characters should not be recorded.

Example: H6439999, General Hospital, Anytown, Illinois, would be recorded 439999.

ACCESSION NUMBER

Item Length: 6
Data Type: Numeric
Required Data Set

The first two digits of the "Accession Number" specify the year in which the patient was first seen at the reporting institution for the diagnosis and/or treatment of cancer. Data collection begins on the registry's reference date. The last four numbers are the numeric order in which the registry entered the case into the data base.

Example: A patient is diagnosed at the reporting institution in 1996. The first two digits of the accession number are 96. This is the 33rd patient accessioned in 1996, making the last four digits of the accession number 0033. The full accession number is 960033.

Assign a unique accession number to each patient. The accession number identifies the patient even if multiple primaries exist. Use the same accession number for all subsequent primaries.

Examples: The registry assigns accession number 940133 to a patient with prostate cancer in 1994. This patient reenters the reporting institution in 1996 to have treatment for a primary lung cancer. The accession number for this second primary (lung) is 940133.

The registry assigns accession number 900150 to a patient with breast cancer in 1990. The patient develops a primary kidney cancer in 1996. The accession number for the kidney tumor is 900150.

Note: Numeric gaps in accession numbers are allowed. When a case is deleted from your database, do not reuse the accession number for another case. This will avoid any chance of two cases having the same accession number.

Classes of case 0, 1, and 6: The first two digits of the accession number are the same as the year in which the patient is seen at the reporting institution *or in a staff physician's office for diagnosis.*[11]

Note: Class of case is defined in Section Four, Cancer Identification.

Exceptions: A patient enters the reporting institution in December 1995 and is diagnosed with cancer in January 1996. The accession number is 96 _ _ _ _.

The registry's reference date is January 1, 1996. A patient is diagnosed with breast cancer and has a partial mastectomy at the reporting institution in December 1995. The patient starts a course of radiation therapy at the reporting institution in January 1996. Assign the accession number 96 _ _ _ _.

Classes of case 2 and 3: The first two digits of the accession number are the year the patient is first seen at the reporting institution for treatment AFTER the registry's reference date.

Examples: A patient had cancer-directed surgery elsewhere in December 1995. The reporting institution initiated outpatient radiation therapy in January 1996. The accession number for this patient is 96 _ _ _ _.

[11]Applies to class of case 6, diagnosed and treated in a physician's office only.

ACCESSION NUMBER **(Continued)**

A patient had initial treatment in another institution in 1994. The patient is admitted and treated at the reporting institution in November 1996 for recurrent cancer. The accession number is 96 _ _ _ _.

Class of case 4: The first two digits are the first year in which the reporting institution saw the patient for the management and/or treatment of active cancer AFTER the registry's reference date.

Example: The registry's reference date is January 1, 1995. The reporting institution treated a patient for cancer of the larynx in 1994. The patient returns in March 1996 for treatment of recurrent laryngeal cancer. The accession number is 96 _ _ _ _.

Class of case 5: The first two digits of the accession number are the year of the patient's death.

Example: An accident victim enters the intensive care unit from the emergency department on December 31, 1995. The patient expires the following day, January 1, 1996. An autopsy shows a previously unsuspected bladder cancer. Accession number is 96 _ _ _ _.

SEQUENCE NUMBER

Item Length: 2
Data Type: Alphanumeric
Required Data Set

The "Sequence Number" represents the order of all primary malignant and/or benign tumor diagnoses during the patient's lifetime. It counts the occurrence of *independent, primary tumors* except basal and squamous cell cancer of the skin (C44.-) that do not meet Commission histology and staging requirements.

Example: If a patient has a history of skin cancer, and information on histology and staging is unavailable, do not sequence.

Malignant Tumors

Codes (malignant primaries):

00 One primary only

01 First of two or more primaries

02 Second of two or more primaries

03 Third of three or more primaries

.. (Actual number of this primary)

99 Unspecified sequence number

The sequence number 00 indicates that this patient has only one primary malignancy. Change the sequence number from 00 to 01 if the patient develops another primary malignancy. The sequence 01 indicates that this case is the first of multiple primaries.

Example: In January 1995, the registry assigns a 00 sequence number to a patient with malignant melanoma. The patient develops a second primary cancer of the lung in July 1996. Assign an 02 sequence number to the second cancer (lung). Change the sequence number of the first cancer (malignant melanoma) to 01.

When malignancies occur simultaneously, assign the first sequence number (01) to the primary with the worse prognosis. When you cannot determine the severity of the prognosis, the assignment of a sequence number is arbitrary.

Examples: A patient enters the reporting institution with simultaneous carcinoma in situ of the cervix and invasive adenocarcinoma of the colon. Assign sequence number 01 to the colon primary.

A patient has simultaneous adenocarcinoma in situ in a colon polyp and squamous cell carcinoma in situ in a vocal cord polyp. Assign sequence numbers in any order, since both primaries have similar prognoses.

The sequence number counts the patient's independent, primary malignancies regardless of the location(s) or institution(s) where those primaries were diagnosed and treated.

Example: The reporting institution diagnoses colon cancer. The patient has a history of kidney cancer diagnosed and treated elsewhere. The colon cancer is the second of this patient's multiple primary cancers. Assign a sequence number 02 to the colon cancer.

SEQUENCE NUMBER **(Continued)**

These sites/histologies are single primaries. Any reappearance of the original disease is documented as a recurrence. Assign a sequence number to the first disease occurrence. Do not assign another sequence number to any subsequent occurrences.

- Bladder primaries with morphology codes 8120-8130.
- Kaposi's sarcoma (9140/3)

Note: Report Kaposi's sarcoma as one primary. Refer to Section Four, Cancer Identification and Primary Site for coding rules.

- Patients diagnosed with skin cancer (C44.-) must be included if the histology is 8000-8004, 8010-8045, 8050-8076, 8081-8082, 8090-8110 and the AJCC stage group at diagnosis is II (T3), III, or IV. For details, see General Principles in Coding, Case Eligibility.

Note: Each occurrence of melanoma of the skin is a new/separate primary UNLESS a physician states otherwise.

Nonmalignant Tumors (Benign and Borderline)

AA One benign tumor only

BB Second of two or more benign tumors

CC Third of two or more benign tumors

DD Fourth of three or more benign tumors

.. (Letters representing actual number of benign tumors)

XX Unspecified number of benign tumors

The benign sequence code does not affect the malignant sequence code. They are independent.

Example: A patient develops colon cancer in 1995. The sequence number is 00. The patient develops a benign meningioma in 1996. Meningiomas are reportable-by-agreement in the reporting facility, so the registry assigns the sequence number AA (one benign tumor only). The sequence number for the first primary (carcinoma of the colon) remains 00.

Use the sequence number 99 when it is impossible to estimate whether the patient has been diagnosed with an earlier malignancy (primary). If more information becomes available, change the sequence number(s).

Example: A patient is diagnosed in the reporting hospital with cancer of the colon. The medical record contains the statement "The patient recently had a salivary gland tumor removed. The patient does not know if the lesion was malignant." The registry assigns a 99 sequence number to the colon primary. The patient returns to the reporting facility a year later for treatment of prostate cancer. The medical record says "The patient has a history of a malignant salivary gland tumor." Change the sequence number of the colon cancer from 99 to 02. Assign the sequence number 03 to the prostate cancer.

YEAR FIRST SEEN FOR THIS PRIMARY (ACCESSION YEAR)

Item Length: 4
Data Type: Numeric
Required Data Set

The "Year First Seen for This Primary" (formerly accession year) is the year the patient was first seen at the reporting institution for diagnosis and/or treatment of this primary, since the reference date of the registry. It is not the year that the registrar accessioned the case. The year first seen for this primary relates only to one primary tumor. A patient with multiple primaries can have a different "Year First Seen for This Primary" on each abstract.

The data item is used to produce an accession register. The accession register identifies all primaries first treated or seen at the reporting institution for a given year.

Record the first year in which the patient was seen at the reporting institution for diagnosis and/or treatment of this primary after the registry's reference date.

Examples: A patient had surgery for rectal carcinoma at another institution in December 1995 and started radiation therapy at the reporting institution in January 1996. Assign 1996 as the year first seen for this primary.

A patient with breast cancer had initial therapy at another institution in July 1994. The patient enters the reporting institution in April 1996 for treatment of recurrent breast cancer. Assign 1996 as the year first seen for this primary.

The registry's reference date is January 1, 1994. A patient entered the reporting institution with cancer of the larynx in July 1993. The patient returns to the reporting institution in August 1996 with recurrent laryngeal cancer. Assign 1996 as the year first seen for this primary.

If the patient has a previous accession (another primary), the year first seen for this primary may differ from the first two digits of the accession number.

Example: The patient had a breast primary in 1990 and was assigned an accession number 900150 and the year first seen for this primary was recorded as 1990. The patient developed a second primary (right kidney) in 1996. Designate 1996 as the year first seen for the kidney primary, but keep the same accession number.

Patients first seen at the end of the year may present unusual problems. A patient may have inconclusive scans or tests in December and be diagnosed in January. Use the year of diagnosis as the year first seen for this primary.

Example: A patient is admitted to the reporting institution in December 1995 and is diagnosed in January 1996. Assign 1996 as the year first seen for this primary.

MEDICAL RECORD NUMBER

Item Length: 11
Data Type: Alphanumeric
Required Data Set
Right Justified
Leading Blanks

The "Medical Record Number" is a patient identification number usually assigned by the reporting institution's health information management (HIM) department. If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.

Example: Medical record number 811234 would be recorded _ _ _ _ _811234.

Record standard abbreviations for departments that do not use HIM medical record numbers.

Examples: Radiation therapy _ _ _ _ _ _ _ _ _ RT

One-day surgery clinic _ _ _ _ _ _ _ _ _ SU

If the medical record number is unknown, record _ _ _ _ _ _ _ _ UNK

When a patient enters a military hospital as a family member of a military sponsor, see data item "Military Medical Record Number Suffix." Do not code the patient's relationship to the military sponsor in this field.

SOCIAL SECURITY NUMBER

Item Length: 9
Data Type: Numeric
Required Data Set

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

Do not record Social Security numbers that end with B or D. These are the spouse's Social Security number. The patient receives benefits under the spouse's number.

MILITARY MEDICAL RECORD NUMBER SUFFIX

Item Length: 2
Data Type: Numeric
Supplementary Data Set

The "Military Medical Record Number Suffix" is a patient identifier used by military hospitals. It records the relationship of the patient to the sponsor.

Codes:

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

The first spouse is always designated as 30. If the sponsor remarries, the second spouse would be designated 31, the third spouse 32, etc.

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

NAME PREFIX

Item Length: 3
Data Type: Alpha
Mixed Case
Optional Data Set
Left Justified

"Name Prefix" is a title that would precede the name in a letter. It helps distinguish between patients with the same names. Do not use punctuation. Leave blank if the patient does not have a name prefix or if you choose not to collect this data item.

Suggested abbreviations:

Title	**Abbreviation**
Brother	Br
Doctor	Dr
Honorable	Hon
Missus	Mrs
Mister	Mr
Miss/Missus	Ms
Reverend	Rev
Sister	Sr

NAME SUFFIX

Item Length: 3
Data Type: Alpha
Mixed Case
Supplementary Data Set
Left Justified

"Name Suffix" is a title that follows a patient's last name. The suffix can identify the generation order in families and provide credential status. Do not use punctuation. Leave blank if the patient does not have a name suffix.

Suggested abbreviations:

Title	**Abbreviation**
Doctor	MD, PhD
Junior	Jr
Senior	Sr
Third	III
Fourth	IV

If multiple suffixes are used, the generation specific suffix is to be recorded.

Example: The patient's name is John C. Smith III, MD. Record the III.

LAST NAME

Item Length: 25
Data Type: Alpha Character
Mixed Case
Required Data Set
Left Justified

Record the patient's last name. Truncate if the name is more than 25 letters. Do not record blanks, spaces, special characters, or punctuation marks in the last name.

Example: Mc Donald is recorded McDonald. O'Hara is recorded OHara.

Hyphenated names are allowed.

Example: The last name is Green-Moss. Record as Green-Moss.

Leave blank if the patient's last name is unknown.

This field should be updated if the last name changes.

Example: Janet White marries and becomes Janet Black. Change the last name to Black and record White in the maiden name field.

FIRST NAME

Item Length: 14
Data Type: Alpha
Mixed Case
Required Data Set
Left Justified

Record the patient's full first name. Truncate names longer than 14 characters.

Example: Patient is admitted as Michael Hogan. Enter Hogan as the last name and Michael as the first name.

Leave blank if the first name is not known. If only a title is known, record the title under the data item "Name Prefix."

MIDDLE NAME
(MIDDLE INITIAL)

Item Length: 14
Data Type: Alpha
Mixed Case
Required Data Set
Left Justified
Blank Fill

Record the patient's middle name. Leave blank if the patient does not have a middle name or initial or if the middle name or initial are unknown.

This field has been expanded to accommodate a patient's full middle name. This will help distinguish between patients with identical names.

MAIDEN NAME

Item Length: 15
Data Type: Alpha
Mixed Case
Supplementary Data Set
Left Justified
Blank Fill

Record the maiden name of female patients who are married or who have been married. This item is useful for matching multiple records on the same patient.

Leave this field blank if the patient does not have a maiden name or information is not available. This item is different than alias.

If the patient has a hyphenated name, you may put the name that precedes the hyphen in the field "maiden name."

Example: The last name is Green-Moss. You may record Green under maiden name.

ALIAS

Item Length: 15
Data Type: Alpha
Supplementary Data Set
Left Justified
Blank Fill

A patient may use a different name or nickname. These different names are aliases. Leave the field blank if the patient does not have an alias or if an alias is not known. This item is useful for matching multiple records on the same patient.

If the patient uses an alias for a first name only, record the last name followed by a blank space and the first name alias.

Example: Ralph Williams uses the name Bud Williams. Record Williams Bud in the alias field.

If the patient uses only a last name alias, record the last name alias followed by a blank space and the real first name.

Example: Janice Smith uses the name Janice Brown. Record Brown Janice.

If the patient uses an alias for the first and last name, record the last name alias followed by a blank space and the first name alias.

Example: Samuel Clemens uses the name Mark Twain. Record Twain Mark in the alias field.

MARITAL STATUS AT DIAGNOSIS
(MARITAL STATUS AT INITIAL DIAGNOSIS)

Item Length: 1
Data Type: Numeric
Allowable Values: 1-5, 9
Optional Data Set

Code the patient's marital status at diagnosis for each primary tumor. The data may be corrected, but never change or update this data item.

Codes:

1 Single (never married)

2 Married (including common law)

3 Separated

4 Divorced

5 Widowed

9 Unknown

Note: If a patient is younger than 15 years of age, assume he/she is single and code 1.

PATIENT ADDRESS

USE THE GUIDELINES ON THIS PAGE FOR ALL PATIENT ADDRESS DATA ITEMS.

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.

For analytic cases (classes 0, 1, 2, and 6), the address would be the patient's home at the time he/she was diagnosed with cancer.

The address for nonanalytic cases (classes 3, 4, 5) is the patient's place of residence at the time he/she was seen at the reporting institution for this primary.

Rules for Persons without Apparent 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 they were staying when the cancer was diagnosed. This could be a shelter or the diagnosing institution.

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

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 Administration (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 family. Military personnel may use the installation address or the surrounding community's address.

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

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

Item Length: 25
Data Type: Alphanumeric
Required Data Set
Left Justified

Record the number and street address of the patient's usual residence when the tumor was diagnosed and treated. Leave a blank between numbers and words if space permits. Do not use punctuation. The use of capital letters is preferred by the US Postal Service; it also guarantees consistent results in queries and reporting. Abbreviate where necessary. If the patient has multiple tumors, the address may be different for subsequent primaries. If the patient address is not known, record UNKNOWN.

Example: The address 103 First Avenue S.W., Apartment #102 may be recorded as 103 FIRST AVE SW APT 102

The address is a 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. Do not update this field if the patient's address changes over time. See "Patient Address" for detailed residency rules.

CITY/TOWN AT DIAGNOSIS
(CITY OR TOWN)

Item Length: 20
Data Type: Alpha
Required Data Set
Left Justified

Record the city or town of the patient's usual residence when the tumor was diagnosed and treated. If patient resides in a rural area, record the name of the city or town used in his or her mailing address. Do not use punctuation or special characters. The use of capital letters is preferred by the US Postal Service. It also guarantees consistent results in queries and reporting. Abbreviate when necessary. If the patient has multiple tumors, the address may be different for each primary. If the city is not known, record UNKNOWN.

The address is a 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. Do not update this field. Changing this field would destroy its usefulness. See "Patient Address" for detailed residency rules.

STATE AT DIAGNOSIS
(STATE)

Item Length: 2
Data Type: Alpha
Upper Case
Required Data Set

Record the US postal service abbreviation for the state or Canadian province of the patient's usual residence when the tumor was diagnosed and treated. If the patient has multiple tumors, the address may be different for subsequent primaries. If the patient is a resident of a country other than Canada or the United States, record XX. If it is known that the patient is not a resident of Canada or the United States, and the country of residence is unknown, code YY.

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

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

STATE AT DIAGNOSIS **(Continued)**

The following are abbreviations for Canadian provinces:

PROVINCE		**PROVINCE**	
Alberta	AB	Nova Scotia	NS
British Columbia	BC	Ontario	ON
Labrador	LB	Prince Edward Island	PE
Manitoba	MB	Quebec	PQ
New Brunswick	NB	Saskatchewan	SK
Newfoundland	NF	Yukon	YT
Northwest Territories	NT		

The address is a 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. Do not update this field. Changing this field would destroy its usefulness. The data field "County at Diagnosis" is not useful for foreign residents. The registry identifies a foreign resident by entering XX into the "State at Diagnosis" field. The data field "County at Diagnosis" then becomes "Country at Diagnosis." A Geocode will appear and the country code may be entered to identify the residence. See "Patient Address" for detailed residency rules.

POSTAL CODE AT DIAGNOSIS
(ZIP CODE)

Item Length: 9
Data Type: Alphanumeric
Required Data Set
Left Justified

For US residents, record the patient's nine-digit extended postal code at the time of diagnosis and treatment for this primary. When the nine-digit extended code is unavailable, record the five-digit postal code, left justified, followed by blanks. For Canadian residents, record the six-character postal code. Do not record hyphens. If the patient has multiple tumors, the postal code may be different for subsequent primaries. When available, record the postal code for other countries. Record 8's when the postal code is not known.

Example: The extended postal code 60611-2797 is recorded as 606112797. When only five digits, 60611, are available, record 60611 _ _ _ _ .

Codes:

888888888 Permanent address in a country other than Canada, United States, or US possessions **and** postal code is unknown.

999999999 Permanent address in Canada, United States, or US possession **and** postal code is unknown.

The address is a 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. Do not update this field. Changing this field would destroy its usefulness. See "Patient Address" for detailed residency rules.

COUNTY AT DIAGNOSIS
(COUNTY)

Item Length: 3
Data Type: Numeric
Required Data Set

Record the county of the patient's usual residence when the tumor was diagnosed. This data item is required for residents of the reporting institution's state only. If the patient has multiple tumors, the county may be different for subsequent primaries.

A list of counties and their codes is usually available from central registries or state health departments. If not available, use the codes issued by the Bureau of Standards in the Federal Information Processing Standards (FIPS). The FIPS list of county codes is available in the publication *Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas*. This publication may be available in a reference library.

Codes:

998 Patient resides outside of the state of the reporting institution

999 Unknown county/country

When the registry records an XX code in the field "State at Diagnosis," it prompts the Geocode to appear in the "County at Diagnosis" field. Enter the Geocode to identify the country in which the patient resides. If the country of residence is unknown, code 999. See "Patient Address" for detailed residency rules.

PATIENT ADDRESS (NUMBER AND STREET) - CURRENT

Item Length: 25
Data Type: Alphanumeric
Required Data Set
Left Justified

Record the number and street address of the patient's usual residence. Leave a blank between numbers and words if space permits. Do not use punctuation. The use of capital letters is preferred by the US Postal Service; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.

Example: The address 103 First Avenue S. W., Apartment #102 may be recorded as 103 FIRST AVE SW APT 102

This item is different from "Patient Address at Diagnosis." It provides a current address for follow-up purposes and should be updated. See "Patient Address" for detailed residency rules.

CITY/TOWN - CURRENT

Item Length: 20
Data Type: Alpha
Required Data Set
Left Justified

Record the city or town of the patient's usual residence. If the patient resides in a rural area, record the name of the city or town used in his or her mailing address. Do not use punctuation or special characters. The use of capital letters is preferred by the US Postal Service; it also guarantees consistent results in queries and reporting. Abbreviate when necessary.

This item is different from "City/Town at Diagnosis." It provides a current city/town for follow-up purposes and should be updated. See "Patient Address" for detailed residency rules.

STATE - CURRENT

Item Length: 2
Data Type: Alpha
Required Data Set
Upper Case

Record the US Postal Service abbreviation for the state or the Canadian province of the patient's usual residence. If the patient is a resident of a country other than Canada or the United States, record XX. If you know the patient is not a resident of Canada or the United States and the country of residence is unknown, code YY.

Common abbreviations:

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

STATE - CURRENT **(Continued)**

The registry identifies a foreign resident by entering XX into the "State-Current" field. The data field "County-Current" then becomes "Country-Current." A Geocode will appear and the country code may be entered to identify the residence. See "Patient Address" for detailed residency rules.

The following are abbreviations for Canadian provinces.

PROVINCE		**PROVINCE**	
Alberta	AB	Nova Scotia	NS
British Columbia	BC	Ontario	ON
Labrador	LB	Prince Edward Island	PE
Manitoba	MB	Quebec	PQ
New Brunswick	NB	Saskatchewan	SK
Newfoundland	NF	Yukon	YT
Northwest Territories	NT		

This item is different from "State at Diagnosis." It provides a current state for follow-up purposes and should be updated.

POSTAL CODE - CURRENT

Item Length: 9
Data Type: Alphanumeric
Required Data Set
Left Justified

Record the US Postal Service nine-digit extended postal code for the city and state of the patient's residence. When the nine-digit extended code is unavailable, record the five-digit postal code, left justified, followed by blanks. Do not record hyphens. When available, record the postal code for other countries. Record 8s, when the postal code is not known.

Example: The extended postal code 60611-2797 is recorded as 606112797. When only five digits, 60611, are available, record 60611 _ _ _ _ .

This item is different from "Postal Code at Diagnosis." It provides a current postal code for follow-up purposes and should be updated.

Codes:

888888888 Permanent address in a country other than Canada, United States, or US possessions and postal code is unknown.

999999999 Permanent address in Canada, United States, or US possession and postal code is unknown.

See "Patient Address" for detailed residency rules.

COUNTY - CURRENT

Item Length: 3
Data Type: Numeric
Optional Data Set

Record the county of the patient's usual residence.

A list of counties and their codes is usually available from central registries or state health departments. If not available, use the codes issued by the Bureau of Standards in the Federal Information Processing Standards (FIPS). The FIPS list of county codes is available in the publication *Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas.* This publication may be available in a reference library.

This item is different from "County at Diagnosis." It provides a current county that may be helpful in providing marketing information for administrative use and should be updated.

"County-Current" may be used in administrative reports to define your referral area. It may be used by marketing and in epidemiologic studies.

See "Patient Address" for detailed residency rules.

When the registry records a 99 code in the field "State-Current," it prompts Geocodes to appear in the "County-Current" field. Enter the Geocode to identify the country in which the patient resides. If the country of residence is unknown, code 999.

CENSUS TRACT

Item Length: 6
Data Type: Numeric
Optional Data Set
Zero Fill

"Census Tract" identifies the patient's usual residence at the time the tumor was diagnosed. The central registry usually codes this item and reports it to the institution's registry. Collection may be required by central registries.

A census tract is a small statistical subdivision of a county. Census tract codes originate from the Bureau of the Census and are constructed using the patient's address. Codes are available from state health departments or the Bureau of the Census. Census tracts change as the population changes.

To code census tract, assume that the decimal point is between the fourth and fifth positions of the field. Add zeros to fill all six positions.

Example: Census tract 409.6 would be coded 040960, and census tract 516.21 would be coded 051621.

Codes:

000000 Area is not census tracted

999999 Area is census tracted, but census tract is not available

CENSUS CODING SYSTEM
(CODING SYSTEM FOR CENSUS TRACT)

Item Length: 1
Data Type: Numeric
Values 0-3
Optional Data Set

The "Census Coding System" identifies which set of Census Bureau definitions was used to code the record. The Census Bureau periodically changes the census tract boundaries. This is usually coded by, and may be required by, central registries.

Codes:

0 Not census tracted

1 1970 census tract definitions

2 1980 census tract definitions

3 1990 census tract definitions

TELEPHONE

Item Length: 10
Data Type: Numeric
Required Data Set

The first three digits of the telephone number are the area code. The last seven digits are the telephone number. Record the area code even if the patient is a local resident.

Do not use dashes or slashes, or leave spaces.

If the patient does not have a telephone, code 0000000000.

If telephone number is unavailable or unknown, code 9999999999.

PLACE OF BIRTH

Item Length: 3
Data Type: Numeric
Optional Data Set

Record the patient's place of birth using the SEER Geocodes for Place of Birth in Appendix C. These codes include states of the United States as well as foreign countries. Use the most specific code possible.

At the time SEER assigned Geocodes in the 1970s, the United States owned or controlled islands in the Pacific. Many of these islands are now independent. Some are controlled by countries other than the United States. The original codes are used for these islands to preserve historic information. The names have been annotated to show the new political designation. The alphabetic list displays the correct code.

Codes:

998 Place of birth outside of the United States, Geocode unknown

999 Place of birth unknown

DATE OF BIRTH

Item Length: 8
Data Type: Numeric
Required Data Set

Record the patient's date of birth in month, day, year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. Do not create alternate codes.

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	..	
08 August	31	
09 September	99 Day unknown	
10 October		
11 November		
12 December		
99 Month unknown		

Example: June 30, 1906 would be recorded 06301906.

Estimate date of birth when information is not available. It is better to estimate than to code as an unknown value.

Examples: The patient is 60 years old on June 15, 1996. The medical record does not have a birth date. Record unknown month (99) and day (99). Estimate the year as 1936 (99991936).

Record the patient's date of birth as 99991927 when the medical record contains only the year of birth (1927).

AGE AT DIAGNOSIS

Item Length: 3
Data Type: Numeric
Supplementary Data Set
Right Justified
Zero Fill

"Age at Diagnosis" is the patient's age at his or her last birthday before diagnosis.

000	Less than one year old
001	One year old, but less than two years old
002	Two years old
...	(Actual age in years)
101	One hundred one years old
...	
120	One hundred twenty years old
...	
999	Unknown age

RACE

Item Length: 2
Data Type: Numeric
Allowable Values: 01-14, 20-22, 25-28, 30-32, 96-99
Required Data Set

"Race" is analyzed with the data item Spanish/Hispanic origin. Both items must be recorded.

Codes:

01 White	21	Chamorran
02 Black	22	Guamanian, NOS
03 American Indian, Aleutian, 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		
12 Hmong	97	Pacific Islander, NOS
13 Kampuchean (Cambodian)	98	Other
14 Thai	99	Unknown
20 Micronesian, NOS		

- White includes Mexican, Puerto Rican, Cuban, and all other Caucasians.
- Black includes the designations Negro or Afro-American.
- A combination of white and any other race is coded to the other race.
- A mixture of Hawaiian and any other race is coded Hawaiian (07).
- A combination of nonwhite races is coded to the first nonwhite race documented.
- Race is based on birthplace information when place of birth is given as China, Japan, or the Philippines, and race is reported only as Asian, Oriental, or Mongolian.

Example: Code race 05 (Japanese) if the patient is reported as Oriental and the place of birth is Japan.

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses and code 14 for 1994 and later cases.

SPANISH ORIGIN—ALL SOURCES
(SPANISH/HISPANIC ORIGIN)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-7, 9
Required Data Set

Code the Spanish/Hispanic origin. This item identifies persons of Spanish/Hispanic surname or ethnicity. A person of Spanish/Hispanic origin may be any race.

Codes:

0 Non-Spanish; non-Hispanic

1 Mexican (includes Chicano)

2 Puerto Rican

3 Cuban

4 South or Central American (except Brazil)

5 Other specified Spanish/Hispanic origin (includes European)

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

Code Portuguese and Brazilians as non-Spanish (0)

SEX

Item Length: 1
Data Type: Numeric
Allowable Values: 1-4, 9
Required Data Set

Code the patient's sex.

Codes:

1 Male
2 Female
3 Other (hermaphrodite)
4 Transsexual
9 Not stated

FOLLOWING PHYSICIAN
(FOLLOW-UP PHYSICIAN)

Item Length: 8
Data Type: Alphanumeric
Required Data Set
Left Justified

The "Following Physician" is the person currently responsible for the patient's medical care. Follow-up letters will be directed to this physician. The registry assigns a unique number to the follow-up physician. The identification number may include numbers and letters. Many registries use the physician's state medical license number.

Change this data item when follow-up becomes the responsibility of another physician.

Code 99999999 when the following physician is unknown or when an identification number is not assigned.

MANAGING PHYSICIAN
(ATTENDING PHYSICIAN)

Item Length: 8
Data Type: Alphanumeric
Supplementary Data Set
Left Justified

"Managing Physician" is the person responsible for the overall management of the patient during diagnosis and/or treatment for this primary. The registry assigns a unique number to the physician. The identification number may include numbers and letters. Many registries use the physician's state medical license number.

The information should not be changed or updated even if the patient receives care from another physician. Administrative, physician, and service referral reports are based on this item.

Code 99999999 when the managing physician is unknown or when an identification number is not assigned.

PRIMARY SURGEON

Item Length: 8
Data Type: Alphanumeric
Required Data Set
Left Justified

Use this data item to identify the surgeon who performed the most definitive surgical procedure.

The registry assigns a unique number to the primary surgeon. The identification number may include numbers and letters. Many registries use the physician's state medical license number.

If the patient did not have cancer-directed surgery, code the surgeon who performed any non cancer-directed surgery or did a surgical consultation.

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

Code 00000000 if the patient had no surgery (non cancer-directed or cancer-directed) and no surgical consultation.

Code 88888888 if the physician who performed a surgical procedure was not a surgeon (radiation oncologist, general practitioner, and so on).

Code 99999999 when the primary surgeon is unknown or when an identification number is not assigned.

PHYSICIAN #3
(OTHER PHYSICIAN)

Item Length: 8
Data Type: Alphanumeric
Supplementary Data Set
Left Justified

This data item identifies another physician involved in the care of the patient. The registry assigns a unique number to the physician. The identification number may include numbers and letters. Many registries use the physician's state medical license number.

Hospitals may elect to limit the use of this field to record radiation oncologists for internal analysis. The data will not be valid for comparison because the use will vary from institution to institution.

Physician name may be used for in-house quality control, follow-up, administrative planning, and/or facility/personnel planning. It is also useful for follow-up.

Code 00000000 (none) if no other physician was involved in the patient's care.

Code 99999999 when the physician is unknown or when an identification number is not assigned.

PHYSICIAN #4
(OTHER PHYSICIAN)

Item Length: 8
Data Type: Alphanumeric
Supplementary Data Set
Left Justified

This data item identifies another physician involved in the care of the patient. The registry assigns a unique number to the physician. The identification number may include numbers and letters. Many registries use the physician's state medical license number.

Hospitals may elect to limit the use of this field to record medical oncologists for internal analysis. The data will not be valid for comparison because the use will vary from institution to institution.

Physician name may be used for in-house quality control, follow-up, administrative planning, and/or facility/personnel planning.

Code 00000000 (none) if no other physician is involved in the patient's care.

Code 99999999 when the physician is unknown or when an identification number is not assigned.

PRIMARY PAYER AT DIAGNOSIS

Item Length: 2
Data Type: Numeric
Allowable Values: 00-02, 10, 20-22
30-32, 40-47, 88, 99
Required Data Set

Code the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment. This item is used in financial analysis and as an indicator for quality and outcome analyses.

Do not update this item.

Codes:

00 Not insured, NOS
01 Not insured, charity write-off
02 Not insured, self-pay
10 Private insurance
20 Managed care provider, NOS
21 Health Maintenance Organization (HMO)
22 Preferred Provider Organization (PPO)
30 State funded, NOS
31 Medicaid
32 Welfare
40 Federally funded, NOS
41 Medicare
42 Medicare with supplement
43 Champus
44 Military
45 Veterans Administration
46 Indian Health Service
47 Public Health Service
88 Insured, NOS
99 Unknown

PRIMARY PAYER AT DIAGNOSIS **(Continued)**

Clarification of code definitions:

CODES	DEFINITIONS
00	Patient has no insurance. Unknown if account paid by patient or if it was a charity write-off.
01	Charity or write-off cases. The patient has no insurance and does not have personal funds to pay the account.
02	The patient has no insurance but assumes personal responsibility to pay the account.
10	Insurance carried by the patient or patient's family other than those listed in codes 20-47.
20	Patient has insurance with a managed care provider; unknown what type (HMO, PPO, etc.)
21	An organization that provides, offers, or arranges comprehensive health care services to a voluntarily enrolled membership for a prepaid fee.
22	A group of participating providers who have agreed to furnish services to covered persons at negotiated fees.
30	The medical care was paid from special state funds available to cover medical care for certain diseases or groups of people.
	Account paid by state funds, unknown what type.
31	State-funded medical insurance for persons who are uninsured, below poverty level, covered under entitlement programs, etc.
32	Some states have both medicaid and welfare programs.
40	Patient's account was paid by a federally funded agency; unknown which agency.
41	Government insurance for persons who are retired or disabled.
42	Patient has Medicare and another insurance to pay costs not covered by Medicare.
43	Military personnel or their dependents who procured a certificate of nonavailability and opted to seek medical attention at a nonmilitary facility.
44	Military personnel or their dependents who are treated in a military facility.
45	Veterans who are treated in Veterans Administration facilities.
46	Patient received care at an Indian Health Service facility or received care at another facility and medical costs were reimbursed by the Indian Health Service.
47	Patient received care at a public health service facility or received care at another facility and medical costs were reimbursed by the Public Health Service.
88	The patient is insured, but the insurance type is unknown.
99	It is unknown if the patient is insured.

USUAL OCCUPATION

Item Length: 40
Data Type: Free Text
Upper and Lower Case
Optional Data Set

The data item "Usual Occupation" is defined identically as on death certificates and conforms to the 1989 revision of the US Standard Certificate of Death. See also: *Guidelines for Reporting Occupation and Industry on Death Certificates,* National Center for Health Statistics, CDC. DHHS Pub. No. (PHS) 88-1149.

Record the patient's usual occupation (that is, the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do *not* record "retired."

If *usual* occupation is not available or is unknown, record the patient's current or most recent occupation or any known occupation.

Update this field if better information is obtained as to the usual occupation of the patient. However, it is NOT the responsibility of facility registrars to update abstracts with information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

If the patient was a housewife/househusband and also worked outside the home most of her/his adult life, record the usual occupation outside the home. If the patient was a housewife/husehusband and did NOT work outside the home for most of her/his adult life, record "housewife" or "husehusband."

If the patient was not a student or housewife and never worked, record "never worked" as the usual occupation.

If no information is available, record "unknown."

This data item applies only to patients who are 14 years or older at the time of diagnosis.

USUAL INDUSTRY

Item Length: 40
Data Type: Free Text
Upper and Lower Case
Optional Data Set

Both occupation and business/industry are required to accurately describe an individual's occupation.

The data item "Usual Industry" (AKA "kind of business/industry") is defined identically as on death certificates and conforms to the 1989 revision of the US Standard Certificate of Death. See also: *Guidelines for Reporting Occupation and Industry on Death Certificates*, National Center for Health Statistics, CDC. DHHS Pub. No. (PHS) 88-1149.

Record the primary type of activity carried on by the business/industry where the patient was employed for the most number of years before diagnosis of this tumor.

Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components.

If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient to record the name of the company (with city or town) for which the patient performed his/her usual occupation. In these situations, if resources permit, a central or regional registry may be able to use the employer name and city/town to determine the type of activity conducted at that location.

If current or most recent occupation, rather than usual occupation was recorded, record the patient's current or most recent business/industry.

Update this field if better information is obtained as to the usual industry of the patient. However, it is NOT the responsibility of facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

There should be an entry for "usual industry" if any occupation is reported. If no information is available regarding the industry in which the reported occupation was carried out, record "unknown."

This data item applies only to patients who are 14 years or older at the time of diagnosis.

FAMILY HISTORY OF CANCER

Item Length: 1
Data Type: Numeric
Allowable Values: 0, 1, 9
Optional Data Set

Code whether the patient has a family history of any reportable malignancy.

Codes:

0 No

1 Yes

9 Unknown

TOBACCO HISTORY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 9
Optional Data Set

Code the patient's past or current use of tobacco.

Codes:

0 Never used
1 Cigarette smoker, current
2 Cigar/pipe smoker, current
3 Snuff/chew/smokeless, current
4 Combination use, current
5 Previous use
9 Unknown

ALCOHOL HISTORY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 9
Optional Data Set

Code the patient's past or current consumption of alcoholic beverages including wine or beer.

Codes:

0 No history of alcohol use

1 Current use of alcohol

2 Past history of alcohol use, does not currently use

9 Alcohol usage unknown

TYPE OF REPORTING SOURCE

Item Length: 1
Data Type: Numeric
Allowable Values: 1, 3-7
Optional Data Set

Code the source of documents used to abstract the cancer being reported. This item is used by central registries.

Codes:

1 Hospital inpatient, hospital outpatient, clinic

3 Laboratory only (hospital or private)

4 Physician office/private medical practitioner

5 Nursing home, convalescent home, convalescent hospital, hospice

6 Autopsy only

7 Death certificate only

ABSTRACTED BY

Item Length: 3
Data Type: Alphanumeric
Required Data Set

Enter the initials or assigned code of the individual who abstracted this case. Do not code the data entry person UNLESS that person is also the abstractor. This item is most useful for multistaffed registries and can be used for quality control and management.

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CANCER IDENTIFICATION

CLASS OF CASE

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 8, 9
Required Data Set

"Class of Case" divides the data into analytic and nonanalytic categories.

Codes:

0 First diagnosed at the reporting institution since the registry's reference date and all of the first course of therapy elsewhere

1 First diagnosed and all or part of the first course of therapy at the reporting institution

2 First diagnosed elsewhere and treatment plan developed and documented and/or the first course of therapy given at the reporting institution after the registry's reference date

3 First diagnosed and all of the first course of therapy elsewhere

4 First diagnosed and first course of therapy at the reporting institution before the reference date of the registry

5 First diagnosed at autopsy

6 Diagnosed and all of the first course of treatment only in a staff physician's office

8 Diagnosis established only by death certificate

9 Unknown

Analytic cases (0, 1, 2, and 6) are:

- Patients diagnosed at the reporting institution since the registry's reference date regardless of whether or not the patient was treated at the reporting facility.
- Patients who received all or part of their first course of treatment at the reporting institution since the registry's reference date.
- Patients diagnosed prior to the registry's reference date whose first course of treatment continues at the reporting institution after the reference date.
- Patients diagnosed and treated only in a staff physician's office.

Note: These cases are included in treatment and survival statistics.

Non-analytic cases (3, 4, 5, 8, and 9) are:

- Patients diagnosed and received all of their first course of treatment at another institution.
- Patients diagnosed and/or received all or part of the first course of treatment at the reporting institution before the registry's reference date.
- Patients diagnosed at autopsy.
- Diagnoses based on death certificates only.

Note: These cases are not usually included in routine treatment or survival statistics.

CLASS OF CASE **(Continued)**

Class 0 cases are diagnosed at the reporting institution and are treated elsewhere. Cases include:

- Patients who choose to be treated elsewhere.
- Patients who are referred elsewhere for treatment.

Examples: Lack of special equipment; proximity of a patient's residence to the treatment center; financial, social, or rehabilitative considerations.

Class 1 cases are diagnosed at the reporting institution. They also fulfill one of the following treatment situations:

- Patient received all or part of his or her first course of treatment at the reporting institution.
- Patient refused any therapy.
- Patient was untreatable because of age, advanced disease, or other medical conditions.
- Specific therapy was recommended but not received at the reporting institution and it is unknown if therapy was ever administered.
- It is unknown if therapy was recommended or administered.
- Patient diagnosed at the reporting institution prior to the registry's reference date, all or part of first course of treatment received at the reporting institution after the registry's reference date.
- Patient first diagnosed and had staging workup at the reporting institution and all or part of the first course of treatment was received in a staff physician's office.
- Patient diagnosed in a staff physician's office and then treated at the reporting institution.
- Patient diagnosed and treatment plan developed and documented at the reporting institution. Therapy was delivered elsewhere in accordance with the treatment plan.

Class 2 cases are diagnosed elsewhere. They also fulfill one of the following treatment situations:

- The reporting institution administered part or all of the first course of treatment.
- The reporting institution developed and documented a treatment plan or made the management decisions.

Class 3 cases are patients who were diagnosed and received all of their first course of treatment elsewhere. They are then seen at the reporting institution for additional therapy or management, and have active disease. This class of case includes:

- No information is available on his or her first course of treatment, patient is now treated or managed at the reporting institution.
- The reporting institution is treating or managing the recurrence, progression, or subsequent treatment of a previously diagnosed malignancy.

Class 4 includes cases that were diagnosed and/or received their first course of treatment at the reporting institution BEFORE the registry's reference date. The reporting institution manages or treats a recurrence or progression of that cancer AFTER the registry's reference date.

CLASS OF CASE **(Continued)**

- Assign a class of case 4 also if it is unknown whether the reporting institution delivered the first course of treatment.

Class 5 refers to an incidental finding of cancer at autopsy. There was no suspicion of cancer before the autopsy.

Class 6 includes patients who were both diagnosed and received all of their first course of treatment in a staff physician's office.[12]

Class 8 should be used only by a central registry and includes:

- Diagnoses based on death certificates only.

Class 9 should be used only by a central registry and includes:

- Unknown if previously diagnosed.
- Unknown if previously treated.
- Previously diagnosed, date unknown.

[12]The requirement extends to those physicians who are members of the institution's medical staff. If a physician holds multiple staff appointments, the physician must assign reporting responsibility to one of the institutions.

INSTITUTION REFERRED FROM

Item Length: 6
Data Type: Numeric
Supplementary Data Set
Right Justified

"Institution Referred From" identifies the facility that referred the patient to the reporting institution. Each institution's identification number is unique.

Institutions should use the ID number assigned by the Cancer Department of the Commission on Cancer of the American College of Surgeons.

Record only the last six digits. Over time some institutions may have been assigned a number that is preceded by an "H" and "6." These two characters should not be recorded. Right justify the six-digit number.

Example: H6439999, General Hospital, Anytown, Illinois, would be recorded 439999.

Code 000000 if the patient was not referred to the reporting institution from another institution

Code 999999 if the patient was referred but the referring institution's ID number is unknown.

If you need a single hospital ID number, call the Cancer Department of the American College of Surgeons. A list of Hospital ID numbers for your state or region is available on disk or hard copy from the Cancer Department of the American College of Surgeons (see Appendix E).

INSTITUTION REFERRED TO

Item Length: 6
Data Type: Numeric
Supplementary Data Set
Right Justified

"Institution Referred To" identifies the institution to which the patient was referred for further care after discharge from the reporting institution. Each institution's identification number is unique.

Institutions should use the ID number assigned by the Cancer Department of the Commission on Cancer of the American College of Surgeons.

Record only the last six digits. Over time some institutions may have been assigned a number that is preceded by an "H" and "6." These two characters should not be recorded. Right justify the six-digit number.

Example: H6439999, General Hospital, Anytown, Illinois, would be recorded 439999.

Code 000000 if the patient was not referred to another institution

Code 999999 if the patient was referred but the institution's ID number is unknown.

If you need a single hospital ID number, call the Cancer Department of the American College of Surgeons. A list of Hospital ID numbers for your state or region is available on disk or hard copy from the Cancer Department of the American College of Surgeons (see Appendix E).

DATE OF INPATIENT ADMISSION

Item Length: 8
Data Type: Numeric
Supplementary Data Set

Record the date of the inpatient admission to the facility for the most definitive surgery. If the patient does not have surgery, use the inpatient admission date for any other cancer-directed therapy. If the patient has no cancer-directed therapy, use the date of inpatient admission for diagnostic evaluation.

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		

Example: Record June 30, 1996 as 06301996.

Code 9 for unknowns:

- Code 99 for unknown month
- Code 99 for unknown day
- Code 9999 for unknown year

If the patient was never an inpatient, code as 00000000.

DATE OF INPATIENT DISCHARGE

Item Length: 8
Data Type: Numeric
Supplementary Data Set

Record the date of the inpatient discharge from the facility for the most definitive surgery. If the patient did not have surgery, use the inpatient discharge date for any other cancer-directed therapy. If the patient has no cancer-directed therapy, use the date of inpatient discharge for diagnostic evaluation.

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		

Example: Record June 30, 1996 as 06301996.

Code 9 for unknowns:

- Code 99 for unknown month
- Code 99 for unknown day
- Code 9999 for unknown year

If the patient was never an inpatient, code as 00000000.

INPATIENT/OUTPATIENT STATUS

Item Length: 1
Data Type: Numeric
Allowable Values: 1-3, 8, 9
Optional Data Set

"Inpatient/Outpatient Status" allows the facility to identify points of access used to initially diagnose and/or treat the patient.

Code the access point from which the patient first entered the hospital system for either the initial diagnosis or treatment. If the patient was initially diagnosed or treated (all first course) before entering the reporting facility, code 8 (other).

Codes:

1 Inpatient only

2 Outpatient only

3 In and outpatient*

8 Other, including physician's office

9 Unknown

* This applies to patients who entered the institution as an outpatient and were admitted as an inpatient on the same day.

SCREENING DATE **Item Length: 8**
Data Type: Numeric
Optional Data Set

Record the most recent date on which the patient participated in a screening program related to this primary cancer.

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		

Example: Record June 30, 1996 as 06301996.

Code 9 for unknowns:

- Code 99 for unknown month
- Code 99 for unknown day
- Code 9999 for unknown year

If the patient did not participate in a screening program related to this primary, code as 00000000.

SCREENING RESULT

Item Length: 1
Data Type: Numeric
Allowable Values: 0-4, 8, 9
Optional Data Set

This item categorizes findings from the most recent screening(s), serves as a triage for patient notification, and acts as a tickler file to aid the institution in meeting patient notification requirements.

Codes:

0 Within normal limits

1 Abnormal/not suggestive of cancer

2 Abnormal/suggestive of cancer

3 Equivocal/no follow-up necessary

4 Equivocal/evaluation recommended

8 Not applicable

9 Unknown result, not specified

DATE OF INITIAL DIAGNOSIS

Item Length: 8
Data Type: Numeric
Required Data Set

"Date of Initial Diagnosis" is the month, day, and year (MMDDCCYY) that this primary cancer was first diagnosed by a recognized medical practitioner.

The first two digits record the month, the third and fourth digits record the day, and the last four digits record the year of diagnosis.

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		

Example: Record June 30, 1996 as 06301996.

Code 9 for unknowns:

- Code 99 for unknown month
- Code 99 for unknown day
- Code 9999 for unknown year

The first diagnosis is often clinical and may never be histologically confirmed. Do not change the date of diagnosis when a later biopsy or cytology provides confirmation of a clinical diagnosis.

Examples: A March 12, 1996 mammogram reveals a mass in the upper-outer quadrant of a patient's right breast compatible with carcinoma. On March 20, 1996, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Date of diagnosis is 03121996.

A physician notes a prostate nodule that is suspicious for cancer during a May 12, 1996 physical examination. On June 15, 1996 an ultrasound guided needle biopsy of the prostate provides histologic confirmation of adenocarcinoma. Date of diagnosis is 05121996.

DATE OF INITIAL DIAGNOSIS **(Continued)**

If the physician states, that in retrospect, the patient had cancer at an earlier date, use the earlier date as the date of diagnosis.

Example: A patient has a total abdominal hysterectomy for endometriosis in January 1995. The patient is admitted to the hospital with abdominal pain and distention in November 1996. A laparoscopy with omental biopsy shows metastatic cystadenocarcinoma. Pathologists review the 1995 hysterectomy specimen. They identify an area of cystadenocarcinoma in the left ovary. Date of diagnosis is 01991995.

The date of death is the date of diagnosis for a class of case 5.

Estimate the date of diagnosis if you do not know the exact date. Approximation is preferable to recording the date as unknown.

Example: If the patient is diagnosed elsewhere before entering the reporting institution and the date of diagnosis is unknown, record the date the patient was first seen at the reporting institution as the date of diagnosis.

Use the date therapy was started as the date of diagnosis if the patient receives cancer-directed treatment before a definitive diagnosis.

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

PRIMARY SITE

Item Length: 4
Data Type: Alphanumeric
Allowable Values: "C" followed by three digits
Required Data Set

Record the ICD-O-2 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-2 Topography, Numerical List section (pages 1-20) and in the Alphabetic Index (pages 51-136). Follow the ICD-O-2 coding rules outlined on pages xx - xxiii.

The topography codes are indicated by a C preceding the three-digit code number. Do not record the decimal point.

Example: Breast, upper-outer quadrant appears in the ICD-O-2 as C50.4 and is recorded C504.

Use the subcategory 8 for single tumors that overlap the boundaries of two or more subsites and the point of origin is not known.

Examples: Code overlapping lesion (C10.8) 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.

Code overlapping lesion of the bladder (C67.8) when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.

Use the subcategory 9 for multiple tumors that originate in one organ.

Example: Code bladder, NOS (C67.9) when multiple lesions arise in both the trigone (C67.0) and lateral wall (C67.2).

Code adenocarcinoma in multiple polyps as a single primary even if they involve more than one segment of the colon.

Example: 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 "General Coding Principles: Determining Multiple Primaries."

Code leukemias to bone marrow (C42.1).

Exceptions: Myeloid sarcoma and leukemic reticuloendotheliosis. See ICD-O-2 for coding rules.

Lymphoma

Most lymphomas arise in lymph nodes (C77.-), or lymphatic tissue, such as tonsils, spleen, Waldeyer's ring, or thymus. Lymphomas arising in lymphatic tissue are coded to the site of origin (tonsil C09.-, spleen C42.2, Waldeyer's ring C14.2, or thymus C37.9) but analyzed with the "nodal" group. "Extranodal" lymphomas arise from lymphatic cells in organs such as intestine or stomach. Extranodal lymphomas are coded to the organ of origin and are analyzed separately.

Example: A lymphoma of the stomach would be coded stomach (C16.-).

PRIMARY SITE **(Continued)**

Lymphoma may be present in both an extralymphatic organ and at least one lymph node chain. Carefully identify the origin of the tumor. Do not code the biopsy site or a metastatic site. Code the primary site as the extranodal organ or the lymph nodes as directed by the managing physician or physician advisor. Code to lymph nodes, NOS (C77.9) if the site of origin is not identified.

Code to lymph nodes, NOS (C77.9) when:

- A patient has diffuse lymphoma and a primary site is unknown or not specified.
- A mass is identified as "retroperitoneal," "inguinal," "mediastinal," or "mesentery" and no specific information is available to indicate what tissue is involved.
- Bone marrow metastases are present and the primary site is unknown or not specified.

Code to lymph nodes, multiple regions (C77.8) when multiple lymph node chains are involved with disease. Do NOT code a specific lymph node chain.

Code mycosis fungoides and cutaneous lymphomas to skin (C44.-).

Kaposi's Sarcoma

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

Melanomas

Each occurrence of melanoma of the skin is a new/separate primary UNLESS a physician says otherwise. If a patient is diagnosed with metastatic melanoma and the primary site is not identified, code to skin, NOS (C44.9).

LATERALITY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-4, 9
Required Data Set

Laterality refers to a side of the body. It applies to the primary site only. Do not code metastatic sites.

Codes:

0 Not a paired site

1 Right: origin of primary

2 Left: origin of primary

3 Only one side involved, right or left origin unspecified

4 Bilateral involvement, side of origin unknown, stated to be a single primary.

Including:

Both ovaries simultaneously involved with a single histology

Bilateral retinoblastomas

Bilateral Wilms' tumors

9 Paired site, but lateral origin unknown; midline tumor

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

Use code 1-9 for the following sites, except as noted. The listing includes major categories. Code laterality for all subheadings included in the ICD-O-2 under these headings, unless specifically excluded. Exclusions should be coded as "0."

ICD-O-2	SITE
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum code "0")
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1 - C34.9	Lung

LATERALITY **(Continued)**

ICD-O-2	SITE
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 code “0”)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis code “0”)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face (midline code “9”)
C44.5	Skin of trunk (midline code “9”)
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

HISTOLOGY

Item Length: 4
Data Type: Numeric
Required Data Set

Record the histology using the ICD-O-2 codes in the Morphology-Numeric section (pages 25-49) and in the Alphabetic Index (pages 51-136). The ICD-O-2 identifies the morphology codes with an M preceding the code number. Do not record the M. Follow the coding rules outlined on pages xxiv - xxxi of the ICD-O-2.

Review all pathology reports. Reports based on specimens from the definitive cancer-directed surgery are usually the most explicit.

Exception: When the biopsy removes all of the tumor.

Example: The pathology report from a skin biopsy identifies superficial malignant melanoma (8720/3). At wide excision, no residual tumor was found. Code the histology superficial malignant melanoma (8720/3) as reported in the biopsy.

Code the FINAL pathologic diagnosis.

Exception: At times the final diagnosis is "Not Otherwise Specified" (carcinoma, NOS, melanoma, NOS, sarcoma, NOS, lymphoma, NOS, or malignant tumor, NOS). Code the histology from the microscopic description or comment if it identifies a more specific histologic type (higher ICD-O-2 code) such as adenocarcinoma, amelanotic melanoma, spindle cell sarcoma.

Example: Final pathologic diagnosis is carcinoma, NOS (8010/3) of the prostate. Microscopic diagnosis specifies adenocarcinoma (8140/3) of the prostate. Record adenocarcinoma (8140/3).

Note: The codes for cancer, NOS (8000/3) and carcinoma, NOS (8010/3) are NOT interchangeable. If the physician says that the patient has carcinoma, code carcinoma, NOS (8010/3).

Lymphomas may be classified by the Rappaport classification or the Working Formulation. If both systems are used to classify the disease, the term used to describe the lymphoma may differ, and the Working Formulation term should take precedence.

Example: In the pathology report, the Working Formulation describes malignant lymphoma, diffuse, large cell, cleaved (9681/3). The Rappaport classification describes malignant lymphoma, diffuse, histiocytic (9680/3). Code 9681/3.

HISTOLOGY CODING RULES

Note: See Section Two for detailed instructions.

Same Histology

- Multiple terms may describe a single histology.
- If the first three digits of the ICD-O-2 morphology codes are identical, the histology is the same.
- Lesion(s) may have both invasive and in situ components. This is a single primary. Code the histology of the invasive component.

Note: This rule is also used when multiple lesions are present. One lesion may be invasive and another lesion in situ, or each of the lesions may have invasive and in situ components.

HISTOLOGY **(Continued)**

Mixed or Multiple Histologies

- A difference in the first three digits of the ICD-O-2 morphology code indicates a different histologic type.

  Exception: Lymphatic and hematopoietic disease. See Appendix B.
- A single lesion with mixed histologic types is one primary.
- 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-2 morphology code.

Single Primary

Same Histology

- A single lesion is one primary even if the lesion crosses site boundaries.
- Lesion(s) with the same histology that recur at the same site as an earlier malignancy would be:
  - The same primary tumor if diagnosed within two months.
  - A new primary tumor if diagnosed after two months, unless a physician says that it is recurrent or metastatic.

    Exceptions: The following are recurrences of the original disease without time limits.
    - Bladder primaries with morphology codes 8120-8130.
    - Kaposi's sarcoma (9140/3).

      Note: Report Kaposi's sarcoma as one primary. Refer to Cancer Identification and Primary Site for coding rules.
    - Basal or squamous cell cancers of the skin as described in Section One in the reportable list.

      Note: Each occurrence of melanoma of the skin is a new/separate primary UNLESS a physician states otherwise.
- Simultaneous multiple lesions with the same histologic type in the same site are a single primary. If one lesion has a behavior code of in situ (2) and the other a behavior code of malignant (3), this is still a single primary. The behavior is invasive (3).

HISTOLOGY **(Continued)**

Multiple Primaries

Same Histology

- Multiple lesions with the same histology occurring in different sites are individual primaries UNLESS a physician says they are metastatic.

Mixed or Multiple Histologies

- Multiple lesions with different histologies in a single site are separate primaries, whether they occur simultaneously or at different times.

  Exception: Within each breast, combinations of ductal and lobular carcinoma occurring within two months of each other are a single primary and the histology coded according to ICD-O-2.

- Multiple lesions with different histologies occurring in different sites are separate primaries, UNLESS a physician says otherwise.

Behavior is a separate data item.

BEHAVIOR CODE
(Separate From Histology)

Item Length: 1
Data Type: Numeric
Required Data Set

The fifth digit of the morphology code, which appears after the slash, is the behavior code.[13] The Commission requires the inclusion of tumors ending in a fifth digit behavior code of 2 or 3. Since tumor registries include only primary sites, behavior codes 6 and 9 are not used. The behavior code 6 identifies a metastatic site. If the only specimen is from a metastatic site, code the histology of the metastatic site and code a "3" for the behavior code.

Example: If the patient had a biopsy of the lung showing metastatic adenocarcinoma (8140/6), the primary site is unknown (C80.9). Code the histology as adenocarcinoma (8140/3).

The following terms are synonymous with in situ (behavior code 2):

- Adenocarcinoma in an adenomatous polyp with no invasion of stalk
- Bowen's disease
- Clark's level 1 for melanoma (limited to epithelium)
- Comedocarcinoma, noninfiltrating (C50.-)
- Confined to epithelium
- Hutchinson's 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's erythroplasia (C60.-)

Code behavior as malignant (3) if any invasion is present, no matter how limited.

Example: The pathology report reads "intraductal carcinoma (8500/2) with focal areas of invasion." Code to the invasive component, infiltrating ductal carcinoma (8500/3).

[13]*International Classification of Diseases for Oncology*, 1990 (ICD-O-2) p. xxiv.

GRADE/DIFFERENTIATION

Item Length: 1
Data Type: Numeric
Allowable Values: 1-7, 9
Required Data Set

The grade or differentiation of the tumor describes the tumor's resemblance to normal tissue. Well differentiated (grade I) is the most like normal tissue. The codes, as defined in the ICD-O-2, are as follows:

CODE	GRADE/CELL	DESCRIPTION
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
5	T cell	Lymphomas and leukemias, T cell
6	B cell	Lymphomas and leukemias, B cell, Pre B, B precursor
7	Null cell	Leukemias only, null cell, non T, non B
9	Grade/differentiation unknown	Grade/cell type not determined, not stated, or not applicable

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. Do not use "high grade," "low grade," or "intermediate grade" descriptions for lymphomas as a basis for differentiation. The terms are categories in the Working Formulation of lymphoma diagnoses and do not relate to the grade.

Code the grade or differentiation as stated in the FINAL pathologic diagnosis.

Example: Microscopic Description: Moderately differentiated squamous cell carcinoma with poorly differentiated areas.

Final Pathologic Diagnosis: Moderately differentiated squamous cell carcinoma.

Code: Moderately differentiated (2)

Exception: If the differentiation is <u>not</u> stated in the final pathologic diagnosis, use the information from the microscopic description or comments.

When the pathology report(s) list more than one grade of tumor, code to the highest grade (rule 6, page xxvii in ICD-O-2).

Examples: Code moderately to poorly differentiated carcinoma as poorly differentiated (3).

Code a combination of grades I and II carcinoma as moderately differentiated (2).

Code the grade for in situ lesions if the information is available.

GRADE/DIFFERENTIATION **(Continued)**

Note: It may be possible to establish the grade of a tumor through Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) when there is no tissue diagnosis. Brain tumors can be graded using these methods.

Table of Codes, Grades, and Terminology

When there is variation in the usual terms for degree of differentiation, use the following conversions:

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

Occasionally tumor grade is described as I/IV or 1/4 which means grade one in a four-grade system. Occasionally a three-grade system is used. If the grade is written II/III or 2/3, this is a grade 2 of a three-grade system.

DOCUMENTED	DOCUMENTED	USE ROADS CODE
I/III	1/3	2
II/III	2/3	3
III/III	3/3	4

Prostate

Both the tumor differentiation and Gleason's score and/or pattern may be given. Code the tumor grade/differentiation when it is available. Use the following conversion when the reports give only the Gleason's score (2-10) or Gleason's pattern (1-5):

CODE	SCORE	PATTERN	GRADING	
1	2, 3, 4	1, 2	I	Well differentiated
2	5, 6, 7	3	II	Moderately differentiated
3	8, 9, 10	4, 5	III	Poorly differentiated

GRADE/DIFFERENTIATION **(Continued)**

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

SITE	ICD-O-2
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 0, I only)	C61.9
Cerebral meninges	C70.0
Brain	C71.0 - C71.9
Thyroid (undifferentiated carcinoma only)	C73.9

DIAGNOSTIC CONFIRMATION

Item Length: 1
Data Type: Numeric
Allowable Values: 1, 2, 4-9
Required Data Set

Diagnostic confirmation shows whether a malignancy was confirmed microscopically at any time during the disease course. This is a priority coding scheme with code 1 taking precedence. A low number takes priority over all higher numbers.

This data item is dynamic and must be changed to the lower code if a more definitive method confirms the diagnosis at any time during the course of the disease.

Example: A chest x-ray dated 12/1/93 diagnoses a probable lung cancer. The patient refuses a diagnostic workup. The registry codes the diagnostic confirmation to radiography (7). The patient allows a lymph node biopsy on 2/3/94. The biopsy confirms small cell carcinoma. Change the diagnostic confirmation code to positive histology (1).

Codes:

Microscopically Confirmed

1 Positive histology

2 Positive cytology, no positive histology

4 Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

5 Positive laboratory test/marker study

6 Direct visualization without microscopic confirmation

7 Radiography and other imaging techniques without microscopic confirmation

8 Clinical diagnosis only (other than 5, 6, or 7)

Confirmation Unknown

9 Unknown whether or not microscopically confirmed

DIAGNOSTIC CONFIRMATION **(Continued)**

Clarification of code definitions:

CODES	DEFINITIONS
1	Tissue specimens from biopsy, frozen section, surgery, autopsy, or dilatation and curettage. Bone marrow biopsy and bone marrow aspiration. Hematologic confirmation of leukemia (that is, peripheral blood smear).
2	Microscopic examination of cells removed from a neoplasm. Fine-needle aspiration (FNA) is frequently used to obtain a cytologic specimen. Cells may be recovered from exudate, secretions, or washings from tissue. (Sputum smears, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical and vaginal smears. Also includes paraffin-block specimens from concentrated spinal, pleural, or peritoneal fluid.)
4	The case is reported as microscopically confirmed but no information is provided about the method (histology, cytology).
5	Diagnoses of cancer based on certain laboratory tests or marker studies that are clinically diagnostic. (An abnormal electrophoretic spike for multiple myeloma or Waldenstrom's macroglobulinemia.)
6	Use this code only in the absence of positive histology or cytology. Diagnosis made at surgical exploration or by endoscopy (colposcope, mediastinoscope, laparoscope). Autopsy only case (only information is from gross autopsy report).
7	Use this code only in the absence of positive histology or cytology. Diagnosed by radiology, including ultrasound, computerized (axial) tomography (CT or CAT scans) and magnetic resonance imaging (MRI).
8	Use this code only in the absence of positive histology or cytology. Cases diagnosed by clinical methods not mentioned previously.
9	Death-certificate-only cases. Method of confirmation is unknown.

TUMOR MARKER ONE

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 8, 9
Supplementary Data Set

"Tumor Marker One" records prognostic indicators for specific sites or histologies. If a patient has multiple markers, record the results that influenced the clinical management of the patient.

Codes:

0 None done (test was not ordered and was not performed)

1 Positive

2 Negative

3 Borderline, undetermined whether positive or negative

8 Ordered, but results not in chart

9 Unknown or no information (all sites other than those specified in the table)

This table lists the site/histology for which the tumor marker is collected.

SITE/HISTOLOGY	MARKER #1
Breast (C50.0-C50.9)	Estrogen Receptor Assay (ERA)
Colorectal (C18.0-18.9, C19.9, C20.9)	Carcinoembryonic Antigen (CEA)
Liver (C22.0, C22.1)	Alpha Fetoprotein (AFP)
Neuroblastoma (9500/3)	Urine catecholamine
Ovary (C56.9)	Carbohydrate Antigen 125 (CA-125)
Prostate (C61.9)	Acid Phosphatase (PAP)
Testis (C62.0, C62.1, C62.9)	Alpha Fetoprotein (AFP)

TUMOR MARKER TWO

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 8, 9
Supplementary Data Set

"Tumor Marker Two" records prognostic indicators for specific sites or histologies. If the patient has multiple markers, record the results that influenced the clinical management of the patient.

Codes:

0 None done (not ordered and was not performed)

1 Positive

2 Negative

3 Borderline, undetermined whether positive or negative

8 Ordered, but results not in chart

9 Unknown or no information (all sites other than those specified in the table)

SITE	MARKER #2
Breast (C50.0-50.9)	Progesterone Receptor Assay (PRA)
Prostate (C61.9)	Prostatic Specific Antigen (PSA)
Testis (C62.0, C62.1, C62.9)	Human chorionic gonadotropin (hCG)

PRESENTATION AT CANCER CONFERENCE

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Supplementary Data Set

This item documents case presentation at a cancer conference and the type or format of presentation. The number of cancer conferences, sites presented, and types of presentation can be analyzed and reported for administrative use, quality control, and survey preparation.

Codes:

0 Not presented
1 Prospective presentation (diagnostic)
2 Prospective presentation (treatment)
3 Prospective presentation (follow-up care)
4 Prospective presentation (combinations of 1, 2, or 3)
5 Prospective, NOS
6 Retrospective presentation
7 Follow-up presentation
8 Presentation, NOS
9 Unknown

Clarification of code definitions:

CODES	DEFINITIONS
0	Case was not presented at cancer conference.
1, 2, 3, 4, 5	Presentation at a time when the multidisciplinary discussion could influence treatment choices.
6	The case is presented at a cancer conference after all treatment decisions have been made. The cancer conference participants discuss appropriateness or effectiveness of treatment.
7	The case is presented after a disease-free interval or disease progression.
8	The case was presented at a cancer conference, but it is unknown whether the conference was prospective, retrospective, or follow-up review.
9	It is unknown if the case was presented at cancer conference.

DATE OF CANCER CONFERENCE

Item Length: 8
Data Type: Numeric
Optional Data Set

Enter the date on which the case was first presented at a cancer conference in a month, day, year (MM/DD/CCYY) format. The number of cancer conferences, sites presented, types of presentations, and dates can be analyzed and reported for administration, quality control, and Commission on Cancer survey preparation. Update this item if a patient is presented at a subsequent cancer conference.

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		

Example: Record June 30, 1996 as 06301996.

Code 9 for unknowns:

- Code 99 for unknown month
- Code 99 for unknown day
- Code 9999 for unknown year

If the patient was never presented at a cancer conference, code as 00000000.

REFERRAL TO SUPPORT SERVICES

Item Length: 1
Data Type: Numeric
Allowable Values: 0, 1, 9
Supplementary Data Set

Codes:

0 No

1 Yes

9 Unknown, not specified

Record if the patient was referred to any of the following services.

Enterostomal/stomal therapy

Home care

Hospice

Infusion/parenteral therapy

Nutritionist

Occupational therapy

Other

Patient services (American Cancer Society)

Patient services (other)

Patient support group (American Cancer Society)

Patient support group (hospital operated)

Patient support group (other organization/agency)

Physical therapy

Referral; service unspecified

Rehabilitation facility

Respiratory therapy

Speech therapy

Visiting nurse assistance

Institutions may elect to record an individual response for each service.

STAGE OF DISEASE AT DIAGNOSIS

SIZE OF TUMOR

Item Length: 3
Data Type: Numeric
Required Data Set
Right Justified

Size of tumor is the largest dimension, or the diameter of the primary tumor, and is always recorded in millimeters.

Conversion/Rounding

- To convert centimeters to millimeters, move the decimal point one digit to the right (or multiply the centimeters by 10).

  Example: 3.2 cm becomes 032 mm.

- Round off decimals to the nearest tenth.

  Example: 3.21 cm becomes 3.2 cm and is recorded as 032.

  2.16 cm becomes 2.2 cm and is recorded as 022.

General Size Rules

- Differentiate between tumor size and specimen size.

  Examples: The pathology report describes a specimen that measures 2 x 3 cm with a focus (microscopic) of infiltrating carcinoma. Record tumor size for focus (microscopic) as given in the conversion chart (001 mm).

  The pathology report describes the breast biopsy specimen as 2 x 3 cm with most of the specimen involved with tumor. Record the clinical size from the mammogram or physical examination.

- Record the largest size when the tumor has multiple measurements.

  Example: The pathology report describes the tumor size as 3 x 4.4 x 2.5 cm. Record size as 044 mm.

- Record the size of the largest tumor when a patient has multiple tumors in one primary site.

  Example: The patient has a 1 cm nodule in the right upper lobe and a 1.3 cm nodule in the right middle lobe of the lung. Record size as 013 mm.

- Record the size of the invasive component only when a tumor has both in situ and invasive components.

  Examples: The pathology report describes a breast mass as a 2 x 1.5 cm intraductal carcinoma and a 1 cm nodule of infiltrating ductal carcinoma. Record tumor size as 010 mm.

  The pathology report describes a 3.3 cm intraductal carcinoma in the upper-outer quadrant of the right breast and a 1.6 cm infiltrating ductal carcinoma in the lower-inner quadrant of the right breast. Record tumor size as 016 mm.

SIZE OF TUMOR **(Continued)**

Recording Pathologic Size or Clinical Size

- Record the size documented on the pathology report when
  - The pathologist identifies the size of a completely excised primary tumor
- The surgical margins were grossly free of disease (there may be microscopic involvement)
- Record the clinical size when
  - The primary tumor was not surgically excised
  - The primary tumor was excised but the margins were grossly involved
  - The primary tumor was excised but the pathology report does not specify tumor size
  - The patient was treated with radiation therapy, chemotherapy, hormone therapy, or immunotherapy before the primary was surgically excised
- Record the clinical tumor size documented in the following reports/examinations (listed in preference order):
  - Operative report
  - Scans
  - X-rays
  - Physical examination

Codes

- Record 000 when a primary tumor is not identified (AJCC T0).

  Note: Use this code only for solid tumors.

  Example: A patient has a biopsy of an axillary mass. The pathology report identifies infiltrating ductal carcinoma in an axillary node. Workup reveals no breast lesion.

- Record 998 when the following terms describe tumor involvement in these specific sites:

Esophagus (C15.0-C15.9):	Entire circumference
Stomach (C16.0-C16.9):	Diffuse; widespread, 3/4 or more; linitis plastica
Colorectal (C18.0-C20.9):	Familial/multiple polyposis (histology 8220 or 8221 with a behavior code of 2 or 3)
Lung (C34.0-C34.9):	Diffuse, entire lobe of lung
Breast (C50.0-C50.9):	Diffuse; widespread, 3/4 or more; inflammatory carcinoma

SIZE OF TUMOR **(Continued)**

- Record 999 when:
  - Tumor size is not recorded or not available
  - Prostatic chips or bladder chips are the only measurement (Do NOT add). Transurethral resections of the prostate or bladder produce chips and fragments of tissue. Do not estimate a size from those chips or fragments. A clinical size may be possible from physical examination, ultrasound of the prostate, or cystoscopy of the bladder.
  - For the following sites and diseases:
    - Hematopoietic neoplasms.
    - Hodgkin's and non-Hodgkin's lymphomas; mycosis fungoides of skin.
    - Kaposi's sarcoma.
    - Letterer-Siwe's disease.
    - Leukemia.
    - Multiple myeloma.
    - Reticuloendotheliosis.
    - Unknown or ill-defined primary site or sites.

Malignant Melanoma

Record the depth of invasion for malignant melanoma in the "Size of Tumor" field.

SIZE OF TUMOR **(Continued)**

Size Conversion

Use the following list for size conversion when tumor size is described.

OBJECT	MM	OBJECT	MM	OBJECT	MM
Fruits		Hazel	020	**Money**	
Apple	070	Hickory	030	Dime	010
Apricot	040	Peanut	010	Dollar, silver	040
Cherry	020	Pecan	030	Dollar, half	030
Date	040	Walnut	030	Nickel	020
Fig, dried	040	**Vegetables**		Quarter	020
Grape	020	Bean	010	Penny	010
Grapefruit	100	Bean, lima	020	**Other**	
Kumquat	050	Pea	009	Ball, golf	040
Lemon	080	Pea, split	009	Ball, ping-pong	030
Olive	020	**Miscellaneous Food**		Ball, tennis	060
Orange	090	Doughnut	090	Baseball	070
Peach	060	Egg	050	Fist	090
Pear	090	Egg, bantam	040	Marble	010
Plum	030	Egg, goose	070	Match head	009
Tangerine	060	Egg, hen	030	Pencil eraser	009
Nuts		Egg, pigeon	030	1 cm	010
Almond	030	Egg, robin	020	1 inch	025
Chestnut	040	Lentil	009	.394 inches	010
Chestnut, horse	040	Millet	009	Microscopic (focus)	001

SIZE OF TUMOR **(Continued)**

AJCC Sites That Require Tumor Size

AJCC staging criteria require a tumor size for the following sites to assign a value for T:

ICD-O-2 CODE	SITE
C00.0-C00.9	Lip (T1, T2, T3)
C01.9	Base of tongue, NOS (T1, T2, T3)
C02.0-C02.9	Other and unspecified parts of tongue (T1, T2, T3)
C03.0-C03.9	Gum (T1, T2, T3)
C04.0-C04.9	Floor of mouth (T1, T2, T3)
C05.0-C05.9	Palate (T1, T2, T3)
C06.0-C06.9	Other and unspecified parts of mouth (T1, T2, T3)
C07.9	Parotid gland (T1, T2, T3, T4)
C08.0-C08.9	Other and unspecified major salivary glands (T1, T2, T3, T4)
C09.0-C09.9	Tonsil (T1, T2, T3)
C10.0-C10.9	Oropharynx (excludes anterior surface of epiglottis C10.1) (T1, T2, T3)
C21.0-C21.8	Anus and anal canal (T1, T2, T3)
C22.0-C22.1	Liver and intrahepatic bile ducts (T1, T2, T3)
C25.0 - C25.9	Pancreas (excludes islets of Langerhans C25.4) (T1a, T1b)
C34.0-C34.9	Bronchus and lung (T1, T2)
C38.0	Heart (soft tissue) (T1, T2)
C38.1	Anterior mediastinum (soft tissue) (T1, T2)
C38.2	Posterior mediastinum (soft tissue) (T1, T2)
C38.3	Mediastinum, NOS (soft tissue) (T1, T2)
C38.8	Overlapping lesion of heart, mediastinum, and pleura (soft tissue) (T1, T2)
C44.0-C44.9	Skin (excluding melanoma) (T1, T2, T3)
C47.0-C47.9	Peripheral nerves and autonomic nervous system (soft tissue) (T1, T2)
C48.0-C48.8	Retroperitoneum and peritoneum (soft tissue) (T1, T2)
C49.0-C49.9	Connective, subcutaneous and other soft tissues (T1, T2)
C50.0-C50.9	Breast (T1, T2, T3)
C51.0-C51.9	Vulva (T1, T2)
C63.2	Scrotum (skin of) (T1, T2, T3)

SIZE OF TUMOR **(Continued)**

ICD-O-2 CODE	SITE
C64.9	Kidney (T1, T2)
C69.0	Conjunctiva (excluding melanoma) (T1, T2)
C69.3	Choroid (excluding melanoma) (T1, T2, T3)
C69.5	Lacrimal gland (carcinoma) (T1, T2, T3, T4)
C69.6	Orbit, NOS (sarcoma) (T1, T2)
C69.8	Overlapping lesion of eye and adnexa (sarcoma) (T1, T2)
C70.0	Cerebral meninges (T1, T2)
C71.0-C71.9	Brain (T1, T2)
C73.9	Thyroid gland (T1, T2, T3)
C74.0-C74.9	Adrenal glands (neuroblastoma) (cT1, cT2, cT3)

EXTENSION (SEER EOD)
(EXTENSION)

Item Length: 2
Data Type: Numeric
Supplementary Data Set

"Extension (SEER EOD)" describes the primary tumor growth within the organ of origin or its extension to neighboring organs, or its metastasis to distant sites as summarized in a two-digit code.

REGISTRIES IN APPROVED PROGRAMS ARE NOT REQUIRED TO COLLECT THIS SUPPLEMENTARY DATA SET ITEM. THE INFORMATION IS PRIMARILY COLLECTED BY SEER REGISTRIES. REFER TO *THE SEER EXTENT OF DISEASE 1988: CODES AND CODING INSTRUCTIONS: SECOND EDITION, JUNE 1992*.

LYMPH NODES (SEER EOD)
(LYMPH NODES)

Item Length: 1
Data Type: Numeric
Supplementary Data Set

Regional lymph nodes are listed for each site and then, as necessary, the regional (first station) lymph nodes are classified in terms of size, laterality, number of involved nodes, and distance of the lymph nodes from the primary site. "Lymph Nodes (SEER EOD)" is a one-digit field, a hierarchical code.

REGISTRIES IN APPROVED PROGRAMS ARE NOT REQUIRED TO COLLECT THIS SUPPLEMENTARY DATA SET ITEM. THE INFORMATION IS PRIMARILY COLLECTED BY SEER REGISTRIES. REFER TO *THE SEER EXTENT OF DISEASE 1988: CODES AND CODING INSTRUCTIONS: SECOND EDITION, JUNE 1992*.

REGIONAL NODES EXAMINED

Item Length: 2
Data Type: Numeric
Required Data Set

"Regional Nodes Examined" describes the total number of surgically removed regional nodes that a pathologist examined. Use only regional lymph nodes (identify regional nodes using the pN classification from the *AJCC Manual for Staging of Cancer*, Fourth Edition).

Removal of the primary tumor and a lymph node dissection may be done in one procedure, or the nodes may be removed in a separate procedure.

- Record in "Regional Nodes Examined" if the lymph node dissection is documented in the treatment plan and is done as part of the first course of therapy.
- Do not record in "Regional Nodes Examined" if the lymph node dissection is performed after the first course of therapy (nodes removed to establish recurrence or progression of disease).

Codes:

00 No nodes examined, no nodes surgically removed

01 One node examined

02 Two nodes examined

..

10 Ten nodes examined

..

97 97 or more lymph nodes examined

98 Nodes examined, but number not specified

99 Unknown if nodes were examined, not applicable

Use code 99 for sites for which information about the field is unknown or not applicable.

Examples: Brain

Leukemia

Lymphoma (nodal)

Multiple myeloma

Patient was treated with radiation, chemotherapy, hormone therapy, or immunotherapy before surgery

Reticuloendotheliosis

Letterer-Siwe's disease

Unknown primaries

REGIONAL NODES POSITIVE

Item Length: 2
Data Type: Numeric
Required Data Set

"Regional Nodes Positive" describes the number of surgically removed regional nodes examined by the pathologist and reported as containing tumor. Code only regional lymph nodes (identify regional nodes using the pN classification from the *AJCC Manual for Staging of Cancer,* Fourth Edition).

Codes:

00 All nodes examined negative

01 One positive lymph node

02 Two positive lymph nodes

..

10 10 positive lymph nodes

..

96 96 or more positive lymph nodes

97 Positive nodes but number not specified

98 No nodes examined

99 Unknown if nodes are positive or negative, not applicable

Example: The pathology report reads 11/17 nodes examined were found to contain metastatic squamous cell carcinoma. Record 11 in the field "Regional Nodes Positive."

Use code 98 when no nodes are removed or examined.

Use code 99 for sites for which information about the field is unknown or not applicable.

Examples: Brain

Leukemia

Lymphoma (nodal)

Multiple myeloma

Patient was treated with radiation, chemotherapy, hormone therapy, or immunotherapy before surgery

Reticuloendotheliosis

Letterer-Siwe's disease

Unknown primaries

The number of positive lymph nodes cannot exceed the number of regional lymph nodes examined.

SITE OF DISTANT METASTASIS #1

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Supplementary Data Set

Code only the site(s) of distant metastasis identified during initial diagnosis and workup. Do not update this field over the course of the patient's disease. Use the *AJCC Manual for Staging of Cancer*, Fourth Edition to identify distant sites. Cases with sites of distant metastasis would be coded M1. Do not code sites of regional or local metastasis defined in the "T" field. Do not leave blanks. If there are more than three sites of distant metastasis, code three of the sites. Record a zero in this field if there are no distant metastases. Record 9 if carcinomatosis is present, for disseminated disease, leukemias, and if the site is unknown. Do not code specific metastatic sites for unknown primaries (C80.9).

Codes:

0 None
1 Peritoneum
2 Lung
3 Pleura
4 Liver
5 Bone
6 Central nervous system
7 Skin
8 Lymph nodes (distant)
9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

SITE OF DISTANT METASTASIS #1 **(Continued)**

Clarification of code definitions:

CODES	DEFINITIONS
0	No distant metastases present.
1	Peritoneum, including peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
2	Lung, including the visceral pleura.
3	Pleura, including the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
4	Liver only.
5	Bones other than the primary site.
6	Includes brain and spinal cord, but NOT the external eye.
7	Skin other than the primary site.
8	Includes lymph nodes not classified as regional. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site. (Use the *AJCC Manual for Staging of Cancer*, Fourth Edition to identify distant nodes.)
9	Bone marrow metastases, carcinomatosis, generalized disease, unknown primary.

A biopsy may distinguish the source of distant disease in a patient with multiple primaries. If there is no histologic or cytologic confirmation, consult the physician to help identify which primary has metastasized. If the physician is unable to decide which primary has metastasized, code both primaries as having metastatic disease. If at a later date, the primary is identified, update the codes as appropriate.

SITE OF DISTANT METASTASIS #2

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Supplementary Data Set

Code the second site of distant metastasis identified during initial diagnosis and workup. Do not update this field over the course of the patient's disease. Use the *AJCC Manual for Staging of Cancer*, Fourth Edition to identify distant sites. Cases with sites of distant metastasis would be coded M1. Do not code any sites of regional or local metastasis defined in the "T" field. Do not leave blanks. Record a zero in this field if there is no second site of distant metastases. Record 9 if carcinomatosis is present, for disseminated disease, leukemias, and if the site is unknown. Do not code specific metastatic sites for unknown primaries (C80.9).

Codes:

0 None, no second site of distant metastasis
1 Peritoneum
2 Lung
3 Pleura
4 Liver
5 Bone
6 Central nervous system
7 Skin
8 Lymph nodes (distant)
9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

SITE OF DISTANT METASTASIS #2 **(Continued)**

Clarification of code definitions:

CODES	DEFINITIONS
0	No second site of distant metastasis present.
1	Peritoneum, including peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
2	Lung, including the visceral pleura.
3	Pleura, including the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
4	Liver only.
5	Bones other than the primary site.
6	Includes brain and spinal cord, but NOT the external eye.
7	Skin other than the primary site.
8	Includes lymph nodes not classified as regional. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site. (Use the *AJCC Manual for Staging of Cancer*, Fourth Edition to identify distant nodes.)
9	Bone marrow metastases, carcinomatosis, generalized disease, unknown primary.

A biopsy may distinguish the source of distant disease in a patient with multiple primaries. If there is no histologic or cytologic confirmation, consult the physician to help identify which primary has metastasized. If the physician is unable to decide which primary has metastasized, code both primaries as having metastatic disease. If at a later date, the primary is identified, update the codes as appropriate.

SITE OF DISTANT METASTASIS #3

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Supplementary Data Set

Code the third site of distant metastasis identified during initial diagnosis and workup. Do not update this field over the course of the patient's disease. Use the *AJCC Manual for Staging of Cancer*, Fourth Edition to identify distant sites. Cases with sites of distant metastasis would be coded M1. Do not code any sites of regional or local metastasis defined in the "T" field. Do not leave blanks. Record a zero in this field if there is no third site of distant metastases. Record 9 if carcinomatosis is present, for disseminated disease, leukemias, and if the site is unknown. Do not code specific metastatic sites for unknown primaries (C80.9).

Codes:

0 None, no third site of distant metastasis
1 Peritoneum
2 Lung
3 Pleura
4 Liver
5 Bone
6 Central nervous system
7 Skin
8 Lymph nodes (distant)
9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

SITE OF DISTANT METASTASIS #3 **(Continued)**

Clarification of code definitions:

CODES	DEFINITIONS
0	No third site of distant metastasis present.
1	Peritoneum, including peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
2	Lung, including the visceral pleura.
3	Pleura, including the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
4	Liver only.
5	Bones other than the primary site.
6	Includes brain and spinal cord, but NOT the external eye.
7	Skin other than the primary site.
8	Includes lymph nodes not classified as regional. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site. (Use the *AJCC Manual for Staging of Cancer*, Fourth Edition to identify distant nodes.)
9	Bone marrow metastases, carcinomatosis, generalized disease, unknown primary.

A biopsy may distinguish the source of distant disease in a patient with multiple primaries. If there is no histologic or cytologic confirmation, consult the physician to help identify which primary has metastasized. If the physician is unable to decide which primary has metastasized, code both primaries as having metastatic disease. If at a later date, the primary is identified, update the codes as appropriate.

GENERAL SUMMARY STAGE (SEER)
(REQUIRED ONLY IN THE ABSENCE OF AJCC CLASSIFICATION)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 7, 9
Required Data Set

"General Summary Stage" is limited to all information available within two months of diagnosis.

Exception: General Summary Stage for prostate primaries is limited to all information available within the first four months of diagnosis for cases diagnosed on or after January 1, 1995.

Exclude metastasis or disease progression that develops after the original diagnosis.

"General Summary Stage" for all sites is based on pathologic, operative, and clinical assessments. The priority for using these reports is as follows:

- Pathologic
- Operative (particularly important when the surgical procedure does not remove all malignant tissue)
- Clinical

Apply the same rules when autopsy reports are used to stage the disease.

Codes:

0 In situ
1 Localized
2 Regional by direct extension
3 Regional to lymph nodes
4 Regional (both 2 and 3)
5 Regional, NOS
7 Distant metastases/systemic disease
9 Unstaged, unknown, or unspecified

Code the following primary sites as distant metastases/systemic disease (7):

- Leukemia
- Multiple myeloma
- Reticuloendotheliosis
- Letterer-Siwe's disease

Code the following unstaged, unknown, or unspecified (9):

- Unknown primaries
- Class 3 or 4 cases when the stage at initial diagnosis is unknown

GENERAL SUMMARY STAGE (SEER) **(Continued)**

Note: Refer to *SEER Book 6 or the Summary Staging Guide 1977* for site-specific schemes for General Summary Stage. In this manual, localized, regional, direct extension, and distant are subdivided and coded as follows:

L1, L2, L3, LX Code 1 (localized)

R1, R2 Code 2 (regional by direct extension)

D1, D2 Code 7 (distant metastases/systemic disease)

The Commission requires General Summary Stage only for sites that do not have AJCC staging schemes. Those sites are:

SITE CODE	SITE GROUP	SUBSITE
C17.3	Small intestine	Meckel's diverticulum
C25.4	Pancreas	Islets of Langerhans
C26.0 C26.8 C26.9	Other and ill-defined digestive organs	Intestinal tract, NOS Overlapping lesion of digestive system Gastrointestinal tract, NOS
C30.0 C30.1	Nasal cavity and middle ear	Nasal cavity Middle ear
C31.1 C31.2 C31.3 C31.8 C31.9	Accessory sinuses	Ethmoid sinus Frontal sinus Sphenoid sinus Overlapping lesion of accessory sinuses Accessory sinus, NOS
C33.9	Trachea	Trachea
C37.9	Thymus	Thymus
C39.0 C39.8 C39.9	Other and ill-defined sites within respiratory system and intrathoracic organs	Upper respiratory tract, NOS Overlapping lesion of respiratory system and intrathoracic organs Ill-defined sites within respiratory system
C42.0 C42.1 C42.2 C42.3 C42.4	Hematopoietic and reticuloendothelial systems	Blood Bone marrow Spleen Reticuloendothelial system, NOS Hematopoietic system, NOS

GENERAL SUMMARY STAGE (SEER) **(Continued)**

SITE CODE	SITE GROUP	SUBSITE
C57.0 C57.1 C57.2 C57.3 C57.4 C57.7 C57.8 C57.9	Other and unspecified female genital organs	Fallopian tube Broad ligament Round ligament Parametrium Uterine adnexa Other specified parts of female genital organs Overlapping lesion of female genital organs Female genital tract, NOS
C58.9	Placenta	Placenta
C63.0 C63.1 C63.7 C63.8 C63.9	Other and unspecified male genital organs	Epididymis Spermatic cord Other specified parts of male genital organs Overlapping lesion of male genital organs Male genital organs, NOS
C69.1 C69.9	Eye, brain, and other parts of central nervous system	Cornea, NOS Eye, NOS
C70.1 C70.9	Meninges	Spinal meninges Meninges, NOS
C72.0 C72.1 C72.2 C72.3 C72.4 C72.5 C72.8 C72.9	Spinal cord, cranial nerves, and other parts of central nervous system	Spinal cord Cauda equina Olfactory nerve Optic nerve Acoustic nerve Cranial nerve, NOS Overlapping lesion of brain and central nervous system Nervous system, NOS
C74.0 C74.1 C74.9	Adrenal gland	Cortex of adrenal gland Medulla of adrenal gland Adrenal gland, NOS

GENERAL SUMMARY STAGE (SEER) **(Continued)**

SITE CODE	SITE GROUP	SUBSITE
C75.0	Other endocrine glands and related structures	Parathyroid gland
C75.1		Pituitary gland
C75.2		Craniopharyngeal duct
C75.3		Pineal gland
C75.4		Carotid body
C75.5		Aortic body and other paraganglia
C75.8		Overlapping lesion of endocrine glands and related structures
C75.9		Endocrine gland, NOS
C76.0	Other and ill-defined sites	Head, face or neck, NOS
C76.1		Thorax, NOS
C76.2		Abdomen, NOS
C76.3		Pelvis, NOS
C76.4		Upper limb, NOS
C76.5		Lower limb, NOS
C76.7		Other ill-defined sites
C76.8		Overlapping lesion of ill-defined sites
C80.9	Unknown primary site	Unknown primary site

AJCC STAGING SYSTEM

cTNM

pTNM

The staging basis (clinical, pathologic, other) sets the parameters for staging cancer. Refer to the *AJCC Manual for Staging of Cancer*, Fourth Edition for coding rules. The Commission requires that approved programs collect either pathologic or clinical stage for the sites included in the *AJCC Manual for Staging of Cancer*, Fourth Edition.

The clinical and pathologic staging elements are now separate fields. The Commission requires Commission-approved programs to collect either clinical or pathologic stage. Separate fields will allow the institution a choice of collecting the most appropriate stage as required or collecting both the clinical and pathologic stage. The separation also aids data retrieval, merging, and may also reduce data collection errors.

The clinical classification is based on information and evidence obtained before treatment. Use it for sites that are accessible for clinical examination, including cervix, oral cavity, and larynx. Use clinical classification where only clinical findings are used or available to evaluate the extent of disease. The physical examination, imaging, endoscopy, biopsy, surgical exploration, and other relevant findings are the basis of clinical staging. Evaluate the clinical stage of disease using all information available before the first cancer-directed treatment.

Pathologic classification is based on information obtained before treatment and is supplemented by additional evidence from surgery and the pathologic examination of the resected specimen. It is a combination of all findings. The pathologic stage provides the most precise data to estimate prognosis and calculate end results. Pathologic assessment of the primary tumor requires either a resection of the primary tumor or a biopsy adequate to evaluate the highest pT category. The pathologic assessment of the regional lymph nodes requires the surgical removal and pathologic examination of enough nodes to confirm the absence of regional lymph node metastasis or evaluate the highest pN category.

Pathologic staging takes precedence over clinical.

Exceptions: There are some diseases and sites for which clinical staging takes precedence. Clinical staging takes precedence when the patient has radiation or chemotherapy preoperatively and when the patient does not have cancer-directed surgery.

Examples: Cervical cancer treated preoperatively with radiation

Breast cancer treated preoperatively with chemotherapy and radiation

Prostate cancer biopsied and treated with hormones

Small cell carcinoma of the lung biopsied and treated with chemotherapy

Pancreas primary diagnosed without histologic confirmation

CLINICAL T

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

The T evaluates the primary tumor and reflects tumor size and/or extension.

The clinical T classification is based on information and evidence obtained before treatment. Use for sites that are accessible for clinical examination, including cervix, oral cavity, and larynx. Use clinical classification where only clinical findings are used or available to evaluate the extent of disease. The physical examination, imaging, endoscopy, biopsy, surgical exploration, and other relevant findings are the basis of clinical staging. Evaluate the clinical stage of disease using all information available before the first cancer-directed treatment.

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. Choose the lower (less advanced) T category when there is any uncertainty. Refer to the *AJCC Manual for Staging of Cancer*, Fourth Edition for coding rules.

The addition of code 88 to the "T" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, and so on.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Manual for Staging of Cancer*, Fourth Edition applies only to carcinomas. Record T88.

- Record X when the site or histologic type has an AJCC staging scheme but there is not enough information to assign a T value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow-up. AJCC staging requires tumor size and palpation of axillary lymph nodes for clinical staging. Record TX NX MX.

CLINICAL T **(Continued)**

The following general definitions are used throughout the TNM classification.

TX Primary tumor cannot be assessed or is unknown

T0 No evidence of a primary tumor

Tis Carcinoma in situ

T1, T2, T3, and T4 describe increasing size and/or local extent of the primary tumor

Tumor size is necessary to classify T for several sites. See data item "Size of Tumor" for a table identifying these sites.

Codes:

TX = X
T0 = 0
Ta = A
Tis = IS
T1 = 1
T1A = 1A
T1B = 1B
T1C = 1C
T2 = 2
T2A = 2A
T2B = 2B
T2C = 2C
T3 = 3
T3A = 3A
T3B = 3B
T3C = 3C
T4 = 4
T4A = 4A
T4B = 4B
T4C = 4C
T4D = 4D

Not applicable = 88

CLINICAL N

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

"Clinical N" classifies the regional lymph nodes and describes the absence or presence and the extent of node metastases.

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. Choose the lower (less advanced) N category when there is any uncertainty. Refer to the *AJCC Manual for Staging of Cancer*, Fourth Edition for coding rules.

The addition of code 88 to the "N" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Manual for Staging of Cancer*, Fourth Edition applies only to carcinomas. Record N88.

- Record X when the site or histologic type has an AJCC staging scheme but there is not enough information to assign an N value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow-up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

The following general definitions are used throughout the TNM classification:

NX Regional lymph nodes cannot be assessed or status is unknown.

N0 Nodes were assessed and there was no evidence of regional lymph node metastasis.

N1, N2, and N3 indicate increasing involvement of regional lymph nodes.

CLINICAL N **(Continued)**

Classify a primary tumor that directly extends into lymph nodes as lymph node metastasis.

Codes:

NX = X
N0 = 0
N1 = 1
N1A = 1A
N1B = 1B
N2 = 2
N2A = 2A
N2B = 2B
N2C = 2C
N3 = 3
Not applicable = 88

CLINICAL M

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

"Clinical M" records the presence or absence of distant metastases. Choose the lower (less advanced) M category when there is any uncertainty.

The following general definitions are used throughout the TNM classification:

MX The presence of distant metastasis cannot be assessed or is unknown.

M0 No known distant metastasis.

M1 Distant metastases are present.

Truncate the least significant subdivision of the category from the right as needed. Refer to the *AJCC Manual for Staging of Cancer*, Fourth Edition for coding rules.

The addition of code 88 to the "M" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Manual for Staging of Cancer*, Fourth Edition applies only to carcinomas. Record M88.

- Record X when the site or histologic type has an AJCC staging scheme but there is not enough information to assign an M value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow-up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

CLINICAL M **(Continued)**

Codes:

MX = X

M0 = 0

M1 = 1

M1A = 1A

M1B = 1B

M1C = 1C

Not applicable = 88

Prostate cancer has codes M1a, b, and c. Codes indicate metastases to:

M1a Nonregional lymph node(s)

M1b Bone(s)

M1c Other site(s)

Malignant melanoma of the skin and of the eyelid have codes M1a and b. Codes indicate metastases to:

M1a Skin or subcutaneous tissue or lymph node(s) beyond the regional lymph nodes

M1b Visceral metastases

CLINICAL STAGE GROUP

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

"Clinical Stage Group" defines the anatomic extent of disease based on the previously coded T, N, and M elements.

If the stage is only one digit, record to the left and blank fill. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) stage grouping when there is any uncertainty. Refer to the *AJCC Manual for Staging of Cancer*, Fourth Edition for specific coding rules.

Convert all Roman numerals to Arabic numerals and use upper case (capital letters) only.

Examples: Stage IV converts to stage 4

Stage IIA converts to stage 2A

The addition of code 88 to the stage group enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The staging scheme in the *AJCC Manual for Staging of Cancer*, Fourth Edition applies only to carcinomas. Record Stage 88.

- Record 99 when the site or histologic type has an AJCC staging scheme but there is not enough information to assign a stage.

  Example: A nursing home resident enters your facility for a needle biopsy of the breast. The pathology report identifies infiltrating ductal carcinoma. The medical record does not describe tumor size. The AJCC staging elements are TX NX MX. The stage group cannot be assigned. Record 99.

CLINICAL STAGE GROUP **(Continued)**

Codes:

Stage 0 = 0
Stage 0A = 0A
Stage Occult = OC
Stage 0is = 0S
Stage I = 1
Stage IA = 1A
Stage IB = 1B
Stage IC = 1C
Stage II = 2
Stage IIA = 2A
Stage IIB = 2B
Stage IIC = 2C
Stage III = 3
Stage IIIA = 3A
Stage IIIB = 3B
Stage IIIC = 3C
Stage IV = 4
Stage IVA = 4A
Stage IVB = 4B
Not applicable = 88
Recurrent, unknown, Stage X = 99

There are several sites in which the size of tumor or the grade/differentiation is necessary to determine the stage grouping. See data item “Size of Tumor” and data item “Grade or Differentiation” for tables identifying these sites.

CLINICAL STAGE (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 9
Supplementary Data Set

These descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

The institution can produce more detailed survival analysis by using clinical stage prefix/suffix descriptors.

Codes:

0 None

1 E (extranodal, lymphomas only)

2 S (spleen, lymphomas only)

3 M (multiple primary tumors in a single site)

4 Y (classification during or after initial multimodality therapy)

5 E&S (extranodal and spleen)

6 M&Y (multiple primary tumors and initial multimodality therapy)

9 Unknown

Clarification of code definitions:

CODES	DEFINITIONS
0	There are no prefix or suffix descriptors that would be used for this case.
1	A lymphoma case involving an extranodal site. (See the *AJCC Manual for Staging of Cancer*, Fourth Edition, pp 253-261.)
2	A lymphoma case involving the spleen. (See the *AJCC Manual for Staging of Cancer*, Fourth Edition, pp 253-261.)
3	This is one primary with multiple tumors in the primary site AT THE TIME OF DIAGNOSIS.
4	The first method of therapy is other than cancer-directed surgery. The patient is first treated with radiation therapy, chemotherapy, hormone therapy, immunotherapy, "other" therapy, or any combination of these therapies. The stage is based on a pathologic resection of the primary done after at least one of the other therapies has started. The other therapy may or may not be complete. This stage should supplement the clinical AJCC stage, not replace it.
5	A lymphoma case with involvement of both an extranodal site and the spleen. (See the *AJCC Manual for Staging of Cancer*, Fourth Edition, pp 253-261.)
6	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	A prefix or suffix would describe this stage, but it is not known which would be correct.

STAGED BY (CLINICAL STAGE)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Supplementary Data Set

"Staged By (Clinical Stage)" identifies the person who documented the clinical AJCC staging elements and the stage group. The Commission requires analytic cases to be staged by the managing physician. Compliance with Commission-approved program requirements can be analyzed using this data item.

Codes:

0 Not staged
1 Managing physician
2 Pathologist
3 Other physician
4 Any combination of 1, 2, or 3
5 Registrar
6 Any combination of 5 with 1, 2, or 3
7 Other
8 Staged, individual not specified
9 Unknown if staged

Clarification of Codes:

CODES	DEFINITIONS
0	Staging was not done
1	Staged by the managing physician only
2	Staged by the pathologist only
3	Staged by a physician other than the managing physician or pathologist
4	Staged by more than one of the individuals specified in codes 1-3
5	Staged by the cancer registrar only
6	Staged by the cancer registrar and one of the physicians specified in codes 1-3
7	Staged by someone other than a physician or the cancer registrar (resident, student, physician's assistant, etc.)
8	The case has been staged; the individual who did the staging is not identified
9	Unknown if case was staged

PATHOLOGIC T

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

"Pathologic T" evaluates the primary tumor and identifies tumor size and/or extension.

Pathologic classification is based on information obtained before treatment and supplemented by additional evidence from surgery and pathologic examination of the resected specimen. It is a combination of all findings. The pathologic stage provides the most precise data to estimate prognosis and calculate end results. Pathologic assessment of the primary tumor requires a resection of the primary tumor or a biopsy specimen adequate to evaluate the highest pT category. The pathologic assessment of the regional lymph nodes requires the removal of enough nodes to confirm the absence of regional lymph node metastasis or evaluate the highest pN category.

Pathologic staging takes precedence over clinical.

Exceptions: There are some diseases and sites for which clinical staging takes precedence. Clinical staging takes precedence when the patient has radiation or chemotherapy preoperatively and when the patient does not have cancer-directed surgery.

Examples: Cervical cancer treated preoperatively with radiation, breast cancer treated preoperatively with chemotherapy and radiation, biopsy of prostate cancer done and patient treated with hormones, biopsy of small cell carcinoma of the lung and patient treated with chemotherapy.

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. Choose the lower (less advanced) T category when there is any uncertainty. Refer to the *AJCC Manual for Staging of Cancer*, Fourth Edition for coding rules.

The addition of code 88 to the "T" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Manual for Staging of Cancer*, Fourth Edition applies only to carcinomas. Record T88.

- Record X when the site or histologic type has an AJCC staging scheme but there is not enough information to assign a T value.

PATHOLOGIC T **(Continued)**

Example: A patient has a fine-needle biopsy of a breast mass. The biopsy cytology identifies infiltrating ductal carcinoma. The patient is lost to follow-up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

The following general definitions are used throughout the TNM classification.

TX Primary tumor cannot be assessed or is unknown.

T0 No evidence of a primary tumor.

Tis Carcinoma in situ.

T1, T2, T3, and T4 describe increasing size and/or local extension of the primary tumor.

A microscopic deposit, up to 2 or 3 mm, in the connective tissue of a lymph drainage area without histologic evidence of residual lymph node is classified in the T category as discontinuous extension.

Tumor size is necessary to classify T for several sites. See data item "Size of Tumor" for a table identifying these sites.

Codes:

TX = X
T0 = 0
Ta = A
Tis = IS
T1 = 1
T1A = 1A
T1B = 1B
T1C = 1C
T2 = 2
T2A = 2A
T2B = 2B
T2C = 2C
T3 = 3
T3A = 3A
T3B = 3B
T3C = 3C
T4 = 4
T4A = 4A
T4B = 4B
T4C = 4C
T4D = 4D
Not applicable = 88

PATHOLOGIC N

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

"Pathologic N" classifies the regional lymph nodes and describes the absence or presence and the extent of node metastases.

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. Choose the lower (less advanced) N category when there is any uncertainty. Refer to the *AJCC Manual for Staging of Cancer*, Fourth Edition for coding rules.

The addition of code 88 to the "N" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Manual for Staging of Cancer*, Fourth Edition applies only to carcinomas. Record N88.

- Record X when the site or histologic type has an AJCC staging scheme but there is not enough information to assign an N value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow-up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

The following general definitions are used throughout the TNM classification:

NX Regional lymph nodes cannot be assessed or status is unknown.

N0 Nodes were assessed and there was no evidence of regional lymph node metastasis.

N1, N2, and N3 indicate increasing involvement of regional lymph nodes.

Classify a primary tumor that directly extends into lymph nodes as lymph node metastasis.

Classify a metastatic nodule as lymph node metastasis when:

- It is removed from the connective tissue in a lymph drainage area.
- The nodule is larger than 2-3 mm.
- There is no histologic evidence of residual lymph node.
- The nodule is grossly recognizable.

Note: Evaluate the nodule in the T category (discontinuous extension) if it is microscopic (up to 2-3 mm).

PATHOLOGIC N **(Continued)**

Codes:

NX = X
N0 = 0
N1 = 1
N1A = 1A
N1B = 1B
N2 = 2
N2A = 2A
N2B = 2B
N2C = 2C
N3 = 3
Not applicable = 88

PATHOLOGIC M

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

"Pathologic M" records the presence or absence of distant metastases. Choose the lower (less advanced) M category when there is any uncertainty.

The following general definitions are used throughout the TNM classification:

MX The presence of distant metastasis cannot be assessed or is unknown.

M0 No known distant metastasis.

M1 Distant metastases are present.

Truncate the least significant subdivision of the category from the right as needed. Refer to the *AJCC Manual for Staging of Cancer*, Fourth Edition for coding rules.

The addition of code 88 to the "M" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Manual for Staging of Cancer*, Fourth Edition applies only to carcinomas. Record M88.

- Record X when the site or histologic type has an AJCC staging scheme but there is not enough information to assign an M value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow-up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

Codes:

MX = X

M0 = 0

M1 = 1

M1A = 1A

M1B = 1B

M1C = 1C

Not applicable = 88

PATHOLOGIC M **(Continued)**

Prostate cancer has codes M1a, b, and c. Codes indicate metastases to:

M1a Non-regional lymph node(s)

M1b Bone(s)

M1c Other site(s)

Malignant melanoma of the skin and of the eyelid have codes M1a and b. Codes indicate metastases to:

M1a Skin or subcutaneous tissue or lymph node(s) beyond the regional lymph nodes

M1b Visceral metastases

PATHOLOGIC STAGE GROUP

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

"Pathologic Stage Group" defines the anatomic extent of disease based on the T, N, and M elements.

If the stage is only one digit, record to the left and blank fill. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) stage grouping when there is any uncertainty. Refer to the *AJCC Manual for Staging of Cancer*, Fourth Edition for specific coding rules.

Convert all Roman numerals to Arabic numerals and use upper case (capital letters) only.

Examples: Stage IV converts to stage 4

Stage IIA converts to stage 2A

The addition of code 88 to the stage group enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Manual for Staging of Cancer*, Fourth Edition applies only to carcinomas. Record 88.

- Record 99 when the site or histologic type has an AJCC staging scheme but there is not enough information to assign a stage.

  Example: A nursing home resident enters your facility for a needle biopsy of the breast. The pathology report identifies infiltrating ductal carcinoma. The medical record does not describe tumor size. The AJCC staging elements are TX NX MX. The stage group cannot be assigned. Record 99.

PATHOLOGIC STAGE GROUP **(Continued)**

Codes:

Stage 0 = 0
Stage 0A = 0A
Stage 0is = 0S
Stage I = 1
Stage IA = 1A
Stage IB = 1B
Stage IC = 1C
Stage II = 2
Stage IIA = 2A
Stage IIB = 2B
Stage IIC = 2C
Stage III = 3
Stage IIIA = 3A
Stage IIIB = 3B
Stage IIIC = 3C
Stage IV = 4
Stage IVA = 4A
Stage IVB = 4B
Not applicable = 88
Recurrent, unknown, Stage X = 99

There are several sites in which the size of tumor or the grade/differentiation is necessary to determine the stage grouping. See data item “Size of Tumor” and data item “Grade or Differentiation” for tables identifying these sites.

PATHOLOGIC STAGE (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 9
Supplementary Data Set

These descriptors identify special cases that need separate data analysis but do not change the stage group.

The institution can produce a more detailed survival analysis by using pathologic stage prefix/suffix descriptors.

Codes:

0 None

1 E (extranodal, lymphomas only)

2 S (spleen, lymphomas only)

3 M (multiple primary tumors in a single site)

4 Y (classification during or after initial multimodality therapy)

5 E&S (extranodal and spleen)

6 M&Y (multiple primary tumors and initial multimodality therapy)

9 Unknown

Clarification of code definitions:

CODES	DEFINITIONS
0	There are no prefix or suffix descriptors that would be used for this case.
1	A lymphoma case involving an extranodal site. (See the *AJCC Manual for Staging of Cancer*, Fourth Edition, pp 253-261.)
2	A lymphoma case involving the spleen. (See the *AJCC Manual for Staging of Cancer*, Fourth Edition, pp 253-261.)
3	This is one primary with multiple tumors in the primary site AT THE TIME OF DIAGNOSIS.
4	The first method of therapy is other than cancer-directed surgery. The patient is first treated with radiation therapy, chemotherapy, hormone therapy, immunotherapy, "other" therapy, or any combination of these therapies. The stage is based on a pathologic resection of the primary done after at least one of the other therapies has started. The other therapy may or may not be complete. This stage should supplement the clinical AJCC stage, not replace it.
5	A lymphoma case with involvement of both an extranodal site and the spleen. (See the *AJCC Manual for Staging of Cancer*, Fourth Edition, pp 253-261.)
6	A case meeting the parameters of both 3 (multiple primary tumors in a single site) and 4 (classification during or after initial multimodality therapy).
9	A prefix or suffix would describe this stage, but it is not known which would be correct.

STAGED BY (PATHOLOGIC STAGE)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Required Data Set

"Staged By (Pathologic Stage)" identifies the person who documented the pathologic AJCC staging elements and the stage group. The Commission requires analytic cases to be staged by the managing physician. Compliance with Commission-approved program requirements can be analyzed using this data item.

Codes:

0 Not staged
1 Managing physician
2 Pathologist
3 Other physician
4 Any combination of 1, 2, or 3
5 Registrar
6 Any combination of 5 with 1, 2, or 3
7 Other
8 Staged, individual not specified
9 Unknown if staged

Clarification of Codes:

CODES	DEFINITIONS
0	Staging was not done
1	Staged by the managing physician only
2	Staged by the pathologist only
3	Staged by a physician other than the managing physician or pathologist
4	Staged by more than one of the individuals specified in codes 1-3
5	Staged by the cancer registrar only
6	Staged by the cancer registrar and one of the physicians specified in codes 1-3
7	Staged by someone other than a physician or the cancer registrar (resident, student, physician's assistant, etc.)
8	The case has been staged; the individual who did the staging is not identified
9	Unknown if case was staged

OTHER T

Item Length: 2
Data Type: Alphanumeric
Upper Case
Supplementary Data Set
Left Justified
Blank Fill

The "other" AJCC staging elements and group allow the institution to collect AJCC retreatment stages. Cases with AJCC retreatment stages must be analyzed separately. The "other" group will also facilitate data conversion by providing a category for historical surgical-evaluative cases.

"Other T" evaluates the primary tumor and identifies tumor size and/or extension.

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. Choose the lower (less advanced) T category when there is any uncertainty. Refer to the *AJCC Manual for Staging of Cancer,* Fourth Edition for coding rules.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Manual for Staging of Cancer,* Fourth Edition applies only to carcinomas. Record T88.

- Record X when the site or histologic type has an AJCC staging scheme but there is not enough information to assign a T value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow-up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

The following general definitions are used throughout the TNM classification:

TX Primary tumor cannot be assessed or is unknown.

T0 No evidence of a primary tumor.

Tis Carcinoma in situ.

T1, T2, T3, and T4 describe increasing size and/or local extent of the primary tumor.

A microscopic deposit, up to 2 or 3 mm, in the connective tissue of a lymph drainage area without histologic evidence of residual lymph node is classified in the T category as discontinuous extension.

Tumor size is necessary to classify T for several sites. See data item "Size of Tumor" for a table identifying these sites.

OTHER T **(Continued)**

Codes:

TX = X
T0 = 0
Ta = A
Tis = IS
T1 = 1
T1A = 1A
T1B = 1B
T1C = 1C
T2 = 2
T2A = 2A
T2B = 2B
T2C = 2C
T3 = 3
T3A = 3A
T3B = 3B
T3C = 3C
T4 = 4
T4A = 4A
T4B = 4B
T4C = 4C
T4D = 4D
Not applicable = 88

OTHER N

Item Length: 2
Data Type: Alphanumeric
Upper Case
Supplementary Data Set
Left Justified
Blank Fill

The "other" AJCC staging elements and group allow the institution to collect AJCC retreatment stages. Cases with AJCC retreatment stages must be analyzed separately. The "other" group will also facilitate data conversion by providing a category for historical surgical-evaluative cases.

"Other N" classifies the regional lymph nodes and describes the absence or presence and the extent of node metastases.

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. Choose the lower (less advanced) N category when there is any uncertainty. Refer to the *AJCC Manual for Staging of Cancer,* Fourth Edition for coding rules.

The addition of code 88 to the "N" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Manual for Staging of Cancer,* Fourth Edition applies only to carcinomas. Record N88.

- Record X when the site or histologic type has an AJCC staging scheme but there is not enough information to assign an N value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow-up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

The following general definitions are used throughout the TNM classification:

NX Regional lymph nodes cannot be assessed or status is unknown.

N0 Nodes were assessed and there was no evidence of regional lymph node metastasis.

N1, N2, and N3 indicate increasing involvement of regional lymph nodes.

OTHER N **(Continued)**

Classify a primary tumor that directly extends into lymph nodes as lymph node metastasis.

Classify a metastatic nodule as lymph node metastasis when:

- It is removed from the connective tissue in a lymph drainage area.
- The nodule is larger than 2-3 mm.
- There is no histologic evidence of residual lymph node.
- The nodule is grossly recognizable.

Note: Evaluate the nodule in the T category (discontinuous extension) if it is microscopic (up to 2-3 mm).

Codes:

NX = X
N0 = 0
N1 = 1
N1A = 1A
N1B = 1B
N2 = 2
N2A = 2A
N2B = 2B
N2C = 2C
N3 = 3
Not applicable = 88

OTHER M

Item Length: 2
Data Type: Alphanumeric
Upper Case
Supplementary Data Set
Left Justified
Blank Fill

The "other" AJCC staging elements and group allow the institution to collect AJCC retreatment stages. Cases with AJCC retreatment stages must be analyzed separately. The "other" group will also facilitate data conversion by providing a category for historical surgical-evaluative cases.

"Other M" records the presence or absence of distant metastases. Choose the lower (less advanced) M category when there is any uncertainty.

The following general definitions are used throughout the TNM classification:

MX The presence of distant metastasis cannot be assessed or is unknown.

M0 No known distant metastasis.

M1 Distant metastases are present.

Refer to the *AJCC Manual for Staging of Cancer,* Fourth Edition for coding rules.

The addition of code 88 to the "M" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Manual for Staging of Cancer,* Fourth Edition applies only to carcinomas. Record M88.

- Record X when the site or histologic type has an AJCC staging scheme but there is not enough information to assign an M value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow-up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

OTHER M **(Continued)**

Codes:

MX = X

M0 = 0

M1 = 1

M1A = 1A

M1B = 1B

M1C = 1C

Not applicable, unstaged = 88

Prostate cancer has codes M1a, b, and c. Codes indicate metastases to:

M1a Non-regional lymph node(s)

M1b Bone(s)

M1c Other site(s)

Malignant melanoma of the skin and of the eyelid have codes M1a and b. Codes indicate metastases to:

M1a Skin or subcutaneous tissue or lymph node(s) beyond the regional lymph nodes

M1b Visceral metastases

OTHER STAGE GROUP

Item Length: 2
Data Type: Alphanumeric
Upper Case
Supplementary Data Set
Left Justified
Blank Fill

The "other" AJCC staging elements and group allow the institution to collect AJCC retreatment stages. Cases with AJCC retreatment stages must be analyzed separately. The "other" group will also facilitate data conversion by providing a category for historical surgical-evaluative cases.

"Other Stage Group" defines the anatomic extent of disease based on the T, N, and M elements.

If the stage is only one digit, record to the left and blank fill. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) stage grouping when there is any uncertainty. Refer to the *AJCC Manual for Staging of Cancer*, Fourth Edition for specific coding rules.

Convert all Roman numerals to Arabic numerals and use upper case only.

Examples: Stage IV converts to stage 4

Stage IIA converts to stage 2A

The addition of code 88 to the stage group enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Manual for Staging of Cancer*, Fourth Edition applies only to carcinomas. Record 88.

- Record 99 when the site or histologic type has an AJCC staging scheme but there is not enough information to assign a stage.

  Example: A nursing home resident enters your facility for a needle biopsy of the breast. The pathology report identifies infiltrating ductal carcinoma. The medical record does not describe tumor size. The AJCC staging elements are TX NX MX. The stage group cannot be assigned. Record 99.

OTHER STAGE GROUP **(Continued)**

Codes:

Stage 0 = 0
Stage 0A = 0A
Stage Occult = OC
Stage 0is = 0S
Stage I = 1
Stage IA = 1A
Stage IB = 1B
Stage IC = 1C
Stage II = 2
Stage IIA = 2A
Stage IIB = 2B
Stage IIC = 2C
Stage III = 3
Stage IIIA = 3A
Stage IIIB = 3B
Stage IIIC = 3C
Stage IV = 4
Stage IVA = 4A
Stage IVB = 4B
Not applicable = 88
Recurrent, unknown, Stage X = 99

There are several sites in which the size of tumor or the grade/differentiation is necessary to determine the stage grouping. See data item “Size of Tumor” and data item “Grade or Differentiation” for tables identifying these sites.

OTHER STAGE (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1
Data Type: Numeric
Supplementary Data Set

The "other" AJCC staging elements and group will allow the institution to collect AJCC retreatment stages. Cases with AJCC retreatment stages must be analyzed separately. The "other" group will also facilitate data conversion by providing a category for historical surgical-evaluative cases.

"Other Stage (Prefix/Suffix) Descriptor" identifies special cases that need separate analysis. The use of a descriptor does not change the stage group.

Codes:

0 None
1 E (extranodal, lymphomas only)
2 S (spleen, lymphomas only)
3 M (multiple primary tumors in a single site)
4 Y (classification during or after initial multimodality therapy)
5 E&S (extranodal and spleen)
6 M&Y (multiple primary tumors and initial multimodality therapy)
9 Unknown

Clarification of code definitions:

CODES	DEFINITIONS
0	There are no prefix or suffix descriptors that would be used for this case.
1	A lymphoma case involving an extranodal site. (See the *AJCC Manual for Staging of Cancer*, Fourth Edition, pp 253-261.)
2	A lymphoma case involving the spleen. (See the *AJCC Manual for Staging of Cancer*, Fourth Edition, pp 253-261.)
3	This is one primary with multiple tumors in the primary site AT THE TIME OF DIAGNOSIS.
4	The first method of therapy is other than cancer-directed surgery. The patient is first treated with radiation therapy, chemotherapy, hormone therapy, immunotherapy, "other" therapy, or any combination of these therapies. The stage is based on a pathologic resection of the primary done after at least one of the other therapies has started. The other therapy may or may not be complete. This stage should supplement the clinical AJCC stage, not replace it.
5	A lymphoma case with involvement of both an extranodal site and the spleen. (See the *AJCC Manual for Staging of Cancer*, Fourth Edition, pp 253-261.)
6	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	A prefix or suffix would describe this stage, but it is not known which would be correct.

STAGED BY (OTHER STAGE)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Required Data Set

"Staged By (Other Stage)" identifies the person who documented the other AJCC staging elements and the stage group. The Commission requires analytic cases to be staged by the managing physician. Compliance with Commission-approved program requirements can be analyzed using this data item.

Codes:

0 Not staged
1 Managing physician
2 Pathologist
3 Other physician
4 Any combination of 1, 2, or 3
5 Registrar
6 Any combination of 5 with 1, 2, or 3
7 Other
8 Staged, individual not specified
9 Unknown if staged

Clarification of Codes:

CODES	DEFINITIONS
0	Staging was not done
1	Staged by the managing physician only
2	Staged by the pathologist only
3	Staged by a physician other than the managing physician or pathologist
4	Staged by more than one of the individuals specified in codes 1-3
5	Staged by the cancer registrar only
6	Staged by the cancer registrar and one of the physicians specified in codes 1-3
7	Staged by someone other than a physician or the cancer registrar (resident, student, physician's assistant, etc.)
8	The case has been staged; the individual who did the staging is not identified
9	Unknown if case was staged

OTHER STAGING SYSTEM

Item Length: 15
Data Type: Free Text
Optional Data Set

"Other Staging System" allows institutions the opportunity to collect additional staging classifications, for example, Dukes, AUA.

Free text field allows entry of a staging system not included in the data base.

Examples: Duke's B
FIGO II

TYPE OF STAGING SYSTEM (PEDIATRIC)

Item Length: 2
Data Type: Numeric
Allowable Values: 00-15, 88, 97, 99
Required Data Set

The Commission requires staging of pediatric patients using AJCC or the staging criteria of the pediatric intergroup studies and the pediatric cooperative groups.

Record the type of pediatric staging system used.

Codes:

00 None
01 American Joint Committee on Cancer (AJCC)
02 Ann Arbor
03 Children's Cancer Group (CCG)
04 Evans
05 General Summary
06 Intergroup Ewings
07 Intergroup Hepatoblastoma
08 Intergroup Rhabdomyosarcoma
09 International System
10 Murphy
11 National Cancer Institute (pediatric oncology)
12 National Wilms' Tumor Study
13 Pediatric Oncology Group (POG)
14 Reese-Ellsworth
15 SEER Extent of Disease
88 Not applicable
97 Other
99 Unknown

Record none (00) when a pediatric case is unstaged. Record not applicable (88) if the patient is an adult. Code other (97) when the case is staged using pediatric staging system other than those identified in codes 01–15. Code unknown (99) if the case is staged, but the staging system is unknown.

PEDIATRIC STAGE

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

Record the pediatric stage as specified in the pediatric staging system selected. If the pediatric stage 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.

Codes:

Stage I		=	1
Stage IA	(rhabdomyosarcomas and related sarcomas only)	=	1A
Stage IB	(rhabdomyosarcomas and related sarcomas only)	=	1B
Stage II		=	2
Stage IIA	(rhabdomyosarcomas and related sarcomas only)	=	2A
Stage IIB	(rhabdomyosarcomas and related sarcomas only)	=	2B
Stage IIC	(rhabdomyosarcomas and related sarcomas only)	=	2C
Stage III		=	3
Stage IIIA	(liver, rhabdomyosarcomas and related sarcomas, Wilms' tumor only)	=	3A
Stage IIIB	(liver, rhabdomyosarcomas and related sarcomas, Wilms' tumor only)	=	3B
Stage IIIC	(Wilms' tumor only)	=	3C
Stage IIID	(Wilms' tumor only)	=	3D
Stage IIIE	(Wilms' tumor only)	=	3E
Stage IV		=	4
Stage IVA	(bone only)	=	4A
Stage IVB	(bone only)	=	4B
Stage IVS	(neuroblastoma only)	=	4S
Stage V	(Wilms' tumor, retinoblastoma only)	=	5
Stage A	(neuroblastoma only)	=	A
Stage B	(neuroblastoma only)	=	B
Stage C	(neuroblastoma only)	=	C
Stage D	(neuroblastoma only)	=	D
Stage DS	(neuroblastoma only)	=	DS
Not applicable (not pediatric case)		=	88
Unstaged, unknown		=	99

STAGED BY (PEDIATRIC STAGE)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Required Data Set

"Staged By (Pediatric Stage)" identifies the person who documented the pediatric staging system and the stage. The Commission requires analytic cases to be staged by the managing physician. The institution can confirm compliance with the Commission's approved program requirements by using this data item.

Codes:

0 Not staged
1 Managing physician
2 Pathologist
3 Other physician
4 Any combination of 1, 2, or 3
5 Registrar
6 Any combination of 5 with 1, 2, or 3
7 Other
8 Staged, individual not specified
9 Unknown if staged

Clarification of Codes:

CODES	DEFINITIONS
0	Staging was not done
1	Staged by the managing physician only
2	Staged by the pathologist only
3	Staged by a physician other than the managing physician or pathologist
4	Staged by more than one of the individuals specified in codes 1-3
5	Staged by the cancer registrar only
6	Staged by the cancer registrar and one of the physicians specified in codes 1-3
7	Staged by someone other than a physician or the cancer registrar (resident, student, physician's assistant, etc.)
8	The case has been staged; the individual who did the staging is not identified.
9	Unknown if case was staged

TNM EDITION NUMBER

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 8, 9
Required Data Set
Position

"TNM Edition Number" identifies the edition of the *AJCC Manual for Staging of Cancer* used to stage the case. This will allow analysis of cases grouped by edition number.

Codes:

0 Not staged (cases that have AJCC staging scheme and staging was not done)

1 First edition

2 Second edition

3 Third edition

4 Fourth edition

5 Fifth edition

8 Not applicable (cases that do not have an AJCC staging scheme)

9 Unknown edition

Note: All Commission on Cancer approved programs were required to use the fourth edition of the *AJCC Manual for Staging of Cancer* for cases diagnosed and/or treated on or after January 1, 1992. The fifth edition will be published in 1997.

DATE OF FIRST POSITIVE BIOPSY

Item Length: 8
Data Type: Numeric
Optional Data Set

Record the date of the first positive incisional or excisional biopsy. The biopsy may be taken from the primary or a secondary site. This data item refers to a tissue biopsy/positive histology only. The first positive biopsy specimen may be at any time during the disease course. It may be non cancer-directed or cancer-directed surgery.

The first two digits record the month, the third and fourth digits record the day, and the last four digits record the year of the first positive biopsy.

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		

Example: Record June 30, 1996 as 06301996.

Code 9 for unknowns:

- Code 99 for unknown month
- Code 99 for unknown day
- Code 9999 for unknown year

If a positive biopsy was never obtained, code as 00000000.

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

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FIRST COURSE OF TREATMENT

DATE OF FIRST COURSE TREATMENT
(Date Started)

Item Length: 8
Data Type: Numeric
Required Data Set

"Date of First Course Treatment" is the month, day, and year (MMDDCCYY) of the first cancer-directed therapy. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year of the first course of treatment.

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		

Example: Record December 15, 1996 as 12151996.

If the physician decides not to treat the patient, record the date of this decision as the "Date of First Course Treatment." The physician may decide not to treat the patient because of comorbid conditions, advanced disease, or because the accepted management of the cancer is to observe until the disease progresses or until the patient becomes symptomatic.

Example: On February 12, 1996 the physician says that a low-stage prostate cancer patient will be observed until the Prostatic Specific Antigen (PSA) level starts to rise. Enter 02121996 as the date of first course treatment.

Code 00000000 when no treatment is given and for autopsy-only cases.

Code 99999999 when it is unknown if any treatment was given, or the date is not known, or the case was identified by death certificate only.

If the exact date of the beginning of treatment is not available, record an approximate date.

DATE OF NON CANCER-DIRECTED SURGERY **Item Length: 8**
Data Type: Numeric
Required Data Set

"Date of Non Cancer-Directed Surgery" is the month, day, and year (MMDDCCYY) that non cancer-directed surgery was performed. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

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

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		

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no non cancer-directed surgery is performed and for autopsy-only cases.

Code 99999999 when it is unknown if any non cancer-directed surgery was performed, or the date is not known, or the case was identified by death certificate only.

If the exact date of non cancer-directed surgery is not available, record an approximate date.

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

NON CANCER-DIRECTED SURGERY

Item Length: 2
Data Type: Numeric
Required Data Set

Non Cancer-Directed Surgery

Surgical procedures performed to diagnose/stage disease (exploratory) or for relief of symptoms (palliative) are non cancer-directed surgery. Valid codes are 01-09.

Examples of exploratory surgery are:

- Celiotomy
- Laparotomy
- Cystotomy
- Nephrotomy
- Gastrotomy
- Thoracotomy

Examples of palliative bypass surgery are:

- Colostomy
- Nephrostomy
- Esophagostomy
- Tracheostomy
- Gastrostomy
- Urethrostomy

Brushings, washings, aspiration of cells, and hematologic findings (peripheral blood smears) are not surgical procedures.

Record the type of non cancer-directed surgery performed as part of the initial diagnosis and workup, whether performed at your institution or at other institutions.

NON CANCER-DIRECTED SURGERY **(Continued)**

Codes:

00 No surgical procedure

01 Incisional biopsy of other than primary site
Needle biopsy of other than primary site
Aspiration biopsy of other than primary site

02 Incisional biopsy of primary site
Needle biopsy of primary site
Aspiration biopsy of primary site

03 Exploratory ONLY (no biopsy)

04 Bypass surgery (no biopsy); - ostomy ONLY (no biopsy)

05 Exploratory ONLY and incisional or needle biopsy of primary site or other sites

06 Bypass surgery and incisional or needle biopsy of primary site or other sites
- ostomy ONLY and incisional or needle biopsy of primary site or other sites

07 Non cancer-directed surgery, NOS

09 Unknown if non cancer-directed surgery done

Priority of Codes

In the site-specific surgery code schemes, except where otherwise noted, the following priorities hold:

- Codes 01-07 have priority over code 09.
- In the range 01-06, the higher code has priority.
- Codes 01-06 have priority over code 07.

NON CANCER-DIRECTED SURGERY AT THIS FACILITY **Item Length: 2**
Data Type: Numeric
Supplementary Data Set

Record the type of non cancer-directed surgery performed at this facility. Do not include procedures done at other institutions.

Codes:

00 No surgical procedure
01 Incisional biopsy of other than primary site
Needle biopsy of other than primary site
Aspiration biopsy of other than primary site
02 Incisional biopsy of primary site
Needle biopsy of primary site
Aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery (no biopsy); - ostomy ONLY (no biopsy)
05 Exploratory ONLY and incisional or needle biopsy of primary site or other sites
06 Bypass surgery and incisional or needle biopsy of primary site or other sites
- ostomy ONLY and incisional or needle biopsy of primary site or other sites
07 Non cancer-directed surgery, NOS
09 Unknown if non cancer-directed surgery done

Priority of Codes

In the site-specific surgery code schemes, except where otherwise noted, the following priorities hold:

- Codes 01-07 have priority over code 09.
- In the range 01-06, the higher code has priority.
- Codes 01-06 have priority over code 07.

DATE OF CANCER-DIRECTED SURGERY

Item Length: 8
Data Type: Numeric
Required Data Set

Date of cancer-directed surgery is the month, day, and year (MMDDCCYY) that cancer-directed surgery was performed. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

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

If your software allows the collection of only one date, record the first date on which the patient had cancer-directed surgery.

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		

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no cancer-directed surgery is performed and for autopsy-only cases.

Code 99999999 when it is unknown if any cancer-directed surgery was performed and the date is unknown, or if the case was identified by death certificate only.

If the exact date of cancer-directed surgery is not available, record an approximate date.

DATE OF CANCER-DIRECTED SURGERY **(Continued)**

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

CANCER-DIRECTED SURGERY **Item Length: 2**
Data Type: Numeric
Required Data Set

Cancer-directed surgery modifies, controls, removes, or destroys proliferating cancer tissue. Valid codes for cancer-directed surgery are 10-90. An excisional biopsy is cancer-directed surgery.

Note: When the surgeon states the procedure is an excisional biopsy, record as an excisional biopsy even if the pathology report shows microscopic involvement of the margins.

Record all cancer-directed procedures performed as part of the first course of treatment at the reporting institution and other institutions.

Disregard the surgical approach when coding procedures.

Example: Laser for initial incision, laparoscope.

The operative report title may not be sufficient to determine the cancer-directed procedure. Use the operative report text and the pathology report to confirm the operative procedure. Use the information from the pathology report when an operative report is unclear or inconsistent.

Exception: Do not use the pathology report if it does not precisely describe the removed organs or tissues (tumor encasement, crush artifact, and so on).

Recording Procedures Performed as First Course of Treatment

The surgical codes in the range 10-70 are hierarchical. As the code numbers ascend, the procedures represented are more invasive and/or radical. The surgical code descriptions may define the limits of the procedure and not be identical to what is reported in the medical record.

Surgical codes 60 and 70 often describe the partial or total removal of the primary site plus a partial or total removal of other organs. Code all non-primary organs that the surgeon removes with the intent of changing the course of disease. Code the removal of these organs even when the pathology report notes they are free of cancer. Do not code non-primary organs removed for reasons other than changing the disease course (incidental appendectomy, incidental cholecystectomy).

Example: The operative report describes a transverse colon tumor as adherent to the stomach wall. The pathology report notes the specimen includes a section of transverse colon and stomach. It reports the stomach is free of disease. Use the surgical code for a hemicolectomy or total colectomy PLUS partial or total removal of other organs.

If you record only one date and one surgical procedure, code the first excisional biopsy date and the most invasive, extensive surgical procedure performed during the first course of treatment.

Example: A patient has an excisional breast biopsy on January 15, 1996 followed by a modified radical mastectomy in February 1996. Code the procedures as follows:

DATE	PROCEDURE	SURGERY CODE
01151996	Modified radical mastectomy	50

CANCER-DIRECTED SURGERY **(Continued)**

If a series of dates and cancer-directed procedures may be recorded, the codes are cumulative and progressive.

Example: A patient has an excisional breast biopsy on January 15, 1996 followed by a lymph node dissection on February 20, 1996. The pathology report reveals an axillary node with micrometastasis. The patient elected to have a mastectomy on March 17, 1996. Code the procedures as follows:

DATE	PROCEDURE	SURGERY CODE
01151996	Excisional biopsy	10
02201996	Previous excisional biopsy PLUS lymph node dissection	20
03171996	Modified radical mastectomy PLUS previous lymph node dissection	50

When surgery removes the remaining portion of an organ, code the total removal of an organ. The code shows that no part of that organ remains in the patient's body.

Examples: The cancer patient had a resection of a stomach remnant. The patient has a history of a partial gastrectomy for a benign condition. Code as a total gastrectomy (50).

A patient has a lobectomy for lung cancer on August 20, 1996. The remainder of the lung was surgically removed on November 17, 1996 because of recurrent disease. Codes are as follows:

DATE	PROCEDURE	SURGERY CODE
08201996	Lobectomy	30
11171996	Pneumonectomy (subsequent therapy)	50

Surgery for extranodal lymphomas should be recorded using the scheme for the extranodal site.

Example: Use the scheme for the stomach to record a gastrectomy for a primary lymphoma of the stomach.

Lymph Node Removal

Record a lymph node dissection when:

- A minimum of four lymph nodes are surgically removed and described in the pathology report.

  Note: The nodes examined must be from the same anatomic area or region (such as the groin). They do not have to be from the same chain.

  Example: A patient with prostate cancer had a lymph node dissection for staging. The pathology report identified 15 nodes. Code a lymph node dissection.
- Pathology reports the nodes are matted and cannot be counted.
- Pathology uses the terms "multiple nodes" or "many nodes."
- The name of some procedures does not include "lymph node dissection" because it is implied in the title (modified radical mastectomy, pelvic exenteration, Miles' operation).

CANCER-DIRECTED SURGERY **(Continued)**

Do not code a lymph node dissection when:

- Pathology reports fewer than four nodes were examined.

  Example: The operation is labeled as a modified radical mastectomy. The pathology report says three nodes were examined. The code would be total (simple) mastectomy (breast only) WITHOUT axillary node dissection (40).

- Pathology uses the terms "few nodes" or "several nodes" to describe the number of nodes examined.
- The operative title contains the term lymph node dissection but the pathology report does not confirm the procedure.

Surgery for Multiple Primaries

Record the appropriate surgical procedure performed for each site when multiple primaries are excised at the same time.

Examples: A patient has cancer of the cervix and of the endometrium, and a total abdominal hysterectomy is performed. Record a total abdominal hysterectomy as cancer-directed surgery for each of the two primaries.

A patient has colon and skin cancer. The patient had a hemicolectomy and a wedge resection of the skin lesion. Code the colectomy for colon and the wedge resection for skin.

Site-Specific Surgery Codes

There are *site-specific* surgical procedure codes in Appendix D for the following sites:

ICD-O-2 CODE	SITE
C00.0-C14.8	Oral cavity
C16.0-C16.9	Stomach
C18.0-C18.9	Colon
C19.9	Rectosigmoid
C20.9	Rectum
C25.0-C25.9	Pancreas
C32.0-C32.9	Larynx
C34.0-C34.9	Bronchus and lung
C40.0-C41.9	Bones, joints, and articular cartilage
C42.2	Spleen
C44.0-C44.9	Skin
C47.0-C47.9	Peripheral nerves and autonomic nervous system
C49.0-C49.9	Connective, subcutaneous, and other soft tissues

CANCER-DIRECTED SURGERY **(Continued)**

ICD-O-2 CODE	SITE
C50.0-C50.9	Breast
C53.0-C53.9	Cervix uteri
C54.0-C54.9	Corpus uteri
C56.9	Ovary
C61.9	Prostate
C62.0-C62.9	Testis
C64.9	Kidney
C65.9	Renal pelvis
C66.9	Ureter
C67.0-C67.9	Bladder
C70.1, C72.0	Meninges
C70.0, C71.0 - C71.9, C72.1 - C72.9	Brain and parts of central nervous system
C73.9	Thyroid
C77.0-C77.9	Lymph nodes

Priority of Codes

In the site-specific surgery code schemes, except where otherwise noted, the following priorities hold:

- Codes 10-70 have priority over codes 80-90.
- In the range 10-70, the higher code has priority.
- Surgery of primary not included in any category should be coded 90.

General Surgery Codes

Use the general cancer-directed surgery scheme in Appendix D for the following sites:

ICD-O-2 CODE	SITE
C15.0-C15.9	Esophagus
C17.0-C17.9	Small intestine
C21.0-C21.8	Anus and anal canal
C22.0	Liver
C22.1	Intrahepatic bile ducts
C23.9	Gallbladder
C24.0-C24.9	Other and unspecified parts of biliary tract
C26.0-C26.9	Other and ill-defined digestive organs

CANCER-DIRECTED SURGERY **(Continued)**

ICD-O-2 CODE	SITE
C30.0-C30.1	Nasal cavity and middle ear
C31.0-C31.9	Accessory sinuses
C33.9	Trachea
C37.9	Thymus
C38.0-C38.8	Heart, mediastinum, and pleura
C39.0-C39.9	Other and ill-defined sites within respiratory system and intrathoracic organs
C42.0-C42.1	Blood and bone marrow
C42.3-C42.4	Reticuloendothelial system, NOS; hematopoietic system, NOS
C48.0-C48.8	Retroperitoneum and peritoneum
C51.0-C51.9	Vulva
C52.9	Vagina
C55.9	Uterus
C57.0-C57.9	Other and unspecified female genital organs
C58.9	Placenta
C60.0-C60.9	Penis
C63.0-C63.9	Other and unspecified male genital organs
C68.0-C68.9	Other and unspecified urinary organs
C69.0-C69.9	Eye and adnexa
C74.0-C74.9	Adrenal gland
C75.0-C75.9	Other endocrine glands and related structures
C76.0-C76.8	Other and ill-defined sites
C80.9	Unknown primary

CANCER-DIRECTED SURGERY AT THIS FACILITY

Item Length: 2
Data Type: Numeric
Supplementary Data Set

Record the type of cancer-directed surgery performed at the reporting facility. Follow the same instructions as listed in data item "Surgery." Refer to Appendix D for a listing of site-specific surgery codes.

Do not record procedures done at other institutions. Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid in program planning.

SURGICAL APPROACH

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 8, 9
Required Data Set

"Surgical Approach" describes the method used to approach the surgical field. Use codes 1-9 only if the patient had cancer-directed surgery of the primary site. Use code 0 if the patient did not have cancer-directed surgery of the primary site.

Use code 8 for TURP, TURB, and colonoscope with polypectomy, and so on.

This item records information on the increasing use of less invasive procedures. The data will make possible a comparative analysis of traditional and laparoscopic approaches.

Codes:

0 No surgery performed
1 Open approach, endoscopy not used
2 Open approach, assisted by laparoscope
3 Laparoscopic approach only
4 Laparoscopy, NOS (unknown if with or without open approach)
5 Video Assisted Thoracoscopy (VAT)
6 Thoracoscopy, NOS
8 Endoscopy, NOS
9 Unknown approach, not applicable

RESIDUAL PRIMARY TUMOR FOLLOWING CANCER-DIRECTED SURGERY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 8, 9
Required Data Set

Residual tumor refers to the primary tumor only, not to metastatic or regional disease. Residual tumor describes the amount of remaining primary tumor AFTER the most definitive resection. Use information only from the operative and pathology reports to evaluate this data field.

This is a hierarchical code with microscopic confirmation taking precedence over macroscopic.

Codes:

0 No residual tumor

1 Microscopic residual tumor

2 Macroscopic residual tumor

8 Not applicable

9 Unknown

Clarification of code definitions:

CODES	DEFINITION
0	The primary tumor was surgically removed and all margins were microscopically free of disease.
1	Primary tumor, too small to be seen by the human eye, remains after surgical resection. The pathology report identifies cancer cells in/at the surgical margins.
2	Primary tumor, large enough to be seen by the human eye, remains after surgical resection. There is grossly identifiable tumor in the surgical margin. If grossly visible tumor was transected in the margin of excision, additional macroscopic tumor would be present.
8	All cases in which the primary tumor is not surgically removed. Example: Reticuloendothelial disease, leukemia, multiple myeloma, unknown primary, prostate cancer diagnosed with a needle biopsy and treated with hormones.
9	Microscopic residual cannot be ruled out. Example: Pathology evaluates “chips” or fragments of tissue from transuretral resections of the prostate or bladder. Margins cannot be evaluated.

RECONSTRUCTIVE SURGERY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Supplementary Data Set

"Reconstructive Surgery" reconstructs, restores, or improves the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies. Reconstruction may be a part of the first course of treatment or may be done after the first course is completed.

Codes:

0 No reconstruction
1 Immediate reconstruction without implant/prosthesis
2 Immediate reconstruction with implant/prosthesis
3 Delayed reconstruction without implant/prosthesis
4 Delayed reconstruction with implant/prosthesis
5 Reconstruction without implant/prosthesis, timing unspecified
6 Reconstruction with implant/prostheses, timing unspecified
7 Reconstruction, NOS
8 Not applicable, no cancer-directed surgery performed
9 Unknown

Clarification of code definitions:

CODES	DEFINITION
0	Reconstruction was not done.
1	Reconstruction was done simultaneously with the surgical procedure. No implants or prosthesis were used.
2	Reconstruction was done simultaneously with the surgical procedure. Implants or prosthesis were used.
3	Reconstruction was performed as a separate procedure, and not in conjunction with cancer-directed treatment. No implants or prosthesis were used.
4	Reconstruction was performed as a separate procedure, and not in conjunction with cancer-directed treatment. Implants or prosthesis were used as part of the reconstructive process.
5	Reconstruction was performed without implants or prosthesis. Sequence (immediate or delayed) is unknown.
6	Reconstruction was performed with implants or prosthesis. Sequence (immediate or delayed) is unknown.
7	The patient had reconstruction. It is unknown if implants or prosthesis were used.
8	The patient did not have cancer-directed surgery, not applicable.
9	It is unknown if reconstructive surgery was performed.

RECONSTRUCTIVE SURGERY **(Continued)**

Examples of reconstructive surgery of the primary site are as follows:

- Breast reconstruction
- Facial reconstruction for head and neck tumors
- Ileal pouch-anal anastomosis for colon primary

REASON FOR NO SURGERY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 6-9
Supplementary Data Set

Record the reason for no cancer-directed surgery. Codes 1-9 are valid only when the field "Cancer-Directed Surgery" is coded 00.

Codes:

0 Cancer-directed surgery performed

1 Cancer-directed surgery not recommended

2 Contraindicated because of other conditions, autopsy-only cases

6 Reason unknown for no cancer-directed surgery

7 Patient or patient's guardian refused surgery

8 Surgery recommended, unknown if done

9 Unknown if cancer-directed surgery recommended or performed; death certificate-only cases

REASON FOR NO SURGERY **(Continued)**

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
0	Cancer-directed surgery was performed. The field "surgery" is coded in the range 10-90.	
1-9	No cancer-directed surgery known to have been performed. The field "Cancer-Directed Surgery" must be coded 00.	
1	Cancer-directed surgery is not recommended for this stage of disease, histologic type, or site.	Small cell carcinoma of the lung; widely metastatic colon cancer; leukemia
2	Cases in which cancer-directed surgery would have been the treatment of choice, but could not be performed because of comorbid conditions. Cases in which surgery was recommended, but the patient expired before it could be performed. Autopsy-only cases (class 5).	Stage I adenocarcinoma of the lung. Patient has severe COPD. Cannot remove any part of the lung because pulmonary function is not adequate.
6	Cancer-directed surgery would have been the treatment of choice; surgery was not performed, but the reason is not given.	
7	Cancer-directed surgery was the treatment of choice and was recommended by the physician. The patient, a family member, or guardian refused surgical treatment.	
8	Cancer-directed surgery was recommended by a physician; no follow-up information available to confirm if surgery was performed.	
9	No cancer-directed surgery known to have been performed. No confirmation if surgery was recommended or performed (frequently non-analytic cases) Death certificate-only cases.	

DATE RADIATION STARTED

Item Length: 8
Data Type: Numeric
Required Data Set

"Date Radiation Started" is the month, day, and year (MMDDCCYY) first course of radiation therapy was started. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Collecting dates for each treatment modality will allow sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

Record the date on which radiation therapy was initiated.

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		

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no radiation therapy is administered, or a case is identified only at autopsy.

Code 99999999 when it is unknown if any radiation therapy was administered, the date is unknown, or the case was identified only from death certificate information.

If the exact date radiation started is not available, record an approximate date.

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

RADIATION
(RADIATION THERAPY)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 9
Required Data Set

Record the type of radiation administered to the primary site or any metastatic site. Include all procedures that are a part of the first course of treatment, whether delivered at the reporting institution or at other institutions.

Codes:

0 None

1 Beam radiation

2 Radioactive implants

3 Radioisotopes

4 Combinations of beam radiation, with radioactive implants, or radioisotopes (combination of 1 with 2 and/or 3)

5 Radiation therapy, NOS (method or source not specified)

9 Unknown if radiation therapy recommended or administered; death certificate cases only

Clarification of code definitions:

CODES	DEFINITION
0	No radiation therapy was administered.
1	X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intraoperative radiation and stereotactic radiosurgery (gamma knife and proton beam).
2	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials (cesium, radium, radon, and radioactive gold).
3	Internal use of radioactive isotopes (iodine-131, phosphorus-32, strontium 89 and 90). Can be administered orally, intracavitary, or by intravenous injection.
4	The patient was treated with a combination of beam radiation and at least one of the two methods described by codes 2 and 3.
5	Radiation was administered, but the method or source is not documented (radiation therapy, NOS).
9	No confirmation if radiation therapy was recommended or performed (frequently non-analytic cases); unknown if radiation therapy administered. Death certificate cases only.

RADIATION AT THIS FACILITY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 9
Supplementary Data Set

Code the type of radiation the patient received at the reporting facility. Record radiation administered to the primary site or any metastatic site as a part of the first course of treatment.

Do not record procedures done at other institutions. Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Codes:

0 None

1 Beam radiation

2 Radioactive implants

3 Radioisotopes

4 Combinations of beam radiation, with radioactive implants, or radioisotopes (combination of 1 with 2 and/or 3)

5 Radiation therapy, NOS (method or source not specified)

9 Unknown if radiation therapy administered

Clarification of code definitions:

CODES	DEFINITION
0	No radiation therapy was administered.
1	X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intraoperative radiation and stereotactic radiosurgery (gamma knife and proton beam).
2	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials (cesium, radium, radon, and radioactive gold).
3	Internal use of radioactive isotopes (iodine-131, phosphorus-32, strontium 89 and 90). Can be administered orally, intracavitary, or by intravenous injection.
4	The patient was treated with a combination of beam radiation and at least one of the two methods described by codes 2 and 3.
5	Radiation was administered, but the method or source is not documented (radiation therapy, NOS).
9	No confirmation if radiation therapy was recommended or performed (frequently non-analytic cases); unknown if radiation therapy administered.

REGIONAL DOSE: cGy

Item Length: 5
Data Type: Numeric
Optional Data Set
Right Justified

"Regional Dose: cGy" is used to code the dominant or most clinically significant dose delivered. This may be highly subjective and require assistance from the radiation oncologist for consistent coding. The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pairs, and so on). For maximum consistency in this field, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the dose as indicated in the summary in the chart.

Do not include boost doses.

This data item is used by radiation oncology departments to evaluate patterns of care and may be helpful in comparing the practices of different institutions.

Record the actual dose delivered.

Examples: A patient with stage III prostate carcinoma receives pelvic irradiation to 5,000 cGy followed by a prostate boost to 7,000 cGy. Record the regional dose as 5,000 cGy.

A patient with stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the access dose of the breast to 5,000 cGy. The supraclavicular lymph nodes are treated to 4,500 cGy, calculated at a depth of 3 cm, and interstitial boost in the primary tumor bed delivers an additional 2,500 cGy to a small volume within the breast. The breast is the primary target; record a regional dose of 5,000 cGy.

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 of 6,450 cGy. Record regional dose reflecting the prescribed dose of 6,000 cGy.

Code 00000 if no radiation therapy was administered.

Code 99999 if radiation therapy was administered but dose is unknown.

NUMBER OF TREATMENTS TO THIS VOLUME

Item Length: 2
Data Type: Numeric
Optional Data Set
Right Justified

Record the actual number of treatment sessions.

A treatment session may include several treatment portals but they are delivered within a relatively confined interval of time, usually a few minutes, and should be counted as one session.

This item is used primarily to evaluate patterns of care and the appropriateness of treatment schedules.

Examples: A patient with stage IIIB bronchogenic carcinoma receives 25 treatments to the left hilum and mediastinum, given in 25 daily treatments over five weeks. A left hilar boost is then given in 10 additional treatments. Record 35 treatments.

A patient with breast carcinoma has treatment sessions in which treatment is delivered to the chest wall and separately to the ipsilateral supraclavicular region for a total of three treatment portals. Twenty-five treatment sessions are given. Record 25 total treatments to the volume.

A patient with advanced head and neck cancer is treated using "hyperfractionation." Three fields are delivered in each session, two sessions are given each day, six hours apart, with each session delivering a total dose of 150 cGy. Treatment is given for a total of 25 days. Record 50 treatments to the volume.

Code 00 if no radiation therapy was administered.

Code 99 if radiation therapy was administered but the number of treatments is unknown.

RADIATION ELAPSED TREATMENT TIME (DAYS)

Item Length: 3
Data Type: Numeric
Optional Data Set
Right Justified

"Radiation Elapsed Treatment Time (Days)" is the actual number of treatment days, including weekend days and intervals of rest.

Count the first day of treatment as day zero (0). If a patient receives only two treatments and they are given on successive days, then the elapsed treatment time would be one day.

Many radiation oncologists believe this is an important factor in tumor control and treatment morbidity. It is potentially useful in quality assurance for evaluating success of patient support programs designed to maintain continuity of treatment.

Example: A patient begins treatment on Monday, January 3rd and completes treatment on Thursday, January 27th. The elapsed treatment time is 27 - 3 = 24 days. Record 24 days.

Code 000 if no radiation therapy was administered.

Code 999 if radiation therapy was administered but the number of treatment days is unknown.

RADIATION TREATMENT VOLUME

Item Length: 2
Data Type: Numeric
Allowable Values: 00-39, 98, 99
Optional Data Set

This field is intended primarily to provide a simple expression of the most common radiation volumes treated.

This item may be used as a quality assurance monitor to evaluate the overall pattern of care within a facility. It is potentially useful as a monitor of appropriateness and efficacy of treatment and in selecting patients for outcome reporting.

In many cases, radiation treatment volume will be most appropriately coded by the radiation oncologist.

Codes:

00 Consult only, no radiation therapy, not applicable
01 Eye/orbit
02 Pituitary
03 Brain (NOS)
04 Brain (limited)
05 Head and neck (NOS)
06 Head and neck (limited)
07 Glottis
08 Sinuses
09 Parotid
10 Chest/lung (NOS)
11 Lung (limited)
12 Esophagus
13 Stomach
14 Liver
15 Pancreas
16 Kidney
17 Abdomen (NOS)
18 Breast
19 Breast/lymph nodes
20 Chest wall
21 Chest wall/ lymph nodes
22 Mantle
23 Lower extended field
24 Spine

RADIATION TREATMENT VOLUME **(Continued)**

Codes:

25 Skull
26 Ribs
27 Hip
28 Pelvic bones
29 Pelvis (NOS)
30 Skin
31 Soft tissue
32 Hemibody
33 Whole body
34 Bladder and pelvis
35 Prostate and pelvis
36 Uterus
37 Shoulder
38 Extremities
39 Inverted Y
98 Other volume
99 Unknown volume

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
00	Patient did not receive radiation therapy.	
01	The radiation therapy target volume is limited to the eye and/or orbit.	Lymphoma of the orbit treated with 4 cm x 4 cm portals.
02	The target volume is restricted to the pituitary gland and all adjacent volumes are irradiated incidentally.	Pituitary adenomas receiving small opposed field or rotational treatment.
03	Treatment is directed at tumors lying within the substance of the brain.	The entire brain is treated for metastatic disease.
04	The treatment volume encompasses less than the total brain.	Limited field irradiation of an oligodendroglioma.

RADIATION TREATMENT VOLUME **(Continued)**

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
05	The treatment volume is directed at a primary tumor of the oropharyngeal complex, usually encompassing regional lymph nodes.	Carcinoma of the left tonsil treated with opposed lateral fields to the neck and an anterior supraclavicular field.
06	Limited volume treatment of a head and neck primary.	Interstitial implant utilized to treat a small carcinoma of the lateral tongue.
07	Treatment is limited to a volume in the immediate neighborhood of the vocal cords.	Small lateral fields utilized to treat a T1 or T2 glottic tumor.
08	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	The primary target is one of the parotid glands. There may be secondary regional lymph node irradiation as well.	
10	Radiation treatment is directed to some combination of hilar mediastinal supraclavicular or peripheral lung structures.	
11	Radiation treatment is directed at just one region of the lung.	Small portal treatment is delivered to the right hilar region to stop hemoptysis.
12	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.	
13	The primary malignancy is in the stomach. Radiation is directed to the stomach and possibly adjacent lymph nodes.	
14	The primary target is all or a portion of the liver, for either primary or metastatic disease.	
15	The primary tumor is in the pancreas. The treatment field encompasses the pancreas and possibly adjacent lymph node regions.	

RADIATION TREATMENT VOLUME **(Continued)**

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
16	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	Include all cases of treatment of abdominal contents that do not fit codes 12-16.	Irradiation for hypersplenism due to lymphoma.
18	The primary target is the intact breast and no attempt has been made to irradiate the regional lymph nodes.	
19	A deliberate attempt has been made to include regional lymph nodes in the treatment of an intact breast.	The radiation therapy record shows that tangent fields have been arranged in a manner that will encompass internal mammary lymph nodes in a patient with a medial primary.
20	The target includes soft-tissue structures of the chest wall (the patient is not being irradiated for rib metastases).	Following mastectomy, a patient has prophylactic chest wall irradiation to prevent local recurrence; a thoracotomy scar is irradiated because of known contamination with tumor.
21	Treatment encompasses the chest wall (after mastectomy) plus fields directed at regional lymph nodes.	
22	Use this code exclusively for patients with Hodgkin's or non-Hodgkin's lymphoma in which a large radiation field has been designed to encompass all the regional lymph nodes above the diaphragm, including cervical, supraclavicular, axillary, mediastinal, and hilar.	
23	The target zone includes lymph nodes below the diaphragm along the periaortic axis. It may include extension to one side of the pelvis. This coding includes the "hockey stick" field utilized to treat seminomas.	

RADIATION TREATMENT VOLUME **(Continued)**

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
24	The primary target relates to the bony structures of the spine, including the sacrum. Note that primary spinal chord malignancies would be coded 98.	An inverted "T" field is utilized to treat painful metastases in the lumbar vertebra and sacrum in a patient with prostate carcinoma.
25	Treatment is directed at the bony structures within the skull. Any brain irradiation is a secondary consequence.	Patient with myeloma receives total skull irradiation for numerous "punched out" lesions that are causing discomfort.
26	Treatment is directed toward metastatic disease in one or more ribs. Fields may be tangential or direct. If soft-tissue disease is present in the region, it is not the primary target of the treatment.	
27	This term is not used very precisely in some radiation therapy practices. It generally refers to treatment of the proximal femur for metastatic disease. In many cases, there may be acetabular disease as well.	
28	The target includes structures of the bony pelvis other than the hip and sacrum.	
29	Irradiation is directed at soft tissues within the pelvic region, and codes 34-36 do not apply.	
30	The primary malignancy originates in the skin and the skin is the primary target. Note that so-called skin metastases are usually subcutaneous and should be coded 31.	
31	All cases of primary or metastatic soft-tissue malignancies not fitting other categories.	
32	A single treatment volume encompasses all structures above the diaphragm (or all structures below the diaphragm). This is almost always administered for palliation of wide-spread bony metastases in patients with prostate or breast cancer.	

RADIATION TREATMENT VOLUME **(Continued)**

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
33	Entire body included in a single treatment	Patient with chronic lymphocytic leukemia receives five treatments of 10 cGy each to reduce adenopathy to lymphocyte count.
34	The primary malignancy originated in the bladder, all or most of the pelvis is treated as part of the plan, usually with a boost to the bladder.	
35	The primary malignancy originated in the prostate, all or most of the pelvis is treated as part of the plan, usually with a boost to the prostate.	
36	Treatment is confined to the uterus. If the entire pelvis is included in a portion of the treatment, code to 29.	Patient receives intracavitary therapy alone for a high-grade stage IA carcinoma of the endometrium.
37	Treatment is directed to the proximal humerus, lateral clavicle, or other components of the shoulder complex, usually for control of symptoms for metastases.	
38	Bony structures of the arms (excluding proximal humerus) or legs (excluding proximal femur).	The distal forearm is treated for a metastatic lesion involving the radius.
39	Treatment has been given to a field that encompasses the periaortic and bilateral inguinal or inguinal-femoral lymph nodes in a single portal.	Stage I-A Hodgkin's disease presenting in an inguinal lymph node.
98	Include all categories that do not fit the above definitions.	Anterior neck is treated for a primary thyroid lymphoma.
99	Radiation has been administered, but the records available do not clearly define the volume.	

LOCATION OF RADIATION TREATMENT

Item Length: 1
Data Type: Numeric
Allowable Values: 0-4, 8, 9
Optional Data Set

Record the location where radiation treatment was administered.

This field provides information useful for assessing the quality and outcome of radiation treatment by delivery site and monitoring the referral pattern for these services.

Codes:

0 No radiation treatment

1 All radiation treatment at this facility

2 Regional treatment at this facility, boost elsewhere

3 Boost radiation at this facility, regional elsewhere

4 All radiation treatment elsewhere

8 Other, NOS

9 Unknown

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
0	No radiation treatment.	
1	The record shows that all radiation treatment was administered at this institution.	
2	Most of the patient's treatment was delivered at this institution. The patient was sent to another institution specifically for a boost treatment, where the boost volume is generally smaller than the regional volume.	Patient with carcinoma of the nasopharynx receives treatment to the entire head and neck region at this institution but is sent to another institution for a high-dose-rate (HDR) intracavitary boost.

LOCATION OF RADIATION TREATMENT **(Continued)**

CODES	DEFINITION	EXAMPLE
3	Only the boost treatment is administered at this institution. Other treatment to the region was administered elsewhere.	The reporting institution has HDR treatments available. A patient with carcinoma of the nasopharynx is diagnosed at another institution and receives regional external beam radiation therapy there and then is referred to the reporting institution for intracavitary HDR treatment.
4	All radiation treatment was administered at another institution. The data in adjacent radiation treatment fields identify the treatment given elsewhere.	
8	The patient's treatment pattern does not fit the above categories.	Regional treatment is initiated at another institution and midway through treatment, the patient is transferred to the reporting institution for completion of therapy while he or she resides with a nearby relative.
9	Patient is known to have received radiation treatment, but the records do not define the location.	

INTENT OF TREATMENT (RADIATION)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 4-6, 8,9
Optional Data Set

Code the intent of radiation treatment.

This item is useful in assessing the appropriateness of treatment and correlating outcome with original intent of the treatment. The choice in this data field is subjective.

The responsible radiation oncologist is the best person to provide this information.

Codes:

0 No radiation treatment

1 Curative (primary)

2 Curative (adjuvant)

4 Palliative (pain control)

5 Palliative (other, cosmetic)

6 Prophylactic (no symptoms, preventive)

8 Other, NOS

9 Unknown

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
0	Patient did not receive radiation therapy as part of the first course of treatment.	
1	Radiation treatment, which is administered as part of the primary plan for control of the disease, is believed to be a major factor in the control of the disease, that is, recurrence would be very likely without the radiation therapy.	The breast is irradiated following local excision for Infiltrating ductal carcinoma; mediastinal and hilar structures are irradiated with curative intent in a patient with inoperable stage IIIA bronchogenic carcinoma.
2	Radiation treatment is administered as a supplement to some other therapy that is generally recognized as the primary modality for control of the disease. The radiation is intended to “improve the odds” of local/regional control.	Pelvic irradiation following anterior resection for carcinoma of the sigmoid colon, stage III.

INTENT OF TREATMENT (RADIATION) **(Continued)**

CODES	DEFINITION	EXAMPLE
4	Radiation treatment is directed to a site primarily for the purpose of pain control. Other benefits of the radiation are considered secondary contributions to the patient's quality of life.	Painful hip metastasis from prostate carcinoma with no evidence of impending hip fracture.
5	This classification encompasses most other noncurative applications of radiation treatment, in which pain is not a major factor.	Lymphoma patients with a large axillary mass that is painless, but interferes with movement and activity, radiation therapy is directed to reduce the size of the mass; HIV patient with Kaposi's sarcoma nodules on the face that are asymptomatic, but cause distressing disfigurement.
6	Prophylactic radiation therapy is administered for the purpose of preventing the development of symptoms in a setting in which clinical evidence indicates that problems are likely to develop if treatment is not administered.	Patient with lung cancer has a pelvic X-ray with the incidental finding of a large, but painless, lytic lesion of the left hip, and radiation treatment is administered to stop the destruction that might lead to fracture; an asymptomatic supraclavicular mass is irradiated to prevent the development of a brachial plexus injury.
8	Record this value for those special circumstances not fitting any of the earlier categories.	
9	The patient received radiation treatment, but information on the record does not clearly indicate the purpose.	

REGIONAL TREATMENT MODALITY

Item Length: 2
Data Type: Numeric
Allowable Values: 00-16, 98, 99
Optional Data Set

"Regional Treatment Modality" is intended to identify the dominant modality of therapy delivered to the primary volume of interest. In some cases, it may be appropriate to choose a code for its academic or economic interest, even though it may not reflect the majority of the patient's therapy. For example, a patient with carcinoma of the nasopharynx may receive original treatment using a linear accelerator and then have a boost with High-Dose-Rate (HDR) brachytherapy. In a department with a special interest in brachytherapy, the code 15 would be chosen.

This field can be useful in assessing resource utilization, planning for expansion, or monitoring quality. It should be used at the discretion of the Radiation Oncologist.

Codes:

00 No radiation therapy
01 Orthovoltage
02 Cobalt 60, cesium 137
03 X-Rays (2-5 MV)
04 X-Rays (6-10 MV)
05 X-Rays (11-19 MV)
06 X-Rays (>19 MV)
07 X-Rays (mixed energies)
08 Electrons
09 X-Rays and electrons (mixed)
10 Neutrons (with or without X-Ray/electrons)
11 Megavoltage (NOS)
12 Protons
13 Stereotactic radiosurgery
14 Brachytherapy (standard)
15 Brachytherapy, High-Dose-Rate (HDR)
16 Intraoperative radiation therapy (IORT)
98 Other, NOS
99 Unknown

REGIONAL TREATMENT MODALITY (Continued)

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
00	Treatment not administered	
01	External beam treatment administered using equipment with a maximum voltage of less than one (1) MV	
02	External beam therapy using a machine containing either a cobalt 60 or cesium 137 source. Intracavitary use of these sources would be coded to "14."	
03-06	All or most of the patient's treatment was delivered by external beam using an X-ray producing machine, such as a linear accelerator or Van de Graf accelerator. The breakdown here follows the rules used for CPT coding.	
07	All or most of the treatment was delivered by external beam X-ray, but more than one energy was utilized in the course of treatment.	
08	All of the treatment was delivered by electron beam.	
09	Treatment was administered with some combination of X-rays and electrons.	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-MeV electrons.
10	Any part of the patient's radiation treatment was delivered using neutron beam.	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.

REGIONAL TREATMENT MODALITY **(Continued)**

CODES	DEFINITION	EXAMPLE
11	The patient is known to have received external beam therapy but the specific energies are unknown.	A patient with a head and neck cancer is referred from another institution for an HDR brachytherapy boost. Detailed treatment records from the other institution are not available.
12	Any portion of the patient's treatment was delivered by proton therapy.	A patient with prostate carcinoma receives pelvic irradiation at his home institution and is then referred to a major medical center for experimental proton therapy boost.
13	Any portion of the patient's treatment has included stereotactic radiosurgery.	
14	Use this to code all cases of interstitial or intracavitary therapy with radioisotopes.	Patient receives external pelvic treatment to 4,500 cGy for cervix carcinoma then receives two Fletcher intracavitary implants; a patient treated with breast conservation has an interstitial boost at the time of the the excisional biopsy. The implant uses Ir-192 and is left in place for three days.
15	The patient receives primary or boost therapy using HDR brachytherapy equipment. Typically, the treatment application takes just a few minutes and the patient is rarely, if ever, admitted to the hospital.	

REGIONAL TREATMENT MODALITY **(Continued)**

CODES	DEFINITION	EXAMPLE
16	Part or all of the treatment was administered using external beam (X-ray) equipment in an operating room environment.	Patient with a suspected carcinoma of the pancreas has exploratory surgery in the radiation therapy department and during the operation, external beam radiation is administered to the tumor.
98	Code all treatments that do not fit one of the above categories.	
99	It is known that the patient received radiation treatment, but the records do not provide enough information to code the modality.	

RADIATION THERAPY TO CNS
(RADIATION THERAPY TO THE CENTRAL NERVOUS SYSTEM)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-1, 7-9
Optional Data Set

These data are being kept for historical purposes. Do not code for cases diagnosed as of January 1, 1996. Cases diagnosed on or after January 1, 1996, should be coded in the field "Radiation."

Radiation treatment to the central nervous system (CNS) codes 0-8 are valid only for patients with lung or leukemia primaries. Code 9 (not applicable) for all other cases.

Codes:

0 No radiation therapy to the brain or central nervous system

1 Radiation therapy

7 Patient or patient's guardian refused radiation therapy

8 Radiation therapy recommended, unknown if administered

9 Unknown

Clarification of code definitions:

CODES	DEFINITION
0	Lung or leukemia primary, no radiation treatment to CNS. Autopsy only (lung or leukemia primary).
1	Lung or leukemia primary, radiation was administered to the brain or CNS. (This is coded if radiation is prophylactic or if there are CNS metastases present. The code states only that radiation was administered; it does not confirm the absence or presence of CNS metastases.)
7	Lung or leukemia primary, radiation to CNS was recommended but the patient, the patient's family, or guardian refused the treatment.
8	Lung or leukemia primary, radiation treatment to CNS was recommended by a physician or patient was referred for a radiation consult with the intent of delivering radiation to CNS. Follow-up does not confirm that treatment was received.
9	All other sites and histologic types (NOT lung or leukemia). Death certificate only (lung and leukemia cases).

RADIATION/SURGERY SEQUENCE
(RADIATION THERAPY SEQUENCE WITH SURGERY)

Item Length: 1
Data Type: Numeric
Acceptable Values: 0, 2-6, 9
Optional Data Set

Radiation treatment sequence with surgery defines the order in which radiation therapy and cancer-directed surgery were delivered during first course of treatment. Code in the range of 2-6 ONLY if the patient had both cancer-directed surgery AND radiation therapy as first course of treatment. Surgery is limited to cancer-directed only (the field "Cancer-Directed Surgery" must be coded in the range of 10-90). Non cancer-directed surgery (biopsy, bypass, exploratory) does not qualify.

For patients who had both surgery and radiation, code the sequence of events.

Codes:

0 No radiation therapy and/or cancer-directed surgery
2 Radiation therapy before surgery
3 Radiation therapy after surgery
4 Radiation therapy both before and after surgery
5 Intraoperative radiation therapy
6 Intraoperative radiation therapy with other radiation therapy administered before or after surgery
9 Sequence unknown, but both surgery and radiation therapy were administered

RADIATION TREATMENT COMPLETION STATUS

Item Length: 1
Data Type: Numeric
Optional Data Set
Allowable Values: 0-9

"Radiation Treatment Completion Status" is useful in evaluating treatment outcomes and the appropriateness of the initial decision to treat.

This field indicates whether the patient's radiation therapy was completed as outlined in the initial treatment plan. This information is generally available only in the radiation treatment chart.

Codes:

0 No radiation treatment

1 Treatment completed

2 Radiation not complete, patient health

3 Radiation not complete, patient expired

4 Radiation not complete, patient choice

5 Radiation not complete, family choice

6 Radiation not complete, complications

7 Radiation not complete, cytopenia

8 Radiation not complete, other reason

9 Radiation not complete, reason unknown

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
0	Patient did not receive radiation treatment.	
1	Radiation therapy was completed to the point outlined in the original treatment prescription.	
2	Treatment was discontinued because of concurrent medical problems that were not related to the radiation treatment.	Patient receiving primary treatment for bronchogenic carcinoma has a severe myocardial infarction. The patient is judged to have a very poor prognosis because of the heart disease, and the radiation treatment is discontinued.
3	The patient expired while receiving therapy but before completing treatment.	

RADIATION TREATMENT COMPLETION STATUS **(Continued)**

CODES	DEFINITION	EXAMPLE
4	The patient elected to discontinue treatment.	An alcoholic patient receiving treatment for a tonsillar carcinoma develops severe oral mucositis. The patient is last seen in a local tavern and does not return for therapy.
5	Treatment is discontinued at the request of one or more family members; the patient is unable to participate in this decision-making process.	
6	Treatment is discontinued because of the unplanned effects of acute radiation treatment complications.	An elderly patient with rheumatoid arthritis had been receiving low-dose methotrexate for control of joint symptoms before pelvic treatment was initiated for rectal carcinoma. At 3,000 cGy, the patient develops severe proctitis and bleeding, and treatment is stopped.
7	Treatment is discontinued because of low peripheral blood counts. This classification should be reserved for those circumstances in which the cytopenia is considered directly due the radiation therapy and not some other cause, such as concurrent chemotherapy.	The patient is scheduled to have sequential hemibody irradiation. The second phase of the treatment is never administered because the patient develops cytopenia after upper hemibody irradiation and the blood counts never return to normal.
8	Use this classification when a reason for discontinuance of treatment is known, but it does not fit the above categories.	
9	Patient did not complete the planned treatment and the reason is not specified on the record.	

RADIATION THERAPY LOCAL CONTROL STATUS (IRRADIATED VOLUME)

Item Length: 1
Data Type: Numeric
Optional Data Set
Allowable Values: 0-4, 8, 9

"Radiation Therapy Local Control Status" records the radiation treatment results in terms of disease control within the irradiated volume. The data may be used in quality assurance studies to assess the effectiveness of treatment. This is a dynamic data item. To be clinically useful, these data must be evaluated at each follow-up.

Codes:

0 No radiation treatment

1 Tumor control status not evaluable

2 Tumor/symptoms controlled

3 Tumor/symptoms have returned

4 Tumor/symptoms never adequately controlled

8 Other, NOS

9 Unknown

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
0	Patient did not receive radiation treatment.	
1	A volume has been treated but there are no objective criteria for assessing tumor control.	An asymptomatic patient with known carcinoma of the pancreas receives pancreatic irradiation. There are no follow-up CT studies on the record, the patient never becomes symptomatic and dies of cardiac disease.

RADIATION THERAPY LOCAL CONTROL STATUS **(Continued)**

CODES	DEFINITION	EXAMPLE
2	Available objective and subjective evidence indicates that there is no sign of active disease in the irradiated volume.	Irradiation is given to the breast following local excision. At the time of last follow-up, there was no evidence of local recurrence; a patient with stage III carcinoma of the prostate receives definitive treatment, and at the last follow-up, the PSA is normal, and the prostate is palpably normal; the patient with stage III prostate carcinoma is treated definitively, the gland returns to normal, and PSA returns to normal; the gland remains normal at last follow-up but the PSA is 20—local control appears to have been maintained; the PSA may be a reflection of metastatic disease.
3	Initially there is evidence of local tumor control, but at last follow-up, the symptoms have recurred.	Patient with stage III prostate carcinoma received definitive irradiation, the PSA dropped into the normal range, and the prostate became palpably normal. Now the PSA remains normal, but a new nodule is palpable in the prostate.

RADIATION THERAPY LOCAL CONTROL STATUS **(Continued)**

CODES	DEFINITION	EXAMPLE
4	There was measurable disease within the treatment volume that never achieved a complete response after irradiation.	Patient with stage III prostate carcinoma presented with elevated PSA. After irradiation, the gland remains abnormal to palpation and the PSA never returns into the normal range.
8	Use this code for any patient that does not fit one of the above categories; this code should rarely be used.	
9	The local tumor control status remains unknown.	

REASON FOR NO RADIATION

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 6-9
Supplementary Data Set

Record the reason the patient did not receive radiation treatment.

Codes:

0 Radiation treatment performed

1 Radiation treatment not recommended

2 Radiation contraindicated because of other conditions; autopsy only cases

6 Reason unknown for no radiation therapy

7 Patient or patient's guardian refused radiation

8 Radiation treatment recommended, unknown if administered

9 Unknown if radiation recommended or performed; death certificate only cases

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
0	Radiation therapy was performed as part of the first course of treatment.	
1	Radiation therapy was considered but not recommended as appropriate for this stage of disease, for this histologic type, or for this site.	Stage I colon carcinoma after wide local resection with clear margins.
2	Cases in which radiation therapy would have been recommended as part of the treatment plan but could not be performed because of comorbid conditions. Cases in which radiation therapy was recommended, but the patient expired before radiation was given. Autopsy only cases (class 5)	Stage I adverse inviltrating ductal carcinoma of the breast, completely locally excised, in a patient with severe and poorly compensated cardiac disease, not expected to live more than a year.
6	Radiation therapy was part of the treatment plan, but it was not done and the reason is not given.	Breast conservation surgery performed in a young, healthy woman. Radiation therapy is not given and the records do not state why.

REASON FOR NO RADIATION **(Continued)**

CODES	DEFINITION	EXAMPLE
7	Radiation therapy was the treatment of choice and was recommended by the physician. The patient, a family member, or guardian refused radiation treatment.	
8	Radiation therapy was recommended. There is no information on whether the patient received radiation.	
9	Available medical records do not state whether radiation therapy was considered, consultation performed, treatment recommended, or treatment performed. Death certificate only cases.	

DATE CHEMOTHERAPY STARTED

Item Length: 8
Data Type: Numeric
Required Data Set

Record the month, day, and year (MMDDCCYY) first course of chemotherapy was started. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

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

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		

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no chemotherapy is administered and for cases diagnosed at autopsy.

Code 99999999 when it is unknown if any chemotherapy was administered, the date is unknown, or the case was identified from death certificate information.

If the exact date chemotherapy started is not available, record an approximate date.

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

CHEMOTHERAPY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 9
Required Data Set

Record the type of chemotherapy administered as first course of treatment at your institution and at all other institutions. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Codes:

0 None

1 Chemotherapy, NOS

2 Chemotherapy, single agent

3 Chemotherapy, multiple agents (combination regimen)

9 Unknown if chemotherapy recommended or administered; death certificate only cases

Chemotherapeutic agents may be administered by intravenous infusion or given orally.

Other methods of administration include the following:

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.

Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy drugs. The interval of a treatment cycle varies and chemotherapy may be administered for several weeks or several years.

Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs*, Third Edition, for drug categories.

CHEMOTHERAPY (Continued)

Clarification of terms:

TERMS	DEFINITIONS
Adjuvant chemotherapy	Chemotherapy is given after other methods have destroyed the clinically detectable cancer cells. Chemotherapy is given to destroy micrometastases (undetectable cancer cells). The intent is to prevent or delay a recurrence. *Example:* The patient has breast cancer with positive nodes. The patient is clinically free of disease after a modified radical mastectomy. The patient is treated with adjuvant chemotherapy to prevent or delay disease recurrence.
Multimodality therapy Combined modality therapy Concurrent therapy	Chemotherapy given before, during, or after other treatment modalities (surgery, radiation) as a part of the treatment plan.
Neo-adjuvant therapy	Given prior to surgical resection or radiation therapy to reduce the bulk of a locally advanced primary cancer. *Example*: A patient with locally advanced breast cancer receives chemotherapy to reduce tumor size. Chemotherapy is followed by a modified radical mastectomy.

CHEMOTHERAPY **(Continued)**

Chemotherapy group classifications:

GROUP	SUBGROUP(S)	EXAMPLES
Alkylating agents	Nitrogen mustard	Mechlorethamine (Mustargen), phenylalanine mustard (Melphalan), chlorambucil (Leukeran), cyclophosphamide (Cytoxan)
	Ethylenimine derivatives	Triethylene-thiophosphoramide (Thio-TEPA)
	Alkyl sulfonates	Busulfan (Myleran)
	Nitrosoureas	Carmustine (Lomustine)
	Triazines	DTIC (Dacarbazine)
Antimetabolites	Folic acid analogues	Methotrexate (Amethopterin, MTX)
	Pyrimidine analogues	5-fluorouracil (5-FU)
	Purine analogues	6-mercaptopurine (6-MP)
Natural products	Anti-tumor	Dactinomycin (Actinomycin D), doxorubicin (Adriamycin), daunorubicin (Daunomycin), bleomycin (Blenoxane), mitomycin C (Mutamycin)
	Plant alkaloids	Vinblastine (Velban, VBL), vincristine (Oncovin, VCR)
	Enzymes	L-asparaginase (Elspar)
Miscellaneous		Cis-diammine dichloroplatinum II (Cisplatin), hydroxyurea (Hydrea), procarbazine (Matulane)

If the patient has an adverse reaction, the physician may change one of the drugs in a combination regimen. If the replacement drug belongs to the same group as the original drug, there is no change in the regimen. If the replacement drug is in a different group than the original drug, code the new regimen as subsequent therapy.

Example: The physician documents a multimodality treatment plan that includes a combination regimen of chemotherapy. Velban is one of the drugs in the chemotherapy regimen. After two cycles of chemotherapy, the physician says the Velban will be replaced with Oncovin and the chemotherapy will continue as planned. This is a continuation of the planned first course of therapy.

Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs*, Third Edition, for drug categories.

CHEMOTHERAPY AT THIS FACILITY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 9
Supplementary Data Set

Record the type of chemotherapy administered at the reporting facility as first course of treatment. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis. See data item "Chemotherapy" for a detailed description of chemotherapeutic terms and agents.

Record only chemotherapy administered at or by the reporting facility. Do not record chemotherapy delivered by other institutions. Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Codes:

0 None

1 Chemotherapy, NOS

2 Chemotherapy, single agent

3 Chemotherapy, multiple agents (combination regimen)

9 Unknown if chemotherapy administered

CHEMOTHERAPY FIELD #1

Item Length:
Data Type:
Optional Data Set

In development.

CHEMOTHERAPY FIELD #2

Item Length:
Data Type:
Optional Data Set

In development.

CHEMOTHERAPY FIELD #3

Item Length:
Data Type:
Optional Data Set

In development.

CHEMOTHERAPY FIELD #4

Item Length:
Data Type:
Optional Data Set

In development.

REASON FOR NO CHEMOTHERAPY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 6-9
Supplementary Data Set

Record the reason the patient did not receive chemotherapy. "Reason for No Chemotherapy" is useful in survival analysis. It is a quality assurance monitor of appropriateness of treatment.

Codes:

0 Chemotherapy administered

1 Chemotherapy not recommended

2 Chemotherapy contraindicated because of other conditions; autopsy only cases

6 Reason unknown for no chemotherapy

7 Patient or patient's guardian refused chemotherapy

8 Chemotherapy recommended, unknown if administered

9 Unknown if chemotherapy recommended or administered; death certificate only cases

CODES	DEFINITION
0	Chemotherapy was administered. The field "Chemotherapy" is coded in the range 1-3.
1-9	No chemotherapy. The field "Chemotherapy" must be coded 0 or 9.
1	Chemotherapy is not the method recommended for this stage of disease, this histologic type, or this site.
2	Cases in which chemotherapy would have been the treatment of choice, but could not be performed because of comorbid conditions. Cases in which chemotherapy was recommended, but patient expired before the treatment was started. Autopsy only cases (class 5)
6	Chemotherapy would have been the treatment of choice, but was not administered; the reason is not given.
7	Chemotherapy was the treatment of choice and was recommended by the physician. The patient, a family member, or guardian refused chemotherapy.
8	Chemotherapy was recommended by a physician; no follow-up information available to confirm if chemotherapy was administered.
9	No confirmation if chemotherapy was recommended or administered (frequently nonanalytic cases) Death certificate only cases.

DATE HORMONE THERAPY STARTED **Item Length: 8**
Data Type: Numeric
Required Data Set

Record the month, day, and year (MMDDCCYY) first course of hormone therapy was started. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Collecting dates for each treatment modality will allow sequencing of multiple therapies and aid evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

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		

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no hormone treatment is administered and for cases diagnosed at autopsy.

Code 99999999 when it is unknown if any hormone treatment was administered, the date is unknown, or the case was identified from death certificate information.

If the exact date hormone treatment started is not available, record an approximate date.

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

HORMONE THERAPY
(HORMONE/STEROID [ENDOCRINE] THERAPY)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 9
Required Data Set

Record the type of hormone therapy the patient received as a part of first course of treatment at your institution and all other institutions.

Codes:

0 None

1 Hormone (including NOS and antihormones)

2 Endocrine surgery and/or endocrine radiation therapy (if cancer is of another site)

3 Combination of 1 and 2

9 Unknown if hormonal therapy recommended or administered; death certificate only cases

Hormones can be used to alter the growth of cancer. Some tissues, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone responsive. Other primaries and histologic types may be hormone responsive, such as melanoma and hypernephroma. Hormonal therapy may effect a long-term control of the cancer growth. It is not usually used to "cure" the cancer.

Record Prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

Exception: When prednisone is administered for other reasons, do not code as hormone therapy.

Examples: A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy.

A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Do not code the prednisone as hormone therapy.

Tumor involvement or cancer-directed 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 the replacement therapy as a cancer-directed hormone treatment.

Example: Patients with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. These patients must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy.

Exception: Thyroid hormone replacement inhibits the pituitary production of thyroid-stimulating hormone (TSH). Because TSH could stimulate tumor growth, the thyroid hormone replacement is also a cancer-directed treatment.

HORMONE THERAPY **(Continued)**

Irradiation and/or surgery must be bilateral to qualify as endocrine surgery. If only one gland is intact, surgery and/or radiation to that remaining gland qualifies as endocrine surgery. Endocrine surgery and radiation are used for prostate cancer.

Refer to *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs*, Third Edition, for drug categories.

HORMONE THERAPY AT THIS FACILITY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 9
Supplementary Data Set

Record the type of hormone therapy administered at the reporting facility as a part of first course of treatment. See data item "Hormone Therapy" for detailed description.

Record only hormone therapy received at the reporting facility. Do not record therapy administered at other institutions. Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Codes:

0 None

1 Hormone (including NOS and antihormones)

2 Endocrine surgery and/or endocrine radiation therapy (if cancer is of another site)

3 Combination of 1 and 2

9 Unknown if hormonal therapy recommended or administered; death certificate only cases

Irradiation and/or surgery must be bilateral to qualify as endocrine surgery. If only one gland is intact, surgery and/or radiation to that remaining gland qualifies as endocrine surgery. Endocrine surgery and radiation are used for prostate cancer.

Refer to *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs*, Third Edition, for drug categories.

REASON FOR NO HORMONE THERAPY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 6-9
Supplementary Data Set

Code the reason the patient did not receive hormone therapy.

Codes:

0 Hormone therapy administered

1 Hormone therapy not recommended

2 Hormone therapy contraindicated because of other conditions; autopsy only cases

6 Reason unknown for no hormone therapy

7 Patient or patient's guardian refused hormone therapy

8 Hormone therapy recommended, unknown if administered

9 Unknown if hormone therapy recommended or administered; death certificate only cases

Clarification of code definitions:

CODES	DEFINITION
0	Hormone therapy was given. The field "Hormone Therapy" is coded in the range 1-3.
1-9	No hormone therapy given. The field "Hormone Therapy" must be coded 0 or 9.
1	Hormone therapy is not the method recommended for this stage of disease, this histologic type, or this site.
2	Cases in which hormone therapy would have been the treatment of choice, but could not be administered because of comorbid conditions. Cases in which hormone therapy was recommended, but the patient expired before therapy was administered. Autopsy only cases (class 5).
6	Hormone therapy would have been the treatment of choice, but was not administered; the reason is not given.
7	Hormone therapy was the treatment of choice and was recommended by the physician. The patient, a family member, or guardian refused hormone therapy.
8	Hormone therapy was recommended, but no information is available about whether the patient received hormones.
9	No confirmation if hormone therapy was recommended or administered (frequently nonanalytic cases). Death certificate only cases.

DATE IMMUNOTHERAPY STARTED

Item Length: 8
Data Type: Numeric
Required Data Set

Record the month, day, and year (MMDDCCYY) first course of immunotherapy was started. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

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

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		

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no immunotherapy is administered and for cases diagnosed at autopsy.

Code 99999999 when it is unknown if any immunotherapy was administered, the date is unknown, or the case was identified from death certificate information.

If the exact date immunotherapy started is not available, record an approximate date.

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

IMMUNOTHERAPY
(BIOLOGICAL RESPONSE MODIFIER THERAPY)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 7-9
Required Data Set

Record the immunotherapy (biological response modifier) the patient received as a part of first course of treatment at the reporting institution and all other institutions. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

Codes:

0 None
1 Biological response modifier
2 Bone marrow transplant - autologous
3 Bone marrow transplant - allogeneic
4 Bone marrow transplant, NOS
5 Stem cell transplant
6 Combination of 1 and any 2, 3, 4, or 5
7 Patient or patient's guardian refused
8 Biological response modifier therapy recommended, unknown if administered
9 Unknown if biological response modifier therapy recommended or administered

Immunotherapy includes:

- BCG vaccine
- C-Parvum
- Interferon
- Levamisole
- MVE-2
- Pyran copolymer
- Thymosin
- Vaccine therapy
- Virus therapy

Refer to *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs*, Third Edition, for drug categories.

IMMUNOTHERAPY AT THIS FACILITY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 7-9
Supplementary Data Set

Record the immunotherapy (biological response modifier) the patient received at the reporting facility as a part of first course of treatment. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

Record only immunotherapy received at the reporting facility. Do not record procedures done at other institutions. Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Codes:

0 None
1 Biological response modifier
2 Bone marrow transplant - autologous
3 Bone marrow transplant - allogeneic
4 Bone marrow transplant, NOS
5 Stem cell transplant
6 Combination of 1 and any 2, 3, 4, or 5
7 Patient or patient's guardian refused
8 Biological response modifier therapy recommended, unknown if administered
9 Unknown if biological response modifier therapy recommended or administered

Immunotherapy includes:

- BCG vaccine
- C-Parvum
- Interferon
- Levamisole
- MVE-2
- Pyran copolymer
- Thymosin
- Vaccine therapy
- Virus therapy

Refer to *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs*, Third Edition, for drug categories.

DATE OTHER TREATMENT STARTED

Item Length: 8
Data Type: Numeric
Required Data Set

Record the month, day, and year (MMDDCCYY) first course of other treatment was started. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

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

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		

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no other treatment is administered and for cases diagnosed at autopsy.

Code 99999999 when it is unknown if any other treatment was administered, the date is unknown, or the case was identified from death certificate information.

If the exact date other treatment started is not available, record an approximate date.

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

OTHER TREATMENT
(OTHER CANCER-DIRECTED THERAPY)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 6-9
Required Data Set

Record other cancer-directed therapy received by the patient as part of the first course of treatment at the reporting institution and all other institutions.

"Other Treatment" includes therapies designed to modify or control the cancer cells that are not defined in "Surgery," "Radiation," "Chemotherapy," or "Hormone Therapy" fields.

Codes:

0 No other cancer-directed therapy, except as coded elsewhere

1 Other cancer-directed therapy

2 Other experimental cancer-directed therapy (not included elsewhere)

3 Double-blind clinical trial, code not yet broken

6 Unproven therapy (including laetrile, krebiozen, etc.)

7 Patient or patient's guardian refused therapy which would have been coded 1-3 above

8 Other cancer-directed therapy recommended, unknown if administered

9 Unknown if other cancer-directed therapy administered

Clarification of code definitions:

CODES	DEFINITION
0	All cancer-directed therapy was coded in other treatment fields. Patient received no cancer-directed therapy.
1	Cancer-directed therapy that cannot be appropriately assigned to other specific treatment codes. *Examples:* hyperbaric oxygen (as adjunct to cancer-directed treatment) or hyperthermia.
2	This code is not defined. It may be used for institution-based clinical trials.
3	Patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind clinical trial code is broken.
6	Treatments given by nonmedical personnel.
7	The physician recommended cancer-directed therapy that could not be appropriately assigned to other specific treatment codes. The patient or the patient's family refused treatment.
8	The physician recommended cancer-directed therapy that could not be appropriately assigned to other specific treatment codes. No follow-up information is available to confirm whether the patient received the therapy.
9	There is reason to believe that other cancer-directed therapy was recommended or given, but there is no information to confirm the recommendation or administration of treatment.

OTHER TREATMENT **(Continued)**

Do not code ancillary drugs in this field. There is no coding scheme for ancillary drugs.

Examples: Ancillary drugs:

Allopurinol

G-CSF (growth stimulating factors)

Epogen

Nupogen

Note: This is a partial list. See the *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs*, Third Edition, for a more complete listing.

OTHER TREATMENT AT THIS FACILITY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 6, 8, 9
Supplementary Data Set

Record other cancer-directed therapy received by the patient at the reporting facility as part of the first course of treatment.

Record only other cancer-directed treatment received at the reporting facility. Do not record procedures done at other institutions. Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Codes:

0 No other cancer-directed therapy, except as coded elsewhere

1 Other cancer-directed therapy

2 Other experimental cancer-directed therapy (not included elsewhere)

3 Double-blind clinical trial, code not yet broken

6 Unproven therapy (including laetrile, krebiozen, etc.)

8 Other cancer-directed therapy recommended, unknown if administered

9 Unknown if other cancer-directed therapy administered

Clarification of code definitions:

CODES	DEFINITION
0	All cancer-directed therapy was coded in other treatment fields. Patient received no cancer-directed treatment.
1	Cancer-directed therapy that cannot be appropriately assigned to other specific treatment codes. *Examples*: hyperbaric oxygen (as adjunct to cancer-directed treatment) or hyperthermia.
2	This code is not defined. It may be used for institution-based clinical trials.
3	Patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind clinical trial code is broken.
6	Treatments given by nonmedical personnel.
8	The physician recommended cancer-directed therapy that could not be appropriately assigned to other specific treatment codes. No follow-up information is available to confirm whether the patient received the therapy.
9	There is reason to believe that other cancer-directed therapy was recommended or given, but there is no information to confirm the recommendation or administration of treatment.

OTHER TREATMENT AT THIS FACILITY **(Continued)**

Do not code ancillary drugs in this field. There is no coding scheme for ancillary drugs.

Examples: Ancillary drugs:

Allopurinol

G-CSF (growth stimulating factors)

Epogen

Nupogen

Note: This is a partial list. See the *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs,* Third Edition, for a more complete listing.

PROTOCOL ELIGIBILITY STATUS

Item Length: 1
Data Type: Numeric
Allowable Values: 0-4, 6-9
Supplementary Data Set

Record the eligibility status of the patient to be entered into a protocol. Analysis of protocol eligibility status assists program planning.

Codes:

0 Protocol not available

1 On protocol

2 Patient ineligible (age, stage, etc.)

3 Patient ineligible (comorbidity, preexisting condition)

4 Patient entered but withdrawn from study

6 Patient eligible, not entered, reason not specified

7 Patient eligible, patient or patient's guardian refused

8 Protocol not recommended

9 Unknown if on protocol

Clarification of code definitions:

CODE	DEFINITION
0	No protocols available for this type of case (for example, site, histologic type)
1	The patient was enrolled in the protocol and started treatment
2	Patient was not entered into protocol because he or she did not meet eligibility criteria (age, stage of disease)
3	Patient was not entered into protocol because he or she did not meet eligibility criteria (pre-existing condition or comorbidity)
4	Patient met eligibility criteria, entered protocol, started treatment, then stopped participating in the protocol. The decision to stop may be the patient's or physician's.
6	Patient met eligibility criteria, did not start treatment, reason is not known
7	Patient did meet eligibility criteria but refused protocol enrollment
8	The physician discussed the protocol with the patient and assessed the patient for protocol participation. The physician did not recommend entering the patient into the protocol.
9	Unknown if protocol was discussed with patient or if patient is participating in a protocol.

PROTOCOL PARTICIPATION

Item Length: 2
Data Type: Numeric
Allowable Values: 00-11, 99
Supplementary Data Set

Record whether the patient was enrolled in and treated on a protocol. A physician may treat a patient following the guidelines of an established protocol; however, the patient is not enrolled into the protocol. For these patients, use code 00 (not on/not applicable).

Codes:

00 Not on/not applicable
01 NSABP
02 GOG
03 RTOG
04 SWOG
05 ECOG
06 POG
07 CCG
08 CALGB
09 NCI
10 ACS
11 National protocol, NOS
99 Unknown

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RECURRENCE

DATE OF FIRST RECURRENCE

Item Length: 8
Data Type: Numeric
Required Data Set

Record the month, day, and year (MMDDCCYY) of first recurrence, based on the best available information. The term "recurrence" defines the return or reappearance of the cancer after a disease-free intermission or remission. Date of first recurrence is the date a medical practitioner diagnoses metastatic or recurrent cancer.

The first two digits record the month, the third and fourth digits record the day, and the last four digits record the year of recurrence.

Month	**Day**	**Year**
01 January	1	Use four digit year
02 February	2	9999 Year unknown
03 March	3	
04 April	..	
05 May	..	
06 June	..	
07 July	30	
08 August	31	
09 September	99 Day unknown	
10 October		
11 November		
12 December		
99 Month unknown		

Example: Record December 13, 1996 as 12131996.

Code 00000000 if the patient became disease free after treatment, or never had a recurrence, or if the patient was never disease free.

Code 99999999 when it is unknown if the patient had a first recurrence.

If the exact date of first recurrence is not available, record an approximate date.

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	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
Data Type: Numeric
Allowable Values: 00, 10, 11, 15, 20-22, 25, 30, 40, 70, 88, 99
Required Data Set

Record the type of recurrence. "Type of First Recurrence" defines the return or reappearance of the cancer after a disease-free intermission or remission.

The patient may have more than one site of recurrence (that is, both regional and distant metastases). Code one site in this data field and the other site in "Other Type of First Recurrence."

Codes:

00 None, disease free
10 Local
11 Trochar site
15 Combination of 10 and 11
20 Regional, NOS
21 Regional tissue
22 Regional lymph nodes
25 Combination of 21 and 22
30 Any combination of 10, 11, and 20, 21, or 22
40 Distant
70 Never disease free
88 Recurred, site unknown
99 Unknown if recurred

TYPE OF FIRST RECURRENCE (Continued)

Clarification of code definitions:

CODES	DEFINITION
00	Became disease free after treatment, never had a recurrence.
10	Recurrence is confined to the remnant of the organ of origin. Recurrence is confined to the site of the organ of origin (to the anastomosis or to scar tissue where the organ previously existed)
11	Recurrence in the trochar path or entrance site.
15	Recurrence in both the site of the organ of origin and the trochar path or site.
20	Recurrence is regional, unknown if lymph nodes or tissue involved.
	Recurrence in both regional nodes and scar tissue.
21	Recurrence in tissues adjacent to the organ of origin.
22	Recurrence in regional lymph nodes.
25	Recurrence in both the regional tissue and lymph nodes.
30	Recurrence in the site of the organ of origin and trochar path and in the regional nodes or tissue.
40	Recurrence distant from the organ of origin.
70	Has never been disease free since diagnosis. Cases with distant metastasis at diagnosis, systemic disease,* unknown primary, or minimal disease that is not treated.
88	The patient has had a recurrence, the type or site of recurrence is unknown.
99	Cases in which it is unknown if the patient has had a recurrence or was never disease free.

* ***Exception:*** Code leukemias that are in remission 00. If the patient relapses, code recurrence status 40.

OTHER TYPE OF FIRST RECURRENCE **Item Length: 2**
Data Type: Numeric
Allowable Values: 00, 10, 11, 15, 20-22, 25, 30, 40, 70, 88, 99
Supplementary Data Set

Record the "Other Type of First Recurrence." "Recurrence" is the return or reappearance of the cancer after a disease-free intermission or remission.

The patient may have more than one site of recurrence (that is, both regional and distant metastases). Code one site in the data field "Type of First Recurrence," and the other site in this field.

If the patient has only one site of recurrence or has been disease free since treatment, code 00.

Codes:

00 None, disease free
10 Local
11 Trochar site
15 Combination of 10 and 11
20 Regional, NOS
21 Regional tissue
22 Regional lymph nodes
25 Combination of 21 and 22
30 Any combination of 10, 11, and 20, 21, or 22
40 Distant
70 Never disease free
88 Recurred, site unknown
99 Unknown if recurred

OTHER TYPE OF FIRST RECURRENCE **(Continued)**

Clarification of code definitions:

CODES	DEFINITION
00	Became disease free after treatment, never had a recurrence, or had only one site of first recurrence.
10	Recurrence confined to the remnant of the organ of origin. Recurrence confined to the site of the organ of origin (to the anastomosis or to scar tissue where the organ previously existed).
11	Recurrence in the trochar path or entrance site.
15	Recurrence in both the site of the organ of origin and the trochar path or site.
20	Recurrence is regional, unknown if lymph nodes or tissue involved. Recurrence in both regional nodes and tissue.
21	Recurrence in tissues adjacent to the organ of origin.
22	Recurrence in regional lymph nodes.
25	Recurrence in both the regional tissue and lymph nodes.
30	Recurrence in the site of the organ of origin and trochar path and in the regional nodes or tissue.
40	Recurrence occurs in a site distant from the organ of origin.
70	Has never been disease free since diagnosis. Cases with distant metastasis at diagnosis, systemic disease,* unknown primary, or minimal disease that is not treated.
88	The patient has had a recurrence, the type or site of recurrence is unknown.
99	Cases in which it is unknown if the patient has had a recurrence or was never disease free.

****Exception:*** Code leukemias that are in remission 00. If the patient relapses, code recurrence status 40 as appropriate.

DATE(S) OF SUBSEQUENT TREATMENT(S) FOR RECURRENCE OR PROGRESSION (SECOND COURSE OF THERAPY - DATE STARTED)

Item Length Combined: 24
Data Type: Numeric
Supplementary Data Set
2nd Course: Item Length 8
3rd Course: Item Length 8
4th Course: Item Length 8

"Date of Subsequent Treatment for Recurrence or Progression" records the date(s) of treatment(s) administered after the first course of treatment is complete for progression or recurrence of disease. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year (MMDDCCYY).

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		

Example: Record December 13, 1996 as 12131996.

Enter dates in chronological order. Applies to the collection of each modality of treatment delivered over the lifetime of the patient.

00000000 No subsequent treatment was initiated.

99999999 Unknown if any subsequent treatment administered.

If the exact date(s) of treatment(s) are not available, record an approximate date.

DATE(S) OF SUBSEQUENT TREATMENT(S) (Continued)

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

TYPE(S) OF SUBSEQUENT TREATMENT(S) FOR RECURRENCE OR PROGRESSION (SECOND COURSE OF THERAPY - TYPE OF TREATMENT)

Item Length: 45
Data Type: Numeric
Supplementary Data Set

SECOND COURSE (combined length: 15)
Date (item length 8)
Surgery (item length 2)
Radiation (item length 1)
Chemotherapy (item length 1)
Hormone Therapy (item length 1)
Biological Response Modifier (item length 1)
Other Therapy (item length 1)
THIRD COURSE (combined length: 15)
Date (item length 8)
Surgery (item length 2)
Radiation (item length 1)
Chemotherapy (item length 1)
Hormone Therapy (item length 1)
Biological Response Modifier (item length 1)
Other Therapy (item length 1)
FOURTH COURSE (combined length: 15)
Date (item length 8)
Surgery (item length 2)
Radiation (item length 1)
Chemotherapy (item length 1)
Hormone Therapy (item length 1)
Biological Response Modifier (item length 1)
Other Therapy (item length 1)

"Type(s) of Subsequent Treatment(s) for Recurrence or Progression" consists of all treatments administered after the first course of therapy is stopped. It defines the patient's treatments subsequent to the first course of therapy and administered for progression or recurrence of disease.

Types of therapy:

- Surgery
- Radiation
- Chemotherapy
- Hormone therapy
- Immunotherapy (biological response modifier)
- Other cancer-directed therapy.

Use the first course of treatment codes from Appendix D (cancer-directed surgery codes) and Section Four, coding instructions for radiation, chemotherapy, hormone therapy, immunotherapy, and other treatment.

RECURRENCE SITE(S)
(DISTANT SITE[S] OF FIRST RECURRENCE)

Item Length: 3
Data Type: Numeric
Allowable Values: 0-9
Optional Data Set
Left Justified
Zero Fill

"Recurrence Site(s)" documents a maximum of three metastatic sites. When there are fewer than three sites, left justify and code remaining sites 0 (none). Record 000 if there are no distant sites or no known metastases. Use the *AJCC Manual for Staging of Cancer*, Fourth Edition, to identify distant sites. Do not code sites of regional or local metastases identified in the "T" field.

Codes:

0 None or none known
1 Peritoneum
2 Lung
3 Pleura
4 Liver
5 Bone
6 Central nervous system
7 Skin
8 Lymph nodes (distant)
9 Other, generalized, NOS, carcinomatosis

RECURRENCE SITE(S) **(Continued)**

Clarification of code definitions:

CODES	DEFINITION
0	No distant metastases identified.
1	Peritoneum, including peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
2	Lung, including the visceral pleura.
3	Pleura, including the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
4	Liver only.
5	Bones other than the primary site.
6	Includes brain and spinal cord, but NOT the external eye.
7	Skin other than the primary site.
8	Lymph nodes not classified as regional. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site. (Use the *AJCC Manual for Staging of Cancer*, Fourth Edition, to identify distant nodes.)
9	Bone marrow metastases, carcinomatosis, generalized disease.

A biopsy may distinguish the source of distant disease in a patient with multiple primaries. If there is no histologic or cytologic confirmation, consult the physician to help identify which primary has metastasized. If the physician is unable to decide which primary has metastasized, code both primaries as having metastatic disease. If at a later date, the primary is identified, update the codes as appropriate.

Code 999 if carcinomatosis is present.

FOLLOW-UP

DATE OF LAST CONTACT OR DEATH

Item Length: 8
Data Type: Numeric
Required Data Set

Record the month, day, and year (MMDDCCYY) of the date of last contact or death. If the patient is deceased, record the date of death. The first two digits are the month, the third and fourth digits are the day, and the last four digits record the year.

Do not use the date information was received in the mail or the date information was requested from a patient, physician, or clinic. If a patient has multiple primaries, all records should have the same date of last contact.

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		

Example: Record December 13, 1996 as 12131996.

If the exact date of last contact or death is not available, record an approximate date.

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

VITAL STATUS

Item Length: 1
Data Type: Numeric
Allowable Values: 0, 1
Required Data Set

Code the patient's vital status as of the date recorded in the "Date of Last Contact or Death." Use the most accurate information available. If a patient has multiple primaries, all records should have the same vital status.

Codes:

0 Dead

1 Alive

CANCER STATUS

Item Length: 1
Data Type: Numeric
Allowable Values: 1, 2, 9
Required Data Set

"Cancer Status" is the absence or presence of clinical evidence of cancer as of the "Date of Last Contact or Death." Cancer status changes if the patient has a recurrence or relapse. It is coded independently for each primary. If a patient has multiple primaries, each primary could have a different cancer status.

Codes:

1 No evidence of this cancer

2 Evidence of this cancer

9 Unknown, indeterminate whether this cancer is present

For patients with hematopoietic disease who are in remission, code 1, no evidence of this cancer.

Death certificates do not always record the presence of cancer. If registry abstract indicates that the patient had cancer immediately before death, code evidence of this cancer (2). Consult the registry physician when questions arise. Decisions on cancer status coding can be based on information such as:

- How much time elapsed between the last follow-up and patient's death?
- Was the last follow-up and cancer status information from a medical source (physician, hospital admission)?
- Are autopsy findings available to the registry?

Example: A patient with prostate cancer has a two-year history of metastatic disease. The patient had a bone scan at the reporting institution in April 1996. The urologist's diagnosis was progressive bony metastases and the bone scan confirmed extensive bone destruction. The registrar finds an obituary documenting the patient's death in a nursing home in June 1996. Record the cancer status as evidence of this cancer (2).

QUALITY OF SURVIVAL

Item Length: 1
Data Type: Numeric
Allowable Values: 0-4, 8, 9
Optional Data Set

Record the patient's ability to carry on the activities of daily living at the date of last contact. "Quality of Survival" reflects the patient's overall status, not just cancer-related disabilities. This data item changes over time.

Codes:

0 Normal activity

1 Symptomatic and ambulatory

2 Ambulatory more than 50% of the time, occasionally needs assistance

3 Ambulatory less than 50% of the time, nursing care needed

4 Bedridden, may require hospitalization

8 Not applicable, dead

9 Unknown or unspecified

Do not consider transient health problems when assigning a quality of life code. Examples of transient problems:

- Broken leg
- Any side effects of treatment that are expected to improve after treatment is complete

These codes are taken from the American Joint Committee on Cancer's Host Performance Scale, which is adapted from the Karnofsky Scale and the Eastern Cooperative Oncology Group (ECOG) Scale.[14]

Record 8 when the patient has expired.

[14]*AJCC Manual for Staging of Cancer*, Third Edition (1988).

FOLLOWING REGISTRY

Item Length: 6
Data Type: Numeric
Optional Data Set

Record the six-digit institution identification number for the facility responsible for following the patient.

Record 999999 if the following registry's identification number is unknown.

This item is useful when multiple registries follow the same patient. A written agreement may be drawn up between two registries noting which hospital will be responsible for follow-up.

FOLLOW-UP SOURCE
(FOLLOW-UP METHOD)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 7-9
Supplementary Data Set

"Follow-up Source" identifies the source of the latest follow-up information.

Codes:

0 Reported hospitalization
1 Readmission
2 Physician
3 Patient
4 Department of Motor Vehicles
5 Medicare/Medicaid file
7 Death certificate
8 Other
9 Unknown

Clarification of code definitions:

CODES	DEFINITION
0	Hospitalization at another institution/hospital or first admission to the reporting institution.
1	Hospitalization or outpatient visit at the reporting institution.
2	Information from a physician.
3	Direct contact with the patient.
4	The Department of Motor Vehicles confirmed that the patient has a current license.
5	The Medicare or Medicaid office confirmed that the patient is alive.
7	Information from death certificate only.
8	Friends, relatives, employers, other registries, or any sources not covered by other codes.
9	Unknown/unspecified.

NEXT FOLLOW-UP SOURCE
(NEXT FOLLOW-UP METHOD)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 8, 9
Supplementary Data Set

"Next Follow-up Source" identifies the method planned for the next follow-up.

Codes:

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

Code 8: Foreign residents do not have to be followed. This is not a blanket policy recommending that registries not attempt follow-up.

Code 9: Cases for which follow-up is not required.

Example: Reportable-by-Agreement

UNUSUAL FOLLOW-UP METHOD

Item Length: 1
Data Type: Numeric
Optional Data Set
User Defined

This data item is used to flag a case that needs unusual follow-up methods.

The available codes are 0-9. There are no standards for this item. Each registry assigns codes as needed. Document code assignments in your procedure manual to assure data consistency.

Examples of code assignments:

Code 1: Patient unaware of diagnosis.

Code 2: Patient not mentally competent.

CAUSE OF DEATH
(UNDERLYING CAUSE OF DEATH [ICD CODE])

Item Length: 4
Data Type: Alphanumeric
Optional Data Set
Left Justified

Record the cause of death listed on the death certificate. Central registries are the primary users of this data item. Use the underlying cause of death (ICD code) identified by state health department.

Codes:

0000 Patient alive at last follow-up

7777 State death certificate or listing not available

7797 State death certificate or listing available, but underlying cause of death not coded

All other cases: ICDA-8, ICD-9, or ICD-10 underlying cause of death code.

Some codes may have an optional fifth digit. The fifth digit is not used in coding cause of death.

If the fourth digit for the underlying cause of death is "X", "blank", or "-", fill with a 9.

Use code 7797 when the coded underlying cause of death is not available.

Examples:

UNDERLYING CAUSE OF DEATH	ICDA-8 or ICD-9	CODE
Cancer of the thyroid	193	1939
Acute appendicitis with peritonitis	540.0	5400
Adenocarcinoma of stomach	151.9	1519

Beginning in the late 1990s, all deaths will be coded using the *International Statistical Classification of Diseases and Related Health Problems*, Tenth Revision (ICD-10). The ICD-10 codes consist of four characters—a letter followed by two or three digits.

Example:

UNDERLYING CAUSE OF DEATH	ICD-10	CODE
Cancer of the thyroid	C73	C739
Acute appendicitis with peritonitis	K35.0	K350
Adenocarcinoma of stomach	C16.9	C169

ICD REVISION NUMBER

Item Length: 1
Data Type: Numeric
Allowable Values: 0, 1, 8, 9
Optional Data Set

"ICD Revision Number" identifies the ICD edition used to code cause of death.

Codes:

0 Patient alive at last follow-up

1 ICD-10

8 ICDA-8

9 ICD-9

AUTOPSY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 9
Optional Data Set

Record whether the patient had an autopsy. Codes 1-9 are used only if the patient has expired.

Codes:

0 Patient alive

1 Autopsy performed

2 No autopsy performed

9 Patient expired, unknown if autopsy performed

COMMISSION ON CANCER CODING SYSTEM - CURRENT

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 9
Required Data Set

"Commission on Cancer Coding System - Current" identifies the coding scheme used for data collection. Promotes data standardization.

Codes:

0 No Commission on Cancer coding system used
1 Pre-1988 (Cancer Program Manual Supplement)
2 1988 Data Acquisition Manual
3 1989 Data Acquisition Manual Revisions
4 1990 Data Acquisition Manual Revisions
5 1994 Data Acquisition Manual (Interim/Revised)
6 Registry Operations and Data Standards (ROADS)
9 Unknown

Appendix A

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Appendix A

THESE ICD-O-2 CODES ARE REGARDED AS ONE PRIMARY SITE WHEN DETERMINING MULTIPLE PRIMARIES

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

ICD-O-2 CODES	SITE GROUPINGS
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 - C38.3	Mediastinum
C38.8	Overlapping lesion of heart, mediastinum, and pleura
C38.4	Pleura
C51	Vulva
C52	Vagina
C57.7	Other specified female genital organs
C57.8 - C57.9	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

ICD-O-2 CODES	SITE GROUPINGS
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

Appendix B

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Appendix B

DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Hodgkin's disease (9650-9667)	Non-Hodgkin's lymphoma (9591-9595, 9670-9686, 9690-9698, 9702-9714)	Hodgkin's disease[1] (9650-9667)
	Burkitt's lymphoma (9687)	Malignant lymphoma, NOS (9590)
	Mycosis fungoides or Sezary's disease (9700-9701)	
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	
	True histiocytic lymphoma (9723)	
	Plasmacytoma or multiple myeloma (9731, 9732)	
	Mast cell tumor (9740-9741)	
	Waldenstrom's macroglobulinemia (9761)	
	Any leukemia (9800-9941)	

[1]Code to the term with the higher histology code.

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DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Malignant lymphoma, NOS[1] (9590)	Burkitt's lymphoma (9687)	Non-Hodgkin's lymphoma[2] (9590-9595, 9670-9686, 9690-9698, 9702-9714)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Hodgkin's disease[2] (9650-9667)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	True histiocytic lymphoma (9723)
	Mast cell tumor (9740, 9741)	Plasmacytoma[2] or multiple myeloma (9731, 9732)
	Acute leukemia, NOS (9801)	Leukemia, NOS (9800)
	Nonlymphocytic leukemias (9840-9842, 9860-9910)	Chronic leukemia, NOS (9803)
	Myeloid sarcoma (9930)	Lymphoid or lymphocytic leukemia (9820-9827)
	Acute panmyelosis (9931)	Plasma cell leukemia (9830)
	Acute myelofibrosis (9932)	Lymphosarcoma cell leukemia (9850)
	Hairy cell leukemia (9940)	Waldenstrom's macroglobulinemia (9761)
	Leukemic reticuloendotheliosis (9941)	

[1] If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

[2] Presumably this is the correct diagnosis. Code the case to this histologic type.

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DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Non-Hodgkin's[4] lymphoma (9591-9595, 9670-9686, 9690-9698, 9711-9714)	Hodgkin's disease (9650-9667)	Non-Hodgkin's lymphoma[5] (9590-9595, 9670-9686, 9690-9698, 9702-9714)
	Burkitt's lymphoma (9687)	Plasmacytoma[6] or multiple myeloma (9731, 9732)
	Mycosis fungoides or Sezary's disease (9700, 9701)	True histiocytic lymphoma (9723)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Leukemia, NOS (9800)
	Mast cell tumor (9740-9741)	Chronic leukemia, NOS (9803)
	Acute leukemia, NOS (9801)	Lymphoid or lymphocytic leukemia (9820-9827)
	Nonlymphocytic leukemias (9840-9842, 9860-9910)	Plasma cell leukemia (9830)
	Myeloid sarcoma (9930)	Lymphosarcoma cell leukemia (9850)
	Acute panmyelosis (9931)	Waldenstrom's macroglobulinemia (9761)
	Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	

[4] If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic diagnosis, then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

[5] Code to the term with the higher histology code.

[6] Presumably this is the correct diagnosis. Code the case to this histologic type.

DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Burkitt's lymphoma (9687)	Specific non-Hodgkin's lymphoma (9593-9594, 9670-9686, 9690-9698, 9702-9714)	Malignant lymphoma, NOS (9590-9591, 9595)
	Hodgkin's disease (9650-9667)	Lymphosarcoma (9592)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Burkitt's lymphoma (9687)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Burkitt's leukemia (9826)
	Plasmacytoma or multiple myeloma (9731, 9732)	Lymphoid or lymphocytic leukemia (9820-9822, 9824-9825, 9827)
	True histiocytic lymphoma (9723) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Chronic lymphocytic leukemia (9823) Nonlymphocytic leukemias (9840-9842, 9860-9910) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	

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DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Cutaneous and peripheral T-cell lymphomas (9700-9709)	Specific non-Hodgkin's lymphoma (9593-9594, 9670-9687, 9690-9698, 9711-9714)	Malignant lymphoma, NOS (9590-9591, 9595)
	Hodgkin's disease (9650-9667)	Lymphosarcoma (9592)
	Malignant histiocytosis or Letterer-Siwe disease (9720-9722)	Cutaneous and peripheral T-lcell ymphomas (9700-9709)
	True histiocytic lymphoma (9723)	Leukemia, NOS (9800)
	Plasmacytoma or multiple myeloma (9731, 9732)	Acute leukemia, NOS (9801)
	Mast cell tumor (9740, 9741)	Chronic leukemia, NOS (9803)
	Waldenstrom's macroglobulinemia (9761)	Lymphoid or lymphocytic leukemia unless specifically identified as B-cell (9820-9827)
	Lymphoid or lymphocytic leukemia specified as B-cell (9820-9827) Plasma cell leukemia (9830) Nonlymphocytic leukemia (9840-9842, 9860-9910) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemia reticuloendotheliosis (9941)	

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DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Malignant histiocytosis or Letterer-Siwe disease (9720, 9722, 9723)	Specific non-Hodgkin's lymphoma (9592-9594, 9670-9686, 9690-9698, 9702-9714)	Non-Hodgkin's lymphoma, NOS (9590-9591, 9595)
	Hodgkin's disease (9650-9667)	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722, 9723)
	Burkitt's lymphoma (9687)	Hairy cell leukemia (9940)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Leukemic reticuloendotheliosis (9941)
	Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Leukemia except hairy cell and leukemic reticuloendotheliosis (9800-9932)	

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DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Plasmacytoma or multiple myeloma (9731, 9732)	Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma (9592-9594, 9670, 9672-9677, 9683, 9685-9686, 9690-9697, 9702-9713)	Malignant lymphoma, NOS (9590, 9591, 9595)
	Hodgkin's disease (9650-9667)	Immunoblastic or large cell lymphoma[7] (9671, 9680-9682, 9684, 9698, 9714)
	Burkitt's lymphoma (9687)	Plasmacytoma or multiple myeloma (9731, 9732)
	Mycosis fungoides or Sezary's (9700, 9701)	Waldenstrom's macroglobulinemia disease (9761)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Plasma cell leukemia (9830)
	True histiocytic lymphoma (9723) Mast cell tumor (9740, 9741) Leukemia except plasma cell (9800-9827, 9840-9941)	

[7] Occasionally multiple myeloma develops an immunoblastic or large cell lymphoma phase. This is to be considered one primary, multiple myeloma. Consult your medical advisor or pathologist if questions remain.

DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Mast cell tumor (9740, 9741)	Non-Hodgkin's lymphoma (9590-9595, 9670-9687, 9690-9698, 9702-9714)	Mast cell tumor (9740, 9741)
	Hodgkin's disease (9650-9667)	Leukemia, NOS (9800)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Acute leukemia, NOS (9801)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Chronic leukemia, NOS (9803)
	True histiocytic lymphoma (9723)	Monocytic leukemia (9890-9894)
	Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Chronic lymphocytic leukemia (9823) Plasma cell leukemia (9830) Nonlymphocytic leukemias (9840-9842, 9860-9880, 9910) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	Mast cell leukemia (9900)

DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Waldenstrom's macroglobulinemia (9761)	Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma (9593-9594, 9673-9677, 9683, 9685-9686, 9690-9697, 9702-9713)	Malignant lymphoma, NOS 9590, 9591, 9595)
	Hodgkin's disease (9650-9667)	Lymphosarcoma (9592)
	Burkitt's lymphoma (9687)	Immunoblastic or large cell lymphoma (9671, 9680-9682, 9684, 9698, 9714)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Malignant lymphoma, lymphocytic disease (9670, 9672)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Plasmacytoma or multiple myeloma (9731, 9732)
	True histiocytic lymphoma (9723)	Waldenstrom's macroglobulinemia (9761)
	Mast cell tumor (9740, 9741) Leukemia except plasma cell (9800-9827, 9840-9941)	Plasma cell leukemia (9830)

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DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Leukemia, NOS (9800)	Non-Hodgkin's lymphoma[8] (9590-9595, 9670-9687, 9690-9698, 9702-9714)	Any leukemia[9] (9800-9941)
	Hodgkin's disease (9650-9667)	Sezary's disease[10] (9701)
	Mycosis fungoides (9700) Malignant histiocytosis or Letterer-Siwe disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761)	

[8] If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

[9] Note: Leukemia, NOS (9800) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

[10] Presumably this is the correct diagnosis. Code the case to this histologic type.

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DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Acute leukemia, NOS (9801)	Non-Hodgkin's lymphoma (9590-9595, 9670-9687, 9690-9698, 9702-9714)	Any leukemia[11] (9800-9941)
	Hodgkin's disease (9650-9667)	Sezary's disease[12] (9701)
	Mycosis fungoides (9700) Malignant histiocytosis or Letterer-Siwe disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761)	

[11] Note: Acute leukemia, NOS (9801) should be upgraded to a more specific type of acute leukemia (higher number) when it is found, but not considered a second primary.

[12] Presumably this is the correct diagnosis. Code the case to this histologic type.

Appendix B

DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Chronic leukemia, NOS (9803)	Hodgkin's disease (9650-9667)	Non-Hodgkin's lymphoma[13] (9590-9595, 9670-9686, 9690-9698, 9702-9714)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Burkitt's lymphoma (9687)
	Mast cell tumor (9740, 9741)	Mycosis fungoides or Sezary's disease (9700, 9701) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Any leukemia[14] (9800-9941)

[13] If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

[14] Note: Chronic leukemia, NOS (9803) should be upgraded to a more specific type of chronic leukemia (higher number) when it is found, but not considered a second primary.

DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Lymphocytic leukemia (9820-9827)	Hodgkin's disease (9650-9667)	Non-Hodgkin's lymphoma[16] (9592-9595, 9670-9687, 9690-9698, 9702-9714)
	Malignant histiocytosis or Letterer-Siwe disease[15] (9720, 9722)	Malignant lymphoma, NOS[16] (9590-9591)
	Plasmacytoma or multiple myeloma (9731, 9732)	Mycosis fungoides or Sezary's disease[17] (9700, 9701)
	Mast cell tumor (9740, 9741)	True histiocytic lymphoma (9723)
	Waldenstrom's macroglobulinemia (9761)	Leukemia, NOS (9800)
	Nonlymphocytic leukemias[15] (9840-9842, 9860-9910)	Acute leukemia, NOS (9801)
	Myeloid sarcoma[15] (9930)	Chronic leukemia, NOS (9803)
	Acute panmyelosis[15] (9931)	Lymphocytic leukemia[17] (9820-9827)
	Acute myelofibrosis[15] (9932)	Plasma cell leukemia[15] (9830) Lymphosarcoma cell leukemia[15] (9850) Hairy cell leukemia[15] (9940) Leukemic reticuloendotheliosis[15] (9941)

[15] If any of these diagnoses are made within four months of lymphocytic leukemia, NOS (9820) or acute lymphocytic leukemia (9821), one of the two diagnoses probably is wrong. The case should be reviewed.

[16] If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, then code only to chronic lymphocytic leukemia (9823). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

[17] Note: Lymphocytic leukemia, NOS (9820) should be upgraded to a more specific diagnosis that is not considered a second primary.

DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Plasma cell leukemia (9830)	Non-Hodgkin's lymphoma (9590-(9595, 9670-9686, 9690-9698, 9702-9714)	Plasmacytoma or multiple myeloma (9731, 9732)
	Hodgkin's disease (9650-9667)	Waldenstrom's macroglobulinemia (9761)
	Burkitt's lymphoma (9687)	Leukemia, NOS (9800)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Acute leukemia, NOS (9801)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Chronic leukemia, NOS (9803)
	True histiocytic lymphoma (9723)	Lymphocytic leukemia (9820-9827)
	Mast cell tumor (9740, 9741)	Plasma cell leukemia (9830)
	Nonlymphocytic leukemia (9840-9842, 9860-9910)	Lymphosarcoma cell leukemia (9850)
	Myeloid sarcoma (9930)	Hairy cell leukemia (9940)
	Acute panmyelosis (9931)	Leukemic reticuloendotheliosis (9941)
	Acute myelofibrosis (9932)	

Appendix B

DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Lymphosarcoma cell leukemia (9850)	Hodgkin's disease (9650-9667)	Non-Hodgkin's lymphoma (9590-9595, 9670-9687, 9690-9698, 9702-9714)
	Mycosis fungoides or Sezary's disease (9700, 9701)	True histiocytic lymphoma (9723)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Plasmacytoma or multiple myeloma (9731-9732)
	Mast cell tumor (9740, 9741)	Waldenstrom's macroglobulinemia (9761)
	Nonlymphocytic leukemia (9840-9842, 9860-9941)	Leukemia, NOS (9800)
		Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Lymphocytic leukemia (9820-9827) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850)

Appendix B

DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Nonlymphocytic leukemias (9840-9842, 9860-9894, 9910-9932)	Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9690-9698, 9702-9714)	Leukemia, NOS (9800)
	Hodgkin's disease (9650-9667)	Acute leukemia, NOS (9801)
	Burkitt's lymphoma (9687)	Chronic leukemia, NOS (9803)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Nonlymphocytic leukemias[18] (9840-9842, 9860-9894, 9910-9932)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Lymphocytic leukemia (9820-9827) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850) Mast cell leukemia (9900) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	

[18] Code to the term with the higher histology code.

DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Mast cell leukemia (9900)	Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9690-9698, 9702-9714)	Mast cell tumor (9740, 9741)
	Hodgkin's disease (9650-9667)	Leukemia, NOS (9800)
	Burkitt's lymphoma (9687)	Acute leukemia, NOS (9801)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Chronic leukemia, NOS (9803)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Any other leukemia (9820-9894, 9910-9941)	Mast cell leukemia (9900)

DETERMINATION OF SUBSEQUENT PRIMARIES FOR LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES (CONTINUED)

Reprinted from *The SEER Program Code Manual,* Revised Edition, June 1992

FIRST PRIMARY	PRESUMABLY A SECOND PRIMARY	PRESUMABLY NOT A SUBSEQUENT PRIMARY (ONLY ONE PRIMARY)
Hairy cell leukemia or leukemic reticuloendotheliosis (9940, 9941)	Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9690-9698, 9702-9714)	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)
	Hodgkin's disease (9650-9667)	Lymphocytic leukemia, NOS (9820)
	Burkitt's lymphoma (9687)	Hairy cell leukemia or leukemic reticuloendotheliosis (9940, 9941)
	Mycosis fungoides or Sezary's disease (9700, 9701) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Any nonlymphocytic leukemia (9800-9804, 9830-9932) Lymphocytic leukemia (9821-9827)	

Appendix C

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Appendix C

GEOCODES

Numerical List

Codes for the United States are by section of the country. The second digit represents the first digit of the ZIP code.

Continental United States and Hawaii

000 United States

- 001 New England and New Jersey
  - 002 Maine
  - 003 New Hampshire
  - 004 Vermont
  - 005 Massachusetts
  - 006 Rhode Island
  - 007 Connecticut
  - 008 New Jersey
- 010 North Mid-Atlantic States
  - 011 New York
  - 014 Pennsylvania
  - 017 Delaware
- 020 South Mid-Atlantic States
  - 021 Maryland
  - 022 District of Columbia
  - 023 Virginia
  - 024 West Virginia
  - 025 North Carolina
  - 026 South Carolina
- 030 Southeast States
  - 031 Tennessee
  - 033 Georgia
  - 035 Florida
  - 037 Alabama
  - 039 Mississippi
- 040 North Central States
  - 041 Michigan
  - 043 Ohio
  - 045 Indiana
  - 047 Kentucky
- 050 Northern Midwest States
  - 051 Wisconsin
  - 052 Minnesota
  - 053 Iowa
  - 054 North Dakota
  - 055 South Dakota
  - 056 Montana
- 060 Central Midwest States
  - 061 Illinois
  - 063 Missouri
  - 065 Kansas
  - 067 Nebraska
- 070 Southern Midwest States
  - 071 Arkansas
  - 073 Louisiana
  - 075 Oklahoma
  - 077 Texas
- 080 Mountain States
  - 081 Idaho
  - 082 Wyoming
  - 083 Colorado
  - 084 Utah
  - 085 Nevada
  - 086 New Mexico
  - 087 Arizona
- 090 Pacific Coast States
  - 091 Alaska
  - 093 Washington
  - 095 Oregon
  - 097 California
  - 099 Hawaii

United States Possessions

When these codes were originally assigned during the 1970s, the United States owned or controlled islands in the Pacific. Many of these islands have been either granted independence or control has been returned to another country. To be consistent, these islands are still coded to the original codes. The names have been annotated to indicate the new political designation.

100 Atlantic/Caribbean area
- 101 Puerto Rico
- 102 U.S. Virgin Islands
- 109 Other Atlantic/Caribbean area

110 Canal Zone

120 Pacific area
- 121 American Samoa
- 122 Canton and Enderbury Islands (Kiribati)
- 123 Caroline Islands (Trust Territory of Pacific Islands)
- 124 Cook Islands (New Zealand)
- 125 Gilbert (Kiribati) and Ellice (Tuvalu) Islands
- 126 Guam
- 127 Johnston Atoll
- 128 Line Islands, Southern (Kiribati)
- 129 Mariana Islands (Trust Territory of Pacific Islands)
- 131 Marshall Islands (Trust Territory of Pacific Islands)
- 132 Midway Islands
- 133 Nampo-Shoto, Southern
- 134 Ryukyu Islands (Japan)
- 135 Swan Islands
- 136 Tokelau Islands (New Zealand)
- 137 Wake Island

North and South America, Exclusive of the United States and its Possessions

210 Greenland

220 Canada
- 221 Maritime Provinces (Newfoundland, Nova Scotia, Prince Edward Island, New Brunswick)
- 222 Quebec
- 223 Ontario
- 224 Prairie Provinces (Manitoba, Saskatchewan, Alberta)
- 225 Yukon Territory, Northwest Territories
- 226 British Columbia

230 Mexico

240 North American Islands
- 241 Cuba
- 242 Haiti
- 243 Dominican Republic
- 244 Jamaica
- 245 Other Caribbean Islands
- 246 Bermuda
- 247 Bahamas

250 Central America
- 251 Guatemala
- 252 Belize (British Honduras)
- 253 Honduras
- 254 El Salvador
- 255 Nicaragua
- 256 Costa Rica
- 257 Panama

300 South America
- 311 Colombia
- 321 Venezuela
- 331 Guyana (British Guiana)
- 332 Suriname (Dutch Guiana)
- 333 French Guiana
- 341 Brazil
- 345 Ecuador
- 351 Peru
- 355 Bolivia
- 361 Chile
- 365 Argentina
- 371 Paraguay
- 375 Uruguay

Europe

Europe, NOS (see code 499)

400 United Kingdom
- 401 England, Channel Islands
- 402 Wales
- 403 Scotland
- 404 Northern Ireland (Ulster)

410 Ireland (Eire)

420 Scandinavia
- 421 Iceland
- 423 Norway
- 425 Denmark
- 427 Sweden
- 429 Finland

430 Germanic countries
- 431 Germany (East and West)
- 432 Netherlands
- 433 Belgium
- 434 Luxembourg
- 435 Switzerland
- 436 Austria
- 437 Liechtenstein

440 Romance-language countries
- 441 France, (Corsica), Monaco
- 443 Spain, (Canary Islands, Balearic Islands), Andorra
- 445 Portugal (Madeira Islands, Azores, Cape Verde Islands)
- 447 Italy, (Sardinia, Sicily), San Marino
- 449 Romania

450 Slavic countries
- 451 Poland
- 452 Czechoslovakia (Bohemia, Moravia, Slovakia)
- 453 Yugoslavia (Serbia, Croatia, Dalmatia, Montenegro, Macedonia, Slavonia, Slovenia)
- 454 Bulgaria
- 455 Russian S.F.S.R. (Russia)
- 456 Ukrainian S.S.R. (The Ukraine) and Moldavian S.S.R. (Bessarabia)
- 457 Byelorussian S.S.R. (White Russia)
- 458 Estonian S.S.R. (Estonia)
- 459 Latvian S.S.R. (Latvia)
- 461 Lithuanian S.S.R. (Lithuania)

470 Other mainland Europe
- 471 Greece
- 475 Hungary
- 481 Albania
- 485 Gibraltar

490 Other Mediterranean islands
- 491 Malta
- 495 Cyprus

499 Europe, NOS

Africa

500 Africa

- 510 North Africa
  - 511 Morocco
  - 513 Algeria
  - 515 Tunisia
  - 517 Libya (Tripoli, Tripolitania, Cyrenaica)
  - 519 Egypt (United Arab Republic)
- 520 Sudanese countries (Western [Spanish] Sahara, Mauritania, Mall, Niger, Chad, Sudan, Upper Volta)
- 530 West Africa
  - 531 Nigeria
  - 539 Senegal, Gambia, Portuguese Guinea, Guinea, Sierra Leone, Liberia, Ivory Coast, Ghana, Togo, Benin (Dahomey), Cameroon (Kameroon), Equatorial Guinea, (Fernando Poo, Bioko, Rio Muni), Gabon, Congo-Brazzaville (French Congo), Central African Republic
- 540 South Africa
  - 541 Congo-Leopoldville (Zaire, Belgian Congo)
  - 543 Angola, Sao Tome, Principe, Cabinda
  - 545 Republic of South Africa (Cape Colony, Orange Free State, Natal, Transvaal), Namibia (South West Africa), Lesotho (Basutoland), Botswana (Bechuana-land), Ciskel, Swaziland, Transkei, Bophuthatswana, Venda
  - 547 Zimbabwe (Rhodesia, Southern Rhodesia)
  - 549 Zambia (Northern Rhodesia)
  - 551 Malawi (Nyasaland)
  - 553 Mozambique
  - 555 Madagascar (Malagasy Republic)
- 570 East Africa
  - 571 Tanzania (Tanganyika, Tanzanyika, Zanzibar)
  - 573 Uganda
  - 575 Kenya
  - 577 Rwanda (Ruanda)
  - 579 Burundi (Urundi)
  - 581 Somalia (Somali Repub-lic, Somaliland)
  - 583 Afars and Issas (Djibouti, French Somaliland)
  - 585 Ethiopia (Abyssinia, Eritrea)

Asia

600 Asia, NOS

- 610 Near-East
  - 611 Turkey
- 620 Asian Arab countries
  - 621 Syria
  - 623 Lebanon
  - 625 Jordan (Transjordan) and former Arab Palestine
  - 627 Iraq
  - 629 Arabian Peninsula (Saudi Arabia, Yemen, People's Democratic Republic of Yemen, (Southern Yemen),United Arab Emirates (Trucial States), Aden, Bahrain, Kuwait, Oman and Muscat, Qatar)

631 Israel and former Jewish Palestine
633 Caucasian Republics of the U.S.S.R. (Georgia, Armenia, Azerbaijan)
634 Other Asian Republics of the U.S.S.R. (Kazakh S.S.R., Kirghiz S.S.R., Tadzhik S.S.R., Turkmen S.S.R., Uzbek, S.S.R.)
637 Iran (Persia)
638 Afghanistan
639 Pakistan (West Pakistan)

640 Mid-East
641 India
643 Nepal, Bhutan, Sikkim
645 Bangladesh (East Pakistan)
647 Ceylon (Sri Lanka)
649 Burma

650 Southeast Asia
651 Thailand (Siam)

660 Indochina
661 Laos
663 Cambodia
665 Vietnam (Tonkin, Annam, Cochin China)
671 Malaysia, Singapore, Brunei
673 Indonesia (Dutch East Indies)
675 Philippines (Philippine Islands)

680 East Asia
681 China (not otherwise specified)
682 China (People's Republic of China)
683 Hong Kong
684 Taiwan (Formosa) (Republic of China)
685 Tibet
686 Macao (Macau)

691 Mongolia
693 Japan
695 Korea (North and South)

Australia and Oceania

711 Australia and Australian New Guinea
715 New Zealand
720 Pacific Islands
721 Melanesian Islands *
723 Micronesian Islands*
725 Polynesian Islands *

Place of Birth Unknown

998 Place of birth stated not to be in the United States, but no other information available
999 Place of birth unknown

*Except possessions of the United States.

Appendix C

GEOCODES

Alphabetical List

A

585	Abyssinia
629	Aden
583	Afars and Issas
638	Afghanistan
500	Africa
570	Africa, East
510	Africa, North
540	Africa, South
545	Africa, South West
530	Africa, West
037	Alabama
091	Alaska
481	Albania
224	Alberta
513	Algeria
250	America, Central
___	America, North (use more specific term)
300	America, South
121	American Samoa
641	Andaman Islands
443	Andorra
543	Angola
245	Anguilla
665	Annam
245	Antigua
245	Antilles, Netherlands
625	Arab Palestine
629	Arabia, Saudi
629	Arabian Peninsula
365	Argentina
087	Arizona
071	Arkansas
633	Armenia (U.S.S.R.)
611	Armenia (Turkey)
245	Aruba
600	Asia, NOS
680	Asia, East
640	Asia, Mid-East
610	Asia, Near-East
650	Asia, Southeast
620	Asian-Arab countries
634	Asian Republics of the U.S.S.R., other
109	Atlantic/Caribbean area, other U.S. Possessions
100	Atlantic/Caribbean area, U.S. possessions
711	Australia
711	Australian New Guinea
436	Austria
633	Azerbaidzhan S.S.R.
445	Azores

B

247	Bahamas
629	Bahrain
443	Balearic Islands
645	Bangladesh
245	Barbados
245	Barbuda
545	Basutoland
431	Bavaria
545	Bechuanaland
541	Belgian Congo
433	Belgium
252	Belize
539	Benin
246	Bermuda
456	Bessarabia
643	Bhutan
452	Bohemia
355	Bolivia
545	Bophuthatswana
673	Borneo
545	Botswana
341	Brazil
226	British Columbia

331	British Guiana
252	British Honduras
245	British Virgin Islands
671	Brunei
454	Bulgaria
649	Burma
579	Burundi
457	Byelorussian S.S.R.

C

543	Cabinda
245	Caicos Islands
097	California
663	Cambodia
539	Cameroon
220	Canada
110	Canal Zone
443	Canary Islands
122	Canton Islands
545	Cape Colony
445	Cape Verde Islands
245	Caribbean Islands, other
123	Caroline Islands
711	Cartier Islands
633	Caucasian Republics of the U.S.S.R.
245	Cayman Islands
539	Central African Republic
250	Central America
060	Central Midwest States
647	Ceylon
520	Chad
401	Channel Islands (British)
361	Chile
681	China (not otherwise specified)
665	China, Cochin
682	China, People's Republic of
684	China, Republic of
723	Christmas Island
545	Ciskel
665	Cochin China
711	Cocos (Keeling) Islands
311	Colombia
083	Colorado
540	Comoros
226	Columbia, British
022	Columbia, District of
539	Congo-Brazzaville
541	Congo-Leopoldville
541	Congo, Belgian
539	Congo, French
007	Connecticut
124	Cook Islands
441	Corsica
256	Costa Rica
471	Crete
453	Croatia
241	Cuba
245	Curaco
495	Cyprus
517	Cyrenaica
452	Czechoslovakia

D

539	Dahomey
453	Dalmatia
017	Delaware
425	Denmark
022	District of Columbia
583	Djibouti
449	Dobruja
245	Dominica
243	Dominican Republic
673	Dutch East Indies
332	Dutch Guiana

E

570	East Africa
680	East Asia
431	East Germany

673	East Indies, Dutch
645	East Pakistan
345	Ecuador
519	Egypt
410	Eire
254	El Salvador
125	Ellice Islands
122	Enderbury Islands
401	England
539	Equatorial Guinea
585	Eritrea
458	Estonian S.S.R. (Estonia)
585	Ethiopia
499	Europe, NOS
470	Europe, other mainland

F

420	Faeroe Islands
300	Falkland Islands
431	Federal Republic of Germany
539	Fernando Poo
721	Fiji
429	Finland
035	Florida
684	Formosa
721	Fortuna
441	France
539	French Congo
333	French Guiana
725	French Polynesia
583	French Somaliland
245	French West Indies

G

539	Gabon
345	Galapagos Islands
539	Gambia
033	Georgia (U.S.A.)
633	Georgia (U.S.S.R.)
430	Germanic countries
431	German Democratic Republic
431	Germany
431	Germany, East
431	Germany, Federal Republic of
431	Germany, West
539	Ghana
485	Gibraltar
125	Gilbert Islands
471	Greece
210	Greenland
245	Grenada
245	Grenadines, The
245	Guadeloupe
126	Guam
251	Guatemala
401	Guernsey
331	Guiana, British
332	Guiana, Dutch
333	Guiana, French
539	Guinea
539	Guinea-Bissau
539	Guinea, Equatorial
___	Guinea, New (See New Guinea)
539	Guinea, Portuguese
331	Guyana

H

242	Haiti
099	Hawaii
432	Holland
253	Honduras
252	Honduras, British
683	Hong Kong
475	Hungary

I

421	Iceland
081	Idaho

061 Illinois
641 India
045 Indiana
673 Indies, Dutch East
660 Indochina
673 Indonesia
053 Iowa
637 Iran
627 Iraq
410 Ireland
404 Ireland, Northern
400 Isle of Man
631 Israel
583 Issas
447 Italy
539 Ivory Coast

J

244 Jamaica
423 Jan Mayen
693 Japan
673 Java
401 Jersey
631 Jewish Palestine
127 Johnston Atoll
625 Jordan
453 Jugoslavia

K

539 Kameroon
663 Kampuchea
065 Kansas
634 Kazakh S.S.R.
047 Kentucky
575 Kenya
634 Kirghiz S.S.R.
___ Kiribati (code to specific island group)
695 Korea
695 Korea, North
695 Korea, South
629 Kuwait

L

221 Labrador
661 Laos
459 Latvian S.S.R. (Latvia)
623 Lebanon
545 Lesotho
539 Liberia
517 Libya
437 Liechtenstein
128 Line Islands, Southern
461 Lithuanian S.S.R. (Lithuania)
073 Louisiana
434 Luxembourg

M

686 Macao
686 Macau
453 Macedonia
555 Madagascar
445 Madeira Islands
002 Maine
555 Malagasy Republic
551 Malawi
671 Malay Peninsula
671 Malaysia
640 Maldives
520 Mali
491 Malta
224 Manitoba
129 Mariana Islands
221 Maritime provinces, Canada
131 Marshall Islands
245 Martinique
021 Maryland
005 Massachusetts
520 Mauritania

540	Mauritius
540	Mayotte
490	Mediterranean islands, other
721	Melanesian Islands
230	Mexico
041	Michigan
723	Micronesian Islands
640	Mid-East Asia
132	Midway Islands
052	Minnesota
240	Miquelon
039	Mississippi
063	Missouri
449	Moldavia (Romania)
456	Moldavian S.S.R. (U.S.S.R)
441	Monaco
691	Mongolia
056	Montana
453	Montenegro
245	Montserrat
452	Moravia
511	Morocco
080	Mountain States
553	Mozambique
629	Muscat

N

545	Namibia
133	Nampo-shoto, Southern
545	Natal
723	Nauru
610	Near-East Asia
067	Nebraska
643	Nepal
432	Netherlands
245	Netherlands Antilles
332	Netherlands Guiana
085	Nevada
221	New Brunswick
725	New Caledonia
001	New England
673	New Guinea, except Australian and North East
711	New Guinea, Australian
711	New Guinea, North East
003	New Hampshire
721	New Hebrides
008	New Jersey
086	New Mexico
011	New York
715	New Zealand
221	Newfoundland
255	Nicaragua
520	Niger
531	Nigeria
715	Niue
711	Norfolk Island
510	North Africa
___	North America (use more specific term)
240	North American islands
671	North Borneo (Malaysia)
025	North Carolina
040	North Central States
054	North Dakota
711	North East New Guinea
695	North Korea
010	North Mid-Atlantic States
404	Northern Ireland
129	Northern Mariana Islands
050	Northern Midwest States
549	Northern Rhodesia
225	Northwest Territories (Canada)
423	Norway
998	Not United States, NOS
221	Nova Scotia
551	Nyasaland

O

043	Ohio
075	Oklahoma
629	Oman
223	Ontario

545	Orange Free State
095	Oregon
403	Orkney Islands

P

120	Pacific area, U.S. Possessions
090	Pacific Coast States
720	Pacific Islands
___	Pacific Islands, Trust Territory of the (code to specific islands)
639	Pakistan
645	Pakistan, East
639	Pakistan, West
625	Palestine, Arab
631	Palestine, Jewish
257	Panama
711	Papua New Guinea
371	Paraguay
014	Pennsylvania
629	People's Democratic Republic of Yemen
682	People's Republic of China
637	Persia
351	Peru
675	Philippine Islands
675	Philippines
725	Pitcairn
451	Poland
725	Polynesian Islands
445	Portugal
539	Portuguese Guinea
224	Prarie Provinces, Canada
221	Prince Edward Island
543	Principe
101	Puerto Rico

Q

629	Qatar
222	Quebec

R

684	Republic of China
545	Republic of South Africa
540	Reunion
006	Rhode Island
547	Rhodesia
549	Rhodesia, Northern
547	Rhodesia, Southern
539	Rio Muni
440	Romance-language countries
449	Romania
449	Roumania
577	Ruanda
449	Rumania
455	Russia
455	Russia S.F.S.R.
457	Russian, White
577	Rwanda
134	Ryukyu Islands

S

520	Sahara, Western
121	Samoa, American
725	Samoa, Western
245	St. Christopher-Nevis
540	St. Helena
245	St. Lucia
240	St. Pierre
245	St. Vincent
447	San Marino
543	Sao Tome
447	Sardinia
224	Saskatchewan
629	Saudi Arabia
420	Scandinavia
403	Scotland
539	Senegal
453	Serbia
540	Seychelles

403	Shetland Islands
651	Siam
447	Sicily
539	Sierra Leone
643	Sikkim
671	Singapore
450	Slavic countries
453	Slavonia
452	Slovakia
453	Slovenia
721	Solomon Islands
581	Somali Republic
581	Somalia
581	Somaliland
583	Somaliland, French
540	South Africa
545	South Africa, Republic of
545	South Africa, Union of
300	South America
026	South Carolina
055	South Dakota
020	South Mid-Atlantic States
545	South West Africa
650	Southeast Asia
030	Southeastern States
128	Southern Line Islands
070	Southern Midwest States
133	Southern Nampo-shoto
547	Southern Rhodesia
629	Southern Yemen
___	Soviet Union (see individual republics)
443	Spain
520	Spanish Sahara
647	Sri Lanka
520	Sudan
520	Sudanese countries
673	Sumatra
332	Surinam
423	Svalbard
135	Swan Islands
545	Swaziland
427	Sweden
435	Switzerland
621	Syria

T

634	Tadzhik S.S.R.
684	Taiwan
571	Tanzania
571	Tanzanyika
571	Tanganyika
031	Tennessee
077	Texas
651	Thailand
685	Tibet
245	Tobago
539	Togo
136	Tokelau Islands
725	Tonga
665	Tonkin
625	Trans-Jordan
545	Transkei
545	Transvaal
449	Transylvania
245	Trinidad
517	Tripoli
517	Tripolitania
629	Trucial States
515	Tunisia
611	Turkey
634	Turkmen S.S.R.
245	Turks Islands
125	Tuvalu

U

573	Uganda
456	Ukraine
456	Ukrainian S.S.R.
404	Ulster
545	Union of South Africa

___	Union of Soviet Socialist Republics (U.S.S.R.) (see individual republics)
629	United Arab Emirates
519	United Arab Republic
400	United Kingdom
000	United States
102	U.S. Virgin Islands
999	Unknown
520	Upper Volta
375	Uruguay
579	Urundi
084	Utah
634	Uzbek S.S.R.

V

721	Vanuatu
440	Vatican City
545	Venda
321	Venezuela
004	Vermont
665	Vietnam
245	Virgin Islands (British)
102	Virgin Islands (U.S.)
023	Virginia

W

137	Wake Island
402	Wales
449	Wallachia
721	Wallis
093	Washington (state)
022	Washington, D.C.
530	West Africa
431	West Germany
___	West Indies (see individual islands)
639	West Pakistan
024	West Virginia
520	Western Sahara
725	Western Samoa
457	White Russia
051	Wisconsin
082	Wyoming

Y

629	Yemen
629	Yemen, People's Democratic Republic of
453	Yugoslavia
225	Yukon Territory

Z

541	Zaire
549	Zambia
571	Zanzibar
547	Zimbabwe

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Appendix D
Cancer-Directed Surgical Codes

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SITE-SPECIFIC CANCER-DIRECTED SURGERY CODES

ORAL CAVITY (C00.0 - C14.8)

Codes:

10 Electrocautery WITHOUT pathology specimen
Cryosurgery WITHOUT pathology specimen
Laser surgery WITHOUT pathology specimen

20 Laser surgery WITH pathology specimen
Excisional biopsy WITH pathology specimen

30 Local surgical excision

40 Radical excision

50 Local excision WITH (radical) neck dissection
Radical excision WITH (radical) neck dissection

70 Radical neck dissection ONLY

80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.
- Code 60 is not used/assigned.

STOMACH (C16.0 - C16.9)

Codes:

10 Local surgical excision WITH evidence of cancer

Polypectomy WITH evidence of cancer

Excision of ulcer WITH evidence of cancer

Excision of other lesions WITH evidence of cancer

Excision of stomach tissue WITH evidence of cancer

20 Hemigastrectomy: upper (proximal) portion

Note: Partial, subtotal and hemigastrectomies may include part of the esophagus, such as an esophagogastrectomy.

Partial gastrectomy

Note: Partial gastrectomy includes sleeve resection of stomach.

Subtotal gastrectomy

30 Hemigastrectomy: lower (distal) portion

Note: Partial, subtotal and hemigastrectomies may include part of the duodenum, such as an gastropylorectomy.

Billroth I : indicates anastomosis to duodenum (duodenostomy)

Billroth II : indicates anastomosis to jejunum (jejunostomy)

Antrectomy : resection of pyloric antrum of stomach

Partial gastrectomy

Note: Partial gastrectomy includes sleeve resection of stomach.

Subtotal gastrectomy

40 Hemigastrectomy, NOS

Partial gastrectomy

Note: Partial gastrectomy includes sleeve resection of stomach.

Subtotal gastrectomy

Resection of portion of the stomach, NOS

50 Gastrectomy

Note: Includes resection with pouch left for anastomosis; total gastrectomy following previous partial resection for another cause.

Total gastrectomy

Near total gastrectomy

Note: Near total gastrectomy means 80 percent or more.

60 Gastrectomy, NOS

STOMACH **(Continued)**

70 Gastrectomy PLUS partial or total removal of other organs
Partial gastrectomy PLUS partial or total removal of other organs
Total gastrectomy PLUS partial or total removal of other organs
Radical gastrectomy PLUS partial or total removal of other organs

80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 10-70 may include removal of spleen, nodes, omentum, mesentery, or mesocolon.
- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

Do not code:

Incidental removal of gallbladder, bile ducts, appendix, or vagus nerve

COLON (C18.0 - C18.9)
(Excludes rectosigmoid and rectum)

Codes:

10 Local tumor destruction WITHOUT pathology specimen
- Laser WITHOUT pathology specimen
- Cryosurgery WITHOUT pathology specimen
- Electrocautery WITHOUT pathology specimen
- Fulguration WITHOUT pathology specimen

20 Local surgical excision WITH pathology specimen
- Polypectomy WITH pathology specimen
- Snare WITH pathology specimen
- Laser surgery WITH pathology specimen

30 Partial colectomy, but LESS than hemicolectomy
- Cecectomy
- Appendectomy
- Sigmoidectomy
- Partial resection of transverse colon and flexures
- Ileocolectomy
- Enterocolectomy

Subtotal colectomy, but LESS than hemicolectomy

Segmental resection, but LESS than hemicolectomy

Partial colectomy, NOS, but LESS than hemicolectomy

Subtotal colectomy, NOS, but LESS than hemicolectomy

40 Hemicolectomy or greater, but LESS than total

Right colectomy

Left colectomy

Note: Includes all of right or left colon and a portion of the transverse

50 Total colectomy

Note: Resection beginning with cecum and ending with the sigmoid/rectum or part of rectum

60 Colectomy, NOS

70 Colectomy PLUS partial or total removal of other organs
- Subtotal colectomy PLUS partial or total removal of other organs
- Hemicolectomy PLUS partial or total removal of other organs
- Total colectomy PLUS partial or total removal of other organs

COLON **(Continued)**

80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 30-70 may include removal of lymph nodes, mesentery, mesocolon, peritoneum, a portion of terminal ileum, or omentum.
- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

Do not code:

Incidental removal of appendix, gallbladder, bile ducts, or spleen

RECTOSIGMOID, RECTUM (C19.9, C20.9)

Codes:

10 Local tumor destruction WITHOUT pathology specimen
- Laser surgery WITHOUT pathology specimen
- Cryosurgery WITHOUT pathology specimen
- Electrocautery WITHOUT pathology specimen
- Fulguration WITHOUT pathology specimen

20 Local surgical excision WITH pathology specimen
- Polypectomy WITH pathology specimen
- Snare WITH pathology specimen
- Laser surgery WITH pathology specimen

30 Anterior/posterior resection

Wedge or segmental resection

Transsacral rectosigmoidectomy

Hartmann's operation

Partial proctectomy

Rectal resection, NOS

40 Pull-through resection WITH sphincter preservation
- Turnbull's operation WITH sphincter preservation
- Swenson's operation WITH sphincter preservation
- Soave's submucosal resection WITH sphincter preservation
- Altemeier's operation WITH sphincter preservation
- Duhamel's operation WITH sphincter preservation

50 Abdominoperineal resection
- Miles' operation
- Rankin's operation

Complete proctectomy

60 Any of codes 30-50 PLUS partial or total removal of other organs

70 Pelvic exenteration (partial or total)

Posterior exenteration

Note: Includes rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes

Total exenteration

Note: Includes removal of all pelvic contents and pelvic lymph nodes

Extended exenteration

Note: Includes pelvic blood vessels or bony pelvis.

RECTOSIGMOID, RECTUM **(Continued)**

80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 30-70 may include removal of lymph nodes and/or a section of the colon.
- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

Do not code:

Incidental removal of appendix, gallbladder, or bile ducts

Definitions:

Duhamel's operation: A modification of a pull-through procedure with longitudinal anastomosis between the proximal ganglionated segment of the colon and the rectum, leaving the rectum functional.

Hartmann's operation: A one-stage resection of primary rectal cancer with colostomy. The lower part of the sigmoid or the upper part of the rectum is resected distal to the neoplasm. The bowel is divided in the region of the descending colon. After the intervening segment of bowel has been removed, the proximal end of the descending colon is brought to the surface, as in a single-barreled colostomy. The proximal end of the distal segment is oversewn and left in place, leaving a blind rectal pouch.

Miles' operation: An abdominoperineal resection for cancer of the lower sigmoid and rectum, which includes permanent colostomy; removal of the pelvic colon, mesocolon, and adjacent lymph nodes; and wide perineal excision of the rectum and anus.

Pull-through operation: Permits removal of the desired portion of bowel (may include rectum, sigmoid, and, when indicated, descending colon and part of transverse colon) in one stage with retained sphincters, and end-to-end anastomosis. This operation is performed largely through the abdomen and does not require resection or removal of any part of the bony pelvis.

Swenson's operation: A pull-through resection with sphincter preservation.

Swenson's procedure: An abdomino-anal pull-through resection with partial internal sphincterectomy.

PANCREAS (C25.0 - C25.9)

Codes:

10 Local surgical excision of pancreas
Partial surgical excision of pancreas

20 Total pancreatectomy WITH or WITHOUT splenectomy

30 Subtotal gastrectomy with complete or partial pancreatectomy WITH or WITHOUT splenectomy
Duodenectomy with complete or partial pancreatectomy WITH or WITHOUT splenectomy
Whipple's operation

40 Radical regional (partial) pancreatectomy WITH lymph node dissection AND adjacent soft tissue resection

50 Pancreatectomy, NOS

80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 10-50 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-50, the higher code has priority.
- Codes 60 and 70 are not used; surgical procedures have not been assigned.

LARYNX (C32.0 - C32.9)

Codes:

10 Laser surgery WITHOUT pathology specimen

20 Local surgical excision or destruction of lesion WITH pathology specimen

Laser surgery WITH pathology specimen

Stripping WITH pathology specimen

30 Partial laryngectomy WITH or WITHOUT lymph node dissection

40 Total laryngectomy WITHOUT lymph node dissection

Total laryngectomy, NOS WITHOUT lymph node dissection

50 Total laryngectomy WITH lymph node dissection

Radical laryngectomy, NOS WITH lymph node dissection

60 Laryngectomy, NOS

80 Surgery of regional site(s)

Surgery of regional nodes

Surgery of distant site(s)

Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 10-60 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-60, the higher code has priority.
- Code 70 is not used; a surgical procedure has not been assigned.

BRONCHUS AND LUNG (C34.0 - C34.9)

Codes:

10 Local surgical excision
Local destruction of lesion

20 Partial resection
Wedge resection
Segmental resection
Lingulectomy
Partial lobectomy
Sleeve resection
Note: Bronchus only

30 Lobectomy WITHOUT lymph node dissection
Bilobectomy WITHOUT lymph node dissection
Lobectomy PLUS segmental/sleeve resection WITHOUT lymph node dissection
Radical lobectomy WITHOUT lymph node dissection
Partial pneumonectomy WITHOUT lymph node dissection

40 Lobectomy WITH lymph node dissection
Bilobectomy WITH lymph node dissection
Lobectomy PLUS segmental/sleeve resection WITH lymph node dissection
Radical lobectomy WITH lymph node dissection
Partial pneumonectomy WITH lymph node dissection

50 Complete pneumonectomy
Note: Complete, total and standard pneumonectomies include hilar and parabronchial lymph nodes
Total pneumonectomy
Standard pneumonectomy
Pneumonectomy, NOS

60 Radical pneumonectomy
Note: Complete pneumonectomy PLUS dissection of mediastinal lymph nodes

70 Extended radical pneumonectomy PLUS lymph nodes
Note: Includes parietal pleura, pericardium, and/or chest wall (with diaphragm)

80 Surgery of regional site(s)
Note: Includes removal of mediastinal mass ONLY
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

BRONCHUS AND LUNG **(Continued)**

90 Resection of lung, NOS
Surgery, NOS

Code priorities:

- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

Do not code:

Incidental removal of ribs. This is an operative approach.

BONES, JOINTS, AND ARTICULAR CARTILAGE; PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM; CONNECTIVE, SUBCUTANEOUS AND OTHER SOFT TISSUES (C40.0 - C41.9, C47.0 - C47.9, C49.0 - C49.9)

Codes:

10 Local excision of lesion
Wide excision of lesion
20 Partial resection
Internal hemipelvectomy (pelvis)
30 Radical excision/resection
Limb salvage
Arm
Leg
40 Amputation of limb
Partial amputation of limb
Total amputation of limb
50 Amputation, forequarter
Note: Includes scapula
Amputation, hindquarter
Note: Includes ilium/hip bone
Hemipelvectomy
60 Excision, NOS
Resection, NOS
80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes
90 Surgery, NOS

Code priorities:

- Codes 10-60 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-60, the higher code has priority.
- Code 70 is not used; a surgical procedure has not been assigned.

SPLEEN AND LYMPH NODES (C42.2, C77.0 - C77.9)

Codes:

10 Excision of localized tumor mass

20 Splenectomy

Partial splenectomy

Total splenectomy

Splenectomy, NOS

30 Lymph node dissection, one chain

31 Lymph node dissection, one chain PLUS splenectomy

40 Lymph node dissection, two or more chains AND/OR adjacent organ(s)

41 Lymph node dissection, two or more chains AND/OR adjacent organ(s) PLUS splenectomy

50 Lymph node dissection, NOS

51 Lymph node dissection, NOS PLUS splenectomy

80 Surgery of regional site(s)

Surgery of regional nodes

Surgery of distant site(s)

Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 10-50 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-51, the higher code has priority.
- Codes 60 and 70 are not used; surgical procedures have not been assigned.

SKIN (C44.0 - C44.9)

Codes:

10 Local tumor destruction WITHOUT pathology specimen
- Laser surgery WITHOUT pathology specimen
- Cryosurgery WITHOUT pathology specimen
- Fulguration WITHOUT pathology specimen
- Electrocauterization WITHOUT pathology specimen

20 Simple excision WITH pathology specimen
- Excisional biopsy WITH pathology specimen
- Shave biopsy WITH pathology specimen
- Punch biopsy WITH pathology specimen
- Local surgical excision WITH pathology specimen
- Wedge resection WITH pathology specimen
- Laser surgery WITH pathology specimen
- Excision, NOS WITH pathology specimen

30 Shave biopsy followed by excision of lesion (not a wide excision)
Punch biopsy followed by excision of lesion (not a wide excision)
Biopsy, NOS followed by excision of lesion (not a wide excision)

40 Wide excision WITHOUT lymph node dissection
Re-excision WITHOUT lymph node dissection
Minor (local) amputation WITHOUT lymph node dissection
- Digits
- Ear
- Eyelid
- Lip
- Nose

45 Radical excision WITHOUT lymph node dissection

50 Codes 10-45 WITH lymph node dissection

60 Amputation (other than code 40) WITHOUT lymph node dissection
Amputation, NOS WITHOUT lymph node dissection

70 Amputation (other than code 40) WITH lymph node dissection

80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

90 Surgery, NOS

SKIN **(Continued)**

Code priorities:

- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

BREAST (C50.0 - C50.9)

Codes:

10 Partial mastectomy WITHOUT axillary lymph node dissection
Less than total mastectomy WITHOUT axillary lymph node dissection
Segmental mastectomy WITHOUT axillary lymph node dissection
Lumpectomy WITHOUT axillary lymph node dissection
Quadrantectomy WITHOUT axillary lymph node dissection
Tylectomy WITHOUT axillary lymph node dissection
Wedge resection WITHOUT axillary lymph node dissection
Nipple resection WITHOUT axillary lymph node dissection
Excisional biopsy WITHOUT axillary lymph node dissection
Partial mastectomy, NOS WITHOUT axillary lymph node dissection

20 Partial mastectomy WITH axillary lymph node dissection
Less than total mastectomy WITH axillary lymph node dissection
Segmental mastectomy WITH axillary lymph node dissection
Lumpectomy WITH axillary lymph node dissection
Quadrantectomy WITH axillary lymph node dissection
Tylectomy WITH axillary lymph node dissection
Wedge resection WITH axillary lymph node dissection
Nipple resection WITH axillary lymph node dissection
Excisional biopsy WITH axillary lymph node dissection
Partial mastectomy, NOS WITH axillary lymph node dissection

30 Subcutaneous mastectomy WITH or WITHOUT axillary lymph node dissection

40 Mastectomy WITHOUT axillary lymph node dissection
Note: Excision of breast only
Total mastectomy WITHOUT axillary lymph node dissection
Simple mastectomy WITHOUT axillary lymph node dissection

50 Mastectomy WITH axillary lymph node dissection
Note: May include portion of pectoralis major
Modified radical mastectomy WITH axillary lymph node dissection
Total mastectomy WITH axillary lymph node dissection
Simple mastectomy WITH axillary lymph node dissection

60 Radical mastectomy WITH dissection of majority of pectoralis major WITH axillary lymph node dissection

BREAST **(Continued)**

70 Extended radical mastectomy (code 60) PLUS internal mammary node dissection
Note: May include chest wall and ribs

80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

90 Mastectomy, NOS
Surgery, NOS

Code priorities:

- Codes 10-70 apply to unilateral resection of primary tumor and have priority over codes 80-98.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

Do not code:

Removal of fragments or tags of muscles

Removal of pectoralis minor

Resection of pectoralis muscles, NOS

Resection of fascia with no mention of muscle

Definitions:

Halsted radical mastectomy: An en bloc resection of the entire breast and skin; pectoralis major and minor muscles; and contents of the axilla.

Patey's and Dyson's operations: Modified radical mastectomies with removal of the breast, pectoralis minor muscle, and axillary contents. The pectoralis major muscle remains intact.

Urban's extended radical mastectomy: Radical mastectomy and excision of internal mammary nodes.

CERVIX UTERI (C53.0 - C53.9)

Codes:

10 Cryosurgery WITHOUT pathology specimen

Laser surgery WITHOUT pathology specimen

15 Dilatation and curettage (in situ ONLY)

Endocervical curettage (in situ ONLY)

17 10 + 15 (in situ ONLY)

20 Local surgical excision WITH pathology specimen

Excisional biopsy WITH pathology specimen

Trachelectomy WITH pathology specimen

Amputation of cervix or cervical stump WITH pathology specimen

Laser surgery WITH pathology specimen

Conization WITH pathology specimen

30 Hysterectomy WITHOUT removal of tubes and ovaries WITHOUT lymph node dissection

Note: Includes both corpus and cervix uteri, may include a portion of vaginal cuff

Total hysterectomy WITHOUT removal of tubes and ovaries WITHOUT lymph node dissection

Pan hysterectomy WITHOUT removal of tubes and ovaries WITHOUT lymph node dissection

Simple hysterectomy WITHOUT removal of tubes and ovaries WITHOUT lymph node dissection

35 Hysterectomy WITH lymph node dissection WITHOUT removal of tubes and ovaries

Note: Includes both corpus and cervix uteri, may include a portion of vaginal cuff

Total hysterectomy WITH lymph node dissection WITHOUT removal of tubes and ovaries

Pan hysterectomy WITH lymph node dissection WITHOUT removal of tubes and ovaries

Simple hysterectomy WITH lymph node dissection WITHOUT removal of tubes and ovaries

40 Hysterectomy WITH removal of tube(s) and ovary(ies) WITHOUT lymph node dissection

Total hysterectomy WITH removal of tube(s) and ovary(ies) WITHOUT lymph node dissection

Pan hysterectomy WITH removal of tube(s) and ovary(ies) WITHOUT lymph node dissection

Simple hysterectomy WITH removal of tube(s) and ovary(ies) WITHOUT lymph node dissection

50 Hysterectomy

Note: Includes uterus, tube(s), ovary(ies); para-aortic and pelvic lymph nodes; may include vaginal cuff

Modified radical hysterectomy

Extended hysterectomy

CERVIX UTERI **(Continued)**

Radical hysterectomy

Note: Includes uterus, tubes, ovaries, vagina, all parametrial and paravaginal tissue, and para-aortic and pelvic lymph nodes

Wertheim's operation

60 Hysterectomy, NOS

Abdominal hysterectomy

Vaginal hysterectomy

70 Pelvic exenteration

Partial pelvic exenteration

Total pelvic exenteration

Anterior exenteration

Note: Includes bladder, distal ureters, and genital organs with their ligamentous attachments and pelvic lymph nodes

Posterior exenteration

Note: Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes

Total exenteration

Note: Includes removal of all pelvic contents and pelvic lymph nodes

Extended exenteration

Note: Includes pelvic blood vessels or bony pelvis

80 Surgery of regional site(s)

Surgery of regional nodes

Surgery of distant site(s)

Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 30, 35, and 40 may include a portion of vaginal cuff.
- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

CERVIX UTERI **(Continued)**

Do not code:

Incidental removal of appendix

Omentectomy if it was the only surgery performed in addition to hysterectomy

Surgical approach (abdominal or vaginal)

For invasive cancers only, code dilatation and curettage as an incisional biopsy

Reconstructive surgery for this primary site

Definition:

Wertheim's operation: A radical abdominal hysterectomy for cancer of the cervix and uterus. The uterus and as much of the parametrial tissue as possible are removed, as well as a wide margin of the vagina.

Loop electrocautery excisional procedure (LEEP) WITH pathology specimen is coded 20 (laser surgery).

CORPUS UTERI (C54.0 - C54.9)

Codes:

10 Polypectomy
Myomectomy (simple excision)
Simple excision, NOS

20 Subtotal hysterectomy WITH or WITHOUT removal of tubes and ovaries
Supracervical hysterectomy WITH or WITHOUT removal of tubes and ovaries
Fundectomy WITH or WITHOUT removal of tubes and ovaries
Note: Cervix left in place

30 Hysterectomy WITHOUT removal of tube(s) and ovary(ies) WITHOUT lymph node dissection
Note: Includes both corpus and cervix uteri; may include a portion of vaginal cuff
Total hysterectomy
Pan hysterectomy
Simple hysterectomy

35 Hysterectomy WITHOUT removal of tube(s) and ovary(ies) WITH lymph node dissection
Note: Includes both corpus and cervix uteri; may include a portion of vaginal cuff
Total hysterectomy
Pan hysterectomy
Simple hysterectomy

40 Hysterectomy WITH removal of tube(s) and ovary(ies) WITHOUT lymph node dissection
Note: May include a portion of vaginal cuff
Total hysterectomy
Pan hysterectomy
Simple hysterectomy

50 Hysterectomy
Note: Includes uterus, tube(s), ovary(ies); para-aortic and pelvic lymph nodes; may include vaginal cuff
Modified radical hysterectomy
Extended hysterectomy
Radical hysterectomy
Note: Includes uterus, tube(s), ovary(ies), vagina, all parametrial and paravaginal tissue, and para-aortic and pelvic lymph nodes
Wertheim's operation

60 Hysterectomy, NOS
Abdominal hysterectomy
Vaginal hysterectomy

CORPUS UTERI **(Continued)**

70 Pelvic exenteration

Partial exenteration

Total exenteration

Anterior exenteration

Note: Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes

Posterior exenteration

Note: Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes

Total exenteration

Note: Includes removal of all pelvic contents and pelvic lymph nodes

Extended exenteration

Note: Includes pelvic blood vessels or bony pelvis

80 Surgery of regional site(s)

Surgery of regional nodes

Surgery of distant site(s)

Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 30, 35, and 40 may include a portion of vaginal cuff.
- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

For invasive and in situ cancers code dilatation and curettage as non cancer-directed surgery, an incisional biopsy (02).

Do not code:

Incidental removal of appendix

Omentectomy if it was the only surgery performed in addition to hysterectomy

Surgical approach (abdominal or vaginal)

Definition:

Wertheim's operation: A radical abdominal hysterectomy for cancer of the cervix and uterus. The uterus and as much of the parametrial tissue as possible are removed, as well as a wide margin of the vagina.

OVARY (C56.9)

Codes:

10 (Salpingo)-oophorectomy WITHOUT hysterectomy

Subtotal (salpingo)-oophorectomy WITHOUT hysterectomy

Partial (salpingo)-oophorectomy WITHOUT hysterectomy

Unilateral (salpingo)-oophorectomy WITHOUT hysterectomy

Wedge resection WITHOUT hysterectomy

20 (Salpingo)-oophorectomy WITH hysterectomy

Subtotal (salpingo)-oophorectomy WITH hysterectomy

Partial (salpingo)-oophorectomy WITH hysterectomy

Unilateral (salpingo)-oophorectomy WITH hysterectomy

30 Bilateral (salpingo)-oophorectomy WITHOUT hysterectomy

(Salpingo)-oophorectomy, NOS WITHOUT hysterectomy

40 Bilateral (salpingo)-oophorectomy WITH hysterectomy

50 Omentectomy WITH unilateral or bilateral (salpingo)-oophorectomy, unknown if hysterectomy done

Partial omentectomy WITH unilateral or bilateral (salpingo)-oophorectomy, unknown if hysterectomy done

Total omentectomy WITH unilateral or bilateral (salpingo)-oophorectomy, unknown if hysterectomy done

Omentectomy, NOS WITH unilateral or bilateral (salpingo)-oophorectomy, unknown if hysterectomy done

51 Omentectomy WITH unilateral or bilateral (salpingo)-oophorectomy WITHOUT hysterectomy

Partial omentectomy WITH unilateral or bilateral (salpingo)-oophorectomy WITHOUT hysterectomy

Total omentectomy WITH unilateral or bilateral (salpingo)-oophorectomy WITHOUT hysterectomy

Omentectomy, NOS WITH unilateral or bilateral (salpingo)-oophorectomy WITHOUT hysterectomy

52 Omentectomy WITH unilateral or bilateral (salpingo)-oophorectomy WITH hysterectomy

Partial omentectomy WITH unilateral or bilateral (salpingo)-oophorectomy WITH hysterectomy

Total omentectomy WITH unilateral or bilateral (salpingo)-oophorectomy WITH hysterectomy

Omentectomy, NOS WITH unilateral or bilateral (salpingo)-oophorectomy WITH hysterectomy

60 Debulking of ovarian tumor mass

Note: May include ovarian tissue.

OVARY **(Continued)**

70 Pelvic exenteration

Partial exenteration

Total exenteration

Anterior exenteration

Note: Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes

Posterior exenteration

Note: Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes

Total exenteration

Note: Includes removal of all pelvic contents and pelvic lymph nodes

Extended exenteration

Note: Includes pelvic blood vessels or bony pelvis

80 Surgery of regional site(s)

Surgery of regional nodes

Surgery of distant site(s)

Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

Do not code:

Incidental removal of appendix

Definition:

Debulking: The partial removal of tumor mass. It is usually followed by other treatment modalities.

PROSTATE (C61.9)

Codes:

10 Transurethral resection of prostate (TURP) WITHOUT lymph node dissection
Cryoprostatectomy WITHOUT lymph node dissection
Local surgical excision of lesion WITHOUT lymph node dissection

20 Transurethral resection of prostate (TURP) WITH lymph node dissection
Cryoprostatectomy WITH lymph node dissection
Local excision of lesion WITH lymph node dissection

30 Subtotal prostatectomy WITHOUT lymph node dissection
Simple prostatectomy WITHOUT lymph node dissection
Note: Segmental resection or enucleation leaving capsule intact

40 Subtotal prostatectomy WITH lymph node dissection
Simple prostatectomy WITH lymph node dissection
Note: Segmental resection or enucleation

50 Radical prostatectomy WITHOUT lymph node dissection
Total prostatectomy WITHOUT lymph node dissection
Note: Excised prostate, ejaculatory ducts (ductus deferens) and seminal vesicles

60 Radical prostatectomy WITH lymph node dissection
Total prostatectomy WITH lymph node dissection
Note: Excised prostate, ejaculatory ducts (ductus deferens) and seminal vesicles

70 Cystoprostatectomy WITH or WITHOUT lymph node dissection
Radical cystectomy WITH or WITHOUT lymph node dissection
Pelvic exenteration WITH or WITHOUT lymph node dissection

80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

90 Prostatectomy, NOS
Surgery, NOS

PROSTATE **(Continued)**

Code priorities:

- Codes 10-70 have priority over codes 80-90.
- In the range 10-70, the higher code has priority.
- Surgery of primary not included in any category should be coded 90.

Do not code:

Orchiectomy is coded as hormone/steroid (endocrine) therapy

Surgical approach: suprapubic, retropubic, or perineal

TESTIS (C62.0 - C62.9)

Codes:

10 Local surgical excision of testicle
Partial resection of testicle

20 Excision of testicle WITHOUT cord

30 Excision of testicle WITH cord
Excision of testicle, cord not mentioned

40 Excision of testicle WITH unilateral lymph node dissection

50 Excision of testicle WITH bilateral lymph node dissection
Excision of testicle WITH lymph node dissection, NOS

60 Orchiectomy, NOS

80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 10-60 have priority over codes 80-90.
- In the range 10-60, the higher code has priority.
- Surgery of primary not included in any category should be coded 90.
- Code 70 is not used; a surgical procedure has not been assigned.

The spermatic cord is usually removed with the testicle. If the pathology report and operative report fail to mention the cord, code the surgery 30 (excision of testicle with cord).

Exception: If the operative report states the cord was NOT removed.

KIDNEY, RENAL PELVIS, AND URETER (64.9, C65.9, C66.9)

Codes:

10 Partial nephrectomy
Subtotal nephrectomy
Local excision
Wedge resection
Segmental resection
Partial ureterectomy

20 Nephrectomy WITHOUT lymph node dissection
Note: For kidney parenchyma C64.9
Complete nephrectomy WITHOUT lymph node dissection
Total nephrectomy WITHOUT lymph node dissection
Simple nephrectomy WITHOUT lymph node dissection
Nephroureterectomy including bladder cuff WITHOUT lymph node dissection
Note: For renal pelvis C65.9 and ureter C66.9

30 Nephrectomy WITH lymph node dissection
Note: For kidney parenchyma C64.9
Complete nephrectomy WITH lymph node dissection
Total nephrectomy WITH lymph node dissection
Simple nephrectomy WITH lymph node dissection
Nephroureterectomy including bladder cuff WITH lymph node dissection
Note: For renal pelvis C65.9 and ureter C66.9

40 Radical nephrectomy WITHOUT lymph node dissection
Note: Includes removal of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial ureter

50 Radical nephrectomy WITH lymph node dissection
Note: Includes removal of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial ureter

60 Nephrectomy, NOS
Ureterectomy, NOS

70 Codes 20-60 PLUS other organs (such as bladder or colon)

80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

90 Surgery, NOS

KIDNEY, RENAL, PELVIS, AND URETER (Continued)

Code priorities:

- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

Do not code:

Incidental removal of ribs is an operative approach

BLADDER (C67.0 - C67.9)

Codes:

10 Transurethral resection of bladder (TURB)

Local destruction

Electrocoagulation

Fulguration

Cryosurgery

Excisional biopsy

20 Cystectomy WITHOUT pelvic lymph node dissection

Note: Includes segmental resection

Partial cystectomy WITHOUT pelvic lymph node dissection

Subtotal cystectomy WITHOUT pelvic lymph node dissection

30 Cystectomy WITH pelvic lymph node dissection

Note: Includes segmental resection

Partial cystectomy WITH pelvic lymph node dissection

Subtotal cystectomy WITH pelvic lymph node dissection

40 Cystectomy WITHOUT lymph node dissection

Complete cystectomy WITHOUT lymph node dissection

Total cystectomy WITHOUT lymph node dissection

Simple cystectomy WITHOUT lymph node dissection

50 Cystectomy WITH lymph node dissection

Complete cystectomy WITH lymph node dissection

Total cystectomy WITH lymph node dissection

Simple cystectomy WITH lymph node dissection

60 Cystectomy, NOS

70 Radical cystectomy

Note: In men, includes removal of bladder, prostate, seminal vesicles, surrounding perivesical tissues, and distal ureters.

In women, includes removal of bladder, uterus, ovaries, fallopian tubes, surrounding peritoneum, and sometimes urethra and vaginal wall.

Pelvic exenteration

Partial exenteration

Total exenteration

Extended exenteration

BLADDER **(Continued)**

Anterior exenteration

Note: Includes bladder, distal ureters, and genital organs, WITH their ligamentous attachments and pelvic lymph nodes

Posterior exenteration

Note: Includes rectum and rectosigmoid, WITH ligamentous attachments or pelvic lymph nodes

Total exenteration

Note: Includes removal of all pelvic contents and pelvic lymph nodes

Extended exenteration

Note: Includes pelvic blood vessels or bony pelvis

80 Surgery of regional site(s)

Surgery of regional nodes

Surgery of distant site(s)

Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

Do not code:

Partial removal of ureter when coding cystectomy

BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM (C70.0 - C70.9, C71.0 - C71.9, C72.0 - C72.9)

Codes:

10 Local tumor destruction

20 Excision of tumor, lesion, or mass

Note: This includes debulking of tumor

Subtotal resection

Partial resection

30 Excision of tumor, lesion, or mass

Total resection

Gross resection

Resection, NOS

Excision, NOS

Removal of tumor, NOS

Excisional biopsy

40 Partial resection of primary site

Note: Includes resection of part of lobe, meninges, or nerves

50 Resection of primary site

Gross resection

Total resection (lobectomy of brain)

60 Radical resection

Note: Resection of primary site plus partial or total removal of surrounding organs/tissue

80 Surgery of regional site(s)

Surgery of regional nodes

Surgery of distant site(s)

Surgery of distant nodes

90 Surgery, NOS

BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM (Continued)

Code priorities:

- Codes 10-60 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-60, the higher code has priority.
- Code 70 is not used; a surgical procedure has not been assigned.
- If there is a tissue diagnosis and the only surgery is craniotomy, NOS or laminectomy, NOS, code as non cancer-directed surgery, a biopsy of the primary site (02).

Do not code:

For spinal cord primaries, ignore laminectomy and code only the surgery done to the spinal cord

THYROID (C73.9)

Codes:

10 Local surgical excision
Partial removal of lobe

20 Lobectomy WITH or WITHOUT isthmectomy WITH or WITHOUT lymph node dissection

30 Near total thyroidectomy
Lobectomy WITH or WITHOUT lymph node dissection
Isthmectomy WITH or WITHOUT lymph node dissection
Partial removal of contralateral lobe WITH or WITHOUT lymph node dissection

40 Total thyroidectomy WITHOUT lymph node dissection

50 Total thyroidectomy WITH limited lymph node dissection
Nodal sampling
"Berry picking"
Total thyroidectomy WITH lymph node dissection, NOS

60 Total thyroidectomy WITH radical/modified lymph node dissection

70 Thyroidectomy, NOS

80 Surgery of regional site(s)
Surgery of regional nodes
Surgery of distant site(s)
Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 10-70 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-70, the higher code has priority.

LYMPH NODES AND SPLEEN (C77.0 - C77.9, C42.2)

Codes:

10 Excision of localized tumor mass

20 Splenectomy

Partial splenectomy

Total splenectomy

Splenectomy, NOS

30 Lymph node dissection, one chain

31 Lymph node dissection, one chain PLUS splenectomy

40 Lymph node dissection, two or more chains AND/OR adjacent organ(s)

41 Lymph node dissection, two or more chains AND/OR adjacent organ(s) PLUS splenectomy

50 Lymph node dissection, NOS

51 Lymph node dissection, NOS PLUS splenectomy

80 Surgery of regional site(s)

Surgery of regional nodes

Surgery of distant site(s)

Surgery of distant nodes

90 Surgery, NOS

Code priorities:

- Codes 10-50 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-51, the higher code has priority.
- Codes 60 and 70 are not used; surgical procedures have not been assigned.

ALL OTHER SITES (C15.0-C15.9, C17.0-C17.9, C21.0-C21.8, C22.0-C22.1, C23.9, C24.0-C24.9, C26.0-C26.9, C30.0-C30.1, C31.0-C31.9, C33.9, C37.9, C38.0-C38.8, C39.0-C39.9, C42.0-C42.1, C42.3-C42.4, C48.0-C48.8, C51.0-C51.9, C52.9, C55.9, 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, C76.0-C76.8, C80.9)

Codes:

10 Cryosurgery

20 Cautery WITHOUT pathology specimen
Fulguration WITHOUT pathology specimen
Laser surgery WITHOUT pathology specimen

30 Laser surgery WITH pathology specimen

35 Excisional biopsy
Polypectomy
Excision of lesion

40 Partial surgical removal of primary site WITHOUT lymph node dissection
Simple surgical removal of primary site WITHOUT lymph node dissection

50 Partial surgical removal of primary site WITH lymph node dissection
Simple surgical removal of primary site WITH lymph node dissection

55 Stated as “debulking” WITH or WITHOUT dissection of lymph nodes

60 Radical surgery
Note: Partial/total removal of primary site plus partial or total removal of other organs.

80 Surgery of regional site(s)
Surgery of regional node(s)
Surgery of distant site(s)
Surgery of distant node(s)

90 Surgery, NOS

Code priorities:

- Codes 10-60 have priority over codes 80-90.
- Surgery of primary not included in any category should be coded 90.
- In the range 10-60 the higher code has priority.
- Code 70 is not used; a surgical procedure has not been assigned.

ALL OTHER SITES **(Continued)**

Tumor excisions involving primary sites such as the mediastinal area or the retroperitoneal space should be coded 35 unless debulking is mentioned. If any organ is removed with the tumor mass, code 60.

Definition:

Debulking: The partial removal of tumor mass. It is usually followed by other treatment modalities.

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Appendix E

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Standards of the Commission on Cancer Volume II Registry Operations and Data Standards (ROADS)

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A special recognition to the members of the Uniform Data Standards Committee of the North American Association of Central Cancer Registries for their expert review.

Preface

The *Registry Operations and Data Standards (ROADS)* is Volume II of a three-volume series, *Standards of the Commission on Cancer*. Volume I, *Cancer Program Standards (CPS)*, addresses the standards that a cancer program must meet to be approved by the Commission on Cancer (COC). The *ROADS* contains detailed specifications on registry operations as well as the data items, coding rules, codes, and definitions. Registries in Commission-approved cancer programs must comply with the standards for operations and must maintain the required data set, including the codes and coding rules as defined in this text.

Data Standards

The new codes have been developed in consultation with physicians, nurses, cancer registrars, administrators, central and national registry organizations, software providers, and the Uniform Data Standards Committee of the North American Association of Central Cancer Registries (NAACCR). The collaborative effort of these individuals and groups has encouraged accurate, uniform data collection. Whenever possible, throughout the text, "None or not done" is coded as 0; "Not applicable" is coded as 8, and code 9 is used to indicate "Unknown."

Data Sets

The data set has been categorized as follows:

Required

These data items must be included in the registry in a Commission-approved cancer program. The COC coding rules, codes, and definitions must be used. Manual registries must record the appropriate code for the data item. This will promote uniform data collection and will assist facilities if they should elect to computerize their registry.

Supplementary

Registries can extend the versatility and uses of the data by collection of the supplementary data set. Data items in this set may be of interest in most registries, but not useful for all programs. The Commission recommends, but does not require, collection of the supplementary data set.

Optional

The optional data set includes items from earlier editions of the *Cancer Program Manual* (1991) and the *Data Acquisition Manual* (1994). Some of these may have been required, but were recommended for deletion from the new standards. Rather than delete the data items, they were moved to the optional data set, so that registries may continue collection. Also in the optional data set are new data items. Since the 1991 publication of the cancer program manual, many suggestions have been received relative to additions or deletions to the data set. In addition, the Data Set Task Force made suggestions. A rationale for inclusion or

exclusion was prepared for every data item in the overall data set. Those items for which the rationales could not support inclusion in the required or supplementary data set were incorporated into the optional category. To ensure uniform data collection of these optional fields, codes, coding rules, and definitions have been established.

Using the Data Standards Section

The header that precedes each data item contains the following information:

Data Item Name	Appears at the left margin. The names of pre-existing data items may have been changed. The previous name for the item appears in parentheses.
Item Length	The total of the numbers and/or letters contained in a field (code) appears at the right margin.
Data Type	This refers to the nature of the field. Alpha = alphabetic only; alphanumeric = a combination of alphabetic and numeric; numeric = numbers only; alpha character = alphabetical or character, such as / or &; and free text = any alphabetic, numeric, or character value. Data type may also provide additional instructions on the use of upper or lower case.
Data Set	Indicates whether an item is from the required, supplementary, or optional data set.

Other

Each institution is assigned a unique identifier used by the Commission in all communication with the institution. Copies of institution identification numbers are available from the Cancer Department on diskette or in hard copy. Instructions for ordering the list on diskette or hard copy appear in the Appendix. Individual programs should call the Cancer Department if they do not know their identification number.

Each approved program has been sent one complimentary copy of the *Registry Operations and Data Standards.* Additional manuals may be ordered from the American College of Surgeons (see appendix).