SECTION THREE – CODING INSTRUCTIONS

Required Data Items

It is important to code cases according the manuals and reference materials that are applicable to the year of diagnosis. Please refer to Appendix G: *Reference Materials for Hospitals* and Appendix H: *Effective Dates for Registry Standards*.

The following is a list of the required data items to be reported to the Maine Cancer Registry. The list is arranged according to the order that information is usually abstracted into registry software. The list includes the NAACCR item number, NAACCR item name, the diagnosis year(s) for which each data item is reportable to the MCR, and the page where the specific coding instructions can be found in this section. Section Three also includes data items that are not required by MCR, but may be related or are required by most registry software systems.

MCR Required Data Items for Hospitals, as of 11/05

PATIENT IDENTIFICATION/DEMOGRAPHIC INFORMATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
550	**Accession Number – Hospital**	**2005+**	**29**
2230	Name--Last	All	30
2240	Name--First	All	31
2250	Name--Middle	All	32
2390	Name--Maiden	All	33
2280	**Name – Alias**	**2005 +**	**34**
2320	Social Security Number	All	35
2300	**Medical Record Number**	**2005 +**	**36**
2350	Addr Current - No & Street	All	37
2355	**Addr Current – Supplementl**	**2005 +**	**38**
1810	Addr Current - City	All	39
1820	Addr Current - State	All	40
1830	Addr Current - Postal	All	42
1840	**County – Current**	**2005 +**	**43**
240	Birth Date	All	44
250	Birthplace	2001 +	45
220	Sex	All	46
160	Race 1	All	47
161	Race 2	2001 +	51
162	Race 3	2001 +	52
163	Race 4	2001 +	53
164	Race 5	2001 +	54
190	Spanish/Hispanic Origin	All	55

CANCER IDENTIFICATION

NAACCR Item #	NAACCR Item Name	Diagnosis Year Required	Page Number
400	Primary Site	All	56
560	Sequence Number - Hospital	All	57
410	Laterality	All	58
522	Histologic Type ICD-O-3	2001 +	59
523	Behavior Code ICD-O-3	2001 +	64
420	Histology ICD-O-2	1992-2000	66
430	Behavior ICD-O-2	1992-2000	67
440	Grade	All	68
490	Diagnostic Conformation	All	71
500	Type of Reporting Source	2004 +	72
610	Class of Case	2004 +	73
580	Date of 1st Contact (previously Date of Adm)	All	74
390	Date of Diagnosis	All	75
1080	**Date of 1st Positive BX**	**2005 +**	**76**
630	Primary Payer at DX	2004 +	77
STAGING AND EXTENT OF DISEASE INFORMATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
2800	CS Tumor Size	2004 +	79
2810	CS Extension	2004 +	82
2820	CS Tumor Size/Ext Eval	2004 +	84
830	Regional Nodes Examined	2001 +	86
820	Regional Nodes Positive	2001 +	87
2830	CS Lymph Nodes	2004 +	88
2840	CS Reg Nodes Eval	2004 +	91
2850	CS Mets at DX	2004 +	93
2860	CS Mets Eval	2004 +	95
2880	CS Site-Specific Factor 1	2004 +	97
2890	CS Site-Specific Factor 2	2004 +	98
2900	CS Site-Specific Factor 3	2004 +	99
2910	CS Site-Specific Factor 4	2004 +	100
2920	CS Site-Specific Factor 5	2004 +	101
2930	CS Site-Specific Factor 6	2004 +	102
760	SEER Summary Stage 1977	Prior to 2001	104
759	SEER Summary Stage 2000	2001-2003	105
1060	TNM Edition Number	Prior to 2004	107
880	TNM Path T	Prior to 2004	108
890	TNM Path N	Prior to 2004	109
900	TNM Path M	Prior to 2004	110
910	TNM Path Stage Group	Prior to 2004	111
920	TNM Path Descriptor	Prior to 2004	112

940	TNM Clin T	Prior to 2004	113
950	TNM Clin N	Prior to 2004	114
960	TNM Clin M	Prior to 2004	115
970	TNM Clin Stage Group	Prior to 2004	116
980	TNM Clin Descriptor	Prior to 2004	117
1090	**Site of Distant Met 1**	**2005 +**	**118**
1100	**Site of Distant Met 2**	**2005 +**	**118**
1110	**Site of Distant Met 3**	**2005 +**	**118**
FIRST COURSE OF TREATMENT/THERAPY			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
1280	RX Date -- DX/Stg Proc (noncancer-directed surgery)	All	119
1350	**RX Summ – DX/Stg Proc (if done)**	**2005 +**	**120**
1270	Date of 1st Crs RX--COC (if done)	All	122
1200	RX Date -- Surgery (if done)	All	123
1290	RX Summ--Surg Prim Site (if done)	All	124
1292	RX Summ--Scope Reg LN Sur (if done)	2001 +	125
1294	RX Summ--Surg Oth Reg/Dis (if done)	2001 +	127
1646	RX Summ - Surg Site (if done)	Prior to 2003	128
1647	RX Summ - Scope Reg (if done)	Prior to 2003	129
1296	RX Summ--Reg LN Examined (if done)	Prior to 2003	130
1648	RX Summ - Surg Oth (if done)	Prior to 2003	131
1380	RX Summ - Surg/Rad Seq (if done)	All	132
1340	Reason for no Surgery	All	133
1430	Reason for no Radiation	All	134
1220	RX Date--Chemo (if done)	All	135
1390	RX Summ - Chemo (if done)	All	136
1230	RX Date--Hormone (if done)	All	137
1400	RX Summ - Hormone (if done)	All	138
1240	RX Date--BRM (if done)	All	139
1410	RX Summ - BRM (if done)	All	140
None	**Date Hematalogic Transplant/Endocrine Procedure**	**2005+**	**141**
3250	**RX Summ – TransplInt/Endocr**	**2005 +**	**142**
1250	RX Date -- Other (if done)	All	143
1420	RX Summ - Other (if done)	All	144
1210	RX Date -- Radiation (if done)	All	145
1570	Rad - Regional RX Modality (if done)	All	150
DIAGNOSIS MISCELLANEOUS DATA/PATIENT STATUS			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
2460	Physician - Managing (previously Attending)	All	157
None	Physician - Referring	All	158
1750	Date of Last Contact	2001 +	160
1760	Vital Status	2001 +	161

1910	Cause of Death (if available)	2001 +	162
1920	**ICD Revision Number**	**2005 +**	**163**
1940	**Place of Death**	**2005 +**	**164**
2330	Addr at DX--No & Street	All	165
2335	**Addr at DX - Supplementl**	**2005 +**	**166**
70	Addr at DX--City	All	167
80	Addr at DX--State	All	168
100	Addr at DX--Postal Code	All	170
90	County at DX	All	171
DIAGNOSIS CASE ADMIISTRATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
540	**Reporting Hospital**	**2005 +**	**172**
1460	RX Coding System--Current (if done)	All	173
2935	CS Version 1st	2004 +	174
2936	CS Version Latest	2004 +	175
TEXT FIELDS			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
2520	Text--Dx Proc--PE	All	178
2530	Text--DX Proc--X-ray/scan	All	179
2540	Text--DX Proc--Scopes	All	180
2550	Text--DX Proc--Lab Tests	All	181
2560	Text--DX Proc--Op	All	182
2570	Text--DX Proc--Path	All	183
2580	Text--Primary Site Title	All	184
2590	Text--Histology Title	All	185
2600	Text--Staging	All	186
2610	RX Text--Surgery	All	187
2620	**RX Text – Radiation (Beam)**	**2005 +**	**188**
2630	**RX Text – Radiation Other**	**2005 +**	**189**
2640	**RX Text – Chemo**	**2005 +**	**190**
2650	**RX Text – Hormone**	**2005 +**	**191**
2660	**RX Text - BRM**	**2005 +**	**192**
2670	**RX Text - Other**	**2005 +**	**193**
2680	**RX Text – Remarks**	**2005+**	**194**
310	Text--Usual Occupation (if available)	All	195
320	Text--Usual Industry (if available)	All	196
2690	**Place of Diagnosis**	**2005+**	**197**

Bold items are newly required items for cases diagnosed in 2005

How to Use the Coding Instructions

Except where otherwise noted, the instructions for coding in Section Three of this manual are adapted from *FORDS Revised for 2004* with the permission of the Commission on Cancer (CoC). For a few data items, the *FORDS* instructions are supplemented with more detailed instructions from the *SEER Program Coding and Staging Manual 2004*. This section includes coding instructions for all of the data items required by the MCR and additional items that are either closely associated with a required data item or required by our software.

Each data item is listed in a box like the one below:

(1) NAACCR ITEM NAME **(2) [ALTERNATE NAME]**	(3) Item Length: (4) NAACCR Item # (5) Source of Standard: (6) Dx Yr Req by MCR:

(1) NAACCR ITEM NAME: The name assigned to this data item by NAACCR*

(2) ALTERNATE NAME: Another name for this data item; (i.e., another descriptive name for this data field such as one assigned by a FORDS or a software vendor)

(3) Item Length: The number of characters allowed for this data item in the NAACCR format

(4) NAACCR Item #: The number assigned by NAACCR for this data item

(5) Source of Standard: The Standard Setter(s) responsible for this data item:
AJCC = American Joint Committee on Cancer Staging
CoC = Commission on Cancer of the American College of Surgeons
NAACCR = North American Association of Central Cancer Registries
NPCR = National Program for Cancer Registries of the CDC
SEER = Surveillance Epidemiology & End Results Program of the NCI
MCR = Maine Cancer Registry

(6) Dx Yr Req by MCR: The diagnosis year(s) for which this data item is required by the MCR
N/R = not required

Underneath the box is a brief ***Description*** and **Instructions for Coding** for each data item. In addition, the pertinent pages in *FORDS Revised for 2004* and/or any other applicable resource(s) are referenced.

Coding instructions, special notes and examples added by or specific to the MCR appear in shaded boxes.

** The North American Association of Central Cancer Registries, Inc. (NAACCR, Inc.), is a professional organization that develops and promotes uniform data standards for cancer registration*

Patient Identification/Demographic Information

ACCESSION NUMBER – HOSP	Item Length: 9 NAACCR Item #550 Source of Standard: CoC (Revised 01/04) Dx Yr Req by MCR: 2005+

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

Instructions for Coding (See *FORDS Revised for 2004* p. 33)

- The first four digits specify the year the patient was first seen at the reporting facility for the diagnosis and treatment of cancer, and the last five digits are the numeric order in which the patient was entered into the registry database. Within a registry, all primaries for an individual must have the same accession number. Do not assign new accession number(s) for subsequent primaries. (See Sequence Number)

  Example: Patient enters your hospital in 2004 and is diagnosed with colon cancer. The patient is the 25th patient accessioned in 2004. Your accession number is 2004/000025.

- When a patient is deleted from the database, **do not** reuse the accession number for another patient.

- Numeric gaps are allowed in accession numbers.

- A patient's accession number is never reassigned.

NAME – LAST	Item Length: 25 NAACCR Item #2230 Source of Standard: NAACCR (Revised 01/04) Dx Yr Req by MCR: All

Description: *Identifies the last name of the patient.*

Instructions for Coding (See *FORDS Revised for 2004* p. 39)

- Record the last name of the patient. Truncate the name if more than 25 letters long. Blanks, spaces, hyphens and apostrophes* are allowed. Do not use other punctuation, such as periods.

For complex names that include a period, replace the period with a space.

Example: St. Amand should be recorded as St Amand.

****Note*:** MCR software does not allow apostrophes.

- Do not leave blank. Code as unknown if the patient's last name is unknown.
- This field may be updated, if the last name changes.

NAME – FIRST	Item Length: 14 NAACCR Item #2240 Source of Standard: NAACCR Dx Yr Req by MCR: All

Description: *Identifies the first name of the patient.*

Instructions for Coding (See *FORDS Revised for 2004* p. 40)

- Record the first name of the patient. Truncate the name if more than 14 letters long. Do not use punctuation.

If the patient's name consists of a first initial followed by a middle name, record only the first initial in this field

> ***Example:*** If the patient's name is listed as A. Robert, record only the A in this field. Robert should be recorded in the *Name – Middle* field

If the patient's name is a complex first name (either hyphenated or not), this should be recorded as reported.

> ***Example:*** If the patient's name is listed as Mary-Rose, record Mary-Rose; Mary Lou should be recorded as Mary Lou.

NAME – MIDDLE **(MIDDLE INITIAL)**	Item Length: 14 NAACCR Item #2250 Source of Standard: CoC Dx Yr Req by MCR: All

Description: *Identifies the middle name or middle initial of the patient.*

Instructions for Coding (See *FORDS Revised for 2004* p. 41)

- Record the middle name of the patient, if available. Truncate the name if more than 14 letters long. Do not use punctuation.
- Record the middle initial if the complete name is not provided.
- Leave blank if the patient does not have a middle name or initial, or if the middle name or initial is unknown.

NAME – MAIDEN	Item Length: 15 NAACCR Item #2390 Source of Standard: SEER Dx Yr Req by MCR: All

Description: *Identifies the maiden name of female patients who have been married.*

Instructions for Coding (See *ROADS p. 51)**

- Record the maiden name of a female patient who is or has been married, if available. Truncate the name if more than 15 letters long. Blanks, spaces, hyphens and apostrophes* are allowed. Do not use other punctuation, such as periods.
- Leave blank if the female patient does not have a maiden name or the information is unavailable.

For complex names that include a period, replace the period with a space.

Example: St. Amand should be recorded as St Amand.

Note: The MCR software does not allow apostrophes.

****Note:*** As January 1, 2003, this data item is no longer supported by the CoC.

NAME – ALIAS **[ALIAS (COC)]**	Item Length: 15 NAACCR Item #2280 Source of Standard: SEER Dx Yr Req by MCR: 2005+

Description: *Records an alternate name or "AKA" (also known as) used by the patient if known. Note that maiden name is recorded in item #2390.*

Instructions for Coding (See *ROADS p. 52)**

- 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.
- If the patient uses only a last name alias, record the last name alias followed by a blank space and the actual first name.
- If the patient uses an alias for the first and last name, record last name alias followed by a blank space and the first name alias.
- If the patient has no known alias, leave the field blank.

****Note:*** As January 1, 2003, this data item is no longer supported by the CoC.

SOCIAL SECURITY NUMBER	Item Length: 9 NAACCR Item #2320 Source of Standard: CoC Dx Yr Req by MCR: All

Description: *Records the patient's Social Security number.*

Instructions for Coding (**See *FORDS Revised for 2004* p. 37)**

- Record the patient's Social Security number.
- A patient's Medicare claim number may not always be identical to the person's Social Security number.
- Record Social Security numbers that end with "B" or "D" as 999999999. The patient receives benefits under the spouse's number and this is the spouse's Social Security number.
- Record 999999999 if the patient does not have a social security or if the social security number is not available. Do not leave blank.

MEDICAL RECORD NUMBER	Item Length: 11 NAACCR Item #2300 Source of Standard: CoC Dx Yr Req by MCR: 2005+

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

Instructions for Coding (See *FORDS Revised for 2004* p. 36)

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

This data item is required by the MCR software. Do not leave blank.

ADDRESS (NUMBER AND STREET) CURRENT	Item Length: 40 NAACCR Item #2350 Source of Standard: CoC (Revised 09/04) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* p. 49)

- Record the number and street address or the rural mailing address of the patient's current usual residence.

  Do not record a Post Office Box in this field. See *Current Address – Supplemental*.

- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.

- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.

- If the street or physical address is not available, record unknown.

- Update this data item if the patient's address changes.

- Do not change this item when the patient dies.

- See "Residency Rules" in *FORDS Revised for 2004* Section One pages 20-21 for further instructions.

ADDRESS – SUPPLEMENTAL CURRENT	Item Length: 40 NAACCR Item #2355 Source of Standard: CoC (Revised 09/04) Dx Yr Req by MCR: 2005+

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

Instructions for Coding (See *FORDS Revised for 2004* p. 50)

- Record information about the patient's current usual address that is either additional to street address, such as the name of a place or facility (i.e., a nursing home or an apartment complex).

  Record information other than a physical address (i.e., post office box).

- If this field is not needed, leave blank.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Update this data item if a patient's address changes.
- Do not change this item when the patient dies.
- See "Residency Rules" in *FORDS Revised for 2004* Section One pages 20-21 for further instructions.

ADDRESS – CITY (OR TOWN) **CURRENT**	Item Length: 20 NAACCR Item #1810 Source of Standard: CoC (Revised 09/04) Dx Yr Req by MCR: All

Description: *Identifies the name of the city or town of the patient's current usual residence.*

Instructions for Coding (See *FORDS Revised for 2004* p. 51)

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

> The name of the city or town must be spelled out completely. Do not use abbreviations, punctuation, special characters or numbers.
>
> ***Examples:*** Record Fort Kent not Ft. Kent; Mount Vernon not Mt. Vernon; Old Orchard Beach not OOB.

- If the patient has multiple malignancies, the current city or town should be the same for all tumors.
- Record unknown, if the city or town is not known. Do not leave blank.
- Update this data item if the patient's city/town of residence changes.
- Do not change this item when the patient dies.
- See "Residency Rules" in *FORDS Revised for 2004* Section One pages 20-21 for further instructions.

ADDRESS – STATE CURRENT	Item Length: 2 NAACCR Item #1820 Source of Standard: CoC (Revised 09/04) Dx Yr Req by MCR: All

Description: *Identifies the patient's current state of residence.*

Instructions for Coding (See *FORDS Revised for 2004* p. 52)

- Record the U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory of the patient's current usual residence. See the following page for common abbreviations.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
  - Record XX if the patient is a resident of a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country is known.
  - Record YY if the patient is a resident of a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country is unknown.
- If the patient is a resident of the U.S., NOS (including its territories, commonwealths or possessions) or Canada, NOS; record ZZ.
- If the patient has multiple tumors, the current state of residence should be the same for all tumors.
- Update this data item if the patient's state of residence changes.
- Do not change this item when the patient dies.

Abbreviations for U.S. States:

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

Abbreviations for Canadian provinces or territories:

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

ADDRESS – POSTAL CODE CURRENT [ZIP CODE]	Item Length: 9 NAACCR Item #1830 Source of Standard: CoC (Revised 01/04) Dx Yr Req by MCR: All

Description: *Identifies the postal code of the patient's current address.*

Instructions for Coding (See *FORDS Revised for 2004* p. 54)

- For U.S. residents, record the nine-digit extended postal code for the patient's current usual residence.

  See Appendix C for a listing of Maine cities and towns with corresponding county and zip codes.

- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple tumors, the postal code should be the same.
- Update this data item if the patient's postal code changes.
- Do not change this item when the patient dies.

Codes in addition to U.S. or Canadian postal codes:

Code	Definition
888888888	Resident of country other than United States (including positions, etc.) or Canada and postal code unknown
999999999	Resident of United States (including positions, etc.) or Canada and postal code unknown

COUNTY
CURRENT

Item Length: 3
NAACCR Item # 1840
Source of Standard: NAACCR
Dx Yr Req by MCR: 2005+

Description: *Identifies the county of the patient's current (last known) residence.*

Instructions for Coding (See *ROADS p. 66)**

- For Maine residents, use the codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas* (See table below).

  See Appendix C for a listing of Maine cities and towns with corresponding county and zip codes.

- Codes in addition to FIPS and geocodes:
  - 998: Patient is a resident outside of Maine.
  - 999: Patient is a resident of Maine, but county is unknown.
- If the patient is a non-U.S. resident and XX is coded in *Current State of Residence* (NAACCR Item #1820), then code the patient's country of residence in this field
  - For country codes, see Appendix D in this manual or the *SEER Program Coding and Staging Manual 2004*, Appendix B.
- If the patient has multiple tumors, the current county of residence should be the same for all tumors.

Code	County Name	Code	County Name
001	Androscoggin	017	Oxford
003	Aroostook	019	Pennobscot
005	Cumberland	021	Piscataquis
007	Franklin	023	Sagadahoc
009	Hancock	025	Somerset
011	Kennebec	027	Waldo
013	Knox	029	Washington
015	Lincoln	031	York
998	Patient is a resident outside of Maine	999	Patient is a resident of Maine, but county is unknown

**Note: As of January 1, 2003, this data item is no longer supported by the CoC.*

BIRTH DATE **[DATE OF BIRTH]**	Item Length: 8 NAACCR Item #240 Source of Standard: SEER/CoC Dx Yr Req by MCR: All

Description: *Identifies the date of birth of the patient.*

Instructions for Coding (See *FORDS Revised for 2004* p. 57)

- Record the patient's date of birth as indicated in the patient record in the format *mm/dd/ccyy*.

BIRTH PLACE **[PLACE OF BIRTH]**	Item Length: 3 NAACCR Item #250 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: 2001+

Description: *Records the patient's place of birth.*

Instructions for Coding (See *FORDS Revised for 2004* p. 56)

- Use the SEER Geocodes for "Place of Birth." These codes include states of the United States as well as foreign countries.
- Use the most specific code.
- For SEER Geocodes, see Appendix D in this manual or the *SEER Program Coding and Staging Manual 2004,* Appendix B.

SEX	Item Length: 1 NAACCR Item #220 Source of Standard: SEER/CoC Dx Yr Req by MCR: All

Description: *Identifies the sex of the patient.*

Instructions for Coding (See *FORDS Revised for 2004* p. 66)

- Record the patient's sex (gender)* as indicated in the medical record.

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

**Note:* Transsexual indicates an individual who has had surgical intervention to change his/her genitalia to the opposite gender. Individuals who retain their birth genitalia but live as the opposite gender are not truly transsexual and should be coded to their birth gender.

RACE 1	Item length: 2 NAACCR Item #160 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: All

Description: *Identifies the primary race of the patient. Race (and ethnicity) is defined by specific physical, hereditary and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.*

General Instructions for Coding (See *FORDS Revised for 2004* pp. 59-60)

- Code the primary race of the patient. If the patient is multiracial, then code all races reported using *Race 2* (NAACCR Item #161) through *Race 5* (NAACCR Item #164), and code all remaining *Race* items 88. **See Detailed coding instructions on the following page.**
- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 1* is coded 99, then *Race 2* through *Race 5* must all be coded 99.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991.
- If *Race Coding System–Current* (NAACCR Item #170) is less than six (6) for cases diagnosed prior to January 1, 2000, then *Race 2* through *Race 5* must be blank.
- If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System–Current* must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

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

Detailed Coding Instructions (*SEER Program Coding and Staging Manual 2004* pp 46-49)

1. Code the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. The five race fields allow for the coding of multiple races consistent with the Census 2000. Rules 2 - 8 further specify how to code Race 1, Race 2, Race 3, Race 4 and Race 5. See *SEER Program Coding and Staging Manual 2004* - Editing Guidelines pp 49-50 for further instructions.

2. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white in the next race field.

3. If a person's race is a combination of Hawaiian and any other race(s), code Race 1 as 07 Hawaiian and code the other races in Race 2, Race 3, Race 4, and Race 5 as appropriate.

   Example*:* Patient is described as Japanese and Hawaiian. Code Race 1 as 07 Hawaiian, Race 2 as 05 Japanese, and Race 3 through Race 5 as 88.

4. If the person is not Hawaiian, code Race 1 to the first stated non-white race (02-98).

   Example: Patient is stated to be Vietnamese and Black. Code Race 1 as 10 Vietnamese, Race 2 as 02 Black, and Race 3 through Race 5 as 88.

   Note**:** in the following scenarios, only the race code referred to in the example is coded. For cases diagnosed after January 1, 2000, all race fields must be coded.

5. The fields Place of Birth, Race, Marital Status, Name, Maiden Name, and Hispanic Origin are inter-related. Use the following guidelines in priority order:

   a. Code the patient's stated race, if possible. Refer to the *SEER Program Coding and Staging Manual 2004*, Appendix D "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" for guidance.

      Example 1*:* Patient is stated to be Japanese. Code as 05 Japanese.

      Example 2: Patient is stated to be German-Irish. Code as 01 White.

      Example 3: Patient is described as Arabian. Code as 01 White.

      Exception*:* When the race is recorded as Oriental, Mongolian, or Asian (coded to 96 Other Asian) and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birthplace information.

         Example 4: The person's race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 Japanese because it is more specific than 96 Asian, NOS.

         Example 5: The person describes himself as an Asian-American born in Laos. Code race as 11 Laotian because it is more specific than 96 Asian, NOS.

6. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to list the non-white race(s) first.

   ***Example*:** The patient is described as Asian-American with Korean parents. Code race as 08 Korean because it is more specific than 96 Asian [-American].

7. If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of a race category.

   ***Example 1**:* Patient described as a black female. Code as 02 Black.

   Example 2: Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code as 02 Black.

   Example 3: Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as 25 Polynesian, Race 2 as 26 Tahitian and Race 3 through Race 5 as 88.

8. If race is unknown or not stated in the medical record and birthplace is recorded, in some cases race may be inferred from the nationality. Refer to the *SEER Program Coding and Staging Manual 2004*, Appendix D "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" to identify nationalities from which race codes may be inferred.

   Example 1: Record states: "this native of Portugal..." Code race as 01 White per Appendix D.

   ***Example 2**:* Record states: "this patient was Nigerian..." Code race as 02 Black per Appendix D.

   Exception: If the patient's name is incongruous with the race inferred on the basis of nationality, code Race 1 through Race 5 as 99, Unknown.

      Example 1: Patient's name is Siddhartha Rao and birthplace is listed as England. Code Race 1 through Race 5 as 99 Unknown.

      Example 2: Patient's name is Ping Chen and birthplace is Ethiopia. Code Race 1 through Race 5 as 99 Unknown.

9. Use of patient name in determining race:

   a. Do not code race from name alone, especially for females with no maiden name given.

   b. In general, a name may be an indicator of a racial group, but should not be taken as the only indicator of race.

   c. A patient name may be used to identify a more specific race code.

***Example 1*:** Race reported as Asian, name is Hatsu Mashimoto. Code race as 05 Japanese.

***Example 2**:* Birthplace is reported as Guatemala and name is Jose Chuicol [name is identified as Mayan]. Code race as 03 Native American

d. A patient name may be used to infer Spanish ethnicity or place of birth, but a Spanish name alone (without a statement about race or place of birth) cannot be used to determine the race code. Refer to ethnicity guidelines for further information.

   Example: Alice Gomez is a native of Indiana (implied birthplace: United States). Code Race 1 through Race 5 as 99 Unknown, because nothing is known about her race.

10. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do not code a patient stated to be Hispanic or Latino as 98 Other Race in Race 1 and 88 in Race 2 through Race 5.

    Example: Sabrina Fitzsimmons is a native of Brazil. Code race as 01 White per *SEER Program Coding and Staging Manual 2004*, Appendix D.

11. When the race is recorded as Negro or African-American, code race as 02 Black.

12. Code 03 should be used for any person stated to be Native American or [western hemisphere] Indian, whether from North, Central, South, or Latin America. For Central, South, or Latin American Indians, see additional ethnicity coding guidelines under Spanish Surname or Origin.

13. Death certificate information may be used to supplement antemortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.

    Example 1: In the cancer record Race 1 through Race 5 are coded as 99 Unknown. The death certificate states race as black. Change cancer record for Race 1 to 02 Black and Race 2 through Race 5 to 88.

    Example 2: Race 1 is coded in the cancer record as 96 Asian. Death certificate gives birthplace as China. Change Race 1 in the cancer record to 04 Chinese and code Race 2 through Race 5 as 88.

RACE 2	Item length: 2 NAACCR Item #161 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: 2001+

Description: *Identifies the patient's race.*

Instructions for Coding (See *FORDS Revised for 2004* p. 61)

- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- See *Race 1* for detailed coding instructions from the *SEER Program Coding and Staging Manual 2004*.
- If no further Race information is known, code 88.
- If *Race 1* (NAACCR Item #160) is coded 99, then *Race 2* must be coded 99.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991.

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

RACE 3	Item length: 2 NAACCR Item #162 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: 2001+

Description: *Identifies the patient's race.*

Instructions for Coding (See *FORDS Revised for 2004* p. 62)

- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- See *Race 1* for detailed coding instructions from the *SEER Program Coding and Staging Manual 2004*.
- If *Race 2* (NAACCR Item #161) is coded 88 or 99, then *Race 3* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991.

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

RACE 4	Item length: 2 NAACCR Item #163 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: 2001+

Description: *Identifies the patient's race.*

Instructions for Coding (See *FORDS Revised for 2004* p. 63)

- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- See *Race 1* for detailed coding instructions from the *SEER Program Coding and Staging Manual 2004*.
- If *Race 3* (NAACCR Item #162) is coded 88 or 99, then *Race 4* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991.

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

RACE 5	Item length: 2 NAACCR Item #164 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: 2001+

Description: *Identifies the patient's race.*

Instructions for Coding (See *FORDS Revised for 2004* p. 64)

- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- See *Race 1* for detailed coding instructions from the *SEER Program Coding and Staging Manual 2004*.
- If *Race 4* (NAACCR Item #163) is coded 88 or 99, then *Race 5* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991.

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

SPANISH ORIGIN—ALL SOURCES (SPANISH/HISPANIC ORIGIN)	Item Length: 1 NAACCR Item #190 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: All

Description: *Identifies persons of Spanish or Hispanic origin.*

Instructions for Coding (See *FORDS Revised for 2004* p. 65)

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

Code	Label
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name that the 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
8	Dominican Republic (for use with patients who were diagnosed with cancer January 1, 2005, or later
9	Unknown whether Spanish or not; not stated in patient record

Cancer Identification

PRIMARY SITE	Item Length: 4 NAACCR Item #400 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: All

Description: *Identifies the primary site. The International Classification of Diseases for Oncology, Third Edition (ICD-O-3) is the standard reference for coding the primary site for tumors diagnosed in 2001 and later. Refer to ICD-O-2 for tumors diagnosed prior to 2001.*

Instructions for Coding (See *FORDS Revised for 2004* p. 91)

- See Section Two of this manual for rules determining single vs. multiple primaries.
- Record the ICD-O-3 topography code for the site of origin.
- Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
- Primary site codes may be found in the ICD-O-3 Topography, Numerical List section (ICD-O-3, pp. 43-65) and in the Alphabetic Index (ICD-O-3, pp. 105-218).
- Topography codes are indicated by a "C" preceding the three-digit code number (do not record the decimal point).
- Follow the coding rules outlined in ICD-O-3, pp. 20–40.
- Always code to the most specific sub-site.

  Example: If the medical record states breast upper-outer quadrant, code to C50.4**. Please refer to Appendix F for the breast clock diagram.**
- Use subcategory 8 for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is not known.
- Use subcategory 9 for multiple tumors that originate in one organ.
- Code adenocarcinoma in multiple polyps as a single primary even if they involve more than one segment of the colon.
- Code leukemias to bone marrow (C42.1).

  Exception: Code myeloid sarcoma to the site of origin (see ICD-O-3 for coding rules).

SEQUENCE NUMBER – HOSPITAL	Item Length: 2 NAACCR Item #560 Source of Standard: CoC (Revised 01/04) Dx Yr Req by MCR: All

Description: *Indicates the sequence of malignant and non-malignant neoplasms over the lifetime of the patient.*

Instructions for Coding (See *FORDS Revised for 2004* pp. 34-35)

- Codes 00-35 and 99 indicate neoplasms of in situ or malignant behavior (Behavior equals 2 or 3). Codes 60-88 indicate neoplasms of non-malignant behavior (Behavior equals 0 or 1).
- Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent malignant or in situ primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.
- Code 60 only if the patient has a single non-malignant primary. If the patient develops a subsequent nonmalignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant primaries sequentially.
- If two or more malignant or in situ neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- If two or more non-malignant neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- Any tumor in the patient's past which is reportable or reportable-by-agreement must be taken into account when sequencing subsequently accessioned tumors.

Malignant or in situ

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

Non-malignant

Code	Definition
60	Only one non-malignant primary
61	First of two or more independent non-malignant primaries
62	Second of two or more independent non-malignant primaries
…	(Consecutive number of non-malignant primaries)
87	Twenty-seventh of twenty-seven independent non-malignant primaries
88	Unspecified number of neoplasms in this category

LATERALITY	Item Length: 1 NAACCR Item #410 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* pp. 92)

- Code laterality for all paired sites. (See *FORDS Revised for 2004* pp. 11-12 for a list of paired organ sites.)
- Code all nonpaired sites 0.
- Record laterality for unknown primary site (C80.9) as 0 (not a paired site).
- Do not code metastatic sites as bilateral involvement.
- Code midline lesions 9.

Code	Definition
0	Organ is not considered to be a paired site.
1	Origin of primary is right.
2	Origin of primary is left.
3	Only one side involved, right or left origin not specified.
4	Bilateral involvement, side of origin unknown, stated to be a single primary. This includes: • Both ovaries simultaneously involved with a single histology • Bilateral retinoblastomas • Bilateral Wilms' tumors
9	Paired site, but lateral origin unknown; midline tumor.

HISTOLOGIC TYPE (ICD-O-3)	Item Length: 4 NAACCR Item #522 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: 2001+

Description: *Identifies the microscopic anatomy of cells. The data item Histologic Type describes the microscopic composition of cells and/or tissue for a specific primary. The International Classification of Diseases for Oncology, Third Edition (ICD-O-3) is the standard reference for coding the histology for tumors diagnosed in 2001 and later.*

General Instructions for Coding (See *FORDS Revised for 2004* p. 93 and *SEER Program Coding and Staging Manual 2004* pp. 84-85)

- The histology can be coded only after the determination of multiple primaries has been made.
- Record histology using the ICD-O-3 codes in the Numeric Lists/Morphology section (ICD-O-3, pp. 69–104) and in the Alphabetic Index (ICD-O-3, pp. 105–218).
- ICD-O-3 identifies the morphology codes with an "M" preceding the code number. Do not record the "M."
- Follow the coding rules outlined on pages 20 through 40 of ICD-O-3.
- **Synonyms and Equivalent Terms:** Mixed, combined, and complex are usually used as synonyms when describing histology.
- **Definitions**
  - The codes for cancer, NOS (8000) and carcinoma, NOS (8010) are not interchangeable. If the physician says that the patient has carcinoma, then code carcinoma, NOS (8010).
  - **Different histology**: The first three digits of the ICD-O-3 histology code are different.
  - **Different subtypes:** The NOS cell types often have multiple subtypes; for example, scirrhous adenocarcinoma (8143), adenocarcinoma, intestinal type (8144), and linitis plastica (8141) are subtypes of Adenocarcinoma, NOS (8140).
  - **Same histology:** The first three digits of the ICD-O-3 histology code are identical.
  - **Mixed/combined histology:** Different cell types in one tumor; terms used interchangeably. In most cases, the terms mixed and combined are used as synonyms; however the term mixed may designate a specific tumor.

    Complex (mixed, combined) histology: The pathologist uses **multiple histologic terms** to describe a tumor. The histologic terms are frequently connected by the word "and" (for example ductal and lobular carcinoma.
  - **Not Otherwise Specified (NOS):** "Not Otherwise Specified."

Detailed Coding Instructions (*SEER Program Coding and Staging Manual 2004* pp 85-89)

Refer to "Single vs. Multiple Primaries" in Section Two of this manual to determine the number of primaries. Use all of the information for a single primary to code the histology.

1. If there is no tumor specimen, code the histology described by the medical practitioner.

   Example 1: The patient has a CT scan of the brain with a final diagnosis of glioblastoma multiforme (9440). The patient refuses all further workup or treatment. Code the histology to glioblastoma multiforme (9440).

   ***Example 2*:** If a physician says that the patient has carcinoma, code carcinoma, NOS (8010).

2. Review all pathology reports. Use the histology stated in the **final diagnosis** from the pathology report. Use the pathology from the procedure that resected the majority of the primary tumor. If a more specific histologic type is definitively described in the microscopic portion of the pathology report or the comment, code the more specific diagnosis.

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

3. Lymphomas may be classified by the **WHO** Classification, **REAL** system, **Rappaport,** or **Working Formulation**. The WHO Classification is preferred. See page 13 in the ICD-O-3 for a discussion of hematologic malignancies.

4. Cases reported to the central registry cannot have a metastatic (/6) behavior code. If the only pathology specimen is from a metastatic site, code the appropriate histology code and the malignant behavior code /3. The primary site and its metastatic site(s) have the same basic histology.

Histology Coding Rules for Single Tumor

- The rules are in hierarchical order. Rule 1 has the highest priority.
- Use the rules in priority order.
- Use the first rule that applies to the case. (Do not apply any additional rules.)

1. Code the histology if only one type is mentioned in the pathology report.

2. Code the **invasive histology** when both invasive and in situ tumor are present.

   Example: Pathology report reads infiltrating ductal carcinoma and cribriform ductal carcinoma in situ. Code the invasive histology 8500/3.

Exception: If the histology of the invasive component is an 'NOS' term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma), then code the histology of the specific term associated with the in situ component and an invasive behavior code.

3. Use a **mixed** histology code if one exists.

   Examples of mixed codes: (This is not a complete list, these are examples only)

   8490 Mixed tumor, NOS
   9085 Mixed germ cell tumor
   8855 Mixed liposarcoma
   8990 Mixed mesenchymal sarcoma
   8951 Mixed mesodermal tumor
   8950 Mixed Mullerian tumor
   9362 Mixed pineal tumor
   8940 Mixed salivary gland tumor, NOS
   9081 Teratocarcinoma, mixed embryonal carcinoma and teratoma

4. Use a **combination** histology code if one exists.

   Examples of combination codes: (This is not a complete list; these are examples only)

   8255 Renal cell carcinoma, mixed clear cell and chromophobe types
   8523 Infiltrating duct carcinoma mixed with other types of carcinoma
   8524 Infiltrating lobular carcinoma mixed with other types of carcinoma
   8560 Adenosquamous carcinoma
   8045 Combined small cell carcinoma, combined small cell-large cell

5. Code the **more specific term** when one of the terms is 'NOS' and the other is a more specific description of the same histology.

   Example 1: Pathology report reads poorly differentiated carcinoma, probably squamous in origin. Code the histology as squamous cell carcinoma rather than the non-specific term "carcinoma."

   Example 2: The pathology report from a nephrectomy reads renal cell carcinoma (8312) (renal cell identifies the affected organ system rather than the histologic cell type) in one portion of the report and clear cell carcinoma (8310) (a histologic cell type) in another section of the report. Code clear cell carcinoma (8310); renal cell carcinoma (8312) refers to the renal system rather than the cell type, so renal cell is the less specific code.

6. Code the **majority** of tumor.

   a. Based on the pathology report description of the tumor.

   b. Based on the use of majority terms. See majority terms on the following page.

Terms that mean the majority of tumor	Terms that do not mean the majority of tumor
Predominantly	With foci of
With features of	Focus of/focal
Major	Areas of
Type[1]	Elements of
With …. Differentiation[1]	Component
Pattern (Only if written in College of American Pathologists [CAP] Protocol)	
Architecture (Only if written in College of American Pathologists [CAP] Protocol)	

7. Code the **numerically higher** ICD-O-3 code. This is the rule with the lowest priority and should be used infrequently.

Histology Coding Rules for Multiple Tumors with Different Behaviors in the Same Organ Reported as a Single Primary

1. Code the histology of the invasive tumor when one lesion is in situ (/2) and the other is invasive (/3).

   Example: At mastectomy for removal of a 2 cm invasive ductal carcinoma, an additional 5 cm area of intraductal carcinoma was noted. Code histology and behavior as invasive ductal carcinoma (8500/3).

Histology Coding Rules for Multiple Tumors in Same Organ Reported as a Single Primary

1. Code the histology when multiple tumors have the same histology.

2. Code the histology to adenocarcinoma (8140/_; in situ or invasive) when there is an adenocarcinoma and an adenocarcinoma in a polyp (8210/_, 8261/_, 8263/) in the same segment of the colon or rectum.

3. Code the histology to carcinoma (8010/_; in situ or invasive) when there is a carcinoma and a carcinoma in a polyp (8210/_) in the same segment of the colon or rectum.

4. Use a **combination** code for the following:

   a. Bladder: Papillary and urothelial (transitional cell) carcinoma (8130)

   b. Breast: Paget Disease and duct carcinoma (8541)

   c. Breast: Duct carcinoma and lobular carcinoma (8522)

   d. Thyroid: Follicular and papillary carcinoma (8340)

5. Code the more specific term when one of the terms is ‘NOS’ and the other is a more specific description of the same histology.

6. Code all other multiple tumors with different histologies as multiple primaries.

How to determine same vs. different histologies for benign and borderline primary intracranial and CNS tumors (C70.0-C72.9, C75.1-C75.3) (Based on histologic groupings)

When there are **multiple tumors**, use the following table to determine if the tumors are the same histology or different histologies.

Histologic groupings to determine same histology for non-malignant brain tumors

Histologic Group	ICD-O-3 Code
Choroid plexus neoplasm	9390/0, 9390/1
Ependymoma	9383, 9394, 9444
Neuronal and neuronal-glial neoplasm	9384, 9412, 9413, 9442, 9505, 9506
Neurofibroma	9540/0, 9540/1, 9541, 9550, 9560
Neurinomatosis	9560
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571

Instructions for Using Histologic Group Table

1. Both histologies are listed in the table:

    a. Histologies that are in the same grouping or row in the table are the same histology.

    Note: Histologies that are in the same grouping are a progression, differentiation or subtype of a single histologic category.

    b. Histologies listed in different groupings in the table are different histologies.

2. One or both of the histologies is not listed in the table:

    a. If the ICD-O-3 codes for both histologies have the identical first three digits, the histologies are the same.

    b. If the first three digits of the ICD-O-3 histology code are different, the histology types are different.

Leukemia/Lymphoma (Chronic Lymphocytic Leukemia [CLL] and Small Lymphocytic Lymphoma [SLL])

Code the diagnosis of chronic lymphocytic leukemia (9823/3) and/or small lymphocytic lymphoma (9670/3) to SLL if there are positive lymph nodes or deposits of lymphoma/leukemia in organs or in other tissue. Code the histology to CLL if there are no physical manifestations of the disease other than a positive blood study or positive bone marrow.

BEHAVIOR CODE **(ICD-O-3)**	Item Length: 1 NAACCR Item #523 Source of Standard: SEER/CoC (Revised 04/04) Dx Yr Req by MCR: 2001+

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

Instructions for Coding (See *FORDS Revised for 2004* p. 94)

- See ICD-O-3, page 66 for behavior codes and definitions.
- Code 3 if any invasion is present, no matter how limited.
- If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior.

> ***Note:*** Behavior codes 6 and 9 are not used by cancer registries. The behavior code 6 identifies a metastatic site. If the only pathologic specimen is from a metastatic site, code the histology of the metastatic site and use code 3 for the behavior code.
>
> ***Example:*** If the patient had a biopsy of the lung showing metastatic adenocarcinoma (8140/6) and no primary site is identified in the record, code the primary site unknown (C80.9). Code the histology adenocarcinoma (8140/3).

- The ICD-O-3 behavior code given for juvenile astrocytoma (9421/1) is 1, which is not reportable. To ensure the capture of these historical cases, please code the behavior as 3. Refer to "Case Eligibility" in Section One of FORDS Revised for 2004 for information.

Code	Label	Definition
0*	Benign	Benign
1*	Borderline	Uncertain whether benign or malignant Borderline malignancy Uncertain malignant potential
2**	In situ and/or carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk. Clark level 1 for melanoma (limited to epithelium Comedocarcinoma, noninfiltrating (C50._)
2	Synonymous with in situ	Confined to epithelium Hutchinson melanotic freckle, NOS (C44._) Intracystic, noninfiltrating Intraductal Intraepidermal, NOS Intraepithelial, NOS Involvement up to, but not including the basement membrane Lentigo maligna (C44._) Lobular neoplasia (C50._) Lobular, noninfiltrating (C50._)

Code	Label	Definition
		Non infiltrating Noninvasive No stromal involvement Papillary, noninfiltrating or intraductal Precancerous melanosis (C44._) Queyrat erythroplasia (C60._) **AIN III (C21._) reportable per NPCR requirement** **VIN III (C51._) reportable per NPCR requirement** **VAIN III (52.9) reportable per NPCR requirement**
3	Invasive	Invasive or microinvasive

* Report only primary tumors of the brain, CNS and other intracranial sites.

** Effective for cases diagnosed on or after January 1, 2004, do not report carcinoma in situ of the cervix.

HISTOLOGY (92-00) **(ICD-O-2)**	Item Length: 4 NAACCR Item #420 Source of Standard: SEER/CoC Dx Yr Reg by MCR: 1992-2000

Description: *Identifies the microscopic anatomy of cells.* ***This data item is required for tumors diagnosed from January 1, 1992 through December 31, 2000.***

Instructions for Coding (See *ROADS* pp. 108-109)

- Record histology using the ICD-O-2 codes in the Morphology-Numeric section (ICD-O-2, pp. 25–49) and in the Alphabetic Index (ICD-O-2, pp. 51–136).
- 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 xv-xliii of ICD-O-2.
- Review all pathology reports.
- Code the **final** pathologic diagnosis.

  Exception**:** If the final diagnosis is "Not Otherwise Specified" (carcinoma, NOS; melanoma, NOS; sarcoma, NOS; lymphoma, NOS; or malignant tumor, NOS), then code the histology from the microscopic description or comment if it identifies a more specific histologic type (higher ICD-O-3 code) such as adenocarcinoma, amelanotic melanoma, spindle cell sarcoma.
- The codes for cancer, NOS (8000) and carcinoma, NOS (8010) are **not** interchangeable. If the physician says that the patient has carcinoma, then code carcinoma, NOS (8010).
- Lymphomas may be classified by the Rappaport classification or the Working Formulation. If both systems are used to classify the disease, then the term used to describe the lymphoma may differ. The Working Formulation term should take precedence.

BEHAVIOR CODE (92-00)
(ICD-O-2)

Item Length: 1
NAACCR Item #430
Source of Standard: SEER/CoC
Dx Yr Req by MCR: 1992-2000

Description: *Records the behavior of the tumor being reported. The fifth digit of the morphology code is the behavior code.* ***This data item is required for tumors diagnosed from January 1, 1992 through December 31, 2000.***

Instructions for Coding (See *ROADS* pp. 110)

- See ICD-O-2, page 22 for behavior codes and definitions.
- Record tumors with behavior codes of 2 or 3 and nonmalignant CNS & intracranial sites (behavior codes 0 or 1).
- Code 3 if any invasion is present, no matter how limited.
- If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior. Since cancer registries include only primary sites, behavior codes 6 and 9 are not used. The behavior code 6 identifies a metastatic site. If the only pathologic specimen is from a metastatic site, code the histology of the metastatic site and use code 3 for the behavior code.

  Example: If the patient had a biopsy of the lung showing metastatic adenocarcinoma (8140/6) and no primary site is identified in the record, the primary site is unknown (C80.9). Code the histology 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
Queyrat's erythoplasia (C60._)

GRADE/DIFFERENTIATION	Item Length: 1 NAACCR Item #440 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* pp. 96-97)

- Code the grade according to ICD-O-3 (pp. 30–31 and 67).
- Code the grade or differentiation as stated in the **final** pathologic diagnosis. If the differentiation is not stated in the final pathologic diagnosis, use the information from the microscopic description or comments.
- When the pathology report(s) lists more than one grade of tumor, code to the highest grade, even if the highest grade is only a focus (Rule G, ICD-O-3, p. 21).
- Code the grade or differentiation from the pathologic examination of the primary tumor, not from metastatic sites.
- When there is no tissue diagnosis, it may be possible to establish grade through magnetic resonance imaging (MRI) or positron emission tomography (PET). When available, code the grade based on the recorded findings from these imaging reports.
- If the primary site is unknown, code the grade/differentiation as 9 (Unknown).
- Code the grade for in situ lesions if the information is available. If the lesion is both invasive and in situ, code only the invasive portion. If the invasive component grade is unknown, then code 9.
- **Do not** use "high grade," "low grade," or "intermediate grade" descriptions for lymphomas as a basis for differentiation. These terms are categories in the Working Formulation of Lymphoma Diagnoses and do not relate to the grade.
- Codes 5–8 define T-cell or B-cell origin for leukemias and lymphomas. T-cell, B-cell, or null cell classifications have precedence over grading or differentiation.
- Do not use the WHO grade to code this data item.
- If no grade is given for astrocytomas, then code 9 (Unknown).
- If no grade is given for glioblastoma multiforme, then code 9 (Unknown).
- Refer to the following grading terminology conversion tables for specific coding instructions.

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

Coding Three-grade Systems

Three grade systems apply to peritoneum (C48.1, C48.2), breast (C50.0–C50.9), endometrium (C54.1), fallopian tube (C57.0), prostate (C61.9), kidney (C64.9), and brain and spinal cord (C71.0–C72.9). For sites other than breast, prostate and kidney, code the tumor grade using the following priority order: 1) Terminology; 2) Histologic Grade; and 3) Nuclear Grade as shown in the table below.

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

Coding Two-grade Systems

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

Code	Terminology	Histologic Grade
2	Low grade	1/2
4	High grade	2/2

Breast (C50. 0-C50.9)

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

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

Kidney (C64.9)

For kidney cancers, code the tumor grade using the following priority rules: 1) Fuhrman Grade; 2) Nuclear Grade; 3) Terminology (well diff, mod. diff.); 4) Histologic Grade. These prioritization rules do not apply to Wilm's tumor (M-8960).

Prostate (C61.9)

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

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

DIAGNOSTIC CONFIRMATION	Item Length: 1 NAACCR Item #490 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* pp. 99)

- This is a hierarchical schema to identify how the malignancy was determined—from histologic confirmation (1) being most precise to unknown (9) being the least. Code 1 is the highest determination and takes precedence.
- This data item must be changed to the lower code if a more definitive method confirms the diagnosis at any time during the course of the disease.
- Code 1 for positive hematologic findings and bone marrow specimens for leukemia, including peripheral blood smears and aspiration biopsies.
- Code 2 for positive brushings, washings, cell aspiration, and hematologic findings (except for leukemia).

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

TYPE OF REPORTING SOURCE

Item Length: 1
NAACCR Item #500
Source of Standard: SEER
Dx Yr Req by MCR: 2004+

Description: *Code identifying source documents used to abstract the tumor being reported. This may not be the source of the original case finding; rather, it is the source that provided the best information. (For example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician's office, code this item 4).*

Instructions for Coding (See *SEER Program Coding and Staging Manual 2004* pp. 31-32)

- Coding is hierarchical. Within codes 1-5, assign codes in the following priority: 1, 4, 5, 3.

Code Definitions

Code	Label	Definition
1	Hospital Inpatient/Outpatient or Clinic	One of the source documents used to abstract the case was from a hospital admission as an inpatient or an outpatient. Includes outpatient services, such as Oncology or Radiation Therapy and large multi-specialty physician group practices.
3	Laboratory Only (Hospital or Private)	Source documents from a laboratory were used to abstract the case. There were no source documents from codes 1, 4, or 5.
4	Physician's Office/Private Medical Practitioner (LMD)	Source documents are from a physician's office that is NOT a large multi-specialty physician group practice. There were no source documents from code 1.
5	Nursing/Convalescent Home/Hospice	The source documents are from a nursing or convalescent home or a hospice. There were no source documents from codes 1 or 4.
6	Autopsy Only	The cancer was first diagnosed on autopsy. There are no source documents from codes 1-5.
7	Death Certificate Only (Used only be central registry)	Death certificate is the only source of information; followback activities did not identify source documents from codes 1-6. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1-6.

CLASS OF CASE

Item Length: 1
NAACCR Item #610
Source of Standard: CoC
Dx Yr Req by MCR: 2004+

Description: *Classifies cases recorded in the database.*

Instructions for Coding (See *FORDS Revised for 2004* pp. 83-84)

- Class of Case has ten categories 0–9. Analytic cases are coded 0–2. Nonanalytic cases are coded 3–9.

If a patient whose tumor was originally abstracted and submitted to the MCR as a Class 7 (pathology only) case subsequently receives first course treatment at the reporting facility, update *Class of Case* and all other pertinent data items to reflect the patient's in-person contact with the reporting facility and resubmit a paper abstract to MCR with a note explaining the reason the case is being resubmitted. **Do not resubmit the case electronically**.

Note: Class of Case is a CoC concept and does not directly apply to central registry records; however, information about Class of Case is helpful to the MCR when consolidating records that are reported by multiple reporting sources.

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

See Section Two *"New and Recurrent Cases"* in this manual for more detailed definitions of Class of Case.

DATE OF FIRST CONTACT	Item Length: 8 NAACCR Item #580 Source of Standard: CoC (Revised 12/04/02) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* pp. 87-88)

- Date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or treatment of a reportable tumor.
- This may be the date of an outpatient visit for a biopsy, x-ray, or laboratory test, or the date a pathology specimen was collected at the hospital.
- If this is a pathology only (Class 7) case, then use the date the specimen was collected.
- If this is an autopsy-only (Class 5) or death certificate-only (Class 8) case, then use the date of death.

Date of first contact cannot be before a diagnosis is made. If the tumor was diagnosed at the reporting facility, *Date of Initial Diagnosis* (NAACCR Item # 390) and *Date of First Contact* will be the same.

DATE OF INITIAL DIAGNOSIS	Item Length: 8 NAACCR Item #390 Source of Standard: SEER/CoC (Revised 09/04) Dx Yr Req by MCR: All

Description: *Records the date of initial diagnosis by a physician for the tumor being reported. The date of initial diagnosis is the month, day, and year that this primary cancer was first diagnosed by a recognized medical practitioner. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. Note: If the exact date on which the diagnosis was made is not available, then record an approximate date.*

Instructions for Coding (See *FORDS Revised for 2004* pp. 89-90)

- Use the first date of diagnosis whether clinically or histologically confirmed.
- Refer to the list of "Ambiguous Terms" in Section Two of this manual for language that represents a diagnosis of cancer.
- If the physician states that in retrospect the patient had cancer at an earlier date, then use the earlier date as the date of diagnosis.
- Use the date therapy was started as the date of diagnosis if the patient receives a first course of treatment before a definitive diagnosis.
- The date of death is the date of diagnosis for a Class of Case 5 (autopsy only case)
- Use the Date of Birth as the Date of Initial Diagnosis for an in-utero diagnosis.
- If exact date of initial diagnosis is not known, record an approximate date.

> If the month and year is known but not the day, code day to "15".
>
> If the date of diagnosis is unknown and cannot be estimated, then use the date of first contact at your facility and document it in the "Remarks" text field.
>
> ***Note:*** Whenever using an estimated date, please document in a text field.

- ♦ If information is limited to a descriptive term use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

DATE OF FIRST POSITIVE BIOPSY	Item Length: 8 NAACCR Item #1080 Source of Standard: CoC Dx Yr Req by MCR: 2005+

Description: *Records the date first positive tissue biopsy/histology.*

Instructions for Coding (See *ROADS p. 177)**

- Record the date on which the first positive incisional or excisional biopsy (positive histology) was performed at this or any facility.
  - The biopsy may be taken from the primary or a secondary site.
  - The first positive biopsy may be at any time during the disease course.
  - It may be noncancer-directed or cancer-directed surgery.

> If *Diagnostic Confirmation* is anything other than "1", then Date of First Positive Biopsy must be blank.

- If exact date of the first positive biopsy is not known, record an approximate date.

> If the month and year is known but not the day, code day to "15".
>
> ***Note:*** Whenever using an estimated date, please document in a text field.

  - If information is limited to a descriptive term use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

**Note: As of January 1, 2003, this date is no longer supported by CoC.*

PRIMARY PAYER AT DIAGNOSIS

Item Length: 2
NAACCR Item #630
Source of Standard: CoC
Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *FORDS Revised for 2004* pp. 67-68)

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

Code	Label	Definition
01	Not insured	Patient has no insurance and is declared a charity write-off.
02	Not insured, self-pay	Patient has no insurance and is declared responsible for charges.
10	Insurance, NOS	Type of insurance unknown or other than the types listed in codes 20, 31, 35, 36, 50-56
20	Managed Care, HMO, PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of the four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than those described in codes 35 and 36.
35	Medicaid administered through a Managed Care plan	State government administered insurance which is administered through a commercial Managed Care plan such as an HMO or PPO for persons who are uninsured, below the poverty level, or covered under entitlement programs.
36	Medicaid with Medicare supplement	State government administered Medicaid insurance with Federal Medicare supplement.
50	Medicare	Federal government funded insurance for persons who are retired or disabled. Not described in codes 51 and 52.
51	Medicare with supplement	Patient has Medicare and another insurance to pay costs not covered by Medicare.
52	Medicare with Medicaid supplement	Federal government Medicare insurance with State Medicaid administered supplement.
53	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents. Formally CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
54	Military	Military personnel or their dependents who are treated at a military facility.
55	Veterans Affairs	Veterans who are treated in Veterans Affairs facilities.
56	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility or at another facility, and the medical costs are reimbursed by the Indian Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

Staging and Extent of Disease Information

Collaborative Staging

Collaborative Staging (CS) is to be used for cases diagnosed on or after January 1, 2004. This staging system should not to be used for cases diagnosed prior to that date.

How Collaborative Staging Works: Collaborative Staging was designed for registrar use. This staging system relieves registrars from the necessity of staging a single case according to more than one staging system. For Collaborative Staging, registrars code discrete pieces of information once and the CS computer algorithm derives the values for AJCC T, N, M and Stage Group, Summary Stage 1977, and Summary Stage 2000.

The timing rule for CS coding was designed to make use of the most complete information possible to yield the "best stage" information for the tumor at the time of diagnosis — "use all information gathered through completion of surgery(ies) in first course of treatment or all information available within four months of the date of diagnosis in the absence of disease progression, whichever is *longer*." Disease progression is defined as further direct extension or distant metastasis known to have developed after the diagnosis was established. Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression is documented should be excluded from the CS coding.

Like the AJCC and Summary Stage codes that are derived from it, CS is a site-specific staging system. The CS algorithm uses tumor site and histology to determine which CS schema to apply. Depending on the schema, the coding instructions and code definitions will vary. Collaborative Staging codes are defined for every site and histology combination. The *AJCC Cancer Staging Manual* does not cover all sites, and some histologies are excluded from sites with an AJCC coding scheme. When the CS algorithm processes a site-histology combination that does not have an applicable AJCC code, it assigns the display string "NA" for "Not applicable."

Coding CS Items: The complete instructions and site-histology defined codes are available in the *Collaborative Staging Manual and Coding Instructions* (CS Manual)*. Part I provides general instructions and the instructions and codes for generic (non site-specific) items. Part II contains the site-specific instructions and codes.

The *CS Manual* and related information is available electronically on the AJCC Web site at http://www.cancerstaging.org.

*Collaborative Staging Task Force of the American Joint Committee on Cancer. *Collaborative Staging Manual and Coding Instructions, version 1.0* Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004. NIH Publication Number 04-5496.

CS TUMOR SIZE	Item Length: 3 NAACCR Item #2800 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 25-27)

- Refer to general guidelines for Collaborative Staging for timing rules for data collection.
- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.
- Record tumor size information in the following order:
  - Record tumor size from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.
  - If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the largest size of tumor prior to treatment.
  - Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, just above a physical exam.
  - If there is a difference in reported tumor size among imaging and radiographic techniques, record the largest size of tumor reported in the record.
  - In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, more extensive after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Tumor Size/Ext Eval as 6, based on pathology/operative report after treatment.
- Record the exact size of the primary tumor for all sites/histologies except those for which it is stated to be not applicable. Code 999 if no size is given.
  - Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

- Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

- Record the size of the invasive component, if given.

- If both an in situ and an invasive component are present, and the invasive component is measured, record the size of the invasive component even if it is smaller.

- ***Additional rule for breast primaries:*** If the size of the invasive component is ***not*** given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

  - For purely in situ lesions, code the size as stated.

  - Microscopic residual tumor does not affect overall tumor size.

  - Do **not** add pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size.

  - If an excisional biopsy is performed and residual tumor at the time of resection of the primary is found to be larger than the excisional biopsy, code the size of the residual tumor.

  - For an incisional needle biopsy, code tumor size 999. Do not code the tumor size from a needle biopsy unless no residual tumor is found on further resection.

  - Record tumor size (lateral dimension) for malignant melanoma. Depth of invasion is coded in a site-specific factor.

- Special codes

  - Tumor dimension is to be recorded for all schemas, except as noted below. Other information collected in this field in previous staging systems, such as depth of invasion for melanoma, has been moved to Site-Specific Factors for those sites/Histologies.

  - If size is not reported, code as 999, which means unknown size, not applicable, or not documented in the patient record.

  - The descriptions in code 998 take precedence over any mention of size. Code 998 is used only for the following sites:
    Esophagus (C15.0–C15.5, C15.8–C15.9): Entire circumference
    Stomach (C16.0–C16.6, C16.8–C16.9): Diffuse, widespread—¾ or more, linitis plastica
    Colorectal (M-8220/8221 with /2 or /3): Familial/multiple polyposis
    Lung and main stem bronchus (C34.0–C34.3, C34.8–C34.9): Diffuse, entire lobe or lung
    Breast (C50.0–C50.6, C50.8–C50.9): Diffuse

- Code 990, Microscopic focus or foci only, should be used when no gross tumor is seen and tumor is only identified microscopically.

  Note: The terms microscopic focus, microfocus, and microinvasion are **not** the same as [macroscopic] focal or focus. A macroscopic focus or foci indicates a very small or isolated area, pinpoint, or spot of tumor that may be visible grossly. Only tumor identified microscopically should be coded 990.

- Codes 991 through 995 are non-specific size descriptions that, for some sites, could still be used to determine a T category. However, if a specific size is given, the more specific size should be coded in the range 001–989.

- Other special codes in the range 996 to 997 are used on a site-specific basis. See the individual site/histology schemas for further information and definitions.

Note: For the following diagnoses and/or primary sites, size is not applicable. Record as code 888.

Disseminated Langerhans cell histiocytosis (Letterer-Siwe disease)
Hematopoietic neoplasms
Immunoproliferative diseases
Leukemia
Malignant lymphoma (Hodgkin lymphoma and non-Hodgkin lymphoma)
Multiple myeloma and other plasma cell tumors
Myelodysplastic syndromes
Myeloproliferative diseases

- The source of the tumor size (radiographs, endoscopy, pathology specimen, etc.) is documented in the CS Tumor Size/Ext Eval field.

- **It is strongly recommended that the choice of tumor size codes be documented in a related text field on the abstract.**

CS EXTENSION	Item Length: 2 NAACCR Item #2810 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

Description: *Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in CS Extension. See site-specific schemas for detailed codes and coding instructions.*

Instructions for Coding (See *CS Manual* pp. 28-29)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.

- Code the farthest documented extension of the primary tumor. Do not include discontinuous metastases to distant sites. These are coded in *CS Mets at Dx* (NAACCR Item #2850) except for ovary and corpus uteri.

- Record extension information in the following order:

  - Record extension from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

  - If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest extension identified prior to treatment (clinically).

  - In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, more extensive after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code *CS Tumor Size/Ext Eval* as 6, based on pathology/operative report after treatment.

  - Information on extent of disease from imaging/radiographic techniques can be used to code extension when there is no more specific extension information from a pathology or operative report.

  - If an involved organ or tissue is not mentioned in the schema, approximate the location and code by comparing it with listed organs or tissues in the same anatomic area.

  - With the exception of corpus uteri and ovary, all codes represent contiguous (direct) extension of tumor from the site of origin to the organ/structure/tissue represented in the code.

- Refer to the Ambiguous Terminology section of the *CS Manual* for terms that constitute tumor involvement or extension.

- If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the T category stated by the physician.

- If the only indication of extension in the record is the physician's statement of a T category from the TNM staging system or a stage from a site-specific staging system, such as Dukes' C, record the numerically lowest equivalent extension code for that T category.

- Some site or histology schemas include designations such as T1, NOS; T2, NOS; Localized, NOS; and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as T1a, T1b, T1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as T1 NOS" when the appropriate subset (e.g., T1a or T1b) cannot be determined.

- Distant metastases must be coded in *CS Mets at Dx* (NAACCR Item #2850).

- Do not code *CS Extension* as in situ if there is any evidence of nodal or metastatic involvement; use the code for 'Localized, NOS' if there is no better information.

- The presence of microscopic residual disease or positive tumor margins does not increase the extension code.

- **It is strongly recommended that the choice of extension codes be documented in a related text field on the abstract.**

CS TUMOR SIZE/EXT EVAL	Item Length: 1 NAACCR Item #2820 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 30-32)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.

- Select the code that documents the report or procedure from which the information about the farthest extension or size of the primary tumor was obtained. This may not be the numerically highest Eval code.

- For primary sites/histologies where tumor size is not a factor in determining the T category in TNM (see Table 5 in General Instructions of the *CS Manual*), code this data item on the basis of *CS Extension* (NAACCR Item #2810) only.

- For primary sites where both tumor size and extension determine the T category in TNM (see Table 4 in the General Instructions of the *CS Manual*), select the code that best explains how the information in the *CS Tumor Size* (NAACCR Item #2800) and *CS Extension* (NAACCR Item #2810) data items were determined.

  - If there is a difference between the derived category for the tumor size and the CS extension, select the evaluation code that reflects how the worse or higher category was determined.

  - Code 0, 1, or 9 if the patient had no surgery.

    Exception: Lung cancer with mediastinoscopy showing direct extension into mediastinum. Use code 1. Staging algorithm will identify information as pathologic (p), because mediastinoscopy is defined as a pathologic procedure in TNM.

  - Code 3 or 9 if the patient had surgery followed by other treatment(s).

  - Code 5 if the size or extension of the tumor determined prior to treatment was the basis for neoadjuvant therapy.

  - Code 6 if the size or extension of the tumor was greater after presurgical treatment than before treatment. The code is likely to be used infrequently and maps to the "y" intercurrent treatment staging basis.

- Code 2 if the patient had an autopsy and the diagnosis was known or suspected prior to death.

- Code 8 if the patient had an autopsy and the malignancy was not known or suspected prior to death.

- For sites/histologies where there is no TNM schema, this data item may be coded 9, "Not applicable." (See Table 6 in General Instructions of the *CS Manual*.)

- Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

- Codes 0-3 are oriented to the AJCC staging basis. Code 1 generally includes microscopic analysis of tissue insufficient to meet the requirements for pathologic staging in the TNM system. Pathologic staging requirements vary by site; for some site schemas, code 1 may be classified as pathologic. For specific classification rules, refer to the *AJCC Cancer Staging Manual, Sixth Edition*.

- Code 1 also includes observations at surgery, such as an exploratory laparotomy in which unresectable pancreatic cancer is identified, where further tumor extension is not biopsied.

- Code 3 is considered pathologic staging across all sites. Use code 3 for a biopsy of tumor extension that meets the requirements for pathologic staging basis. That is, if the biopsy documents the highest T category, the biopsy meets the requirements for pathologic staging basis and *CS Tumor Size/Ext Eval* should be coded 3.

REGIONAL LYMPH NODES EXAMINED	Item Length: 2 NAACCR Item #830 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: 2001+

Description: *Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Staging System (CS).*

Instructions for Coding (See *CS Manual* p. 42 and *FORDS Revised for 2004* pp. 102-102A)

- Only record information about regional lymph nodes in this data item. Involved distant lymph nodes should be coded in *CS Mets at Dx* (NAACCR Item #2850).

- This data item is based on pathology information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, code 00.

- Record the total number of regional lymph nodes removed and examined by the pathologist.

  - The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

  - Code 98 if lymph nodes are aspirated and other lymph nodes are removed.

  - This data item is to be recorded regardless of whether the patient received preoperative treatment.

- If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, code 96.

- Code 99 for the following primary sites and histologies:

  Placenta (C58.9) Brain and Cerebral Meninges (C70.0, C71.0-C71.9)
  Other Parts of Central Nervous System (C70.1, C70.9, C72.0-C72.5, C72.8-C72.9)
  Hodgkin and non-Hodgkin Lymphoma (M-959-972) **except** 9700/3 and 9701/3
  Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
  (M-9731-9734, 9740-9742, 9750-9758, 9760-9762, 9764-9769, 9800-9801, 9805, 9820, 9823, 9826-9827, 9831-9837, 9840, 9860-9861, 9863, 9866-9867, 9870-9876, 9891, 9895-9897, 9910, 9920, 9930-9931, 9940, 9945-9946, 9948, 9950, 9960-9964, 9970, 9975, 9980, 9982-9987, 9989)
  Unknown and Ill-Defined Primary Sites
  (C42.0-C42.4, C76.0-C76.5, C76.7-C76.8, C77.0-C77.5, C77.8-C77.9, C80.9
  Note: For C42. and C77._, other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin Lymphomas as listed above, and Kaposi sarcoma 9140/3)

REGIONAL LYMPH NODES POSITIVE	Item Length: 2 NAACCR Item #820 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: 2001+

Description: *Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Staging System (CS).*

Instructions for Coding (See *CS Manual* p. 41 and *FORDS Revised for 2004* p. 103)

- Only record information about regional lymph nodes in this item. Involved distant lymph nodes should be coded in *CS Mets at Dx* (NAACCR Item #2850).

- This item is based on pathology information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, code 98.

- Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.

  - The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

  - This item is recorded regardless of whether the patient received preoperative treatment.

- Any combination of positive aspirated, biopsied, sampled or dissected lymph nodes is coded 97 if the number of involved nodes cannot be determined on the basis of cytology or histology.

- Code 99 for the following primary sites and histologies:
  Placenta (C58.9)
  Brain and Cerebral Meninges (C70.0, C71.0BC71.9)
  Other Parts of Central Nervous System (C70.1, C70.9, C72.0BC72.5, C72.8BC72.9)
  Hodgkin and non-Hodgkin Lymphoma (M-959B972 **except** 9700/3 and 9701/3)
  Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
  (M-9731-9734, 9740-9742, 9750-9758, 9760-9762, 9764-9769, 9800-9801, 9805, 9820, 9823, 9826-9827, 9831-9837, 9840, 9860-9861, 9863, 9866-9867, 9870-9876, 9891, 9895-9897, 9910, 9920, 9930-9931, 9940, 9945-9946, 9948, 9950, 9960-9964, 9970, 9975, 9980, 9982-9987, 9989)
  Unknown and Ill-Defined Primary Sites
  (C42.0-C42.4, C76.0-C76.5, C76.7-C76.8, C77.0-C77.5, C77.8-C77.9, C80.9

  Note: For C42._ and C77._ , other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin Lymphomas as listed above, and Kaposi sarcoma 9140/3).

CS LYMPH NODES	Item Length: 2 NAACCR Item #2830 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 33-38)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.

- Record the specific regional lymph node chain farthest from the primary site that is involved by tumor either clinically or pathologically.

  - Regional lymph nodes are listed for each site/histology. In general, the regional lymph nodes in the chain(s) closest to the primary site have the lower codes. Nodes farther away from the primary or in farther lymph node chains have higher codes. Record the highest applicable code.

    Exception: The higher codes for 'Regional lymph nodes, NOS'; 'Lymph nodes, NOS'; 'Stated as N1, no other information'; 'Stated as N2a, no other information', and so forth, should only be used when there is no available information as to the name(s) of the regional nodes involved.

  - Record involved regional lymph nodes from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

  - If there is a discrepancy between clinical information and pathologic information about the same lymph nodes, the pathologic information takes precedence if no preoperative treatment was administered.

  - **For inaccessible sites, primarily for localized or early stage (T1, T2) cancers:** record regional lymph nodes as negative rather than unknown (based on clinical evaluation) when there is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing or surgical exploration, and the patient receives what would be usual treatment to the primary site (see the *CS Manual* for further discussion).

  - If there is direct extension of the primary tumor into a regional lymph node, record the involved node in this data item.

  - If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest involved regional lymph nodes, based on information prior to surgery.

- In the infrequent event that clinically involved regional lymph nodes do no respond to neoadjuvant treatment and are, in fact, more extensively involved after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code *CS Regional Nodes Eval* as 6, based on pathology/operative report after treatment.

- Code 00 for lymph node involvement when the *CS Extension* (NAACCR Item #2810) is coded in situ, even if no lymph nodes are removed, since "in situ" by definition means noninvasive. If there is evidence of nodal involvement associated with a tumor described as in situ, it would indicate that an area of invasion was missed and the primary tumor is not an in situ lesion, so lymph nodes can be coded as appropriate for the case.

- For solid tumors, the terms "fixed" or "matted" and "mass in the hilum, mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are considered involvement of lymph nodes.

  - Any other terms such as "palpable," "enlarged," "visible swelling," "shotty," or "lymphadenopathy" should be ignored (except for adenopathy, enlargement, and mass in the hilum or mediastinum for lung primaries), unless there is a statement of involvement by the clinician.

  - For lymphomas, *any* mention of lymph nodes is indicative of involvement of those lymph nodes.

  - Regional lymph nodes are not palpable for inaccessible sites such as bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary. The best description concerning regional lymph nodes will be on imaging studies or in the surgeon's evaluation at the time of exploratory surgery or definitive surgery. If regional lymph nodes for these inaccessible sites are not mentioned on imagine or exploratory surgery, they are presumed to be clinically negative.

  - The terms "homolateral," "ipsilateral," and "same side" are used interchangeably.

  - Any unidentified nodes included with the resected primary site specimen are to be coded as 'Regional lymph nodes, NOS.'

  - Where more specific categories are provided, the codes for 'Regional lymph nodes, NOS' and 'Lymph nodes, NOS' should be used *only* after an exhaustive search for more specific information.

- When size of involved regional lymph nodes is required, code from pathology report, if available.

  - Code the size of the metastasis, not the entire node, unless otherwise stated in site-specific schemas. The size of the metastasis within the lymph node can be inferred if the size for the entire node falls within one of the codes. For example, a single involved node 1.5 cm in size can be coded to 'Single lymph node < 2 cm' because the metastasis cannot be larger than 1.5 cm.

- If the only indication of lymph node involvement in the record is the physician's statement of an N category from the TNM staging system or a stage from a site-specific staging system, such as Dukes' C, record the numerically lowest equivalent *CS Lymph Nodes* code for that N category.

  - If there is a discrepancy between documentation in the medical record and the physician's assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM.

  - If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, lymph node involvement may be inferred from the N category stated by the physician.

  - Some site or histology schemas include designations such as N1, NOS; N2, NOS, and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as N1a, N1b, N1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as N1 NOS" when the appropriate subset (e.g., N1a or N1b) cannot be determined.

  - For colon, rectosigmoid and rectum primaries, if there is a statement about tumor nodule(s) in the pericolic or perirectal fat, use the following guidelines for coding regional lymph node involvement:

    - Code as regional lymph node involvement if the nodule has a smooth contour.

    - Code as tumor extension if the nodule has an irregular contour.

  - **It is strongly recommended that the choice of regional lymph node codes be documented in a related text field on the abstract.**

CS REG NODES EVAL	Item Length: 1 NAACCR Item #2840 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 39-40)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.
- Select the code that documents the report or procedure from which the information about the farthest involved regional lymph nodes was obtained; this may not be the numerically highest Eval code.
- Code 9 may be used for this data item for sites/histologies where there is no TNM schema (see Table 5 in General Instructions of the *CS Manual*).
- Select the code that best explains how the information for *CS Lymph Nodes* (NAACCR Item #2830) was determined.
  - Code 0, 1, or 9 if the patient had no removal of lymph node(s).
  - Code 3 or 9 if the patient had removal of lymph node(s) surgery followed by other treatment(s).
  - Code 5 if the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, and the size, number or extension of regional lymph node involvement determined prior to treatment was the basis for neoadjuvant therapy.
  - Code 6 if more extensive tumor is found during lymph node examination after neoadjuvant therapy.
  - Code 2 if the patient had an autopsy and the diagnosis was known or suspected prior to death.
  - Code 8 if the patient had an autopsy and the malignancy was not known or suspected prior to death.
- Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

- Codes 0-3 are oriented to the AJCC staging basis. Code 1 includes microscopic analysis of tissue insufficient to meet the requirements for pathologic staging in the TNM system.

- Code 3 if the lymph node procedure meets the requirements for the pathologic staging basis of regional lymph nodes.

- Code 1 also includes observations at surgery, such as abdominal exploration at the time of a colon resection, where regional lymph nodes are not biopsied.

CS METS AT DX	Item Length: 2 NAACCR Item #2850 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 43-44)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.

- This data item represents distant metastases (the TNM M component or distant stage in Summary Staging) at the time of diagnosis. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to a site remote from the primary tumor.

  Note: The structure of this data item is based on the M category of TNM. In some schemas, there may be additional items in *CS Extension* (NAACCR Item #2810) or *CS Lymph Nodes* (NAACCR Item #2830) that map to distant stage in Summary Staging (77 and/or 2000) and there may be some items in *CS Mets at Dx* that map to regional stage in Summary Staging. Regardless of where such items are recorded, the staging algorithms will properly account for the information.

- Assign the highest applicable code for metastasis at diagnosis, whether the determination was clinical or pathological and whether or not the patient had any preoperative systemic therapy.

- Metastasis known to have developed after the extent of disease was established (also referred to as progression of disease) should not be recorded in this data item.

- Use code 00, rather than code 99, when the clinician proceeds with standard treatment of the primary site for localized or early (T1, T2) stage, since this action presumes that there are no distant metastasis that would otherwise alter the treatment approach. Code 99 can and should be used in situations where there is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastasis.

- If the only indication of extension in the record is the physician's statement of an M category from the TNM staging system or a stage from a site-specific staging system, such as Dukes' D, record the numerically lowest equivalent extension code for that M category. In most cases, this will be 40, 'Distant metastasis, NOS.'

- If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the M category stated by the physician.

- Some site or histology schemas include a designation of M1, NOS. The NOS is added when there is further breakdown of the category into subsets (such as M1a, M1b, M1c), but the

correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC terminology. The data collector should only code to a category such as "Stated as M1 NOS" when the appropriate subset (such as M1a or M1b) cannot be determined.

- **It is strongly recommended that the choice of distant lymph nodes and/or distant metastasis codes be documented in a related text field on the abstract.**

CS METS EVAL	Item Length: 1 NAACCR Item #2860 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 45-46)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.
- Select the CS Mets Eval code that documents the report or procedure from which the information about metastatic involvement farthest from the primary site was obtained; this may not be the numerically highest eval code.
- Code 9 may be used for primary sites/histologies where there is no TNM schema (See Table 4 of the *CS Manual*).
- Select the code that best explains how the information in *CS Mets at Dx* (NAACCR Item #2850) was determined.
    - Code 0, 1, or 9 if the patient had no examination of metastatic tissue.
    - Code 3 if the patient had removal of presumed metastatic tissue (even though the pathology report was negative).
    - Code the method of evaluation for the site(s) farthest from the primary.
    - Code 8 if metastasis at diagnosis were identified at autopsy.
    - Code 2 if the patient had an autopsy and the diagnosis was known or suspected prior to death.
    - Code 8 if the patient had an autopsy and the malignancy was not known or suspected prior to death.
- Code 6 if biopsies taken after pre-operative treatment are negative for metastasis and clinical evidence of metastasis remains.
- Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

- Code 1 includes microscopic analysis of tissue insufficient to meet the requirements for pathologic staging in the TNM system.

- Code 3 if the diagnosis of distant metastasis meets the requirements for the pathologic staging basis.

- Code 1 also includes observations at surgery, such as abdominal exploration at the time of a colon resection, where distant metastasis is not biopsied.

CS SITE-SPECIFIC FACTOR 1

Item Length: 3
NAACCR Item #2880
Source of Standard: AJCC
Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 47-48)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites/histologies use *Site-Specific Factor 1* to code information. See the site specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and neck*	Size of Lymph Nodes
Colon	Carcinoembryonic Antigen (CEA)
Rectosigmoid, rectum	Carcinoembyronic Antigen (CEA)
Liver	Alpha Fetoprotein (AFP)
Pleura	Pleural Effusion
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Measured Thickness (Depth), Breslow's Measurement
Mycosis Fungoides	Peripheral Blood Involvement
Breast	Estrogen Receptor Assay (ERA)
Ovary	Carbohydrate Antigen 125 (CA-125)
Placenta	Prognostic Scoring Index
Prostate	Prostatic Specific Antigen (PSA) Lab Value
Testis	Alpha Fetoprotein (AFP)
Malignant Melanoma of Conjunctiva	Measured Thickness (Depth), Breslow's Measurement
Malignant Melanoma of Choroid	Measured Thickness (Depth), Breslow's Measurement
Malignant Melanoma of Iris and Ciliary Body	Measured Thickness (Depth), Breslow's Measurement
Retinoblastoma	Extension Evaluated at Enucleation
Brain	WHO Grade
Other CNS	WHO Grade
Thyroid	Solitary vs. Multifocal
Other Endocrine	WHO Grade
Kaposi Sarcoma	Associated with HIV/AIDS **
Hodgkin Lymphoma and Non-Hodgkin Lymphoma	Associated with HIV/AIDS**

* Refer to the *CS Manual* for a list of head and neck schemas.

- Code 000 when there is a statement in the record that a test was not performed.
  - Code 999 if there is no report of a lab test in the patient record.
  - For Kaposi sarcoma, if AIDS status is not documented, use code 999 (Unknown), rather than 002 (Not Present)

**Note: Values for AIDS and/or HIV status will be converted to blanks when

CS SITE-SPECIFIC FACTOR 2	Item Length: 3 NAACCR Item #2890 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 49-50)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites use *Site-Specific Factor 2* to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	**Factor**
Head and neck*	Extracapsular Extension, Lymph Nodes for Head and Neck
Liver	Fibrosis Score
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Ulceration
Breast	Progesterone Receptor Assay (PRA)
Prostate	Prostatic Specific Antigen (PSA)
Testis	Human Chorionic Gonadotropin (HCG)
Hodgkin and non-Hodgkin Lymphoma	Symptoms at Diagnosis

*Refer to the *CS Manual* for a list of head and neck schemas.

- Code 000 when there is a statement in the record that a test was not performed.
  - Code 999 if there is no report of a lab test in the patient record.
  - For malignant melanoma of skin, if ulceration is not mentioned in the pathology report, code 000.

CS SITE-SPECIFIC FACTOR 3	Item Length: 3 NAACCR Item #2900 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 51-52)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites use *Site-Specific Factor 3* to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and Neck*	Levels I-III, Lymph Nodes of Head and Neck
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Clinical Status of Lymph Node Mets
Breast	Number of Positive Ipsilateral Axillary Lymph Nodes
Prostate	CS Extension - Pathologic Extension
Testis	Lactate Dehydrogenase (LDH)
Lymphoma	International Prognostic Index (IPI) Score

* Refer to the *CS Manual* for a list of head and neck schemas.

- Code 000 when there is a statement in the record that a test was not performed.
  - Code 999 if there is no report of a lab test in the patient record.
  - For the lymphomas, if the IPI score is not stated in the record, code 999. It is not necessary to calculate the IPI score from other information in the record.
- **For Head and Neck sites only:**
  - Use code 999 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code an unknown value (999) in some positions and a known value in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.
  - When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS, code 000 in all digits of Site-Specific Factors 3-6.
  - See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of head and neck, including definitions.

CS SITE-SPECIFIC FACTOR 4

Item Length: 3
NAACCR Item #2910
Source of Standard: AJCC
Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 53-54)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites use *Site-Specific Factor 4* to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and Neck*	Levels IV-V, Lymph Nodes of Head and Neck
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Lactate Dehydrogenase (LDH)
Breast	Immunohistochemistry (IHC) of Regional Lymph Nodes
Prostate	Prostate Apex Involvement (effective as of version 1.02.00) [Prostatic Acid Phosphatase (PAP) – OBSOLETE as of version 1.02.00]
Testis	Radical Orchiectomy Performed

*Refer to the *CS Manual* for a list of head and neck schemas.

- Code 000 when there is a statement in the record that a test was not performed.
  - Code 999 if there is no report of a lab test in the patient record.
- **For Head and Neck sites only:**
  - Use code 999 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code an unknown value (999) in some positions and a known value in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.
  - When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS, code 000 in all digits of Site-Specific Factors 3-6.
  - See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of head and neck, including definitions.

CS SITE-SPECIFIC FACTOR 5	Item Length: 3 NAACCR Item #2920 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 55-56)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites use *Site-Specific Factor 5* to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and Neck*	Levels VI-VIII, Lymph Nodes of Head and Neck
Breast	Molecular Studies of Regional Lymph Nodes
Prostate	Gleason Primary Pattern and Secondary Pattern Value
Testis	Size of Metastasis in Lymph Nodes

* Refer to the *CS Manual* for a list of head and neck schemas.

- Code 000 when there is a statement in the record that a test was not performed.
  - Code 999 if there is no report of a lab test in the patient record.
- **For Head and Neck sites only:**
  - Use code 999 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code an unknown value (999) in some positions and a known value in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.
  - When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS, code 000 in all digits of Site-Specific Factors 3-6.
  - See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of head and neck, including definitions.

CS SITE-SPECIFIC FACTOR 6	Item Length: 3 NAACCR Item #2930 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

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

Instructions for Coding (See *CS Manual* pp. 57-58)

- Refer to site/histology-specific instructions in the *Collaborative Staging Manual and Coding Instructions* (*CS Manual*) for additional information.
- Code 888 if there is no site/histology-specific factor for a schema.
- The following primary sites use *Site-Specific Factor 6* to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and Neck*	Parapharyngeal, Parotid, Preauricular, and Sub-Occipital Lymph Nodes, Lymph Nodes for Head and Neck
Breast	Size of Tumor--Invasive Component
Prostate	Gleason Score

* Refer to the *CS Manual* for a list of head and neck schemas.

- Code 000 when there is a statement in the record that a test was not performed.
  - Code 999 if there is no report of a lab test in the health record.
- **For Head and Neck sites only:**
  - Use code 9 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code an unknown value (999) in some positions and a known value in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.
  - When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS, code 0 in all digits of Site-Specific Factors 3-6.
  - See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of head and neck, including definitions.

Summary Staging (Required for All Cases Diagnosed Prior to 2004)

Summary staging is the most basic way of categorizing how far a cancer has spread from its point of origin. Summary staging has also been called General Staging, California Staging, and SEER Staging. For most cancer sites summary stage classifies depth of invasion within the primary site, extension to neighboring tissues and organs, involvement of regional lymph nodes and common sites of metastases. The categories localized, regional and distant were subdivided for use when a more detailed classification was desired.

The stage groupings or categories are defined as follows:

In situ: A neoplasm with all the characteristics of malignancy except invasion; it has not penetrated the basement membrane nor extended beyond the epithelial tissue. Some synonyms are intraepithelial (confined to epithelial tissue), noninvasive and noninfiltrating.

Localized: An invasive malignant neoplasm confined entirely to the organ of origin.

Regional: A malignant neoplasm that (1) has extended beyond the limits of the organ of origin directly into surrounding organs or tissues; (2) involves regional lymph nodes by way of the lymphatic system or (3) has both regional direct extension and involvement of regional lymph nodes.

Distant: A malignant neoplasm that has spread to parts of the body remote from the primary tumor either by direct extension or by discontinuous metastases (i.e., implantation or seeding) to distant organs or tissues, or via the lymphatic system to distant lymph nodes.

SEER SUMMARY STAGE 1977 **(GEN STAGE)**	Item Length: 1 NAACCR Item #760 Source of Standard: SEER Dx Yr Req by MCR: Prior to 2001

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

Instructions for Coding (See *SEER Program Coding and Staging Manual 2004* p. 166)

- Record the SEER Summary Stage 1977 code for all cases diagnosed prior to 2001.
- SEER Summary Staging 1977 is limited to information available within 2 months of the date of diagnosis.
- Refer to the *SEER Summary Staging Guide* for site-specific coding instructions.

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

SEER SUMMARY STAGE 2000 **(GEN STAGE)**	Item Length: 1 NAACCR Item #759 Source of Standard: SEER Dx Yr Req by MCR: 2001-2003

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

Instructions for Coding (See *SEER Program Coding and Staging Manual 2004* p. 167)

- Record the SEER Summary Stage 2000 code for all cases diagnosed from January 1, 2001 through December 31, 2003.
- Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.
- Refer to the *SEER Summary Staging Manual 2000* for site-specific coding instructions.

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

While this data item is not required by the MCR for cases diagnosed in 2004 or later, your registry software may not allow this data item to be left blank. The MCR recommends that the *Derived Summary Stage 2000* be entered in this field.

AJCC TNM Staging (Required for Eligible Cases Diagnosed Prior to 2004)

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

- Refer to the applicable edition of the *AJCC Cancer Staging Manual* for site-specific definitions of staging components and stage groups.
- All eligible cases should use the following time guidelines for evaluating stage: through first course of surgery or four months, whichever is longer.
- All eligible cases should be confirmed microscopically for TNM classification (including clinical information). Rare cases that do not have biopsy or cytology of the tumor can be staged but should be analyzed separately and should not be included in survival analyses.
- If a patient has multiple primaries, stage each primary independently.
- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, the physician identifies which primary has metastasized, update the stage(s) as appropriate.
- If the stage group cannot be determined from the recorded components, then record it as unknown.
- Code the edition number of the AJCC TNM stage system being used.

Ambiguous Terminology

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

List of Ambiguous Terms Describing Tumor Spread

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

TNM EDITION NUMBER **[AJCC EDITION]**	Item Length: 2 NAACCR Item 1060 Source of Standard: CoC (Revised 01/04) Dx Yr Req by MCR: Prior to 2004

Description: *A code that indicates the edition of* the AJCC Cancer Staging Manual *used to stage the tumor. It does not apply to the Derived AJCC T, N, M and AJCC Stage Group fields.*

Instructions for Coding (See *FORDS Revised for 2004* p. 234)

- Code the applicable *AJCC Cancer Staging Manual* edition used to stage the tumor based on the date of diagnosis.

AJCC Edition	Dates Applicable
06	2003+
05	1998 - 2002
04	1993 -1997
88	Not applicable (cases that do not have an AJCC staging scheme)

TNM PATH T	Item Length: 2 NAACCR Item #880 Source of Standard: AJCC Dx Yr Req by MCR: Prior to 2004

Description: *Evaluates the primary tumor (T) and reflects the pathologic tumor size and/or extension using detailed site-specific codes as defined by AJCC.*

Instructions for Coding (See *AJCC Cancer Staging Manual, Sixth Edition* pp. 5-8)

- Refer to the applicable *AJCC Cancer Staging Manual* for site-specific coding rules.
- Use code 88 for sites and/or site/histology combinations not eligible for AJCC staging.

TNM PATH N	Item Length: 2 NAACCR Item #890 Source of Standard: AJCC Dx Yr Req by MCR: Prior to 2004

Description: *Identifies the absence or presence of regional lymph node (N) metastasis and describes the pathologic extent of regional lymph node metastasis using detailed site-specific codes as defined by AJCC.*

Instructions for Coding (See *AJCC Cancer Staging Manual, Sixth Edition* pp. 5-8)

- Refer to the applicable *AJCC Cancer Staging Manual* for site-specific coding rules.
- Use code 88 for sites and/or site/histology combinations not eligible for AJCC staging.

TNM PATH M	Item Length: 2 NAACCR Item #900 Source of Standard: AJCC Dx Yr Req by MCR: Prior to 2004

Description: *Identifies the presence or absence of pathologic distant metastasis (M) using detailed site-specific codes as defined by AJCC.*

Instructions for Coding (See *AJCC Cancer Staging Manual, Sixth Edition* pp. 5-8)

- Refer to the applicable *AJCC Cancer Staging Manual* for site-specific coding rules.
- Use code 88 for sites and/or site/histology combinations not eligible for AJCC staging.

TNM PATH STAGE GROUP	Item Length: 2 NAACCR Item #910 Source of Standard: AJCC Dx Yr Req by MCR: Prior to 2004

Description: *Identifies the anatomic pathologic extent of disease based on the T, N, and M elements using site-specific codes as defined by AJCC.*

Instructions for Coding (See *AJCC Cancer Staging Manual, Sixth Edition* pp. 5-8)

- Refer to the applicable *AJCC Cancer Staging Manual* for site-specific coding rules.
- If pathologic M (NAACCR Item #900) is coded as either X or blank and clinical M (NAACCR Item #960) is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging elements pT, pN, and cM (NAACCR Item #s 880, 890, 960) may be used to complete the pathologic stage group.
- Use code 88 for sites and/or site/histology combinations not eligible for AJCC staging.

TNM PATH DESCRIPTOR (PREFIX/SUFFIX)

Item Length: 1
NAACCR Item #920
Source of Standard: AJCC
Dx Yr Req by MCR: Prior to 2004

Description: *Identifies the AJCC pathologic stage (prefix/suffix) descriptor. Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group.*

Instructions for Coding (See *AJCC Cancer Staging Manual, Sixth Edition* pp. 5-8)

- Refer to the applicable *AJCC Cancer Staging Manual* for site-specific coding rules.

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

TNM CLIN T	Item Length: 2 NAACCR Item #940 Source of Standard: AJCC Dx Yr Req by MCR: Prior to 2004

Description: *Evaluates the primary tumor (T) and reflects the clinical tumor size and/or extension using detailed site-specific codes as defined by AJCC.*

Instructions for Coding (See *AJCC Cancer Staging Manual, Sixth Edition* pp. 5-8)

- Refer to the applicable *AJCC Cancer Staging Manual* for site-specific coding rules.
- Use code 88 for sites and/or site/histology combinations not eligible for AJCC staging.

TNM CLIN N	Item Length: 2 NAACCR Item #950 Source of Standard: AJCC Dx Yr Req by MCR: Prior to 2004

Description: *Identifies the absence or presence of regional lymph node (N) metastasis and describes the clinical extent of regional lymph node metastasis using detailed site-specific codes as defined by AJCC.*

Instructions for Coding (See *AJCC Cancer Staging Manual, Sixth Edition* pp. 5-8)

- Refer to the applicable *AJCC Cancer Staging Manual* for site-specific coding rules.
- Use code 88 for sites and/or site/histology combinations not eligible for AJCC staging.

TNM CLIN M	Item Length: 2 NAACCR Item #960 Source of Standard: AJCC Dx Yr Req by MCR: Prior to 2004

Description: *Identifies the presence or absence of clinical distant metastasis (M) using detailed site-specific codes as defined by AJCC.*

Instructions for Coding (See *AJCC Cancer Staging Manual, Sixth Edition* pp. 5-8)

- Refer to the applicable *AJCC Cancer Staging Manual* for site-specific coding rules.
- Use code 88 for sites and/or site/histology combinations not eligible for AJCC staging.

TNM CLIN STAGE GROUP	Item Length: 2 NAACCR Item #970 Source of Standard: AJCC Dx Yr Req by MCR: Prior to 2004

Description: *Identifies the anatomic clinical extent of disease based on the T, N, and M elements using site-specific codes as defined by AJCC.*

Instructions for Coding (See *AJCC Cancer Staging Manual, Sixth Edition* pp. 5-8)

- Refer to the applicable *AJCC Cancer Staging Manual* for site-specific coding rules.
- If pathologic M (NAACCR Item #900) is coded as either X or blank and clinical M (NAACCR Item #960) is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging elements pT, pN, and cM (NAACCR Item #s 880, 890, 960) may be used to complete the pathologic stage group.
- Use code 88 for sites and/or site/histology combinations not eligible for AJCC staging.

TNM CLIN DESCRIPTOR (PREFIX/SUFFIX)

Item Length: 1
NAACCR Item #980
Source of Standard: AJCC
Dx Yr Req by MCR: Prior to 2004

Description: *Identifies the AJCC clinical stage (prefix/suffix) descriptor. Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group.*

Instructions for Coding (See *AJCC Cancer Staging Manual, Sixth Edition* pp. 5-8)

- Refer to the applicable *AJCC Cancer Staging Manual* for site-specific coding rules.

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

SITE OF DISTANT MET (1, 2 AND 3) [DISTANT SITES 1, 2 AND 3]	Item Length: 1 NAACCR Items #1090, #1100, #1110 Source of Standard: CoC Dx Yr Req by MCR: 2005+

Description: *Identifies the site(s) of distant metastasis found at initial diagnosis and work up. There are three individual one-digit codes for a site of metastasis.*

Instructions for Coding (See *ROADS pp. 131-136)**

- Use the applicable *AJCC Manual for Staging Cancer* to identify distant sites for each primary site.
- 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.
- Record 9 if carcinomatosis is present, for disseminated disease, leukemia, 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
9	Lymph nodes (distant)
9	Other, generalized, carcinomatosis, disseminated, not specified, leukemia, unknown primary

***Note**: As of January 1, 2003, these data items are no longer required by CoC.*

First Course of Treatment/Therapy

RX DATE – DX/STG PROC [DATE OF SURGICAL DIAGNOSTIC AND STAGING PROCEDURE (NONCANCER-DIRECTED SURGERY)]	Item Length: 8 NAACCR Item #1280 Source of Standard: CoC Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* pp. 107-108)

- Record the date on which the surgical diagnostic and/or staging procedure described in *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350) was performed at this or any facility.
- If the exact date of the procedure is not available, record an approximate date.

> If the month and year is known but not the day, code day to "15".
>
> ***Note:*** Whenever using an estimated date, please document in a text field.

- ♦ If information is limited to a descriptive term use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

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

RX SUMM – DX/STG PROC [SURGICAL DIAGNOSTIC AND STAGING (NONCANCER-DIRECTED SURGERY)]	Item Length: 2 NAACCR Item #1350 Source of Standard: CoC (Revised 01/04) Dx Yr Req by MCR: 2005+

Description: *Identifies the noncancer-directed surgical procedure(s) performed in an effort to diagnose and/or stage disease.*

Instructions for Coding: **(See *FORDS Revised for 2004* pp. 109-110)**

- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.

- Do not code surgical procedures which aspirate, biopsy, or remove *regional lymph nodes* in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). See instructions for *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292).

- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* (NAACCR Item #490). These are not considered surgical procedures and should not be coded in this item.

- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* (NAACCR Item #1290) to code these procedures.

- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* (NAACCR Item #3270) to code these procedures.

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

Examples of Surgical Diagnostic and Staging Procedures [Non-cancer Directed Surgeries]

Code	Reason
00	A lung cancer primary was diagnosed by CT scan. The patient expired. No surgical diagnostic or staging surgical procedure was performed.
00	A sputum sample is examined cytologically to confirm a diagnosis of suspected lung cancer. The procedure is not surgical.
01	A thoracentesis is performed on a patient to stage a lung primary, and the withdrawn fluid is examined cytologically for confirmation of malignant pleural effusion.
01	A needle biopsy of a liver metastasis in a patient with suspected widespread colon cancer was done. Gross residual tumor is left at the biopsy site.
02*	During a colonoscopy, a biopsy of a primary rectal mass was done. Gross residual tumor is left at the biopsy site.
03*	During abdominal exploratory surgery, a gastric lesion and suspicious retroperitoneal lymph nodes were observed. No biopsy or treatment was done.
04	An abdominal exploration of a patient revealed pancreatic carcinoma with extension into surrounding organs and arteries. No attempt to treat. A bypass was performed to alleviate symptoms.
05	An exploratory procedure was performed for primary colon carcinoma with biopsy of suspicious liver lesions.
06	Esophagogastrostomy was performed for infiltrating gastric tumor following a biopsy of the primary site.
07	Stage III lung carcinoma was diagnosed and staged prior to admission.
09	A patient expires in the emergency room with recently diagnosed metastatic melanoma. It is unknown whether a diagnostic or staging procedure was done.

*An endoscopic exam is <u>not a surgical exploration</u>. If a biopsy is performed during an endoscopic exam, code the biopsy only.

DATE OF 1ST CRS RX – COC DATE OF FIRST COURSE OF TREATMENT	Item Length: 8 NAACCR Item #1270 Source of Standard: CoC Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* pp. 129-130)

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

> If the month and year is known but not the day, code day to "15".
>
> ***Note:*** Whenever using an estimated date, please document in a text field.

- ♦ If information is limited to a descriptive term use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

RX DATE – SURGERY **DATE OF FIRST SURGICAL PROCEDURE**	Item Length: 8 NAACCR Item #1200 Source of Standard: CoC Dx Yr Req by MCR: All

Description: *Records the earliest date on which any first course surgical procedure was performed. Formerly called "Date of Cancer-Directed Surgery."*

Instructions for Coding (See *FORDS Revised for 2004* pp. 131-132)

- Record the date of the first surgical procedure of the types coded as *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Surgical Procedure/Other Site* (NAACCR Item #1294) performed at this or any facility.

- The date in this item may be the same as that in *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170), if the patient received only one surgical procedure and it was a resection of the primary site.

- If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item *Date of First Course Treatment* (NAACCR Item #1270).

- If exact date that the first surgical procedure was performed is not known, record an approximate date.

> If the month and year is known but not the day, code day to "15".
>
> ***Note:*** Whenever using an estimated date, please document in a text field.

- ♦ If information is limited to a descriptive term use the following:

Descriptive Term Used	**Date Code**
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

RX SUMM – SURG PRIMARY SITE **[SURGICAL PROCEDURE OF PRIMARY SITE]**	Item Length: 2 NAACCR Item #1290 Source of Standard: SEER/CoC (Revised 09/04) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* p. 135)

- Site-specific codes for this data item are found in *FORDS Revised for 2004* Appendix B.
- If registry software allows multiple surgical procedures to be recorded, document each surgical procedure separately.
- If registry software allows only one surgical procedure to be collected, document the most invasive surgical procedure for the primary site, but code the date of surgical procedure to *Rx Date – Surgery [Date of First Surgical Procedure] (*NAACCR Item #1200).
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is unavailable.
- Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in this item.
- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix B.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care** (NAACCR Item #3270)

****Note:*** Information about palliative procedures is not required by the MCR.

RX SUMM – SCOPE REG LN SUR [SCOPE OF REGIONAL LYMPH NODE SURGERY]	Item Length: 1 NAACCR Item #1292 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: 2001+

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

Instructions for Coding (See *FORDS Revised for 2004* pp. 138-139)

- The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
- Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item *Date Surgery.*
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9), code 9.
- For lymphomas (M-9590–9596, 9650–9719, 9727–9729) with a lymph node primary site (C77.0–C77.9), code 9.
- For an unknown or ill-defined primary site (C76.0–C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field *Surgical Procedure/Other Site* (NAACCR Item #1294).
- Refer to the applicable *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Car*e* (NAACCR Item #3270).

***Note:** Information about palliative procedures is not required by the MCR.

Codes for Scope of Regional Lymph Node Surgery

Code	Label	Definition
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease.
2	Sentinel lymph node biopsy	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel node biopsy.
4	1–3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

RX SUMM – SURG OTH REG/DIS [SURGICAL PROCEDURE/OTHER SITE]	Item Length: 1 NAACCR Item #1294 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: 2001+

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

Instructions for Coding (See *FORDS Revised for 2004* p. 142)

- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s)* and/or regional/distant tissue or organs.
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site."
- Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989).
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care** (NAACCR Item #3270).

> ****Note:*** Information about palliative procedures is not required by the MCR.

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

RX SUMM – SURG SITE 98-02 **[SURGERY OF PRIMARY SITE]**	Item Length: 2 NAACCR Item #1646 Source of Standard: SEER/CoC Dx Yr Req by MCR: Prior to 2003

Description: *Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at all facilities as part of first course treatment.* ***This field is to be used for*** **ROADS** ***codes after the*** **ROADS** ***to*** **FORDS** ***conversion. It is also to be used to code Surgery Primary Site when applicable for all tumors diagnosed prior to 2003.***

Instructions for Coding (See *ROADS* pp. 187-189)

- Site-specific codes for this data item are found in *ROADS* Appendix B.
- Only record surgeries of the primary site.
- Document the most invasive surgical procedure for the primary site.
- If no primary site surgery was done, code 00.

RX SUMM – SCOPE REG 98-02 **[NUMBER OF REG LN REMOVED]**	Item Length: 1 NAACCR Item #1647 Source of Standard: SEER/CoC Dx Yr Req by MCR: Prior to 2003

Description: *Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities.* ***This field is to be used for* ROADS *codes after the* ROADS *to* FORDS *conversion. It is also to be used to code Scope of Regional Lymph Node Surgery when applicable for all tumors diagnosed prior to 2003.***

Instructions for Coding (See *ROADS* p. 192)

- For the majority of sites, "Scope of Regional Lymph Nodes Surgery" defines the removal of regional lymph node(s). There is no minimum number of nodes that must be removed. This refers to the farthest regional lymph nodes removed regardless of involvement with disease. If at least one regional lymph node was removed, the code for this field must be in the range of 1-5. If a regional lymph node was aspirated or biopsied, code regional lymph node(s) removed, NOS (1).

- For head and neck sites, this field describes neck dissections. Codes 2-5 indicate only that a neck dissection procedure was done; they do not imply that nodes were found during the pathologic examination of the surgical specimen. Code the neck dissection even if no nodes were found in the specimen.

- For an unknown primary, leukemia, lymphoma and brain primaries, code 9.

RX SUMM – REG LN EXAMINED **[NUMBER OF REG LN REMOVED]**	Item Length: 2 NAACCR Item #1296 Source of Standard: SEER/CoC Dx Yr Req by MCR: Prior to 2003

Description: *Codes for the number of regional lymph nodes examined in conjunction with surgery performed as part of first course treatment. This includes treatment given at all facilities as part of first course treatment.* ***This field is to be used when applicable only for tumors diagnosed prior to 2003.***

Instructions for Coding (See *ROADS p. 193)**

- Record the number of regional lymph nodes that were microscopically examined and identified in the pathology report for this surgical procedure only. Do not add numbers of nodes removed during different surgical events.
- If no regional lymph nodes are identified in the pathology report, code 00 even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or if the operative report documents removal of nodes.
- Because this field is not cumulative and not affected by timing, it does not replace or duplicate the field "Regional Lymph Nodes Examined" in the staging section. Do not copy the value from one field to another.
- For an unknown primary (C80.9), code 99.

*Note: As of January 1, 2003, this data item is no longer required or recommended by CoC; however, it is required by the MCR when applicable for cases diagnosed prior to 2003.

RX SUMM – SURG OTH 98-02 **[SURGERY OF OTHER REGIONAL SITE(S),** **DISTANT SITE(S) OR DISTANT LYMPH NODES]**	Item Length: 1 NAACCR Item #1648 Source of Standard: SEER/CoC Dx Yr Req by MCR: Prior to 2003

Description: *Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site at all facilities as part of first course treatment.* ***This field is to be used for* ROADS *codes after the* ROADS *to* FORDS *conversion. It is also to be used to code Surgery Regional/Distant Sites when applicable for all tumors diagnosed prior to 2003.***

Instructions for Coding (See *ROADS* p. 194)

- This field is for all procedures that do not meet the definitions of "Surgery of Primary Site" or "Scope of Regional Lymph Node(s)".

- Code the removal of non-primary tissue which was removed because the surgeon suspected it was involved with malignancy even if the pathology is negative.

- Do not code the incidental removal of tissue. Incidental is defined as tissue removed for reasons other than the malignancy.

RX SUMM – SURG/RAD SEQ RADIATION/SURGERY SEQUENCE	Item Length: 1 NAACCR Item #1380 Source of Standard: SEER/CoC Rev (01/04) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* pp. 164-165)

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

- If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site*, *Regional Lymph Node Surgery*, or *Surgical Procedure/Other Site*, then code this item 2–9, as appropriate.

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

REASON FOR NO SURGERY (OF PRIMARY SITE)	Item Length: 1 NAACCR Item #1340 Source of Standard: SEER/CoC Rev (01/04) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* p. 147)

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

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

REASON FOR NO RADIATION	Item Length: 1 NAACCR Item #1430 Source of Standard: CoC (Revised 09/04) Dx Yr Req by MCR: All

Description: *Records the reason that no regional radiation therapy was administered to the patient.*

Instructions for Coding (See *FORDS Revised for 2004* p. 168)

- If there was no radiation therapy (*Regional Treatment Modality* - NAACCR Item #1570), then record the reason based on documentation in patient record.
- Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include radiation therapy.
- Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Cases coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple options, but it is unknown which treatment, if any, was provided.

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

RX DATE – CHEMO **[DATE CHEMOTHERAPY STARTED]**	Item Length: 8 NAACCR Item # 1220 Source of Standard: NAACCR Dx Yr Req by MCR: All

Description: *Records the date of initiation of chemotherapy that is part of the first course of treatment. Collecting dates for each treatment modality allows sequencing of multiple treatments.*

Instructions for Coding (See *ROADS p. 227)**

- Record the first or earliest date on which chemotherapy (NAACCR Item #1390) was administered.
- If exact date that chemotherapy was initiated is not known, record an approximate date.

> If the month and year is known but not the day, code day to "15".
>
> ***Note:*** Whenever using an estimated date, please document in a text field.

- ♦ If information is limited to a descriptive term use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

***Note:** As of January 1, 2003, this data item is no longer supported by the CoC.*

RX SUMM – CHEMOTHERAPY	Item Length: 2 NAACCR Item # 1390 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: All

Description: *Records the type of chemotherapy administered as first course treatment at this and all other facilities. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.*

Instructions for Coding (See *FORDS Revised for 2004* pp. 171-172)

- For cases diagnosed prior to 2005, refer to the SEER *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of chemotherapeutic agents. Effective for cases diagnosed January 1 2005 refer to **SEER*Rx.**

- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and *only the original agent or regimen is recorded as first course therapy*.

- If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy administered in the item *Palliative Care** (NAACCR Item #3270).

  ***Note:** Information about palliative procedures is not required by the MCR.

Code	Definition
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multiagent chemotherapy administered as first course therapy.

Note: **SEER*Rx**, an interactive antineoplastic drug database, replaces the printed SEER Book 8 (published in 1993) and the update to Book 8 issued in May 2002. The categories for a few drugs have changed, notably some monoclonal antibodies such as Avastin, Velcade, Rituxan, Herceptin, and a few others that have been determined to be cytostatic chemotherapy agents rather than traditional immunotherapy. Recoding of these agents for cases diagnosed prior to 2005 is not required or recommended.

SEER*Rx can be downloaded from http://www.seer.cancer.gov/seerrx at no charge.

RX DATE – HORMONE **[DATE HORMONE THERAPY STARTED]**	Item Length: 8 NAACCR Item # 1230 Source of Standard: NAACCR Dx Yr Req by MCR: All

Description: *Records the date of initiation of hormone therapy that is part of the first course of treatment. Collecting dates for each treatment modality allows sequencing of multiple treatments.*

Instructions for Coding (See *ROADS p. 237)**

- Record the first or earliest date on which hormone therapy (NAACCR Item #1400) was administered.
- If exact date that hormone therapy was initiated is not known, record an approximate date.

> If the month and year is known but not the day, code day to "15".
>
> ***Note:*** Whenever using an estimated date, please document in a text field.

  - ♦ If information is limited to a descriptive term use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

***Note:** This data item is no longer supported by the CoC (as of January 1, 2003).*

RX SUMM – HORMONE THERAPY (HORMONE/STEROID THERAPY)	Item Length: 2 NAACCR Item # 1400 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: All

Description: *Records the type of hormone therapy administered as first course treatment at this and all other facilities. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.*

Instructions for Coding (See *FORDS Revised for 2004* pp. 175-176)

- For cases diagnosed prior to 2005, refer to the SEER *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of hormonal agents. Effective for cases diagnosed January 1 2005 refer to **SEER*Rx.**
- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item *Palliative Care** (NAACCR Item #3270).

Note: Information about palliative procedures is not required by the MCR.

Code	Definition
01	Hormone therapy administered as first course therapy.

Note: **SEER*Rx**, an interactive antineoplastic drug database, replaces the printed SEER Book 8 (published in 1993) and the update to Book 8 issued in May 2002. The categories for a few drugs have changed, notably some monoclonal antibodies such as Avastin, Velcade, Rituxan, Herceptin, and a few others that have been determined to be cytostatic chemotherapy agents

RX DATE – BRM **[DATE IMMUNOTHERAPY STARTED]**	Item Length: 8 NAACCR Item # 1240 Source of Standard: NAACCR Dx Yr Req by MCR: All

Description: *Records the date of initiation of immunotherapy that is part of the first course of treatment. Collecting dates for each treatment modality allows sequencing of multiple treatments.*

Instructions for Coding (See *ROADS p. 242)**

- Record the first or earliest date on which immunotherapy (NAACCR Item #1410) was administered.
- If exact date that immunotherapy was initiated is not known, record an approximate date.

> If the month and year is known but not the day, code day to "15".
>
> ***Note:*** Whenever using an estimated date, please document in a text field.

- ♦ If information is limited to a descriptive term use the following:

Descriptive Term Used	**Date Code**
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

***Note:** As of January 1, 2003, this data item is no longer supported by the CoC.*

RX SUMM – BRM [IMMUNOTHERAPY]	Item Length: 2 NAACCR Item # 1410 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: All

Description: *Records the type of immunotherapy administered as first course treatment at this and all other facilities. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.*

Instructions for Coding (See *FORDS Revised for 2004* pp. 179-180)

- For cases diagnosed prior to 2005, refer to the SEER *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of chemotherapeutic agents. Effective for cases diagnosed January 1 2005 refer to **SEER*Rx**.
- If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy administered in the item *Palliative Care** (NAACCR Item #3270).

> ****Note:*** Information about palliative procedures is not required by the MCR.

Code	Definition
01	Immunotherapy administered as first course therapy.

Note: **SEER*Rx**, an interactive antineoplastic drug database, replaces the printed SEER Book 8 (published in 1993) and the update to Book 8 issued in May 2002. The categories for a few drugs have changed, notably some monoclonal antibodies such as Avastin, Velcade, Rituxan, Herceptin, and a few others that have been determined to be cytostatic chemotherapy agents rather than traditional immunotherapy. Recoding of these agents for cases diagnosed prior to 2005 is not required or recommended.

[DATE HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE PROCEDURES STARTED]	Item Length: 8 NAACCR Item N/A Source of Standard: Dx Yr Req by MCR: 2005+

Description: *Records the date of initiation of hematologic transplant and/or endocrine procedures that is part of the first course of treatment. Collecting dates for each treatment modality allows sequencing of multiple treatments.*

Instructions for Coding*

Record the first of earliest date on which a hematolgic transplant or endocrine procedure (NAACCR Item #3250) was performed.

If exact date that immunotherapy was initiated is not known, record an approximate date.

If the month and year is known but not the day, code day to "15".

Note: Whenever using an estimated date, please document in a text field.

- If information is limited to a descriptive term use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

***Note:** This data item is not supported by the CoC. It is required by the MCR software in order to record the treatment.*

RX SUMM – TRANSPLNT/ENDOCR [HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES]	Item Length: 2 NAACCR Item # 3250 Source of Standard: CoC (Revised 01/04) Dx Yr Req by MCR: 2005+

Description: *Identifies systemic therapeutic procedures administered as part of the first course of treatment at this and all other facilities. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.*

Instructions for Coding (See *FORDS Revised for 2004 p. 182-183*)**

- Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.

- Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.

- Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or effect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

- If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hematologic transplant or endocrine procedure provided in the items *Palliative Care** (NAACCR Item #3270).

> ***Note:*** Information about palliative procedures is not required by the MCR.

Code	Definition
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant -- autologous.
12	Bone marrow transplant -- allogeneic.
20	Stem cell harvest and infusion.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20.)

**Note: For Cases diagnosed prior to 2003, the information in this data item was coded as immuntherapy. See* ROADS *p 24.)*

RX DATE – OTHER **[DATE OTHER TREATEMENT STARTED]**	Item Length: 8 NAACCR Item # 1250 Source of Standard: CoC Dx Yr Req by MCR: All

Description: *Records the date on which other treatment began at any facility. Collecting dates for each treatment modality allows sequencing of multiple treatments.*

Instructions for Coding (See *FORDS Revised for 2004* pp. 184-185)

- Other treatment is that which cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in *FORDS Revised for 2004*.

- If other treatment is the first or only treatment administered to the patient, then the date other treatment started should be the same as the *Date of First Course of Treatment* (NAACCR Item #1270).

- If exact date that other treatment was initiated is not known, record an approximate date.

  If the month and year is known but not the day, code day to "15".

  Note: Whenever using an estimated date, please document in a text field.

  - If information is limited to a descriptive term use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

RX SUMM – OTHER **[OTHER TREATMENT]**	Item Length: 1 NAACCR Item # 1420 Source of Standard: SEER/CoC (Revised 01/04) Dx Yr Req by MCR: All

Description: *Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.*

Instructions for Coding (See *FORDS Revised for 2004* p. 186)

- Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the ususal definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Such treatments include phlebotomy, transfusions, and aspirin (see *FORDS Revised for 2004* Section One), and should be coded 1.

- A complete description of the treatment plan should be recorded in the text field for "Other Treatment" on the abstract.

- If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care** (NAACCR Item #3270).

> ****Note:*** Information about palliative procedures is not required by the MCR.

Code	Label	Definition
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases (see Notes below).
2	Other—Experimental	This code is not defined. It may be used to record participation in institution based clinical trials.
3	Other—Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other—Unproven	Cancer treatments administered by nonmedical personnel.

RX DATE – RADIATION **[DATE RADIATION STARTED]**	Item Length: 8 NAACCR Item #1210 Source of Standard: CoC (Revised 1/22/03) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* p. 148)

- If radiation therapy is the first or only treatment administered to the patient, then the date radiation started should be the same as the date entered into the item *Date of First Course of Treatment* (NAACCR Item #1270).
- The date when treatment started will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- If exact date that radiation therapy was started is not known, record an approximate date.

> If the month and year is known but not the day, code day to "15".
>
> ***Note:*** Whenever using an estimated date, please document in a text field.

- ♦ If information is limited to a descriptive term use the following:

Descriptive Term Used	**Date Code**
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

RX DATE – RADIATION ENDED
[DATE RADIATION ENDED]

Item Length: 8
NAACCR Item #3220
Source of Standard: CoC
Dx Yr Req by MCR: N/R

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

Instructions for Coding (See *FORDS Revised for 2004* p. 166)

- The date when treatment ended will typically be found in the radiation oncologist's summary of first course of treatment.
- If exact date that radiation therapy ended is not known, record an approximate date.

If the month and year is known but not the day, code day to "15".

Note: Whenever using an estimated date, please document in a text field.

- ♦ If information is limited to a descriptive term use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"Fall/autumn"	October
"Winter"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

RAD – TREATMENT VOLUME
[RADIATION TREATMENT VOLUME]

Item Length: 2
NAACCR Item #1540
Source of Standard: CoC
(Revised 01/04)
Dx Yr Req by MCR: N/R

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

Instructions for Coding (See *FORDS Revised for 2004* p. 151-154)

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

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	Eye/orbit	The radiation therapy target volume is limited to the eye and/or orbit.
02	Pituitary	The target volume is restricted to the pituitary gland and all adjacent volumes are irradiated incidentally.
03	Brain (NOS)	Treatment is directed at tumors lying within the substance of the brain, or its meninges.
04	Brain (limited)	The treatment volume encompasses less than the total brain, or less than all of the meninges.
05	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the oropharyngeal complex, usually encompassing regional lymph nodes.
06	Head and neck (limited)	Limited volume treatment of a head and neck primary with the exception of glottis (code 7), sinuses (code 8), or parotid (code 9).
07	Glottis	Treatment is limited to a volume in the immediate neighborhood of the vocal cords.
08	Sinuses	The primary target is one or both of the maxillary sinuses or the ethmoidal frontal sinuses. In some cases, the adjacent lymph node regions may be irradiated.
09	Parotid	The primary target is one of the parotid glands. There may be secondary regional lymph node irradiation as well.
10	Chest/lung (NOS)	Radiation therapy is directed to some combination of hilar, mediastinal, and/or supraclavicular lymph nodes, and/or peripheral lung structures.
11	Lung (limited)	Radiation therapy is directed at one region of the lung without nodal irradiation.
12	Esophagus	The primary target is some portion of the esophagus. Regional lymph nodes may or may not be included in the treatment. Include tumors of the gastroesophageal junction.
13	Stomach	The primary malignancy is in the stomach. Radiation is directed to the stomach and possibly adjacent lymph nodes.
14	Liver	The primary target is all or a portion of the liver, for either primary or metastatic disease.
15	Pancreas	The primary tumor is in the pancreas. The treatment field encompasses the pancreas and possibly adjacent lymph node regions.
16	Kidney	The target is primary or metastatic disease in the kidney or the kidney bed after resection of a primary kidney tumor. Adjacent lymph node regions may be included in the field.
17	Abdomen (NOS)	Include all treatment of abdominal contents that do not fit codes 12–16.
18	Breast	The primary target is the intact breast and no attempt has been made to irradiate the regional lymph nodes. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy (C50.0–C50.9, Surgical Procedure of Primary Site [NAACCR Item #1290] codes 0–24).
19	Breast/lymph nodes	A deliberate attempt has been made to include regional lymph nodes in the treatment of an intact breast. See definition of intact breast above.

Code	Label	Definition
20	Chest wall	Treatment encompasses the chest wall (following mastectomy).
21	Chest wall/lymph nodes	Treatment encompasses the chest wall (following mastectomy) plus fields directed at regional lymph nodes.
22	Mantle, Mini-mantle	Treatment consists of a large radiation field designed to encompass all of the regional lymph nodes above the diaphragm, including cervical, supraclavicular, axillary, mediastinal, and hilar nodes (mantle), or most of them (mini-mantle). This code is used exclusively for patients with Hodgkin's or nonHodgkin's lymphoma.
23	Lower extended field	The target zone includes lymph nodes below the diaphragm along the paraaortic chain. It may include extension to one side of the pelvis. This code includes the "hockey stick" field utilized to treat seminomas.
24	Spine	The primary target relates to the bones of the spine, including the sacrum. Spinal cord malignancies should be coded 40 (Spinal cord).
25	Skull	Treatment is directed at the bones of the skull. Any brain irradiation is a secondary consequence.
26	Ribs	Treatment is directed toward metastatic disease in one or more ribs. Fields may be tangential or direct.
27	Hip	The target includes the proximal femur for metastatic disease. In many cases there may be acetabular disease as well.
28	Pelvic bones	The target includes structures of the bones of the pelvis other than the hip or sacrum.
29	Pelvis (NOS)	Irradiation is directed at soft tissues within the pelvic region and codes 34–36 do not apply.
30	Skin	The primary malignancy originates in the skin and the skin is the primary target. So-called skin metastases are usually subcutaneous and should be coded 31 (Soft tissue).
31	Soft tissue	All treatment of primary or metastatic soft tissue malignancies not fitting other categories.
32	Hemibody	A single treatment volume encompassing either all structures above the diaphragm, or all structures below the diaphragm. This is almost always administered for palliation of widespread bone metastasis in patients with prostate or breast cancer.
33	Whole body	Entire body included in a single treatment.
34	Bladder and pelvis	The primary malignancy originated in the bladder, all or most of the pelvis is treated as part of the plan, typically with a boost to the bladder.
35	Prostate and pelvis	The primary malignancy originated in the prostate, all or most of the pelvis is treated as part of the plan, typically with a boost to the prostate.
36	Uterus and cervix	Treatment is confined to the uterus and cervix or vaginal cuff, usually by intracavitary or interstitial technique. If entire pelvis is included in a portion of the treatment, then code 29 (Pelvis, NOS).
37	Shoulder	Treatment is directed to the proximal humerus, scapula, clavicle, or other components of the shoulder complex. This is usually administered for control of symptoms for metastases.
38	Extremity bone, NOS	Bones of arms or legs. This excludes the proximal femur, code 27 (Hip) This excludes the proximal humerus, code 37 (Shoulder).
39	Inverted Y	Treatment has been given to a field that encompasses the paraaortic and bilateral inguinal or inguinofemoral lymph nodes in a single port.
40	Spinal cord	Treatment is directed at the spinal cord or its meninges.
41	Prostate	Treatment is directed at the prostate with or without the seminal vesicles, without regional lymph node treatment.

Code	Label	Definition
50	Thyroid	Treatment is directed at the thyroid gland.
60	Lymph node region, NOS	The target is a group of lymph nodes not listed above. Examples include isolated treatment of a cervical, supraclavicular, or inguinofemoral region.
98	Other	Radiation therapy administered, treatment volume other than those previously categorized.
99	Unknown	Radiation therapy administered, treatment volume unknown or not stated in patient record; it is unknown whether radiation therapy was administered. Death certificate only.

RAD – REGIONAL RX MODALITY **[REGIONAL TREATMENT MODALITY]**	Item Length: 2 NAACCR Item #1570 Source of Standard: CoC (Revised 09/04) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* p. 155-157)

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

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosis at autopsy.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt- 60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2–5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.
24	Photons (6–10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.
25	Photons (11–19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.

Code	Label	Definition
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, HDR	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
80*	Combination modality, specified*	Combination of external beam radiation and either radioactive implants or radioisotopes*
85*	Combination modality, NOS*	Combination of radiation treatment modalities not specified in code 80.*
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	Radiation therapy administered, treatment volume unknown or not stated in the patient record; it is unknown whether radiation therapy was administered. Death certificate only.

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

RAD – REGIONAL DOSE: CGY	Item Length: 5 NAACCR Item #1510 Source of Standard: CoC (Revised 01/04) Dx Yr Req by MCR: N/R

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

Instructions for Coding (See *FORDS Revised for 2004* p. 158)

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the dose as indicated in the summary chart. Determining the exact dose may be highly subjective and require assistance from the radiation oncologist for consistent coding.

- Regional dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the total dose of regional radiation therapy may require assistance from the radiation oncologist for consistent coding.

- Do not include the boost dose, if one was administered.

- Code 88888 when brachytherapy or radioisotopes—codes 50–62 for *Regional Treatment Modality* (NAACCR Item #1570)—were administered to the patient.

- Note that dose is still occasionally specified in "rads." One rad is equivalent to one centiGray (cGy).

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

RAD -- BOOST RX MODALITY [BOOST TREATMENT MODALITY]	Item Length: 2 NAACCR Item #3200 Source of Standard: CoC (Revised 01/04) Dx Yr Req by MCR: N/R

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

Instructions for Coding (See *FORDS Revised for 2004* pp. 159-161)

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

Code	Label Definition	
00	No boost treatment	A boost dose was not administered to the patient. Diagnosed at autopsy.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2–5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.
24	Photons (6–10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.
25	Photons (11–19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without	Treatment delivered using neutron beam.

Code	Label Definition	
	photons/electrons	
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, HDR	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered. Death certificate only.

RAD – BOOST DOSE CGY **[BOOST DOSE CGY]**	Item Length: 5 NAACCR Item #3210 Source of Standard: CoC (Revised 09/04) Dx Yr Req by MCR: N/R

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

Instructions for Coding (See *FORDS Revised for 2004* p. 162)

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the dose as indicated in the summary chart. Consult the radiation oncologist for the exact dose, if necessary.

- Radiation boost treatment dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the additional boost dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.

- Do not include the regional dose. In general, the boost dose will be calculated as the difference between the maximum prescribed dose and the regional dose. Many patients will not have a boost.

- Code 88888 when brachytherapy or radioisotopes—codes 50–62 for *Boost Treatment Modality* (NAACCR Item #3200)—were administered to the patient.

- Note that dose is still occasionally specified in "rads." One rad is equivalent to one centiGray (cGy).

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

RAD – NO OF TREATMENT VOL [NUMBER OF TREATMENTS TO THIS VOLUME]	Item Length: 2 NAACCR Item #1520 Source of Standard: CoC (Revised 09/04) Dx Yr Req by MCR: N/R

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

Instructions for Coding (See *FORDS Revised for 2004* p. 163)

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

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

Diagnosis Miscellaneous Data/Patient Status

PHYSICIAN – MANAGING (PREVIOUSLY ATTENDING)	Item Length: 6 NAACCR Item #2460 Source of Standard: NAACCR Dx Yr Req by MCR: All

Description: Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

Instructions for Coding (See *ROADS p. 77)**

- Record the identification code for the physician responsible for the management of the patient during diagnosis and/or treatment of this cancer.

- Do not change or update this field even if the patient subsequently receives care from another physician.

Use the 5-digit Maine license number, omitting the "M" or the "O" and leading 0 (zero) if applicable.

If registry software has a data field for license number in the physician database, enter the Maine license number in the above format in that field as well.

> ***Example:*** If Dr Smith's Maine license number is M009999, then use the code 09999 for his ID number and enter 09999 in the license number field.

License numbers for Maine physicians may be found on the following websites:

- For medical doctors, go to the Maine Board of Licensure in Medicine website @ www.docboard.org/me/df/mesearch.htm

- For doctors of osteopathy, go to the Maine Board of Osteopathic Licensure website @ www.docboard.org/me-osteo/df/index.htm

**Note: This data item is no longer supported by CoC.*

PHYSICIAN – REFERRING	Item Length: 6 NAACCR Item #N/A Source of Standard: MCR Dx Yr Req by MCR: All

Description: Code for the referring physician. Often this is the Primary Care Provider (PCP).

Instructions for Coding: (MCR defined data item)

- Record the identification code for the referring physician. This is often the patient's primary care provider (PCP).

Use the 5-digit Maine license number, omitting the "M" or the "O" and leading 0 (zero) if applicable.

If registry software has a data field for license number in the physician data base, enter the Maine license number in the above format in that field as well.

Example: If Dr Smith's Maine license number is M009999, then use the code 09999 for his ID number and enter 09999 in the license number field.

License numbers for Maine physicians may be found on the following websites:

- For medical doctors, go to the Maine Board of Licensure in Medicine website @ www.docboard.org/me/df/mesearch.htm
- For doctors of osteopathy, go to the Maine Board of Osteopathic Licensure website @ www.docboard.org/me-osteo/df/index.htm

CASE STATUS	Item Length: 1 NAACCR Item #N/A Source of Standard: Dx Yr Req by MCR: N/R

Description: Code that reflects the current status of this patient record

Instructions for Coding:

- Record the code that reflects the current status of this patient record
- Submit only cases coded/flagged as complete to the MCR.

Maine Cancer Registry Database Case Status Codes*	
S	Suspense case
I	Incomplete case
C	**Complete case** – The record was run through extended edit set and status may not be changed to any other case status
R	Reportable to State Only case
N	Not Reportable case - Hospital may opt to create a minimal abstract in order to document records that, upon review, do not meet MCR criteria for reportability. This can be an alternative to a "Non-reportable List"

*Consult your registry software provider for software specific definitions and coding instructions.

DATE OF LAST CONTACT OR DEATH [LAST FOLLOW UP]	Item Length: 8 NAACCR Item #1750 Source of Standard: SEER/CoC Dx Yr Req by MCR: 2001+

Description: *Records the date of last contact with the patient or the date of death*.

Instructions for Coding (See *FORDS Revised for 2004* p. 199)

- Record the last date on which the patient was known to be alive or the date of death.
- If a patient has multiple primaries, all records should have the same date of last contact.

VITAL STATUS

Item Length: 1
NAACCR Item #1760
Source of Standard: SEER/CoC
Dx Yr Req by MCR: 2001+

Description: Records the vital status of the patient as of the date entered in *Date of Last Contact or Death* (NAACCR Item #1750).

Instructions for Coding ((See *FORDS Revised for 2004* p. 199)

- This field is associated with the patient, not the cancer, so if a patient has multiple primaries, all records should have the same vital status.

Code	Label
0	Dead
1	Alive

Your registry software may not have a field to enter vital status. If there is no V*ital Status* field in your software, and the patient is known to have died, enter the date of death in the *Expiration Date* field. Vital status will be determined by the software based on whether or not a date of death is recorded.

CAUSE OF DEATH (If Available)

Item Length: 4
NAACCR Item #1910
Source of Standard: SEER
Dx Yr Req by MCR: 2001+

Description: *Official cause of death as coded from the death certificate in valid ICD-O-9 or ICD-O-10 codes.*

Instructions for Coding (See *ROADS p. 271 and *SEER Program Coding and Staging Manual* pp. 208-209)**

- Record the cause of death listed on the death certificate. Use the underlying cause of death (ICD code) identified by the state health department.
- If the patient has multiple primaries, the underlying cause of death must be identical on each record.
- Special codes in addition to ICD-O-9 and ICD-O-10 codes:

Code	Definition
0000	Patient alive at last contact
7777	State death certificate not available
7797	State death certificate available but underlying cause of death is not coded.

*Note: As of January 1, 2003, this data item is no longer supported by CoC.

ICD REVISION NUMBER	Item Length: 1 NAACCR Item #1920 Source of Standard: SEER Dx Yr Req by MCR: 2005+

Description: *Indicator for the coding scheme used to code the cause of death.*

Instructions for Coding (See *SEER Program Coding and Staging Manual 2004* p. 207*)*

- If Cause of Death (NAACCR Item #1910) is recorded, indicate the ICD revision used to code the underlying cause of death.
- If the patient has multiple primaries, the ICD Code Revision used for cause of death must be identical on each record.

Code	Definition
0	Patient alive at last follow-up
1	ICD-10
9	ICD-9

PLACE OF DEATH	Item Length: 3 NAACCR Item #1940 Source of Standard: NPCR Dx Yr Req by MCR: 2005+

Description: *Records the state or country where the patient died and where certificate of death is filed.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- Use the SEER Geocodes for "Place of Death." These codes include states of the United States as well as foreign countries.
- Use the most specific code.
- For SEER Geocodes, see Appendix ___ in this manual or the *SEER Program Coding and Staging Manual 2004,* Appendix B.

Codes in addition to geocodes

Code	Definition
997	Not applicable, patient alive
999	Place of death unknown

ADDRESS (NUMBER AND STREET) AT DIAGNOSIS	Item Length: 40 NAACCR Item #2330 Source of Standard: CoC Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* p. 42)

- Record the number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.

  Do not record Post Office Box in this field. See *Address-Supplemental.*

- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.

- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.

- If the street or physical address is not available, record unknown.

- If the patient has multiple tumors, the address may be different for subsequent primaries.

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

- See "Residency Rules" in *FORDS Revised for 2004* Section One pages 20-21 for further instructions.

ADDRESS- SUPPLEMENTAL AT DIAGNOSIS	Item Length: 40 NAACCR Item #2335 Source of Standard: CoC Dx Yr Req by MCR: 2005+

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

Instructions for Coding (See *FORDS Revised for 2004* p. 43)

- Record information about the patient's usual residence when the tumor was diagnosed that is either additional to street address, such as name of a place or facility (i.e., a nursing home or an apartment complex).

Record information other than a physical address (i.e., post office box).

- If this field is not needed, leave blank.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not update this data item if the patient's address changes.
- See "Residency Rules" in *FORDS Revised for 2004* Section One pages 20-21 for further instructions.

ADDRESS – CITY (OR TOWN) AT DIAGNOSIS	Item Length: 20 NAACCR Item #70 Source of Standard: CoC Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* p. 44)

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

> The name of the city or town must be spelled out completely. Do not use abbreviations, punctuation, special characters or numbers.
>
> ***Examples:*** Record Fort Kent not Ft. Kent; Mount Vernon not Mt. Vernon; Old Orchard Beach not OOB.

- If the patient has multiple malignancies, the city or town may be different for subsequent primaries.
- Do not update this data item if the patient's city/town of residence changes.
- See "Residency Rules" in *FORDS Revised for 2004* Section One pages 20-21 for further instructions.

ADDRESS – STATE AT DIAGNOSIS	Item Length: 2 NAACCR Item #80 Source of Standard: CoC Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* p. 45)

- Record the U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory in which the patient resides at the time the tumor is diagnosed and treated. See following page for common abbreviations.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
  - Record XX if the patient is a resident of a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country is known.
  - Record YY if the patient is a resident of a country other than the U.S. (including its territories, commonwealths or possessions) or Canada and the country is unknown.
- If the patient is a resident of the U.S., NOS (including its territories, commonwealths or possessions) or Canada, NOS; record ZZ.
- If the patient has multiple tumors, the state of residence may be different for subsequent primaries
- Do not update this data item if the patient's state of residence changes.

Abbreviations for US States

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

The following are abbreviations for Canadian provinces or territories:

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

ADDRESS POSTAL CODE AT DIAGNOSIS [ZIP CODE]	Item Length: 9 NAACCR Item #100 Source of Standard: CoC (Revised 01/04) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* p. 47)

- For U.S. residents, record the patient's nine-digit extended postal code at the time of diagnosis and treatment.

> See Appendix C for a listing of Maine cities and towns with corresponding county and zip codes.

- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple malignancies, the postal code may be different for subsequent primaries.
- Do not update this data item if the patient's postal code changes.
- See "Residency Rules" in *FORDS Revised for 2004* Section One pages 20-21 for further instructions.

COUNTY AT DIAGNOSIS	Item Length: 3 NAACCR Item #90 Source of Standard: FIPS/SEER (Revised 01/04) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2004* p. 48)

- For Maine residents, use the codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas* (See table below).

  See Appendix C for a listing of Maine cities and towns with corresponding county and zip codes.

- Codes in addition to FIPS and geocodes:
  - 998: Patient is a resident outside of Maine.
  - 999: Patient is a resident of Maine, but county is unknown.
- If the patient is a non-U.S. resident and XX is coded in *Current State of Residence* (NAACCR Item #1820), then code the patient's country of residence in this field.
  - For country codes, see Appendix D of this manual.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- Do not update this data item if the patient's county of residence changes.
- If the patient is a non-U.S. resident and XX is coded in *State at Diagnosis* (NAACCR Item #80), then code the patient's country of residence in this space.

Code	County Name	Code	County Name
001	Androscoggin	017	Oxford
003	Aroostook	019	Pennobscot
005	Cumberland	021	Piscataquis
007	Franklin	023	Sagadahoc
009	Hancock	025	Somerset
011	Kennebec	027	Waldo
013	Knox	029	Washington
015	Lincoln	031	York

Diagnosis Case Administration

REPORTING HOSPITAL [FACILITY IDENTIFICATION NUMBER (FIN)]	Item Length: 10 NAACCR Item #540 Source of Standard: CoC Dx Yr Req by MCR: 2005+

Description: *Identifies the facility reporting the case. Each Facility Identification number (FIN) is unique. The number is used to identify a reporting facility in the central registry database and is useful in monitoring data submissions. The codes for this data item are assigned by the CoC.*

Instructions for Coding (See *FORDS Revised for 2004* p. 208)

- For facilities with seven-digit FINs in the range of 6020009-6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros follwed by the full seven-digit number.

- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros follwed by the full eight-digit number.

> Facility Identification Number (FIN) will be autocoded by your registry software if it has been recorded as a default on the Hospital Defaults Screen (MRS users) or in your utilities program under Global Parameters then Global Tab 1 (Precis users). Consult your software provided for more information.

Note: *The CoC maintains the codes, including those for non-hospital sources of reporting. A complete list of FINs is available on the American College of Surgeons website at* ***http://www.facs.org/***

RX CODING SYSTEM—CURRENT

Item Length: 2
NAACCR Item #1460
Source of Standard: NAACCR
Dx Yr Req by MCR: All

Description: *Describes how treatment for this case is now coded. This information is used for some data analysis and for further item conversions.*

Instructions for Coding (See *FORDS Revised for 2004* p. 235)

- This item is autocoded by the software provider.
- The *FORDS* manual **must** be used to record treatment for all cases diagnosed January 1, 2003, or later and this item **must** be coded 06.

Code	Definition
00	Treatment data not coded/transmitted, ie, all treatment fields blank.
01	Treatment data coded using 1-digit surgery codes.
02	Treatment data coded according to 1983–1992 SEER manuals and CoC manuals 1983–1995.
03	Treatment data coded according to 1996 ROADS manual.
04	Treatment data coded according to 1998 ROADS supplement.
05	Treatment data coded according to 1998 SEER manual.
06	**Treatment data coded according to FORDS.**
99	Other coding, including partial or nonstandard coding.

CS VERSION FIRST	Item Length: 6 NAACCR Item #2935 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

Description: *This item indicates the number of the version initially used to code Collaborative Staging (CS) fields. The CS version number is returned as part of the output of the CS algorithm. It is a 6 digit number. The first two digits represent the major version number; the second two represent the minor version changes; and the last two digits represent even less significant changes, such as corrections of typographic errors that do not affect coding or derivation results.*

Instructions for Coding: (See *FORDS Revised for 2004* p. 235D)

- This item is autocoded by the software provider.

CS VERSION LATEST	Item Length: 6 NAACCR Item #2936 Source of Standard: AJCC Dx Yr Req by MCR: 2004+

Description: *This item indicates the Collaborative Staging (CS) version used most recently to derive the CS output fields. The CS version number is returned as part of the output of the CS algorithm. It is a 6 digit number. The first two digits represent the major version number; the second two represent the minor version changes; and the last two digits represent even less significant changes, such as corrections of typographic errors that do not affect coding or derivation results.*

Instructions for Coding: (See *FORDS Revised for 2004* p. 235E)

- This item is autocoded by the software provider.
- *CS Version Latest* is recorded the first time the CS output fields are derived and should be updated each time the CS Derived fields are re-computed.
- This item should not be blank if the CS Derived items contain stored values.
- This item should be blank if the CS Derived items are empty or the CS algorithm has not been applied.

Edit Overrides

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

When no error message is generated by an edit that uses an override item, no action by the registrar is needed.

If an error message is generated, the problem can often be resolved by checking the accuracy of the entry for each item that contributes to the edit and correcting any problem identified. If correction of data entry errors resolves the problem, no override entry is needed. If the codes reflect the information in the patient record, check for physician notes indicating the unusual combination of circumstances (for example, a colon adenocarcinoma in a child) has been confirmed.

Enter the override code according to the instructions for the data item. If no comment regarding the unusual circumstances can be found in the record, it may be necessary to check with the managing physician or pathologist to determine whether it is appropriate to override the edit.

See *FORDS Revised for 2004* pages 210-221 for instructions in the use of the CoC edits.

Always document the justification for setting an override flag in the "Remarks" text field.

Text Fields

General Guidelines

(1) All text fields are required when the information is available. The **"Primary Site Title"** and **"Histology Title"** text fields must ALWAYS be completed with the terms you used to determine the codes you selected*. If these two text fields are not completed, the data submission will be rejected by the MCR.

(2) Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control at the MCR. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High quality text documentation facilitates consolidation of information from multiple reporting sources and to resolve both intra- and inter-record edits.

(3) If there is no information available to complete a text field (other than Site and Histology), please leave blank or empty. It is not necessary to enter "unknown"

(4) Use text fields to justify coded data items in the abstract. After manual entry of a text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the record.

(5) Do not report non-cancer related information such as psychiatric status or social issues to the MCR. If you need to record these for your institution, check with your software provider for your confidential text field.

(6) DO NOT REPORT HIV/AIDS STATUS to the MCR, even if related to cancer.

(7) Do not send messages to the MCR in these fields (such as "please confirm stage"); these fields are not routinely 100 % reviewed. If you want something checked by MCR staff, send a note along with the data submission.

(8) When in doubt, call the MCR staff person assigned to your hospital for assistance.

Remember: The text should justify the code(s) and not vise versa.

TEXT – DX PROC – PE	Item Length: 200 NAACCR Item #2520 Source of Standard: NPCR Dx Yr Req by MCR: All

Description: *Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- Record relevant positive and negative clinical findings.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include disease related findings on physical exam and/or presenting symptoms; information regarding estimated date of diagnosis and method of diagnosis.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT – DX PROC – XRAY/SCAN	Item Length: 250 NAACCR Item #2530 Source of Standard: NPCR Dx Yr Req by MCR: All

Description: *Text area for manual documentation from all x-rays, scans and/or other imaging examinations that provide information about staging.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- Record relevant positive and negative finding on radiographic or other imaging studies.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include disease related findings on imaging examinations, including x-rays, mammograms, ultrasounds, CT scans, MRIs, PET scans, etc. Include the date the study was performed.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT – DX PROC – SCOPES	Item Length: 250 NAACCR Item #2540 Source of Standard: NPCR Dx Yr Req by MCR: All

Description: *Text area for manual documentation from endoscopic examinations that provide information about staging and treatment.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- Record relevant positive and negative endoscopic findings.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include disease related findings on endoscopic examinations including colonoscopy, esophagogastroduodenoscopy (EGD), laryngoscopy, bronchoscopy, endoscopic retrograde cholangiopancreatography (ERCP), etc. Include the date the study was performed.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT – DX PROC – LAB TESTS	Item Length: 250 NAACCR Item #2550 Source of Standard: NPCR Dx Yr Req by MCR: All

Description: *Text area for manual documentation from laboratory examinations other than cytology or histopathology.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- Record relevant positive and negative laboratory findings.
- NAACCR-approved abbreviations should be utilized (See Appendix __ in this manual).
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include disease related findings on clinical laboratory tests including, but limited to, tumor markers, serum and urine electrophoresis, special studies, etc.

- **Colorectal Cancer: Carcinoembryonic Antigen (CEA)**
- **Breast Cancer:Estrogen Receptor Assay (ERA); Progesterone Receptor Assay (PRA); Her/2-neu**
- **Ovarian Cancer: Carbohydrate Antigen (CA-125)**
- **Prostate Cancer: Prostatic Specific Antigen (PSA)**
- **Testicular Cancer: Human Chorionic Gonadotropin (hCG); Alpha Fetaprotein (AFP); Lactate Dehydrogenase (LDH)**

- **Do not include information that the MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT – DX PROC – OP

Item Length: 250
NAACCR Item #2560
Source of Standard: NPCR
Dx Yr Req by MCR: All

Description: *Text area for manual documentation of all surgical procedures/findings that provide information for staging.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- Record relevant positive and negative surgical findings.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include dates and descriptions of biopsies and other surgical procedures from which staging information was derived. Record disease related findings on operative notes that will not be recorded elsewhere in text fields, such as local/regional spread, residual tumor and nodal assessment.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT – DX PROC – PATH	Item Length: 250 NAACCR Item #2570 Source of Standard: NPCR Dx Yr Req by MCR: All

Description: *Text area for manual documentation of information from cytology and histopathology reports.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- Record relevant positive and negative pathologic findings.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include dates and types of procedures; types of tissue specimens; pathology accession numbers; tumor type and grade (include modifying adjectives such as predominantly, with features of, with foci of, etc); gross tumor size; extent of tumor spread; status of surgical margins; number of lymph nodes involved and examined; any relevant additional comments from the pathologist.

Example 1 : 06/15/05 Sigmoid resection (S05-9999999) 4.5cm adenocarcinoma with mucinous features invades subserosal tissue; margins clear; 0/10 regional lymph nodes.

Example 2: 6/15/05 Lumpectomy L Breast (s05-888888) 1.5cm infiltrating ductal carcinoma cribriform type; margins clear

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT – PRIMARY SITE TITLE

Item Length: 40
NAACCR Item #2580
Source of Standard: NPCR
Dx Yr Req by MCR: All

Description: *Text area for manual documentation of information regarding the primary site and laterality of the tumor.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.

- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.

Suggestions for text: Include the most specific information available on the location of the primary site of the tumor and available information on tumor laterality for pair sites.

Example 1: Right Breast UOQ
Example 2: Lung LUL

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

THIS FIELD MUST BE COMPLETED FOR ALL RECORDS SUBMITTED TO MCR.

TEXT – HISTOLOGY TITLE

Item Length: 40
NAACCR Item #2590
Source of Standard: NPCR
Dx Yr Req by MCR: All

Description: *Text area for manual documentation of information regarding the histologic type (morphology), behavior, and grade (differentiation) of the tumor being reported.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Do not include irrelevant information.

Suggestions for text: Include information on histologic type (morphology) and behavior, as well as, information on differentiation/grade from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc. See Data Item #440 Grade/differentiation for grading terminology conversion tables.

Example 1: Mod Diff Adenoca in a Tubulovillous Adenoma
Exampe 2: Adenocarcinoma Gleason 3+4=7
Example 3: Papillary Urothelial Ca Grade II of III

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

THIS FIELD MUST BE COMPLETED FOR ALL RECORDS SUBMITTED TO MCR.

TEXT – STAGING	Item Length: 300 NAACCR Item #2600 Source of Standard: NPCR Dx Yr Req by MCR: All

Description: *Additional text area for manual documentation of staging information.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Provide a narrative description to justify the coded staging values for this tumor. Include tumor size and/or extension (T status); presence or absence of nodal involvement (N status); presence or absence of distant metastasis (M status) including the distant sites involved. Do not simply repeat the coded TNM or General Summary Stage values.

Remember: Every tumor is eligible for General Summary Staging even if it is not eligible for AJCC (TNM) staging. Describe the extent of disease whether AJCC staging is applicable or not.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT – SURGERY	Item Length: 150 NAACCR Item #2610 Source of Standard: NPCR Dx Yr Req by MCR: All

Description: *Text area for manual documentation of information regarding all surgical procedures performed as part of treatment.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include date and description/type of each surgical procedure; the facility where each procedure was performed; the name of the physician who performed each procedure. If multiple procedures were performed, all procedures should be documented.

Example 1: **6/15/05 Colonoscopy w/ Biopsy @ Hospital Name (Physician)**
7/15/05 Sigmoid Resection @ hospital name (Physician)

Example 2: **6/15/05 Stereotactic Biopsy Left Breast @ Hospital Name (Physician)**

7/15/05 Lumpectomy L Breast w/ SLN and Axillary Dissection @ Hospital Name (Physician)

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT – RADIATION (BEAM)	Item Length: 150 NAACCR Item #2620 Source of Standard: NPCR Dx Yr Req by MCR: 2005+

Description: *Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include dates when radiation treatment started and ended; site(s) irradiated; tumor dose(s); type(s) of beam radiation (e.g., Orthovoltage, Cobalt 60, MV x-rays, Electrons, Mixed modalities); facility where treatment was given.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT – RADIATION (OTHER)

Item Length: 150
NAACCR Item #2630
Source of Standard: NPCR
Dx Yr Req by MCR: 2005+

Description: *Text area for manual documentation of information regarding treatment of tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include date treatment was started; site(s) irradiated; type(s) of non-beam radiation (e.g., high dose rate brachytherapy, seed implant, radioisotopes such as I-131); facility where treatment was given.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT – CHEMO	Item Length: 200 NAACCR Item #2640 Source of Standard: NPCR Dx Yr Req by MCR: 2005+

Description: *Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include date when chemotherapy was started; type of chemotherapy (e.g., name of agent(s) or protocol); facility where treatment was given.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT – HORMONE	Item Length: 200 NAACCR Item #2650 Source of Standard: NPCR Dx Yr Req by MCR: 2005+

Description: *Text area for manual documentation of information about hormonal cancer-directed treatment.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include date treatment was started; type of hormone or antihormone (e.g., Tamoxifen); type of endocrine surgery or radiation (e.g., bilateral orchiectomy); and the facility where treatment was given.

Note: **Until 2003 bilateral orchiectomies, other endocrine surgeries and radiation treatments that were performed for hormonal manipulation were coded as "*Hormone Therapy*". With *FORDS*, these therapies were reclassified as "*Hematologic Transplant and /or Endocrine Procedures*".**
A text field does not exist for this treatment modality; therefore, continue to document these therapies in the "*Hormone*" text field until the new text field is added to the data set.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT – BRM [IMMUNOTHERAPY]	Item Length: 100 NAACCR Item #2660 Source of Standard: NPCR Dx Yr Req by MCR: 2005+

Description: *Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include date treatment was started; type of BRM agent (e.g., Interferon, BCG); BRM procedures (e.g., bone marrow transplant, stem cell transplant); and the facility where treatment was given.

Note: **Until 2003 bone marrow transplants and stem cell harvest & infusions were coded as "*Biological Response Modifiers*" ("*Immunotherapy*"). With *FORDS*, these therapies were reclassified as "*Hematologic Transplant and /or Endocrine Procedures*".**
A text field does not exist for this treatment modality; therefore, continue to document these therapies in the "*BRM*" text field until the new text field is added to the data set.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

RX TEXT – OTHER	Item Length: 100 NAACCR Item #2670 Source of Standard: NPCR Dx Yr Req by MCR: 2005+

Description: *Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include the date treatment was started; type of other treatment (e.g., blinded clinical trial, hyperthemia); facility where the treatment was given.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT – REMARKS

Item Length: 350
NAACCR Item #2680
Source of Standard: NPCR
Dx Yr Req by MCR: 2005+

Description: *Text area for manual documentation of information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data from other text fields can also be placed here. Problematic coding issues can also be discussed in this section.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include information on cancer history if a person was previously diagnosed with another reportable tumor; information regarding synchronous tumors; justification of over-ride flags; any relevant information not documented in another text field.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

TEXT—USUAL OCCUPATION (if available) **[LONGEST OCCUPATION]**	Item Length: 40* NAACCR Item #310 Source of Standard: NPCR Dx Yr Req by MCR: All

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

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do not record "retired". If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation.
- If the patient was a homemaker and also worked outside the home during most of his/her adult life, record the usual occupation outside the home; if the patient was a homemaker and did not work outside the home for most of his/her adult life, record "homemaker."
- If the patient was not a student or homemaker and never worked, record "never worked" as the usual occupation.
- This data item is collected only for patients who are age 14 or older at the time of diagnosis.
- If no information is available, record "unknown."

> ***Note:*** Some registry software programs have an additional text field for *Longest Occupation.* The length of this field is 16 characters.

TEXT—USUAL INDUSTRY (if available) **[LONGEST INDUSTRY]**	Item Length: 40* NAACCR Item #320 Source of Standard: NPCR Dx Yr Req by MCR: All

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

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- Record the primary type of activity carried out by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail" and service components of any industry that performs more than one of these components.

- The information should be based upon the information about occupation; therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry.

- If the patient was a homemaker and did not work outside the home for most of his/her adult life, record "own home" as usual industry.

- If the patient was not a student or homemaker and had never worked outside the home record "never worked" as the usual industry.

- This data item is collected only for patients who are age 14 or older at the time of diagnosis.

- If no information is available regarding the industry in which the reported occupation was carried out, record "unknown."

Note: Some registry software programs have an additional text field for *Longest Industry*. The length of this field is 16 characters.

PLACE OF DIAGNOSIS	Item Length: 50 NAACCR Item #2690 Source of Standard: NPCR Dx Yr Req by MCR: 2005+

Description: *Text area for manual documentation of the facility, physician office, city, state or county where the diagnosis was made.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vise versa.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include the complete name of the hospital or physician office where the diagnosis occurred. For out-of-state residents and facilities, include the city and state where the medical facility is located.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**