Arizona Cancer Registry Coding Handbook
Includes:
Commission on Cancer
FORDS
Facility Oncology Registry Data Standards
Revised for 2011
and the
Arizona Cancer Registry Supplement
Effective for Cases Diagnosed January 1, 2011

ARIZONA CANCER REGISTRY SUPPLEMENT
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OFFICE OF HEALTH REGISTRIES
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Leadership for a Healthy Arizona

Arizona Department of Health Services

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Commission on Cancer

A multidisciplinary program of the American College of Surgeons

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Chair

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Medical Director

The Arizona Cancer Registry wishes to thank the Commission on Cancer for allowing the ACR to use and distribute an electronic version of the FORDS. All ACR pages are clearly marked with ACR Supplement in the top header and all ACR notations on CoC pages are in text boxes and in a blue font. Bookmarks added by ACR are also in a blue font. Questions about the content may be directed to the Arizona Cancer Registry at 602-542-7320.

January 20, 2011

Dear Georgia and the Arizona Registry Community:

I am pleased to give you permission to use **FORDS: Revised for 2011** for your registries. We ask that the entire manual be reproduced in full. We understand that you will add easily distinguishable notations to indicate Arizona's state specifications.

The National Cancer Data Base endeavors to make clear within the definitions of its items when they may apply only to particular diagnosis years. Therefore, we are recommending that registries can begin using this manual for all diagnosis years. There are many clarifications built in. Check the *Preface* and *Appendix C* for the changes since **FORDS: Revised for 2010**.

Sincerely,

Jerri Linn Phillips, M.A., C.T.R.
National Cancer Data Base

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FORDS

FACILITY
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FORDS

Facility Oncology Registry Data Standards Revised for 2011

(Incorporates all updates since FORDS was originally published in July 2002)

Includes updates to January 1, 2011

See Appendix C for a summary of changes.

Commission on Cancer

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Source for data items with a NAACCR # and Abbreviations Listing: Thornton M, (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

Source for SEER clarifications, County Codes, Geocodes: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

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Preface 2011

Facility Oncology Data Standards (FORDS): Revised for 2011 introduces relatively few major changes in comparison to **FORDS: Revised for 2010**.

Data items no longer required by the Commission on Cancer (CoC). Eight data items previously required by the Commission on Cancer (CoC) have been removed from **FORDS: Revised for 2011** and are not required to be coded by CoC accredited programs for cases diagnosed in 2011 or later. These items may be required by the facility's state or central registry, by the Cancer Program, or for registry software function, so registries will want to check with them before discontinuing coding them. *Military Record Number Suffix* (NAACCR Item #2310) is used only for military record-keeping, and will no longer be required by CoC. *Following Physician* (NAACCR Item #2470), *Primary Surgeon* (NAACCR Item #2480), *Physician # 3* (NAACCR Item #2490) and *Physician # 4* (NAACCR Item #2500) are no longer required, but the NPI numbers designating these physicians still are required. Similarly, *Facility Referred From* (NAACCR Item #2410), *Facility Referred To* (NAACCR Item #2420), and *Following Registry* (NAACCR Item # 2440) are no longer required, but the NPI numbers for those facilities still are required. Note that both *Facility Identification Number* (FIN, NAACCR Item #540) and *Archive FIN* (NAACCR Item #3100) are needed by CoC; those items and the applicable facility NPI numbers are required.

New site-specific factor requirements for Collaborative Stage. Seven new Collaborative Stage (CS) site-specific factors (SSF) affecting four CS schema are required. CS version 02.03.xx is required for coding CS cases diagnosed in 2011. That version introduced one new schema (MyelomaPlasmaCell Disorder) for which the Durie-Salmon Staging System value (SSF 2) and Multiple Myeloma Terminology (SSF 3) is required. The Tumor Growth Pattern (SSF 10) is now used in some derivations for the schema BileDuctsIntraHepat, so it is required. The HER2 Summary Result of Testing for the Breast schema is now required to be coded. Finally, for the Testis schema three post-orchiectomy range specifications are required: Alpha Fetoprotein (AFP) Range (SSF 13), Human Chorionic Gonadotropin (hCG) Range (SSF 15), and Lactate Dehydrogenase (LDH) Range (SSF 16). Many histology ranges and a few site codes for the SSF 1-25 items have been corrected in **FORDS: Revised for 2011**. The schema names and SSF item names were not affected by those corrections.

ICD-10-CM. The list of reportable *Comorbidities and Complications (Secondary Diagnoses) 1-10* (NAACCR Item #3120-3164) codes now includes the ICD-10-CM codes as well as the codes for ICD-9-CM, in anticipation of the requirement that hospitals in the United States convert to ICD-10-CM for billing by 2012. Please do not mix ICD-9-CM and ICD-10-CM codes for a single case in these items. It will be important to code *ICD Revision Comorbidities and Complications* (NAACCR Item #3165) correctly to indicate which ICD-CM version is in use.

New site-specific primary site surgery code for breast. A new code 76 (Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma) has been added. It may be used for pre-2011 diagnoses if desired.

Code correction. The correct abbreviation for a Canadian residence when the specific province is unknown is "CD". This correction was made for *State at Diagnosis* (NAACCR Item #80) and *State-Current* (NAACCR Item #1820).

References to original sources. Detailed coding instructions for eleven items have been removed from **FORDS: Revised for 2011**, and registries are referred to the source manuals for specific instructions. Registries are now referred to the current Collaborative Stage manual to code *Grade Path System* (NAACCR Item #449), *Grade Path Value* (NAACCR Item #441) and *Lymph-Vascular Invasion* (NAACCR Item #1182). Similarly, *Ambiguous Terminology at Diagnosis* (NAACCR Item # 442), *Date of Conclusive Diagnosis* (NAACCR Item #442), *Date Conclusive DX Flag* (NAACCR Item #448), *Date of Multiple Tumors* (NAACCR Item #445), *Date of Mult Tumors Flag* (NAACCR Item #439), *Type of Multiple Tumors Reported as One Primary* (NAACCR Item #444) and *Multiplicity Counter* (NAACCR Item #446) should be coded according to the instructions in the most recent version of the Multiple Primary and Histology coding rules.

Revisions to the list of items that must be coded to mark a case "complete". Appendix D has been modified to make clear that *Class of Case* 00 and 20-22 cases must have *either* an institution (*NPI-Inst Referred To* or *NPI-Inst Referred From*, depending on the *Class of Case*) *or* a physician (*NPI-Primary Surgeon, NPI-Physician # 3, NPI-Physician # 4*) coded. More than one may be coded, if applicable.

Many other modifications were made for clarification. Appendix C lists all changes other than modest spelling and style changes made in **FORDS: Revised for 2011**. Note that the modifications result in pagination changes, so communications about **FORDS** content should refer to the Section One heading or the item definition in which the information is found rather than to page numbers.

Preface 2010

The *Facility Oncology Registry Data Standards (FORDS)* manual provides definitions and detailed instructions for coding patient diagnosis, treatment, and outcomes. The manual also describes the types of cases that must be abstracted and followed and explains the relationships among data items. Registry data maintained with standardized quality control mechanisms support meaningful evaluation and analysis.

FORDS: Revised for 2010

Following the initial release of *FORDS* in July 2002, the manual has undergone a series of modifications and revisions. In order to avoid the need to implement major changes in data annually, the registry community has agreed to the adoption of major changes once every three or four years. *FORDS: Revised for 2010* is to be supplemented by the *AJCC Cancer Staging Manual (7th Edition*), the *Collaborative Stage (CS) Data Collection System (Version 2*), and the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* that will be implemented in 2010. *The 2007 Multiple Primary and Histology Coding Rules* will also be required. Implementation of *FORDS: Revised for 2010* is required of all Commission on Cancer (CoC)-approved cancer programs starting with cases diagnosed on January 1, 2010.

In 2010, the format used to transmit dates from hospitals to central registries or NCDB has been modified for interoperability with nonregistry data systems. *FORDS: Revised for 2010* describes the changes. Depending on registry software, these changes may be transparent to registrars. New date flags have been introduced for use when a valid, known date is not entered; those flags are described in this manual.

Some additional new items are incorporated in *FORDS: Revised for 2010*.

- *Date Case Completed – CoC* is inserted automatically by the registry software when data that should be available to the registry following the patient's main contact with the facility has been successfully abstracted, based on *Class of Case*. All items in *FORDS: Revised for2010* are required; it is understood that some information may become available after this date.

- *RX Summ–Treatment Status* provides a simple, summary indicator of whether the patient received any treatment from any facility, is managed by active surveillance (watchful waiting), or is untreated.

- *RX Hosp–Surg App 2010* indicates whether the patient's principle surgery at the facility was open, closed, robotic assisted, or converted from closed or robotic assisted to open.

- *Grade Path System* and *Grade Path Value* were added to *FORDS: Revised for 2010* at the request of AJCC to record the original pathologist's designation of a 2, 3 or 4-grade system and its value. They supplement, and do not replace, the item *Grade/Differentiation.*

- *Lymph-vascular Invasion* was also added at the request of AJCC. It records pathologic evidence of the presence or absence of cancer cells in the lymphatic ducts or blood vessels of the primary tumor.

- Some new CS items have been added. *CS Mets at DX–Bone, CS Mets at DX–Brain, CS Mets at DX–Liver*, and *CS Mets at DX–Lung* record metastases to those sites evident at initial diagnosis. The possible

number of site-specific factors (SSF) for CS schema has been increased from six to 25. Not all are used by CS, and not all are required to be coded by CoC. The software-assigned codes for tracking CS version also have been modified and one additional item has been added.

Some modified codes are also introduced in *FORDS: Revised for 2010*.

- *Clinical Stage (Prefix/Suffix) Descriptor* was clarified in the Februrary 2010 update. In the past, its codes indicated that code 4 (corresponding to "y") is not applicable for clinical stage. Code 4 now no longer is included in the definitions for clinical stage.

- *Class of Case* has been rewritten in response to requests from registrars. The new two-digit codes offer more flexibility for recording diagnosis and treatment by the facility as distinct from diagnosis and treatment performed by a staff physician, and for distinguishing between all or part of first course treatment at the facility. It also has more specificity for recording non-analytic cases, and will handle some situations that previously were not well-handled by any *Class of Case* code. *Class of Case* should be converted automatically to the new codes when registry software for 2010 is implemented.

- *Method of Diagnostic Confirmation* was modified to reflect differences in diagnostic methods used for hematopoietic and lymphoid tumors as compared to solid tumors, and a new code 3 was added.

- *Laterality* now has a specific code (5) for use when the tumor arises from the midline of a paired site. The rules now permit coding non-paired sites to right or left when applicable.

- *Race* codes 1-6 were modified. Code 09 (Asian Indian or Pakistani) has been converted to 15, to avoid accidental use of the code 09 for "unknown". New codes 16 and 17 are now available to differentiate between Asian Indian and Pakistani. The new codes may be used for pre-2010 cases.

- *Surgical Procedure of the Primary Site* for brain was modified to add more specificity for resection of brain tumors. The new codes may be used for pre-2010 cases.

- The radiation item, *Number of Treatments to This Volume*, has been extended from two to three digits, to handle some of the high numbers of treatments given in split fractions.

- Pathologic and clinical AJCC T, N, M and stage group codes have been expanded from two to four digits, so that it is possible to code the longer codes as defined in the *AJCC Manual for Staging*. These items are entered as left-justified, always capitalizing the alphabetic components. The new, longer codes may be used for pre-2010 cases where applicable.

- CS expanded the storage codes for *CS Extension* and *CS Lymph Nodes* from two to three digits to avoid changing the meaning of the original codes. These storage codes are generally invisible to registrars.

Treatment dates for chemotherapy, hormone therapy and immunotherapy are re-introduced for use in 2010. They were discontinued in 2003, but are necessary to evaluate adherence to recommended treatment practices. Many registries continued to collect them after 2003. For registries that did not collect them, those dates may be blank for cases diagnosed from 2003 through 2009.

Some modifications in coding instructions were also made.

- *Section I* instructions for assigning *Date of First Contact* now clarify that the first contact date for analytic cases is the date the case become analytic. For nonanalytic cases, it is the date the case becomes assignable to the respective *Class of Case*. Additional clarification has been added for determining when *Date of First Contact* should be changed if *Class of Case* changes.

- *Section I* has new language distinguishing among treatment, palliative and prophylactic care.

- If the *Date of Initial Diagnosis* is entirely unknown, the rules now require that the year portion be estimated. Because of this rule change, *Date of Diagnosis Flag* was removed from the CoC required items in the February 2010 update.

- The instructions for *Surgical Procedure of the Primary Site* for bladder were modified to clarify the coding of surgical procedures used for men and women with bladder cancer.

- The definitions of codes 0 and 9 for *Radiation/Surgery Sequence* and *Systemic/Surgery Sequence* have been changed for consistency with SEER. For cases diagnosed in 2010 or later, use code 0 (not 9) if it is unknown whether the patient was treated with either surgery or systemic therapy. This change in coding instructions applies only to cases diagnosed in 2010 or later.

- New codes were added to five administrative items to reflect changes in coding versions. *Morphology Coding System–Original* and *Morphology Coding System–Current* have new codes 8 because, beginning with 2010 diagnoses, some new hematopoietic histology codes will be used. TNM Edition Number has a new code 07 to represent use of the *AJCC Cancer Staging Manual*, 7th edition. *Race Coding System–Original* and *Race Coding System–Current* have a code 7 added to reflect the changes in race codes.

The February 2010 updates include changes in histologic specifications for all site-specific primary site surgery codes and for several other items for consistency with the new hematopoietic and lymphoid coding rules. See Appendix C for the changes.

Additional Coding References

The following references are required to code some items. Coding instructions for items from these sources are not reproduced in *FORDS: Revised for 2010* in order to avoid redundancy and possible conflict when the primary manuals are updated. For each, use the most current version applicable for the diagnosis year.

Fritz A, Percy C, Jack A, et al (eds). *ICD-O: International Classification of Diseases for Oncology*, 3rd ed. Geneva, World Health Organization: 2000.

Edge S, Byrd D, Compton C, et al (eds): *AJCC Cancer Staging Manual*, 7th ed. American Joint Committee on Cancer, Chicago IL. Springer: 2009.

Collaborative Stage Data Collection System, Version 2. Available at *http://cancerstaging.org/cstage/manuals.html* .

Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB). Available at

http://seer.cancer.gov/registrars/. (Note: these coding procedures require use of a small number of histology codes not published in *ICD-O-3* above).

Johnson CH, Peace S, Adamo P, et al. *The 2007 Multiple Primary and Histology Coding Rules.* National Cancer Institute, Surveillance, Epidemiology and End Results Program. Bethesda, MD: 2007. Available for download at *http://seer.cancer.gov/registrars/*.

*SEER*Rx – Interactive Drug Database*. National Cancer Institute, Surveillance, Epidemiology and End Results Program, Bethesda MD. Available for download at *http://seer.cancer.gov/registrars/*.

The following references may also be useful.

NAACCR Inc. 2010 Implementation Guidelines and Recommendations. North American Association of Central Cancer Registries. Available at *http://www.naaccr.org/index.asp?Col_SectionKey=7&Col_ContentID=431*
Thornton M, O'Conner L (eds). *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary*, 14th ed. North American Association of Central Cancer Registries, Springfieldfield IL: 2009. Available at *http://www.naaccr.org/index.asp?Col_SectionKey=7&Col_ContentID=133*.

SEER Program Coding and Staging Manual (http://seer.cancer.gov/tools/codingmanuals/index.html).

An interactive tool that incorporates many of the references above is provided free by Registry Plus. The *Registry Plus Online Help* application has full copies of the FORDS, Collaborative Stage, and Multiple Primary and Histology Coding manuals as well as the NAACCR Data Dictionary, the SEER Coding Manual, and the introduction and histology sections of ICD-O-3. It also describes all standard edits with links to the item definitions they use and explanations for interpreting them. *Registry Plus Online Help* is available at *http://www.cdc.gov/cancer/npcr*. Select "Registry Plus" under Tools; select "Online Help" under Registry Plus Components; then select "Technical Information and Installation." Follow the instructions to download and install. Because of the many coding changes planned for implementation in 2010, the version with 2010 documentation may not be available until mid-year in 2010.

SECTION ONE:

Case Eligibility and Overview of Coding Principles

CASE ELIGIBILITY CLARIFICATIONS

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

INSTRUCTIONS FOR SOLID TUMORS

Note: For hematopoietic and lymphoid neoplasms, see the Reportability Instructions in the *2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database*.

CASES DIAGNOSED CLINICALLY ARE REPORTABLE

In the absence of histologic or cytologic confirmation of a reportable cancer, accession a case based on the clinical diagnosis (when a recognized practitioner says the patient has a cancer or carcinoma). A clinical diagnosis may be recorded in the final diagnosis on the face sheet or other parts of the medical record.

Note: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a negative biopsy, the case would not be reported.

Exception 1: If the physician treats a patient for cancer in spite of the negative biopsy, accession the case.

Exception 2: If enough time has passed that it is reasonable to assume that the physician has seen the negative pathology, but the clinician continues to call this a reportable disease, accession the case. A reasonable amount of time would be equal to or greater than 6 months.

Brain or CNS "Neoplasms"

A brain or a CNS 'neoplasm' identified by diagnostic imaging is reportable even when no other information is available (from biopsy or resection, for example).

AMBIGUOUS TERMINOLOGY

Ambiguous terminology may originate in any source document, such as a pathology report, radiology report, or clinical report.

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

HOW TO USE AMBIGUOUS TERMINOLOGY FOR CASE ASCERTAINMENT

1. In Situ and Invasive (Behavior codes /2 and /3)

a. If any of the reportable **ambiguous terms precede** a word that is **synonymous** with an in situ or invasive tumor (e.g.: cancer, carcinoma, malignant neoplasm, etc.), accession the case.

Example: The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma. Accession the case.

CASE ELIGIBILITY CLARIFICATIONS CONTINUED

Negative Example: The final diagnosis on the outpatient report reads: Rule out pancreatic cancer. Do not accession the case.

b. **Discrepancies**

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

1. Do not accession a case when subsequent documents refer to history of cancer and the original source document used a non-reportable ambiguous term.

Example: Report from the dermatologist is “probable melanoma.” Patient admitted later for unrelated procedure and physician listed history of melanoma. Give priority to the information from the dermatologist. The later information is less reliable in this case. ***(ACR Note: Consulted with SEER in this example to verify that this example was reportable and they stated yes, this example is reportable. SEER will consider revising the order of notes and examples.)***

ii. When there is a single report, accept the reportable term and accession the case when one section of a report uses a reportable term such as “apparently” and another section of the same report uses a term that is not on the reportable list.

Example: Abdominal CT reveals a 1 cm liver lesion. “The lesion is consistent with hepatocellular carcinoma” appears in the discussion section of the report. The final diagnosis is “1 cm liver lesion, possibly hepatocellular carcinoma.” Accession the case. "Consistent with" is a reportable ambiguous term. Accept "consistent with" over the non-reportable term "possibly."
Exception: Do not accession a case based ONLY on suspicious cytology.

c. Use these terms when **screening** diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing other than tumor markers.

i. Do not accession a case when resection, excision, biopsy, cytology, or physician’s statement proves the ambiguous diagnosis is not reportable.

Example 1: Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not accession the case.
Example 2: CT report states "mass in the right kidney, highly suspicious for renal cell carcinoma." CT-guided needle biopsy with final diagnosis "Neoplasm suggestive of oncocytoma. A malignant neoplasm cannot be excluded." Discharged back to the nursing home and no other information is available. Do not accession the case. The suspicious CT finding was biopsied and not proven to be malignant. "Suggestive of" is not a reportable ambiguous term.
Example 3: Stereotactic biopsy of the left breast is "focally suspicious for DCIS" and is followed by a negative needle localization excisional biopsy. Do not accession the case. The needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven to be false.
Example 4: Esophageal biopsy with diagnosis of "focal areas suspicious for adenocarcinoma in situ change." Diagnosis on partial esophagectomy specimen “with foci of high grade dysplasia; no invasive carcinoma identified." Do not accession the case. The esophagectomy proved that the suspicious biopsy result was false.

CASE ELIGIBILITY CLARIFICATIONS CONTINUED

2. Benign and **borderline** primary **intracranial** and **CNS** tumors

a. Use the "Ambiguous terms that constitute a diagnosis" list on page 4 to identify benign and borderline primary intracranial and CNS tumors that are reportable.

b. If any of the reportable **ambiguous terms precede** either the word "**tumor**" or the word "**neoplasm**", accession the case.

Example: The mass on the CT scan is consistent with pituitary tumor. Accession the case.

c. **Discrepancies**

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

1. Do not accession a case when subsequent documents refer to history of tumor and the original source document used a non-reportable ambiguous term.

ii. When there is a single report, accept the reportable term and accession the case when one section of a report uses a reportable term such as "apparently" and another section of the same report uses a term that is not on the reportable list.

Exception: Do not accession a case based ONLY on suspicious cytology.

d. Use these terms when **screening** diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing other than tumor markers.

i. Do not accession the case when resection, excision, biopsy, cytology or physician's statement proves the ambiguous diagnosis is not reportable.

Reportability Clarification: Basal Cell Carcinoma and Squamous Cell Carcinoma of the Lip

Source: NAACCR Lip and Oral Cavity Webinar 8/5/2010 and SEER Inquiry System 20031110 Updated 2/26/2009

•Basal cell carcinoma of lip, NOS is coded to C44.0[skin of lip] because basal cell starts on skin cells, not mucous membrane. (This would not be reportable to the ACR.)
•Squamous cell can be either skin or vermillion of lip.

-If the lesion is overlapping skin and vermillion, go with the area of greatest involvement.
-If more than 50% of the lesion is on the vermillion, code to the vermillion [C00._] and it is re portable to SEER (and ACR).
-If the percentage of involvement is not stated and not known, or no specific information on location of the cancer can be found despite review of the operative report and other portions of the medical record for mention of mucosal involvement, assume it is mucosal and report as C00.9. (NAACCR added this statement based on advisors). (This direction is consistent with previous instruction provided by SEER.)

ADDITIONAL CASE ELIGIBILITY INFORMATION AND REPORTABILITY EXAMPLES

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). ***2010 SEER Program Coding and Staging Manual*****. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD**

DIAGNOSIS PRIOR TO BIRTH

Diagnoses made in utero are reportable **only when the pregnancy results in a live birth**. In the absence of documentation of stillbirth, abortion or fetal death, assume there was a live birth and report the case.

Disease Regression

When a reportable diagnosis is confirmed prior to birth and disease is not evident at birth due to regression, accession the case based on the pre-birth diagnosis.

REPORTABILITY EXAMPLES

Reportable

Example 1: Path report says “Atypical fibroxanthoma (superficial malignant fibrous histiocytoma).” The case is reportable because the information in parentheses provides more detail and confirms a reportable malignancy.

Example 2: Positive histology from needle aspiration/biopsy followed by negative resection. This case is reportable based on positive needle biopsy.

Example 3: Biopsy-proven squamous cell carcinoma of the nipple with a subsequent areolar resection showing foreign body granulomatous reaction to suture material and no evidence of residual malignancy in the nipple epidermis. This case is reportable. The fact that no residual malignancy was found in the later specimen does not disprove the malignancy diagnosed by the biopsy.

Example 4: Final diagnosis from dermatopathologist: “ulcerated histologically malignant spindle cell neoplasm, consistent with atypical fibroxanthoma. Note: An exhaustive immunohistochemical work-up shows no melanocytic, epithelial or vascular differentiation. Atypical fibroxanthoma is a superficial form of a malignant fibrous histiocytoma." This case is reportable. The pathologist has the final say on behavior for a particular case. In this case, the pathologist states that this tumor is malignant.

Example 5: “Aggressive adult granulosa cell tumor with one of two lymph nodes positive for malignant metastatic granulosa cell tumor." This case is reportable because malignant granulosa cell tumor is reportable. The lymph node metastases prove malignancy.

Example 6: Carcinoid of the appendix found on appendectomy. Patient returns later with metastases in regional lymph nodes. This case is reportable because of the metastatic lymph nodes. Code the diagnosis date to the date of the appendectomy and the first course of treatment date to the appendectomy date.

Example 7: Ovarian mucinous borderline tumor with foci of intraepithelial carcinoma. This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).

Example 8: "Squamous cell carcinoma of the anus, NOS." Squamous cell carcinoma of the anus is reportable unless the primary site is confirmed to be the skin of anus.

Not Reportable

Example 1: Left thyroid lobectomy shows microfollicular neoplasm with evidence of minimal invasion. Micro portion of path report states "The capsular contour is focally distorted by a finger of the microfollicular nodule which appears to penetrate into the adjacent capsular and thyroid tissue." Do not report this case based on the information provided. There is no definitive statement of malignancy. Search for additional information in the record. Contact the pathologist or the treating physician.

Example 2: Sclerosing hemangioma of the lung with multiple regional lymph nodes involved with sclerosing hemangioma. This case is not reportable. The lymph node involvement is non-malignant. According to the WHO Classification of Lung Tumours, sclerosing hemangioma "behaves in a clinically benign fashion...Reported cases with hilar or mediastinal lymph node involvement do not have a worse prognosis."

Example 3: Carcinoid of the appendix that extends into mesoappendiceal adipose tissue. This case is not reportable. Extension does not make a carcinoid of the appendix reportable. Benign and borderline tumors can and do extend into surrounding tissue.

Example 4: Carcinoid tumorlets are not reportable.

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ACR Supplement Page

ACR NOTATIONS FOR PAGE 3

#3Aa Non-analytic cases are reportable to the ACR. Submit a Non-Analytic Tracking Form. See *FORDS* pp. 3-5 and *ACR Supplement* pp. 90A and 90B.

#3Ab Lesions with a morphology code of "/0" or "/1" become reportable if a pathologist verifies the morphology is "/2" or higher. Intraepithelial neoplasia of the Vulva (VIN III), Vagina (VAIN III), and Anus (AIN III) are reportable to the ACR. PIN III is not reportable.

#3Ac For cases diagnosed January 1, 2003 and later, skin cancer (C44._) with the histologies of 8000-8110 that are a SEER Summary Stage of regional or distant initial diagnosis are *no longer required* to be reported. Cases diagnosed prior to January 1, 2003 with histologies of 8000-8110 are required to be reported if the SEER Summary Stage is regional or distant at the time of diagnosis.

#3Ad In EXCEPTION 2, the ACR does not use AJCC stage to determine reportability; instead, the ACR requires the reporting of SEER Summary Stage of regional or distant at diagnosis as described above in note *3Ac.

#3Ae Basal and squamous cell cancers originating in mucoepidermoid sites; lip (C00.0-C00.9); anus (C21.0); vulva (C51.0-C51.9); vagina (C52.9); penis (C60.0-C60.9); scrotum (C63.2) are reportable. Basal and squamous cell cancers originating in the skin of anus (C44.5) are not reportable. See *ACR Supplement* p. 2C for additional clarifications on lip.

#3Af Effective with cases diagnosed on or after January 1, 1994, carcinoma in situ (CIS) of the cervix is no longer reportable to the ACR.

#3Ag SEER's The Brain Book: Abstracting and Coding Guide for Primary Central Nervous System Tumors (Draft #2) should only be used for malignant cases diagnosed from 1/1/2004 through 12/31/2006. Use the SEER 2007 Multiple Primary and Histology Coding Rules for malignant cases diagnosed on or after 1/1/2007. The Brain Book should be used for non-malignant cases diagnosed from 1/1/2004 through the release of the Multiple Primary and Histology Coding Rules replacement pages for Benign and Borderline Intracranial and CNS Tumors on 5/6/2008. From 5/6/2008 and later, the replacement pages should be used for Benign and Borderline Intracranial and CNS Tumors. The replacement pages are consistent with The Brain Book.

#3Ah Non-malignant primary intracranial or central nervous system tumors of the meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of the central nervous system (C72._) have always been reportable to the ACR. Effective with cases diagnosed January 1, 2001 and later, benign tumors of the pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3) also became reportable.

#3Ai The terms "neoplasm" and "tumor" have always been used as a term that constitute a diagnosis for meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of the central nervous system (C72._). Effective with cases diagnosed January 1, 2001 and later, these terms are also used to constitute a diagnosis for the pituitary gland (C75.1), craniopharyngeal duct (75.2) and pineal gland (C75.3).

ADDITIONAL NOTES

The Multiple Primary and Histology Coding Rules are effective for cases diagnosed on or after 1/1/2007. For cases diagnosed prior to 1/1/2007, use FORDS: Revised for 2004.

CASE ELIGIBILITY

#3a-See additional Case Eligibility Clarifications and Examples on pp. 2A-2D and Notations on p. 3A.

The American College of Surgeons Commission on Cancer (CoC) requires registries in accredited programs to accession, abstract, and conduct follow-up activities for required tumors diagnosed and/or initially treated at the abstracting facility. The tumors must meet the criteria for analytic cases (*Class of Case* 00-22), and pathologically and clinically diagnosed inpatients and outpatients must be included. See #3Aa

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

Malignancies with an ICD-O-3* behavior code of 2 or 3 are required for all sites. See #3Ab

> **EXCEPTION 1:** Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, *is required* and should be recorded as 9421/3 in the registry.
>
> **EXCEPTION 2:** Malignant primary skin cancers (C44._) with histology codes 8000–8110 *are not required* by the CoC. Skin primaries with those histologies diagnosed prior to January 1, 2003, were required to be accessioned and followed if the AJCC stage group at diagnosis was II, III, or IV. Those cases should remain in the registry data and continue to be followed. See #3Ac, #3Ad & #3Ae
>
> **EXCEPTION 3**: Carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III) *are not required* by CoC. See #3Ab & #3Af

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

REPORTABLE-BY-AGREEMENT CASES

#3b-Reportable-by-agreement cases fallling outside the ACR's reportable list should not be reported to the ACR.

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

#3c-These cases are reportable to the ACR if not previously reported by any facility.

Examples of Reportable-by-Agreement Cases:

- The cancer committee requests abstracting and follow-up of *Class of Case* 30 cases.
- The state central registry requests abstracting and reporting of pathology-only cases.

#3d-The ACR does not require the reporting of these cases; however, if a hospital wishes to abstract them, contact the ACR.

AMBIGUOUS TERMS AT DIAGNOSIS

#3e-See additional Case Eligibility Clarifications on pp. 2A-2D.

As part of the registry case-finding activities, all pathology reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included. Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis. For example, "likely" alone does not constitute a diagnosis.

Ambiguous Terms that Constitute a Diagnosis

#4a-See additional Case Eligibility Clarifications on pp. 2A-2D.

Apparent(ly)	Presumed
Appears	Probable
Comparable with	Suspect(ed)
Compatible with	Suspicious (for)
Consistent with	Tumor* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3) #4b
Favors	Typical of
Malignant appearing	
Most likely	
Neoplasm* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3) #4b	

#4b-These terms have always been used for reporting nonmalignant primary intracranial and central nervous system tumors (C70.0-C72.9, C75.1-75.3) for ACR. See #3Ah and #3Ai.

*additional terms for nonmalignant primary intracranial and central nervous system tumors only

EXCEPTION: If a cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer.

Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Examples of Diagnostic Terms:

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

Ambiguous Terms That *Do Not* Constitute a Diagnosis *without additional information*

Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

Examples of Nondiagnostic Terms:

- The inpatient discharge summary documents a chest x-ray *consistent with neoplasm* of the right upper lobe. The patient refused further work-up or treatment. *Consistent with neoplasm* is not indicative of cancer. While "consistent with" can indicate involvement, "neoplasm" without specification of malignancy is not considered diagnostic except for non-malignant primary intracranial and central nervous system tumors.
- Final diagnosis is reported as *possible carcinoma* of the breast. *Possible* is not a diagnostic term for cancer.

Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute a diagnosis.

CLASS OF CASE

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

Analytic Cases

Cases diagnosed and/or administered any of the first course of treatment at the accessioning facility after the registry's reference date are analytic (*Class of Case* 00-22). A network clinic or outpatient center belonging to the facility is considered part of the facility.

Analytic cases *Class of Case* 10-22 are included in treatment and survival analysis.

Analytic cases *Class of Case* 00, diagnosed on or after January 1, 2006, are not required to be staged or followed. *Class of Case* 00 is reserved for patients who were originally diagnosed by the reporting facility and received all of their treatment elsewhere or a decision not to treat was made elsewhere. If the patient received no treatment, either because the patient refused recommended treatment or a decision was made not to treat, the *Class of Case* is 14. If there is no information about whether or where the patient was treated, the *Class of Case* is *10*.

#5a-Class 00 cases are required to be staged and followed per ACR require-ments.

Nonanalytic Cases

Nonanalytic cases (*Class of Case* 30-99) are not usually included in routine treatment or survival statistics. The CoC does not require registries in accredited programs to accession, abstract, or follow these cases. #5b

#5b-Non-analytic cases are reportable to the ACR if not previously reported by any facility.

Modifications to Class of Case in 2010

Class of Case was redefined for use beginning in 2010. The codes in this manual allow differentiation between analytic and nonanalytic cases and make additional distinctions. For analytic cases, the codes distinguish cases diagnosed in a staff physician's office from those diagnosed initially by the facility and patients fully treated at the facility from those partially treated by the reporting facility. Nonanalytic cases are distinguished by whether the patient received care at the facility or did not personally appear there. Patients who received care from the facility are distinguished by the reasons a case may not be analytic: diagnosed prior to the patient's reference date, type of cancer that is not required by CoC to be abstracted, consultation, in-transit care, and care for recurrent or persistent disease. Patients who did not receive care from the reporting facility are distinguished by care given in one or more staff physician offices, care given through an agency whose cancer cases are abstracted by the reporting facility but are not part of it, pathology only cases, and death certificate only cases.

DATE OF FIRST CONTACT

The *Date of First Contact* (NAACCR Item #580) is the date of the facility's first inpatient or outpatient contact with the patient for diagnosis or treatment of the cancer. For analytic cases, the *Date of First Contact* is the date the patient qualifies as an analytic case *Class of Case* 00-22. Usually, the *Date of First Contact* is the date of admission for diagnosis or for treatment. If the patient was admitted for noncancer-related reasons, the *Date of First Contact* is the date the cancer was first suspected during the hospitalization. If the patient's diagnosis or treatment is as an outpatient of the facility, the *Date of First Contact* is the date the patient first appeared at the facility for that purpose.

If the patient was initially diagnosed at the facility and went elsewhere for treatment (*Class of Case* 00), but then returned for treatment that was initially expected to occur elsewhere, the *Class of Case* is updated to 13 or 14 but the *Date of First Contact* is not changed because it still represents the date the patient became analytic. If the *Class of Case* changes from nonanalytic (for example, consult only, *Class of Case* 30) to analytic (for example, part of first course treatment administered at the facility, *Class of Case* 21), the *Date of First Contact* is updated to the date the case became analytic (the date the patient was admitted for treatment).

When a pathology specimen is collected off site and submitted to the facility to be read (and the specimen is positive for cancer), the case is not required by the Commission on Cancer to be abstracted unless the patient receives first course treatment from the facility.

- If the patient subsequently receives first course treatment at the facility, the case is analytic and must be abstracted and followed. The *Date of First Contact* is the date the patient reported to the facility for the treatment; and the *Class of Case* (NAACCR Item #610) is 11 or 12 if the diagnosing physician is a staff physician at the reporting facility or 20 or 21 for any other physician. A staff physician is one who is employed by the facility, is under contract with it, or has routine admitting privileges there.

When a staff physician performs a biopsy off site and the specimen is not submitted to the facility to be read, the case is not required to be abstracted unless the patient receives some first course care at the facility.

- If the patient subsequently receives first course treatment at the facility, the case is analytic and must be abstracted and followed. The *Date of First Contact* is the date the patient reported to the facility for the treatment and the *Class of Case* is 11 or 12.

For nonanalytic cases, the *Date of First Contact* is the date the patient's nonanalytic status begins with respect to the cancer. For example, for a patient diagnosed and treated entirely in a staff physician's office (*Class of Case* 40), the date the physician initially diagnosed the cancer is the *Date of First Contact*. For autopsy only cases, the *Date of First Contact* is the date of death.

If the state or regional registry requires pathology-only cases to be abstracted and reported, the *Date of First Contact* is the date the specimen was collected and the *Class of Case* is 43. If a patient whose tumor was originally abstracted as a *Class of Case* 43 receives first course treatment subsequently as an inpatient or outpatient at the facility, update both *Class of Case* and *Date of First Contact* to reflect the patient's first in-person contact with the facility. #6a #6b

#6a-Class of case 43 cases are not required by the ACR.

#6b-Hospitals must follow the guidelines stated here.

OVERVIEW OF CODING PRINCIPLES

UNIQUE PATIENT IDENTIFIER CODES

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

- Accession numbers are never reassigned, even if a patient is removed from the registry.
- The sequence number is the sequence of all tumors over the lifetime of a patient and is counted throughout the patient's lifetime.
- #7a → Only tumors that would have been reportable at the time of diagnosis for CoC or by agreement with a central registry or the program's cancer committee are required to be counted when assigning sequence numbers. A registry may contain a single abstract for a patient with a sequence number of 02, because the first tumor was not cared for by the program or was not otherwise required to be accessioned. Because of differences in requirements, it is possible for two registries with dissimilar eligibility requirements (for example, a facility registry and a state central registry) to assign different sequence numbers to the same tumor, even though the sequence number codes and instructions applied are the same.

#7a-The sequence number reported to the ACR must be assigned according to ACR rules. See pp. 38-39 for additional notations.

NATIONAL PROVIDER IDENTIFIER #7b

The National Provider Identifier (NPI) is a unique identification number for health care providers that was implemented in 2007 and 2008 by the Centers for Medicare and Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008. Individual item descriptions in Section Two of this volume should be consulted for specific coding instructions.

#7b-The web site https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do provides a look-up for NPI numbers.

The NPI data items are:

NPI–Archive FIN	*(NAACCR Item #3105)* #7c
NPI–Following Physician	*(NAACCR Item #2475)* #7c
NPI–Following Registry	*(NAACCR Item #2445)*
NPI–Institution Referred From	*(NAACCR Item #2415)*
NPI–Institution Referred To	*(NAACCR Item #2425)*
NPI–Managing Physician	*(NAACCR Item #2465)*
NPI–Physician #3	*(NAACCR Item #2495)*
NPI–Physician #4	*(NAACCR Item #2505)*
NPI–Primary Surgeon	*(NAACCR Item #2485)*
NPI–Reporting Facility	*(NAACCR Item #545)* #7c

#7c-NPI data items required by the ACR.

CODING DATES See #8a

Beginning in 2010, the way dates are transmitted between facility registries and central registries or the National Cancer Data Base (NCDB) was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. In the traditional form, some dates also permit 88888888 or 00000000 for special meaning. Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. The following table illustrates the relationship among these items for *Date of Most Definitive Surgical Resection of the Primary Site*, where *each lower case 'b' represents a blank space*. Flags are not used for software-generated dates.

#8a

Description	Traditional Date of Most Definitive Surgical Resection of the Primary Site	Interoperable Date of Most Definitive Surgical Resection of the Primary Site	Rx Date Mst Defn Srg Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No surgery performed	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

CANCER IDENTIFICATION

The following instructions apply to *Primary Site* (NAACCR Item #400), *Laterality* (NAACCR Item #410), *Histology* (NAACCR Item #522), *Behavior Code* (NAACCR Item #523), *Grade/Differentiation* (NAACCR Item #440), *Grade Path Value* (NAACCR Item #441) and *Grade Path System* (NAACCR Item #449).

Primary Site #8b-Also refer to *FORDS* p. 98 & ACR supplemental pp. 98B-98E.

The instructions for coding primary site are found in the "Topography" section of the **ICD-O-3** "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 23–26). The following guidelines should be followed for consistent analysis of primary sites for particular histologies.

Hematopoietic and Lymphoid Cancers #8c #8d

Beginning with cases diagnosed in 2010, the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** is to be used for coding primary site, histology, and grade of hematopoietic and lymphoid tumors (M-9590-9992) and to determine whether multiple conditions represent one or more tumors to be abstracted. Appendix A has the former table for use for tumors diagnosed prior to January 1, 2010, for determining unique or same hematopoietic tumors.

#8c-For cases diagnosed before 2010, refer to the previous *FORDS, Revised for 2009* guidelines on coding lymphoma primaries, p. 10, and *ICD-O-3* coding guidelines for lymphoma, pp. 20 & 26.

Kaposi Sarcoma

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

Melanoma

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

#8a-Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format must be used for transmission to the ACR. The new date flags associated with each date field are also required.

#8d-For cases diagnosed 1/1/2010 and later, the Hematopoietic Database and the Hematopoietic Lymphoid Neoplasm Case Reportability and Coding Manual replace:
-The February 2001 "Single Versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases" table
-Previous casefinding and reportable neoplasm lists for hematopoietic neoplasms (ICD-9-CM and ICD-10)
-Abstracting and Coding Guide for the Hematopoietic Diseases, May 2002, also known as the "Red Book." ACR note: Continue to use this reference in 2010 and later to only identify treatments that maybe coded as "Other." These are not listed in the Database.
-Any other abstracting or coding references, rules, or guidelines for hematopoietic and/or lymphoid neoplasms that were published before 1/1/2010

Specific Tissues with Ill-Defined Sites #9a-Consult with the *ICD-O-3* coding guidelines for ill-defined sites pp. 20 & 24.

- If any of the following histologies appears only with an ill-defined site description (eg, "abdominal" or "arm"), code it to the tissue in which such tumors arise rather than the ill-defined region (C76._) of the body, which contains multiple tissues. Use the alphabetic index in **ICD-O-3** to assign the most specific site if only a general location is specified in the record.

Histology	Description	Code to This Site
8720–8790	Melanoma	C44._, Skin
8800–8811, 8813–8830, 8840–8921, 9040–9044	Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues
8990–8991	Mesenchymoma	C49._, Connective, Subcutaneous and Other Soft Tissues
9120–9170	Blood vessel tumors, lymphatic vessel tumors	C49._, Connective, Subcutaneous and Other Soft Tissues
9580–9582	Granular cell tumor and alveolar soft part sarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues
9240–9252	Mesenchymal chondrosarcoma and giant cell tumors	C40._, C41._ for Bone and Cartilage C49._, Connective, Subcutaneous and Other Soft Tissues
8940–8941	Mixed tumor, salivary gland type	C07._ for Parotid Gland C08._ for Other and Unspecified Major Salivary Glands

Laterality #9b-Refer to *FORDS* page 99.

Laterality (NAACCR Item #410) must be recorded for the following paired organs as 1-5 or 9. Organs that are not paired, unless they are recorded "right" or "left" laterality, are coded 0. Midline origins are coded 5. "Midline" in this context refers to the point where the "right" and "left" sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites can not develop midline tumors. For example, skin of the trunk can have a midline tumor, but the breasts can not.

Paired Organ Sites

ICD-O-3	Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1–C34.9	Lung

C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C50.0–C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0–C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0–C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS (excluding diagnoses prior to 2004)
C71.0	Cerebrum (excluding diagnoses prior to 2004)
C71.1	Frontal lobe (excluding diagnoses prior to 2004)
C71.2	Temporal lobe (excluding diagnoses prior to 2004)
C71.3	Parietal lobe (excluding diagnoses prior to 2004)
C71.4	Occipital lobe (excluding diagnoses prior to 2004)
C72.2	Olfactory nerve (excluding diagnoses prior to 2004)
C72.3	Optic nerve (excluding diagnoses prior to 2004)
C72.4	Acoustic nerve (excluding diagnoses prior to 2004)
C72.5	Cranial nerve, NOS (excluding diagnoses prior to 2004)
C74.0–C74.9	Adrenal gland
C75.4	Carotid body

#10a-For benign and malignant primary intracranial and central nervous tumors of the meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of the central nervous system (C72._) cases diagnosed January 1, 1996 through December 31, 2000, the ACR required the coding of grade using the WHO Classification. The ACR also required the AJCC staging of malignant tumors. The 5th ed. of AJCC did not contain a staging scheme for malignant brain tumors; therefore, for the diagnosis years of 1998 through 2000, the 4th ed. of AJCC was used. Effective with cases diagnosed January 1, 2001 and later, the ACR discontinued this requirement in order to follow national standards. The grade is to be coded as stated in the pathology report only. The AJCC staging of malignant brain cases was no longer required. For all other years, for the coding of grade, the ACR follows *ICD-O* rules. For SEER Summary Stage 2000 (#759) a code of 8 is required for non-malignant tumors, effective with cases diagnosed on or after 01/01/2009. Benign CNS/Brain cases diagnosed prior to 01/01/2009 must be SEER Summary Staged Unknown (9).

Morphology: Histology Code #11a-Refer to *FORDS* page 100. #11b

The instructions for coding histology and behavior of solid tumors are found in the "Morphology" section of the **ICD-O-3** "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 27-30)

To code multiple or mixed histologies present in one primary, the most recent **SEER 2007 Multiple Primary and Histology Coding Rules** replaces all previous multiple histology rules. These rules are effective for cases diagnosed January 1, 2007. and after; do not use them to abstract cases diagnosed before January 1, 2007. #11c-Use the rules in *FORDS 2004* and the *ACR Coding Handbook 3rd Edition* for cases diagnosed on or before 12/31/2006. #11d

Morphology: Grade/Differentiation, Grade Path Value, Grade Path System #11e See #10a

#11e-For grade/ differentiation refer to *FORDS* pp. 103-104 and ACR supplemental pp. 106A-106C. Refer to *FORDS* p. 106 for Grade Path Value. Refer to *FORDS* p. 105 for Grade Path System.

The word "grade" is used to indicate several distinct continua of cellular variability in cancer, and it is necessary to be cognizant of the differences. Cancer registries have collected *Grade/Differentiation* (NAACCR Item #440) for many years, and in recent years registrars have become familiar with certain grade systems that can be converted to grade/differentiation. In 2010 the two items, *Grade Path Value* (NAACCR Item #441) and *Grade Path System* (NAACCR Item #449), were added that record exactly what was recorded by the pathologist prior to conversion to grade/differentiation. In addition, the **Collaborative Stage Data Collection System** version 2 (CSv2) includes a number of specialized grades that are collected as site-specific factors.

The instructions for coding *Grade/Differentiation* (NAACCR Item #440) for solid tumor grade codes 1-4 are found in the "Morphology" section of the **ICD-O-3** "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 30–34). Use the current version of the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** to code lineage of hematopoietic cases (M-9590-9992) in the same item as codes 5-8. Code 9 is used for unknown in either instance. Use the current **Collaborative Stage Data Collection System** coding manual to code *Grade Path Value* (NAACCR Item #441) and *Grade Path System* (NAACCR Item #449).

#11b-For hematopoietic and lymphoid neoplasms consult the *2010 Hematopoietic Database* and *2010 Hematopoietic and Lymphoid Neoplamsm Case Reportablity and Coding Manual*.

Grade/Differentiation (NAACCR Item #440) is a four-grade system. Certain two-grade and three-grade systems can be converted to the four-grade *Grade/Differentiation* (NAACCR Item #440), as described below. These tumors may also have been assigned a four-grade histologic grade. When it is present, that is the grade that should be recorded as *Grade/Differentiation* (NAACCR Item #440).

For sites other than those described below, code the tumor grade using the following priority order: (1) terminology, (2) histologic grade, (3) nuclear grade.

Coding Two-Grade Systems

If the only grade information available for urinary bladder (C67._), colon, rectosigmoid junction, rectum (C18.0–C20.9), or heart (C38.0) is supplied as a two-grade system ("high" or "low"), convert them as shown below.

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

#11d-For hematopoietic malignancies diagnosed 02/01/2001 or later see Appendix A: Definition of Single and Subsequent Primaries for Hematologic Malignancies to determine the number of primaries and additional histology information.

Coding Three-Grade Systems

Three grade-systems that convert to *Grade/Differentiation* (NAACCR Item #440) include peritoneum (C48.1, C48.2), endometrium (C54.1), fallopian tube (C57.0), and brain and spinal cord (C71.0–C72.9). For these sites, code the tumor grade using the following priority order: (1) Terminology, (2) Histologic Grade, and (3) Nuclear Grade as shown in the following table.

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

Breast (C50. 0-C50.9)

If a three-grade grade/differentiation grade is provided for breast, code the tumor grade using the following priority order: (1) Nuclear Grade (2) Terminology, and (3) Histologic Grade as shown in the table below

Code	Nuclear Grade	Terminology	Histologic Grade
1	1/3, 1/2	Well differentiated	I/III or 1/3
2	2/3	Moderately differentiated	II/III or 2/3
3	2/2, 3/3	Poorly differentiated	III/III or 3/3

Prostate (C61.9)

For prostate cancers, code the tumor grade using the table below following priority order: (1) Gleason Score (this is the sum of the patterns, for example, if the pattern is 2+4 the score is 6), (2) Terminology, (3) Histologic Grade, and (4) Nuclear Grade. The following table is used to convert Gleason Score to grade/differentiation. The grouping for conversion to *Grade/Differentiation* (NAACCR Item #440) is not the same as the prognostic grouping used by AJCC to assign stage, because they serve different purposes.

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

Multiple Primaries

#12a-Consult the *Multiple Primary and Histology Coding Rules* manual for solid tumors diagnosed 01/01/2007 or later. Use the rules in *FORDS 2004* and the *ACR Coding Handbook 3rd Edition* for cases diagnosed on or before 12/31/2006.

The most recent **SEER Multiple Primary and Histology Coding Rules** contain site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant and nonmalignant brain primaries. A separate set of rules addresses the specific and general rules for all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions. #12b #12c

If an invasive and an in situ tumor are identified as a single tumor according to the **SEER Multiple Primary and Histology Coding Rules, SEER Multiple Primary and Histology Coding Rules** and they are located in different subsites, the primary site should be identified as the subsite in which the *invasive* tumor is located. If, however, the two tumors are both invasive, then code the subsite as ".9".

#12b-The ACR follows the rules as stated in the *Multiple Primary and Histology Coding Rules* manual. If there is a contradiction between a physician's statement and the rules, follow the rules.

#12c-Also see page 3A-#3Ag for specific information about brain tumors.

The **SEER Multiple Primary and Histology Coding Rules** do not apply to hematopoietic and lymphoid tumors. Use the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** and the **Hematopoietic and Lymphoid Neoplasms Database** to code hematopoietic primaries (lymphoma and leukemia M9590-9989) diagnosed on January 1, 2010, or later. Use the tables in Appendix A of ***FORDS Revised for 2011*** only for hematopoietic and lymphoid cases diagnosed prior to 2010. Primary site and timing are not applicable for determining whether these malignancies represent one or more primaries. See #8d

#13a-For hematopoietic malignancies diagnosed 02/01/2001 or later see Appendix A: Definition of Single and Subsequent Primaries for Hematologic Malignancies to determine the number of primaries.

Paired Organ Sites

A list of paired organ sites can be found earlier in this section. Refer to the **SEER Multiple Primary and Histology Coding Rules** to determine whether involvement of paired sites should be coded as one or two primaries.

Revising the Original Diagnosis #13b

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

#13b-If information is revised as the result of additional information or internal quality control, the ACR requires the revised abstract be sent to the ACR with a notation stating that is has additional or new information.

Example 1
The institution clinically diagnoses a patient with carcinomatosis. The registry enters the case as an unknown primary (C80.9), carcinoma, NOS (8010/3), stage of disease unknown. Nine months later, a paracentesis shows serous cystadenocarcinoma. The physician says that the patient has an ovarian primary. Change the primary site to ovary (C56.9), histology to serous cystadenocarcinoma (8441/3), and diagnostic confirmation to positive cytologic study, no positive histology (code 2). If enough information is available that meets the AJCC timing requirements for staging, change the stage from not applicable (88) to the appropriate staging basis, TNM elements, and stage group, or to unknown. Update the Collaborative Staging input items and rerun the derivation program. If first course surgery was performed, the surgery codes should be reviewed.

Example 2
A physician decides that a previously clinically diagnosed malignancy is a benign lesion. The patient is referred from a nursing home to the facility. The chest X ray shows a cavitary lesion in the right lung. The family requests that the patient undergo no additional workup or treatment. Discharge diagnosis is "probable carcinoma of right lung." The registry abstracts a lung primary (C34.9). Two years later a chest X ray shows an unchanged lesion. The physician documents "lung cancer ruled out." Delete the case from the database. Adjust the sequence number(s) of any other primaries the patient may have. If the deleted case is the patient's only primary, do not reuse the accession number.

PATIENT ADDRESS AND RESIDENCY RULES

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

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

Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau whenever possible. The registry can resolve residency questions by using the Census Bureau's definition,

"the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home." State Vital Statistics rules may differ from Census rules. Do not record residence from the death certificate. Review each case carefully.

Rules for Persons with Ambiguous Residences

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

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

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

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

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

Persons in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their families. Military personnel may use the installation address or the surrounding community's address. The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

IN UTERO DIAGNOSIS AND TREATMENT

Beginning in 2009, diagnosis and treatment dates for a fetus prior to birth are to be assigned the actual date of the event. In the past, those dates were set by rule to the date the baby was born. The exact date may be used for cases diagnosed prior to 2009.

COMORBIDITIES AND COMPLICATIONS

#14a-The ACR does *not* require coding of Comorbidities and Complications.

The CoC requires that the registry record include up to 10 comorbid conditions, factors influencing the health status of the patient, and treatment complications, to be copied from the patient record. All are considered secondary diagnoses. The information is recorded in the **International Classification of Diseases, Ninth or Tenth Revision, Clinical Modification (ICD-9-CM or ICD-10-CM)** code form, typically on the patient's discharge abstract or face sheet of the billing record. Most hospitals in the United States are expected to implement use of ICD-10-CM during 2011. Registries should not combine use of ICD-9-CM and ICD-10-CM in a single record.

The items describing patient comorbid conditions and complications are:

Comorbidities and Complications #1 (NAACCR Item #3110)
Comorbidities and Complications #2 (NAACCR Item #3120)
Comorbidities and Complications #3 (NAACCR Item #3130)
Comorbidities and Complications #4 (NAACCR Item #3140)
Comorbidities and Complications #5 (NAACCR Item #3150)
*Comorbidities and Complications #6 (*NAACCR Item #3160)
*Comorbidities and Complications #7 (*NAACCR Item #3161)
*Comorbidities and Complications #8 (*NAACCR Item #3162)

*Comorbidities and Complications #9 (*NAACCR Item #3163)
Comorbidities and Complications #10 (NAACCR Item #3164)

Three general categories of information are collected: comorbidities, complications, and factors influencing the health status of patients.

Comorbidities are preexisting medical conditions or conditions that were present at the time the patient was diagnosed with this cancer (for example, chronic conditions such as COPD, diabetes, and hypertension).

Complications are conditions that occur during the hospital stay, while the patient is being treated for the cancer (for example, postoperative urinary tract infection or pneumonia). Complications may also occur following the completion of therapy and be a cause for readmission to the hospital. Complications are identified by codes which classify environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. Only complication codes that describe adverse effects occurring during medical care are collected in this data item. They include misadventures to patients during surgical and medical care, and drugs and medicinal and biologic substances causing adverse effects in therapeutic use.

Factors influencing the health status of patients are circumstances or problems that are not themselves a current illness or injury (for example, women receiving postmenopausal hormone replacement therapy, or a history of malignant neoplasm). Only specific codes which describe health characteristics are collected in this data item. They include prophylactic measures, personal health history, pregnancy, contraception, artificial opening and other post surgical states, and prophylactic organ removal.

STAGE OF DISEASE AT INITIAL DIAGNOSIS

#15a-Refer to *FORDS* pp. 129-140. See notations #15b, #16d, and #16f on page 16.

Surgical Diagnostic and Staging Procedures

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

#15b-Always use coding rules from the *AJCC Cancer Staging Manual* that were effective in the year the case was diagnosed:
2010-present:7th ed.
2003-2009: 6th ed.
1998-2002: 5th ed.
1993-1997: 4th ed.
1989-1992: 3rd ed.

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

AJCC TNM STAGING

#15c-Refer to *FORDS* pp. 129-140 for ACR requirements.

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.

- *Clinical staging* includes any information obtained about the extent of cancer before initiation of definitive treatment (surgery, systemic or radiation therapy, active surveillance, or palliative care) or within four months after the date of diagnosis, whichever is *shorter*, as long as the cancer has not clearly progressed during that time frame.
- *Pathologic staging* includes any information obtained about the extent of cancer through completion of definitive surgery as part of first course treatment or identified within 4 months after the date of

diagnosis, whichever is *longer*, as long as there is no systemic or radiation therapy initiated or the cancer has not clearly progressed during that time frame.

The CoC requires the use of AJCC staging to allow physicians to determine appropriate treatment, and a goal of cancer registry staging is to provide high-quality information about cancer stage before and after treatment. Systematic use of this established staging schema enables the reliable evaluation of treatment results and outcomes reported from various institutions on a local, regional and national basis. If the treating physician(s) has not recorded this information, registrars *will* code these items based on the best available information. #16a-AJCC Staging by a physician is *not* required by the ACR.

- The CoC *requires* registries in accredited cancer programs to record the ***clinical*** (pretreatment) classifications of T, N, M, and stage group for *Class of Case* 10–22 cases diagnosed on or after January 1, 2008.
- The CoC *recommends* that registries in accredited cancer programs record the clinical classifications of T, N, M, and stage group for *Class of Case* 00 cases diagnosed on or after January 1, 2008.
- The CoC *recommends* that registries in accredited cancer programs record the pathologic classifications (for surgical cases) of T, N, M, and stage group for cases diagnosed on or after January 1, 2008.
- CoC does not require that registrars use information not available in the facility's records to assign staging information. However, if that information is obtained along with other material from another source, it may be used.

The AJCC items that must be coded for Class of Case 10–22 are: #16b-See ACR AJCC Clinical requirements on pp. 129-134.

Clinical T (NAACCR Item #940)
Clinical N (NAACCR Item #950)
Clinical M (NAACCR Item #960)
Clinical Stage Group (NAACCR Item #970)
Clinical Stage (Prefix/Suffix) Descriptor (NAACCR Item #980)
Staged By (Clinical Stage) (NAACCR Item #990)

The AJCC items that are recommended to be coded are: #16c-See ACR AJCC Pathologic requirements on pp. 135-140.

Pathologic T (NAACCR Item #880)
Pathologic N (NAACCR Item #890)
Pathologic M (NAACCR Item #900)
Pathologic Stage Group (NAACCR Item #910)
Pathologic Stage (Prefix/Suffix) Descriptor (NAACCR Item #920)
Staged By (Pathologic Stage) (NAACCR Item #930)

#16d-Always use the coding rules from the *SEER Summary Stage Manual* that were effective in the year the case was diagnosed:
On or prior to 12/31/2000: SS Guide 1977
01/01/2001 to present: SS Manual 2000

- If a patient has multiple primaries, stage each primary independently.
- If the stage group cannot be determined from the recorded components, then record it as unknown.
- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, the physician identifies which primary has metastasized, update the stage(s) as appropriate.
- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathologic T, N, and M as well as stage group. If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes for both and do not code 88. #16e-Pediatric staging is not required by the ACR. See *FORDS* pp. 129-140 for AJCC TNM Staging rules.

Ambiguous Terminology

If the wording in the patient record is ambiguous with respect to tumor spread, use the following guidelines: #16f-SEER Summary Staging and AJCC (TNM) Staging are required for all cases diagnosed prior to 1/1/2004. For cases diagnosed on and after 01/01/2004, SEER Summary Staging and AJCC Staging continued to be required for non-analytic cases. Collaborative Staging is required for all cases diagnosed on or after 01/01/2004.

Ambiguous Terms Describing Tumor Spread

Terms that Constitute Tumor Involvement or Extension		Terms that *Do Not* Constitute Tumor Involvement or 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	

#17a-The *Collaborative Stage Data Collection System Coding Instructions* has additional ambiguous terminology that should be used when using the Collaborative Stage system. See Part I, Section 1: General Instructions.

COLLABORATIVE STAGING

#17b-The ACR requires Collaborative Staging. Refer to *FORDS* pp. 141-182A for ACR requirements and to the *Collaborative Stage Data Collection System Coding Instructions*.

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

#17c-All 2011 cases and after will be required to be completed in Collaborative Stage Version 02.03.02. Once this version is installed, it will be used to code all cases diagnosed from 2004 forward.

How Collaborative Staging Works

Collaborative Staging was designed for registrar use. It relieves registrars from the necessity of staging a single case according to more than one staging system. It avoids most problems that can occur when it is necessary to consider multiple pieces of information simultaneously to assign a single code. For Collaborative Staging, registrars code discrete pieces of information once and the CS computer algorithm derives the values for the 6th and 7th editions of the **AJCC Cancer Staging Manual** T, N, M, Stage Group, and descriptors, as well as Summary Stage 1977 and Summary Stage 2000. The derived stage codes are ideally suited for data analysis because of the consistency that can be obtained with objectively recorded, identically processed data items.

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.

The following CS data items are coded by the registrar. Items with an asterisk (*) have site-specific variations for some codes.

#17d-Refer to *FORDS* pp. 141-182A for ACR specific requirements.

CS Tumor Size (NAACCR Item #2800) *
CS Extension (NAACCR Item #2810) *
CS Tumor Size/Ext Eval (NAACCR Item #2820)
CS Lymph Nodes (NAACCR Item #2830) *
CS Reg Lymph Nodes Eval (NAACCR Item #2840)
Regional Lymph Nodes Examined (NAACCR Item #830)
Regional Lymph Nodes Positive (NAACCR Item #820)
CS Mets at DX (NAACCR Item #2850) *
CS Mets at DX – Bone (NAACCR Item #2851)
CS Mets at DX – Brain (NAACCR Item #2852)
CS Mets at DX – Liver (NAACCR Item #2853)
CS Mets at DX – Lung (NAACCR Item #2854)
CS Mets Eval (NAACCR Item #2860)
CS Site-Specific Factors 1-25 (Schema-specific)

The CS algorithm produces the output items listed below. The derived AJCC items are separate from the direct-coded AJCC items; and the derived Summary Stage items are separate from the manually coded items collected by the CoC in the past. The derived items must never be manually altered.

Derived AJCC-6 T (NAACCR Item #2940)
Derived AJCC-6 T Descript (NAACCR Item #2950)
Derived AJCC-6 N (NAACCR Item #2960)
Derived AJCC-6 N Descript (NAACCR Item #2970)
Derived AJCC-6 M (NAACCR Item #2980)
Derived AJCC-6 M Descript (NAACCR Item #2990)
Derived AJCC-6 Stage Group (NAACCR Item #3000)
Derived AJCC-7 T (NAACCR Item #3400)
Derived AJCC-7 T Descript (NAACCR Item #3402)
Derived AJCC-7 N (NAACCR Item #3410)
Derived AJCC-7 N Descript (NAACCR Item #3412)
Derived AJCC-7 M (NAACCR Item #3420)
Derived AJCC-7 M Descript (NAACCR Item #3422)
Derived AJCC-7 Stage Group (NAACCR Item #3430)
Derived SS1977 (NAACCR Item #3010)
Derived SS2000 (NAACCR Item #3020)

Finally, the registry software that runs the CS algorithm produces the following flags that describe how the derived items were computed.

Derived AJCC-Flag (NAACCR Item #3030)
Derived SS1997-Flag (NAACCR Item #3040)
Derived SS2000-Flag (NAACCR Item #3050)
CS Version Input Original (NAACCR Item #2935)
CS Version Derived (NAACCR Item #2936)
CS Version Input Current (NAACCR Item #2937)

All derived items are assigned a “storage value,” which is stored in the computer and used for data transmission and analysis, and an associated “display value,” which is displayed on the computer screen or in printed reports. The display values (for example, “N3c”) were designed to be familiar and readily interpretable to registrars and physicians.

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. 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.” A blank display string for a derived item means the CS algorithm was not run for the case.

Coding CS Items

#19a-The ACR requires Collaborative Staging. Refer to *FORDS* pp. 141-182A for ACR requirements and to the *Collaborative Stage Data Collection System Coding Instructions*.

The complete instructions and site-histology defined codes are available in the current version of **Collaborative Stage Data Collection System**.

See the definitions for the Site Specific Factors in this manual for the requirements for staging for cases diagnosed in 2011. This list is likely to change in future years.

Using CS Derived Values

Some differences in the ways that the CS algorithm operates and how the AJCC stage assignment rules are made can result in differences between the derived values for some patients and the direct-coded stages. The differences of most interest to registrars are those that might explain discrepancies between the derived AJCC T, N, M, and Stage Group values and the values recorded for the same cases by physicians.

As a "best stage" system, CS makes use of the most complete information available to stage the tumor. The *AJCC Cancer Staging Manual* distinguishes between clinical staging, based on information available prior to primary treatment, and pathologic staging, based on information gathered as a product of the treatment process (particularly surgery). It also has specific rules governing how the components gathered at different times in the process may be combined. The CS algorithm derives a clinical (c) or pathologic (p) descriptor for each of the T, N, and M stage components based on the source of information used to validate the most extensive spread of the tumor, and uses the components to derive a stage group without reference to the value of the descriptors. Some derived stage groups may involve combinations that are neither clinical nor pathologic according to AJCC rules, so a case that is unstageable for a physician applying AJCC rules may be assigned a Derived AJCC Stage Group value by the CS algorithm. Other cases may involve combinations that do not match either the physician-assigned clinical stage or the pathologic stage.

FIRST COURSE OF TREATMENT

#19b-Treatment data items begin on *FORDS* page 201.

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. "Active surveillance" is a form of planned treatment for some patients; its use is coded in the new *RX Summ–Treatment Status* item. "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. If the patient refuses all treatment, code "patient refused" (code 7 or 87) for all treatment modalities.

Treatment Plan

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

- All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient.
- A discharge plan must be part of the patient's record in a JCAHO-accredited hospital and may contain part or all of the treatment plan.
- An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation.
- If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis."

Time Periods for First Course of Treatment

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

- If no treatment is given, record the date of the decision not to treat, the date of patient refusal, or the date the patient expired if the patient died before treatment could be given.
- If active surveillance ("watchful waiting") was selected, record the date of that decision.
- Additional data items further define the parameters for specific treatments and treatment modalities, as described in the following sections.

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

All Malignancies except Leukemias

The first course of treatment includes all therapy planned and administered by the physician(s) during the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more. Any therapy administered after the discontinuation of first course treatment is subsequent treatment. #20a-The ACR does *not* require the collection of 2nd course/subsequent treatment.

Leukemias

The first course of treatment includes all therapies planned and administered by the physician(s) during the first diagnosis of leukemia. Record all remission-inducing or remission-maintaining therapy as the first course of treatment. Treatment regimens may include multiple modes of therapy. The administration of these therapies can span a year or more. A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment. #20a

Surgery

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

Individual item descriptions in Section Two of this manual should be consulted for specific coding instructions. The paragraphs below describe how the surgery items fit together.

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

#20b-See *FORDS* treatment section to determine data items required by the ACR. Treatment data items begin on *FORDS* page 201.

Surgical Procedure of Primary Site (NAACCR Item #1290)
Radiation/Surgery Sequence (NAACCR Item #1380)
Scope of Regional Lymph Node Surgery (NAACCR Item #1292)
Surgical Procedure/Other Site (NAACCR Item #1294)
Surgical Margins of the Primary Site (NAACCR Item #1320)
Reason for No Surgery of Primary Site (NAACCR Item #1340)
Date of First Surgical Procedure (NAACCR Item #1200)
RX Date–Surgery Flag (NAACCR Item #1201)
Date of Most Definitive Surgical Resection of the Primary Site (NAACCR Item #3170)
RX Date Mst Defn Srg Flag (NAACCR Item #3171)
Date of Surgical Discharge (NAACCR Item #3180)
RX Date Surg Disch Flag (NAACCR Item #3181)
Readmission to the Same Hospital Within 30 Days of Surgical Discharge (NAACCR Item #3190)

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

Surgical Procedure of Primary Site at This Facility (NAACCR Item #670)
RX Hosp–Surg App 2010 (NAACCR Item #668)
Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672)
Surgical Procedure/Other Site at This Facility (NAACCR Item #674)

Relationships among Surgical Items

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

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

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

- *Surgical Procedure of Primary Site* is a site-specific item that describes the most invasive extent of local tumor destruction or surgical resection of the primary site and of surrounding tissues or organs that are removed in continuity with the primary site.

- *Scope of Regional Lymph Node Surgery* describes the removal, biopsy, or aspiration of sentinel nodes and other regional lymph nodes that drain the primary site and may include surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease as well as removal of nodes for treatment of the disease.

Surgical Procedure/Other Site describes first course resection of distant lymph node(s) and/or regional or distant tissue or organs beyond the *Surgical Procedure of the Primary Site* code.

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

The code ranges and corresponding descriptions for site-specific *Surgical Procedure of Primary Site* code are grouped according to the general nature of the procedure:

- Codes 10 through 18 are site-specific descriptions of tumor-destruction procedures that do not produce a pathologic specimen.

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

- The special code 98 applies to specific tumors that cannot be clearly defined in terms of primary nonprimary site. *Surgical Procedure of Primary Site* should be coded 98 for any tumor characterized by the specific sites and/or morphologies identified in the site-specific code instructions for *Unknown and Ill-Defined Primary Sites* and *Hematopoietic/*

Reticuloendothelial/Immunoproliferating/Myeloproliferative Disease. The item *Surgical Procedure/Other Site* is used to indicate whether surgery was performed for these tumors.

When multiple first course primary site surgical procedures are performed for a single tumor, the most extensive or definitive is the last performed, and the code represents the cumulative effect of the separate procedures. #22a-The ACR requires the coding of cumulative *and* progressive treatment.

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

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

To the extent possible, codes and their definitions are the same as those previously assigned in *ROADS* to accommodate analysis in registries that maintain unconverted data. As a result of added and modified codes, however, the numeric code sequence may deviate from the order in which the descriptions of the surgical procedures are listed.

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

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

Scope of Regional Lymph Node Surgery distinguishes between sentinel lymph node biopsy and removal of other regional lymph nodes and distinguishes removal of regional lymph nodes during the same surgical procedure as a sentinel node biopsy from subsequent removal.

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

Surgical Procedure/Other Site describes surgery performed on tissue or organs other than the primary site or regional lymph nodes. It is also used to describe whether surgery was performed for tumors having unknown or ill-defined primary sites or hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease morphologies. If any surgical treatment was performed on these cancers, *Surgical Procedure/Other Site* is coded 1.

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

Six surgery items augment the information recorded in *Surgical Procedure of Primary Site*. The items *Date of Most Definitive Surgical Resection of the Primary Site, Surgical Margins of the Primary Site, Date of Surgical Discharge,* and *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* apply to the most definitive (most invasive) first course primary site surgery performed, that is, to the event recorded under Surgical Procedure of Primary Site. When no surgical procedure of the primary site is performed, the reason is recorded in the item Reason for No Surgery of Primary Site.

- *Date of Most Definitive Surgical Resection* is the date on which the specific procedure recorded in *Surgical Procedure of Primary Site* was performed. If only one first course surgical procedure was performed, then the date will be the same as that for *Date of First Surgical Procedure*.

- *Surgical Margins of the Primary Site* records the pathologist's determination of the presence of microscopic or macroscopic involvement of cancer at the margins of resection following the surgical resection described by *Surgical Procedure of Primary Site*.

- *RX Hosp–Surg App 2010* distinguishes among open surgery, laparoscopic surgery, and robotic assisted surgery when it is performed by the reporting facility. If more than one surgical procedure is performed by the facility, this item refers to the most definitive (most invasive) first course primary site surgery performed.

- *Date of Surgical Discharge* is the date the patient was discharged following the procedure recorded in *Surgical Procedure of Primary Site*. It is on or after the *Date of Most Definitive Surgical Resection*.

- *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* distinguishes a planned from an unplanned hospital admission and is used as a quality of care indicator.

- *Reason for No Surgery* identifies why surgical therapy was not provided to the patient and distinguishes a physician's not recommending surgical therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

Radiation #23a-Refer to *FORDS* pp. 227-249 for radiation data items.

The radiation items in *FORDS* are clinically relevant and reflect contemporary practice. These items record regional and boost treatment information.

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

Date Radiation Started (NAACCR Item #1210)
RX Date–Radiation Flag (NAACCR Item #1211)
Location of Radiation Treatment (NAACCR Item #1550)
Radiation Treatment Volume (NAACCR Item #1540)
Regional Treatment Modality (NAACCR Item #1570)
Regional Dose (cGy) (NAACCR Item #1510)
Boost Treatment Modality (NAACCR Item #3200)
Boost Dose (cGy) (NAACCR Item #3210)
Number of Treatments to This Volume (NAACCR Item #1520)
Radiation/Surgery Sequence (NAACCR Item #1380)
Date Radiation Ended (NAACCR Item #3220)
RX Date Rad Ended Flag (NAACCR Item #3221)
Reason for No Radiation (NAACCR Item #1430)

#23b-See *FORDS* radiation treatment section to determine data items required by the ACR.

Relationships among Radiation Items

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

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

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

The targeted anatomic region is described by *Radiation Treatment Volume*. The treatment volume may be the same as the primary site of disease; however, the available code values provide descriptions of anatomic regions that may extend beyond the primary site of disease and may be used to describe the treatment of metastatic disease. If two distinct volumes are radiated, and one of those includes the primary site, record the radiation involving the primary site in all radiation fields.

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

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

- Codes 40 through 43 describe proton radiation (code 40) and specific type of stereotactic radiotherapy (codes 41–43). If stereotactic radiotherapy is delivered to a patient but the exact modality is not recorded, use code 41 (Stereotactic radiosurgery, NOS).

- Codes 50 through 55 are used to record different types of brachytherapy administration, also known as radioactive seed implants. Code 50 should be used to record the application of radioactive materials not otherwise specified.

- Codes 60 through 62 provide codes to describe the administration of specific radioisotopes. Code 60 (Radioisotopes, NOS) should be used when specific details of the radioisotope administration is not available.

- Code 98 is reserved for cases where it is known that radiation therapy was delivered but the modality is not recorded in the patient record.

- The unit of measure for radiologic dosing is the centigray (cGy), which has replaced the use of “rads” to describe radiation dose.

- If only one radiation treatment modality is delivered to a patient and it is not specified as either regional or boost treatment, assume it’s regional treatment and code the items *Regional Treatment Modality* (NAACCR Item #1570) and *Regional Dose (cGy)* (NAACCR Item #1510) accordingly.

A boost treatment is provided to a smaller volume within the same volume as regional radiation in order to enhance the effect of the regional treatment.

- The boost dose may or may not employ the same treatment modality. For example, external beam radiation may be used for regional treatment and be followed by brachytherapy to provide the boost dose.

- Not all patients who receive radiation therapy receive a boost dose radiation. For these cases, boost modality and dose should be coded as 00 and 00000, respectively.

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

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

- *Radiation/Surgery Sequence* identifies those instances where radiation therapy and the surgical management of the patient are not discrete and overlap with respect to time. Radiation therapy can precede the surgical resection of a tumor and then be continued after the patient's surgery, or radiation can be administered intraoperatively.

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

Systemic Therapy #25a-Refer to *FORDS* pp. 250-276 for systemic data items required by the ACR. #25b

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

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

Date Systemic Therapy Started (NAACCR Item #3230)
RX Date Systemic Flag (NAACCR Item #3231)
Date Chemotherapy Started (NAACCR Item #1220)
RX Date–Chemo Flag (NAACCR Item #1221)
Date Hormone Therapy Started (NAACCR Item #1230)
RX Date–Hormone Flag (NAACCR Item #1231)
Date Immunotherapy Started (NAACCR Item #1240)
RX Date BRM Flag (NAACCR Item #1241)
Systemic/Surgery Sequence (NAACCR Item #1639)
Chemotherapy (NAACCR Item #1390)
Hormone Therapy (NAACCR Item #1400)
Immunotherapy (NAACCR Item #1410)
Hematologic Transplant and Endocrine Procedures (NAACCR Item #3250)

#25b-The *SEER*Rx Database* is effective for cases diagnosed on or after 1/1/2005. Version 1.1.0 was used for cases diagnosed 1/1/2005 through 12/31/2006. Version 1.2.0 was used for cases diagnosed beginning 1/1/2007. Version 1.3.0 was used beginning on the date of distribution, 5/29/09. Version 1.4.0 was used beginning on the date of distribution, 01/2010, and was followed with an update to Version 1.4.1 in 01/2010 to correct an error. Version 1.5.0 was released in 09/2010. For cases diagnosed on or prior to 12/31/2004, use *SEER Book 8*. Do not recode cases coded using *SEER Book 8* to be consistent with *SEER*Rx*.

The following items describe systemic therapy performed at this facility:

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

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

Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy drugs. If a patient has an adverse reaction, the managing physician may change one of the agents in a combination regimen. If the replacement agent belongs to the same group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) as the original agent, there is no change in the regimen. However, if the replacement agent is of a different group than the original agent, the new regimen represents the start of subsequent therapy, *only the original agent or regimen is recorded as first course therapy*. Refer to the *SEER*Rx Interactive Drug Database* (*http://seer.cancer.gov/)* for a list of chemotherapeutic agents. See #25b

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

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

Relationships among Systemic Therapy Items

#26a-Since the ACR records cumulative treatment, ACR requests facilities record multiple dates if your software vendor allows for the recording of all cumulative treatment.

The data item *Date Systemic Therapy Started* describes the first date on which any first course systemic treatment was administered to the patient. Nine out of 10 patients treated with systemic therapy receive only a single class of drugs (chemotherapy, hormone therapy, or immunotherapy). Of the remaining patients who receive a combined regimen of systemic therapies, two-thirds begin these combined regimens simultaneously. For the purposes of clinical surveillance, the collection of multiple dates to describe the sequence of systemic therapy administration is not necessary. #26a

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

describe the reason a particular class of drugs is not administered to the patient and distinguishes a physician's not recommending systemic therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan. The associated date items were previously defined by CoC, though discontinued in ***FORDS*** from 2003 through 2009 and the same fields may be used to collect them now, if allowed by the registry software.

Hematologic Transplant and Endocrine Procedures captures those infrequent instances in which a medical, surgical, or radiation procedure is performed on a patient that has an effect on the hormonal or immunologic balance of the patient. Hematologic procedures, such as bone marrow transplants or stem cell harvests, are typically employed in conjunction with administration of systemic agent(s), usually chemotherapy.

- Endocrine procedures, either radiologic or surgical, may be administered in combination with systemic agent(s), typically hormonal therapeutic agents.

- As first course therapy, hematologic procedures will rarely be administered in conjunction with endocrine radiation or surgery. The use of code 40 in response to this data item should be reviewed and confirmed with the managing physician(s).

Other Treatment #27a-Refer to *FORDS* pp. 277-281 for other treatment data items required by the ACR.

Other Treatment encompasses first course treatment that cannot be described as surgery, radiation, or systemic therapy according to the defined data items found in this manual.

This item is also used for supportive care treatment for reportable hematopoietic diseases that do not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Treatments such as phlebotomy, transfusions, and aspirin are recorded in *Other Treatment* data item for certain hematopoietic diseases, and should be coded 1.

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

Date Other Treatment Started (NAACCR Item #1250)
RX Date–Other Flag (NAACCR Item #1251)
Other Treatment (NAACCR Item #1420)
Other Treatment at This Facility (NAACCR Item #730)

Palliative Care #27b-Refer to *FORDS* pp. 282-284 for palliative data items required by the ACR.

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

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

Palliative Care (NAACCR #3270)
Palliative Care at This Facility (NAACCR Item #3280)

Any surgical procedure, radiation therapy, and/or systemic therapy that is provided to modify, control, remove, or destroy primary or metastatic cancer tissue, is coded in the respective first course of treatment fields and also identified in the *Palliative Care* items. Refer to the preceding discussion of the surgery, radiation and systemic therapy data items for specific coding guidelines. Because these treatments are less aggressive when given for palliation than for treatment, the treatment plan or treatment notes will indicate when they are performed for palliative purposes.

- Record as palliative care any of the treatment recorded in the first course therapy items that was provided to prolong the patient's life by managing the patient's symptoms, alleviating pain, or making the patient more comfortable.

- Palliative care can involve pain management that may not include surgery, radiation or systemic treatment.

- It is possible for a patient to receive one or a combination of treatment modalities in conjunction with palliative care intended to reduce the burden of pain. For example, a patient with metastatic prostate cancer may receive an orchiectomy and systemic hormone therapy in combination with palliative radiation for bone metastasis.

TREATMENT, PALLIATIVE, AND PROPHYLACTIC CARE

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

When first course surgery, systemic treatment, or radiation is undertaken to reduce the patient's symptoms, that treatment should be coded as palliative care. An example is radiation to bone metastases for prostate cancer to reduce bone pain, which is palliative when there is no expectation that the radiation will effectively reduce the cancer burden. Palliative care involving surgery, systemic treatment, or radiation is also coded as treatment. This treatment qualifies the patient as analytic if it is given as part of planned first course treatment.

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

EMBOLIZATION

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

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

Radioembolization is embolization combined with injection of small radioactive beads or coils into an organ or tumor. Code *Radiation Modality* as brachytherapy when tumor embolization is performed using a radioactive agent or radioactive seeds.

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

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

OUTCOMES

The outcomes data items describe the known clinical and vital status of the patient. Follow-up information is obtained at least annually for all living Class of Case 10-22 patients included in a cancer registry's database. Recorded follow-up data should reflect the most recent information available to the registry that originates from reported patient hospitalizations, known patient readmissions, contact with the patient's physician, and/or direct contact with the patient. #29a

#29a-The ACR requires that Class of Case 00 patients be followed.

Individual item descriptions in Section Two of this manual should be consulted for specific coding instructions. The paragraphs below describe the range of follow-up information that should be obtained.

Follow-up items that are required to be in the facility's database:

There may be times when first course treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the necessary treatment information is collected. This includes:

- Complete first course of treatment information when *Surgical Procedure of Primary Site* (NAACCR Item #1290) is delayed six months or more following the *Date of First Contact* (NAACCR Item #580).
- *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* (NAACCR Item #3190) following the most definitive surgery.
- Radiation, chemotherapy, hormone therapy, immunotherapy, hematologic transplant and endocrine procedures, or other treatment that had been indicated as being planned as part of first course of treatment, but not been started or completed as of the most recent follow-up date. Use "reason for no" treatment codes of 88 or 8 as ticklers to identify incomplete treatment information.
- When all planned first course treatment has been recorded, first course treatment items no longer need to be followed.
- The CoC does not require Class 00 cases diagnosed on or after January 1, 2006 to be followed. #29a
- Follow-up for disease recurrence should be conducted until (a) evidence of disease recurrence is reported, or (b) the patient dies. If the *Type of First Recurrence* (NAACCR Item #1880) is coded 70 (never cancer free), when the patient was last seen, but treatment was still underway, then check at follow-up to see whether the patient subsequently became cancer-free. Occasionally, if first course treatment ends due to disease progression, it may be the second course or subsequent treatment that results in a cancer-free status. If the *Type of First Recurrence* is coded 00 (became cancer-free and has had no recurrence), then continue to follow for recurrence and record the type and date when it occurs. Reappearance of a tumor of the same histology in the same primary site during the time period defined by the SEER Multiple Primary and Histology Coding Rules does not constitute a recurrence.

Once the first recurrence has been recorded, do not update recurrence items further.

While the patient is alive, be sure that contact information is kept current. Contact information includes:

Patient Address–Current (NAACCR Item #2350)
City/Town–Current (NAACCR Item #1810)
State–Current (NAACCR Item #1820)
Postal Code–Current (NAACCR Item #1830)
Telephone (NAACCR Item #2360)
Date of Last Contact (NAACCR Item #1750)
Follow-Up Source, (NAACCR Item #1790)
Next Follow-Up Source (NAACCR Item #1800).

Follow-up for *Vital Status* (NAACCR Item #1760) and *Cancer Status* (NAACCR Item #1770) should be conducted annually for all analytic cases in the cancer program's registry. *Class of Case* 00 patients that are not followed will have the most recent information as of the *Date of Last Contact*. See #29a

Once the patient's death has been recorded and all care given prior to death is recorded, no further follow-up is performed.

CASE ADMINISTRATION

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

Administrative Tracking #30a-Refer to the complete list of administrative tracking items on the ACR Required Data Items listing.

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

Abstracted By (NAACCR Item #570)
Facility Identification Number (*FIN)* (NAACCR Item #540)
NPI-Reporting Facility (NAACCR Item #545)
Archive FIN (NAACCR Item #3100)
*NPI-Archive FIN (*NAACCR Item #3105)

Abstracted By, *Facility Identification Number* (FIN), and *NPI-Reporting Facility* identify the individual and facility responsible for compiling the record. *Archive FIN* and *NPI-Archive FIN* store the identification numbers assigned to the original abstracting facility and are used to convey the original identity assigned to a facility that has since merged with another. In a registry with more than one abstractor or serving more than one facility, it will ordinarily be necessary to enter these three numbers only when they change. All of these items should be autocoded by the registry software.

Note: A complete list of FINs is available on the American College of Surgeons Web site at *http://www.facs.org/cancer/coc/fin.html.* NPI numbers are available through the facility's billing or accounting department or at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

EDITS Overrides

Some of the CoC edits identify rare, but possible, code combinations. For these edits, an override flag can be set if, upon review, the unusual combination is verified as being correct. Once set, the error message will not be repeated on subsequent EDITS passes.

- When no error message is generated by an edit that uses an override item, no action by the registrar is needed.
- If an error message is generated, the problem can often be resolved by checking the accuracy of the entry for each item that contributes to the edit and correcting any problems identified. If correction of

data entry errors resolves the problem, do not make an override entry. 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.

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

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

#31a-The ACR requires additional over-rides. See *ACR Supplement* pp. 340A-340I.

Code Versions Used

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

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

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

#31b-Refer to the complete list of administrative tracking items on the ACR Required Data Items listing.

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

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

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

RX Coding System–Current identifies whether the treatment information was recorded using CoC rules or SEER rules and the version of each applied. The CoC requires that the *FORDS* manual be followed for all cases diagnosed January 1, 2003, or later (*RX Coding System–Current* = 06).

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

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

SECTION TWO:
Instructions for Coding

Patient Identification

TYPE OF REPORTING SOURCE

Item Length: 1
Allowable Codes: 1-8
NAACCR Item #500

ACR Required Data Item

Description
This variable codes the source documents used to abstract the majority of information on the tumor being reported. Code identifying source documents used to abstract the cancer being reported. This may not be the source of the original case finding (for example, if a case is first identified through a pathology report review and all source documents used to abstract the case are from a radiation treatment center record, code this item "2," not "3").

Rationale
The code in this field can be used to explain why information may be incomplete on a tumor. For example, death certificate only cases have unknown values for many data items, so one may want to exclude them from some analyses. The field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death certificate-only cases where no hospital admission was involved, but too high a percentage can imply both shortcomings in case-finding and that follow-back to uncover missed hospital reports was not complete.

Instructions for Coding
Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This is a change to reflect the addition of codes 2 and 8 and to prioritize laboratory reports over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

This data item is intended to indicate the completeness of information available to the abstractor. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients, which is why these sources are grouped with inpatients and given the code with the highest priority.

Sources coded with '2' usually have complete information on the cancer diagnosis, staging, and treatment.

Sources coded with '8' would include, but would not be limited to, outpatient surgery and nuclear medicine services. A physician's office that calls itself a surgery center should be coded as a physician's office. Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. If a physician's office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Code	Label
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3	Laboratory only (hospital-affiliated or independent)
4	Physician's office/private medical practitioner (LMD)
5	Nursing/convalescent home/hospice
6	Autopsy only
7	Death certificate only
8	Other hospital outpatient units/surgery centers

Exception: Code (6) "Autopsy Only" or code (7) "Death Certificate Only" are used only if the tumor was not diagnosed, even clinically, while the patient was alive. For example, if the patient was an inpatient with another admitting diagnosis and dies, and the autopsy is disclosed tumor for the first time, use code (6). A clinical diagnosis by any of the sources coded (1-5, 8) has priority over confirmation at autopsy.

CASEFINDING SOURCE

ACR Required Data Item

Item Length: 2
Allowable Codes: 10, 20-29; 30, 40, 50, 60, 70, 75, 80, 85, 90, 95, 99
NAACCR Item #501

Description
This variable codes the earliest source of identifying information. For cases identified by a source other than reporting facilities (such as through death clearance or as a result of an audit), this variable codes the type of source through which the tumor was first identified. This data item cannot be used by itself as a data quality indicator. The timing of the casefinding processes (e.g., death linkage) varies from registry to registry, and the coded value of this variable is a function of that timing.

Rationale
This data item will help reporting facilities as well as regional and central registries in prioritizing their casefinding activities. It will identify reportable tumors that were first found through death clearance or sources other than traditional reporting facilities. It provides more detail than "Type of Reporting Source."

Instructions for Coding
This variable is intended to code the source that first identified the tumor. Determine where the case was first identified and enter the appropriate code. At the regional or central level, if a hospital and a non-hospital source identified the case independently of each other, enter the code for the non-hospital source (i.e., codes 30-95 have priority over codes 10-29). If the case was first identified at a reporting facility (codes 10-29), code the earliest source (based on patient or specimen contact at the facility) of identifying information. If a death certificate, independent pathology laboratory report, consultation-only report from a hospital, or other report was used to identify a case that was then abstracted from a different source, enter the code for the source that first identified the case, not the source from which it was subsequently abstracted.
Codes 10-29 are used primarily by hospitals; codes 30-95 are used primarily by central registries.

Code	Label
10	Reporting Hospital, NOS
20	Pathology Department Review (surgical pathology reports, autopsies, or cytology reports)
21	Daily Discharge Review (daily screening of charts of discharged patients in the medical records department)
22	Disease Index Review (review of disease index in the medical records department)
23	Radiation Therapy Department/Center
24	Laboratory Reports (other than pathology reports, code 20)
25	Outpatient Chemotherapy
26	Diagnostic Imaging/Radiology (other than radiation therapy, codes 23; includes nuclear medicine)
27	Tumor Board
28	Hospital Rehabilitation Service or Clinic
29	Other Hospital Source (including clinic, NOS or outpatient department, NOS)

Case first identified by source other than a reporting facility covered in the codes above:

Code	Label
30	Physician-Initiated Case
40	Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
50	Independent (non-hospital) Pathology-Laboratory Report
60	Nursing Home-Initiated Case
70	Coroner's Office Records Review
75	Managed Care Organization (MCO) or Insurance Records
80	Death Certificate (case identified through death clearance)
85	Out-of-State Case Sharing
90	Other Non-Reporting Hospital Source
95	Quality Control Review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
99	Unknown

ACCESSION NUMBER

ACR Required Data Item #37a

Item Length: 9
NAACCR Item #550
Revised 01/04, 01/10

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

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

Instructions for Coding
- When a patient is deleted from the database, **do not** reuse the accession number for another patient.
- The first four numbers specify the year and the last five numbers are the numeric order in which the patient was entered into the registry database.
- Numeric gaps are allowed in accession numbers.
- A patient's accession number is never reassigned.
- If a patient is first accessioned into the registry, then the registry later changes its reference date and the patient is subsequently accessioned into the registry with a new primary, use the original accession number associated with the patient and code the data item *Sequence Number* (NAACCR Item #560) appropriately.

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

Examples

Code	Reason
200300033	Patient enters the hospital in 2003, and is diagnosed with breast cancer. The patient is the thirty-third patient accessioned in 2003.
200300033	A patient with the accession number 200300033 for a breast primary returns to the hospital with a subsequent colon primary in 2004. The accession number will remain the same. *Sequence Number* (NAACCR Item #560) will distinguish this primary.
200300010	Patient diagnosed in November 2002 at another facility enters the reporting facility in January 2003, and is the tenth case accessioned in 2003.
200300012	Patient diagnosed in staff physician office in December 2002 enters the reporting facility in January 2003, and is the twelfth case accessioned in 2003.
199100067	Patient enters the hospital in 1991 and is diagnosed with prostate cancer. The registry later sets a new reference date of January 1, 1997. The same patient presents with a diagnosis of lymphoma in 2005. *Sequence Number* (NAACCR Item #560) will distinguish this primary.
200300001	First patient diagnosed and/or treated and entered into the registry database for 2003.
200300999	Nine hundred ninety-ninth patient diagnosed and/or treated and entered into the registry database for 2003.
200401504	One thousand five hundred fourth patient diagnosed and/or treated and entered into the registry database for 2004.

SEQUENCE NUMBER

ACR Required Data Item #38a

Item Length: 2
Allowable Values: 00–88, 99
NAACCR Item #560
Revised 06/05, 04/07, 01/10

Description
Indicates the sequence of malignant and nonmalignant neoplasms over the lifetime of the patient.

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

Instructions for Coding

- Codes 00–59 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 nonmalignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent nonmalignant primaries sequentially.
- If two or more malignant or *in situ* neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- Any tumor in the patient's past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes nonreportable later. #38b-The ACR does not accept reportable-by-agreement cases.
- Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

#38c-See additional coding notes #39a, #39b and #39c.

Malignant or In Situ Primaries

Code	Definition
00	One malignant or *in situ* primary only in the patient's lifetime
01	First of two or more independent malignant or *in situ* primaries
02	Second of two or more independent or *in situ* primaries
…	
…	(Actual sequence of this malignant or *in situ* primary)
…	
59	Fifty-ninth of 59 or more independent malignant or *in situ* primaries
99	Unknown number of malignant or *in situ* primaries

Non-Malignant Primaries

Code	Definition
60	One nonmalignant primary only in the patient's lifetime #39a
61	First of two or more independent nonmalignant primaries
62	Second of two or more independent nonmalignant primaries
…	
…	(Actual sequence of this nonmalignant primary)
…	
87	Twenty-seventh of 27 or more independent nonmalignant primaries
88	Unspecified number of independent nonmalignant primaries

Examples

Code	Reason
00	Patient with no previous history of cancer diagnosed with *in situ* breast carcinoma on June 13, 2003
01	The sequence number is changed when the patient with an *in situ* breast carcinoma diagnosed June 13, 2003, is diagnosed with a subsequent melanoma on August 30, 2003
02	Sequence number assigned to the melanoma diagnosed on August 30, 2003, following a breast cancer *in situ* diagnosis on June 13, 2003
04	A nursing home patient is admitted to the hospital for first course surgery for a colon adenocarcinoma. The patient has a prior history of three malignant cancers of the type the registry is required to accession, though the patient was not seen for these cancers at the hospital. No sequence numbers 01, 02 or 03 are accessioned for this patient.
60	The sequence number assigned to a benign brain tumor diagnosed on November 1, 2005, following a breast carcinoma diagnosed on June 13, 2003, and a melanoma on August 30, 2003.
63	Myeloproliferative disease (9975/1) is diagnosed by the facility in 2003 and accessioned as Sequence 60. A benign brain tumor was diagnosed and treated elsewhere in 2002; the patient comes to the facility with a second independent benign brain tumor in 2004. Unaccessioned earlier brain tumor is counted as Sequence 61, myeloproliferative disease is resequenced to 62, and second benign brain tumor is Sequence 63. #39b

#39a-All benign/central nervous system tumors must be sequenced prior to any other non-reportable tumors (referred to as "reportable-by-agreement"). The sequence code of 60 is always a benign brain/central nervous system tumor (one benign tumor only).

#39b-The ACR does not require reportable-by-agreement cases; therefore, in this example, the 2002 brain tumor would be changed from sequence 60 to sequence 61. The later tumor in 2004 would be sequence 62.

#39c-Effective with cases diagnosed on or after January 1, 1994, carcinoma in situ (CIS) of the cervix is no longer reportable to the the ACR. If these cases are collected by a hospital after the noted date, they are to be excluded from ACR sequencing. Do not submit these cases to the ACR.

Example 1:
CIS of cervix diagnosed before 1/1/94
Breast carcinoma diagnosed 1992 = Sequence 01
CIS of cervix diagnosed 1993 = Sequence 02

Example 2:
Other cancer and CIS of cervix diagnosed on or after 1/1/94
Breast carcinoma diagnosed 1995 = Sequence 00
CIS of cervix diagnosed 2000 = Not reportable

Example 3:
CIS of cervix diagnosed on or after 1/1/94
Breast carcinoma diagnosed 1990 = Sequence 01
CIS of cervix diagnosed 1994 = Not reportable
Colon carcinoma diagnosed 1996 = Sequence 02

MEDICAL RECORD NUMBER

Item Length: 11
Right Justified, Leading Blanks
NAACCR Item #2300
Revised 01/11

ACR Required Data Item #40a

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

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

Instructions for Coding

- Record the medical record number.

Examples

Code	Reason
——NNNN	If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.
—-NNNNRT (Radiology) ——-NNSU (One-day surgery clinic)	Record standard abbreviations for departments that do not use HIM medical record numbers.
———UNK	Unknown

SOCIAL SECURITY NUMBER

ACR Required Data Item #41a

Item Length: 9
NAACCR Item #2320

Description
Records the patient's Social Security number.

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

Instructions for Coding

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

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

LAST NAME

Item Length: 40
Mixed Case, Left Justified
NAACCR Item #2230
Revised 01/04, 01/10

ACR Required Data Item #42a

Description
Identifies the last name of the patient.

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

Instructions for Coding

- Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.
- Do not leave blank; code as UNKNOWN if the patient's last name is unknown.
- This field may be updated if the last name changes.

Examples

Code	Reason
Mc Donald	Recorded with space as Mc Donald
O'Hara	Recorded with apostrophe as O'Hara
Smith-Jones	Janet Smith marries Fred Jones and changes her last name to Smith-Jones
UNKNOWN	Patient's last name is not known, use UNKNOWN

FIRST NAME

Item Length: 40
Mixed Case, Left Justified
NAACCR Item #2240
Revised 01/10, 01/11

ACR Required Data Item #43a

Description
Identifies the first name of the patient.

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

Instructions for Coding

- Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.
- This field may be updated if the name changes.

Examples

Code	Reason
Michael	Patient's name is Michael David Hogan
(leave blank)	If patient's first name is not known, do not fill in the space.

MIDDLE NAME
(MIDDLE INITIAL)

ACR Required Data Item #44a

Item Length: 40
Mixed Case, Left Justified
NAACCR Item #2250
Revised 01/10, 01/11

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

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

Instructions for Coding

- Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.
- This field may be updated if the name changes.

Examples

Code	Reason
David	Patient's name is Michael David Hogan
D	Patient's name is Michael D. Hogan
(leave blank)	If patient's middle name is not known or there is none, do not fill in the space.

NAME—MAIDEN

ACR Required Data Item

Item Length: 40
Left Justified
NAACCR Item #2390

Description
Records a maiden name of female patients who are or have been married.

Rationale
This is used to link reports on female patients who changed their name between reports. It is also critical when using Spanish surname algorithms to categorize ethnicity.

Instructions for Coding
Record the "Maiden name" of female patients who are, or have been married. The data item should be left blank if the maiden name is not known or not applicable. Embedded hyphen is allowed, but no other special characters or embedded spaces. If elected to, the name with punctuation may be coded elsewhere on the abstract.

Example: Code Mc Donald as "Mcdonald"; Code O'Hara as "Ohara".

NAME—ALIAS

ACR Required Data Item

Item Length: 40
Left Justified
NAACCR Item #2280

Description
Records an alternate name or AKA (also known as) used by the patient, if known. Note that Maiden Name is recorded in a separate field.

Rationale
This is a useful item for matching multiple records for the same patient.

Instructions for Coding
If the patient uses an alias for a first name only, record the last name followed by the first name alias.

*Example: R*alph Williams uses the name Bud Williams. Record Williams Bud in the alias field.

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

Example: Janice Smith uses the name Janice Brown. Record Brown Janice in the alias field.

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

Example: Joe Smith uses the name Elmer Fudd as an alias. Record Fudd Elmer in the alias field.

Leave this field blank if the patient does not have an alias or if the alias is not known.

NAME—SUFFIX

Item Length: 3
NAACCR Item #2270

Not Required by ACR

Description
Title that follows a patient's last name, such as a generation order or credential status (e.g. MD, Jr.).

Rationale
This is a useful item for matching multiple records for the same patient.

Instructions for Coding
Record the name suffix for the patient.

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ACR Supplement Page

PATIENT ADDRESS (NUMBER AND STREET) AT DIAGNOSIS

ACR Required Data Item #45a

Item Length: 60
Uppercase, Left Justified
NAACCR Item #2330
Revised 01/10

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

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

Instructions for Coding #45b

#45c-See *FORDS* p.14 in Section One and Place of Residence at Diagnosis Clarifications on pp. 46A-46B.

- Record the number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28. #45d-See *ACR Supplement* pp. 46C-46D.
- Punctuation is normally limited to periods (for example, 39.2 RD), slashes for fractional addresses (101 1/2 MAIN ST), and hyphens when a hyphen carries meaning (289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (425 FLOWER BLVD # 72).
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not update this data item if the patient's address changes.
- See "Residency Rules" in Section One for further instructions.

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

#45b-For non-analytic cases, use the patient's place of residence at the time he/she was diagnosed and/or treated for this primary. Therefore, for many non-analytic cases the residence at diagnosis may be unknown.

PATIENT ADDRESS AT DIAGNOSIS –SUPPLEMENTAL

ACR Required Data Item #46a

Item Length: 60
Uppercase, Left Justified
NAACCR Item #2335
Revised 09/06, 01/10

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

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

Instructions for Coding

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

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

PLACE OF RESIDENCE AT DIAGNOSIS CLARIFICATIONS

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

The SEER rules for determining residency at diagnosis are either identical or comparable to rules used by the US Census Bureau, to ensure comparability of definitions of cases (numerator) and the population at risk (denominator). The ACR follows SEER guidelines for residence at diagnosis. The SEER guidelines are consistent with the rules in *FORDS*. See additional information on page 14 of *FORDS.*

Coding Priorities/Sources

1. Code the street address of usual residence as stated by the patient. Definition: US Census Bureau Instructions: "The place where he or she lives and sleeps most of the time or the place the person says is his or her usual home." The residency rules of departments of vital statistics may differ from those of the US Census Bureau/SEER.

2. A post office Box is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Use the post office box address only if no street address information is available after follow-back.

3. Use residency information from a death certificate only when the residency from other sources is coded as unknown. Review each case carefully and apply the US Census Bureau/SEER rules for determining residence. The death certificate may give the person's previous home address rather than the nursing home address as the place of residence; use the nursing home address as the place of residence

4. Do not use legal status or citizenship to code residence.

Person with More than One Residence

1. Code the residence where the patient spends the majority of time (usual residence).

2. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

Examples: The above rules should be followed for "snowbirds" who live in the south for the winter months, "sunbirds" who live in the north during the summer months, and people with vacation residences that they occupy for a portion of the year.

Person with No Usual Residence

Homeless people and transients are examples of persons with no usual residence. Code the patient's residence at the time of diagnosis such as the shelter or the hospital where diagnosis was confirmed.

Temporary Residents

Code the place of usual residence rather than the temporary address for:
•Migrant workers
•Educators temporarily assigned to a university
•Persons temporarily residing with family during cancer treatment
•Military personnel on temporary duty assignments (TDY)
•Boarding school students below college level (code the parent's residence)

Code the residence where the student is living while attending college.

PLACE OF RESIDENCE AT DIAGNOSIS CLARIFICATIONS

Code the address of the institution for Persons in Institutions.
US Census Bureau definition: "Persons under formally authorized, supervised care or custody" are residents of the institution."
•Persons who are incarcerated
•Persons who are physically handicapped, mentally retarded, or mentally ill who are residents of homes, schools, hospitals or wards
•Residents of nursing, convalescent, and rest homes
•Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships (Merchant Marine)

Armed Forces
For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.

Personnel Assigned to Navy, Coast Guard, and Maritime Ships
The US Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and its homeport. Refer to US Census Bureau Publications for detailed rules: http://www.census.gov.

STREET SUFFIX ABBREVIATIONS FOR PATIENT ADDRESS

Source: USPS Postal Addressing Standards, Pub 28, April 2010.

Primary Street Suffix Name	Postal Standard Suffix Abbreviation	Primary Street Suffix Name	Postal Standard Suffix Abbreviation	Primary Street Suffix Name	Postal Standard Suffix Abbreviation
ALLEY	ALY	CROSSING	XING	HEIGHTS	HTS
ANEX	ANX	CROSSROAD	XRD	HIGHWAY	HWY
ARCADE	ARC	CROSSROADS	XRDS	HILL	HL
AVENUE	AVE	CURVE	CURV	HILLS	HLS
BAYOU	BYU	DALE	DL	HOLLOW	HOLW
BEACH	BCH	DAM	DM	INLET	INLT
BEND	BND	DIVIDE	DV	ISLAND	IS
BLUFF	BLF	DRIVE	DR	ISLANDS	ISS
BLUFFS	BLFS	DRIVES	DRS	ISLE	ISLE
BOTTOM	BTM	ESTATE	EST	JUNCTION	JCT
BOULEVARD	BLVD	ESTATES	ESTS	JUNCTIONS	JCTS
BRANCH	BR	EXPRESSWAY	EXPY	KEY	KY
BRIDGE	BRG	EXTENSION	EXT	KEYS	KYS
BROOK	BRK	EXTENSIONS	EXTS	KNOLL	KNL
BROOKS	BRKS	FALL	FALL	KNOLLS	KNLS
BURG	BG	FALLS	FLS	LAKE	LK
BURGS	BGS	FERRY	FRY	LAKES	LKS
BYPASS	BYP	FIELD	FLD	LAND	LAND
CAMP	CP	FIELDS	FLDS	LANDING	LNDG
CANYON	CYN	FLAT	FLT	LANE	LN
CAPE	CPE	FORD	FRD	LIGHT	LGT
CAUSEWAY	CSWY	FORDS	FRDS	LIGHTS	LGTS
CENTER	CTR	FOREST	FRST	LOAF	LF
CENTERS	CTRS	FORGE	FRG	LOCK	LCK
CIRCLE	CIR	FORGES	FRGS	LOCKS	LCKS
CIRCLES	CIRS	FORK	FRK	LODGE	LDG
CLIFF	CLF	FORKS	FRKS	LOOP	LOOP
CLIFFS	CLFS	FORT	FT	MALL	MALL
CLUB	CLB	FREEWAY	FWY	MANOR	MNR
COMMON	CMN	GARDEN	GDN	MANORS	MNRS
COMMONS	CMNS	GARDENS	GDNS	MEADOW	MDW
CORNER	COR	GATEWAY	GTWY	MEADOWS	MDWS
CORNERS	CORS	GLEN	GLN	MEWS	MEWS
COURSE	CRSE	GLENS	GLNS	MILL	ML
COURT	CT	GREEN	GRN	MILLS	MLS
COURTS	CTS	GREENS	GRNS	MISSION	MSN
COVE	CV	GROVE	GRV	MOTORWAY	MTWY
COVES	CVS	GROVES	GRVS	MOUNT	MT
CREEK	CRK	HARBOR	HBR	MOUNTAIN	MTN
CRESCENT	CRES	HARBORS	HBRS	MOUNTAINS	MTNS
CREST	CRST	HAVEN	HVN	NECK	NCK

STREET SUFFIX ABBREVIATIONS FOR PATIENT ADDRESS

Source: USPS Postal Addressing Standards, Pub 28, April 2010.

Continued from page 46C.

Primary Street Suffix Name	Postal Standard Suffix Abbreviation	Primary Street Suffix Name	Postal Standard Suffix Abbreviation	Primary Street Suffix Name	Postal Standard Suffix Abbreviation
ORCHARD	ORCH	RIDGE	RDG	TRACE	TRCE
OVAL	OVAL	RIDGES	RDGS	TRACK	TRAK
OVERPASS	OPAS	RIVER	RIV	TRAFFICWAY	TRFY
PARK	PARK	ROAD	RD	TRAIL	TRL
PARKS	PARK	ROADS	RDS	TRAILER	TRLR
PARKWAY	PKWY	ROUTE	RTE	TUNNEL	TUNL
PARKWAYS	PKWY	ROW	ROW	TURNPIKE	TPKE
PASS	PASS	RUE	RUE	UNDERPASS	UPAS
PASSAGE	PSGE	RUN	RUN	UNION	UN
PATH	PATH	SHOAL	SHL	UNIONS	UNS
PIKE	PIKE	SHOALS	SHLS	VALLEY	VLY
PINE	PNE	SHORE	SHR	VALLEYS	VLYS
PINES	PNES	SHORES	SHRS	VIADUCT	VIA
PLACE	PL	SKYWAY	SKWY	VIEW	VW
PLAIN	PLN	SPRING	SPG	VIEWS	VWS
PLAINS	PLNS	SPRINGS	SPGS	VILLAGE	VLG
PLAZA	PLZ	SPUR	SPUR	VILLAGES	VLGS
POINT	PT	SPURS	SPUR	VILLE	VL
POINTS	PTS	SQUARE	SQ	VISTA	VIS
PORT	PRT	SQUARES	SQS	WALK	WALK
PORTS	PRTS	STATION	STA	WALKS	WALK
PRAIRIE	PR	STRAVENUE	STRA	WALL	WALL
RADIAL	RADL	STREAM	STRM	WAY	WAY
RAMP	RAMP	STREET	ST	WAYS	WAYS
RANCH	RNCH	STREETS	STS	WELL	WL
RAPID	RPD	SUMMIT	SMT	WELLS	WLS
RAPIDS	RPDS	TERRACE	TER		
REST	RST	THROUGHWAY	TRWY		

USPS Secondary Unit Designators - Approved Abbreviations for Patient Address

Description	Approved Abbreviation	Description	Approved Abbreviation	Description	Approved Abbreviation
Apartment	APT	Lobby	LBBY	Side	SIDE
Basement	BSMT	Lot	LOT	Slip	SLIP
Building	BLDG	Lower	LOWR	Space	SPC
Department	DEPT	Office	OFC	Stop	STOP
Floor	FL	Penthouse	PH	Suite	STE
Front	FRNT	Pier	PIER	Trailer	TRLR
Hanger	HNGR	Rear	REAR	Unit	UNIT
Key	KEY	Room	RM	Upper	UPPR

CITY/TOWN AT DIAGNOSIS (CITY OR TOWN)

ACR Required Data Item #47a

Item Length: 50
Uppercase, Left Justified
NAACCR Item #70
Revised 01/10

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

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

Instructions for Coding

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

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

STATE AT DIAGNOSIS
(STATE)

ACR Required Data Item #48a

Item Length: 2
Uppercase
NAACCR Item #80
Revised 09/06, 01/10, 01/11

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

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

Instructions for Coding

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

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

Common U.S. Abbreviations (refer to the ZIP Code directory for further listings):

State		State		State	
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	WV
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unknown	US
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

Canadian Provinces and Territory Abbreviations

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	Canada, province unknown	CD

POSTAL CODE AT DIAGNOSIS (ZIP CODE)

Item Length: 9
Left Justified
NAACCR Item #100
Revised 01/04

ACR Required Data Item #50a

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

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

Instructions for Coding

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

Code	Definition
(fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611_ _ _ _	When the nine-digit extended U.S. ZIP Code is not available, record the five-digit postal code, left justified, followed by four blanks.
M6G2S8_ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks.
88888_ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions **and** postal code is unknown. #50b
99999_ _ _ _ or 999999999	Permanent address in Canada, United States, or U.S. possession **and** postal code is unknown. #50b

#50b-The ACR requires ALL spaces to be filled with either "8" or "9," as appropriate.

COUNTY AT DIAGNOSIS

Item Length: 3
Allowable Values: 001–997, 998, 999
NAACCR Item #90
Revised 09/06, 01/10

ACR Required Data Item #51a

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

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

Instructions for Coding #51b

- For U.S. residents, use codes issued by the Federal Information Processing Standards (FIPS) publication *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. This publication is available in a reference library or can be accessed on the Internet through the U.S. EPA's Envirofacts Data Warehouse and Applications Web site at *http://www.epa.gov/*.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- If the patient is a non-U.S. resident and is coded XX in *State at Diagnosis* (NAACCR Item #80), then code the patient's country of residence in this space.
- For country codes, see the current version of *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*. #51c-See Appendix F.
- Do not update this data item if the patient's county of residence changes.

Code	Label	Definition
001–997	County at diagnosis	Valid FIPS code. #51d
998	Outside state/county code unknown	Known town, city, state, or country of residence, but county code not known **and** a resident outside of the state of the reporting institution (must meet all criteria).
999	County unknown	The county of the patient is unknown. It is not documented in the patient's medical record.

#51b-For non-analytic cases, the county at diagnosis is the patient's place of residence at the time he/she was diagnosed and/or treated for this primary. Therefore, for many non-analytic cases the county at diagnosis may be unknown.

#51d-FIPS County Codes for Arizona

Apache	001	Mohave	015
Cochise	003	Navajo	017
Coconino	005	Pima	019
Gila	007	Pinal	021
Graham	009	Santa Cruz	023
Greenlee	011	Yavapai	025
La Paz	012	Yuma	027
Maricopa	013		

PATIENT ADDRESS (NUMBER AND STREET) CURRENT

ACR Required Data Item #52a

Item Length: 60
Uppercase, Left Justified
NAACCR Item #2350
Revised 09/04, 01/10

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

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

Instructions for Coding

- Record the number and street address or the rural mailing address of the patient's current usual residence.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28. #52b-See *ACR Supplement* pp. 46C-46D.
- Punctuation is normally limited to periods (for example, 39.2 RD), slashes for fractional addresses (101 1/2 MAIN ST), and hyphens when a hyphen carries meaning (289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (425 FLOWER BLVD # 72).
- Update this data item if the patient's address changes.
- Do not change this item when the patient dies.
- See "Residency Rules" in Section One for further instructions.

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

PATIENT ADDRESS CURRENT –SUPPLEMENTAL

Not Required by ACR #53a

Item Length: 60
Uppercase, Left Justified
NAACCR Item #2355
Revised 09/06, 01/10

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

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

Instructions for Coding

- Record the place or facility (for example, a nursing home or name of an apartment complex) of the patient's current usual residence.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Update this data item if a patient's address changes.
- Do not use this data item to record the number and street address of the patient.
- Do not change this item when the patient dies.
- See "Residency Rules" in Section One for further instructions.

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

CITY/TOWN–CURRENT

Item Length: 50
Uppercase, Left Justified
NAACCR Item #1810
Revised 09/04

ACR Required Data Item #54a

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

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

Instructions for Coding

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- If the patient has multiple malignancies, the current city or town should be the same for all tumors.
- Update this data item if the patient's city or town of residence changes.
- Do not change this item when the patient dies.
- See "Residency Rules" in Section One for further instructions.

Code	Definition
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary. #54b
UNKNOWN	The city in which the patient resides is unknown.

#54b-Do not abbreviate the name of a city if there is space for the entire name. For example, do not enter "PHX" for Phoenix. Enter the entire name.

STATE–CURRENT

Item Length: 2
Uppercase
NAACCR Item #1820
Revised 09/06, 01/11

ACR Required Data Item #55a

Description
Identifies the patient's current state of residence.

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

Instructions for Coding

- Use U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory of the patient's current usual residence.
- If the patient has multiple tumors, the current state of residence should be the same for all tumors.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Update this data item if the patient's state of residence changes.
- Do not change this item when the patient dies.

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

Common U.S. abbreviations (refer to the ZIP Code directory for further listings):

State		State		State	
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	WV
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unknown	US
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

Canadian Provinces or Territory abbreviations:

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	Canada, province unknown	CD

POSTAL CODE–CURRENT (ZIP CODE)

ACR Required Data Item #57a

Item Length: 9
Left Justified
NAACCR Item #1830
Revised 01/04

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

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

Instructions for Coding

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

Code	Definition
(fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611_ _ _ _	When the nine-digit extended U.S. ZIP Code is not available, record the five-digit postal code, left justified, followed by four blanks.
M6G2S8_ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks.
88888_ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions **and** postal code is unknown. #57b
99999_ _ _ _ or 999999999	Permanent address in Canada, United States, or U.S. possession **and** postal code is unknown. #57b

#57b-The ACR requires ALL spaces to be filled with either "8" or "9," as appropriate.

TELEPHONE

Not Required by ACR #58a

Item Length: 10
NAACCR Item #2360

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

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

Instructions for Coding

- The telephone number should be the current number with area code of the patient.
- Update this data item if the patient's telephone number changes. #58b

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

#58b-Some cancer data software vendors have additional descriptors in the telephone field. Code per the software. For example, RMCDS has one additional field located at the end of the patient phone number (###-###-####-#). This field is used to designate the person to whom the telephone number belongs. This information can be used for follow-up.
The codes are as follows:
0-Parent
1-Patient
2-Son or Daughter
3-Relative
4-Friend
5-Cell

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ACR Supplement Page

SEER GEOCODES FOR CODING PLACE OF BIRTH

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). ***2010 SEER Program Coding and Staging Manual*****. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD**

See Appendix F for complete listing.

Continental United States and Hawaii

000United States			
001 New England States		050 Northern Midwest States	
002	Maine	051	Wisconsin
003	New Hampshire	052	Minnesota
004	Vermont	053	Iowa
005	Massachusetts	054	North Dakota
006	Rhode Island	055	South Dakota
007	Connecticut	056	Montana
008	New Jersey	060 Central Midwest States	
010 North Mid-Atlantic States		061	Illinois
011	New York	063	Missouri
014	Pennsylvania	065	Kansas
017	Delaware	067	Nebraska
020 South Mid-Atlantic States		070 Southern Midwest States	
021	Maryland	071	Arkansas
022	District of Columbia	073	Louisiana
023	Virginia	075	Oklahoma
024	West Virginia	077	Texas
025	North Carolina	080 Mountain States	
026	South Carolina	081	Idaho
030 Southeastern States		082	Wyoming
031	Tennessee	083	Colorado
033	Georgia	084	Utah
035	Florida	085	Nevada
037	Alabama	086	New Mexico
039	Mississippi	087	Arizona
040 North Central States		090 Pacific Coast States	
041	Michigan	091	Alaska
043	Ohio	093	Washington
045	Indiana	095	Oregon
047	Kentucky	097	California
		099	Hawaii

PLACE OF BIRTH

Item Length: 3
Allowable Values: 000–750, 998, 999
NAACCR Item #250
Revised 09/06

ACR Required Data Item #59a

Description
Records the patient's place of birth.

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

Instructions for Coding

- Use the most specific code.
- Use the SEER Geocodes for "Place of Birth." These codes include states of the United States as well as foreign countries.
- For SEER Geocodes, see the most recent *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*. #59b

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

#59b-See *ACR Supplement* page 58A for the geocodes for the Continental United States and Hawaii, see Appendix F for a complete listing.

DATE OF BIRTH

Item Length: 8
NAACCR Item #240
Revised 1/10

ACR Required Data Item #60a

Description
Identifies the date of birth of the patient.

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

Instructions for Coding

- Record the patient's date of birth as indicated in the patient record. For single-digit day or month, record with a lead 0 (for example, September is 09). Use the full four-digit year for year.
- For *in utero* diagnosis and treatment, record the actual date of birth. It will follow one or both dates for those events.
- If only the patient age is available, calculate the year of birth from age and the year of diagnosis and leave day and month of birth unknown (for example, a 60 year old patient diagnosed in 2010 is calculated to have been born in 1950).
- If month is unknown, the day is coded unknown. If the year can not be determined, the day and month are both coded unknown.
- If the date of birth can not be determined at all, record the reason in *Date of Birth Flag* (NAACCR Item #241)
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about date entry in their own systems. The traditional format for *Date of Birth* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Birth* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date. The *Date of Birth Flag* (NAACCR Item #241) is used to explain why *Date of Birth* is not a known date. See *Date of Birth Flag* for an illustration of the relationships among these items.

#60b-Collection, Storage, and Transmission of Date of Birth
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

DATE OF BIRTH FLAG

Item Length: 2
NAACCR Item #241
Valid Codes: 12, Blank
New Item: 1/1/2010

ACR Required Data Item #61a

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

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate nondate information that had previously been transmitted in date fields.

Instructions for Coding
- Leave this item blank if *Date of Birth* (NAACCR Item #240) has a full or partial date recorded.
- Code 12 if the *Date of Birth* can not be determined at all.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software

Code	Definition
12	A proper value is applicable but not known (for example, birth date is unknown)
(Blank)	A valid date value is provided in item *Date of Birth* (NAACCR Item #240)

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Birth* (NAACCR Item #240) and *Date of Birth Flag* (NAACCR Item #241). ***In the table below, the lowercase letter "b" is used to represent each blank space.***

Description	Traditional Birth Date	Interoperable Birth Date	Date of Birth Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown.**	
Full date known	MMDDCCYY (example: 02181942)	CCYYMMDD (example: 19420218)	bb
Month and year known	MM99CCYY (example: 02991942)	CCYYMMbb (example: 194202bb)	bb
Year only known	9999CCYY (example: 99991942)	CCYYbbbb (example: 1942bbbb)	bb
Unknown date	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

AGE AT DIAGNOSIS

Item Length: 3
Allowable Values: 000–120, 999
Right Justified, Zero-filled
NAACCR Item #230
Revised 09/01/08

ACR Required Data Item #62a

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

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

Instructions for Coding #62b
If the patient has multiple primaries, then the age at diagnosis may be different for subsequent primaries.

Code	Definition
000	Less than one year old; diagnosed *in utero*
001	One year old but less than two years old
002	Two years old
...	Actual age in years
120	One hundred twenty years old
999	Unknown age

#62b-If the software program autocodes age, this method is preferred. If either the Date of Birth and/or the Date of Diagnosis are unknown, code the age at diagnosis as "999."

RACE 1

Item length: 2
Allowable Values: 01–08, 10–17, 20–22, 25–28, 30–32, 96–99
NAACCR Item #160
Revised 01/04, 09/08, 01/10

ACR Required Data Item #63a

Description
Identifies the primary race of the person.

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

#63b-See additional Race 1 through Race 5 coding clarifications in *ACR Supplement* pp. 68A-68B.

Instructions for Coding

- Additional races reported by the person should be coded in *Race 2*, *Race 3*, *Race 4*, and *Race 5*.
- *Race 1* is the field used to compare with race data on cases diagnosed prior to January 1, 2000.
- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If the patient is multiracial, then code all races using *Race 2* (NAACCR Item #161) through *Race 5* (NAACCR Item #164), and code all remaining *Race* items 88.
- If the person is multiracial and one of the races is white, code the other race(s) first with white in the next race field.
- If the person is multiracial and one of the races is Hawaiian, code Hawaiian as *Race 1*, followed by the other race(s).
- A known race code (other than blank or 99) must not occur more than once. For example, do not code "Black" in *Race 1* for one parent and "Black" in *Race 2* for the other parent.
- 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. #63c
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987. #63c
- 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. #63d #63e

#63c-Codes 20-97 were adopted for use effective with 1993 cases and code code 14 became effective with 1994 and later cases.

#63d-The New Mexico SEER Registry and the ACR have an agreement to share American Indian data. Please record the Tribe (ex. Navajo, Pima, etc.) if available in patient record.

#63e-Clarification: For cases diagnosed prior to January 1, 2000, Race 2 through Race 5 must be blank unless the patient has more than one primary with at least one primary diagnosed after January 1, 2000. In this case, the race codes for all primaries must be the same as the one for the primary diagnosed after January 1, 2000.

#63f-Effective with 1/1/2010 dx
15 - Asian Indian or Pakistani, NOS
16 - Asian Indian
17 - Pakistani

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorran
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	96	Other Asian, including Asian, NOS and Oriental, NOS
13	Kampuchean (Cambodian)	97	Pacific Islander, NOS
14	Thai	98	Other
15	Asian Indian or Pakistani, NOS (formerly code 09)	99	Unknown
16	Asian Indian		
17	Pakistani		

Examples

Code	Reason
01	A patient was born in Mexico of Mexican parentage. Code also *Spanish/Hispanic Origin* (NAACCR Item #190).
02	A black female patient.
05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded in *Race 2*).

RACE 2

Item Length: 2
Allowable Values: 01–08, 10–17, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #161
Revised 01/04, 09/08, 01/10

ACR Required Data Item #65a

Description
Identifies the patient's race.

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

#65b-See additional race coding rules on *FORDS* pp. 63-64 and *ACR Supplement* pp. 68A-68B.

Instructions for Coding

- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- 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.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for *Race 1* (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorran
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

RACE 3

Item Length: 2
Allowable Values: 01–08, 10–17, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #162
Revised 01/04, 09/08, 01/10

ACR Required Data Item #66a

Description
Identifies the patient's race.

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

#66b-See additional race coding rules on *FORDS* pp. 63-64 and *ACR Supplement* pp. 68A-68B.

Instructions for Coding

- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- 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.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for Race 1 (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorran
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

RACE 4

ACR Required Data Item #67a

Item Length: 2
Allowable Values: 01–08, 10–17, 20-22, 25–28, 30–32, 88, 96–99
NAACCR Item #163
Revised 01/04, 09/08, 01/10

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

#67b-See additional race coding rules on *FORDS* pp. 63-64 and *ACR Supplement* pp. 68A-68B.

Instructions for Coding

- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- 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.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for *Race 1* (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorran
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

RACE 5

Item Length: 2
Allowable Values: 01–08, 10–17, 20-22, 25–28, 30–32, 88, 96–99
NAACCR Item #164
Revised 01/04, 09/08, 01/10

ACR Required Data Item #68a

Description
Identifies the patient's race.

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

#68b-See additional race coding rules on *FORDS* pp. 63-64 and *ACR Supplement* pp. 68A-68B.

Instructions for Coding

- "Race" is analyzed with *Spanish/Hispanic Origin* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- 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.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for *Race 1* (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorran
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

RACE 1 thru RACE 5 DATA ITEM CLARIFICATIONS

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

1. Do not use patient name as the basis for coding race.

a. See coding instruction 9, exception, for the only situation in which name is taken into account when coding race.

2. Code race using the highest priority source available according to the list below (a is the highest and c is the lowest) when race is reported differently by two or more sources.

a. The patient's self-declared identification
b. Documentation in the medical record
c. Death certificate

3. Code as 01 (White) when

a. The race is described as White or Caucasian regardless of place of birth
b. There is a statement that the patient is Hispanic or Latino(a) and no further information is available

> ***Example:*** Sabrina Fitzsimmons is a Latina. Code race as 01 (White).
> ***Note:*** Do not code 98 (Other) in this situation
>
> ***Note:*** Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually White.

4. Code race as 02 (Black) when the stated race is African-American, Black, or Negro.

5. Assign code 03 for any person stated to be

a. Native American (western hemisphere) OR
b. Indian, whether from North, Central, South, or Latin America.

6. Assign a specific code when a specific Asian race is stated. Code 96 is not applicable when a specific race is known.

> ***Example:*** Patient is described as Asian in a consult note and as second generation Korean-American in the history. Code Race 1 as 08 (Korean) and Race 2 through Race 5 as 88.
>
> ***Note:*** Do not code 96 (Other Asian including Asian, NOS and Oriental, NOS) in a subsequent race field when a specific Asian race has been coded.

7. Code the race based on birthplace information when the race is recorded as Oriental, Mongolian, or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation.

> ***Example 1:*** Race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 (Japanese) because it is more specific than 96.
>
> ***Example 2:*** The person describes himself as an Asian-American born in Laos. Code race as 11 (Laotian) because it is more specific than 96.

RACE 1 thru RACE 5 DATA ITEM CLARIFICATIONS

8. Use the appropriate non-specific code 96 (Other Asian including Asian, NOS and Oriental, NOS), 97 (Pacific Islander, NOS) or 98 (Other) when there is no race code for a specific race.

Note: Document the specified race in a text field

9. Refer to Appendix G "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics when race is unknown or not stated in the medical record and birth place is recorded.

a. In some cases, race may be inferred from the nationality. Use Appendix G 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.

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

Exception: Code Race 1 through Race 5 as 99 (Unknown) when patient's name is incongruous with the race inferred on the basis of nationality. Do not code the inferred raced when then patient's name is incongruent with the race inferred on the basis of nationality**.**

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

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

Coding Examples

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

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

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

Example 4: Patient described as a black female. Code as 02 (Black).

Example 5: 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.

Example 6: Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code Race 1 as 02 (Black) and Race 2 through Race 5 as 88.

Example 7: The patient is described as Asian-American with Korean parents. Code race as 08 (Korean) because it is more specific than 96 Asian [-American].

Example 8: Race 1 through Race 5 in the cancer record are coded as 99 (Unknown). The death certificate states race as black. Change cancer record for Race 1 to 02 (Black) and Race 2 through Race 5 to 88.

Example 9: Race 1 is coded in the cancer record as 96 (Asian). Death certificate gives birthplace as China. Change Race 1 in the cancer record to 04 (Chinese) and code Race 2 through Race 5 as 88.

SPANISH ORIGIN–ALL SOURCES
(SPANISH/HISPANIC ORIGIN)

ACR Required Data Item #69a

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #190
Revised 09/04

Description
Identifies persons of Spanish or Hispanic origin.

Rationale
This code is used by hospital and central registries to identify whether or not the person should be classified as "Hispanic" for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White category) of *Race 1*through *Race 5* (NAACCR Item #s 160–164).

Instructions for Coding

- Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.
- Code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons. ← #69b-Code 0 for Filipinos per SEER.
- If the patient has multiple tumors, all records should have the same code.

Code	Label
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central America (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; 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) #69c
8	Dominican Republic (for use with patients who were diagnosed with cancer on January 1, 2005, or later)
9	Unknown whether Spanish or not; not stated in patient record

#69c-The code for Spanish surname only (7) is to be assigned only by the ACR. The ACR began utilizing this code on an annual basis beginning with 1995 cases via the Spanish surname checking program.

SEX

ACR Required Data Item #70a

Item Length: 1
Allowable Values: 1–4, 9
NAACCR Item #220

Description
Identifies the sex of the patient.

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

Instructions for Coding #70b-Code the sex of the patient at the time of diagnosis.
Record the patient's sex as indicated in the medical record.

Code	Label
1	Male
2	Female
3	Other (hermaphrodite)
4	Transsexual #70c
9	Not stated in patient record

#70c-Transsexual: Surgically altered gender.

#70d-SEER added these clarifications to their 2010 manual
Transgendered: A person who identifies with or expresses a gender identity that differs from the one which corresponds to the person's sex at birth.
Coding Instructions:
1. Assign code 3 for Intersexed (persons with sex chromosome abnormalities).
2. Assign code 4 for Transgendered.

MARITAL STATUS AT DX

ACR Required Data Item

Item Length: 1
Allowable Codes: 1-5, 9
NAACCR Item #150

Description
This is a code for the patient's marital status at the time of diagnosis for the reportable tumor. If the patient has multiple tumors, marital status may be different for each tumor.

Rationale
Incidence and survival with certain cancers vary by marital status. This item also helps in patient identification.

Instructions for Coding
Enter the code that reflects the patient's marital status at diagnosis.

1 Single (never married)
2 Married (including common law)
3 Separated
4 Divorced
5 Widowed
6 Unmarried or Domestic Partner (same sex or opposite sex, registered or unregistered)
9 Unknown

Note: ACR has followed SEER coding rules and definitions for Martial Status at Dx. The following are taken directly from the *SEER Program Coding and Staging Manual,* the 2004 and 2007 edition.

<u>For cases diagnosed on or before 12/31/2006:</u>
Persons of the opposite sex living together as part of a long-term personal relationship would be coded to '2,' Married (including common law).

Persons of the same sex living together as part of a long-term personal relationship would be coded according to their legal status (usually single, separated, divorced, or widowed).

<u>For cases diagnosed on or after 01/01/2007:</u>
Marriage is a self-reported state. If the patient declares themselves as married, assign code 2 "Married (including common law)."

<u>For cases diagnosed on or after 01/01/2011:</u>
Per SEER, code 6 is effective with cases diagnosed 1/1/11 and forward. In some states, couples can register as domestic partners to be entitled to certain legal rights.

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ACR Supplement Page

PRIMARY PAYER AT DIAGNOSIS

Item Length: 2
Allowable Values: 01, 02, 10, 20, 21, 31, 35, 60–68, 99
NAACCR Item #630
Revised 06/05, 01/10

ACR Required Data Item #71a

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

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

Instructions for Coding

- If the patient is diagnosed at the reporting facility, record the payer at the time of diagnosis.
- If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known record the payer when the patient is initially admitted for treatment.
- Record the type of insurance reported on the patient's admission page.
- Codes 21and 65–68 are to be used for patients diagnosed on or after January 1, 2006.
- If more than one payer or insurance carrier is listed on the patient's admission page record the first.
- If the patient's payer or insurance carrier changes, do not change the initially recorded code.

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, 21, 31, 35, 60–68.
20	Private insurance: Managed Care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance.
21	Private insurance: Fee-for-Service	An insurance plan that does not have a negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than described in code 35.
35	Medicaid administered through a Managed Care plan	Patient is enrolled in **Medicaid** through a Managed Care program (for example, HMO or PPO). The Managed Care plan pays for all incurred costs. #71b
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 62 years of age or older, or are chronically disabled (Social Security insurance eligible). Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.
62	Medicare administered through a Managed Care plan	Patient is enrolled in **Medicare** through a Managed Care plan (for example, HMO or PPO). The Managed Care plan pays for all incurred costs.

#71b-Use code "35" for AHCCCS.

Code	Label	Definition
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare.
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement.
65	TRICARE	Department of Defense program providing 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).
66	Military	Military personnel or their dependents who are treated at a military facility.
67	Veterans Affairs	Veterans who are treated in Veterans Affairs facilities.
68	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility or at another facility, and the medical costs are reimbursed by the Indian Health Service. Patient receives care at a Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

Examples

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

TEXT-USUAL OCCUPATION

ACR Required Data Item

Item Length: 100
Free Text
NAACCR Item #310

Description
Text area for information about the patient's usual occupation, also known as usual type of job or work.

Rationale
Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Instructions for Coding
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 had never worked, record "never worked" as the occupation.

If no occupation is available, record unknown.

This data item is usually collected only for patients who are 14 years or older at the time of diagnosis.

See *A Cancer Registrar's Guide to Collecting Industry and Occupation* (DHHS NIOSH Publication Number 2011-173) at http://www.cdc.gov/niosh/docs/2011-173/. The publication provides tips for cancer registrars on text entry for occupation and industry.

Note: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

OCCUPATION CODE—CENSUS

Item Length: 3
NAACCR Item #270

ACR Required Data Item
To be coded by the ACR only

Description
This field is for use by the central registry only, and therefore should not be coded by reporting facilities. Using U.S. Census Bureau codes, assign a numeric code for the patient's usual occupation. This data item applies only to patients who are 14 years or older at the time of diagnosis.

Rationale
Use of the Census Bureau classification system improves consistency of data collected from multiple sources. The Census Bureau occupation classification system is used for coding occupation information from death certificates and from the US Census. The system includes specific coding rules.

Instructions for Coding
This field is not to be coded at reporting facilities. Leave the space blank.

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

TEXT-USUAL INDUSTRY

ACR Required Data Item

Item Length: 100
Free Text
NAACCR Item #320

Description
Text area for information about the patient's usual industry, also known as usual kind of business/ industry.

Rationale
Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Instructions for Coding
Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among manufacturing, wholesale, retail, and service components of an industry that performs more than one of these activities.

The information for industry should be based on the information listed in the "Occupation" field.

If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual industry.

As noted in the Text-Usual Occupation [310] on page 72A, in those situations where the usual occupation is not available or is unknown, the patient's current or most recent occupation is recorded, if available. The information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry.

If no information is available regarding the industry in which the reported occupation was carried out, record "unknown." If the patient was not a student or homemaker and had never worked, record "never worked" as the usual industry. This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

See *A Cancer Registrar's Guide to Collecting Industry and Occupation* (DHHS NIOSH Publication Number 2011-173) at http://www.cdc.gov/niosh/docs/2011-173/. The publication provides tips for cancer registrars on text entry for occupation and industry.

Note: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

INDUSTRY CODE—CENSUS

Item Length: 3
NAACCR Item #280

ACR Required Data Item
To be coded by the ACR only

Description
This field is **for the central registry only.** It is used to assign a numeric U.S. Bureau code for the primary activity of the business or industry where the patient was usually employed. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

Rationale
Use of the Census Bureau classification system improves consistency of data collected from multiple sources. The Census Bureau industrial classification system is used for coding occupation information from death certificates and from the US Census. The system includes specific coding rules.

Instructions for Coding
This field is not to be coded at reporting facilities.

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

NAME—SPOUSE/PARENT

ACR Required Data Item

Item Length: 60
No Standard
NAACCR Item #2290

Description
This field is used to record the name of the patient's spouse or parent.

Rationale
The name of the patient's spouse or parent may be helpful in locating the patient for follow-up or special studies.

Instructions for Coding
Enter the name of the patient's spouse or parent.

Record the full name of the spouse or parent (first and last name).

FOLLOW-UP CONTACT—NAME NAACCR Item #: 2394
FOLLOW-UP CONTACT—PHONE NUM RMCDS FIELD
FOLLOW-UP CONTACT—PHONE TYPE RMCDS FIELD
FOLLOW-UP CONTACT—RELATION RMCDS FIELD
FOLLOW-UP CONTACT—NO & ST NAACCR Item #: 2392
FOLLOW-UP CONTACT—SUPPL NAACCR Item #: 2393
FOLLOW-UP CONTACT—CITY NAACCR Item #: 1842
FOLLOW-UP CONTACT—STATE NAACCR Item #: 1844
FOLLOW-UP CONTACT—POSTAL NAACCR Item #: 1846

Item Length: Varies
Left Justified
ACR Supplemental Data Item

Description
These fields are used to record supplemental information that may aid in contacting the patient at a later date.

Rationale
Although space is limited on the abstract, it is important to list as many follow-up sources as possible (friends, relatives, etc.) to facilitate follow-up in the future.

Instructions for Coding
Record the name in natural order, relationship, telephone number and address of potential sources of follow-up information. Do not repeat spouse information.

Follow the same coding instructions provided for Current Address.

COMORBIDITIES AND COMPLICATIONS #1
(Secondary Diagnoses)

Not Required by ACR #73a

Item Length: 5
Allowable Values: 00000, [ICD-9-CM: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049], [ICD-10-CM: A0000-BZZZZ, E0000-EZZZZ, G0000-PZZZZ, R0000-SZZZZ, T360X-T50Z9, Y6200-Y8490, Z1401-Z2299, Z23001-Z2493, Z6810-Z6854, Z8000-Z8090, Z8500-Z8603, Z8611-Z9989]
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NAACCR Item #3110
Revised 06/05, 01/11

Description
Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM or ICD-10-CM codes. All are considered secondary diagnoses.

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

Instructions for Coding

- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. DO NOT MIX ICD-9-CM and ICD-10-CM codes in the *Comorbidity and Complications* items.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.
- Report the secondary diagnoses for this cancer using the following priority rules:
  - -Surgically treated patients:
    - a) following the most definitive surgery of the primary site
    - b) following other non-primary site surgeries
  - -Non-surgically treated patients:
    - following the first treatment encounter/episode
  - -In cases of non-treatment:
    - following the last diagnostic/evaluative encounter
- If the data item *Readmission To The Same Hospital Within 30 Days Of Surgical Discharge* (NAACCR Item #3190) is coded 1, 2, or 3, report *Comorbidities and Complications* ICD-9-CM or ICD-10-CM codes appearing on the "readmission" discharge abstract.
- If no secondary diagnoses were documented, then code 00000 in this data item, and leave the remaining *Comorbidities and Complications* data items blank.
- If fewer than 10 secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Comorbidities and Complications* data items blank.

ICD-9-CM or ICD-10-CM	Code	Definition, specific instructions
Both	00000	No comorbid conditions or complications documented.
ICD-9-CM	00100–13980, 24000–99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
ICD-9-CM	E8700–E8799, E9300–E9499	Complications: Omit the decimal point between the fourth and fifth characters
ICD-9-CM	V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters
ICD-10-CM	Codes beginning with the following letters: A, B, E, G, H, I, J, K, L, M, N, O, P, R, and S	For ICD-10-CM codes: Omit the decimal point between the third and fourth characters. Omit additional characters beyond 5, if any. If there are fewer than 5 characters, use zeroes after the code to fill the spaces. Capitalize all letters.
	T360x-T50Z9	
	Y6200-Y8490	
	Z1401-Z2290	
	Z3001-Z2349	
	Z6810-Z6854	
	Z8000-Z8090	
	Z8500-Z8603	
	Z8611-Z9989	

Examples

Code	Reason (ICD-9-CM)
49600	COPD (ICD-9-CM code 496)
25001	Type 1 diabetes mellitus (ICD-9-CM code 250.01)
E8732	The patient was inadvertently exposed to an overdose of external beam radiation (ICD-9-CM code E873.2)
E9300	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-9-CM code E930.0)
V1030	The patient has a personal history of breast cancer (ICD-9-CM code V10.3)
Code	**Reason (ICD-10-CM)**
J4490	COPD, unspecified (ICD-10-CM code J44.9)
E1090	Type 1 diabetes mellitus without complications (ICD-10-CM code E10.9)
Y6320	Overdose of radiation given during therarpy (ICD-10-CM code Y63.2)
T360X	Adverse effects of penicillins, initial encounter (ICD-10-CM code T36.0x5A) OR Adverse effects of penicillins, sequela (ICD-10-CM code T36.0x5S)
Z8530	Personal history of malignant neoplasm of breast (ICD-10-CM code Z85.3)

COMORBIDITIES AND COMPLICATIONS #2
(Secondary Diagnoses)

Item Length: 5
Allowable Values: [ICD-9-CM: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049], [ICD-10-CM: A0000-BZZZZ, E0000-EZZZZ, G0000-PZZZZ, R0000-SZZZZ, T360X-T50Z9, Y6200-Y8499, Z1401-Z2299, Z23001-Z2493, Z6810-Z6854, Z8000-Z8090, Z8500-Z8603, Z8611-Z9989]

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NAACCR Item #3120
Revised 06/05, 01/11

Not Required by ACR #75a

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

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

Instructions for Coding
- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. DO NOT MIX ICD-9-CM and ICD-10-CM codes in the *Comorbidity and Complications* items.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- If only one comorbid condition or complication is listed, then leave this data item blank.
- If only two comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the third and fourth characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters. For ICD-10-CM codes there is an assumed decimal between the third and fourth characters.
(leave blank)	Fewer than two comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #3
(Secondary Diagnoses)

Item Length: 5
Allowable Values: [ICD-9-CM: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049], [ICD-10-CM: A0000-BZZZZ, E0000-EZZZZ, G0000-PZZZZ, R0000-SZZZZ, T360X-T50Z9, Y6200-Y8499, Z1401-Z2299, Z23001-Z2493, Z6810-Z6854, Z8000-Z8090, Z8500-Z8603, Z8611-Z9989]

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NAACCR Item #3130
Revised 06/05, 01/11

Not Required by ACR #76a

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

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

Instructions for Coding
- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. DO NOT MIX ICD-9-CM and ICD-10-CM codes in the *Comorbidity and Complications* items.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- If fewer than three comorbid conditions or complications are listed, then leave this data item blank.
- If only three comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications"items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the third and fourth characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters. For ICD-10-CM codes there is an assumed decimal between the third and fourth characters.
(leave blank)	Fewer than three comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #4
(Secondary Diagnoses)

Item Length: 5
Allowable Values: [ICD-9-CM: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049], [ICD-10-CM: A0000-BZZZZ, E0000-EZZZZ, G0000-PZZZZ, R0000-SZZZZ, T360X-T50Z9, Y6200-Y8499, Z1401-Z2299, Z23001-Z2493, Z6810-Z6854, Z8000-Z8090, Z8500-Z8603, Z8611-Z9989]

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NAACCR Item #3140
Revised 06/05, 01/11

Not Required by ACR #77a

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

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

Instructions for Coding
- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. DO NOT MIX ICD-9-CM and ICD-10-CM codes in the *Comorbidity and Complications* items.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- If fewer than four comorbid conditions or complications are listed, then leave this data item blank.
- If only four comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the third and fourth characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters. For ICD-10-CM codes there is an assumed decimal between the third and fourth characters.
(leave blank)	Fewer than four comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #5
(Secondary Diagnoses)

Item Length: 5

Allowable Values: [ICD-9-CM: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049], [ICD-10-CM: A0000-BZZZZ, E0000-EZZZZ, G0000-PZZZZ, R0000-SZZZZ, T360X-T50Z9, Y6200-Y8499, Z1401-Z2299, Z23001-Z2493, Z6810-Z6854, Z8000-Z8090, Z8500-Z8603, Z8611-Z9989]

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NAACCR Item #3150
Revised 06/05, 01/11

Not Required by ACR #78a

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

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

Instructions for Coding
- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. DO NOT MIX ICD-9-CM and ICD-10-CM codes in the *Comorbidity and Complications* items.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- If fewer than five comorbid conditions or complications are listed, then leave this data item blank.
- If only five comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the third and fourth characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters. For ICD-10-CM codes there is an assumed decimal between the third and fourth characters.
(leave blank)	Fewer than five comorbid conditions or complications documented.

COMORBIDITIES AND COMPLICATIONS #6
(Secondary Diagnoses)

Item Length: 5
Allowable Values: [ICD-9-CM: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049], [ICD-10-CM: A0000-BZZZZ, E0000-EZZZZ, G0000-PZZZZ, R0000-SZZZZ, T360X-T50Z9, Y6200-Y8499, Z1401-Z2299, Z23001-Z2493, Z6810-Z6854, Z8000-Z8090, Z8500-Z8603, Z8611-Z9989]

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NAACCR Item #3160
Revised 06/05, 01/11

Not Required by ACR #79a

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

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

Instructions for Coding

- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. DO NOT MIX ICD-9-CM and ICD-10-CM codes in the *Comorbidity and Complications* items.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- If fewer than six comorbid conditions or complications are listed, then leave this data item blank.
- If only six comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the third and fourth characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters. For ICD-10-CM codes there is an assumed decimal between the third and fourth characters.
(leave blank)	Fewer than six comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #7
(Secondary Diagnoses)

Item Length: 5
Allowable Values: [ICD-9-CM: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049], [ICD-10-CM: A0000-BZZZZ, E0000-EZZZZ, G0000-PZZZZ, R0000-SZZZZ, T360X-T50Z9, Y6200-Y8499, Z1401-Z2299, Z23001-Z2493, Z6810-Z6854, Z8000-Z8090, Z8500-Z8603, Z8611-Z9989]

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NAACCR Item #3161
Revised 01/11

Not Required by ACR #80a

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

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

Instructions for Coding

- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. DO NOT MIX ICD-9-CM and ICD-10-CM codes in the *Comorbidity and Complications* items.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- *Comorbidities and Complications #8* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than eight comorbid conditions or complications are listed, then leave this data item blank.
- If only eight comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.

For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the third and fourth characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters. For ICD-10-CM codes there is an assumed decimal between the third and fourth characters.
(leave blank)	Fewer than seven comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #8
(Secondary Diagnoses)

Item Length: 5
Allowable Values: [ICD-9-CM: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049], [ICD-10-CM: A0000-BZZZZ, E0000-EZZZZ, G0000-PZZZZ, R0000-SZZZZ, T360X-T50Z9, Y6200-Y8499, Z1401-Z2299, Z23001-Z2493, Z6810-Z6854, Z8000-Z8090, Z8500-Z8603, Z8611-Z9989]

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NAACCR Item #3162
Revised 01/11

Not Required by ACR #81a

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

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

Instructions for Coding
- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. DO NOT MIX ICD-9-CM and ICD-10-CM codes in the *Comorbidity and Complications* items.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- *Comorbidities and Complications #8* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than eight comorbid conditions or complications are listed, then leave this data item blank.
- If only eight comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4th and 5th characters. For ICD-10-CM codes there is an assumed decimal between the third and fourth characters.
(leave blank)	Fewer than eight comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #9
(Secondary Diagnoses)

Item Length: 5
Allowable Values: [ICD-9-CM: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049], [ICD-10-CM: A0000-BZZZZ, E0000-EZZZZ, G0000-PZZZZ, R0000-SZZZZ, T360X-T50Z9, Y6200-Y8499, Z1401-Z2299, Z23001-Z2493, Z6810-Z6854, Z8000-Z8090, Z8500-Z8603, Z8611-Z9989]

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NAACCR Item #3163
Revised 01/11

Not Required by ACR #82a

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

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

Instructions for Coding
- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. DO NOT MIX ICD-9-CM and ICD-10-CM codes in the *Comorbidity and Complications* items.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- *Comorbidities and Complications #9* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than nine comorbid conditions or complications are listed, then leave this data item blank.
- If only nine comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining "Comorbidities and Complications" items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the third and fourth characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters. For ICD-10-CM codes there is an assumed decimal between the third and fourth characters.
(leave blank)	Fewer than nine comorbid conditions and complications documented.

COMORBIDITIES AND COMPLICATIONS #10
(Secondary Diagnoses)

Item Length: 5
Allowable Values: [ICD-9-CM: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049], [ICD-10-CM: A0000-BZZZZ, E0000-EZZZZ, G0000-PZZZZ, R0000-SZZZZ, T360X-T50Z9, Y6200-Y8499, Z1401-Z2299, Z23001-Z2493, Z6810-Z6854, Z8000-Z8090, Z8500-Z8603, Z8611-Z9989]

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NAACCR Item #3164
Revised 01/11

Not Required by ACR #83a

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

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

Instructions for Coding
- Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. DO NOT MIX ICD-9-CM and ICD-10-CM codes in the *Comorbidity and Complications* items.
- Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters.
- *Comorbidities and Complications #10* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than 10 comorbid conditions or complications are listed, then leave this data item blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note:* For comorbid conditions (ICD-9-CM codes 001–139.8 and 240–999.9) there is an assumed decimal point between the third and fourth characters. *Note:* For complications (ICD-9-CM "E"codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters. For ICD-10-CM codes there is an assumed decimal between the third and fourth characters.
(leave blank)	Fewer than 10 comorbid conditions and complications documented.

NPI–MANAGING PHYSICIAN

Not Required by ACR #84a

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2465
Revised 04/07, 09/08

Description
Identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment of this cancer.

Rationale
The managing physician is responsible for the patient's work-up, plans the treatment, and directs the delivery of patient care in accordance with CoC Standards. In most cases, the managing physician is responsible for AJCC staging.

Instructions for Coding

- Record the 10-digit NPI for the physician responsible for managing the patient's care.
- Check with the billing or health information departments to determine the physician's NPI or search at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Do not update this item. Once the registry has designated a managing physician for the patient, this item should not be changed even if a different managing physician is assigned.

Code	Definition
(fill spaces)	10-digit NPI number for the managing physician.
(leave blank)	NPI for the managing physician is unknown or not available.

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ACR Supplement Page

FOLLOWING PHYSICIAN (FOLLOW-UP PHYSICIAN)

Item Length: 8
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NAACCR Item #2470

ACR Required Data Item

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

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

Instructions for Coding
•The registry assigns a unique number to the following physician. Many registries use the physician's state medical license number.
•The ACR uses the state medical license number to identify Arizona physicians. Refer to either the Arizona Board of Osteopathic Examiners or to the Arizona Medical Board online at http://www.azdo.gov or http://www.azmd.gov to search for an osteopathic physician, a medical doctor, or a physician assistant. Add the number "5" at the beginning of the four-digit osteopathic license number.
•Change this data item when patient follow-up becomes the responsibility of another physician.

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

NPI–FOLLOWING PHYSICIAN

ACR Required Data Item #85a

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2475
Revised 04/07, 09/08, 01/11

Description
Records the NPI for the physician currently responsible for the patient's medical care.

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

Instructions for Coding

- Record the 10-digit NPI for the physician currently responsible for the patient's medical care.
- Check with the billing or health information departments to determine the physician's NPI or search at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- Change this data item when patient follow-up becomes the responsibility of another physician.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later. #85b
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the following physician.
(leave blank)	NPI for the following physician is unknown or not available.

#85b-The ACR requires the coding of NPI numbers for cases diagnosed 1/1/2007 and later.

NPI–PRIMARY SURGEON

Not Required by ACR #86a

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2485
Revised 04/07, 09/08, 01/11

Description
Identifies the physician who performed the most definitive surgical procedure.

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

Instructions for Coding

- Record the 10-digit NPI for the physician who performed the most definitive surgical procedure.
- Check with the billing or health information departments to determine the physician's NPI or search at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Do not update this item. Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.

Code	Definitions
(fill spaces)	10-digit NPI number for the primary surgeon.
(leave blank)	The patient did not have surgery. NPI for the primary surgeon is unknown or not Available. Yhe physician who performed the surgical procedure was not a surgeon (for example, general practitioner).

NPI–PHYSICIAN #3
(Radiation Oncologist–CoC Preferred Use)

Not Required by ACR #87a

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2495
Revised 04/07, 09/08, 01/10, 01/11

Description
Records the NPI for a physician involved in the care of the patient. The Commission on Cancer recommends that this item identify the physician who performed the most definitive radiation therapy.

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

Instructions for Coding

- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI or search at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- Do not update this item. If the registry has designated a primary radiation oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another radiation oncologist.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the primary radiation oncologist.
(leave blank)	NPI for the primary radiation oncologist is unknown or not available.

NPI–PHYSICIAN #4
(Medical Oncologist–CoC Preferred Use)

Not Required by ACR #88a

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2505
Revised 04/07, 09/08, 01/10, 01/11

Description
Records the NPI for a physician involved in the care of the patient. The Commission on Cancer recommends that this data item identify the physician who gives the most definitive systemic therapy.

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

Instructions for Coding

- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI or search at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- Do not update this item. If the registry has designated a primary medical oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another radiation oncologist.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the primary medical oncologist.
(leave blank)	NPI for the primary medical oncologist is unknown or not available.

Cancer Identification

CLASS OF CASE GUIDELINES FOR ACR REPORTABILITY

Codes	Reportable to the ACR?
Analytic Classes of Case	
00-22	Yes
Non-Analytic Classes of Case	
30	Only reportable for the following: •Yes, if a consultation is done that changes the previous diagnosis using a definitive test (yielding pathologic confirmation, or a group of tests). •Yes, if a consultation is for first time histologic confirmation.
31	No
32	Only reportable for the following: •Yes, if not previously reported to the ACR by another facility. Submit the Non-analytic Tracking Form to determine if case reportable. Per the CoC, progression consistent with persistence. Per the CoC, patients with a previous diagnosis (dx/tx elsewhere) and now present with active disease (disease present) are coded to 32.
33	No. History of disease only usually implies that the patient has no current evidence of disease. If the patient has a history of disease and has current evidence of disease then you would report it under code 32 and follow the instructions above.
34	Only reportable for the following primary sites (See *) : •The case is a carcinoma in situ of the cervix (CIS) diagnosed prior to 1994 and initial diagnosis and part or all of first course treatment provided by your facility. •The case is a vulva (VIN III), vagina (VAIN III), or anus (AIN III) regardless of diagnosis year and initial diagnosis and part or all of first course treatment provided by your facility. •The case is a skin cancer (C44._) with a histology code in the 8000-8110 range and a SEER Summary Stage of regional or distant at initial diagnosis and diagnosed prior to 2003 and initial diagnosis and part or all of first course treatment provided by your facility. •The case is a benign brain/CNS site diagnosed prior to 2004 and initial diagnosis and part or all of first course treatment provided by your facility. See notes below.
35	Only reportable for the following: •Yes, if not previously reported to the ACR by another facility. Submit the Non-analytic Tracking Form to determine if the case is reportable.
36	Only reportable for the following primary sites (See *): •The case is a carcinoma in situ of the cervix (CIS) diagnosed prior to 1994 and initial diagnosis elsewhere and all or part of first course treatment provided by your facility. •The case is a vulva (VIN III), vagina (VAIN III), or anus (AIN III) regardless of diagnosis year and initial diagnosis elsewhere and all or part of first course treatment provided by your facility. •The case is a skin cancer (C44._) with a histology code in the 8000-8110 range and a SEER Summary Stage of regional or distant at initial diagnosis and diagnosed prior to 2003 and initial diagnosis elsewhere and all or part of first course treatment provided by your facility. •The case is a benign brain/CNS site diagnosed prior to 2004 and initial diagnosis elsewhere and all or part of first course treatment provided by your facility. See notes below.
37	Only reportable for the following: •Yes, if not previously reported to the ACR by another facility. Submit the Non-analytic Tracking Form to determine if the case is reportable.
38	Only reportable for the following: •Yes, if not previously reported to the ACR by another facility. Submit the Non-analytic Tracking Form to determine if the case is reportable.

CLASS OF CASE GUIDELINES CONTINUED

Codes	Reportable to the ACR?
Non-Analytic Classes of Case	
40	Only reportable for the following: •No, with exception noted. Exception: If the staff physician practices out of a clinic/outpatient treatment facility which your facility owns you are required to report the case.
41	Only reportable for the following: •No, with exception noted. Exception: If the staff physician practices out of a clinic/outpatient treatment facility which your facility owns you are required to report the case.
42	Only reportable for the following: •No, with exception noted. Exception: If the physician practices out of a clinic/outpatient treatment facility which your facility owns you are required to report the case.
43	Only reportable for the following: •No, with exception noted. Exception: If a hospital wishes to abstract these cases please notify the ACR.
49	No. Used by central registries only.
99	No. Used by central registries only.

Notes - Benign (non-malignant) Brain/CNS sites
1. Non-malignant primary intracranial or central nervous system tumors of the meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of the central nervous system (C72._) have always been reportable to the ACR.
2. Non-malignant tumors of the pituitary gland (C75.1), craniopharyngeal duct (C75.2), and pineal gland (C75.3) became reportable to the ACR with cases diagnosed in January 1, 2001 and later.
3. All Non-malignant brain/CNS primary site codes described in notes 1 and 2 are reportable to the CoC starting with 2004 cases and later. If your facility provided initial diagnosis and/or treatment of benign brain/CNS cases diagnosed in 2004 and later, these cases would be coded in the Analytic category 00-22.

*In these examples you do not submit these on a Non-Analytic Tracking Form; you automatically report them with a Class of Case code of a 34 or 36 code (Non-Analytic Case). Exception: You would only submit these types of cases on a Non-Analytic Tracking Form if the patient was previously diagnosed and/or treated elsewhere and now comes into your facility with evidence of disease. The Class of Case code would be 32.

CLASS OF CASE

Item Length: 2
Allowable Values: 00, 10-14, 20-22, 30-38, 40-43, 49, 99
NAACCR Item #610
Revised 09/08, 01/10; 05/10, 01/11

ACR Required Data Item #91a

Description

Class of Case divides cases into two groups. Analytic cases (codes 00–22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and first course of treatment. Nonanalytic cases (codes 30–49 and 99) may be abstracted by the facility to meet central registry requirements or in response to a request by the facility's cancer program. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.

Rationale

Class of Case reflects the facility's role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program's Reference Date.

Instructions for Coding

- The code structure for this item was revised in 2010. See *NAACCR Inc. 2010 Implementation Guidelines and Recommendations* for conversion instructions between code structures.
- Code the *Class of Case* that most precisely describes the patient's relationship to the facility.
- Code 00 applies only when it is known the patient went elsewhere for treatment. If that information is not available, code *Class of Case* 10.
- It is possible that information for coding *Class of Case* will change during the patient's first course of care. If that occurs, change the code accordingly.
- Document *NPI–Institution Referred To* (NAACCR Item #2425) or the applicable physician NPI (NAACCR #s 2585, 2495, 2505) for patients coded 00 to establish that the patient went elsewhere for treatment #91b
- Code 34 or 36 if the diagnosis benign or borderline (*Behavior* 0 or 1) for any site diagnosed before 2004 or for any site other than meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3) that were diagnosed in 2004 or later. #91c
- Code 34 or 36 for carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2 or 8148/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III). #91c
- A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there.
- If the hospital has purchased a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved are staff physicians or not, as with any other physician.

#91c-See *ACR Supplement* pp. 90A & 90B for clarifications.

#91d-All analytic cases (00-22) are required by the ACR.

#91b-NPI-Institution Referred To and the physician NPI numbers noted in this bullet are not required to be reported by ACR standards.

Codes

#91d

Analytic Classes of Case (Required by CoC to be abstracted by accredited programs)		
	Initial diagnosis at reporting facility	
00		Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10		Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11		Initial diagnosis in staff physician's office AND part of first course treatment was done at the reporting facility
12		Initial diagnosis in staff physician's office AND all first course treatment or a decision not to treat was

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

14		Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
	Initial diagnosis elsewhere	
20		Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21		Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
22		Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility
#92a →	**Classes of Case not required by CoC to be abstracted (May be required by Cancer Committee, state or regional registry, or other entity)**	
	Patient appears in person at reporting facility	
30		Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere) #92b
31		Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)
32		Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)
33		Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)
34		Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35		Case diagnosed before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility
36		Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37		Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38		Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death
#92c →	*Patient does not appear in person at reporting facility*	
40		Diagnosis AND all first course treatment given at the same staff physician's office
41		Diagnosis and all first course treatment given in two or more different staff physician offices
42		Nonstaff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43		Pathology or other lab specimens only #92d
49		Death certificate only
99		Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

#92c-Hospitals should only use these codes (40-43) for the exceptions noted in the *ACR Supplement* pp. 90A & 90B.

Examples

Code	Reason
32	After treatment failure, the patient was admitted to the facility for supportive care
11	Patient was diagnosed by a staff physician, received radiation at another facility, then underwent surgical resection at the reporting facility
42	Patients from an unaffiliated, free-standing clinic across the street that hospital abstracts with its cases because many physicians work both at the clinic and the hospital.

#92a-Most non-analytic cases (30-38) are required to be submitted to the ACR if not previously reported by any facility. Check with the ACR using a Non-Analytic Tracking Form in order to determine reportability. Also see guidelines on pp. 90A & 90B of the *ACR Supplement*.

#92b-If a consultation is done that changes the previous diagnosis using a definitive test (yielding pathologic confirmation, or a group of tests) the case is reportable as a class of case 30. If a consultation is for first time histologic confirmation, the case is reportable as a class of case 30.

#92d-The ACR does not require the reporting of these cases by hospitals; however, if a hospital wishes to abstract these cases, contact the ACR.

NPI–INSTITUTION REFERRED FROM

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2415
Revised 04/07, 09/08, 01/11

Not Required by ACR #93a

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

Rationale
Each facility's NPI is unique. This number is used to document and monitor referral patterns.

Instructions for Coding
- Record the 10-digit NPI for the referring facility.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Check with the registry, billing, or health information departments of the facility to determine its NPI, or search on *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.

Code	Definition
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the referring facility is unknown or not available.
(leave blank)	If the patient was not referred to the reporting facility from another facility.

NPI–INSTITUTION REFERRED TO

Not Required by ACR #94a

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2425
Revised 04/07, 09/08, 01/11

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

Rationale
Each facility's NPI is unique. This number is used to document and monitor referral patterns.

Instructions for Coding
- Record the 10-digit NPI for the facility to which the patient was referred.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Check with the registry, billing, or health information departments of the facility to determine its NPI or search on *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.

Code	Definition
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the facility referred to is unknown or not available.
(leave blank)	If the patient was not referred to another facility.

DATE OF INPATIENT ADM

ACR Required Data Item

Item Length: 8
CCYYMMDD
NAACCR Item #590

Description
Date of the inpatient admission to the reporting facility for the most definitive surgery. In the absence of surgery, use the date of inpatient admission for any cancer-directed therapy. In the absence of cancer-directed therapy, use the date of inpatient admission for diagnostic evaluation.

Rationale
Assists the ACR in calculating timeliness and completeness.

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

If this is a non-analytic case, use the date the patient was first admitted to the facility with a cancer diagnosis.

If the patient is admitted to hospital for a diagnosis other than malignancy and is found to have an ACR reportable neoplasm during the hospital stay, then the date of first contact would be the same as the date of diagnosis, not the same as the date of inpatient admission.

<u>Collection, Storage, and Transmission of Date of Inpatient Adm</u>
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

DATE OF INPT ADM FLAG

ACR Required Data Item

Item Length: 2
Allowable Values:10-12, Blank
NAACCR Item #591

Description
This flag explains why there is no appropriate value in the corresponding date field, Date of Inpatient Adm (#590). This data item was added to NAACCR Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes which provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding

Codes

Codes	Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient).
11	No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).
Blank	A valid date value is provided in item Date of Inpatient Adm [590], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

DATE OF INPATIENT DISCH

ACR Required Data Item

Item Length: 8
CCYYMMDD
NAACCR Item #600

Description
Date of the inpatient discharge from the reporting facility after the most definitive surgery. In the absence of surgery, use the date of inpatient discharge for other cancer-directed therapy. In the absence of cancer-directed therapy, use the date of inpatient discharge for diagnostic evaluation. The discharge date corresponds to the admission date described by item 590, Date of Inpatient Admission.

Rationale
Assists the ACR in calculating timeliness and completeness.

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

If this is a non-analytic case, use the date the patient was first admitted to the facility with a cancer diagnosis.

Collection, Storage, and Transmission of Date of Inpatient Disch
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

DATE OF INPT DISCH FLAG

ACR Required Data Item

Item Length: 2
Allowable Values:10-12, Blank
NAACCR Item #601

Description
This flag explains why there is no appropriate value in the corresponding date field, Date of Inpatient Disch [600]. This data item was added to NAACCR Volume II Version 12 (effective January 2010).

Rationale
Prior to version 12 (through 2009 diagnosis), date fields included codes which provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding

Codes

Codes	Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient).
11	No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).
Blank	A valid date value is provided in item Date of Inpatient Disch [600], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

DATE OF FIRST CONTACT

ACR Required Data Item #95a

Item Length: 8
NAACCR Item #580
Revised 09/06, 01/04, 01/10, 01/11

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

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

#95b-For non-analytic cases, the Date of First Contact is the date that the patient is seen at the reporting facility with evidence of disease.

Instructions for Coding #95b #95c

- Record the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or first course treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, X ray, or laboratory test, or the date a pathology specimen was collected at the hospital.
- For analytic cases (Class of Case 00-22), the *Date of First Contact* is the date the patient became analytic. For non-analytic cases, it is the date the patient first qualified for the *Class of Case* that causes the case to be abstracted.
- If this is an autopsy-only or death certificate-only case, then use the date of death.
- When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.
- #95d → Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Contact* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Contact* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date. The *Date of First Contact Flag* (NAACCR Item #581) is used to explain why *Date of First Contact* is not a known date. See *Date of First Contact Flag* for an illustration of the relationships among these items.

Examples

#95c-If the patient is admitted to hospital for a diagnosis other than malignancy and is found to have an ACR reportable neoplasm during the hospital stay, then the Date of First Contact would be the same as the Date of Diagnosis, not the same as the Date of Inpatient Admission.

Patient undergoes a biopsy in a staff physician's office on September 8, 2009. The pathology specimen was sent to the reporting facility and was read as malignant melanoma. The patient enters that same reporting facility on September 14, 2009 for wide reexcision.	September 14, 2009
Patient has an MRI of the brain on December 7, 2010, for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19 removes all gross tumor.	December 7, 2010
Information is limited to the description "Spring," 2011.	April 2011
Information is limited to the description "The middle of the year," 2011.	July 2011
Information is limited to the description "Fall," 2011.	October 2011
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year.	December or January

#95d-Collection, Storage, and Transmission of Date of First Contact
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

DATE OF FIRST CONTACT FLAG

Item Length: 2
NAACCR Item #581
Valid codes: 12, Blank
New Item: 1/1/2010

ACR Required Data Item #96a

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Contact* (NAACCR Item #580).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate nondate information that had previously been transmitted in date fields.

Instructions for Coding

- Leave this item blank if *Date of First Contact* (NAACCR Item #580) has a full or partial date recorded.
- Code 12 if the *Date of First Contact* can not be determined at all.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software

Code	Definition
12	A proper value is applicable but not known (that is, the date of first contact is unknown)
(blank)	A valid date value is provided in item *Date of First Contact* (NAACCR Item #580)

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of First Contact* (NAACCR Item #580) and *Date of First Contact Flag* (NAACCR Item #581). ***In the table below, the lowercase letter "b" is used to represent each blank space.***

Description	Traditional Date of First Contact	Interoperable Date of First Contact	Date of First Contact Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown.**	
Full date known	MMDDCCYY (example: 02182010)	CCYYMMDD (example: 20100218)	bb
Month and year known	MM99CCYY (example: 02992010)	CCYYMMbb (example: 201002bb)	bb
Year only known	9999CCYY (example: 99992010)	CCYYbbbb (example: 2010bbbb)	bb
Unknown date	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

Date of Diagnosis Clarifications

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). ***2010 SEER Program Coding and Staging Manual*****. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD**

1. When the only information available is a positive pathology or cytology report, code the date the biopsy was done, not the date the report was dictated or transcribed.

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

Example 1*:* The patient has an elevated PSA and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the prostate. The biopsy is positive for adenocarcinoma. The date of diagnosis is the date of the biopsy (do not code the date the procedure was dictated or transcribed).

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

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

3**. Suspicious cytology alone** is not diagnostic of cancer. Use the date of clinical, histologic, or **positive** cytologic confirmation as the date of diagnosis.

Note**:** Do **not** use suspicious cytology alone for case ascertainment

4. Code the earlier date as the date of diagnosis when

a. A recognized medical practitioner says that, in **retrospect**, the patient had cancer at an earlier date.

b. The original slides are reviewed and the pathologist documents that cancer was present . Code the diagnosis date as the date the original slides were made.

Example: The patient had an excision of a benign fibrous histiocytoma in January 2010. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The physician documents in the chart that the previous tumor must have been malignant. Code the diagnosis date as January 2010.

Note: Do not back-date the diagnosis

a. When the information on the previous tumor is unclear **AND/OR**

b. There is **no review** of previous slides AND/OR

c. There is **no physician's statement** that, in retrospect, the previous tumor was malignant.

Example: The patient had a total hysterectomy and a bilateral salpingo oophorectomy (BSO) in June 2010 with pathology diagnosis of papillary cystadenoma of the ovaries. In December 2010 the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2010 are not reviewed and there is no physician statement saying the previous tumor was malignant. The date of diagnosis is December 2010.

DATE OF DIAGNOSIS FLAG

ACR Required Data Item

Item Length: 2
NAACCR Item #391
Valid codes: 12, Blank
New Item: 1/1/2010

Description
This flag explains why no appropriate value is in the field, Date of Diagnosis [390]. This data item was first available in NAACCR Volume II Version 12 (effective January 2010).

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding
Use whatever information is available to calculate the Date of Diagnosis, use approximations, or call the physician's office. In the rare instance when you have exhausted all resources, the code for unknown Date of Diagnosis Flag is provided below. This flag can only be used for non-analytic cases.

Codes	Definition
12	A proper value is applicable but not known (e.g., date of diagnosis is unknown)
Blank	A valid date value is provided in item Date of Diagnosis [390], or the date was not expected to have been transmitted

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

DATE OF INITIAL DIAGNOSIS

Item Length: 8
NAACCR Item #390
Revised 09/04, 09/08, 1/10, 01/11

ACR Required Data Item #97a

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

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

Instructions for Coding #97b-See *ACR Supplement* p. 96A for additional clarifications.

- Use the first date of diagnosis whether clinically or histologically established.
- If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis.
- Refer to the list of "Ambiguous Terms" in Section One for language that represents a diagnosis of cancer.
- Use the date treatment was started as the date of diagnosis if the patient receives a first course of treatment before a diagnosis is documented.
- The date of death is the date of diagnosis for a *Class of Case* (NAACCR Item #610) 38 (diagnosed at autopsy) or 49 (death certificate only).
- Use the actual date of diagnosis for an *in utero* diagnosis, for cases diagnosed on January 1, 2009, or later.
- If the year diagnosis can not be identified, it must be approximated. In that instance, the month and day are unknown. #97c-Use whatever information is available to calculate the Date of Diagnosis.

Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Initial Diagnosis* MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Initial Diagnosis* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date.

#97d-The ACR will reject any analytic case that does not have a diagnosis year. Use whatever information is available to calculate the date, use approximations, or call the physician's office for assistance.

Examples

Date	Reason
July 2, 2010	Cytology "suspicious" for cancer June 12, 2010; pathology positive July 2, 2010. Do not consider cytology with ambiguous terms to be diagnostic.
May 17, 2010	Pathology "suspicious" for cancer May 17, 2010; confirmed positive May 22, 2010
April 2010	Physician's referral notes dated July 5, 2010, indicate the patient was diagnosed with cancer spring of 2010. Use April for "spring", July for "summer" or "mid-year", October for "fall" or "autumn". In winter, attempt to determine whether the diagnosis was "late in the year" (use December with the applicable year) or "early in year" (use January with the respective year).

#97e-Collection, Storage, and Transmission of Date of Initial Diagnosis
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

PRIMARY SITE

ACR Required Data Item #98a

Item Length: 4
NAACCR Item #400
Revised 01/04, 09/08, 01/10

Description
Identifies the primary site.

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

#98b-See *FORDS* pp. 8-9 and *ACR Supplement* pp. 98B-98E for additional information and guidelines for coding primary site.

Instructions for Coding

- Record the ICD-O-3 topography code for the site of origin.
- Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
- Topography codes are indicated by a "C" preceding the three-digit code number. Do not record the decimal point.
- Follow the Instructions for Coding in ICD-O-3, pages 20–40 and in the current *SEER Multiple Primary and Histology Coding Rules* to assign site for solid tumors. #98c
- Follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB) for assigning site for lymphomas, leukemia and other hematopoietic neoplasms. #98d
- 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 different subsites of one organ.

Examples

Code	Reason
C108	Overlapping lesion of oropharynx. Code overlapping lesion when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.
C678	Overlapping lesion of bladder. Code overlapping lesion of the bladder when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.
C189	Colon, NOS. Familial polyposis with carcinoma and carcinoma in situ throughout the transverse (C18.4) and descending colon (C18.6) would be one primary and coded to colon, NOS (C18.9). For a full explanation see the *SEER 2007 Multiple Primary and Histology Coding Rules*.
C16–	Stomach (sub-site as identified). An extranodal lymphoma of the stomach is coded to C16.– (sub-site as identified).

#98c-The *Multiple Primary and Histology Coding Rules* are effective for cases diagnosed on or after 1/1/2007. For cases diagnosed prior to 1/1/2007, use *FORDS: Revised for 2004*.

#98d-For cases diagnosed 2010 and later consult the *2010 Hematopoietic Database and 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*. For hematopoietic malignancies diagnosed 1/1/2001 through 12/31/2009 see Appendix A: Definition of Single and Subsequent Primaries for Hematologic Malignancies to determine the number of primaries and additional histology information.

TEXT-PRIMARY SITE TITLE

ACR Required Data Item

Item Length: 100
Free Text
NAACCR Item #2580

Description
Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Instructions for Coding
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized (See Appendix E).
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• Include information on the location of the primary site of the tumor
• Include available information on tumor laterality

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Primary site	400
Laterality	410

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

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ACR Supplement Page

Priority Order of Reports for Coding Primary Site

Source: Johnson CH, Peace S, Adamo P, Fritz A, Percy-Laurry A, Edwards BK. The 2007 Multiple Primary and Histology Coding Rules. National Cancer Institute, Surveillance, Epidemiology and End Results Program. Bethesda, MD, 2007

Head and Neck Sites C000-C148, C300-C329 (Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140) - Effective for cases diagnosed beginning 1/1/2007.

When there are multiple biopsies and the primary site is not documented, or when there is ***discrepant*** information, code the primary site using the following priority order.

1. Tumor board

a. Specialty

b. General

2. Staging physician's site assignment

a. AJCC staging form

b. TNM statement in medical record

If neither 1 nor 2 are available, the priority order for using information depends upon whether the patient had a surgical resection of the primary tumor.

3. Total (complete) resection of primary tumor

Note: The primary tumor is completely removed. The surgical margins may be microscopically positive.

a. Surgeon's statement from operative report

b. Final diagnosis from pathology report

4. No resection (biopsy only):

Documentation from:

a. Endoscopy (physical exam with scope)

b. Radiation oncologist

c. Diagnosing physician

d. Primary care physician

e. Other physician

f. Radiologist impression from diagnostic imaging

g. Physician statement based on physical exam (clinical impression)

When the point of origin cannot be determined use a topography code for overlapping sites:

•C02.8 Overlapping lesion of tongue

•C08.8 Overlapping lesion of major salivary glands

•C14.8 Overlapping lesion of lip, oral cavity, and pharynx

Priority Order of Reports for Coding Primary Site Continued

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD
These rules are documented in Appendix C of the 2010 manual.

These rules were also present in the 2004 and 2007 SEER Program Coding and Staging Manual.

The ACR uses the SEER manual as a guide to code primary site. Some of the rules related to priority order of reports to code a subsite may have been used by the ACR. However, the rules listed below were not fully documented in the ACR manual, therefore rules listed on this page are effective for cases diagnosed beginning 1/1/2009.

Breast C500-C509

Use the information from reports in the following priority order to code a subsite when there is conflicting information:

1. Pathology report
2. Operative report
3. Physical examination
4. Mammogram, ultrasound

Code the subsite with the invasive tumor when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites.

Code the specific quadrant for multifocal tumors all within one quadrant. Do not code C509 (Breast, NOS) in this situation.

Code the primary site to C508 when
• there is a single tumor in two or more subsites and the subsite in which the tumor originated is unknown
•there is a single tumor located at the 12, 3, 6, or 9 o'clock position on the breast

Code the primary site to C509 when there are multiple tumors (two or more) in at least two quadrants of the breast.

Bladder C670-C679

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

Operative report (TURB)
Pathology report

Multifocal Tumors

Invasive tumor in more than one subsite

Assign site code C679 when the tumor is multifocal (separate tumors in more than one subsite of the bladder).

If the TURB or pathology proves invasive tumor in one subsite and insitu tumor in all other involved subsites, code to the subsite involved with invasive tumor.

Primary Site Additional Guidelines and Clarifications

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). ***2010 SEER Program Coding and Staging Manual*****. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD**

Coding Instructions for Solid Tumors

Site-Specific Topography Terms

See the Coding Guidelines for Topography and Morphology in the introduction of the ICD-O-3 for additional details.

1. Code the **site** in which the **primary tumor originated, even if it extends onto/into an adjacent subsite**

Example: The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. Code the primary site to upper inner quadrant of breast (C502).

2. Code the site of the **invasive** tumor when there is an invasive tumor and in situ tumor in different subsites of the same anatomic site.

Example: Patient has an invasive breast tumor in the upper-outer quadrant of the left breast and in situ tumor in multiple quadrants of the left breast. Code the primary site to C504 (upper outer quadrant of breast).

3. Code the last digit of the primary site code to '9' for **single primaries**, when **multiple tumors arise** in **different subsites** of the same anatomic site and the point of origin cannot be determined.

Example: During a TURB, the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).

4. Some histology/behavior terms in ICD-O-3 have a **related site code** in parentheses; for example: Hepatoma (C220).

a. Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a primary site is specified in the medical record.

Example: The pathology report says "infiltrating duct carcinoma of the head of the pancreas." The listing in ICD-O-3 is infiltrating duct carcinoma 8500/3 (C50_). Code the primary site to head of pancreas (C250), NOT to breast (C50_) as suggested by the ICD-O-3.

b. Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or the primary site is unknown.

Example: The biopsy is positive for hepatoma, and no information is available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.

Example: An excision of the right axillary nodes reveals metastatic infiltrating duct carcinoma. The right breast is negative. The ICD-O-3 shows infiltrating duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).

Primary Site Additional Guidelines and Clarifications Continued

5. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).

6. Code 422 (Spleen) as the primary site for angiosarcoma of spleen with mets to bone marrow.

7. Gastrointestinal Stromal Tumors (GIST): Code the primary site to the location where the malignant GIST originated.

8. When the medical record does **not** contain **enough information** to assign a primary site:

a. Consult a physician advisor to assign the site code.

b. Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site.

c. Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category.

Esophagus

Two independent systems divide the esophagus into three subsites. The first system divides the esophagus into the upper third, middle third, and lower third. The second system describes the subsites as the cervical esophagus, thoracic esophagus, and abdominal esophagus. The sites for these two different systems are not identical. Assign the ICD-O-3 topography code that describes the primary documented in the medical record.

LATERALITY

Item Length: 1
Allowable Values: 0–4, 9
NAACCR Item #410
Revised 01/10, 05/10

ACR Required Data Item #99a

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

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

Instructions for Coding

- Code laterality for all paired sites. (See Section One for additional information.) #99b-All paired sites are listed on *FORDS* pp. 9-10.
- Do not code metastatic sites as bilateral involvement.
- Where the right and left sides of paired sites are contiguous (come into contact) and the lesion is at the point of contact of the right and left sides, use code 5, midline. Note that "midline of the right breast" is coded 1, right; midline in this usage indicates the primary site is C50.8 (overlapping sites).
- Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0. #99c

Code	Definition
0	Organ is not 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 at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors #99d
5	Paired site: midline tumor #99e
9	Paired site, but no information concerning laterality

#99c-Laterality may be coded for sites other than those required on *FORDS* pp. 9-10. For example: Code 2 may be assigned for a tumor originating in the left lobe of the thyroid.

#99d-For 2010 SEER expanded the definition of code to include *Diffuse bilateral lung nodules*.

#99e-The new code of "5" may be used retrospectively for cases diagnosed prior to 2010 per the CoC.

#99f-Starting with cases diagnosed January 1, 2004, and later, laterality is coded for selected invasive, benign, and borderline primary intracranial and CNS tumors. See *FORDS* p. 10.

HISTOLOGY

Item Length: 4
NAACCR Item #522
Revised 09/06, 01/10, 03/10

ACR Required Data Item #100a

Description
Identifies the microscopic anatomy of cells.

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

Instructions for Coding

- ICD-O-3 identifies the morphology codes with an "M" preceding the code number. Do not record the "M."
- Record histology using the ICD-O-3 codes in the Numeric Lists/Morphology section (ICD-O-3, pp. 69–104) and in the Alphabetic Index (ICD-O-3, pp. 105–218).
- Follow the coding rules outlined on pages 20 through 40 of ICD-O-3.
- Use the current *Multiple Primary and Histology Coding Rules* when coding the histology for all reportable solid tumors. These rules are effective for cases diagnosed January 1, 2007, or later. Do not use these rules to abstract cases diagnosed prior to January 1, 2007. #100b
- Review all pathology reports.
- Code the **final** pathologic diagnosis for solid tumors.
- For lymphomas, leukemias and other hematopoietic tumors, follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB) #100c
- 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).

#100b-For cases diagnosed prior to 1/1/2007, use *FORDS: Revised for 2004*.

Examples

#100d-Always use the coding rules from the ICD-O book that was effective in the year the case was diagnosed: On or prior to 12/31/2000 use ICD-O-2 & On or afer 1/1/2001: ICD-O-3.

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

#100c-For cases diagnosed 2010 and later consult the *2010 Hematopoietic Database and 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*. For hematopoietic malignancies diagnosed 1/1/2001 through 12/31/2009 see Appendix A: Definition of Single and Subsequent Primaries for Hematologic Malignancies to determine the number of primaries and additional histology information.

#100e-Cases diagnosed prior to January 1, 2001 must have the following data items coded related to histology:
Histology (92-00) ICD-O-2 (NAACCR Item #420)
Behavior (92-00) ICD-O-2 (NAACCR Item #430)
Cases diagnosed on or after January 1, 2001 must have the following data items coded related to histology:
Histology Type ICD-O-3 (NAACCR Item #522)
Behavior Code ICD-O-3 (NAACCR Item #523)

#100f-Some software vendors autocode the non-applicable histology and behavior items. For example, the histology for a 2000 case would be entered in NAACCR Items #420 (Histology (92-00) ICD-O-2) & #430 (Behavior (92-00) ICD-O-2). The vendor may autocode NAACCR Items #522 (Histologic Type ICD-O-3) & #523 (Behavior Code ICD-O-3).
Caution: if a change is made in the histology once it has been autocoded, some software vendors may not correct the other histology that is coded.

TEXT-HISTOLOGY TITLE

ACR Required Data Item

Item Length: 100
Free Text
NAACCR Item #2590

Description
Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Instructions for Coding
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized (See Appendix E).
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• Information on histologic type and behavior
• Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc.

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Histology (92-00) ICD-O-2	420
Behavior (92-00) ICD-O-2	430
Histologic Type ICD-O-3	522
Behavior Code ICD-O-3	523
Grade	440

Source: Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

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ACR Supplement Page

BEHAVIOR CODE

Item Length: 1
Allowable Values: 0–3
NAACCR Item #523
Revised 04/04, 01/10

ACR Required Data Item #101a

Description
Records the behavior of the tumor being reported. The fifth digit of the morphology code is the behavior code. See #102b

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

Instructions for Coding See #100e & #100f

- 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: The ICD-O-3 behavior code for juvenile astrocytoma (9421/1) is coded as 3 by agreement of North American registry standard-setters. Refer to "Case Eligibility" in Section One for information.

Code	Label	Definition
0	Benign	Benign
1	Borderline	Uncertain whether benign or malignant.
		Borderline malignancy.
		Low malignant potential.
		Uncertain malignant potential.
2	In situ and/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 See #102a	Confined to epithelium.
		Hutchinson melanotic freckle, NOS (C44.–).
		Intracystic, noninfiltrating.
		Intraductal.
		Intraepidermal, NOS.
		Intraepithelial, NOS.
		Involvement up to, but not including the basement membrane.
		Lentigo maligna (C44.–).
		Lobular neoplasia (C50.–).
		Lobular, noninfiltrating (C50.–).
		Noninfiltrating.
		No stromal involvement.

Code	Label	Definition
2		Papillary, noninfiltrating or intraductal.
		Precancerous melanosis (C44.–).
		Queyrat erythroplasia (C60.–).
3	Invasive	Invasive or microinvasive.

Example

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

#102a-Synonyms for in-situ include:
AIN III (C211)
Behavior code '2'
Bowen disease (not reportable for C440-C449)
Clark Level I for melanoma (limited to epithelium)
Noninvasive
Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)
VAIN III (C529)
VIN III (C51_)

#102b-Consult with the ICD-O Coding Guidelines for Topography and Morphology pp. 27-30 for detailed information related to Behavior Code. Per ICD-O-3, Rule F (page 20): "Use the appropriate 5th digit behavior code even if the exact term is not listed in ICD-O. The use of the 5th digit behavior code is explained in the Coding Guidelines, page 27, and in Table 20, page 30 (Matrix). The appropriate 5th digit code should be used even if the exact term is not listed in ICD-O; for example, 'benign chordoma' as a diagnosis should be coded M-9370/0. If the pathologist states that the behavior differs from the usual behavior as given in ICD-O, code as the pathologist indicates." Behavior codes of /6 (malignant, metastatic site) and /9 (malignant, uncertain whether primary or metastatic site should not be used.

GRADE/DIFFERENTIATION

Item Length: 1
Allowable Values: 1–9
NAACCR Item #440
Revised 01/04, 09/08, 01/10, 01/11

ACR Required Data Item #103a

Description
Describes the tumor's resemblance to normal tissue. Well differentiated (Grade 1) is the most like normal tissue, and undifferentiated (Grade 4) is the least like normal tissue. Grades 5–8 define particular cell lines for lymphomas and leukemias.

Rationale
This data item is useful for prognosis.

#103b-For additional instructions related to priority order of coding related to Grade refer to *FORDS* pp. 11-12 Section One Morphology: Grade. See also *ACR Supplement* pp. 106A-106C, #103c and see #104a-#104c before coding Grade.

Instructions for Coding
- Code grade according to ICD-O-3 (pp. 30–31 and 67).
- Code the grade or differentiation as stated in the **final** pathologic diagnosis. If grade 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 (ICD-O-3 Rule G, ICD-O-3, p. 21).
- Code the grade or differentiation from the pathologic examination of the primary tumor, not from metastatic sites.
- Code the grade or differentiation from the pathology report prior to any neoadjuvant treatment. If there is no pathology report prior to neoadjuvant treatment, assign code 9.
- When there is no tissue diagnosis, it may be possible to establish grade through magnetic resonance imaging (MRI) or positron emission tomography (PET). When available, code grade based on the recorded findings from these imaging reports.
- If the primary site is unknown, code *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 *Grade/Differentiation*.
- 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 specified for astrocytomas, code 9 (Unknown).
- If no grade is specified for glioblastoma multiforme, code 9 (Unknown).
- See Section I to convert other solid tumor grade systems to *Grade/Differentiation*.
- If *Grade Path System* (NAACCR Item #449) and *Grade Path Value* (NAACCR Item #441) are coded, *Grade/Differentiation* (NAACCR Item #440) must not be 9.

#103c-Coding Rules for Hematopoietic and Lymphoid Neoplasms
Apply the Grade of Tumor Rules in the *2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* for cases diagnosed starting in 2010.

Code	Grade/Cell	Label
1	Grade I,1,i	Well differentiated; differentiated, NOS
2	Grade II,2,ii I/III or 1/3	Moderately differentiated; moderately well differentiated; intermediate differentiation
3	Grade III,3,iii II/III or 2/3	Poorly differentiated; dedifferentiated
4	Grade IV,4,iv III/III or 3/3	Undifferentiated; anaplastic
For Lymphomas and Leukemias		
5		T cell; T-precursor
6		B cell; pre-B; B-precursor
7		Null cell; non T-non B
8		NK (natural killer) cell (effective with diagnosis 1/1/95 and after)
For Use in All Histologies		
9		Cell type not determined, not stated or not applicable; unknown primary; high grade dysplasia (adenocarcinoma in situ)

#104a-Additional Grade Coding Guidelines

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA (eds). *2010 SEER Program Coding and Staging Manual.* National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

1. See site-specific coding guidelines related to priority order of coding grade in *FORDS* pp. 11-12. The site-specific instructions take priority over general instructions.

2. Record the tumor grade from the pathology or cytology report prior to neoadjuvant treatment (This guideline is effective with cases diagnosed in 2010 and later. This is a change from previous rules.)

a. Code grade as 9 when

i. No grade is specified on the pathology reporting findings from cytology or tissue assessment prior to adjuvant treatment

OR

ii. The pathology report from cytology or tissue assessment prior to neoadjuvant treatment is not available.

3. Code the grade from the primary tumor only, never from a metastatic site or a recurrence.

4. If more than one grade is recorded for a single tumor, code the highest grade, even if it is a focus.

Example: Pathology report reads: Grade II adenocarcinoma with a focus of undifferentiated adenocarcinoma. Code the tumor grade as grade 4.

5. Differentiation has priority over nuclear grade when both are specified.

Example: Liver biopsy histology described as "well differentiated hepatocellular carcinoma, nuclear grade 2/4." Code the tumor grade as grade 1.

6. Code the grade of the invasive component when the tumor has both in situ and invasive portions. If the invasive component grade is unknown, code the grade as unknown (9).

7. Do not code the grade assigned to dysplasia.

Example: High grade dysplasia (adenocarcinoma in situ). Code to 9 (unknown grade).

8. Do not code grade based on the FNCLCC (Federation Nationale des Centres de Lutte Contre le Cancer) grade. The FNCLCC grade is collected in one of the Collaborative Stage Site Specific Factors.

9. Code to 9 (unknown grade) when the primary site is unknown.

#104b-Neoadjuvant Therapy Definition

SEER has not issued a definition for neoadjuvant therapy, however CSv02.03.02 Part I, Section I General Instructions provides one that the ACR will use until one is incorporated into the SEER or CoC manual. "Preoperative, or neoadjuvant, treatment is defined as systemic (chemotherapy, hormone therapy, or immunotherapy) treatment or radiation therapy that is administered as an attempt to shrink the tumor, improve resectability, or control symptoms before the patient undergoes surgery."

#104c-Example:

Patient had a biopsy (Grade 1) before the neoadjuvant treatment. The patient then has a resection following the neoadjuvant treatment. The Grade of the resection was Grade 2. Code the Grade 1.

GRADE PATH SYSTEM

Item Length: 1
Allowable Values: 2–4, blank
NAACCR Item #449
Revised 01/11

Not Required by ACR #105a

Description
Indicates whether a two, three or four grade system was used in the pathology report.

Rationale
This item is used to show whether a two, three or four grade system was used in the pathology report to describe the grade. This item is used in conjunction with *Grade Path Value* (NAACCR Item #441).

Instructions for Coding
- Refer to the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

GRADE PATH VALUE

Item Length: 1
Allowable Values: 1–4, blank
NAACCR Item #441
Revised 01/11

Not Required by ACR #106a

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

Rationale
This item records the numeric grade reported in the pathology report. This item supplements but does not replace *Grade/Differentiation* (NAACCR Item #440).

Instructions for Coding
- Refer to the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

TUMOR GRADE NOTES

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

Terminology Conversion Table – The ACR uses the SEER manual as a guide to code tumor grade. Some of the information from the following table may have been used by the ACR. However, the table was not fully documented in the ACR manual, therefore this table is effective for cases diagnosed beginning 1/1/2009.

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

TUMOR GRADE NOTES

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

Sarcomas — The ACR uses the SEER manual as a guide to code tumor grade. Some of the information from the following table may have been used by the ACR. However, the table was not fully documented in the ACR manual, therefore this table is effective for cases diagnosed beginning 1/1/2009.

Sarcomas are graded low, intermediate or high grade by the pathologist. Use the following table to convert these terms to a histologic grade.

Term	Grade	Code
Well differentiated	I	1
Fairly well differentiated	II	2
Low grade	I-II	2
Mid differentiated	II	2
Moderately differentiated	II	2
Partially differentiated	II	2
Partially well differentiated	I-II	2
Partially well differentiated	II	2
Relatively or generally well differentiated	II	2
Medium or intermediate grade	II-III	3
Moderately poorly differentiated	III	3
Moderately undifferentiated	III	3
Poorly differentiated	III	3
Relatively poorly differentiated	III	3
Relatively undifferentiated	III	3
Slightly differentiated	III	3
High grade	III-IV	4
Undifferentiated, anaplastic, not differentiated	IV	4

TUMOR GRADE NOTES

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

Bladder—The ACR uses the SEER manual as a guide to code tumor grade. Some of the information from the following table may have been used by the ACR. However, the table was not fully documented in the ACR manual, therefore this table is effective for cases diagnosed beginning 1/1/2009.

Three-Grade System (Nuclear Grade)

There are several sites for which a three-grade system is used. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into three rather than four categories (see comparison table below). If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the following table to convert the grade to a code.

Term	Grade	Code
1/3, 1/2	Low grade	2
2/3	Intermediate grade	3
3/3, 2/2	High grade	4

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ACR Supplement Page

OTHER PRIMARY TUMORS

ACR Required Data Item

Item Length: 90
Left Justified
NAACCR Item #None

Description
This field is used to record all other primary tumors the patient has had in the past.

Rationale
A listing of all primary tumors assists the hospital registry and the central in performing quality control with regard to sequence numbers and assists the central registry in merging cases.

Instructions for Coding
Record in narrative text the primary site, histology, sequence number, date of diagnosis and the three digit hospital number or location of all other reportable diagnoses. If the sequence number is not a “00” or “61” you must document the other primary tumor information in the Text-Remarks field (#2680).

Note #1: Abbreviations are acceptable for use when documenting in narrative text provided that they are commonly accepted terms. See Appendix E.

Note #2: All facilities, including RMCDS facilities, must document other primary tumors the patient may have in the Text-Remarks field (#2680). Since RMCDS hospitals are now exporting in a NAACCR format the ACR does not receive the “Other Primary Tumors" field.

TEXT-DX PROC -PATH

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2570

Description
This narrative text section is used to provide information from pathology and cytology reports that is pertinent to the diagnosis and extent of the cancer. Use this field to substantiate the histology, behavior, grade, lymph node(s), surgical margin status, extent of disease (e.g. direct extension) as well as the date, place, slide number and specimen.

Rationale
Text is needed to **substantiate the codes** assigned in the abstract and to allow recording information that is not coded at all. It is a component of a complete electronic abstract and **aids in quality control** at the hospital level and **at the central registry**.

Instructions for Coding
Record all pathology (tissue, cytology etc.) reports that pertain to the diagnosis or staging of the tumor.

In the order listed, each pathology report recorded must contain the following:

1. Date pathology slide was read
2. Place where pathology examination was done (may abbreviate using facility initials)
3. Slide number
4. Origin of the specimen being studied (e.g. biopsy, smear, surgical specimen, FNA)
5. Final histologic diagnosis (include microscopic information if a more specific histology and/ or grade is described, following the guidelines in the histology/behavior/grade section of this manual);
6. Lymph node status
7. Surgical (residual) margin as it relates to the residual tumor status;
8. Description of tumor invasion from gross, microscopic and final diagnosis (e.g. through the basement membrane; invasion of the wall without extension though the wall).

Note #1: No codes are to be entered into this field. This field is for narrative text only.

Note #2: Tumor size is to be recorded in the field titled, “DESCRIPTION OF SIZE” in RMCDS software. Facilities that use software other than RMCDS should document tumor size in this field.

Note #3: See Appendix E for acceptable abbreviations.

Note #4: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #5: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

LYMPH-VASCULAR INVASION

ACR Required Data Item #107a
Required for Specific Primary Sites Only, See Note #107b
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 1
Allowable Values: 0-1, 8-9
NAACCR Item #1182
Revised 01/11

Description
Indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist.

Rationale
Lymph-vascular invasion is an indicator of prognosis. This field is used by the CS algorithm to map AJCC T for some primary sites.

Instructions for Coding

- Refer to the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

#107b-Lymph-vascular Invasion is required for the primary sites of penis and testis only. For these primary sites this data item is needed to derive a staging value for the CS algorithm.

DIAGNOSTIC CONFIRMATION

Item Length: 1
Allowable Values: 1, 2, 4–9
NAACCR Item #490
Revised 01/04, 01/10, 01/11

ACR Required Data Item #108a

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

Rationale
This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed only is an indication of whether casefinding is including sources outside of pathology reports. Full incidence calculations must include both clinically and pathologically confirmed cases.

Instructions for Coding Solid Tumors (all tumors *except* M9590-9992)
- See the section following this one for Coding Hematopoietic or Lymphoid Tumors (9590-9992).
- The codes are in **priority order**; code 1 has the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods. This data item must be changed to the lower (higher priority) code if a more definitive method confirms the diagnosis *at any time during* the course of the disease.
- Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or D&C or from aspiration of biopsy of bone marrow specimens.
- Assign code 2 when the microscopic diagnosis is based on cytologic examination of *cells* such as sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. CoC does not require programs to abstract cases that contain ambiguous terminology regarding a cytologic diagnosis.
- Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer.
- Code 6 when the diagnosis is based only on the surgeon's operative report from a surgical exploration or endoscopy or from gross autopsy findings in the absence of tissue or cytological findings.

#108b-Code 6 examples: endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined.

Codes for Solid Tumors

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. Examples include alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is not diagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination. #108b
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.

#109a-SEER Example: CT diagnosis is possible lung cancer. Patient returns to the nursing home with a DNR order. Physician enters a diagnosis of lung cancer in the medical record. Code the diagnostic confirmation to 8: there is a physician's clinical diagnosis - clinical diagnosis made by the physician using the information available for the case.

8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record. #109a
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 nonanalytic).

Instructions for Coding Hematopoietic or Lymphoid Tumors (9590-9992) See #110a & #110b

- There is no priority hierarchy for coding *Diagnostic Confirmation* for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing See the *Hematopoietic Database (DB)* for information on the definitive diagnostic confirmation for specific types of tumors.
- Code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.
- For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.
- Use code 2 when the microscopic diagnosis is based on cytologic examination of *cells* (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.
- Assign code 3 when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.
- Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but no positive histologic confirmation.
- Assign code 6 when the diagnosis is based only on the surgeon's report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.
- Assign code 8 when the case was diagnosed by any clinical method that can not be coded as 6 or 7. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

#109b-Note: The Hematopoietic DB will identify clinical diagnosis as the definitive diagnostic method.

Codes for Hematopoietic and Lymphoid Neoplasms

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
3	Positive histology PLUS • Positive immunophenotyping AND/OR • Positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia. (9861/3) Genetic testing shows AML with inv(16)(p13.1q22) (9871/3).
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.

7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record. See #109b
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 nonanalytic).

#110a-See the glossary in the *2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* for definitions of immunophenotyping and genetic testing.

#110b-See the Hematopoietic DB for information on the definitive diagnostic confirmation method(s) for the specific neoplasm being abstracted.

AMBIGUOUS TERMINOLOGY DIAGNOSIS

Item Length: 1
Allowable Values: 0, 1, 2, and 9
NAACCR Item #442
Revised 01/10, 01/11

ACR Required Data Item #111a

Description
Identifies cases for which an ambiguous term is the most definitive word or phrase used to establish a cancer diagnosis.

Rationale
This data item allows cases to be identified within an analysis file. It also allows these cases to be identified and excluded from patient contact studies.

Instructions for Coding
- Apply the instructions in the current version of *Multiple Primary Histology and Coding Rules* to code this item.
- Leave blank for cases diagnosed prior to January 1, 2007.

DATE OF CONCLUSIVE DIAGNOSIS

Item Length: 8
NAACCR Item #443
Revised 01/10, 01/11

ACR Required Data Item #112a

Description
Records the date when a conclusive cancer diagnosis (based on definitive statement of malignancy) is made 60 days or more following an initial diagnosis that was based only on ambiguous terminology.

Rationale
This data item allows for analysis of the time interval between cancer diagnosis based on ambiguous terminology and confirmation of the cancer diagnosis by conclusive means.

Instructions for Coding #112b

- Apply the instructions in the current version of *Multiple Primary Histology and Coding Rules* to code this item.
- Leave blank for cases diagnosed prior to January 1, 2007.

#112b-Data item is called "Date of Conclusive Terminology" in the *Multiple Primary and Histology Coding Rules* manual.

#112c-Collection, Storage, and Transmission of Date of Conclusive Diagnosis
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

DATE CONCLUSIVE DX FLAG

ACR Required Data Item #113a

Item Length: 2
NAACCR Item #448
Valid codes: 10-12, 15, Blank
Revised 05/10, 01/11

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Conclusive Diagnosis* (NAACCR Item #443).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding
- Apply the instructions in the current version of *Multiple Primary Histology and Coding Rules* to code this item.
- Leave blank for cases diagnosed prior to January 1, 2007.

DATE OF MULTIPLE TUMORS

ACR Required Data Item #114a

Item length: 8
NAACCR Item #445
Revised 04/07, 09/08, 01/10, 01/11

Description
Identifies the date the patient is diagnosed with multiple or subsequent reportable tumor(s) reported as a single primary. Multiple tumors must have the same histologic group as the original tumor and must be located in the same organ or primary site as the original tumor, using the primary site and histology coding rules.

Rationale
This data item allows for the separation of cases with multiple reportable tumors present at the time of initial diagnosis from cases with subsequent reportable tumors. The date allows for tracking the time interval between the date of original diagnosis and the first date of subsequent tumor(s) for specific primary sites and tumor histologies.

Instructions for Coding

- Apply the instructions in the current version of *Multiple Primary Histology and Coding Rules* to code this item.
- Leave blank for cases diagnosed prior to January 1, 2007.

#114b-Collection, Storage, and Transmission of Date of Multiple Tumors
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

DATE OF MULT TUMORS FLAG

Item length: 2
NAACCR Item #439
Valid codes: 11, 12, 15, Blank
Revised 01/11

ACR Required Data Item #115a

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Multiple Tumors* (NAACCR Item #445).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding

- Apply the instructions in the current version of *Multiple Primary Histology and Coding Rules* to code this item.
- Leave blank for cases diagnosed prior to January 1, 2007.

TYPE OF MULTIPLE TUMORS REPORTED AS ONE PRIMARY

Item Length: 2
Allowable Values: 00, 10–12, 20, 30–32, 40, 80, 88, 99
NAACCR Item #444
Revised 07/07, 09/08, 01/10, 01/11

ACR Required Data Item #116a

Description
Identifies cases with multiple tumors that are abstracted as a single primary using the multiple primary rules in terms of the mix of histologic behaviors represented.

Rationale
Patients with multiple tumors that are reported as a single primary for surveillance purposes may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item makes it possible to identify important information about these cases for data analysis. Data collected for this item are used to assess the number, type, and anatomic location of multiple tumors currently abstracted as a single primary using the rules for determining multiple primary cancers and the impact these cases have on cancer case counts and incidence rates.

Instructions for Coding
- Apply the instructions in the current version of *Multiple Primary Histology and Coding Rules* to code this item.
- Leave blank for cases diagnosed prior to January 1, 2007.

MULTIPLICITY COUNTER

Item length: 2
Allowable Values: 01–88, 99
NAACCR Item #446
Revised 09/08, 01/10, 01/11

ACR Required Data Item #117a

Description
Records the number of tumors (multiplicity) reported as a single primary.

Rationale
Patients with multiple tumors reported as a single primary for surveillance purposes may have a worse prognosis and more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis. Data collected for this item will be used to assess the number, type, and anatomic location of multiple reportable tumors currently abstracted as a single primary and the impact of these cases on cancer case counts and incidence rates.

Instructions for Coding

- Apply the instructions in the current version of *Multiple Primary Histology and Coding Rules* to code this item.
- Leave blank for cases diagnosed prior to January 1, 2007.

#117b-New codes for Multiplicity Counter
Per SEER, the new codes are effective for cases diagnosed on or after 01/01/2011. The MP/H Coding Rules on the SEER website have not been updated to reflect these new codes as of 08/11/2011. Registries should start using these codes with their cases diagnosed on or after 01/01/2011.

00-No primary tumor identified
89-Multicentric, multifocal, number unknown

REGIONAL LYMPH NODES EXAMINED

Item Length: 2
Allowable Values: 00–90, 95–99
NAACCR Item #830
Revised 09/06, 01/10

ACR Required Data Item #118a

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 became a component of the Collaborative Staging System (CS).

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

Instructions for Coding
- Refer to the site/histology-specific instructions in the current *CS Manual* for codes and Instructions for Coding.

#118b-For cases diagnosed prior to January 1, 2004 consult with the *FORDS* (2003 version) for guidelines on coding Regional Lymph Nodes Examined and Regional Lymph Nodes Positive.

REGIONAL LYMPH NODES POSITIVE

Item Length: 2
Allowable Values: 00–99
Right Justified, Zero-filled
NAACCR Item #820
Revised 09/06, 01/10

ACR Required Data Item #119a

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 became a component of the Collaborative Staging System (CS).

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

Instructions for Coding
- Refer to the site/histology-specific instructions in the current *CS Manual* for codes and Instructions for Coding.

#119b-For cases diagnosed prior to January 1, 2004 consult with the *FORDS* (2003 version) for guidelines on coding Regional Lymph Nodes Examined and Regional Lymph Nodes Positive.

TUMOR SIZE

ACR Required Data Item
For cases diagnosed prior to 1/1/2004

Source: ***FORDS, Revised for 2009***

Item Length: 3
Allowable Values:000-990-999
NAACCR Item #780
Revised 09/04

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

Rationale
Tumor size is an important prognostic factor for cancer.

Instructions for Coding
•**Code this data item for cases diagnosed on or before December 31, 2003.**
•Code tumor size using *CS Tumor Size* (NAACCR Item #2800) for cases diagnosed on or after January 1, 2004.
•Code the exact size of the primary tumor in millimeters (mm).

Converting units of measure:
-1 mm is one-tenth of a centimeter (cm), thus, a 20-mm or 2-cm tumor is coded as 020.
EXCEPTION:
-For melanomas of the skin (C44.0-C44.9), vulva (C51.0-C51.9), penis (C60.0-C60.9), scrotum (C63.2), and conjunctiva (C69.0), code the depth of invasion in HUNDREDTHS of millimeters.
-Code 989 for melanomas of the skin (C44.0-C44.9), vulva (C51.0-C51.9), penis (C60.0-C60.9), scrotum (C63.2), and conjunctiva (C69.0) which are 9.89 mm or greater in depth.

•Code the largest dimension or diameter of the tumor, whether it is from a biopsy specimen or the complete resection of the primary tumor.
•Code the size of the primary tumor,not the size of polyps, ulcers, cysts, or metastases.
•Record the size the tumor from the pathology, if available.
•Information on tumor size from imaging/radiographic techniques can be used to code size, but should be taken as low priority, just above physical exam.
•Code 001 for tumors less than 1 mm in size.
•Code the size as stated for purely in situ tumors.
•If both an in situ and an invasive component are present, and each is measured, code the size of the invasive component even if it is smaller.
•Code 998 when following terms describe tumor involvement for these specified sites:

-Esophagus (C150.0-C15.5, C15.8, C15.9): Entire circumference.
-Stomach (C16.0-C16.6, C16.8, C16.9): Diffuse, widespread, 3/4 or more, linitis plastica.
-Colorectal (C18.0-C20.9 with M-8220/8221 and /2 or /3): Familial/multiple polyposis.
-Lung and main stem bronchus (C34.0-C34.3, C34.8, C34.9): Diffuse, entire lobe or lung.
-Breast (C50.0-C50.6, C50.8, C50.9): Inflammatory carcinoma; diffuse, widespread, 3/4 or more of breast.

•Code 999, unknown, if only one size is given for a mixed *in situ* and invasive tumor.
•Code the size of the residual tumor if an excisional biopsy is performed and residual tumor at time of resection of the primary site is found to be larger than the excisional biopsy.
•**Do not** add pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor.
•Code 999 if the size of the tumor is unknown or the tumor size is not documented in the patient record.

TUMOR SIZE CONTINUED (#780)

Instructions for Coding Continued

•Code 999 for histologies or sites where size is not applicable:
- -Unknown or ill-defined primary (C76.0-C76.8, C80.9)
- -Hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 and/or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)
- -Multiple myeloma (9732)
- -Letterer-Siwe disease (9754)

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

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

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

DESCRIPTION OF SIZE

Item Length: 30
Free Text
NAACCR Item #None

ACR Required Data Item
For use with RMCDS software.

Description
This data item is to be used to provide narrative text documentation about multiple tumor dimensions (if appropriate) and source used.

Rationale
Narrative description substantiates the codes assigned in the abstract and aids in quality control at the hospital level and at the central registry.

Instructions for Coding
Record in narrative text the complete tumor size and the source used. For example:

Tumor size recorded as: 020 (2 cm)
Description of Tumor size recorded as: 1.3 x 0.5 x 2.0 cm.

Note #1: See Appendix E for acceptable abbreviations.

Note #2: This field is unique to RMCDS software. For facilities using other cancer registry software, a narrative description of the size of the tumor must be entered in NAACCR item #2570, TEXT—DX PROC-PATH or other appropriate text field where tumor size was taken. If for example the tumor size was taken from a radiology report document the entire tumor size in NAACCR item #2530, TEXT-DX PROC-XRAY/SCAN.

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ACR Supplement Page

Stage of Disease at Diagnosis

DATE OF SURGICAL DIAGNOSTIC AND STAGING PROCEDURE ACR Required Data Item #123a

Item Length: 8
NAACCR Item #1280
Revised 01/10, 01/11

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

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

Coding Instructions:

- 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.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this modification does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Surgical Diagnostic and Staging Procedure* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Surgical Diagnostic and Staging Procedure* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date-DX/Stg Proc Flag* (NAACCR Item #1281) is used to explain why *Date of Surgical Diagnostic and Staging Procedure* is not a known date. See *RX Date-DX/Stg Proc Flag* for an illustration of the relationships among these items. #123b

#123b-Collection, Storage, and Transmission of Date of Surgical Diagnostic and Staging Procedure
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#123c-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RX DATE–DX/STG PROC FLAG

NAACCR Item #1281

Item Length: 2
NAACCR Item 281
Valid codes 10–12, Blank
New Item: 1/1/2010

ACR Required Data Item #124a

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions
- Leave this item blank if *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280) has a full or partial date recorded.
- Code 10 if it is unknown whether a surgical diagnostic or staging procedure was performed.
- Code 11 if no surgical diagnostic or staging procedure was performed.
- Code 12 if the *Date of Surgical Diagnostic and Staging Procedure* cannot be determined, but a surgical diagnostic or staging procedure was performed for the patient.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any diagnostic or staging procedure performed).
11	No proper value is applicable in this context (for example, no diagnostic or staging procedure performed; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, diagnostic or staging procedure performed but date is unknown).
(blank)	A valid date value is provided in item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). Case was diagnosed prior to January 1, 2007.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280-) and *RX Date–DX/Stg Proc Flag* (NAACCR Item #1281). ***In this table, the lower-case letter "b" is used to represent each blank space.***

	Traditional Date of Surgical Diagnostic or Staging Procedure	**Interoperable Date of Surgical Diagnostic or Staging Procedure**	**RX Date–DX/Stg Proc Flag**
Description	**Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999**	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
	Date entry	**Date entry**	**Flag value**
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if procedure done	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
Procedure not done	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, procedure done	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

SURGICAL DIAGNOSTIC AND STAGING PROCEDURE

ACR Required Data Item #126a

Item Length: 2
Allowable Values: 00–07, 09
NAACCR Item #1350
Revised 09/06, 09/08

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

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

Instructions for Coding:

- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).
- If a lymph node is biopsied or removed to diagnose or stage *lymphoma*, and that node is NOT the only node involved with lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item *Surgical Procedure of Primary Site* (NAACCR Item #1290) to code these procedures. See #127a
- 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 site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated. See #127b
04	A surgical procedure with a bypass was performed, but no biopsy was done. See #127b
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done. See #127b
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done. See #127b
07	A procedure was done, but the type of procedure is unknown.
09	No information of whether a diagnostic or staging procedure was performed.

Examples:

Code	Reason
00	A lung cancer primary was diagnosed by CT scan. The patient expired. No surgical diagnostic or staging surgical procedure was performed.
00	A sputum sample is examined cytologically to confirm a diagnosis of suspected lung cancer. The procedure is not surgical.
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.
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.

#127a-Clarification-Coding Surgery of Primary Site for Lymph Node Primaries
Surgery of Primary Site for Lymph Nodes C770-C770 (Except for M9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992): Code 25
Use code "25" in the items RX HOSP-SURG PRIM SITE [#670] and/or RX SUMM-SURG PRIM SITE [#1290] in instances where there is a primary in one and only one lymph node, and the single involved lymph node is removed by an excisional biopsy only. See Appendix B, p. 285.

#127b-Examples of Surgical Diagnostic and Staging Procedures include:
Bypass Surgery - colostomy, esophagostomy, gastrostomy, nephrostomy, tracheostomy, urethrostomy
Exploratory Surgery - celiotomy, cystotomy, gastrotomy, laparotomy, nephrotomy, thoracotomy

SURGICAL DIAGNOSTIC AND STAGING PROCEDURE AT THIS FACILITY

ACR Required Data Item #128a

Item Length: 2
Allowable Values: 00–07, 09
NAACCR Item #740
(Revised 01/04, 09/08)

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

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

Instructions for Coding

- Record the type of procedure performed as part of the initial diagnosis and workup at this facility.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).
- If a lymph node is biopsied or removed to diagnose or stage *lymphoma*, and that node is NOT the only node involved with lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item *Surgical Procedure of Primary Site at This Facility* (NAACCR Item #670) to code these procedures. See #127a
- 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 at This Facility* (NAACCR Item #672) 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 at This Facility* (NAACCR Item #672).
- 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 at This Facility* (NAACCR Item #670) to code these procedures.
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure at This Facility* (NAACCR Item #3280) 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 site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated. #128b
04	A surgical procedure with a bypass was performed, but no biopsy was done. #128b
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done. #128b
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done. #128b
07	A procedure was done, but the type of procedure is unknown.
09	No information of whether a diagnostic or staging procedure was performed.

#128b-Examples of Surgical Diagnostic and Staging Procedures include:
Bypass Surgery - colostomy, esophagostomy, gastrostomy, nephrostomy, tracheostomy, urethrostomy
Exploratory Surgery - celiotomy, cystotomy, gastrotomy, laparotomy, nephrotomy, thoracotomy

CLINICAL T

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #940
Revised 09/06, 01/08, 09/08, 01/10

ACR Required Data Item #129a
Required for All Non-Analytic Cases regardless of diagnosis year.
Required for Analytic Cases diagnosed prior to 1/1/2004. See #129c.

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known ***prior*** to the start of any therapy.

#129b-Always use the pathologic basis for staging if possible. Refer to each chapter in the *AJCC Cancer Staging Manual* for site-specific requirements. If the pathologic staging basis cannot be used, then AJCC stage using the clinical staging rules.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding #129b #129c See #130b

- The clinical T staging element must be recorded for *Class of Case* 10-22. #129c
- It is strongly recommended that the clinical T staging element be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows coding of clinical T. #129c
- Code clinical T as documented by the first treating physician or the managing physician in the medical record. #129d
- If the managing physician has not recorded clinical T, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- For lung, occult carcinoma is coded TX.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

#129d-The ACR does not require physicians to complete TNM staging.

Code	Definition	Code	Definition	Code	Definition
(leave blank)	Not recorded.	1B	T1b	3	T3
X	TX	1B1	T1b1	3A	T3a
0	T0	1B2	T1b2	3B	T3b
A	Ta	1C	T1c	3C	T3c
IS	Tis	1D	T1d	3D	T3d
ISPU	Tispu	2	T2	4	T4
ISPD	Tispd	2A	T2a	4A	T4a
1MI	T1mi, T1 mic	2A1	T2a1	4B	T4b
1	T1	2A2	T2a2	4C	T4c
1A	T1a	2B	T2b	4D	T4d
1A1	T1a1	2C	T2c	4E	T4e
1A2	T1a2	2D	T2d	88	Not applicable

#129c-For ALL Non-Analytic Cases regardless of DX Year, the ACR will continue to require all TNM elements (either clinically or pathologic). If the pathologic staging basis cannot be used, then AJCC stage using the clinical staging rules. Usually non-analytic cases contain incomplete information. On non-analytic cases, physicians are more likely to provide Summary Stage and TNM as opposed to providing the specific information needed to derive a value for AJCC in Collaborative Staging. This requirement is necessary in order to provide complete staging information for the State of Arizona. These data items are also required for Analytic cases DX prior to 1/1/2004. If the pathology staging basis cannot be used, then AJCC stage using the clinical staging rules.

CLINICAL N

ACR Required Data Item #130a
Required for All Non-Analytic Cases regardless of diagnosis year.
Required for Analytic Cases diagnosed prior to 1/1/2004. See #129c.

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #950
Revised 09/06, 01/08, 09/08, 01/10

Description
Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known ***prior*** to the start of any therapy. See #129b

Rationale
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding See #129b See #129c #130b

- The clinical N staging element must be recorded for *Class of Case* 10-22. See #129c
- It is strongly recommended that the clinical N staging element be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows coding of clinical N. See #129c
- Record clinical N as documented by the first treating physician or the managing physician in the medical record. See #129d
- If the managing physician has not recorded clinical N, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition
(leave blank)	Not recorded.	1B	N1b
X	NX	1C	N1c
0	N0	2	N2
0I-	N0i-	2A	N2a
0I+	N0i+	2B	N2b
0M-	N0m-	2C	N2c
0M+	N0m+	3	N3
1MI	N1mi	3A	N3a
0A	N0a	3B	N3b
0B	N0b	3C	N3c
1	N1	4	N4
1A	N1a	88	Not applicable

#130b-Always use coding rules from the *AJCC Cancer Staging Manual* that were effective in the year the case was diagnosed:
2010-present: 7th Edition
2003-2009: 6th Edition
1998-2002: 5th Edition
1993-1997: 4th Edition
1989-1992: 3rd Edition

CLINICAL M

ACR Required Data Item #131a
Required for All Non-Analytic Cases regardless of diagnosis year.
Required for Analytic Cases diagnosed prior to 1/1/2004. See #129c.

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #960
Revised 09/06, 01/08, 09/08, 01/10, 01/11

Description
Identifies the presence or absence of distant metastasis (M) of the tumor known ***prior*** to the start of any therapy. See #129b

Rationale
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding See #129b See #129c See #130b

- The clinical M staging element must be recorded for *Class of Case* 10-22. See #129c
- It is strongly recommended that the clinical M staging element be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows coding of clinical M. See #129c
- Record clinical M as documented by the first treating physician or managing physician in the medical record. See #129d
- If the managing physician has not recorded clinical M, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition
(leave blank)	Not recorded.
X (AJCC editions 1-6 only_)	MX (AJCC editions 1-6 only_)
0	M0
0I+	M0(i+)
1	M1
1A	M1a
1B	M1b
1C	M1c
1D	M1d
1E	M1e
88	Not applicable

CLINICAL STAGE GROUP

ACR Required Data Item #132a
Required for All Non-Analytic Cases regardless of diagnosis year.
Required for Analytic Cases diagnosed prior to 1/1/2004. See #129c.

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #970
Revised 09/06, 01/08, 09/08, 01/10, 01/11

Description
Identifies the anatomic extent of disease based on the T, N, and M elements known ***prior*** to the start of any therapy. See #129b

Rationale
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding See #129b See #129c See #130b

- Record the clinical stage group as documented by the first treating physician or the managing physician in See #129d the medical record.
- If the managing physician has not recorded the clinical stage, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- To assign stage group when some, but not all, T, N and/or M components can be determined, interpret missing components as "X".
- If the value does not fill all 4 characters, then record the value to the left and leave the remaining spaces blank.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition	Code	Definition
0	Stage 0	1S	Stage IS	3C1	Stage IIIC1
0A	Stage 0A	2	Stage II	3C2	Stage IIIC2
0IS	Stage 0is	2A	Stage IIA	4	Stage IV
1	Stage I	2A1	Stage IIA1	4A	Stage IVA
1A	Stage IA	2A2	Stage IIA2	4A1	Stage IVA1
1A1	Stage IA1	2B	Stage IIB	4A2	Stage IVA2
1A2	Stage IA2	2C	Stage IIC	4B	Stage IVB
1B	Stage IB	3	Stage III	4C	Stage IVC
1B1	Stage IB1	3A	Stage IIIA	OC	Occult
1B2	Stage IB2	3B	Stage IIIB	88	Not applicable
1C	Stage IC	3C	Stage IIIC	99	Unknown

CLINICAL STAGE (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1
Allowable Values: 0-3, 5, 9
NAACCR Item #980
Revised 09/06, 01/08, 09/08, 01/10, 02/10, 05/10, 01/11

Not Required by ACR #133a

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

Rationale
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the clinical stage (prefix/suffix) descriptor as documented by the first treating physician or the managing physician in the medical record. See #129d
- If the managing physician has not recorded the descriptor, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- Previous editions of FORDS included a code 4 for y-classification, and a note that it was not applicable for clinical stage. Code 4 has been removed from the list of valid codes.

Code	Label	Description
0	None	There are no prefix or suffix descriptors that would be used for this case.
1	E–Extranodal, lymphomas only	A lymphoma case involving an extranodal site.
2	S– Spleen, lymphomas only	A lymphoma case involving the spleen.
3	M–Multiple primary tumors in a single site	This is one primary with multiple tumors in the primary site at the time of diagnosis.
5	E&S–Extranodal and spleen, lymphomas only	A lymphoma case with involvement of both an extranodal site and the spleen.
9	Unknown; not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

STAGED BY (CLINICAL STAGE)

ACR Required Data Item #134a
Required for All Non-Analytic Cases regardless of diagnosis year.
Required for Analytic Cases diagnosed prior to 1/1/2004. See #129c.

Item Length: 1
Allowable Values: 0–9
NAACCR Item #990
Revised 09/06, 01/08, 09/08, 01/10

Description
Identifies the person who documented the clinical AJCC staging elements and the Stage Group.

Rationale
Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. Data captured in this field can be used to evaluate the accuracy and completeness of staging recorded in the registry and form the basis for quality management and improvement studies.

Instructions for Coding
- Record the person who documented the clinical AJCC staging elements and the Stage Group. See #129d
- If code 1, 2, or 5 is used, then all of the staging elements (T, N, and M) and Stage Group must be recorded by the same person.
- The staging elements (T, N, M) and the Stage Group must be recorded.

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

PATHOLOGIC T

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #880
Revised 09/06, 01/08, 09/08, 01/10

ACR Required Data Item #135a
Required for All Non-Analytic Cases regardless of diagnosis year.
Required for Analytic Cases diagnosed prior to 1/1/2004. See #135c.

Description
Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known ***following*** the completion of surgical therapy.

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

Instructions for Coding #135b #135c See #136b

- Code pathologic T as documented by the treating physician(s) or the managing physician in the medical record. #135d
- If the managing physician has not recorded pathologic T, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Truncate the least significant subdivision of the category from the right as needed.
- For lung, occult carcinoma is coded TX.
- The CoC recommends that pathologic T be recorded for *Class of Case* 10-22 cases diagnosed on or after January 1, 2008. #135c

#135d-The ACR does not require physicians to complete TNM staging.

Code	Definition	Code	Definition	Code	Definition
(leave blank)	Not recorded.	1B	T1b	3	T3
X	TX	1B1	T1b1	3A	T3a
0	T0	1B2	T1b2	3B	T3b
A	Ta	1C	T1c	3C	T3c
IS	Tis	1D	T1d	3D	T3d
ISPU	Tispu	2	T2	4	T4
ISPD	Tispd	2A	T2a	4A	T4a
1MI	T1mi, T1 mic	2A1	T2a1	4B	T4b
1	T1	2A2	T2a2	4C	T4c
1A	T1a	2B	T2b	4D	T4d
1A1	T1a1	2C	T2c	4E	T4e
1A2	T1a2	2D	T2d	88	Not applicable

#135b-Always use the pathologic basis for staging if possible. Refer to each chapter in the *AJCC Cancer Staging Manual* for site-specific requirements. If the pathologic staging basis cannot be used, then AJCC stage using the clinical staging rules.

#135c-For ALL Non-Analytic Cases regardless of DX Year, the ACR will continue to require all TNM elements (either clinically or pathologic). If the pathologic staging basis cannot be used, then AJCC stage using the clinical staging rules. Usually non-analytic cases contain incomplete information. On non-analytic cases, physicians are more likely to provide Summary Stage and TNM as opposed to providing the specific information needed to derive a value for AJCC in Collaborative Staging. This requirement is necessary in order to provide complete staging information for the State of Arizona. These data items are also required for Analytic cases DX prior to 1/1/2004. If the pathology staging basis cannot be used, then AJCC stage using the clinical staging rules.

PATHOLOGIC N

ACR Required Data Item #136a
Required for All Non-Analytic Cases regardless of diagnosis year.
Required for Analytic Cases diagnosed prior to 1/1/2004. See #135c.

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #890
Revised 09/06, 01/08, 09/08, 01/10

Description
Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known ***following*** the completion of surgical therapy. See #135b

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

Instructions for Coding See #135b See #135c #136b

- Code pathologic N as documented by the treating physician(s) or managing physician in the medical record. See #135d
- If the managing physician has not recorded pathologic N, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The CoC recommends that pathologic N be recorded for *Class of Case* 10-22 cases diagnosed on or after January 1, 2008. See #135c

Code	Definition	Code	Definition
(leave blank)	Not recorded.	1B	N1b
X	NX	1C	N1c
0	N0	2	N2
0I-	N0i-	2A	N2a
0I+	N0i+	2B	N2b
0M-	N0m-	2C	N2c
0M+	N0m+	3	N3
1MI	N1mi	3A	N3a
0A	N0a	3B	N3b
0B	N0b	3C	N3c
1	N1	4	N4
1A	N1a	88	Not applicable

#136b-Always use coding rules from the *AJCC Cancer Staging Manual* that were effective in the year the case was diagnosed:
2010-present: 7th Edition
2003-2009: 6th Edition
1998-2002: 5th Edition
1993-1997: 4th Edition
1989-1992: 3rd Edition

PATHOLOGIC M

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #900
Revised 09/06, 01/08, 09/08, 01/10

ACR Required Data Item #137a
Required for All Non-Analytic Cases regardless of diagnosis year.
Required for Analytic Cases diagnosed prior to 1/1/2004. See #135c.

Description
Identifies the presence or absence of distant metastasis (M) of the tumor known ***following*** the completion of surgical therapy.

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

Instructions for Coding See #135b See #135c See #136b

- Code pathologic M as documented by the treating physician(s) or the managing physician in the medical See #135d record.
- If the managing physician has not recorded pathologic M, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the treating physician(s).
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The CoC recommends that pathologic M be recorded for *Class of Case* 10-22 cases diagnosed on or after January 1, 2008. See #135c

Code	Definition
(leave blank)	Not recorded.
X (AJCC editions 1-6 only_)	MX (AJCC editions 1-6 only_)
0 (AJCC editions 1-6 only_)	M0 (AJCC editions 1-6 only_)
1	M1
1A	M1a
1B	M1b
1C	M1c
1D	M1d
1E	M1e
88	Not applicable

PATHOLOGIC STAGE GROUP

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #910
Revised 09/06, 01/08, 09/08, 01/10, 01/11

ACR Required Data Item #138a
Required for All Non-Analytic Cases regardless of diagnosis year.
Required for Analytic Cases diagnosed prior to 1/1/2004. See #135c.

Description
Identifies the anatomic extent of disease based on the T, N, and M elements known ***following*** the completion of surgical therapy.

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

Instructions for Coding See #135b See #135c See #136b

- Record the pathologic stage group as documented by the treating physician(s) or the managing physician in the medical record. See #135d
- If the managing physician has not recorded the pathologic stage, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the physician(s).
- To assign stage group when some, but not all, T, N and/or M components can be determined, interpret missing components as "X".
- 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 #880, 890, 960) may be used to complete the pathologic stage group.
- If the value does not fill all 4 characters, then record the value to the left and leave the remaining spaces blank.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The CoC recommends that pathologic stage group be recorded for *Class of Case* 10-22 cases diagnosed on or after January 1, 2008. See #135c

Code	Definition	Code	Definition	Code	Definition
0	Stage 0	1S	Stage IS	3C1	Stage IIIC1
0A	Stage 0A	2	Stage II	3C2	Stage IIIC2
0IS	Stage 0is	2A	Stage IIA	4	Stage IV
1	Stage I	2A1	Stage IIA1	4A	Stage IVA
1A	Stage IA	2A2	Stage IIA2	4A1	Stage IVA1
1A1	Stage IA1	2B	Stage IIB	4A2	Stage IVA2
1A2	Stage IA2	2C	Stage IIC	4B	Stage IVB
1B	Stage IB	3	Stage III	4C	Stage IVC
1B1	Stage IB1	3A	Stage IIIA	OC	Occult
1B2	Stage IB2	3B	Stage IIIB	88	Not applicable
1C	Stage IC	3C	Stage IIIC	99	Unknown

PATHOLOGIC STAGE (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1
Allowable Values: 0–6, 9
NAACCR Item #920

Not Required by ACR #139a

Revised 09/06, 01/08, 01/10

Description
Identifies the AJCC pathologic stage (prefix/suffix) descriptor known ***following*** the completion surgical therapy.

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

Instructions for Coding

- Record the pathologic stage (prefix/suffix) descriptor as documented by the treating physician(s) or the managing physician in the medical record. See #135d
- If the managing physician has not recorded the descriptor, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the physician(s).
- Refer to the current *AJCC Cancer Staging Manual* for staging 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.

STAGED BY (PATHOLOGIC STAGE)

ACR Required Data Item #140a
Required for All Non-Analytic Cases regardless of diagnosis year.
Required for Analytic Cases diagnosed prior to 1/1/2004. See #135c.

Item Length: 1
Allowable Values: 0–9
NAACCR Item #930
Revised 09/06, 01/08, 09/08, 01/10

Description
Identifies the person who recorded the pathologic AJCC staging elements.

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

Instructions for Coding

- Record the person who documented the pathologic AJCC staging elements and the stage group. See #135d
- If code 1, 2, or 5 is used, then all of the staging elements (T, N, and M) and Stage Group must be recorded by the same person.
- The staging elements (T, N, M) and the stage group must be recorded.

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

SEER SUMMARY STAGE 2000

Item Length: 1
Allowable Values:0-5, 7, 9
NAACCR Item #759
Revised 09/04

ACR Required Data Item

Required for All Non-Analytic Cases regardless of DX Year.
Required for Analytic Cases (DX prior to 1/1/2004).

Source: ***FORDS, Revised for 2009***

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

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

Instructions for Coding
•Code this data item for cases diagnosed prior to January 1, 2004.
•Record the SEER Summary Stage 2000 code for all cases that do not have a defined AJCC staging schema.
•Use code 8 for non-malignant tumors only.
•Refer to the *SEER Summary Staging Manual 2000* for site-specific coding instructions. This information can be found online at *http://seer.cancer.gov/tools/ssm/*.

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.
8	Not applicable (non-malignant tumor). ACR Note: Code 8 is effective for cases diagnosed on or after 1/1/2009.
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified); death certificate only.

ACR Notes:
#1-For ALL Non-Analytic Cases regardless of DX Year, the ACR will continue to require Summary Stage. Usually non-analytic cases contain incomplete information. On non-analytic cases, physicians are more likely to provide Summary Stage and TNM as opposed to providing the specific information needed to derive a value for Summary Stage in Collaborative Staging. This requirement is necessary in order to provide complete staging information for the State of Arizona. This data item is also required for Analytic cases DX prior to 1/1/2004. Make sure the appropriate Summary Stage NAACCR data item is coded.
#2-Summary Stage should include all information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer. (*SEER Summary Staging Manual 2000*).
#3-Non-malignant primary intracranial and central nervous system tumors of the meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of the central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3) diagnosed prior to 1/1/2009 are required to be coded to a 9 (Unknown).
#4-The year in which the cancer was diagnosed determines which code manual and data item will be used for Summary Stage:
-Cancers diagnosed before January 1, 2001 should be assigned a summary stage according to *SEER Summary Staging Guide 1977*, and the code should be reported as SEER Summary Stage 1977 (NAACCR data item #760).
-Cancers diagnosed from January 1, 2001 to present should be assigned a summary stage according to the *SEER Summary Staging Guide 2000*, and the code should be reported in data item #759 (SEER Summary Stage 2000).
-Cases diagnosed on or after 1/1/2004 will *not* be required to code Summary Stage 2000 (NAACCR Item #759) with the exceptions noted in ACR Note #1.

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ACR Supplement Page

TEXT-STAGING

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2600

Description
This field is used to provide narrative text to substantiate codes assigned for the stage of disease at diagnosis. This field may also be used for additional text for staging information not entered in the Text-Dx Proc data item.

Rationale
Narrative description substantiates the codes assigned in the abstract and aids in quality control at the hospital level and at the central registry.

Instructions for Coding
No codes are to be written in this field. This field is for narrative documentation only. Write a brief description of the extent of disease. Describe the organs, tissues, and lymph nodes involved with cancer. If the tumor is localized, a statement such as “cancer confined to prostate capsule” or “confined to prostate, nodal and metastatic workup is negative” is sufficient. A regional cancer might be described as “adenocarcinoma of the liver with extension to the gallbladder, extra-hepatic bile ducts and posterior mediastinal lymph nodes”. A distant cancer might be described as “left breast cancer with metastasis to lung, bone, and mediastinal lymph nodes”.

Note #1: See Appendix E for acceptable abbreviations.

Note #2: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #3: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

TEXT-DX Proc—Xray/Scan

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2530

Description
This data item is used to describe in narrative format the date, type of procedure, and all positive and negative findings that substantiate the staging that is recorded. These reports may describe findings that represent metastases to lungs and/or bones, or other internal abnormalities such as organ shadows that appear to be displaced because of malignant involvement. Procedures such as bowel studies (GI series, barium enema), bladder and kidney studies (IVP), or radioisotope scans (brain, bone, liver scans), should be recorded if they provide additional information about the extent of disease, negative or positive.

Rationale
Narrative description substantiates the codes assigned in the abstract and aids in quality control at the hospital level and at the central registry.

Instructions for Coding
Record the date, place, type of imaging technique, and findings.

Note #1: See Appendix E for acceptable abbreviations.

Note #2: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #3: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

TEXT—DX Proc—Lab Tests
ALSO CALLED "LAB TESTS"

Item Length: 1000
Free Text
NAACCR Item #2550

ACR Required Data Item

Description
This data item is used to describe in narrative format the date, type, and value of a lab test that specifically applies to the type of cancer or primary site being abstracted and it is a part of a definitive clinical picture for the disease. Indicate whether positive, negative, elevated, normal, etc. Below are some examples:

Rationale

Breast	Progesterone/Estrogen receptor assay
Prostate	Elevated prostatic specific antigen
Multiple Myeloma	Elevation of monoclonal immunoglobulin in serum protein electrophoresis
Testis	Elevation of six sub-unit of human chorionic gonadotrophin (HCG)
Liver (hepatoma)	Elevation of alphafetoprotein (AFP)
Thyroid (medullary carcinoma)	Elevated calcitonin

Instructions for Coding
Narrative documentation to support the coded ERA & PRA values must be provided. Record the date, place, type of lab test, and findings. If a registrar elects to code other optional lab values, please provide narrative documentation in this free text field.

Note #1: See Appendix E for acceptable abbreviations.

Note #2: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #3: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

Note #4: Document any lab tests that are associated with Collaborative Staging Site Specific Factors (SSF) to substantiate the codes entered in the SSF data items.

TEXT—DX Proc—PE
ALSO CALLED "CLINICAL FINDINGS"

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2520

Description
This data item is used to describe in narrative format the dates of admit/discharge, place, type of visit (inpatient or outpatient), presenting symptoms at diagnosis, physical examination (tumor location, size, extension and lymph nodes), impression, treatment plan, and any other pertinent information that further substantiates codes.

Rationale
Narrative description substantiates the codes assigned in the abstract and aids in quality control at the hospital level and at the central registry.

Instructions for Coding
Record the dates of admit/discharge, place, type of visit, presenting symptoms at diagnosis, results of physical exam, impression and treatment plan (if known).

```
EXAMPLE: 6/20/00-6/23/00 ANYWHERE HOSP, INPATIENT: PRESENTS WITH VOID-
ING SYMPTOMS, HERE FOR TRANSURETHRAL RESECTION OF PROSTATE TO RELIEVE
SYMPTOMS. PHYSICAL EXAM: NO ENLARGED ORGANS OR NODES. DIGITAL RECTAL
EXAM: 1CM PALPABLE NODULE IN LEFT APEX OF PROSTATE, REST WITHIN NORMAL
LIMITS. IMPRESSION: RULE OUT PROSTATE CANCER.
```

The above example can be abbreviated as follows:

```
6/20-6/23/00,AH,IPT: P/W VOIDING SYMPTOMS, HERE FOR TURP TO RELIEVE
SYMPTOMS. P/E: NO ENLGD NODES/ORGANS. DRE: 1CM PALP NODULE, REST OF
PROSTATE WNL. IMP: R/O PROSTATE CA.
```

Note #1: For lymphomas, any mention of lymph nodes, such as "enlarged", "visible swelling", or "palpable" is considered involvement and should be recorded.

Note #2: For prostate cancers, record the results of the digital rectal exam. Any mention of "induration" or "palpable nodule" should be reported.

Note #3: See Appendix E for acceptable abbreviations.

Note #4: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #5: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

TEXT—DX Proc—OP

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2560

Description
Text area for manual documentation of all surgical procedures that provide information for staging.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions for Coding
Enter the following information in narrative format:

- Dates and descriptions of all biopsies and all other surgical procedures from which staging information was derived.
- Number of lymph nodes removed
- Size of tumor removed
- Documentation of residual tumor.
- Evidence of invasion of surrounding areas.

Note #1: See Appendix E for acceptable abbreviations.

Note #2: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #3: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

TEXT-DX PROC –SCOPES

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2540

Description
Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions for Coding
Enter the following information in narrative format:

- Date(s) of endoscopic exams
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Lymph nodes
- Record positive and negative clinical findings. Record positive findings first.

Note #1: See Appendix E for acceptable abbreviations.

Note #2: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #3: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

CS TUMOR SIZE

ACR Required Data Item #141a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 3
Allowable Values: 000–995, 999
NAACCR Item #2800
Revised 09/06, 09/08, 01/10, 01/11

Description
Records the largest dimension or diameter of the **primary tumor** in millimeters.

Rationale
Tumor size at diagnosis is an independent prognostic indicator for many tumors and it is used by Collaborative Stage to derive some TNM-T codes.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

#141b-Consult the *Collaborative Stage Data Collection System Coding Instructions* for more detailed coding guidelines on CS Tumor Size and priority order of reports for coding size.

#141c-Collaborative Stage Version 02.03.02 - note related to all CS data items
All 2011 cases and after will be required to be completed in Collaborative Stage Version 02.03.02. Once this version is installed, it will be used to code all cases diagnosed from 2004 forward.

CS EXTENSION

ACR Required Data Item #142a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 2
Allowable Values: 00–80, 95, 99
NAACCR Item #2810
Revised 09/06, 09/08, 01/10, 01/11

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*.

Rationale
Tumor extension at diagnosis is a prognostic indicator used by Collaborative Stage to derive some TNM-T codes and some SEER Summary Stage codes.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

#142b-Consult the *Collaborative Stage Data Collection System Coding Instructions* for more detailed coding guidelines on CS Extension and priority order of reports for coding extension.

CS TUMOR SIZE/EXT EVAL

ACR Required Data Item #143a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 1
Allowable Values: 0–3, 5, 6, 8, 9
NAACCR Item #2820
Revised 09/06, 09/08, 01/10, 01/11

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.

Rationale
This item is used by Collaborative Stage to describe whether the staging basis for the TNM-T code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

#143b-Consult the *Collaborative Stage Data Collection System Coding Instructions* for more detailed coding guidelines.

CS LYMPH NODES

ACR Required Data Item #144a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 2
Allowable Values: 00–80, 90
NAACCR Item #2830
Revised 09/06, 09/08, 01/10, 01/11

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

Rationale
The involvement of specific regional lymph nodes is a prognostic indicator used by Collaborative Stage to derive some TNM-N codes and SEER Summary Stage codes.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

#144b-Consult the *Collaborative Stage Data Collection System Coding Instructions* for information about inaccessible sites, the coding of CS Lymph Nodes if the patient receives preoperative systemic therapy and more detailed coding guidelines on CS Lymph Nodes.

CS LYMPH NODES EVAL
(CS REG NODES EVAL)

ACR Required Data Item #145a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 1
Allowable Values: 0–3, 5, 6, 8, 9
NAACCR Item #2840
Revised 09/06, 09/08, 01/10, 01/11

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

Rationale
This data item is used by Collaborative Stage to describe whether the staging basis for the TNM-N code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

#145b-Consult the *Collaborative Stage Data Collection System Coding Instructions* for more detailed coding guidelines.

CS METS AT DX

ACR Required Data Item #146a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 2
Allowable Values: 00, 10, 40, 50, 99
NAACCR Item #2850
Revised 09/06, 09/08, 01/10, 01/11

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

Rationale
The presence of metastatic disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive TNM-M codes and SEER Summary Stage codes.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

#146b-Consult the *Collaborative Stage Data Collection System Coding Instructions* for more detailed coding guidelines.

CS METS AT DX–BONE

Not Required by ACR #147a

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #2851
Revised 01/11

Description
Identifies the presence of distant metastatic involvement of bone at time of diagnosis.

Rationale
The presence of metastatic bone disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive TNM-M codes and SEER Summary Stage codes for some sites.

Instructions for Coding
- Refer to the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS METS AT DX–BRAIN

Not Required by ACR #148a

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #2852
Revised 01/11

Description
Identifies the presence of distant metastatic involvement of the brain at time of diagnosis.

Rationale
The presence of metastatic brain disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive TNM-M codes and SEER Summary Stage codes for some sites.

Instructions for Coding
- Refer to the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS METS AT DX–LIVER

Not Required by ACR #149a

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #2853
Revised 01/11

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

Rationale
The presence of metastatic liver disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive TNM-M codes and SEER Summary Stage codes for some sites.

Instructions for Coding
- Refer to the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS METS AT DX–LUNG

Not Required by ACR #150a

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #2854
Revised 01/11

Description
Identifies the presence of distant metastatic involvement of the lung at time of diagnosis.

Rationale
The presence of metastatic lung disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive TNM-M codes and SEER Summary Stage codes for some sites.

Instructions for Coding
- Refer to the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS METS EVAL

ACR Required Data Item #151a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 1
Allowable Values: 0–3, 5, 6, 8, 9
NAACCR Item #2860
Revised 09/06, 09/08, 01/10, 01/11

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

Rationale
This data item is used by Collaborative Stage to describe whether the staging basis for the TNM-M code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

#151b-Consult the *Collaborative Stage Data Collection System Coding Instructions* for more detailed coding guidelines.

CS SITE-SPECIFIC FACTOR 1

ACR Required Data Item #152a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2004.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2880
Revised 04/07, 09/08, 01/10, 02/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding See #154a

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03 or diagnosed in 2011, the following Site-Specific Factor 1 (SSF1) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF1s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 1
Head and Neck*	See note after this table	8000-8713, 8800-9136, 9141-9582, 9700-9701	Size of Lymph Nodes
Mucosal Melanoma**	See note after this table	8720-8790	Size of Lymph Nodes
Esophagus	C15.0-5,8,9	8000-8934, 8940-9136, 9141-9582, 9700-9701	Clinical Assessment of Regional Lymph Nodes
EsophagusGE Junction	C16.0-2	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Clinical Assessment of Regional Lymph Nodes
Stomach	C16.1-6,8-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Clinical Assessment of Regional Lymph Nodes
NETStomach	C16.0-6,8-9	8153, 8240-8242, 8246, 8249	Clinical Assessment of Regional Lymph Nodes
SmallIntestine	C17.0-3,8-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Carcinoembryonic Antigen (CEA)
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Carcinoembryonic Antigen (CEA)
Appendix	C18.1	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Carcinoembryonic Antigen (CEA)
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Carcinoembryonic Antigen (CEA)
Liver	C22.1	8170-8175	Alpha Fetoprotein (AFP) Interpretation
	C22.0	8000-8157, 8162-8175, 8190-9136, 9141-9582, 9700-9701	
BileDucts Intrahepat	C22.0	8160-8161, 8180	Alpha Fetoprotein (AFP) Interpretation
	C22.1	8000-8162, 8180-9136, 9141-9582,	

		9700-9701	
Lung	C34.0-3,8-9	8000-9136, 9141-9582, 9700-9701	Separate Tumor Nodules / Ipsilateral Lung
HeartMediastinum	C38.0-3,8	8000-9136, 9141-9582, 9700-9701	Grade for Sarcomas
Pleura	C38.4	8000-9136, 9141-9582, 9700-9701	Pleural Effusion
Skin	C44.0,2-9	8000-8246, 8248-8713, 8800-9136, 9141-9582	Measured Thickness (Depth)
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	Measured Thickness (Depth), Breslow's Measurement
MerkelCellSkin	C44.0,2-9	8247	Measured Thickness (Depth)
MerkelCellVulva	C51.0-2,8-9	8247	Measured Thickness (Depth)
MerkelCellPenis	C60.0-2,8-9	8247	Measured Thickness (Depth)
MerkelCellScrotum	C63.2	8247	Measured Thickness (Depth)
SoftTissue	C47.0-6,8-9; C49.0-6,8-9	8000-9136, 9141-9582, 9700-9701	Grade for Sarcomas
Retroperitoneum	C48.0	8000-8934, 8940-9136, 9141-9582, 9700-9701	Grade for Sarcomas
Peritoneum	C48.1-2,8	Male: 8800-8921, 8940-9055, 9120-9136, 9141-9582	Grade for Sarcomas
		Female: 8580-8589, 8680-8921, 9120-9136, 9141-9582, 9700-9701	
Peritoneum FemaleGenital	C48.0-2,8 (Females Only)	8000-8576, 8590-8671, 8930-8934, 8940-9110	Carbohydrate Antigen 125 (CA 125)
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	Estrogen Receptor Assay (ERA)
Vagina	C52.9	8000-9136, 9141-9582, 9700-9701	FIGO Stage
Cervix	C53.0-1, 8-9	8000-9136, 9141-9582, 9700-9701	FIGO Stage
Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	FIGO Stage
Corpus Carcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	FIGO Stage
CorpusSarcoma	C54.0-3, 8-9; C55.9	8800-8932, 8934-8974, 8982-9136, 9141-9582	FIGO Stage
Ovary	C56.9	8000-9136, 9141-9582, 9700-9701	Carbohydrate Antigen 125 (CA 125)
FallopianTube	C57.0	8000-9136, 9141-9582, 9700-9701	FIGO Stage
Placenta	C58.9	8000-9136, 9141-9582, 9700-9701	Prognostic Scoring Index
Prostate	C61.9	8000-9136, 9141-9582, 9700-9701	Prostate Specific Antigen (PSA) Lab Value
Scrotum	C63.2	8000-8246, 8248-8713, 8800-9136, 9141-9582	Measured Thickness (Depth)
Kidney Parenchyma	C64.9	8000-9136, 9141-9582, 9700-9701	Invasion Beyond Capsule
KidneyRenalPelvis	C65.9; C66.9	8000-9136, 9141-9582, 9700-9701	WHO/ISUP Grade
Bladder	C67.0-9	8000-9136, 9141-9582, 9700-9701	WHO/ISUP Grade
Urethra	C68.0	8000-9136, 9141-9582, 9700-9701	WHO/ISUP Grade
Retinoblastoma	C69.0-5,8-9	9510-9514	Extension Evaluated at Enucleation
Lymphoma OcularAdnexa	C44.1; C69.0,5,6	9590-9699, 9702-9738, 9811-9818, 9820-9837	Associated with HIV/AIDS
Conjunctiva	C69.0	8000-8713, 8800-9136, 9141-9508, 9510-9514, 9520-9582	Tumor Size
Melanoma Conjunctiva	C69.0	8720-8790	Measured Thickness (Depth)
Brain	C70.0, C71.0-9	8000-9136, 9141-9582, 9700-9701	WHO Grade Classification
CNSOther	C70.1, 9; C72.0-5,8-9	8000-9136, 9141-9582, 9700-9701	WHO Grade Classification
Thyroid	C73.9	8000-9136, 9141-9582, 9700-9701	Solitary vs. Multifocal Tumor
IntracranialGland	C75.1-3	8000-9136, 9141-9582, 9700-9701	WHO Grade Classification
Lymphoma	C00.0-44.0; C44.2-68.9; C69.1-4,8-C80.9	9590-9699, 9702-9729, 9735, 9737-9738	Associated with HIV/AIDS

	C00.0-41.9; C42.2-3,5-44.0; C44.2-68.9; C69.1-4,8-C80.9	9811-9818, 9823, 9827, 9837	
MycosisFungoides	C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2	9700-9701	Peripheral Blood Involvement
KaposiSarcoma	M-9140		Associated with HIV/AIDS
HemeRetic	C00.0-80.9	9740-9809, 9840-9992	JAK-2
	C42.0,1,4	9811-9818, 9823, 9827, 9837	
	C00.0-44.0; C44.2-68.9; C69.1-4,8-C80.9	9733, 9820, 9826, 9231-9836	

* Head and Neck: C00.0-6,8,9; C01 9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9

** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

#154a-Required for primary sites: Brain, Breast, Buccal Mucosa, CNSOther, Conjunctiva, Epiglottis/ Anterior, Esophagus, Esophagus/GE Junction, Floor of Mouth, Gum lower, Gum other, Gum upper, Heart/Mediastinum, Hypopharynx, Intracranial Gland, Larynx/Glottic, Larynx/Other, Larynx/Subglottic, Larynx/Supraglottic, LipLower, Lip/Other, Lip/Upper, Lung, Melanoma/Conjunctiva, Melanoma/Skin, Mouth/Other, Mycosis Fungoides, Nasal Cavity, Nasopharynx, NET Stomach, Oropharynx, Palate hard, Palate soft, Parotid Gland, Peritoneum, Pharyngeal Tonsil, Placenta, Pleura, Prostate, Retinoblastoma, Retroperitoneum, Salivary Gland/Other, Sinus Ethmoid, Sinus Maxillary, Soft tissue, Stomach, Submandibular Gland, Tongue/anterior, and Tongue/base.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 2

ACR Required Data Item #155a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2004.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2890
Revised 09/06, 09/08, 01/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding See #156a

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 2 (SSF2) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF2s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 2
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Clinical Assessment of Regional Lymph Nodes
NETColon	C18.0,2-9	8153, 8240-8242, 8246, 8249	Clinical Assessment of Regional Lymph Nodes
Appendix	C18.1	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Clinical Assessment of Regional Lymph Nodes
CarcinoidAppendix	C18.1	8153, 8240-8242, 8246, 8249	Clinical Assessment of Regional Lymph Nodes
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Clinical Assessment of Regional Lymph Nodes
NETRectum	C19.9; C20.9	8153, 8240-8242, 8246, 8249	Clinical Assessment of Regional Lymph Nodes
SmallIntestine	C17.0-3,8-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Clinical Assessment of Regional Lymph Nodes
Liver	C22.1	8170-8175	Fibrosis Score
	C22.0	8000-8157, 8162-8175, 8190-9136, 9141-9582, 9700-9701	
BileDuctsIntrahepat	C22.0	8160-8161, 8180	Fibrosis Score
	C22.1	8000-8162, 8180-9136, 9141-9582, 9700-9701	
Lung	C34.0-3,8-9	8000-9136, 9141-9582, 9700-9701	Visceral Pleural Invasion (VPI) / Elastic Layer
Pleura	C38.4	8000-9136, 9141-9582, 9700-9701	Histologic Subtype
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	Ulceration
Peritoneum FemaleGenital	C48.0-2,8 (Females Only)	8000-8576, 8590-8671, 8930-8934, 8940-9110	FIGO Stage

Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	Progesterone Receptor Assay (PRA)
Vagina	C52.9	8000-9136, 9141-9582, 9700-9701	Pelvic Nodal Status
Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	Peritoneal Cytology
CorpusCarcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	Peritoneal Cytology
CorpusSarcoma	C54.0-3, 8-9; C55.9	8800-8932, 8934-8974, 8982-9136, 9141-9582	Peritoneal Cytology
Ovary	C56.9	8000-9136, 9141-9582, 9700-9701	FIGO Stage
Placenta	C58.9	8000-9136, 9141-9582, 9700-9701	FIGO Stage
Prostate	C61.9	8000-9136, 9141-9582, 9700-9701	Prostatic Specific Antigen (PSA) Interpretation
Kidney Parenchyma	C64.9	8000-9136, 9141-9582, 9700-9701	Vein Involvement
KidneyRenal Pelvis	C65.9; C66.9	8000-9136, 9141-9582, 9700-9701	Depth of Renal Parenchymal Invasion
Bladder	C67.0-9	8000-9136, 9141-9582, 9700-9701	Size of Metastasis in Lymph Nodes
Lymphoma OcularAdnexa	C44.1; C69.0,5,6	9590-9699, 9702-9738, 9811-9818, 9820-9837	Systemic Symptoms at Diagnosis
MelanomaConjuctiva	C69.0	8720-8790	Quadrants
Melanoma Choroid	C69.3	8720-8790	Measured Basal Diameter
MelanomaCiliary Body	C69.4	8720-8790	Measured Basal Diameter
Lymphoma	C00.0-44.0; C44.2-68.9; C69.1-4,8-C80.9	9590-9699, 9702-9729, 9735, 9737-9738	Systemic Symptoms at Diagnosis
	C00.0-41.9; C42.2-3,5-44.0; C44.2-68.9; C69.1-4,8-C80.9	9811-9818, 9823, 9827, 9837	
MyelomaPlasmaCell Disorder*	C00.0-C44.0, C44.2-C68.9, C69.1-C69.4, C69.8-C80.9	9731-9732, 9734	Durie-Salmon Staging System

*The MyelomaPlasmaCellDisorder schema and this SSF2 was new with CS version 02.03.xx; this item may require updating for converted cases.

#156a-Required for primary sites: Appendix, Bladder, Breast, Carcinoid Appendix, Colon, Corpus/ Adenosarcoma, Corpus/Carcinoma, Corpus/Sarcoma, Lymphoma, Lymphoma/Ocular/Adnexa, Melanoma/Choroid, Melanoma/Ciliary Body, Melanoma/Conjunctiva, Melanoma/Skin, NET Colon, NET Rectum, Rectum, and Small Intestine.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 3

ACR Required Data Item #157a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2004.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2900
Revised 04/07, 09/08, 01/10, 02/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding See #158a

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 3 (SSF3) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF3s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 3
Head and Neck*	See note after this table	8000-8713, 8800-9136, 9141-9582, 9700-9701	Levels I-III Lymph Nodes for Head and Neck
Mucosal Melanoma**	See note after this table	8720-8790	Levels I-III Lymph Nodes for Head and Neck
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Carcinoembryonic Antigen (CEA) Lab Value
Appendix	C18.1	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Carcinoembryonic Antigen (CEA) Lab Value
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Carcinoembryonic Antigen (CEA) Lab Value
SmallIntestine	C17.0-3,8-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Carcinoembryonic Antigen (CEA) Lab Value
Liver	C22.1	8170-8175	Alpha Fetoprotein (AFP) Lab Value
	C22.0	8000-8157, 8162-8175, 8190-9136, 9141-9582, 9700-9701	
HeartMediastinum	C38.0-3,8	8000-9136, 9141-9582, 9700-9701	Bone Invasion
Bone	C40.0-3,8-9; C41.0-4,8-9	8000-9136, 9141-9582, 9700-9701	% Necrosis Post-Neoadjuvant Chemotherapy
SkinEyelid	C44.1	8000-8713, 8800-9136, 9141-9508, 9510-9514, 9520-9582	Clinical Status of Lymph Nodes
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	Clinical Status of Lymph Node Mets
MerkelCellSkin	C44.0,2-9	8247	Clinical Status of Lymph Node Mets

MerkelCellVulva	C51.0-2,8-9	8247	Clinical Status of Lymph Node Mets
MerkelCellPenis	C60.0-2,8-9	8247	Clinical Status of Lymph Node Mets
MerkelCellScrotum	C63.2	8247	Clinical Status of Lymph Node Mets
SoftTissue	C47.0-6,8-9, C49.0-6,8-9	8000-9136, 9141-9582, 9700-9701	Bone Invasion

Peritoneum FemaleGenital	C48.0-2,8 (Females Only)	8000-8576, 8590-8671, 8930-8934, 8940-9110	Residual Tumor Status and Size After Primary Cytoreduction Surgery
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	Number of Positive Ipsilateral Level I-II Axillary Lymph Nodes
Vagina	C52.9	8000-9136, 9141-9582, 9700-9701	Assessment Method of Nodal Pelvic Status
Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	Number of Positive Pelvic Lymph Nodes
CorpusCarcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	Number of Positive Pelvic Lymph Nodes
CorpusSarcoma	C54.0-3, 8-9; C55.9	8800-8932, 8934-8974, 8982-9136, 9141-9582	Number of Positive Pelvic Lymph Nodes
Ovary	C56.9	8000-9136, 9141-9582, 9700-9701	Residual Tumor Status and Size After Primary Cytoreduction Surgery
Prostate	C61.9	8000-9136, 9141-9582, 9700-9701	CS Extension - Pathologic Extension
KidneyParenchyma	C64.9	8000-9136, 9141-9582, 9700-9701	Ipsilateral Adrenal Gland Involvement
Bladder	C67.0-9	8000-9136, 9141-9582, 9700-9701	Extranodal Extension of Regional Lymph Nodes
Lymphoma OcularAdnexa	C44.1; C69.0,5,6	9590-9699, 9702-9738, 9811-9818, 9820-9837	International Prognostic Index (IPI)
MelanomaChoroid	C69.3	8720-8790	Measured Thickness (Depth)
MelanomaCiliary Body	C69.4	8720-8790	Measured Thickness (Depth)
MelanomaIris	C69.4 (Iris)	8720-8790	Measured Thickness (Depth)
Lymphoma	C00.0-44.0; C44.2-68.9; C69.1-4,8-C80.9	9590-9699, 9702-9729, 9735, 9737-9738	International Prognostic Index (IPI)
	C00.0-41.9; C42.2-3,5-44.0; C44.2-68.9; C69.1-4,8-C80.9	9811-9818, 9823, 9827, 9837	
MyelomaPlasmaCell Disorder***	C00.0-C44.0, C44.2-C68.9, C69.1-C69.4, C69.8-C80.9	9731-9732, 9734	Multiple Myeloma Terminology

* Head and Neck: C00.0-6,8,9; C01 9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9

** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

*** The MyelomaPlasmaCellDisorder schema and this SSF3 was new with CS version 02.03.xx; this item may require updating for converted cases.

#158a-Required for primary sites: Breast, Melanoma/Choroid, Melanoma/Ciliary Body, Melanoma/Skin, Merkel Cell/Penis, Merkel Cell/Scrotum, Merkel Cell/Skin, Merkel Cell/Vulva, and Prostate. For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 4

ACR Required Data Item #159a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2004.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2910
Revised 09/06, 09/08, 01/10, 02/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding See #160a

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- The Prostate SSF4 (Prostate Apex Involvement) does not show on this table, because it is considered obsolete in 2010. However, it is required for cases diagnosed through 2009, as it was required in CSv1, even if it is abstracted in CSv2.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 4 (SSF4) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF4s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 4
Head and Neck*	See note after this table	8000-8713, 8800-9136, 9141-9582, 9700-9701	Levels IV-V and Retropharyngeal Lymph Nodes for Head and Neck
Mucosal Melanoma**	See note after this table	8720-8790	Levels IV-V and Retropharyngeal Lymph Nodes for Head and Neck
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Tumor Deposits
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Tumor Deposits
Liver	C22.1	8170-8175	Creatinine Value
	C22.0	8000-8157, 8162-8175, 8190-9136, 9141-9582, 9700-9701	
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	LDH
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	Immunohistochemistry (IHC) of Regional Lymph Nodes
Vagina	C52.9	8000-9136, 9141-9582, 9700-9701	Para-Aortic Nodal Status
Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	Number of Examined Pelvic Nodes
CorpusCarcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	Number of Examined Pelvic Nodes
CorpusSarcoma	C54.0-3, 8-9; C55.9	8800-8932, 8934-8974, 8982-9136, 9141-9582	Number of Examined Pelvic Nodes

FallopianTube	C57.0	8000-9136, 9141-9582, 9700-9701	Number of Positive Pelvic Nodes
Testis	C62.0-1,9	8000-9136, 9141-9582, 9700-9701	Radical Orchiectomy Performed
Kidney Parenchyma	C64.9	8000-9136, 9141-9582, 9700-9701	Sarcomatoid Features
Melanoma Choroid	C69.3	8720-8790	Size of Largest Metastasis
MelanomaIris	C69.4	8720-8790	Size of Largest Metastasis
MelanomaCiliary Body	C69.4	8720-8790	Size of Largest Metastasis
LacrimalGland	C69.5	8000-8713, 8800-9136, 9141-9508, 9520-9582, 9700-9701	Perineural Invasion
Brain	C70.0, C71.0-9	8000-9136, 9141-9582, 9700-9701	MGMT – Methylation of MGMT
CNSOther	C70.1, 9; C72.0-5,8-9	8000-9136, 9141-9582, 9700-9701	MGMT – Methylation of MGMT

* Head and Neck: C00.0-6,8,9; C01 9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9
** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

#160a-Required for primary sites: Breast, Melanoma/Choroid, Melanoma/Ciliary Body, Melanoma/Iris, Melanoma/Skin, Prostate (SSF4 collected for cases diagnosed through 2009), and Testis.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

#161b-Required for primary sites: Breast, GIST/Peritoneum, and Testis.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 5

ACR Required Data Item #161a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2004.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2920
Revised 09/06, 09/08, 01/10, 02/10, 03/10, 01/11

Description

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

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 5 (SSF5) are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF5s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 5
Head and Neck*	See note after this table	8000-8713, 8800-9136, 9141-9582, 9700-9701	Levels VI-VII and Facial Lymph Nodes of Head and Neck
Mucosal Melanoma**	See note after this table	8720-8790	Levels VI-VII and Facial Lymph Nodes of Head and Neck
Liver	C22.1	8170-8175	Creatinine Unit of Measure
	C22.0	8000-8157, 8162-8175, 8190-9136, 9141-9582, 9700-9701	
NETAmpulla	C24.1	8153, 8240-8242, 8246, 8249	Serum Chromogranin A (CgA) Lab Value
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	LDH Value
GIST Peritoneum	C48.0-2,8	8935-8936	Mitotic Count
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	Molecular Studies of Regional Lymph Nodes
Vagina	C52.9	8000-9136, 9141-9582, 9700-9701	Assessment of Para-Aortic Nodal Status
Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	Number of Positive Para-Aortic Lymph Nodes
CorpusCarcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	Number of Positive Para-Aortic Lymph Nodes
CorpusSarcoma	C54.0-3, 8-9; C55.9	8800-8932, 8934-8974, 8982-9136, 9141-9582	Number of Positive Para-Aortic Lymph Nodes
FallopianTube	C57.0	8000-9136, 9141-9582, 9700-9701	Number of Examined Pelvic Lymph Nodes
Testis	C62.0-1,9	8000-9136, 9141-9582, 9700-9701	Size of Metastasis in Lymph Nodes
MelanomaChoroid	C69.3	8720-8790	Chromosome 3 Status
MelanomaIris	C69.4	8720-8790	Chromosome 3 Status
MelanomaCiliary Body	C69.4	8720-8790	Chromosome 3 Status
Brain	C70.0, C71.0-9	8000-9136, 9141-9582, 9700-9701	Gene Deletions 1p
CNSOther	C70.1, 9; C72.0-5,8-9	8000-9136, 9141-9582, 9700-9701	Gene Deletions 1p

* Head and Neck: C00.0-6,8,9; C01 9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9

** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

CS SITE-SPECIFIC FACTOR 6

ACR Required Data Item #162a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2004.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2930
Revised 09/06, 09/08, 01/10, 02/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding See #163a

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 6 (SSF6) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF6s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 6
Head and Neck*	See note after this table	8000-8713, 8800-9136, 9141-9582, 9700-9701	Parapharyngeal, Parotid, and Suboccipital/Retroauricular Lymph Nodes
Mucosal Melanoma**	See note after this table	8720-8790	Parapharyngeal, Parotid, and Suboccipital/Retroauricular Lymph Nodes
GISTEsophagus	C15.0-5,8-9	8935-8936	Mitotic Count
GISTStomach	C16.0-6,8-9	8935-8936	Mitotic Count
GISTSmall Intestine	C17.0-3,8-9	8935-8936	Mitotic Count
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Circumferential Resection Margin (CRM)
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Circumferential Resection Margin (CRM)
Liver	C22.1	8170-8175	Total Bilirubin Value
	C22/0	8000-8157, 8162-8175, 8190-9136, 9141-9582, 9700-9701	
NETAmpulla	C24.1	8153, 8240-8242, 8246, 8249	Urinary 5-HIAA Lab Value
SkinEyelid	C44.1	8000-8713, 8800-9136, 9141-9508, 9510-9514, 9520-9582	Perineural Invasion
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	LDH Upper Limits of Normal
GISTPeritoneum	C48.0-2,8	8935-8936	KIT Immunohistochemistry (IHC)
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	Size of Tumor – Invasive Component
Vagina	C52.9	8000-9136, 9141-9582, 9700-9701	Distant (mediastinal, scalene) Node Status

Corpus Adenosarcoma	C54.0-3, 8-9; C55.9	8933	Number of Examined Para-Aortic Lymph Nodes
CorpusCarcinoma	C54.0-3, 8-9; C55.9	8000-8790, 8980-8981, 9700-9701	Number of Examined Para-Aortic Lymph Nodes
CorpusSarcoma	C54.0-3, 8-9; C55.9	8800-8932, 8934-8974, 8982-9136, 9141-9582	Number of Examined Para-Aortic Lymph Nodes
FallopianTube	C57.0	8000-9136, 9141-9582, 9700-9701	Number of Positive Para-Aortic Lymph Nodes
Testis	C62.0-1,9	8000-9136, 9141-9582, 9700-9701	Preorchiectomy Alpha Fetoprotein (AFP) Lab Value
Kidney Parenchyma	C64.9	8000-9136, 9141-9582, 9700-9701	Fuhrman Grade
Lymphoma OcularAdnexa	C44.1; C69.0,5,6	9590-9699, 9702-9738, 9811-9818, 9820-9837	LDH Interpretation
MelanomaChoroid	C69.3	8720-8790	Chromosome 6p Status
MelanomaIris	C69.4	8720-8790	Chromosome 6p Status
MelanomaCiliary Body	C69.4	8720-8790	Chromosome 6p Status
LacrimalGland	C69.5	8000-8713, 8800-9136, 9141-9508, 9520-9582, 9700-9701	Adenoid Cystic Carcinoma – Presence of Basaloid Pattern
Brain	C70.0, C71.0-9	8000-9136, 9141-9582, 9700-9701	Gene Deletions 19q
CNSOther	C70.1, 9; C72.0-5,8-9	8000-9136, 9141-9582, 9700-9701	Gene Deletions 19q

* Head and Neck: C00.0-6,8,9; C01 9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9

** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

#163a-Required for primary sites: GIST/Esophagus, GIST/Small Intestine, GIST/Stomach, and Skin eyelid.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 7

ACR Required Data Item #164a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2861
Revised 02/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #164b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 7 (SSF7) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF7s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 7
GIST Eosphagus	C15.0-5,8-9	8935-8936	KIT Immunohistochemistry (IHC)
GIST Stomach	C16.0-6,8-9	8935-8936	KIT Immunohistochemistry (IHC)
GIST Small Intestine	C17.0-3,8-9	8935-8936	KIT Immunohistochemistry (IHC)
Liver	C22.1	8170-8175	Total Bilirubin Unit of Measure
	C22.0	8000-8157, 8162-8175, 8190-9136, 9141-9582, 9700-9701	
MelanomaSkin	C44.0-9; C51.0-2, 8-9; C60.0-2,8-9; C63.2	8270-8290	Primary Tumor Mitotic Count/Rate
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	Nottingham or Bloom-Richardson Score / Grade
Vagina	C52.9	8000-9136, 9141-9582, 9700-9701	Assessment Method of Distant (mediastinal, scalene) Node Status
FallopianTube	C57.0	8000-9136, 9141-9582, 9700-9701	Number of Examined Para-Aortic Lymph Nodes
Prostate	C61.9	8000-9136, 9141-9582, 9700-9701	Gleason Primary and Secondary Pattern Value on Needle Core Biopsy / TURP
Testis	C62.0-1,9	8000-9136, 9141-9582, 9700-9701	Preorchiectomy Alpha Fetoprotein (AFP) Interpretation
MelanomaChoroid	C69.3	8720-8790	Chromosome 8q Status
MelanomaIris	C69.4	8720-8790	Chromosome 8q Status
MelanomaCiliary Body	C69.4	8720-8790	Chromosome 8q Status

#164b-Required for primary sites: Melanoma/Skin and Testis.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 8

ACR Required Data Item #165a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2862
Revised 02/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #165b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 8 (SSF8) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF8s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 8
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Perineural Invasion
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Perineural Invasion
Liver	C22.1	8170-8175	International Normalized Ratio for Prothrombin Time (INR)
	C22.0	8000-8157, 8162-8175, 8190-9136, 9141-9582, 9700-9701	
SkinEyelid	C44.1	8000-8713, 8800-9136, 9141-9508, 9510-9514, 9520-9582	Pagetoid Spread
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	HER2: IHC Test Lab Value
Prostate	C61.9	8000-9136, 9141-9582, 9700-9701	Gleason Score on Needle Core Biopsy / TURP
Testis	C62.0-1,9	8000-9136, 9141-9582, 9700-9701	Preorchiectomy Human Chorionic Gonadotropin (hCG) Lab Value
Kidney Parenchyma	C64.9	8000-9136, 9141-9582, 9700-9701	Extranodal Extension of Regional Lymph Nodes
LacrimalGland	C69.5	8000-8713, 8800-9136, 9141-9508, 9520-9582, 9700-9701	Orbital Bone

#165b-Required for primary sites: Breast and Prostate.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 9

ACR Required Data Item #166a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2863
Revised 02/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #166b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 9 (SSF9) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF9s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 9
Head and Neck*	See note after this table	8000-8713, 8800-9136, 9141-9582, 9700-9701	Extracapsular Extension Pathologically, Lymph Nodes for Head and Neck
Mucosal Melanoma**	See note after this table	8720-8790	Extracapsular Extension Pathologically, Lymph Nodes for Head and Neck
Colon	C18.0,2-9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	KRAS
Rectum	C19.9; C20.9	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	KRAS
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	HER2: IHC Test Interpretation
Prostate	C61.9	8000-9136, 9141-9582, 9700-9701	Gleason Primary Pattern and Secondary Pattern Value on Prostatectomy / Autopsy
Testis	C62.0-1,9	8000-9136, 9141-9582, 9700-9701	Preorchiectomy Human Chorionic Gonadotropin (hCG) Interpretation
MelanomaChoroid	C69.3	8720-8790	Mitotic Count
MelanomaIris	C69.4	8720-8790	Mitotic Count
MelanomaCiliary Body	C69.4	8720-8790	Mitotic Count

* Head and Neck: C00.0-6,8,9; C01 9; C02.0-4,8,9; C03.0-1,9; C04.0-1,8,9; C05.0-2,8,9; C06.0-2,8,9; C07.9; C08.0-1,8,9; C09.0-1,8,9; C10.0-4,8,9; C11.0; C30.0-1; C31.0-3,8-9; C32.0-3,8,9
** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

#166b-Required for primary sites: Breast and Testis.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 10

ACR Required Data Item #167a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2864
Revised 02/10, 03/10, 01/11

Description

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

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #167b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 10 (SSF10) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF10s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 10
TongueBase	C01.9, C02.4	8000-8713, 8800-9136, 9141-9582, 9700-9701	HPV (Human Papilloma Virus) Status
PalateSoft	C05.1-2	8000-8713, 8800-9136, 9141-9582, 9700-9701	HPV (Human Papilloma Virus) Status
Ororpharynx	C09.0-1,8-9; C10.0,2-4,8-9	8000-8713, 8800-9136, 9141-9582, 9700-9701	HPV (Human Papilloma Virus) Status
Nasopharynx	11.0-3,8-9	8000-8713, 8800-9136, 9141-9582, 9700-9701	HPV (Human Papilloma Virus) Status
Pharyngeal Tonsil	C11.1	8000-8713, 8800-9136, 9141-9582, 9700-9701	HPV (Human Papilloma Virus) Status
Hypopharynx	C12.9; C13.0-2,8-9	8000-8713, 8800-9136, 9141-9582, 9700-9701	HPV (Human Papilloma Virus) Status
PharynxOther	C14.0-2,8	8000-8713, 8800-9136, 9141-9582, 9700-9701	HPV (Human Papilloma Virus) Status
BileDucts Intrahepat*	C22.0	8160-8161, 8180	Tumor Growth Pattern
	C22.0	8000-8162, 8180-9136, 9141-9582, 9700-9701	
SkinEyelid	C44.1	8000-8713, 8800-9136, 9141-9508, 9510-9514, 9520-9582	Prior Radiation
GISTPeritoneum	C48.0-2,8	8935-8936	Location of Primary Tumor
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	HER2: FISH Test Lab Value
Vulva	C51.0-2,8-9	8000-8246, 8248-9713, 8800-9136, 9141-9582	FIGO Stage
Penis	C60.0-2,8-9	8000-8246, 8248-8713, 8800-9136, 9141-9582	Involvement of Corpus Spongiosum/Corpus Cavernosum
Prostate	C61.9	8000-9136, 9141-9582, 9700-9701	Gleason's Score on Prostatectomy / Autopsy
Testis	C62.0-1,9	8000-8576, 8590-8593, 8940-8950, 8980-8981, 9060-9090, 9100-9105	Preorchiectomy Human Chorionic Gonadotropin (hCG) Interpretation
MelanomaChoroid	C69.3	8720-8790	Mean Diameter Nucleoli (MLN)
MelanomaIris	C69.4	8720-8790	Mean Diameter Nucleoli (MLN)
MelanomaCiliary Body	C69.4	8720-8790	Mean Diameter Nucleoli (MLN)

* BileDuctsIntrahep: This SSF10 was first included in the computation of AJCC T in CS version 02.03; it may need to be coded for converted cases.

#167b-Required for primary sites: BileDuctsIntraHepat, Breast, GIST/Peritoneum, Prostate, and Testis. For primary sites not required by the ACR, refer to notes on other CS Site-Specific Factor pages regarding 988 and 999.

CS SITE-SPECIFIC FACTOR 11

ACR Required Data Item #168a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2865
Revised 02/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #168b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 11 (SSF11) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF11s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 11
Head and Neck*	See note after this table	8000-8713, 8800-9136, 9141-9582, 9700-9701	Measured Thickness (Depth)
Mucosal Melanoma **	See note after this table	8720-8790	Measured Thickness (Depth)
NETStomach	C16.0-6,8-9	8153, 8240-8242, 8246, 8249	Serum Chromogranin A (CgA) Lab Value
GISTColon	C18.0,2-9	8935-8936	Mitotic Count
Appendix	C18.1	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Histopathologic Grading
GISTAppendix	C18.1	8935-8936	Mitotic Count
NETSmall Intestine	C17.0-3,8-9	8153, 8240-8242, 8246, 8249	Serum Chromogranin A (CgA) Lab Value
GISTRectum	C19.9; C20.9	8935-8936	Mitotic Count
BileDuctsIntrahepat	C22.0	8160-8161, 8180	Primary Sclerosing Cholangitis
	C22.1	8000-8162, 8180-9136, 9141-9582, 9700-9701	
BileDuctsPerihilar	C24.0	8000-9136, 9141-9582, 9700-9701	Primary Sclerosing Cholangitis
Skin	C44.0,2-0	8000-8246, 8248-8713, 8800-9136, 9141-9582	Perineural Invasion
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	HER2: FISH Test Interpretation
Vulva	C51.0-2,8-9	8000-8246, 8248-9713, 8800-9136, 9141-9582	Regional Lymph Node - Laterality
MerkelCellVulva	C51.0-2,8-9	8247	Regional Lymph Node - Laterality
Prostate	C61.9	8000-9136, 9141-9582, 9700-9701	Gleason Tertiary Pattern Value on Prostatectomy / Autopsy
MelanomaChoroid	C69.3	8720-8790	Extravascular Matrix Patterns, Loops
MelanomaIris	C69.4	8720-8790	Extravascular Matrix Patterns, Loops
MelanomaCiliary Body	C69.4	8720-8790	Extravascular Matrix Patterns, Loops

* Head and Neck: C00.0-6,8,9; C02.0-3,8-9; C03.0-1,9; C05.8-9; C06.8-9; C30.0; C31.0-3,8-9
** Mucosal Melanoma: C00.0-6,8-9; C01.9; C02.0-4,8-9; C03.0-1,9; C04.0-1,8-9; C05.0-2,8-9; C06.0-2,8-9; C09.0-1,8-9; C10.0-4,8-9; C11.0-3,8-9; C12.9; C13.2,8-9; C14.0,2,8; C30.0,2,8-9; C31.0-3,8-9; C32.0-3,8-9

#168b-Required for primary sites: Appendix, Breast, GIST/Appendix, GIST/Colon, GIST/Rectum, Merkel Cell/Vulva, and Vulva. For primary sites not required by the ACR, refer to notes on other CS Site-Specific Factor pages regarding 988 and 999.

CS SITE-SPECIFIC FACTOR 12

ACR Required Data Item #169a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2866
Revised 02/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #169b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 12 (SSF12) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF1s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 12
NETStomach	C16.0-6,8-9	8153, 8240-8242, 8246, 8249	Urinary 5-HIAA Lab Value Level
NETSmallIntestine	C17.0-3,8-9	8153, 8240-8242, 8246, 8249	Urinary 5-HIAA Lab Value Level
GISTColon	C18.0,2-9	8935-8936	KIT Immunohistochemistry (IHC)
GISTAppendix	C18.1	8935-8936	KIT Immunohistochemistry (IHC)
GISTRectum	C19.9; C20.9	8935-8936	KIT Immunohistochemistry (IHC)
Skin	C44.0,2-9	8000-8246, 8248-8713, 8800-9136, 9141-9582	High Risk Features
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	HER2: CISH Test Lab Value
Prostate	C61.9	8000-9136, 9141-9582, 9700-9701	Number of Cores Positive
Scrotum	C63.2	8000-8246, 8248-8713, 8800-9136, 9141-9582	High Risk Features
MelanomaChoroid	C69.3	8720-8790	Extravascular Matrix Patterns, Networks
MelanomaIris	C69.4	8720-8790	Extravascular Matrix Patterns, Networks
MelanomaCiliary Body	C69.4	8720-8790	Extravascular Matrix Patterns, Networks

#169b-Required for primary sites: Breast, Scrotum, and Skin.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 13

ACR Required Data Item #170a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2867
Revised 02/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #170b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 13 (SSF13) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF13s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 13
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	HER2: CISH Test Interpretation
Prostate	C61.9	8000-9136, 9141-9582, 9700-9701	Number of Cores Examined
MelanomaChoroid	C69.3	8720-8790	Microvascular density (MVD)
MelanomaIris	C69.4	8720-8790	Microvascular density (MVD)
MelanomaCiliary Body	C69.4	8720-8790	Microvascular density (MVD)
Testis*	C62.0-1,9	8000-9136, 9141-9582, 9700-9701	Postorchiectomy Alpha Fetoprotein (AFP) Range

* Testis: This SSF13 was new in CS version 02.03.xx. It requires identifying the level after it has become stable, to be certain to yield the correct stage. It may be necessary to code this item for converted cases.

#170b-Required for primary sites: Breast and Testis.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 14

ACR Required Data Item #171a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2868
Revised 02/10, 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #171b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 14 (SSF14) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF14s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 14
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	HER2: Result of Other or Unknown Test

#171b-Required for primary sites: Breast.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 15

ACR Required Data Item #172a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2869
Revised 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #172b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 15 (SSF15) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF15s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 14
Breast*	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	HER2: Summary result of testing
Testis**	C62.0-1,9	8000-9136, 9141-9582, 9700-9701	Postorchiectomy Human Chorionic Gonadotropin (hCG) Range

*Breast: This SSF15 is required beginning with cases diagnosed in 2011.
** Testis: This SSF15 was new in CS version 02.03.xx. It requires identifying the range after it has become stable, to be certain to yield the correct stage. It may be necessary to code this item for converted cases.

#172b-Required for primary sites: Breast and Testis.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 16

ACR Required Data Item #173a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2870
Revised 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #173b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 16 (SSF16) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF16s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 16
NETColon	C18.0,2-9	8153, 8240-8242, 8246, 8249	Serum Chromogranin A (CgA) Lab Value
NETRectum	C19.9; C20.9	8153, 8240-8242, 8246, 8249	Serum Chromogranin A (CgA) Lab Value
Skin	C44.0,2-9	8000-8246, 8248-8713, 8800-9136, 9141-9582	Size of Lymph Nodes
MerkelCellSkin	C44.0,2-9	8247	Size of Metastases in Lymph Nodes
MerkelCellVulva	C51.0-2,8-9	8247	Size of Metastases in Lymph Nodes
MerkelCellPenis	C60.0-2,8-9	8247	Size of Metastases in Lymph Nodes
Testis*	C62.0-1,9	8000-9136, 9141-9582, 9700-9701	Postorchiectomy Lactate Dehydrogenase (LDH) Range
MerkelCellScrotum	C63.2	8247	Size of Metastases in Lymph Nodes
Scrotum	C63.2	8000-8246, 8248-8713, 8800-9136, 9141-9582	Size of Lymph Nodes

* Testis: This SSF16 was new in CS version 02.03.xx. It requires identifying the range after it has become stable, to be certain to yield the correct stage. It may be necessary to code this item for converted cases.

#173b-Required for primary sites: Breast, Scrotum, Skin, and Testis.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 17

ACR Required Data Item #174a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2871
Revised 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #174b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 17 (SSF17) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF17s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 17
NETColon	C18.0,2-9	8153, 8240-8242, 8246, 8249	Urinary 5-HIAA Lab Value Level
NETRectum	C19.9; C20.9	8153, 8240-8242, 8246, 8249	Urinary 5-HIAA Lab Value Level
MerkelCellSkin	C44.0,2-9	8247	Extracapsular Extension of Regional Lymph Nodes
MerkelCellVulva	C51.0-2,8-9	8247	Extracapsular Extension of Regional Lymph Nodes
MerkelCellPenis	C60.0-2,8-9	8247	Extracapsular Extension of Regional Lymph Nodes
MerkelCellScrotum	C63.2	8247	Extracapsular Extension of Regional Lymph Nodes
Penis	C60.0-2,8-9	8000-8246, 8248-8713, 8800-9136, 9141-9582	Extranodal Extension of Regional Lymph Nodes

#174b-Required for primary sites: Penis.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 18

ACR Required Data Item #175a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2872
Revised 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #175b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 18 (SSF18) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF18s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 18
MerkelCellSkin	C44.0,2-9	8247	Isolated Tumor Cells (ITCs) in Regional Lymph Node(s)
MerkelCellVulva	C51.0-2,8-9	8247	Isolated Tumor Cells (ITCs) in Regional Lymph Node(s)
MerkelCellPenis	C60.0-2,8-9	8247	Isolated Tumor Cells (ITCs) in Regional Lymph Node(s)
MerkelCellScrotum	C63.2	8247	Isolated Tumor Cells (ITCs) in Regional Lymph Node(s)

#175b-Required for primary sites: None.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 19

ACR Required Data Item #176a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2873
Revised 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #176b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

No Site-Specific Factor 19 (SSF19) items are *required* by CoC to be coded. Registries are *encouraged* to code prognostic SSF19s used by the facility.

#176b-Required for primary sites: None.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 20

ACR Required Data Item #177a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2874
Revised 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #177b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

No Site-Specific Factor 20 (SSF20) items are *required* by CoC to be coded. Registries are *encouraged* to code prognostic SSF20s used by the facility.

#177b-Required for primary sites: None.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 21

ACR Required Data Item #178a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2875
Revised 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #178b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 21 (SSF21) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF21s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 21
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	Response to Neoadjuvant Therapy

#178b-Required for primary sites: None.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 22

ACR Required Data Item #179a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2876
Revised 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #179b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 22 (SSF22) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF22s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 22
MerkelCellSkin	C44.0,2-9	8247	Profound Immune Suppression
MerkelCellVulva	C51.0-2,8-9	8247	Profound Immune Suppression
MerkelCellPenis	C60.0-2,8-9	8247	Profound Immune Suppression
MerkelCellScrotum	C63.2	8247	Profound Immune Suppression
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	Multigene Signature Method

#179b-Required for primary sites: None.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 23

ACR Required Data Item #180a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2877
Revised 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #180b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

For tumors abstracted in CS v02.03.xx or diagnosed in 2011, the following Site-Specific Factor 23 (SSF23) items are *required* by CoC to be coded. Registries are *encouraged* to code other prognostic SSF23s used by the facility.

CS Schema	Sites	Histologies	Site-Specific Factor 23
Breast	C50.0-6, 8-9	8000-9136, 9141-9582, 9700-9701	Result/Score of the Multigene Signature

#180b-Required for primary sites: None.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 24

ACR Required Data Item #181a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2878
Revised 03/10, 01/11

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

Rationale
Site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding #181b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

No Site-Specific Factor 24 (SSF24) items are *required* by CoC to be coded. Registries are *encouraged* to code prognostic SSF24s used by the facility.

#181b-Required for primary sites: None.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

CS SITE-SPECIFIC FACTOR 25

ACR Required Data Item #182a
Required for Specific Primary Sites Only, See Pages 182A-182B
Effective for cases diagnosed on or after 01/01/2010.

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2879
Revised 02/10, 01/11

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

Rationale
CS Site-Specific Factor25 is used to discriminate between CS staging schema or between AJCC chapters where site and histology alone are insufficient to identify the tumor type or location to identify the applicable staging method. Use of this item is limited to specific subsites and histologies as shown below.

Instructions for Coding #182b

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.

The following Site-Specific Factor 25 (SSF25) schema discriminators are *required* by CoC to be coded. SSF25 must be coded 988 for all schema *not* listed below.

CS Schema	Sites	Histologies	Site-Specific Factor 25
Nasopharynx	C11.1	8000-8713, 8800-9136, 9141-9582, 9700-9701	Schema Discriminator
PharyngealTonsil	C11.1	8000-8713, 8800-9136, 9141-9582, 9700-9701	Schema Discriminator
EsophagusGE Junction	C16.1-2	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Involvement of Cardia and Distance from Esophagogastric Junction (EGJ)
Stomach	C16.1-2	8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701	Involvement of Cardia and Distance from Esophagogastric Junction (EGJ)
Cystic Duct	C24.0	8000-9136, 9141-9582,9700-9701	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
BileDuctsPerihilar	C24.0	8000-9136, 9141-9582, 9700-9701	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
BileDuctsDistal	C24.0	8000-9136, 9141-9582, 9700-9701	Schema Discriminator: Subsite of Extrahepatic Bile Ducts
Peritoneum	C48.1-2,8	Male: 8000-8576, 8590-8671, 8930-8934, 8940-9110	Schema Discriminator
		Female: 8580-8589, 8680-8921, 9120-9136, 9141-9582, 9700-9701	
PeritoneumFemaleGen	C48.1-2,8	8000-8576, 8590-8671, 8930-8934, 8940-9110	Schema Discriminator
MelanomaCiliaryBody	C69.4	8720-8790	Schema Discriminator: Melanoma Ciliary Body / Melanoma Iris
MelanomaIris	C69.4	8720-8790	Schema Discriminator: Melanoma Ciliary Body / Melanoma Iris
LacrimalGland	C69.5	8000-8713, 8800-9136, 9141-9508, 9520-9582, 9700-9701	Schema Discriminator: Lacrimal Gland/Lacrimal Sac
LacrimalSac	C69.5	8000-8713, 8800-9136, 9141-9508, 9520-9582, 9700-9701	Schema Discriminator: Lacrimal Gland/Lacrimal Sac

#182b-Required for primary sites: Bile Duct/Distal, Bile Duct/Perihilar, Cystic Duct, Esophagus/GE Junction, Lacrimal Gland, Lacrimal Sac, Melanoma/Ciliary Body, Melanoma/Iris, Nasopharynx, Peritoneum, Peritoneum/Female Genital, Pharyngeal Tonsil, and Stomach.
For primary sites not required by the ACR, the ACR is requiring all CS Site-Specific Factors be entered with the not applicable (988) code unless a registry decides to code them. If a not applicable (988) code does not exist, code to unknown (999). Some vendors may default to a not applicable code.

ACR REQUIRED CSv2 SITE-SPECIFIC FACTORS TABLE

All other site-specific factors not indicated in the table require the not applicable code (988) to be entered unless your registry decides to code them. If a not applicable code (988) does not exist, code to unknown (999).

SITE	SSF Required	SITE	SSF Required	SITE	SSF Required
Appendix	2, 11	Heart/Mediastinum	1	NET Stomach	1
Bile Duct/Distal	25	Hypopharynx	1	Oropharynx	1
BileDuctsIntraHepat	10	IntracranialGland	1	Palate, hard	1
Bile Duct/Perihilar	25	Lacrimal Gland	25	Palate, soft	1
Bladder	2	Lacrimal Sac	25	Parotid Gland	1
Brain	1	Larynx/Glottic	1	Penis	17
Breast	1-5, 8-16	Larynx/Other	1	Peritoneum	1, 25
Buccal Mucosa	1	Larynx/Subglottic	1	Peritoneum, female genital	25
Carcinoid Appendix	2	Larynx/Supraglottic	1	Pharyngeal Tonsil	1, 25
CNSOther	1	LipLower	1	Placenta	1
Colon	2	Lip/other	1	Pleura	1
Conjunctiva	1	Lip/Upper	1	Prostate	1, 3, 8, 10 (SSF4 collected for cases dx through 2009)
Corpus/Adenosarcoma	2	Lung	1	Rectum	2
Corpus/Carcinoma	2	Lymphoma	2	Retinoblastoma	1
Corpus/Sarcoma	2	Lymphoma/Ocular/ Adnexa	2	Retroperitoneum	1
Cystic Duct	25	Melanoma/Choroid	2, 3, 4	Salivary gland/other	1
Epiglottis/Anterior	1	Melanoma/Ciliary Body	2, 3, 4, 25	Scrotum	12, 16
Esophagus	1	Melanoma/ Conjunctiva	1, 2	Sinus Ethmoid	1
Esophagus/GE Junction	1, 25	Melanoma/Iris	4, 25	Sinus Maxillary	1
Floor of Mouth	1	Melanoma/Skin	1-4, 7	Skin	12, 16
GIST/Appendix	11	Merkel Cell/Penis	3	Skin, eyelid	6
GIST/Colon	11	Merkel Cell/Scrotum	3	Small intestine	2
GIST/Esophagus	6	Merkel Cell/Skin	3	Soft tissue	1
GIST/Peritoneum	5, 10	Merkel Cell/Vulva	3, 11	Stomach	1, 25
GIST/Rectum	11	Mouth/Other	1	Submandibular gland	1
GIST/Small Intestine	6	Mycosis Fungoides	1	Testis	4, 5, 7, 9, 10,13, 15, 16
GIST/Stomach	6	Nasal Cavity	1	Tongue/anterior	1
Gum, lower	1	Nasopharynx	1, 25	Tongue/base	1
Gum, other	1	NET Colon	2	Vulva	11
Gum, upper	1	NET Rectum	2		

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ACR Supplement Page

DERIVED AJCC-6 T

ACR Required Data Item #183a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 2
NAACCR Item #2940
Revised 09/08, 01/10

Description
This item is the derived AJCC "T" staging element from coded fields using the CS algorithm.

Rationale
Derived AJCC-6 T can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for the site-specific "T" descriptions.

DERIVED AJCC-6 T DESCRIPT

ACR Required Data Item #184a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 1
NAACCR Item #2950
Revised 09/04, 01/10

Description
This item is the derived AJCC "T Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-6 T Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Surgical resection performed **after** pre-surgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC-6 N

ACR Required Data Item #185a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 2
NAACCR Item #2960
Revised 01/10

Description
This item is the derived AJCC "N" staging element from coded fields using the CS algorithm.

Rationale
The CS *Derived AJCC-6 N* can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for the site-specific "N" descriptions.

DERIVED AJCC-6 N DESCRIPT

ACR Required Data Item #186a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 1
NAACCR Item #2970
Revised 09/04, 01/10

Description
This item is the derived AJCC "N Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-6 N Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Lymph nodes removed for examination **after** pre-surgical systemic treatment or radiation and lymph node evaluation based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC-6 M

ACR Required Data Item #187a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 2
NAACCR Item #2980
Revised 01/10

Description
This item is the derived AJCC "M" staging element from coded fields using the CS algorithm.

Rationale
Derived AJCC-6 M can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for the site-specific "M" descriptions.

DERIVED AJCC-6 M DESCRIPT

ACR Required Data Item #188a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 1
NAACCR Item #2990
Revised 09/04, 01/10

Description
This item is the derived AJCC "M Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-6 M Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Pathologic examination of metastatic tissue performed **after** pre-surgical systemic treatment or radiation and extension based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC-6 STAGE GROUP

ACR Required Data Item #189a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 2
NAACCR Item #3000
Revised 01/10, 01/11

Description
This item is the derived AJCC "Stage Group" from coded fields using the CS algorithm.

Rationale
The CS *Derived AJCC-6 Stage Group* can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for the site-specific Stage Group descriptions.

DERIVED AJCC-7 T

ACR Required Data Item #190a
Required for cases diagnosed on or after 1/1/2010.

Item Length: 2
NAACCR Item #3400
New Item 01/2010

Description
This item is the derived AJCC "T" staging element from coded fields using the CS algorithm.

Rationale
Derived AJCC-7 T can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for the site-specific "T" descriptions.

DERIVED AJCC-7 T DESCRIPT

ACR Required Data Item #191a
Required for cases diagnosed on or after 1/1/2010.

Item Length: 1
NAACCR Item #3402
New Item 01/2010

Description
This item is the derived AJCC "T Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-7 T Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Surgical resection performed **after** pre-surgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC-7 N

ACR Required Data Item #192a
Required for cases diagnosed on or after 1/1/2010.

Item Length: 2
NAACCR Item #3410
New Item 01/2010

Description
This item is the derived AJCC "N" staging element from coded fields using the CS algorithm.

Rationale
The CS *Derived AJCC-7 N* can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for the site-specific "N" descriptions.

DERIVED AJCC-7 N DESCRIPT

ACR Required Data Item #193a
Required for cases diagnosed on or after 1/1/2010.

Item Length: 1
NAACCR Item #3412
New Item 01/2010

Description
This item is the derived AJCC "N Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-7 N Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Lymph nodes removed for examination **after** pre-surgical systemic treatment or radiation and lymph node evaluation based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC-7 M

ACR Required Data Item #194a
Required for cases diagnosed on or after 1/1/2010.

Item Length: 2
NAACCR Item #3420
New Item 01/2010

Description
This item is the derived AJCC "M" staging element from coded fields using the CS algorithm.

Rationale
Derived AJCC-7 M can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for the site-specific "M" descriptions.

DERIVED AJCC-7 M DESCRIPT

ACR Required Data Item #195a
Required for cases diagnosed on or after 1/1/2010.

Item Length: 1
NAACCR Item #3422
New Item 01/2010

Description
This item is the derived AJCC "M Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-7 M Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Pathologic examination of metastatic tissue performed **after** pre-surgical systemic treatment or radiation and extension based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC-7 STAGE GROUP

ACR Required Data Item #196a
Required for cases diagnosed on or after 1/1/2010.

Item Length: 2
NAACCR Item #3430
Revised 01/11

Description
This item is the derived AJCC "Stage Group" from coded fields using the CS algorithm.

Rationale
The CS *Derived AJCC-7 Stage Group* can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for the site-specific Stage Group descriptions.

DERIVED SS1977

ACR Required Data Item #197a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 1
Allowable Values: 0–5, 7, 9
NAACCR Item #3010
Revised 09/08, 01/10

Description
This item is the derived "SEER Summary Stage 1977" from the CS algorithm.

Rationale
Derived SS1977 can be used to evaluate patterns of disease spread at diagnosis, track treatment patterns, and analyze outcomes, especially when comparing or combining cases diagnosed prior to 2001 (when an updated version was implemented) with those diagnosed later.

Instructions for Coding
- Refer to the *SEER Summary Staging Manual, 1977* for descriptions of the site-specific categories.
- Refer to the current *CS Manual* for the calculation procedures for this item.

Code	Description
0	In situ
1	Localized
2	Regional, direct extension only.
3	Regional, regional lymph nodes only.
4	Regional, direct extension and regional lymph nodes.
5	Regional, NOS.
7	Distant metastases/systemic disease.
8	Not applicable
9	Unstaged, unknown, or unspecified.
(blank)	Not derived.

DERIVED SS2000

ACR Required Data Item #198a
Required for cases diagnosed on or after 1/1/2004.

Item Length: 1
Allowable Values: 0–5, 7, 9
NAACCR Item #3020
Revised 09/08, 01/10

Description
This item is the derived "SEER Summary Stage 2000" from the CS algorithm.

Rationale
Derived SS2000 can be used to evaluate patterns of disease spread at diagnosis, track treatment patterns, and analyze outcomes.

Instructions for Coding
- Refer to the *SEER Summary Staging Manual, 2000* for descriptions of the site-specific categories.
- Refer to the current *CS Manual* for the calculation procedures for this item.

Code	Description
0	In situ
1	Localized
2	Regional, direct extension only.
3	Regional, regional lymph nodes only.
4	Regional, direct extension and regional lymph nodes.
5	Regional, NOS.
7	Distant metastases/systemic disease.
8	Not applicable
9	Unstaged, unknown, or unspecified.
(blank)	Not derived.

First Course of Treatment

HOSPITAL

Item Length: 10
NAACCR Item #None

ACR Required Data Item

Description
A unique three-digit code used to identify a hospital, clinic, or physician's office.
This data item appears at the top of the "pop up" first course treatment page in RMCDS and is used to identify the facility that administered the treatments coded in the fields beneath it.
Note: This field replaces the old "attribute" codes that were part of the treatment fields.

Rationale
Hospital specific fields allow studies of referral patterns and treatment by type of hospital. Knowing what part of the treatment was given at a particular hospital also helps to resolve coding issues.

Instructions for Coding
Enter the three-digit code for your facility or for the facility that provided the treatment. If you do not know where previous treatment was administered, code 999. Code all treatments given at the facility. To code treatments given at other facilities, click on the "Next" button at the bottom of the page. A new blank treatment page will pop up Again, code the three-digit hospital code and enter all treatments for that facility. Notice the bottom center of the treatment page, where "Record ##" tells which treatment record is being viewed. RMCDS will allow about twenty treatment records.

Note: The ACR assigns all reporting facilities a three-digit identification number (known as the reporting hospital number) for use within the state of Arizona. It is mandatory to use this number when submitting documents to the ACR. If you do not have a three-digit identification number, contact the ACR.

Note to facilities using software other than RMCDS: Software must have the ability to distinguish between treatments given at your facility and treatments given at other reporting facilities. Item length is listed as ten because when a NAACCR file is created, the three-digit hospital number is converted into a ten-digit ACoS number.

Code	Label	Definition
601-697	Hospital	Unique facility identification number for hospitals in Arizona. Refer to Appendix H for Arizona Reporting Facility Directory.
550	Physician's Office	Used to identify all physician offices not part of a larger hospital.
3__ __	Hospital Labs	The lab number corresponds to the last two digits of the hospital identification number. For example, Mayo Clinic is #696, therefore the hospital lab would be #396.
999	Unknown	Unknown whether facility is a hospital, physician's office, hospital lab or free-standing lab.

FIRST COURSE OF TREATMENT

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

General Guidelines and Considerations for Coding First Course of Treatment Items

1. Code all treatment that was started and administered, whether completed or not.
Example: The patient completed only the first dose of a planned 30-day chemotherapy regimen. Code chemotherapy as administered.
2. Code the treatment on both abstracts when a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary.
Example 1*:* The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate cancer was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional lymph nodes for the bladder. Code the radiation as treatment for both the bladder and prostate cases.
Example 2: The patient had a hysterectomy for ovarian cancer. The pathology report reveals a previously unsuspected microinvasive cancer of the cervix. Code the hysterectomy as surgical treatment for both the ovarian and cervix primaries.
3. Code the treatments only for the site that is affected when a patient has multiple primaries and the treatment given affects only one of the primaries.
Example: The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and regional nodes. Do not code the radiation for the colon. Do not code the hemicolectomy for the tonsil.
4. Code the treatment given as first course even if the correct primary is identified later when a patient is diagnosed with an unknown primary.
Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Code the chemotherapy as first course of treatment.
a. Do not code treatment added to the plan when the primary site is discovered as first course. This is a change in the treatment plan.

> *Example:* The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code the chemotherapy as first course of treatment. The hormone therapy is second course because it was not part of the initial treatment plan.

Other Hematopoietic

The following treatments are coded as "other" in Other Treatment even though they do not "modify, control, remove, or destroy proliferating cancer tissue." Follow the guidelines in the *Abstracting and Coding Guide for the Hematopoietic Diseases* to identify treatments. Some examples of "other" treatment include:
Example 1: Phlebotomy may be called blood removal, blood-letting, or venisection.
Example 2: Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.
Example 3: Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia.
a. Record aspirin therapy only if it is given to thin the blood for symptomatic control of thrombocythemia. Use the following guidelines to determine whether aspirin is administered for thinning of blood for thrombocythemia rather than for pain control or cardiovascular protection:

> i. Aspirin treatment for essential thrombocythemia is low dose, approximately 70-100 mg/day
> ii. The dosage for pain control is approximately 325-1000 mg every 3-4 hours.
> iii. Cardiovascular protection is usually one baby aspirin per day.

DATE OF FIRST COURSE OF TREATMENT

Item Length: 8
NAACCR Item #1270
Revised 01/10, 01/11

ACR Required Data Item #201a

Description
Records the date on which treatment (surgery, radiation, systemic, or other therapy) of the patient began at any facility. #201b

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

Instructions for Coding

#201c-Refer to *FORDS* Section One pp. 19-29 for treatment information and for additional information see *ACR Supplement* p. 200B. See #202b.

- 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).
- If active surveillance or watchful waiting is selected as the first course of treatment (*RX Summ–Treatment Status* [NAACCR Item #1285] = 2) record the date this decision is made.
- In cases of nontreatment (*RX Summ–Treatment Status* [NAACCR Item #1285] = 0), in which a physician decides not to treat a patient or a patient's family or guardian declines all treatment, the date of first course of treatment is the date this decision was made.
- Leave this item blank if the cancer was diagnosed at autopsy and not suspected prior to that.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Course of Treatment* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Course of Treatment* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date 1st Crs Rx Flag* (NAACCR Item #1271) is used to explain why *Date of First Course of Treatment* is not a known date. See *Date 1st Crs Rx Flag* for an illustration of the relationships among these items. #201d

Examples

#201e-In Utero Treatment Note: Record the actual date of treatment when treatment is performed prior to birth.

A patient has a core biopsy on February 12, 2004 and subsequently undergoes an excisional biopsy on February 14, 2004	February 14, 2004 #201f
A patient begins receiving preoperative radiation therapy elsewhere on April 21, 2005 and subsequent surgical therapy at this facility on June 2, 2005	April 21, 2005

#201b-Per the CoC: The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis."

#201d-Collection, Storage, and Transmission of Date of First Course Treatment
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#201f-Coding Example: A patient had a breast core needle biopsy with a diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual tumor noted. Code the date of the needle biopsy as the excisional biopsy date.

DATE 1st CRS RX FLAG

Item Length: 2
NAACCR Item #1271
Valid Codes: 10-12, Blank
New Item: 1/1/2010

ACR Required Data Item #202a

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Course of Treatment* (NAACCR Item #1270).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions
- Leave this item blank if *Date of First Course of Treatment* (NAACCR Item #1270) has a full or partial date recorded.
- Code 12 if the *Date of First Course of Treatment* can not be determined, but the patient did receive first course treatment.
- Code 10 if it is unknown whether any treatment was administered.
- Code 11 if the initial diagnosis was at autopsy.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any treatment was given).
11	No proper value is applicable in this context (for example, autopsy only).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, treatment was given but the date is unknown).
(blank)	A valid date value is provided in item *Date of First Course of Treatment* (NAACCR Item #1270).

#202b-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of First Course of Treatment* (NAACCR Item #1270) and *Date 1st Crs Rx Flag* (NAACCR Item #1271). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date of First Course of Treatment**	**Interoperable Date of First Course of Treatment**	**Date 1st Crs Rx Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any treatment given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
Diagnosis at autopsy only	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, treatment given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

RX SUMM – TREATMENT STATUS

Item Length: 1
Allowable Values: 0-2, 9
NAACCR Item #1285
Revised: 01/11

ACR Required Data Item #204a

Description
This data item summarizes whether the patient received any treatment or the tumor was under active surveillance.
#204b-This data item is required for cases diagnosed on or after 01/01/2010.

Rationale
This item documents active surveillance (watchful waiting) and eliminate searching each treatment modality to determine whether treatment was given. It is used in conjunction with *Date of First Course of Treatment* [NAACCR Item #1270] to document whether treatment was or was not given, it is unknown if treatment was given, or treatment was given on an unknown date.

Instructions for Coding

- This item may be left blank for cases diagnosed prior to 2010.
- Treatment given after a period of active surveillance is considered subsequent treatment and it not coded in this item.
- Use code 0 when treatment is refused or the physician decides not to treat for any reason such as the presence of comorbidities.

Code	Definition
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

Examples:

Code	Reason
0	An elderly patient with pancreatic cancer requested no treatment.
0	Patient is expected to receive radiation, but it has not occurred yet (*Reason for No Radiation* [NAACCR Item #1430] = 8)
2	Treatment plan for a lymphoma patient is active surveillance.

DATE OF FIRST SURGICAL PROCEDURE

Item Length: 8
NAACCR Item #1200
Revised 01/10, 01/11

ACR Required Data Item #205a

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

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

Instructions for Coding
- Record the date of the first surgical procedure of the types coded as *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Surgical Procedure/Other Site* (NAACCR Item #1294) performed at this or any facility.
- The date in this item may be the same as that in *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170), if the patient received only one surgical procedure and it was a resection of the primary site.
- If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item *Date of First Course Treatment* (NAACCR Item #1270).
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Surgical Procedure* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Surgical Procedure* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Rx Date–Surgery Flag* (NAACCR Item #1201) is used to explain why *Date of First Surgical Procedure* is not a known date. See *Rx Date–Surgery Flag* for an illustration of the relationships among these items. #205b

Examples

A melanoma patient had an excisional biopsy on March 23, 2008, then a wide excision on March 28, 2008.	March 23, 2008
The patient had a small (0.5 cm) lump removed from her breast on November 16, 2009.	November 16, 2009
The patient's primary tumor was treated with radiation beginning on April 16, 2007, after a distant metastasis was removed surgically on March 27, 2007.	March 27, 2007

#205b-Collection, Storage, and Transmission of Date of First Surgical Procedure
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#205c-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RX DATE–SURGERY FLAG

ACR Required Data Item #206a

Item Length: 2
NAACCR Item #1201
Valid Codes: 10-12, Blank
New Item: 1/1/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Surgical Procedure* (NAACCR Item #1200).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions
- Leave this item blank if *Date of First Surgical Procedure* (NAACCR Item #1200) has a full or partial date recorded.
- Code 12 if the *Date of First Surgical Procedure* can not be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of First Surgical Procedure* (NAACCR Item #1200).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of First Surgical Procedure* (NAACCR Item #1200) and *Rx Date–Surgery Flag* (NAACCR Item #1201). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date of First Surgical Procedure**	**Interoperable Date of First Surgical Procedure**	**Rx Date–Surgery Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No surgery performed	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

DATE OF MOST DEFINITIVE SURGICAL RESECTION OF THE PRIMARY SITE

ACR Required Data Item #208a

Item Length: 8
NAACCR Item #3170
Revised 09/08, 01/10, 01/11

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

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

Instructions for Coding

- Record the date on which the surgery described by *Surgical Procedure of Primary Site* (NAACCR Item #1290) was performed at this or any facility.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Most Definitive Surgical Resection of the Primary Site* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Most Definitive Surgical Resection of the Primary Site* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date Mst Defn Srg Flag* (NAACCR Item #3171) is used to explain why *Date of Most Definitive Surgical Resection of the Primary Site* is not a known date. See *RX Date Mst Defn Srg Flag* for an illustration of the relationships among these items. #208b

#208b-Collection, Storage, and Transmission of Date of Most Definitive Surgical Resection of the Primary Site
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#208c-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RX DATE MST DEFN SRG FLAG

Item Length: 2
NAACCR Item #3171
Valid Codes: 10-12, Blank
Revised: 01/11

ACR Required Data Item #209a

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions
- Leave this item blank if *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170) has a full or partial date recorded.
- Code 12 if the *Date of Most Definitive Surgical Resection of the Primary Site* can not be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave blank for cases diagnosed prior to January 1, 2003.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170). Case was diagnosed prior to January 1, 2003.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170) and *Rx Date Mst Defn Srg Flag* (NAACCR Item #3171). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date of Most Definitive Surgical Resection of the Primary Site**	**Interoperable Date of Most Definitive Surgical Resection of the Primary Site**	**Rx Date Mst Defn Srg Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No surgery performed	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

RX TEXT—SURGERY

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2610

Description
Text area for information describing all surgical procedures performed as part of treatment.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions for Coding
Enter the following information in narrative format:

- Date of procedure
- Where surgery was done (e.g. name of this facility or another facility)
- Type of surgical procedure(s), including excisional biopsies and surgery to other and distant sites
- Lymph nodes removed
- Regional tissues removed
- Metastatic sites
- Positive and negative findings; record positive findings first

Note #1: If endoscopy is performed prior to the surgery that provides information about the extent of disease or the site of origin of the cancer, include this in the narrative format (e.g. “cystoscopy was done prior to a transurethral resection of the bladder, revealing a lesion in the trigone.”).

Note #2: See Appendix E for acceptable abbreviations.

Note #3: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #4: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

Note #5: Text must be provided on any coded surgery. Text must also be provided to support *Collaborative Stage Data Collection System* data items, and on cases where *AJCC Cancer Staging* and *SEER Summary Staging* data items are required.

SURGICAL PROCEDURE OF PRIMARY SITE CLARIFICATIONS

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

Coding Instructions

1. Code an **excisional biopsy**, even when documented as **incisional**, when:

a. All disease is removed (**margins free)** OR
b. All gross disease is removed and there is only microscopic residual at the margin

Note: Do not code an excisional biopsy when there is macroscopic residual disease.

2. Code total **removal of the primary site** when a previous procedure resected a portion of the site and the current surgery removed the rest of the organ. The previous procedure may have been cancer directed or non-cancer directed surgery.

3. Code the removal of regional or distant **tissue/organs** when they are resected in continuity with the primary site **(en bloc)** and that regional organ/tissue is listed in the Surgery of Primary Site codes. Specimens from an en bloc resection may be submitted to pathology separately.

Example: Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

4. Code **98** for the following sites unless the case is death certificate only:

a. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease

i. Primary sites: C420, C421, C423, or C424 (all histologies)
ii. Histologies: 9727, 9733, 9740-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992 (all sites). See ACR Note #1 below.
iii. Unknown or ill-defined sites (C760-C768, C809) (all histologies)

ACR Note #1: The histologies noted in ii above are a change from the ACR Supplement 2009 version. This change is effective with cases diagnosed 2010 and later. Refer to previous codes in the *Arizona Cancer Registry Handbook* which includes *FORDS, Revised for 2009* and the *Arizona Cancer Registry Supplement* for cases diagnosed prior to 2010.

SURGICAL PROCEDURE OF PRIMARY SITE

Item Length: 2
Allowable Values: 00, 10–80, 90, 98, 99
L/R Justified, Zero-filled
NAACCR Item #1290
Revised 06/05, 01/10

ACR Required Data Item #211a

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

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

Instructions for Coding #211b

- Site-specific codes for this data item are found in Appendix B. #211c-See also *ACR Supplement* p. 210B.
- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site. #211d
- If registry software allows multiple procedures to be recorded, this item refers to the most invasive surgical procedure of the primary site.
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is not available.
- Excisional biopsies (those that remove the entire 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).
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.

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

#211b-For cases diagnosed before 1/1/2003, it is required to code SURGICAL PROCEDURE OF PRIMARY SITE (NAACCR Item #1290) and RX SUMM-SURG SITE 98-02 (NAACCR Item #1646).

#211d-If software allows, the ACR requires the coding of 1st course surgery to be cumulative and progressive. If software allows for coding of only one surgical event, code the most definitive surgery.

SURGICAL PROCEDURE OF PRIMARY SITE AT THIS FACILITY

ACR Required Data Item #212a

Item Length: 2
Allowable Values: 00, 10–80, 90, 98, 99
L/R Justified, Zero-filled
NAACCR Item #670
Revised 09/04, 01/10

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

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

Instructions for Coding #212b

- Site-specific codes for this data item are found in Appendix B. #212c-See also *ACR Supplement* p. 210B.
- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site. #212d
- If registry software allows multiple procedures to be collected, this item refers to the most invasive surgical procedure for the primary site.
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is not available.
- Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item.
- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results.
- 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 at This Facility* (NAACCR Item #3280).

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

#212b-For cases diagnosed before 1/1/2003, it is required to code SURGICAL PROCEDURE OF PRIMARY SITE (NAACCR Item #1290) and RX SUMM-SURG SITE 98-02 (NAACCR Item #1646).

#212d-If software allows, the ACR requires the coding of 1st course surgery to be cumulative and progressive. If software allows for coding of only one surgical event, code the most definitive surgery.

APPROACH – SURGERY OF THE PRIMARY SITE AT THIS FACILITY
(RX HOSP – SURG APP 2010)

Item Length: 1
Allowable Values: 0-5, 9
NAACCR Item #668
Revised 05/10, 01/11

Not Required by ACR #213a

Description
This item is used to describe the surgical method used to approach the primary site for patients undergoing surgery of the primary site at this facility.

Rationale
This item is used to monitor patterns and trends in the adoption and utilization of minimally-invasive surgical techniques.

Instructions for Coding

- This item may be left blank for cases diagnosed prior to 2010.
- If the patient has multiple surgeries of the primary site, this item describes the approach used for the most invasive, definitive surgery.
- For ablation of skin tumors, assign code 3.
- Assign code 2 or 4 if the surgery began as robotic assisted or endoscopic and was converted to open.
- If both robotic and endoscopic or laparoscopic surgery are used, code to robotic (codes 1 or 2).
- This item should not be confused with the obsolete item published in Registry Operations and Data Standards (ROADS), *Surgical Approach* (NAACCR Item #1310)

Code	Definition
0	No surgical procedure of primary site at this facility; Diagnosed at autopsy
1	Robotic assisted
2	Robotic converted to open
3	Endoscopic or laparoscopic
4	Endoscopic or laparoscopic converted to open.
5	Open or approach unspecified
9	Unknown whether surgery was performed at this facility

Examples:

Code	Reason
0	Patient received radiation at this facility after having surgery elsewhere
3	Surgery was performed endoscopically
5	The surgical report described conventional open surgery, but did not use the term “open”

SURGICAL MARGINS OF THE PRIMARY SITE

ACR Required Data Item #214a

Item Length: 1
Allowable Values: 0–3, 7–9
NAACCR Item #1320
Revised 08/02, 01/10, 02/10

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

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

Instructions for Coding
- Record the margin status as it appears in the pathology report.
- Codes 0–3 are hierarchical; if two codes describe the margin status, use the numerically higher code.
- Code 7 if the pathology report indicates the margins could not be determined.
- If no surgery of the primary site was performed, code 8.
- Code 9 if the pathology report makes no mention of margins.
- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0–C77.9), code 9.
- For an unknown or ill-defined primary site (C76.0–C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4, or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), code 9.

Code	Label	Definition
0	No residual tumor	All margins are grossly and microscopically negative.
1	Residual tumor, NOS	Involvement is indicated, but not otherwise specified.
2	Microscopic residual tumor	Cannot be seen by the naked eye.
3	Macroscopic residual tumor	Gross tumor of the primary site which is visible to the naked eye.
7	Margins not evaluable #214b	Cannot be assessed (indeterminate).
8	No primary site surgery	No surgical procedure of the primary site. Diagnosed at autopsy.
9	Unknown or not applicable #214b	It is unknown whether a surgical procedure to the primary site was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

Example:

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

#214b-Use code "9" if nothing is stated in the pathology report about the surgical margin. Use code "7" if the pathologist specifically states that the margins are not evaluable or indeterminate.

SCOPE OF REGIONAL LYMPH NODE SURGERY

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #1292
Revised 01/04, 09/08, 02/10, 01/11

ACR Required Data Item #215a

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

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

Instructions for Coding #215b

- The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
- Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item *Date of First Course of Treatment* (NAACCR Item #1270) and/or *Date of First Surgical Procedure* (NAACCR Item #1200) if applicable.
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- For intracranial and central nervous system primaries (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9, C75.1–C75.3), code 9.
- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0–C77.9), code 9.
- For an unknown or ill-defined primary site (C76.0–C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field *Surgical Procedure/Other Site* (NAACCR Item #1294).
- Refer to the current *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 Care* (NAACCR Item #3270).

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.

#215b-For cases diagnosed 1/1/2003, it is required to code SCOPE OF REGIONAL LYMPH NODE SURGERY (NAACCR Item #1292) and RX SUMM-SCOPE REG 98-02 (NAACCR Item #1647).

Code	Label	Definition
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.

Examples

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

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

SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY

ACR Required Data Item #217a

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #672
Revised 01/04, 09/08, 02/10

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

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

Instructions for Coding #217b

- The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
- If a surgical procedure which aspirates, biopsies, or removes regional lymph nodes to diagnose or stage this cancer, record the scope of regional lymph nodes surgery in this data item. Record the date of this surgical procedure in data item *Date of First Course of Treatment* (NAACCR Item #1270) and/or *Date of First Surgical Procedure* (NAACCR Item #1200) as appropriate.
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9, C75.1–C75.3), code 9.
- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0–C77.9), code 9.
- For all unknown or ill-defined primary sites (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. They are coded in the data field *Surgical Procedure/Other Site* (NAACCR Item #1294).
- Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.
- 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 at This Facility* (NAACCR Item #3280).

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.

#217b-For cases diagnosed 1/1/2003, it is required to code SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY (NAACCR Item #672) and RX HOSP-SCOPE REG 98-02 (NAACCR Item #747).

Code	Label	Definition
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.

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

SURGICAL PROCEDURE/OTHER SITE

Item Length: 1
Allowable Values: 0–5, 9
NAACCR Item #1294
Revised 01/04, 09/08, 01/10, 02/10

ACR Required Data Item #219a

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

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

Instructions for Coding See #220a

- If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific *Surgical Procedure of the Primary Site* (NAACCR Item #1290 or #670) code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s).*
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site." #219b
- *Surgical Procedure/Other Site* is collected for each surgical event even if surgery of the primary site was not performed.
- Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992).
- 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).

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 only.

#219b-Do not code tissue or organs such as an appendix that were removed incidentally, and the organ was not involved with cancer. Note: Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer. Examples of incidental removal of organ(s) would be removal of appendix, gallbladder, etc. during abdominal surgery.

Examples

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

#220a-For cases diagnosed before 1/1/2003, it is required to code SURGICAL PROCEDURE/OTHER SITE (NAACCR Item #1294) and RX SUMM-SURG OTH 98-02 (NAACCR Item #1648).

SURGICAL PROCEDURE/OTHER SITE AT THIS FACILITY

ACR Required Data Item #221a

Item Length: 1
Allowable Values: 0–5, 9
NAACCR Item #674
Revised 01/04, 01/10, 02/10

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

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

Instructions for Coding #221b

- If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific *Surgical Procedure of the Primary Site* (NAACCR Item #1290 or #670) code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s).*
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site." See #219b
- *Surgical Procedure/Other Site* is collected for each surgical event even if surgery of the primary site was not performed.
- Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992).
- 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).

Code	Label	Definition
0	None	No nonprimary surgical site resection was performed. Diagnosed at autopsy.
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	Nonprimary surgical procedure to other regional sites	Resection of regional site.
3	Nonprimary surgical procedure to *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 only.

#221b-For cases diagnosed before 1/1/2003, it is required to code SURGICAL PROCEDURE/OTHER SITE AT THIS FACILITY (NAACCR Item #674) and RX HOSP-SURG OTH 98-02 (NAACCR Item #748).

DATE OF SURGICAL DISCHARGE

Not Required by ACR #222a

Item Length: 8
NAACCR Item #3180
Revised 01/10, 01/11

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

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

Instructions for Coding

- Record the date the patient was discharged from the hospital following the event recorded in *Surgical Procedure of Primary Site* (NAACCR Item #1290).
- If the patient died following the event recorded in *Surgical Procedure of Primary Site* (NAACCR Item #1290), but before being discharged from the treating facility, then the *Date of Surgical Discharge* is the same as the date recorded in the data item *Date of Last Contact or Death* (NAACCR Item #1750).
- If the patient received out-patient surgery, then the date of surgical discharge is the same as the date recorded in the data item *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170).
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Surgical Discharge* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Surgical Discharge* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date Surg Disch Flag* (NAACCR ITEM #3181) is used to explain why *Date of Surgical Discharge* is not a known date. See *RX Date Surg Disch Flag* for an illustration of the relationships among these items. #222b

#222b-Collection, Storage, and Transmission of Date of Surgical Discharge
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#222c-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RX DATE SURG DISCH FLAG

Not Required by ACR #223a

Item Length: 2
NAACCR Item #3181
Valid Codes: 10-12, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Surgical Discharge* (NAACCR Item #3180).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Surgical Discharge* (NAACCR Item #3180) has a full or partial date recorded.
- Code 12 if the *Date of Surgical Discharge* can not be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave blank for cases diagnosed prior to January 1, 2003.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery was performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of Surgical Discharge* (NAACCR Item #3180). The case was diagnosed prior to January 1, 2003.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Surgical Discharge* (NAACCR Item #3180) and *Rx Date Surg Disch Flag* (NAACCR Item #3181). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date of Surgical Discharge**	**Interoperable Date of Surgical Discharge**	**Rx Date Surg Disch Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No primary site surgery performed	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, primary site surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

READMISSION TO THE SAME HOSPITAL WITHIN 30 DAYS OF SURGICAL DISCHARGE

Not Required by ACR #225a

Item Length: 1
Allowable Values: 0–3, 9
NAACCR Item #3190
Revised 06/05, 01/10

Description

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

Rationale

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

Instructions for Coding

- Consult patient record or information from the billing department to determine if a readmission to the same hospital occurred within 30 days of the date recorded in the item *Date of Surgical Discharge* (NAACCR Item #3180).
- Only record a readmission related to the treatment of this cancer.
- Review the treatment plan to determine whether the readmission was planned.
- If there was an unplanned admission following surgical discharge, check for an ICD-9-CM "E" code and record it, space allowing, as an additional *Comorbidities and Complications* (NAACCR Item #3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, 3124).
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.

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

Examples

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

REASON FOR NO SURGERY OF PRIMARY SITE ACR Required Data Item #226a

Item Length: 1
Allowable Values: 0–2, 5–9
Revised 01/04

NAACCR Item #1340

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

Rationale
This data item provides information related to the quality of care and describes why primary site surgery was not performed.

#226b-SEER Examples: Assign Code 1 when
•Patient elected to pursue no treatment following discussion of surgery. Discussion does not equal a recommendation.
•Watchful waiting/active surveillance (prostate)

Instructions for Coding #226b

- If *Surgical Procedure of Primary Site* (NAACCR Item #1290) is coded 00, 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.
- Code 8 if it is known that a physician recommended primary site surgery, but no further documentation is available yet to determine whether surgery was performed.
- 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, progression of tumor prior to planned surgery etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in patient record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

Examples

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

DATE RADIATION STARTED

ACR Required Data Item #227a

Item Length: 8
NAACCR Item #1210
Revised 06/05, 01/10, 01/11

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

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

Instructions for Coding

- If radiation therapy is the first or only treatment administered to the patient, then the date radiation started should be the same as the date entered into the item *Date of First Course of Treatment* (NAACCR Item #1270).
- The date when treatment started will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Radiation Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Radiation Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–Radiation Flag* (NAACCR ITEM #1211) is used to explain why *Date Radiation Started* is not a known date. See *RX Date–Radiation Flag* for an illustration of the relationships among these items. #227b

Examples

A patient has external beam radiation on December 15, 2003.	December 15, 2003
A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on October 12, 2003.	October 12, 2003
A patient enters the facility for interstitial radiation boost for prostate cancer that is performed on August 6, 2003. Just prior to this, the patient had external beam therapy to the lower pelvis that was started on June 2, 2003 at another facility.	June 2, 2003

#227b-Collection, Storage, and Transmission of Date Radiation Started
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#227c-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RX DATE–RADIATION FLAG

ACR Required Data Item #228a

Item Length: 2
NAACCR Item #1211
Valid Codes: 10-12, 15, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Started* (NAACCR Item #1210).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date Radiation Started* (NAACCR Item #1210) has a full or partial date recorded.
- Code 12 if the *Date Radiation Started* can not be determined, but the patient did receive first course radiation.
- Code 10 if it is unknown whether any radiation was given.
- Code 11 if no radiation is planned or given.
- Code 15 if radiation is planned, but has not yet started and the start date is not yet available. Follow this patient for radiation treatment and update this item, *Date Radiation Started*, and all other radiation items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given).
11	No proper value is applicable in this context (for example, no radiation given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (for example, radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item *Date Radiation Started* (NAACCR Item #1210).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Radiation Started* (NAACCR Item #1210) and *Rx Date–Radiation Flag* (NAACCR Item #1211). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date Radiation Started**	**Interoperable Date Radiation Started**	**Rx Date–Radiation Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any radiation given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No radiation given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, radiation given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Radiation not started yet	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

LOCATION OF RADIATION TREATMENT

Not Required by ACR #230a

Item Length: 1
Allowable Values: 0–4, 8, 9
NAACCR Item #1550
Revised 01/04

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

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

Instructions for Coding
If the radiation 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 radiation administered in the items *Palliative Care* (NAACCR Item #3270) and/or *Palliative Care at This Facility* (NAACCR Item #3280), as appropriate.

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

Examples

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

RX HOSP—RADIATION

ACR Required Data Item

Item Length: 1
Allowable Codes: 0, 1-5, 9
NAACCR Item #690

Description
Defines the type of radiation therapy the patient received as a part of the initial treatment for the reportable tumor at the reporting facility.

Rationale
Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Instructions for Coding
Code the type of radiation the patient received at the reporting facility.

0 None
1 Beam radiation
2 Radioactive implants (ACR Note- Includes radioembolization)
3 Radioisotopes
4 Combination of 1 with 2 or 3
5 Radiation, NOS—method or source not specified
9 Unknown if radiation therapy administered

Note #1: This data item continues to be required by SEER. Additionally, RMCDS feels that it may be beneficial to continue collecting radiation data in this field to facilitate comparison between historic data and new data.
Note #2: Coding of all first course treatment is required, whether given at the reporting facility or another facility.
Note #3: If radiation 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 radiation administered in the item Palliative Care (NAACCR Item #3280). See page 284.
Note #4: See *FORDS* p. 29 for definition of radioembolization.

Code	Definition
0	No radiation therapy was administered.
1	X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intraoperative radiation and stereotactic radiosurgery (gamma knife and proton beam).
2	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials (cesium, radium, radon, and radioactive gold).
3	Internal use of radioactive isotopes (iodine-131, phosphorus-33, strontium 89 and 90). Can be administered orally, intracavitary, or by intravenous injection.
4	The patient was treated with a combination of beam radiation and at least one of the two methods described by codes 2 and 3.
5	Radiation was administered, but the method or source is not documented (radiation therapy, NOS).
9	No confirmation if radiation was recommended or performed (frequently non-analytic cases); unknown if radiation therapy administered. Death certificate cases only.

RX SUMM—RADIATION

ACR Required Data Item

Item Length: 1
Allowable Codes: 0, 1-5, 9
NAACCR Item #1360

Description
Defines the type of radiation therapy the patient received as a part of the initial treatment for the reportable tumor.

Rationale
Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Instructions for Coding
Code the type of radiation the patient received at this and all other facilities.

0 None
1 Beam radiation
2 Radioactive implants (ACR Note- Includes radioembolization)
3 Radioisotopes
4 Combination of 1 with 2 or 3
5 Radiation, NOS—method or source not specified
9 Unknown if radiation therapy administered

Note#1: This data item continues to be required by SEER. Additionally, RMCDS feels that it may be beneficial to continue collecting radiation data in this field to facilitate comparison between historic data and new data.
Note #2: Coding of all first course treatment is required, whether given at the reporting facility or another facility.
Note #3: If radiation 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 radiation administered in the item Palliative Care (NAACCR Item #3270). See pages 282-283.
Note #4: See *FORDS* p. 29 for definition of radioembolization.

Code	Definition
0	No radiation therapy was administered.
1	X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intraoperative radiation and stereotactic radiosurgery (gamma knife and proton beam).
2	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials (cesium, radium, radon, and radioactive gold).
3	Internal use of radioactive isotopes (iodine-131, phosphorus-33, strontium 89 and 90). Can be administered orally, intracavitary, or by intravenous injection.
4	The patient was treated with a combination of beam radiation and at least one of the two methods described by codes 2 and 3.
5	Radiation was administered, but the method or source is not documented (radiation therapy, NOS).
9	No confirmation if radiation was recommended or performed (frequently non-analytic cases); unknown if radiation therapy administered. Death certificate cases only.

RX TEXT—RADIATION (BEAM)

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2620

Description
Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions for Coding
Enter the following information in narrative format:

- Date radiation treatment began
- Where treatment was given (e.g. name of this facility or another facility)
- Type of beam radiation (e.g. orthovoltage, Cobalt 60, Electrons, Mixed modalities)
- Other treatment information (e.g. discontinued after ## treatments, unknown if given)

Note #1: See Appendix E for acceptable abbreviations.

Note #2: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #3: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

RX TEXT—RADIATION (OTHER)

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2630

Description
Text area for manual documentation of information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions for Coding
Enter the following information in narrative format:

- Date treatment was started
- Where radiation was done (e.g. name of this facility or another facility)
- Type of non-beam radiation (e.g. High Dose rate brachytherapy, seed implant, radioembolization)
- Other treatment information

Note #1: See Appendix E for acceptable abbreviations.

Note #2: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #3: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

RADIATION TREATMENT VOLUME

Not Required by ACR #231a

Item Length: 2
Allowable Values: 00–41, 50, 60, 98, 99
NAACCR Item #1540
Revised 01/04, 01/11

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

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

Instructions for Coding
- Radiation treatment volume will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact treatment volume may require assistance from the radiation oncologist for consistent coding.
- If two discrete volumes are treated and one of those includes the primary site, record the treatment to the primary site.

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.

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

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

Examples

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

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

CODING RX HOSP/SUMM-RADIATION and REGIONAL AND BOOST TREATMENT MOD.

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). ***2010 SEER Program Coding and Staging Manual*****. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD**

The tables below are intended to assist registrars in coding the Rx—Hosp Radiation item (NAACCR Item #690)/ Rx-Summ Radiation item (NAACCR Item #1360) and the items Regional Treatment Modality (NAACCR Item # 1570) and Boost Treatment Modality (NAACCR Item #3200). These items are inter-related; they all refer to the energy source/type that is used for radiation treatment.

Translation of Regional Treatment Modality and/or Boost Treatment Modality Field to Radiation
*January 1, 2003 and later cases: Record only the dominant modality if multiple radiation therapy modalities were employed in the treatment of the patient.

RADIATION	CODE	REGIONAL TREATMENT MODALITY AND/OR BOOST TREATMENT
0 None	00	No radiation
1 Beam radiation	20	External beam, NOS
	21	Orthovoltage
	22	Cobalt-60, Cesium-137
	23	Photons (2-5 MV)
	24	Photons (6-10 MV)
	25	Photons (11-19 MV)
	26	Photons (> 19 MV)
	27	Photons (Mixed energies)
	28	Electrons
	29	Protons and electrons mixed
	30	Neutrons, with or without protons/ electrons
	31	IMRT
	32	Conformal or 3-D therapy
	40	Protons
	41	Sterotactic radiosurgery, NOS
	42	Linac radiosurgery
	43	Gamma knife
2 Radioactive implants	50	Brachytherapy, NOS
	51	Brachytherapy, intracavitary, LDR
	52	Brachytherapy, intracavitary, HDR
	53	Brachytherapy, interstitial, LDR
	54	Brachytherapy, interstitial, HDR
	55	Radium
3 Radioisotopes	60	Radioisotopes, NOS
	61	Strontium-89
	62	Strontium-90
4 Combination of 1 with 2 or 3	80 (Pre-2003) *	Combination modality, specified
	85 (Pre-2003) *	Combination modality, NOS
5 Radiation therapy, NOS, method or source unspecified	98	Other, NOS
9 Unknown	99	Unknown

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ACR Supplement Page

REGIONAL TREATMENT MODALITY

Item Length: 2
Allowable Values: 00, 20–32, 40–43, 50–55, 60–62, 98, 99
NAACCR Item #1570
Revised 09/06, 09/08, 01/11

ACR Required Data Item #235a

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. #235b-See *ACR Supplement* p. 234A.

Rationale
Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important. #235c-If radiation 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 radiation administered in the item Palliative Care (NAACCR Item #3270 & #3280). See *FORDS* pages 282-284.

Instructions for Coding

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.
- Note that in some circumstances the boost treatment may precede the regional treatment.
- For purposes of this data item, photons and x-rays are equivalent.
- Code IMRT or conformal 3D whenever either is explicitly mentioned.
- Code radioembolization as brachytherapy. #235d-See *FORDS* p. 29 for definition of radioembolization.

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

Code	Label	Definition
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, 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	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Examples

Code	Reason
00	A patient was treated for melanoma with PUVA (psoralen and long-wave ultraviolet radiation). Code this treatment as *Other Treatment* (NAACCR Item #14200, code 1.
20	A patient with prostate carcinoma receives pelvic irradiation at the reporting facility, and is then referred to a major medical center for experimental proton therapy boost.
24	A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days. This is followed by 6 MV photon treatment of the entire breast. In this case, the "boost" precedes the regional treatment.
25	In an experimental program, a patient with as Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.
25	Patient receives 15 MV external pelvic treatment to 4,500 cGy for cervical carcinoma, and then receives two Fletcher intracavitary implants.
29	A patient with carcinoma of the parotid receives daily treatments of which 60% are delivered by 15 MV photons and 40% of the dose is delivered by 16 MV electrons.
53	A prostate cancer patient is treated with I-125 seeds. I-125 is low dose brachytherapy.
98	A patient with a head and neck cancer underwent regional radiation treatment elsewhere and was referred to reported facility for an HDR brachytherapy boost. Detailed treatment records from the other facility are not available.

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

REGIONAL DOSE: cGy

Not Required by ACR #238a

Item Length: 5
Right Justified, Zero-filled
NAACCR Item #1510
Revised 01/04

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

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

Instructions for Coding

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

Code	Definition
(fill spaces)	Record the actual regional dose delivered.
00000	Radiation therapy was not administered. 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.

Examples

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

BOOST TREATMENT MODALITY

Item Length: 2
Allowable Values: 00, 20–32, 40–43, 50–55, 60–62, 98, 99
NAACCR Item #3200
Revised 01/04, 09/08

Not Required by ACR #239a

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

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

Instructions for Coding #239b-See *ACR Supplement* p. 234A.

- 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 radioembolization as brachytherapy. #239c-See *FORDS* p. 29 for definition of radioembolization.

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.

Code	Label	Definition
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, 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.

Examples

Code	Reason
29	A patient with carcinoma of the tonsil receives 4,500 cGy to the head and neck region with 6 MV photons. The primary site and involved regional lymph nodes are then boosted, ie, taken to a maximum dose of 7,400 cGy, using a sequence of beam arrangements involving 6 MV photons, 15 MV photons, and 12 MV electrons.
30	In an experimental program, a patient with Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.

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

BOOST DOSE: cGy

Not Required by ACR #242a

Item Length: 5
Right Justified, Zero-filled
NAACCR Item #3210
Revised 06/05

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

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

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

Code	Definition
(fill spaces)	Record the actual boost dose delivered.
00000	Boost dose therapy was not administered. Diagnosed 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.

Examples

Code	Reason
02000	A patient with Stage III prostate carcinoma receives pelvic irradiation to 5,000 cGy followed by a conformal prostate boost to 7,000 cGy. Record the prescribed (and delivered) boost dose, 2,000 cGy (7,000 cGy minus 5,000 cGy).
00000	A patient with a left supraclavicular metastasis from a gastric carcinoma receives 6,000 cGy to the left supraclavicular region. The dose is calculated at a prescribed depth of 3 cm. A secondary calculation shows a D_{max} dose (dose at depth of maximum dose) of 6,450 cGy. Do not confuse D_{max} doses with boost doses. In this case, there is no planned boost. Record the boost dose as 00000 cGy.
88888	A patient with a Stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the central axis dose in the breast to 5,040 cGy. The supraclavicular lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm, and an interstitial boost in the primary tumor bed is delivered to a small volume in the breast. Record the boost dose as 88888. Note that standards for describing an interstitial or intracavitary treatment with a single number are somewhat variable.

NUMBER OF TREATMENTS TO THIS VOLUME

Item Length: 3
Allowable Values: 000–999
Right Justified, Zero-filled
NAACCR Item #1520
Revised 09/04, 01/10, 05/10

Not Required by ACR #243a

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

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

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

Code	Label	Definition
000	None	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
001–998	Number of treatments	Total number of treatment sessions administered to the patient.
999	Unknown	Radiation therapy was administered, but the number of treatments is unknown. Or, it is unknown whether radiation therapy was administered. Death certificate only.

Examples

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

RADIATION/SURGERY SEQUENCE

Item Length: 1
Allowable Values: 0, 2–6, 9
NAACCR Item #1380
Revised 01/04, 01/10, 01/11

ACR Required Data Item #244a

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

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

Instructions for Coding #244b

- 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, or it is not know whether the patient received both surgery and radiation, then this item should be coded 0.
- If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *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 therapy and/or surgical procedures	No radiation therapy given or unknown if radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s) or it is unknown whether any surgery given.
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	Radiation therapy both before and after surgery	At least two courses of radiation therapy are given, before and after any surgery, to the primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before 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.

#244b-Per the CoC: "The definitions of codes 0 and 9 for Radiation/Surgery Sequence and Systemic/Surgery Sequence have been changed for consistency with SEER. For cases diagnosed in 2010 or later, use code 0 (not 9) if it is unknown whether the patient was treated with either surgery or systemic therapy. This change in coding instructions applies only to cases diagnosed in 2010 or later."

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

DATE RADIATION ENDED

Item Length: 8
NAACCR Item #3220
Revised 06/05, 01/10, 01/11

Not Required by ACR #246a

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

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

Instructions for Coding
- The date when treatment ended will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- For brachytherapy if the treatment is applied only once, this date will be the same as *Date Radiation Started* (NAACCR Item #1210).
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Radiation Ended* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Radiation Ended* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–Radiation Flag* (NAACCR Item #1211) is used to explain why *Date Radiation Ended* is not a known date. See *RX Date–Radiation Flag* for an illustration of the relationships among these items. #246b

Examples

A patient starts IMRT radiation treatment on December 15, 2004 and treatment continues until January 4, 2005.	January 4, 2005
A patient receives one radiation treatment on October 2, 2009, then refuses further treatments.	October 2, 2009
A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on April 4, 2006.	April 4, 2006

#246b-Collection, Storage, and Transmission of Date Radiation Ended
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#246c-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RX DATE RAD ENDED FLAG

Not Required by ACR #247a

Item Length: 2
NAACCR Item #3221
Valid Codes: 10-12, 15, Blank
New Item: 01/2010, revised 02/10, 03/10

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Ended* (NAACCR Item #3200).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions
- Leave this item blank if *Date Radiation Ended* (NAACCR Item #3200) has a full or partial date recorded.
- Code 12 if the *Date Radiation Ended* can not be determined, but the patient did receive first course radiation.
- Code 10 if it is unknown whether any radiation was given.
- Code 11 if no radiation is planned or given..
- Code 15 if radiation is ongoing. Follow this patient for radiation treatment and update this item, *Date Radiation Ended*, and all other radiation items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given).
11	No proper value is applicable in this context (for example, no radiation was administered).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, radiation therapy had begun at the time of the most recent follow-up but was not yet completed).
(blank)	A valid date value is provided in item *Date Radiation Ended* (NAACCR Item #3200).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Radiation Ended* (NAACCR Item #3200) and *Rx Date Rad Ended Flag* (NAACCR ITEM #3201). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date Radiation Ended**	**Interoperable Date Radiation Ended**	**Rx Date–Rad Ended Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any radiation given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No radiation given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, radiation given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Radiation is ongoing	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

REASON FOR NO RADIATION

ACR Required Data Item #249a
Required for cases diagnosed on or after 1/1/2011.

Item Length: 1
Allowable Values: 0–2, 5–9
NAACCR Item #1430
Revised 09/04

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

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

Instructions for Coding
- If *Regional Treatment Modality* (NAACCR Item #1570) is coded 00, then record the reason based on documentation in patient record.
- Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include radiation therapy.
- Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.
- Code 8 to indicate referral to a radiation oncologist was made and the registry should follow to determine whether radiation was administered. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, code 1.
- 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, progression of tumor prior to planned radiation etc.).
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate and autopsy cases only.

Example

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

DATE SYSTEMIC THERAPY STARTED

Item Length: 8
NAACCR Item #3230
Revised 01/10, 01/11

ACR Required Data Item #250a

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

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

Instructions for Coding
- Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes *Chemotherapy* (NAACCR Item #1390), *Hormone Therapy* (NAACCR Item #1400), *Immunotherapy* (NAACCR Item #1410), and *Hematologic Transplant and Endocrine Procedures* (NAACCR Item #3250).
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Systemic Therapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Systemic Therapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date Systemic Flag* (NAACCR Item #1231) is used to explain why *Date Systemic Therapy Started* is not a known date. See *RX Date Systemic Flag* for an illustration of the relationships among these items. #250b

Examples

A patient with breast cancer begins her regimen of chemotherapy on December 15, 2003, and is subsequently given Tamoxifen on January 20, 2004.	December 15, 2003
A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2003. He is then started on a regime of hormonal agents on June 9, 2003.	June 2, 2003

#250b-Collection, Storage, and Transmission of Date Systemic Therapy Started
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#250c-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RX DATE SYSTEMIC FLAG

Item Length: 2
NAACCR Item #3231
Valid Codes: 10-12, 15, Blank
New Item: 01/2010

ACR Required Data Item #251a

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Systemic Therapy Started* (NAACCR Item #3230).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions
- Leave this item blank if *Date Systemic Therapy Started* (NAACCR Item #3230) has a full or partial date recorded.
- Code 12 if the *Date Systemic Therapy Started* can not be determined, but the patient did receive first course systemic therapy.
- Code 10 if it is unknown whether any systemic therapy was given.
- Code 11 if no systemic therapy is planned or given.
- Code 15 if systemic therapy is planned, but not yet started. Follow this patient for systemic therapy and update this item, *Date Systemic Therapy Started*, and all relevant systemic therapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any systemic therapy was given).
11	No proper value is applicable in this context (for example, no systemic therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, systemic therapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, systemic therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *Date Systemic Therapy Started* (NAACCR Item #3230).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Systemic Therapy Started* (NAACCR Item #3230) and *Rx Date Systemic Flag* (NAACCR Item #3201). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date Systemic Therapy Started**	**Interoperable Date Systemic Therapy Started**	**Rx Date Systemic Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any systemic therapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No systemic therapy given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, systemic therapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Systemic therapy is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

RX TEXT—CHEMO

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2640

Description
Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions for Coding
Enter the following information in narrative format:

- Date when chemotherapy began
- Where treatment was given (e.g. at this facility or another facility)
- Type of chemotherapy (e.g., name of agent(s) or protocol, chemoembolization procedure)
- Other treatment information (e.g. treatment cycle incomplete, unknown if given)

Note #1: See Appendix E for acceptable abbreviations.

Note #2: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #3: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

Note #4: Text documentation should include when chemotherapy is recommended or not recommended and reasons why, documentation should also include if patient refuses treatment or if none was given.

CHEMOTHERAPY DEFINITIONS & CODING CLARIFICATIONS

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

Chemotherapeutic Agents

Chemotherapeutic agents are chemicals that affect cancer tissue by means other than hormonal manipulation. Chemotherapeutic agents can be divided into five groups
•Alkylating agents
•Antimetabolites
•Natural Products
•Targeted therapy
•Miscellaneous

Alkating Agents
Alkylating agents are **not cell-cycle-specific**. Although they are toxic to all cells, they are most active in the resting phase of the cell. Alkylating agents directly damage DNA to prevent the cancer cell from reproducing.
Antimetabolites
Antimetabolites are **cell-cycle-specific**. Antimetabolites are very similar to normal substances within the cell. When the cells incorporate these substances into the cellular metabolism, they are unable to divide. Antimetabolites are classified according to the substances with which they interfere.
Natural Products
Plant Alkaloids are **cell-cycle phase-specific** which means they attack the cells during various phases of division. They block cell division by preventing microtubule function. Microtubules are vital for cell division. Without them, division cannot occur. Plant alkaloids, as the name implies, are derived from certain types of plants.
Target therapy
Targeted therapy agents are a group of newer cancer drugs that act directly against abnormal proteins in cancer cells.
Miscellaneous
Miscellaneous Antineoplastics that are unique (i.e. Ribonuclotide reductase inhibitor: Hydroxyurea).

Definitions

Chemotherapy recommended: Consult recommended chemotherapy, or the attending physician documented that chemotherapy was recommended. A referral to a clinical oncologist is equivalent to a recommendation.

Multiple agent chemotherapy: Planned first course of therapy included two or more chemotherapeutic agents and those agents were administered. The planned first course of therapy may or may not have included other agents such as hormone therapy, immunotherapy, or other treatment in addition to the chemotherapeutic agents.

Single agent chemotherapy: Only one chemotherapeutic agent was administered to destroy cancer tissue during the first course of therapy. The chemotherapeutic agent may or may not have been administered with other drugs classified as immunotherapy, hormone therapy, ancillary, or other treatment.

CHEMOTHERAPY CONTINUED

Coding Instructions

1. Code the chemotherapeutic agents whose actions are chemotherapeutic only; **do not code** the method of **administration.**

2. When chemotherapeutic agents are used as radiosensitizers or radioprotectants, they are given at a much lower dosage and do not affect the cancer. Radiosensitizers and radioprotectants are classified as ancillary drugs. **Do not code as chemotherapy**.

Note: Do not assume that a chemo agent given with radiation therapy is a radiosensitizer. See additional information. Compare the dose given to the dose normally given for treatment.
For additional information, see: The National Cancer Institute's Physician Data Query (PDQ), Health Professional Version http://www.cancer.gov/cancertopics/pdq And/Or The National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology http://www.nccn.org/professionals/physician_gls/f_guidelines.asp.

3. The physician may change a drug during the first course of therapy because the patient cannot tolerate the original agent.

a. This is a continuation of the first course of therapy when the chemotherapeutic agent that is substituted belongs to the same group (Alkylating, antimetabolites, natural products, or other miscellaneous).

b. Do **not** code the new agent as first course therapy when the original chemotherapeutic agent is changed to one that is NOT in the same group. Code only the original agent as first course.

4. Code as treatment for both primaries when the patient receives chemotherapy and has in situ carcinoma in one breast and inflammatory in the other breast. Chemotherapy would likely affect both primaries.

5. Assign **code 00** when

a. There is no information in the patient's medical record about chemotherapy **AND**
i. It is known that chemotherapy is not usually performed for this type and/or stage of cancer **OR**
ii. There is no reason to suspect that the patient would have had chemotherapy.

b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include chemotherapy.

c. Patient elects to pursue no treatment following the discussion of chemotherapy. Discussion does not equal a recommendation.

d. Watchful waiting/active surveillance (CLL).

e. Patient diagnosed at autopsy.

Example: Patient is diagnosed with multiple myeloma. There is no mention of treatment or treatment plans in the medical record. Follow-back finds that the patient died three months after diagnosis. There are not additional medical records or other pertinent information available. Assign code 00 since there is no reason to suspect that the patient had been treated.

CHEMOTHERAPY CONTINUED

Coding Instructions Continued

6. Do not code combination of ancillary drugs administered with single agent chemotherapeutic agents as multiple chemotherapy. For example the administration of 5-FU (antimetabolite) and Leucovorin (ancillary drug) is coded to single agent (Code 02).

7. Assign **code 82** when chemotherapy is a customary option for the primary site/histology but it was not administered due to patient risk factors, such as:

a. Advanced **age**.

b. **Cormorbid** condition(s) (heart disease, kidney failure, other cancer, etc.).

8. Assign **code 88** when the only information available is

a. The patient was referred to an oncologist

b. Insertion of port-a-cath

Note: Review cases coded 88 periodically for later confirmation of chemotherapy

9. Assign **code 99** when there is no documentation that chemotherapy was recommended or administered.

DATE CHEMOTHERAPY STARTED

Item Length: 8
NAACCR Item #1220
Revised: 01/11

ACR Required Data Item #253a

Description
Records the date of initiation of chemotherapy that is part of the first course of treatment.

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

Instructions for Coding
- Record the first or earliest date on which chemotherapy was administered by any facility. This date corresponds to administration of the agents coded in *Chemotherapy* (NAACCR Item #1390).
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Chemotherapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Chemotherapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–Chemo Flag* (NAACCR Item #1221) is used to explain why *Date Chemotherapy Started* is not a known date. See *RX Date–Chemo Flag* for an illustration of the relationships among these items. #253b

#253b-Collection, Storage, and Transmission of Date Chemotherapy Started
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#253c-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RX DATE–CHEMO FLAG

ACR Required Data Item #254a

Item Length: 2
NAACCR Item #1221
Valid Codes: 10-12, 15, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Chemotherapy Started* (NAACCR Item #1220).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions
- Leave this item blank if *Date Chemotherapy Started* (NAACCR Item #1220) has a full or partial date recorded.
- Code 12 if the *Date Chemotherapy Started* can not be determined, but the patient did receive first course chemotherapy.
- Code 10 if it is unknown whether any chemotherapy was given.
- Code 11 if no chemotherapy is planned or given.
- Code 15 if chemotherapy is planned, but not yet started. Follow this patient for chemotherapy and update this item, *Date Chemotherapy Started*, and the relevant chemotherapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 (inclusive) if this facility did not collect *Date Chemotherapy Started* at that time.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any chemotherapy was given).
11	No proper value is applicable in this context (for example, no chemotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, chemotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *Date Chemotherapy Started* (NAACCR Item #1220). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Chemotherapy Started* (NAACCR Item #1220) at that time.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Chemotherapy Started* (NAACCR Item #1220) and *Rx Date–Chemo Flag* (NAACCR Item #1221). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date Chemotherapy Started**	**Interoperable Date Chemotherapy Started**	**Rx Date–Chemo Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any chemotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No chemotherapy given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, chemotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Chemotherapy is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

CHEMOTHERAPY

Item Length: 2
Allowable Values: 00–03, 82, 85–88, 99
NAACCR Item #1390
Revised 06/05, 09/08, 01/10

ACR Required Data Item #256a

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

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

Instructions for Coding #256b-See additional definitions and coding instructions *ACR Supplement* pp. 252B-252D.

- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration
- Code 88 to indicate referral was made medical oncologist and the registry must follow to determine whether it was given. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.
- Cases coded 88 must be followed to determine what kind of chemotherapy was administered or why it was not.
- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.
- Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved. #256c
- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and *only the original agent or regimen is recorded as first course therapy*.
- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of chemotherapeutic agents. See #257a
- 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).

#256c-See *FORDS* p. 29 for definition for chemoembolization.

Code	Definition
00	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multiagent chemotherapy administered as first course therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age progression of tumor prior to administration, etc.).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.

Code	Definition
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

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

#257a-For cases diagnosed prior to 1/1/2005, use *SEER Book 8*. The S*EER*Rx Database* is effective for cases diagnosed on or after 1/1/2005. Version 1.1.0 was used for cases diagnosed 1/1/2005 through 12/31/2006. Version 1.2.0 was used for cases diagnosed beginning 1/1/2007. Version 1.3.0 was used beginning on the date of distribution, 5/29/09. Version 1.4.0 was used beginning on the date of distribution, 01/2010, and was followed with an update to Version 1.4.1 in 01/2010 to correct an error. Version 1.5.0 was released in 09/2010.

CHEMOTHERAPY AT THIS FACILITY

ACR Required Data Item #258a

Item Length: 2
Allowable Values: 00–03, 82, 85–88, 99
NAACCR Item #700
Revised 06/05, 09/08, 01/10

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

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

Instructions for Coding #258b-See additional definitions and coding instructions *ACR Supplement* pp. 252B-252D.

- Record only chemotherapy received at this facility. Do not record agents administered at other facilities.
- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration
- Cases coded 88 must be followed to determine what kind of chemotherapy was administered or why it was not.
- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.
- Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved. #258c
- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and *only the original agent or regimen is recorded as first course therapy*.
- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of chemotherapeutic agents. See #259a
- 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).

#258c-See *FORDS* p. 29 for definition for chemoembolization.

Code	Definition
00	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as first course therapy; but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multiagent chemotherapy administered as first course therapy
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of tumor prior to planned administration).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.

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

#259a-For cases diagnosed prior to 1/1/2005, use *SEER Book 8*. The S*EER*Rx Database* is effective for cases diagnosed on or after 1/1/2005. Version 1.1.0 was used for cases diagnosed 1/1/2005 through 12/31/2006. Version 1.2.0 was used for cases diagnosed beginning 1/1/2007. Version 1.3.0 was used beginning on the date of distribution, 5/29/09. Version 1.4.0 was used beginning on the date of distribution, 01/2010, and was followed with an update to Version 1.4.1 in 01/2010 to correct an error. Version 1.5.0 was released in 09/2010.

DATE HORMONE THERAPY STARTED

Item Length: 8
NAACCR Item #710 NAACCR #1230
Revised: 01/11

ACR Required Data Item #260a

Description
Records the date of initiation of hormone therapy that is part of the first course of treatment.

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

Instructions for Coding
- Record the first or earliest date on which hormone therapy was administered by any facility. This date corresponds to administration of the agents coded in *Hormone Therapy* (NAACCR Item #1390).
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Hormone Therapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Hormone Therapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–Hormone Flag* (NAACCR Item #1231) is used to explain why *Date Hormone Therapy Started* is not a known date. See *RX Date–Hormone Flag* for an illustration of the relationships among these items. #260b

#260b-Collection, Storage, and Transmission of Date Hormone Therapy Started
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#260c-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RX DATE–HORMONE FLAG

ACR Required Data Item #261a

Item Length: 2
NAACCR Item #1231
Valid Codes: 10-12, 15, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Hormone Therapy Started* (NAACCR Item #1230).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions
- Leave this item blank if *Date Hormone Therapy Started* (NAACCR Item #1230) has a full or partial date recorded.
- Code 12 if the *Date Hormone Therapy Started* can not be determined, but the patient did receive first course hormone therapy.
- Code 10 if it is unknown whether any hormone therapy was given.
- Code 11 if no hormone therapy is planned or given.
- Code 15 if hormone therapy is planned, but not yet started. Follow this patient for hormone therapy and update this item, *Date Hormone Therapy Started*, and the relevant hormone therapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 if this facility did not collect *Date Hormone Therapy Started* at that time.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any hormone therapy was given).
11	No proper value is applicable in this context (for example, no hormone therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, hormone therapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, hormone therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *Date Hormone Therapy Started* (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Hormone Therapy Started* (NAACCR Item #1230) at that time.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Hormone Therapy Started* (NAACCR Item #1230) and *Rx Date–Hormone Flag* (NAACCR Item #1231). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date Hormone Therapy Started**	**Interoperable Date Hormone Therapy Started**	**Rx Date–Chemo Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any hormone therapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No hormone therapy given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, hormone therapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Hormone therapy is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

RX TEXT—HORMONE

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2650

Description
Text area for information hormonal cancer-directed treatment.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions for Coding
Enter the following information in narrative format:

- Date treatment started
- Where treatment was given
- Type of hormone or antihormone
- Type of endocrine surgery or radiation (e.g. orchiectomy)
- Other treatment information (e.g. treatment cycle incomplete, unknown if given)

Note #1: See Appendix E for acceptable abbreviations.

Note #2: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #3: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

Note #4: Text documentation should include when hormone treatment is recommended or not recommended and reasons why, documentation should also include if patient refuses treatment or if none was given.

HORMONE THERAPY DEFINITIONS & CODING CLARIFICATIONS

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). ***2010 SEER Program Coding and Staging Manual*****. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD**

Hormones may be divided into several categories:
•Androgens: Fluoxymesterone
•Anti-androgens: Bicalutamide (Casodex), flutamide (Eulexin), and nilutamde (Nilandron)
•Corticosteroids: Adrenocorticotrophic agents
•Estrogens
•Progestins
•Estrogen antagonists, Anti-estrogens: Fulvestrant (Faslodex), tamoxifen, and toremifene (Fareston).
•Aromatase inhibitors, Antiaromatase: Anastrozole (arimidex), exemestane (Aromasin), and letrozole (Femara)
•GnRH or LH-RH: Lupron, Zoladex

Coding Instructions
1. Code the hormonal agent given as part of combination chemotherapy (e.g. MOPP or COPP), whether it affects the cancer cells or not.

2. Assign **code 00** when
a. There is no information in the patient's medical record about hormone therapy **AND**
i. It is known that hormone therapy is not usually performed for this type and/or stage of cancer **OR**
ii. There is no reason to suspect that the patient would have had hormone therapy
b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include hormone therapy
c. Patient elects to pursue no treatment following the discussion of hormone therapy treatment. Discussion does not equal a recommendation.
d. Watchful waiting, active surveillance (prostate)
e. Patient diagnosed at autopsy
f. Hormone treatment was given for a non-reportable condition or as chemoprevention prior to diagnosis of a reportable condition
Example 1: Tamoxifen given for hyperplasia of breast four years prior to breast cancer diagnosis. Code 00 in Hormone therapy. Do not code tamoxifen given for hyperplasia as treatment for breast cancer.
Example 2: Patient with a genetic predisposition to breast cancer is on preventive hormone therapy. Do not code hormone therapy given before cancer is diagnosed.

3. Assign **code 88** when the only information available is that the patient was referred to an oncologist.
Note: Review cases coded 88 periodically for later confirmation of hormone therapy.

4. Assign **code 99 when** there is no documentation that hormone therapy was recommended or performed

Coding Examples
Example 1: Endometrial cancer may be treated with progesterone. Code all administration of progesterone to patients with endometrial cancer in this field. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer.
Example 2: **Follicular** and **papillary** cancers of the **thyroid** are often treated with thyroid hormone to suppress serum thyroid-stimulation hormone (TSH). If a patient with papillary and/or follicular cancer of the thyroid is given a thyroid hormone, code the treatment in this field.
Example 3: Bromocriptine suppresses the production of prolactin, which causes growth in pituitary adenoma. Code Bromocriptine as hormone treatment for pituitary adenoma.

CODING GUIDELINES FOR HORMONE THERAPY FOR THYROID GLAND

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). ***2010 SEER Program Coding and Staging Manual*****. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD**

Code Hormone Therapy as 01 for follicular and/or papillary thyroid cancer when thyroid hormone therapy is given.

Do not code replacement therapy as treatment **unless** the tumor is papillary and/or follicular. The thyroid gland produces hormones that influence essentially every organ, tissue and cell in the body. When the thyroid is partially or totally removed, it is no longer able to secrete these essential hormones and the patient is placed on hormone replacement therapy.

The growth of follicular cell cancer depends on thyroid stimulating hormone. Suppression of these hormones is thought to deprive the cells of a growth-promoting influence. Patients with follicular cellderived cancers have been treated with supraphysiologic doses of thyroid hormone to suppress serum thyroid-stimulating hormones. This treatment has been an industry standard for more than forty years.

<u>Generic Thyroid Drug Names</u>
Levothyroxine /L-thyroxine
Liothyronine
Liotrix
Methimazole
Natural Thyroid
Propylthiouracil / PTU
Thyrotropin alfa

<u>Thyroid Drugs Brand Names</u>
Armour Thyroid
Cytomel
Levothroid
Levoxyl
Naturethroid
Synthroid
Tapazole
Thyrogen
Thyrolar
Unithroid
Westhroid

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ACR Supplement Page

HORMONE THERAPY
(HORMONE/STEROID THERAPY)

ACR Required Data Item #263a

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #1400
Revised 06/05, 09/08, 01/10

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

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

Instructions for Coding #263b-See additional definitions and coding instructions *ACR Supplement* pp. 262B & 262C.

- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth. #263c-See *ACR Supplement* p. 262C.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate the patient was referred to a medical oncologist and the registry should follow the case for hormone therapy. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.
- Cases coded 88 should be followed to determine whether they received hormone therapy or why not.
- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of hormonal agents. See #264a
- 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).

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

Examples

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

#264a-For cases diagnosed prior to 1/1/2005, use *SEER Book 8*. The S*EER*Rx Database* is effective for cases diagnosed on or after 1/1/2005. Version 1.1.0 was used for cases diagnosed 1/1/2005 through 12/31/2006. Version 1.2.0 was used for cases diagnosed beginning 1/1/2007. Version 1.3.0 was used beginning on the date of distribution, 5/29/09. Version 1.4.0 was used beginning on the date of distribution, 01/2010, and was followed with an update to Version 1.4.1 in 01/2010 to correct an error. Version 1.5.0 was released in 09/2010.

HORMONE THERAPY AT THIS FACILITY (HORMONE/STEROID THERAPY)

ACR Required Data Item #265a

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #710
Revised 06/05, 09/08, 01/10

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

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

Instructions for Coding #265b-See additional definitions and coding instructions *ACR Supplement* pp. 262B & 262C.

- Record only hormone therapy received at this facility. Do not record procedures done at other facilities.
- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth. #265c-See *ACR Supplement* p. 262C.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.
- Cases coded 88 should be followed to determine whether they received hormone therapy or why not.
- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of hormonal agents. See #266a
- 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).

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

Code	Definition
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

#266a-For cases diagnosed prior to 1/1/2005, use *SEER Book 8*. The S*EER*Rx Database* is effective for cases diagnosed on or after 1/1/2005. Version 1.1.0 was used for cases diagnosed 1/1/2005 through 12/31/2006. Version 1.2.0 was used for cases diagnosed beginning 1/1/2007. Version 1.3.0 was used beginning on the date of distribution, 5/29/09. Version 1.4.0 was used beginning on the date of distribution, 01/2010, and was followed with an update to Version 1.4.1 in 01/2010 to correct an error. Version 1.5.0 was released in 09/2010.

RX TEXT—BRM

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2660

Description
Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions for Coding
Enter the following information in narrative format:

- Date treatment started
- Type of BRM agent (e.g. Interferon, BCG)
- BRM Procedures (e.g. bone marrow transplant)
- Other treatment information (e.g. treatment cycle incomplete, unknown if given)

Note #1: See Appendix E for acceptable abbreviations.

Note #2: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #3: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

Note #4: Text documentation should include when BRM treatment is recommended or not recommended and reasons why, documentation should also include if patient refuses treatment or if none was given.

Note #5: This data item should also be used to document text for Hematologic Transplant and Endocrine Procedures.

IMMUNOTHERAPY DEFINITIONS & CODING CLARIFICATIONS

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). ***2010 SEER Program Coding and Staging Manual*****. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD**

Immunotherapy is designed to:

1. Make **cancer cells** more **recognizable** and therefore more **susceptible** to destruction by the immune system.
2. **Boost** the killing power of **immune** system cells, such as T-cells, NK-cells, and macrophages.
3. **Alter** the **growth patterns** of cancer cells to promote behavior like that of healthy cells.
4. **Block** or **reverse** the process that **changes** a normal cell or a pre-cancerous cell into a cancerous cell.
5. **Enhance** the body's ability to **repair** or **replace** normal cells damaged or destroyed by other forms of cancer treatment, such as chemotherapy or radiation.
6. **Prevent** cancer cells from **spreading** to other parts of the body.

Types of immunotherapy

Cancer Vaccines: Cancer vaccines are still in the experimental phase and are not coded in this data item. They may be coded in the field Other Therapy. Currently clinical trials use cancer vaccines for brain, breast, colon, kidney, lung, melanoma and ovary.

Interferons: Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

Interleukins (IL-2) are often used to treat kidney cancer and melanoma.

Monoclonal Antibodies: Monoclonal antibodies (Mab) are produced in a laboratory. The artificial antibodies are used in a variety of ways in systemic therapy and can be chemotherapy, immunotherapy, or ancillary drugs. Some are injected into the patient to seek out and disrupt cancer cell activities. When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy. Other Mabs are linked to radioisotopes (conjugated monoclonal antibodies). The Mab finds and attaches to the target tumor cells and brings with it the radioisotope that actually kills the tumor cell. The monoclonal antibody itself does nothing to enhance the immune system. Conjugated monoclonal antibodies such as tositumomab (Bexxar) or ibritumomab (Zevalin) are coded to the part of the drug that actually kills the cells, usually radioisotopes. A third function of Mabs is to enhance the immune response against the cancer, either by identifying tumor cells that are mimicking normal cells, or by boosting the body's natural defenses that destroy foreign cells. Consult SEER*Rx for the treatment category in which each monoclonal antibody should be coded.

IMMUNOTHERAPY CONTINUED

Coding Instructions

1. Assign **code 00**

a. When there is no information in the patient' medical record about immunotherapy **AND**
i. It is known that immunotherapy is not usually performed for this type and/or stage of cancer **OR**
ii. There is no reason to suspect that the patient would have had immunotherapy.
b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include immunotherapy.
c. Patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation.
d. Watchful waiting, active surveillance (prostate)
e. Patient diagnosed at autopsy
f. For anti-thymocyte globulin treatment. Anti-thymocyte globulin is used to treat transplant rejection. Do not code as immunotherapy.

2. Assign **code 87** when

a. The patient refused recommended immunotherapy
b. The patient made a blanket refusal of all recommended treatment and immunotherapy is a customary option for the primary site/histology
c. If the patient refused all treatment before any was recommended

3. Assign **code 88** when the only information available is that the patient was referred to an oncologist.

Note: Review cases coded 88 periodically for later confirmation of immunotherapy.

4. Assign **code 99** when there is no documentation that immunotherapy was recommended or performed.

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ACR Supplement Page

DATE IMMUNOTHERAPY STARTED

Item Length: 8
NAACCR Item #1240
Valid Codes: 10-12, 15, Blank
Revised: 01/11

ACR Required Data Item #267a

Description
Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment.

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

Instructions for Coding
- Record the first or earliest date on which immunotherapy or a biologic response modifier was administered by any facility. This date corresponds to administration of the agents coded in *Immunotherapy* (NAACCR Item #1410).
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Immunotherapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Immunotherapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–BRM Flag* (NAACCR Item #1241) is used to explain why *Date Immunotherapy Started* is not a known date. See *RX Date–BRM Flag* for an illustration of the relationships among these items. #267b

#267b-Collection, Storage, and Transmission of Date Immunotherapy Started
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#267c-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RX DATE–BRM FLAG

ACR Required Data Item #268a

Item Length: 2
NAACCR Item #1241
Valid Codes: 10-12, 15, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Immunotherapy Started* (NAACCR Item #1240).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions
- Leave this item blank if *Date Immunotherapy Started* (NAACCR Item #1240) has a full or partial date recorded.
- Code 12 if the *Date Immunotherapy Started* can not be determined, but the patient did receive first course immunotherapy or a biologic response modifier.
- Code 10 if it is unknown whether any immunotherapy or a biologic response modifier was given.
- Code 11 if no immunotherapy or biologic response modifier is planned or given.
- Code 15 if immunotherapy or a biologic response modifier is planned, but not yet started. Follow this patient for immunotherapy and update this item, *Date Immunotherapy Started*, and the relevant immunotherapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 if this facility did not collect *Date Immunotherapy Started* at that time.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any immunotherapy was given).
11	No proper value is applicable in this context (for example, no immunotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, immunotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, immunotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *Date Immunotherapy Started* (NAACCR Item #1240). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Immunotherapy Started* (NAACCR Item #1240) at that time.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Immunotherapy Started* (NAACCR Item #1240) and *Rx Date–BRM Flag* (NAACCR Item #1241). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date Immunotherapy Started**	**Interoperable Date Immunotherapy Started**	**Rx Date–BRM Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any immunotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No immunotherapy given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, immunotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Immunotherapy is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

IMMUNOTHERAPY

ACR Required Data Item #270a
Data item may also be labeled "BRM."

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #1410
Revised 06/05, 09/08, 01/10

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

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

Instructions for Coding #270b-See additional definitions and coding instructions *ACR Supplement* pp. 266B & 266C.

- • Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy.
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended immunotherapy but no further documentation is available yet to confirm its administration.
- Code 88 to indicate a referral was made to a medical oncologist about immunotherapy and the registry should follow the case to determine whether it was given or why not. If follow-up to the specialist or facility determines the patient was never there, code 00.
- Cases coded 88 should be followed and the code updated as appropriate.
- Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- • Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of immunotherapeutic agents. See #271a
- 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).

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

99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

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

#271a-For cases diagnosed prior to 1/1/2005, use *SEER Book 8*. The S*EER*Rx Database* is effective for cases diagnosed on or after 1/1/2005. Version 1.1.0 was used for cases diagnosed 1/1/2005 through 12/31/2006. Version 1.2.0 was used for cases diagnosed beginning 1/1/2007. Version 1.3.0 was used beginning on the date of distribution, 5/29/09. Version 1.4.0 was used beginning on the date of distribution, 01/2010, and was followed with an update to Version 1.4.1 in 01/2010 to correct an error. Version 1.5.0 was released in 09/2010.

IMMUNOTHERAPY AT THIS FACILITY

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #720
Revised 06/05, 09/08, 01/10

ACR Required Data Item #272a

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

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

Instructions for Coding #272b-See additional definitions and coding instructions *ACR Supplement* pp. 266B & 266C.

- Record only immunotherapy received at this facility. Do not record agents administered at other facilities.
- Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy.
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended the patient receive immunotherapy but no further documentation is available yet to confirm its administration.
- Cases coded 88 should be followed to determine whether they received immunotherapy or why not.
- Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of immunotherapeutic agents. See #271a
- 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 at This Facility* (NAACCR Item #3280).

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

HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES

ACR Required Data Item #273a

Item Length: 2
Allowable Values: 00, 10–12, 20, 30, 40, 82, 85–88, 99
NAACCR Item #3250
Revised 06/05, 01/10

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

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

Instructions for Coding #273b-See additional definitions and coding instructions *ACR Supplement* pp. 274A & 274B.

- 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 affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.
- Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.
- If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended a hematologic transplant or endocrine procedure, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate referral to a specialist for hematologic transplant or endocrine procedures and the registry should follow the case. If follow-up to the specified specialist or facility determines the patient was never there, code 00.
- Cases coded 88 should be followed to determine whether they were given a hematologic transplant or endocrine procedure or why not.
- Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- 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) and/or *Palliative Care at This Facility* (NAACCR Item #3280), as appropriate.

Code	Definition
00	No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant–autologous.
12	Bone marrow transplant–allogeneic.
20	Stem cell harvest and infusion. Umbilical cord stem cell transplant.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20.)
82	Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of disease prior to administration, etc.).
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient’s physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient’s physician, but this treatment was refused by the patient, a patient’s family member, or the patient’s guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES DEFINITIONS & CODING CLARIFICATIONS

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). ***2010 SEER Program Coding and Staging Manual*****. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD**

Definitions

Bone marrow transplant (BMT): Procedure used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.

BMT Allogeneic: Receives bone marrow or stem cells from a donor.

BMT Autologous: Uses the patient's own bone marrow and/or stem cells. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.

Note: Used for breast cancer, lymphoma, leukemia, anaplastic anemia, myeloma, germ cell tumors, ovarian cancer, and small cell lung cancer.

Conditioning: High-dose chemotherapy with or without radiation administered prior to transplants such as BMT and stem cell to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field and the radiation is coded in the Radiation field.

Hematopoietic Growth Factors: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.

Non-Myeloablative Therapy: Uses immunosuppressive drugs pre- and post-transplant to ablate the bone marrow. These are not recorded as therapeutic agents.

Peripheral Blood Stem Cell Transplantation (PBSCT): Rescue that replaces stem cells after conditioning.

Rescue: Rescue is the actual BMT or stem cell transplant done after conditioning.

Stem Cells: Immature cells found in bone marrow, blood stream and umbilical cords. The stem cells mature into blood cells.

HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES CONTINUED

Coding Instructions

1. Assign **code 00**

a. When there is no information in the patient's medical record about transplant procedure or endocrine therapy **AND**
i. It is known that transplant procedure or endocrine therapy is not usually performed for this type and/ or stage of cancer **OR**
ii. There is no reason to suspect that the patient would have had transplant procedure or endocrine therapy.
b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include transplant procedure or endocrine therapy.
c. Patient elects to pursue no treatment following the discussion of transplant procedure or endocrine therapy. Discussion does not equal a recommendation.
d. Watchful waiting/active surveillance (CLL)
f. Patient diagnosed at autopsy

2. Assign **code 10** if the patient has "mixed chimera transplant (mini-transplant or non-myeloablative transplant). These transplants are a mixture of the patient's cells and donor cells.

3. **Codes 11 And 12** have priority over code 10 (BMT, NOS).

4. Assign **code 12** (allogeneic) for a syngeneic bone marrow transplant (from an identical twin) or for a transplant from any person other than the patient.

5. Assign **code 20** when the patient has a stem cell harvest followed by a rescue or reinfusion (stem cell transplant, including allogenic stem cell transplant) as first course therapy. If the patient does not have a rescue, code the stem cell harvest as 88, recommended, unknown if administered.

6. Assign **code 30** for endocrine radiation and/or surgery. Endocrine organs are testes and ovaries. Endocrine radiation and/or surgical procedures must be bilateral, or must remove the remaining paired organ for hormonal effect.

7. Assign **code 87**
a. If the patient refused recommended transplant or endocrine procedure.
b. If the patient made a **blanket refusal** of all recommended treatment and the treatment coded in this data item is a customary option for the primary site/histology.
c. If the patient **refused all treatment** before any was recommended.

8. Assign **code 88** when the only information available is that he patient was referred to an oncologist.

Note: Review cases coded 88 periodically for later confirmation of transplant procedure or endocrine therapy.

9. Assign **code 99** when there is documentation that transplant procedure or endocrine therapy was recommended or performed.

SYSTEMIC/SURGERY SEQUENCE

ACR Required Data Item #275a

Item Length: 1
Allowable Values: 0, 2–6, 9
NAACCR Item #1639
Revised 01/10, 01/11

Description
Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

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

Instructions for Coding #275b

- *Systemic/Surgery Sequence* is to be used for patients diagnosed on or after January 1, 2006.
- Code the administration of systemic therapy in sequence with the first surgery performed, described in the item *Date of First Surgical Procedure* (NAACCR Item #1200).
- If none of the following surgical procedures was performed: *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292), *Surgical Procedure/Other Site* (NAACCR Item #1294), then this item should be coded 0.
- If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *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), then code this item 2–9, as appropriate.

Code	Label	Definition
0	No systemic therapy and/or surgical procedures	No systemic therapy was given; and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed. It is unknown whether both surgery and systemic treatment were provided.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	At least two courses of systemic therapy were given, before and after any surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other systemic therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
9	Sequence unknown	Both surgery and systemic therapy were provided, but the sequence is unknown.

#275b-Per the CoC: "The definitions of codes 0 and 9 for Radiation/Surgery Sequence and Systemic/Surgery Sequence have been changed for consistency with SEER. For cases diagnosed in 2010 or later, use code 0 (not 9) if it is unknown whether the patient was treated with either surgery or systemic therapy. This change in coding instructions applies only to cases diagnosed in 2010 or later."

Examples

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2	Patient with prostate cancer received hormone therapy prior to a radical prostatectomy.
3	Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen.
4	Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen.
5	Patient with a intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity.
6	Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver.
9	An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown. The patient enters for radiation therapy.

DATE OTHER TREATMENT STARTED

Item Length: 8
NAACCR Item #1250
Revised 01/10, 01/11

ACR Required Data Item #277a

Description
Records the date on which other treatment began at any facility.

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

Instructions for Coding
- Record the date on which the care coded as *Other Treatment* [NAACCR Item #1420] was initiated.
- 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).
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Other Treatment Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Other Treatment Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–Other Flag* (NAACCR Item #1251) is used to explain why *Date Other Treatment Started* is not a known date. See *RX Date–Other Flag* for an illustration of the relationships among these items. #277b

Examples

A patient with metastatic disease was started on an experimental therapy on March 16, 2010.	March 16, 2010
Alcohol was used as an embolizing agent for a patient on August 1, 2009	August 1, 2009
A polycythemia vera patient was given several phlebotomies, the first being on September 17, 2008	September 17, 2008

#277b-Collection, Storage, and Transmission of Date Other Treatment Started
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#277c-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RX DATE–OTHER FLAG

Item Length: 2
NAACCR Item #1251
Valid Codes: 10-12, Blank
New Item: 01/2010

ACR Required Data Item #278a

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Other Treatment Started* (NAACCR Item #1250).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions
- Leave this item blank if *Date Other Treatment Started* (NAACCR Item #1250) has a full or partial date recorded.
- Code 12 if the *Date Other Treatment Started* can not be determined, but the patient did receive first course other treatment.
- Code 10 if it is unknown whether any other treatment was given (*Other Treatment* [NAACCR Item #1420] is 9).
- Code 11 if no other treatment is planned or given (*Other Treatment* [NAACCR Item #1420] is 0, 7 or 8).
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any Other Treatment was given).
11	No proper value is applicable in this context (for example, no Other Treatment given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, Other Treatment was given but the date is unknown).
(blank)	A valid date value is provided in item *Date Other Treatment Started* (NAACCR Item #1250).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Other Treatment Started* (NAACCR Item #1250) and *Rx Date–Other Flag* (NAACCR Item #1251). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date Other Treatment Started**	**Interoperable Date Other Treatment Started**	**Rx Date–Other Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if other treatment given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No other treatment given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, other treatment given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

OTHER TREATMENT

ACR Required Data Item #280a

Item Length: 1
Allowable Values: 0–3, 6–9
NAACCR Item #1420
Revised 06/05, 09/08, 01/10, 01/11

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

Rationale
Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Instructions for Coding #280b-See additional definitions and coding instructions *ACR Supplement* p. 280B.

- The principal treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that "modifies, controls, removes, or destroys" proliferating cancer tissue. Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (Code 1) for the hematopoietic diseases ONLY. (See instructions for coding in Section One). #280c-The ACR has been following this SEER guideline.
- Code 1 for embolization using alcohol as an embolizing agent.
- Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.
- Code 1 for PUVA (psoralen and long-wave ultraviolet radiation)
- Do not code presurgical embolization that given for a purpose to shrink the tumor.
- 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).
- Code 8 if it is known that a physician recommended treatment coded as Other Treatment, and no further documentation is available yet to confirm its administration
- Code 8 to indicate referral to a specialist for Other Treatment and the registry should follow. If follow-up with the specialist or facility determines the patient was never there, code 0.

Code	Label	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy).
2	Other–Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other–Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other–Unproven	Cancer treatments administered by nonmedical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

RX TEXT—OTHER

ACR Required Data Item

Item Length: 1000
Free Text
NAACCR Item #2670

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.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions for Coding
Enter the following information in narrative format:

- Date treatment started
- Where treatment was given (e.g. at this facility or another facility)
- Type of other treatment (e.g. blinded clinical trial, hyperthermia, embolization using alcohol, embolization using unknown agent for sites other than liver)
- Other treatment information (treatment cycle incomplete, unknown if given)

Note #1: See Appendix E or acceptable abbreviations.

Note #2: For systems that allow unlimited text, NAACCR recommends that it be indicated to abstractors in reporting facilities how much of the text will be transmitted in a data exchange record so that they can prioritize data entry to ensure that the most important data is sent to the central registry.

Note #3: This data item is a defined text area according to the NAACCR format. By entering this text in the designated area the data transmission to the ACR will be received in the correct format. Overflow data can be placed in the TEXT-REMARKS (NAACCR #2680) data item.

Note #4: Text documentation should include when Other treatment is recommended or not recommended and reasons why, documentation should also include if patient refuses treatment or if none was given.

OTHER TREATMENT CODING CLARIFICATIONS

Source: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). ***2010 SEER Program Coding and Staging Manual*****. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD**

Coding Instructions

1. Assign **code 0** when
a. There is no information in the patient's medical record about other therapy **AND**
i. It is known that other therapy is not usually performed for this type and/or stage of cancer **OR**
ii. There is no reason to suspect that the patient would have had other therapy.
b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy.
c. Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation.
d. Patient diagnosed at autopsy.

2. Assign **code 1**
a. Hematopoietic treatments such as: phlebotomy, transfusions, or aspirin.
b. PUVA (Psoralen (P) and long-wave ultraviolet radiation (UVA) in the **RARE** event that it is used as treatment for extremely thin melanomas or cutaneous T-cell lymphomas (e.g. mycosis fungoides).
c. Cancer treatment that could not be assigned to the previous treatment fields (surgery, radiation, chemotherapy, immunotherapy, or systemic therapy).

3. Assign **code 2** for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy.
Note: Hyperbaric oxygen has been used to treat cancer in clinical trials, but is also used to promote tissue healing following head and neck surgeries. Do not code the administration of hyperbaric oxygen to promote healing as an experimental treatment.

4. Assign **code 3** when the patient is enrolled in a double blind clinical trial. When the trial is complete and the code is broken, review and recode the therapy.

5. Assign **code 6**
a. **Unconventional** methods whether they are the only therapy or are given **in combination** with conventional therapy
b. Alternative therapy ONLY if the patient receives no other type of treatment

6. Assign **code 8** when **other therapy was recommended** by the physician but there is not information that the treatment was given.

7. Assign **code 9** when there is **no documentation** that other therapy was recommended or performed
A quote from the website for the National Cancer Institute (NCI), Office of Cancer Complementary and Alternative Medicine (OCCAM) defines Complementary and Alternative Medicine (CAM) as any medical system, practice, or product that is not thought of as "western medicine" or standard medical care.
•Complementary medicine means it is used along with standard medicine, also called conventional medicine.
•Alternative medicine is used in place of standard treatments.
CAM treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation.
See complete information on types of complementary and alternative medicine specific to cancer at http://www.cancer.gov/cam/.

OTHER TREATMENT AT THIS FACILITY

ACR Required Data Item #281a

Item Length: 1
Allowable Values: 0–3, 6–9
NAACCR Item #730
Revised 01/04, 09/08, 01/10

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

Rationale
Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Instructions for Coding #281b-See additional definitions and coding instructions *ACR Supplement* p. 280B.

- The principal treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that "modifies, controls, removes, or destroys' proliferating cancer tissue. Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (Code 1) for the hematopoietic diseases ONLY. (See instructions for coding in Section One). #281c-The ACR has been following this SEER guideline.
- Code 1 for embolization using alcohol as an embolizing agent.
- Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.
- Do not code presurgical embolization that given for a purpose to shrink the tumor.
- 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 #3280).
- Code 8 if it is known that a physician recommended the patient receive treatment coded as Other Treatment, but no further documentation is available yet to confirm its administration.

Code	Label	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy). Use this code for treatment unique to hematopoietic diseases .
2	Other–Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other–Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other–Unproven	Cancer treatments administered by nonmedical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

PALLIATIVE CARE
(PALLIATIVE PROCEDURE)

ACR Required Data Item #282a

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #3270
Revised 01/04, 01/10

Description
Identifies any care provided in an effort to palliate or alleviate symptoms. Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or other pain management therapy.

Rationale
This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative in intent.

Instructions for Coding
- Record the type of palliative care provided.
- Surgical procedures, radiation therapy, or systemic therapy provided to prolong the patient's life by controlling symptoms, to alleviate pain, or to make the patient comfortable should be coded palliative care and as first course therapy if that procedure removes or modifies either primary or metastatic malignant tissue. #282b
- Palliative care is not used to diagnose or stage the primary tumor.
- Do not code routine pain management following surgery or other treatment; do code first course pain management for persistent pain.

Code	Definition
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for pain management therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in the patient record. Palliative care was provided that does not fit the descriptions for codes 1–6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

#282b-Effective with cases diagnosed 1/1/2003 and forward: Palliative treatment must be double-coded with first course of treatment if the treatment removes or modifies primary or secondary malignant tissue.

Examples

Code	Reason
0	No palliative care was given.
1	A patient undergoes palliative surgical removal of brain metastasis. [Surgery recorded in *Surgical Procedure/Other Site* (NAACCR Item #1294)]
1	A patient with unresectable pancreatic carcinoma (no surgical procedure of the primary site is performed) receives bypass surgery to alleviate jaundice and pain.
2	A patient is diagnosed with Stage IV prostate cancer. His only symptoms are painful bony metastases in his right hip and lower spine. XRT is given to those areas. (Record all radiotherapy items also).
2	A patient with lung cancer with a primary tumor extending into the spine is treated with XRT to shrink tumor away from spine/nerves to provide pain relief. (Record all radiotherapy items also).
3	A patient is given palliative chemotherapy for Stage IIIB lung cancer. (Record all chemotherapy items also).
4	A 93-year old patient is diagnosed with multiple myeloma and enters a pain management clinic to treat symptoms. No other therapy is planned due to other medical problems.
5	A patient is diagnosed with widely disseminated small cell lung cancer. A palliative resection of a solitary brain metastasis is performed followed by XRT to the lower spine for painful bony metastasis. There is no known pain management. (Record all surgery and radiotherapy items also).
6	A patient diagnosed with colon cancer receives bypass surgery to alleviate symptoms and XRT to the liver for metastasis, and then enters a pain management clinic for treatment for unremitting abdominal pain. (Record all radiotherapy items also).
7	A patient enters the facility with a clinical diagnosis of unresectable carcinoma of the pancreas. A stent was inserted into the bile duct to relieve obstruction and improve the bile duct flow.

PALLIATIVE CARE AT THIS FACILITY
(PALLIATIVE PROCEDURE AT THIS FACILITY)

ACR Required Data Item #284a

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #3280
Revised 01/04, 01/10

Description
Identifies care provided at this facility in an effort to palliate or alleviate symptoms. Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or other pain management therapy.

Rationale
This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative in intent.

Instructions for Coding
- Record only the type of palliative care at this facility.
- Surgical procedures, radiation therapy, or systemic therapy provided to prolong the patient's life by controlling symptoms, to alleviate pain, or to make the patient comfortable at this facility should be coded as palliative care and as first course therapy if that procedure removes or modifies either primary or secondary malignant tissue. #284b
- Palliative care is not used to diagnose or stage the primary tumor.
- Do not code routine pain management following surgery or other treatment; do code first course pain management for persistent pain.

Code	Definition
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for pain management therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in the patient record. Palliative care was provided that does not fit the descriptions for codes 1–6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

#284b-Effective with cases diagnosed 1/1/2003 and forward: Palliative treatment must be double-coded with first course of treatment if the treatment removes or modifies primary or secondary malignant tissue.

Outcomes

DATE OF FIRST RECURRENCE

ACR Required Data Item #287a

Item Length: 8
NAACCR Item #1860
Revised 06/05, 01/10, 01/11

Description
Records the date of the first recurrence.

#287b-Consult the *Multiple Primary and Histology Coding Rules* manual for detailed coding guidelines regarding recurrences for cases diagnosed 01/01/2007 or later.

Rationale
This data item is used to measure the efficacy of the first course of treatment.

Instructions for Coding

- Record the date the physician diagnoses the first progression, metastasis, or recurrence of disease after a disease-free period.
- Reappearance of a tumor of the same histology in the same primary site during the time period defined by the SEER Multiple Primary and Histology Coding Rules does not constitute a recurrence.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Recurrence* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Recurrence* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Recurrence Date–1st Flag* (NAACCR Item #1861) is used to explain why *Date of First Recurrence* is not a known date. See *Recurrence Date–1st Flag* for an illustration of the relationships among these items. #287c

#287c-Collection, Storage, and Transmission of Date of First Recurrence
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

#287d-Examples for Coding Date Estimations (dates are in date transmission format)
If information is limited to the description "Spring," 2003, then code 200304bb.
If information is limited to the description "The middle of the year," 2003, then code 200307bb.
If information is limited to the description "Fall," 2003, then code 200310bb.
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year. Code January or December as indicated. Code either 200312bb or 200401bb.
*The lowercase letter "b" is used to represent each blank space in the examples.

RECURRENCE DATE–1st FLAG

ACR Required Data Item #288a

Item Length: 2
NAACCR Item #1861
Valid Codes: 10-12, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Recurrence* (NAACCR Item #1860).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding
- Leave this item blank if *Date of First Recurrence* (NAACCR Item #1860) has a full or partial date recorded.
- Code 12 if the *Date of First Recurrence* can not be determined, but the patient did have a recurrence following a disease-free period.
- Code 10 if it is unknown whether the patient had a recurrence.
- Code 11 if the patient was never disease free, became disease free but had no recurrence, or was initially diagnosed at autopsy.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if the patient was ever disease-free or had a first recurrence)
11	No proper value is applicable in this context (that is, patient became disease-free after treatment and never had a recurrence; or patient was never disease-free; autopsy only case)
12	A proper value is applicable but not known (that is, there was a recurrence, but the date is unknown
(blank)	A valid date value is provided in item *Date of First Recurrence* (NAACCR Item #1860).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of First Recurrence* (NAACCR Item #1860) and *Recurrence Date–1st Flag* (NAACCR Item #1861). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date of First Recurrence**	**Interoperable Date of First Recurrence**	**Recurrence Date–1st Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if patient had a recurrence	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No recurrence; never disease-free	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, but patient had a recurrence	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

TYPE OF FIRST RECURRENCE

ACR Required Data Item #290a

Item Length: 2
Allowable Values: 00, 04, 06, 10, 13–17, 20–22, 25–27, 30, 36, 40, 46, 51–59, 60, 62, 70, 88, 99
NAACCR Item #1880
Revised 06/05, 01/10, 01/11

Description
Identifies the type of first recurrence after a period of documented disease-free intermission or remission.
Rationale
This item is used to evaluate treatment efficacy and as a long-term prognostic factor.
Instructions for Coding See #291a & #291b

- Code the type of first recurrence. First recurrence may occur well after completion of the first course of treatment or after subsequent treatment.
- Check the SEER *Multiple Primary and Histology Coding Rules Manual* fto determine which subsequent tumors should be coded as recurrences.
- If the patient has never been disease-free (code 70), continue to track for disease-free status. This may occur after subsequent treatment has been completed.
- If the patient is disease-free (code 00), continue to track until a recurrence occurs. First recurrence may occur well after completion of the first course of treatment.
- Once a recurrence has been recorded (code 04-62 or 88), subsequent recurrences are NOT to be recorded.
- Codes 00 through 70 are hierarchical. Record the highest-numbered applicable response.
- If the tumor was originally diagnosed as in situ, code recurrence to 06, 16, 17, 26, 27, 36, or 46 only. Do not use those codes for any other tumors. Codes 00, 88, or 99 may apply to any tumor.
- Codes 51–59 (organ or organ system of distant recurrence) apply only if all first occurrences were in a single category. There may be multiple metastases (or “seeding”) within the distant location.
- Code lymphomas or leukemias that are in remission 00. If the patient relapses, then code recurrence as 59.
- If there is more than one primary tumor and the physician is unable to decide which has recurred, code the recurrent disease for each tumor. If the recurrent primary is identified later, revise the codes appropriately.

#290b-Refer to #291a and #291b before making decisions about recurrence.

Code	Definition
00	Patient became disease-free after treatment and has not had a recurrence.
04	In situ recurrence of an invasive tumor.
06	In situ recurrence of an in situ tumor.
10	Local recurrence, and there is insufficient information available to code to 13–17. Local recurrence includes recurrence confined to the remnant of the organ of origin, to the organ of origin, to the anastomosis, or to scar tissue where the organ previously existed.
13	Local recurrence of an invasive tumor.
14	Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.
15	Both local and trocar recurrence of an invasive tumor (both 13 and 14).
16	Local recurrence of an in situ tumor, NOS
17	Both local and trocar recurrence of an in situ tumor.
20	Regional recurrence, and there is insufficient information available to code to 21–27.
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22	Recurrence of an invasive tumor in regional lymph nodes only.

Code	Definition
25	Recurrence of an invasive tumor in adjacent tissue or organ(s) and in regional lymph nodes (both 21 and 22) at the same time.
26	Regional recurrence of an in situ tumor, NOS.
27	Recurrence of an in situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30	Both regional recurrence of an invasive tumor in adjacent tissue or organs(s) and/or regional lymph nodes (20–25) **and** local and/or trocar recurrence (10, 13, 14, or 15).
36	Both regional recurrence of an in situ tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) **and** local and/or trocar recurrence (16 or 17).
40	Distant recurrence, to a site not listed in 46-62 or there is insufficient information available to code to 46–62.
46	Distant recurrence of an in situ tumor.
51	Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
54	Distant recurrence of an invasive tumor in the liver only.
55	Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site.
56	Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but **not** the external eye.
57	Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58	Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59	Distant systemic recurrence of an invasive tumor only. This includes lymphoma, leukemia, bone marrow metastasis, carcinomatosis, generalized disease.
60	Distant recurrence of an invasive tumor in a single distant site (51–58) **and** local, trocar and/or regional recurrence (10–15, 20–25, or 30).
62	Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51–59).
70	Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
88	Disease has recurred, but the type of recurrence is unknown.
99	It is unknown whether the disease has recurred or if the patient was ever disease-free.

#291a-Consult the *Multiple Primary and Histology Coding Rules* manual for detailed coding guidelines regarding recurrences for cases diagnosed 1/1/2007 or later. These guidelines must be used to determine if the case is a new primary or recurrence.

Examples

Code	Reason
52	Distant recurrence in the lung.
62	Recurrence in liver, lung and bone

#291b-For cases diagnosed from 1/1/1997 through 12/31/2006, if there is an *in situ* cancer followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated by a physician to be a recurrence.

DATE OF LAST CONTACT OR DEATH

ACR Required Data Item #292a

Item Length: 8
NAACCR #1750
Revised 06/05, 01/10, 01/11

Description
Records the date of last contact with the patient or the date of death.

Rationale
This information is used for patient follow-up and outcomes studies.

Instructions for Coding

- Record the last date on which the patient was known to be alive or the date of death.
- If a patient has multiple primaries, all records should have the same date of last contact.
- As of January 1, 2006, the CoC does not require *Class of Case* 00 cases to be followed.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Last Contact or Death* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Last Contact or Death* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Last Contact Flag* (NAACCR Item #1751) is used to explain why *Date of Last Contact or Death* is not a known date. See *Date of Last Contact Flag* for an illustration of the relationships among these items. #292c

#292b-The ACR does require Class of Case 00 to be followed.

#292c-Collection, Storage, and Transmission of Date of Last Contact or Death
Dates may be collected and stored in any format, including the traditional date format (MMDDCCYY) or the new interoperable date format (CCYYMMDD). The new interoperable date format (CCYYMMDD) must be used for transmission to the ACR. The new transmission requirement is intended to improve the interoperability of cancer registry data with other electronic record systems.

DATE OF LAST CONTACT FLAG

Item Length: 2
NAACCR #1751
Valid Codes: 12, Blank
New Item: 01/2010

ACR Required Data Item #293a

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Contact or Death* (NAACCR Item #1750).

Rationale
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions for Coding
- Leave this item blank if *Date of Last Contact or Death* (NAACCR Item #1750) has a full or partial date recorded.
- Code 12 if the *Date of Last Contact or Death* can not be determined
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Description
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, the date of last contact is unknown).
(blank)	A valid date value is provided in item *Date of Last Contact or Death* (NAACCR Item #1750).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Last Contact or Death* (NAACCR Item #1750) and *Date of Last Contact Flag* (NAACCR Item #1751). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date of Last Contact or Death	Interoperable Date of Last Contact or Death	Date of Last Contact Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Date is unknown	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

VITAL STATUS

ACR Required Data Item #294a

Item Length: 1
Allowable Values: 0, 1
NAACCR Item #1760

Description
Records the vital status of the patient as of the date entered in *Date of Last Contact or Death* (NAACCR Item #1750).

Rationale
This information is used for patient follow-up and outcomes studies.

Instructions for Coding
- This item is collected during the follow-up process with *Date of Last Contact or Death* (NAACCR Item #1750).
- If a patient has multiple primaries, all records should have the same vital status.

Code	Label
0	Dead
1	Alive

Example

Code	Reason
0	Death clearance information obtained from a state central registry confirms the death of the patient within the past year.
1	In response to a follow-up letter to a patient's following physician, it is learned the patient is alive.

CANCER STATUS

ACR Required Data Item #295a

Item Length: 1
Allowable Values: 1, 2, 9
NAACCR Item #1770
Revised 01/04

Description
Records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as of the *Date of Last Contact or Death* (NAACCR Item #1750).

Rationale
This information is used for patient follow-up and outcomes studies.

Instructions for Coding
- Cancer status is based on information from the patient's physician or other official source such as a death certificate.
- The patient's cancer status should be changed **only** if new information is received from the patient's physician or other official source. If information is obtained from the patient, a family member, or other nonphysician, then cancer status is not updated.
- Cancer status changes if the patient has a recurrence or relapse.
- If a patient has multiple primaries, each primary could have a different cancer status.

Code	Label
1	No evidence of this tumor
2	Evidence of this tumor
9	Unknown, indeterminate whether this tumor is present; not stated in patient record

Example

Code	Reason
1	Patient with hematopoietic disease who is in remission.
1	A patient is seen by the physician on February 2, 2004 with no evidence of this tumor. The patient did not return to the physician. The patient was then called by the registry on August 29, 2005. The *Date of Last Contact or Death* (NAACCR Item #1750) is updated, but the cancer status is not.
2	A patient with prostate cancer is diagnosed with bone metastasis in April 2003. The registrar finds an obituary documenting the patient's death in a nursing home in June 2003.

NPI–FOLLOWING REGISTRY

Not Required by ACR #296a

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2445
Revised 04/07, 09/08, 01/11

Description
Records the registry responsible for following the patient.

Rationale
This data item is useful when the same patient is recorded in multiple registries.

Instructions for Coding
- Record the 10-digit NPI for the facility of the registry responsible for following the patient.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Check with the registry, billing, or health information departments of the facility to determine its NPI, or search at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.

Code	Definition
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the facility of the following registry is unknown or not available.

FOLLOW-UP SOURCE

Not Required by ACR #297a

Item Length: 1
Allowable Values: 0–5, 7–9
NAACCR Item #1790

Description
Records the source from which the latest follow-up information was obtained.

Rationale
This data item is used by registries to identify the most recent follow-up source.

Instructions for Coding

Code	Label	Definition
0	Reported hospitalization	Hospitalization at another institution/hospital or first admission to the reporting facility.
1	Readmission	Hospitalization or outpatient visit at the reporting facility.
2	Physician	Information from a physician.
3	Patient	Direct contact with the patient.
4	Department of Motor Vehicles	The Department of Motor Vehicles confirmed the patient has a current license.
5	Medicare/Medicaid file	The Medicare or Medicaid office confirmed the patient is alive.
7	Death certificate	Information from the death certificate only.
8	Other	Friends, relatives, employers, other registries, or any sources not covered by other codes.
9	Unknown; not stated in patient record	The follow-up source is unknown or not stated in patient record.

NEXT FOLLOW-UP SOURCE
(NEXT FOLLOW-UP METHOD)

Not Required by ACR #298a

Item Length: 1
Allowable Values: 0–5, 8, 9
NAACCR Item #1800
Revised 01/10

Description
Identifies the method planned for the next follow-up.

Rationale
This data item is used by registries to identify the method planned for the next follow-up.

Instructions for Coding
- Registries in CoC-accredited cancer programs are not required to follow foreign residents.
- As of January 1, 2006, the CoC does not require *Class of Case* 00 cases to be followed.

Code	Definition
0	Chart requisition
1	Physician letter
2	Contact letter
3	Phone call
4	Other hospital contact
5	Other, NOS
8	Foreign residents (not followed)
9	Not followed. Other cases for which follow-up is not required.

FOLLOW-UP SOURCE CENTRAL

Not Required by the ACR
Only Coded by ACR

Item Length: 40
Allowable Codes: 00, 01-12, 29, 30-35, 39, 40-43, 48, 49, 50, 51, 59, 60-65, 98, 99
NAACCR Item #1791

Description
This field records the source from which the consolidated information was obtained on a patient's vital status and date of last contact. Follow-up Source Central would be updated when new or more reliable information becomes available. However, when the existing date of last contact/vital status is deemed to be more reliable than newly obtained information, then neither the date of last contact/vital status nor the follow-up source central would be changed.

Rationale
This field could help evaluate the success rates of various methods of follow-up. When new follow-up information conflicts with the existing information, knowing the follow-up source can help resolve any discrepancies. Because follow-up information includes follow-up address and cancer status as well as date of last contact/vital status, and may come from different sources, it is important to note that Follow-up Source Central refers to the two fields, date of last contact and vital status.

Instructions for Coding
00 Follow-up not performed for this patient

Codes 01-29 are used by central registries and are usually not applicable to hospital registries.

	(01-29) File Linkages
01	Medicare/Medicaid File
02	Center for Medicare and Medicaid Services (CMS, formerly HCFA)
03	Department of Motor Vehicle Registration
04	National Death Index (NDI)
05	State Death Tape/Death Certificate File
06	County/Municipality Death Tape/ Death Certificate File
07	Social Security Administration Death Master File
08	Hospital Discharge Data
09	Health Maintenance Organization (HMO) file
10	Social Security Epidemiological Vital Status Data
11	Voter Registration File
12	Research/Study Related Linkage
29	Linkages, NOS
	(30-39) Hospitals and Treatment Facilities
30	Hospital in-patient/outpatient
31	Casefinding
32	Hospital cancer registry
33	Radiation treatment center
34	Oncology clinic
35	Ambulatory surgical center
39	Clinic/facility, NOS

	(40-49) Physicians
40	Attending physician
41	Medical oncologist
42	Radiation oncologist
43	Surgeon
48	Other specialist
49	Physician, NOS
	(50-59) Patient
50	Patient contact
51	Relative contact
59	Patient, NOS
	(60-98) Other
60	Central or Regional cancer registry
61	Internet sources
62	Hospice
63	Nursing homes
64	Obituary
65	Other research/study related sources
98	Other, NOS
99	Unknown Source

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

DESCRIBE PLACE OF DEATH

ACR Supplemental Data Item

Item Length: 30
Free Text
NAACCR Item #None

Description
This data item is used to describe, in narrative format, the place where the patient died (if known).

Rationale
Assists the central registry in performing death clearance. When a hospital reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate would be requested.

Instructions for Coding
Record in narrative text the place where the patient died (hospital, pts home, another state, or any other information that will assist the central registry in locating the state where the death certificate information would be available).

Note: See Appendix E for acceptable abbreviations.

PLACE OF DEATH

ACR Required Data Item

Item Length: 3
Right Justified
NAACCR Item #1940

Description
State or country where the patient died and where the certificate of death is filed.

Rationale
This field also helps carry out death clearance. When a facility reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate is to be requested.

Instructions for Coding
If the patient is expired and you know what state he/she died in, code the geocode as listed in Appendix F.

Additionally, the following codes may be used:

997 Not applicable, patient alive
999 Place of death unknown

CAUSE OF DEATH
ALSO CALLED "UNDERLYING CAUSE OF DEATH"

ACR Required Data Item

Item Length: 4
Allowable codes include any valid ICD-7, 8, 9 or 10 codes; also 0000, 7777, and 7797
NAACCR Item #1910

Description
Official cause of death as coded from the death certificate in valid ICD-7, ICD-8, ICD-9 and ICD-10 codes. The underlying cause of death as coded by a State Health Department is to be used. Even when the code is believed to be in error, the entry is coded by a State Health Department.

Rationale
Cause of death is used for calculation of adjusted survival rates by the life table method. The adjustment corrects for deaths other than from the diagnosed cancer.

Special Codes (in addition to ICD codes)
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.

If the patient has multiple records, the underlying cause of death must be identical on each record.

AUTOPSY

ACR Required Data Item

Item Length: 1
Allowable Codes: 0-2, 9
NAACCR Item #1930

Description
This field is used to indicate whether an autopsy was performed.

Rationale
The original source for this code was the Commission on Cancer (CoC), presumably to track the use of autopsy examinations in cancer patients. Beginning January 1, 2003, the COC will no longer support this data item.

Instructions for Coding
Record whether the patient had an autopsy. Codes 1, 2, and 9 are to be used only if the patient has expired.

0 Not Applicable, patient alive
1 Autopsy performed
2 No Autopsy performed
9 Patient expired, unknown if autopsy performed

LETTER FREQUENCY

Item Length: 1
Left Justified
NAACCR Item #None

ACR Required Data Item
For use with RMCDS software.

Description
This data item is unique to RMCDS software and is used to designate the frequency of follow-up letters (re-examination reports) generated on each patient. If this field is left blank, letters will automatically be sent on an annual schedule from the date last seen. Once a case is coded on a particular schedule, it will remain on the schedule until changed.

Rationale
This field helps to automate follow-up activities by generating letters based on the date last seen.

Instructions for Coding
Code as follows:

1 Quarterly
2 Semi-annually
3 Annually
7 No follow up (patient is a resident of a foreign country)
8 Letter sent to hospital registry in first position
9 Letter stop, non-analytic case that facility has chosen not to follow (do not generate letters for this patient).

Note #1: The code of 7 (No follow-up) is used for foreign residents **only**.

Note #2: The ACR does not require follow-up activity on non-analytic cases

Note #3: Generation of letters is automatically stopped when the patient's vital status changes to "0" (expired).

Note #4: All analytic cases of patients who are alive must be followed a minimum of once per year.

Note #5: The RMCDS computer program looks at the code entered in the following physician field to determine who the follow-up letter gets addressed to.

Note #6: Software vendors must provide for the ability to identify cases that are due for follow up.

TEXT—REMARKS
ALSO CALLED "COMMENTS"

Item Length: 1000
Free Text
NAACCR Item #2680

ACR Required Data Item
(Required by ACR only if overflow text is entered in this field)
(Required by ACR to indicate other primary tumors the patient may have)

Description
Text area for information not elsewhere provided for and for overflow from other text areas.

Instructions for Coding
Record additional narrative text (e.g. family history of cancer, insurance company, or any additional follow-up information).

Note #1: See Appendix E for acceptable abbreviations.

Note #2: Overflow data from other text fields can be placed in this field.

Note#3: To record all other primary tumors.

SUSPENSE CASE

ACR Required Data Item

Item Length: 1
Left Justified
NAACCR Item #None

Description
Indicates whether or not a case is being held in suspense.

Rationale
The use of this data item allows reporting facilities and the ACR to easily distinguish among cases that are completed for submission to the ACR, cases that are collected by the reporting facility but not the ACR, and incomplete cases.

Instructions for Coding

The following codes and meanings are to be assigned by the reporting facility only:

0 Reportable analytic and non-analytic case (cases to be submitted to the ACR)
1 Suspense file cases
2 Non-analytic cases/other cases (benign, reportable-by-agreement cases not sent to the ACR, not required to be reported to the ACR)

The following codes and meanings are to be assigned by the ACR only:

0 Case not in suspense/quality controlled
1 Suspense case (not quality controlled/non-merge)
3 Suspense case (not quality controlled/merge)

Note #1: In order for a case to be sent to the ACR, the suspense field must be coded (0). Code (1) is to be used only as a temporary code. The appropriate use of the code (1) is when there is an outstanding issue that prevents the abstract from being completed or the abstractor has not completed the case. Once the outstanding issue(s) are settled, the abstract is to be updated to the appropriate code.

Note #2: *Note to facilities using software other than RMCDS*—Software must have the ability to exclude cases from submission to the ACR. Vendors may develop their own method.

Case Administration

ABSTRACTED BY

ACR Required Data Item #301a

Item Length: 3
Left Justified Alphanumeric
NAACCR Item #570

Description
Records the initials or assigned code of the individual abstracting the case.

Rationale
This item can be used for quality control and management in multistaffed registries.

Instructions for Coding
Code the initials of the abstractor.

301b-The ACR assigns a number to all abstractors in the state. Contact the ACR if you have not been assigned a number.

Code	Definition
(fill spaces)	Initials or code of abstractor.

FACILITY IDENTIFICATION NUMBER (FIN)

Item Length: 10
Right Justified, Zero-filled
NAACCR Item #540
Revised 09/08

ACR Required Data Item #302a
NAACCR data item name is "Reporting Facility."

Description
Identifies the facility reporting the case.

Rationale
Each facility's identification number (FIN) is unique. The number is essential to the National Cancer Data Base (NCDB) for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Instructions for Coding #302b

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

Examples

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

Note: A complete list of FINs is available on the American College of Surgeons Web site at *http://www.facs.org/cancer/coc/fin.html* .

#302b-The ACR assigns all reporting facilities a three-digit identification number (known as the reporting hospital number) for use within the State of Arizona. It is mandatory to use this number when submitting documents to the ACR. If your facility does not have a three-digit identification number, contact the ACR.
Note: Do not confuse the 3-digit reporting hospital code number with the 10-digit *"facility identification number (FIN)"* assigned by the Commission on Cancer (CoC). The FIN number is to be used when submitting data to the CoC and is maintained within the parameters of the RMCDS software. RMCDS software can convert the 3-digit state specific identification number to the 10-digit FIN number as needed. For other cancer data software, this number may be maintained within a separate software program within the cancer registry software (contact your vendor for more information).

NPI–REPORTING FACILITY

ACR Required Data Item #303a

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #545
Revised 04/07, 09/08, 01/10

Description
Identifies the facility whose data are in the record.

Rationale
Each facility's NPI is unique. The number is essential to the National Cancer Data Base (NCDB) for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

NPI–Reporting Facility is the NPI equivalent of *Facility Identification Number* (NAACCR Item #540). Both are required during a period of transition.

Instructions for Coding
- *NPI–Reporting Facility* is automatically coded by the software provider.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- The facility's NPI can be obtained from the billing or accounting department, or searched at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- If the facility has more than one NPI number assigned, use the "umbrella" number that applies to the entire facility.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definitions
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the facility is unknown or not available.

ARCHIVE FIN

ACR Required Data Item #304a

Item Length: 10
Right Justified, Zero-filled
NAACCR Item #3100
Revised 01/10

Description
Identifies the facility that originally abstracted the case.

Rationale
It is essential for hospital registries to have the ability to distinguish cases originally accessioned by each registry of the merged unit. This enables the CoC to manage the receipt of historical data and to appropriately attribute these data.

Instructions for Coding
- *Archive FIN* is automatically coded by the software provider.
- This data item never changes and must be included as part of the patient record when data are submitted to the NCDB.
- For facilities that have not merged, the *Archive FIN* and *FIN* (NAACCR Item #540) will be the same.
- If facilities merged after January 1, 2003, a new FIN was assigned to represent the merged facility. This new FIN was assigned to all cases in the *merged* registry, but the *Archive FIN* for cases from each registry prior to the merger **does not** change.
- If a merged program continues to operate multiple campuses, the Archive FIN is the historic FIN for the respective facilities that are now separate campuses of the same hospital.
- For facilities with seven-digit FINs in the range of 6020009–6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number. The Archive FIN must be recorded similarly.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros followed by the full eight-digit number. The Archive FIN must be recorded similarly.

Examples

Code	Reason
0006439999	General Hospital, Anytown, Illinois (FIN: 6439999). Original diagnosis was made at this facility; both the FIN and the Archive FIN are the same.
0006439999 or 0006430000	General Hospital (FIN: 6439999) and Anytown Medical Center (FIN: 6430000) in Anytown IL merged; the two cancer registries were combined and now report as Anytown Medical Center. The new FIN for this reporting facility is 10000099. All cases from the merged General Hospital and Anytown Medical Center registry have the new FIN (0010000099) assigned to them. In addition, either the General Hospital Archive FIN (0006439999) or the Anytown Medical Center Archive FIN (0006430000) is retained in each record depending on which registry originally accessioned the case.

NPI–ARCHIVE FIN

ACR Required Data Item #305a

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #3105
Revised 01/10

Description
Identifies the facility that originally abstracted the case.

Rationale
It is essential for hospital registries to have the ability to distinguish cases originally accessioned by each registry of the merged unit. This enables the CoC to manage the receipt of historical data and to appropriately attribute these data.

NPI–Archive FIN is the NPI equivalent of *Archive FIN* (NAACCR Item #3100). Both are required during a period of transition.

Instructions for Coding
- *NPI–Archive FIN* is automatically coded by the software provider.
- This data item never changes and must be included as part of the patient record when data are submitted to the NCDB.
- For facilities that have not merged, the *NPI–Archive FIN* and the *NPI–Reporting Facility* (NAACCR Item #545) will be the same.
- If the facility has more than one NPI number assigned, use the "umbrella" number that applies to the entire facility.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later. #305b
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the facility is unknown or not available.

#305b-The ACR requires the coding of NPI numbers for cases diagnosed 1/1/2007 or later.

DATE CASE COMPLETED – COC

Not Required by ACR #306a

Item Length: 8
NAACCR Item #2092
New Item: 1/1/2010

Description
This data item identifies the date that specified items are completed, based on the *Class of Case*, and those items pass the relevant edits. Follow-up information, including delayed treatment received elsewhere, may be coded after the *Date Case Completed–CoC*. This item should be autocoded by the registry software. The CoC specifications will not necessarily be the same as those used for *Date Case Completed* [NAACCR Item #2090], which CoC does not require.

Rationale
This item was created to measure abstracting timeliness of information that should be available when the facility's main involvement in the patient's first course care is completed, based on *Class of Case*. CoC Standard 3.3 requires that 90% of all cases be abstracted within 6 months of the patient's first contact with the facility in CoC accredited programs. It is assumed that for all except some unusual cases, all required items, not just those used to determine *Date Case Completed – CoC*, will have been completed for all analytic cases by the time the NCDB annual Call for Data begins.

Instructions
- This item may be left blank for cases diagnosed prior to 2010.
- Follow-up information, information about delayed treatment received elsewhere, and information about multiple tumors diagnosed later may be coded after the *Date Case Completed – CoC*.
- Corrections and updates may be made after the *Date Case Completed – CoC*.
- Appendix D provides a list of items in each broad completion category below.
- After all required items identified below for the patient's *Class of Case* have been abstracted, the registrar should run the standard NAACCR edit set "Hosp: vs 12 CoC Required - All" using the registry software. The registry software will record the *Date Case Completed – CoC* when those items are abstracted and the case passes all edits in that set.

Class of Case	Description	Items that Must Be Completed by Date Case Completed - CoC
00-22	All analytic cases	Identification, demographic, diagnostic
10-22	Patient received part or all first course treatment from facility	Staging, hospital-specific treatment
10, 12, 14, 20, 22	Patient received all first course treatment from facility, or unspecified whether all or part	Summary treatment (treatment at any facility)
00	Patient diagnosed at facility, received all treatment elsewhere	Facility referred to OR a treating physician
20-22	Patient diagnosed elsewhere, received part or all of treatment from facility	Facility referred from OR the managing physician

OVERRIDE ACSN/CLASS/SEQ

ACR Required Data Item #307a

Item Length: 1
Allowable Values: 1
NAACCR Item #1985
Revised 09/06, 09/08, 01/10

Description
Used with the EDITS software to override the edit *Accession Number, Class of Case, Seq Number (CoC)*.

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
The edit, *Accession Number, Class of Case, Seq Number (CoC)*, checks the following:

- If the case is the only case or the first of multiple cases diagnosed at the facility (*Sequence Number–Hospital* = 00, 01, 60 or 61, and *Class of Case* = 00, 10, 12, 13, or14), then the first 4 characters of the *Accession Number* (NAACCR Item #550) must equal the year of the *Date of First Contact* (NAACCR Item #580).
- If the case is first diagnosed at autopsy (*Class of Case* = 38), and the case is the only case or the first of multiple cases for a patient (*Sequence Number–Hospital* = 00, 01, 60, or 61), then the first 4 characters of the *Accession Number* must equal the year of the *Date of Last Contact or Death* (NAACCR Item #1750) AND must equal the year of the *Date of First Contact*.
- If the case is first diagnosed at autopsy (*Class of Case* = 38), and the case is the second or more case for a patient (*Sequence Number–Hospital* greater than 01 or greater than 61), then the year of the *Date of First Contact* must equal the year of *Date of Last Contact or Death*.

There are some exceptions to the above rules. *Override Acsn/Class/Seq* may be used to override the edit when the circumstances fit the following situation or one similar to it:

- The case may be the only or the first of multiple malignant cases for a patient (*Sequence Number–Hospital* = 00 or 01), but there is an earlier benign case (with an earlier year of the *Date of First Contact*) for which the *Accession Number* applies.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the edit *Accession Number, Class of Case, Sequence Number (CoC)*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

OVERRIDE HOSPSEQ/DXCONF

ACR Required Data Item #308a

Item Length: 1
Allowable Values: 1
NAACCR Item #1986
Revised 09/06, 09/08

Description
Used with the EDITS software to override the edit *Diagnostic Confirm, Seq Num–Hosp (CoC)*.

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
The edit, *Diagnostic Confirm, Seq Num–Hosp (CoC)*, does the following:

- If any case is one of multiple primaries and is not microscopically confirmed or positive lab test/marker study, i.e., *Diagnostic Confirmation* > 5 and *Sequence Number–Hospital* > 00 (more than one primary), review is required.
- If *Primary Site* (NAACCR Item #400) specifies an ill-defined or unknown primary (C76.0–C76.8, C80.9), no further checking is done. If *Sequence Number–Hospital* is in the range of 60-88, this edit is skipped.

It is important to verify that the non-microscopically-confirmed case is indeed a separate primary from any others that may have been reported. This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study.

- If this edit is failed and the suspect case is confirmed accurate as coded, and the number of primaries is correct, set the *Override HospSeq/DxConf* to 1. Do not set the override flag on the patient's other primary cancers.
- However, if it turns out that the non-microscopically-confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically-confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary. Also check for other data items on the remaining cases that may need to be changed as a result of the corrections, such as stage and treatment.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the edit *Diagnostic Confirm, Seq Num–Hosp (CoC)*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

OVERRIDE COC–SITE/TYPE

Item Length: 1
Allowable Values: 1
NAACCR Item #1987
Revised 09/06, 09/08

ACR Required Data Item #309a

Description
Used with the EDITS software to override the edits *Primary Site, Morphology-Type ICDO2 (CoC), Primary Site, Morphology-Type ICDO3 (CoC)*, and/or *Primary Site, Morphology-Type, Behavior ICDO3 (CoC)*.

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
There are multiple versions of edits of the type, *Primary Site, Morphology-Type*, which check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different override flag. The CoC version of the edit will accept Override CoC-Site/Type or Override Site/Type as equivalent.

- The Site/Histology Validation List (available on the SEER Web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not be included. These edits require review of all combinations *not* listed.
- Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if *Primary Site* (NAACCR Item #400) is in the range C44.0-C44.9 (skin), and the ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No override is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether the combination is biologically implausible or there are cancer registry coding conventions that would dictate different codes for the diagnosis (See *Cancer Identification* in Section I). Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for edits of the type *Primary Site, Morphology-Type*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms they are correct and coded in conformance with coding rules.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

OVERRIDE HOSPSEQ/SITE

ACR Required Data Item #310a

Item Length: 1
Allowable Values: 1
NAACCR Item #1988
Revised 09/06 09/08, 02/10

Description
Used with the EDITS software to override the edit *Seq Num–Hosp, Primary Site, Morph ICDO2 (CoC)* and/or the edit *Seq Num–Hosp, Primary Site, Morph ICDO3 (CoC)*.

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
Edits of the type, *Seq Num–Hosp, Primary Site, Morph,* differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site-morphology combination that could indicate a metastatic site rather than a primary site. If *Sequence Number–Hospital* indicates the person has had more than one primary, then any case with one of the following site-histology combinations requires review:

- C76.0–C76.8 (Ill-defined sites) or C80.9 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. (Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of “abdominal carcinomatosis” may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.)
- Lymph node primary sites (C77.0-C77.9) for histologies other than lymphomas, or hematopoietic primary sites for histologies not in range for hematopoietic diseases. (That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.)
- Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. (Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.)

If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for an edit of the type *Seq Num–Hosp, Primary Site, Morph*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

OVERRIDE SITE/TNM-STAGE GROUP

Item Length: 1
Allowable Values: 1
NAACCR Item #1989
Revised 09/04, 09/08, 01/10

ACR Required Data Item #311a

Description
Used with the EDITS software to override the edits of the type *Primary Site, AJCC Stage Group,*for AJCC staging editions 6 and later.

Rationale
This override flag allows identification of pediatric cancers that were staged according to a system other than the **AJCC** staging manual (which is predominantly directed toward adult staging) if they are not also **AJCC**-staged. In that situation an otherwise-stageable case may be coded 88 (not applicable) for all **AJCC** items.

EDITS Use
Edits of the type, *Primary Site, AJCC Stage Group*, check that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the *AJCC Cancer Staging Manual, Sixth or Edition*, using the codes described for the items *Clinical Stage Group* (NAACCR Item #970) and *Pathologic Stage Group* (NAACCR Item #910). Combinations of site and histology not represented in any AJCC schema must be coded 88. Unknown codes must be coded 99. Blanks are not permitted.

Since pediatric cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, use *Override Site/TNM-Stage Group* to indicate the case was coded according to a pediatric staging system if it was not also coded according to the AJCC manual. Pediatric stage groups should *not* be recorded in the *Clinical Stage Group* or *Pathologic Stage Group* items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any AJCC component is used to stage a pediatric case, follow the instructions for coding AJCC items and leave *Override Site/TNM-Stage Group* blank.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the edits of the type, *Primary Site, AJCC Stage Group*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case is confirmed to be a pediatric case that was coded using a pediatric coding system.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

OVERRIDE AGE/SITE/MORPH

ACR Required Data Item #312a

Item Length: 1
Allowable Values: 1
NAACCR Item #1990
Revised 04/07, 09/08, 01/10

Description
Used with the EDITS software to override edits of the type *Age, Primary Site, Morphology; Age, Primary Site, Morph ICDO3–Adult,* and *Age, Primary Site, Morph ICDO3–Pediatric.*

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
Edits of the type *Age, Primary Site, Morphology Age; Primary Site, Morph ICDO3–Adult;* and *Age, Primary Site, Morph ICDO3–Pediatric* require review if a site-morphology combination occurs in an age group for which it is extremely rare or if the cancer was diagnosed in utero.

If the edit generates an error or warning message, check that the primary site and histologic type are coded correctly and that the age, date of birth, and date of diagnosis are correct.

Instructions for Coding

- Leave blank if the EDITS program does not generate an error message for the *Age, Primary Site, Morphology*; *Age, Primary Site, Morph ICDO3–Adult*, and *Age, Primary Site, Morph ICDO3–Pediatric* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 for an unusual occurrence of a particular age/site/histology combination for a given age has been confirmed by review to be correct.
- Code 2 if the case was diagnosed in utero.
- Code 3 if both conditions apply.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed; age, site, and morphology combination confirmed as reported.
2	Reviewed; diagnosis in utero.
3	Reviewed; both conditions apply.

OVERRIDE SURG/DXCONF

Item Length: 1
Allowable Values: 1
NAACCR Item #2020
Revised 09/06, 09/08

ACR Required Data Item #313a

Description
Used with the EDITS software to override the edits *RX Summ–Surg Prim Site, Diag Conf (SEER IF76); RX Summ–Surgery Type, Diag Conf (SEER IF46);* and/or the edit *RX Summ–Surg Site 98-02, Diag Conf (SEER 106).*

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
Edits of the type, *RX Summ–Surg Prim Site, Diag Conf*, check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed.

If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer.

- Verify the surgery and diagnostic confirmation codes, and correct any errors.
- Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery, for example, the tissue removed may be inadequate for evaluation.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for edits of the type, *RX Summ–Surg Prim Site, Diag Conf*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

OVERRIDE SITE/TYPE

ACR Required Data Item #314a

Item Length: 1
Allowable Values: 1
NAACCR Item #2030
Revised 09/06, 09/08, 01/10

Description
Used with the EDITS software to override edits of the type *Primary Site, Morphology-Type* and *Primary Site, Morphology-Type, Behavior ICDO3.*

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
There are multiple versions of edits of the type, *Primary Site, Morphology-Type,* which check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different override flag. The CoC version of the edit will accept *Override CoC-Site/Type* or *Override Site/Type* as equivalent.

- The Site/Histology Validation List (available on the SEER website) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not be included. These edits require review of all combinations *not* listed.
- Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if *Primary Site* (NAACCR Item #400) is in the range C440-C449 (skin), and the ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No override is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether the combination is biologically implausible or there are cancer registry coding conventions that would dictate different codes for the diagnosis (See *Cancer Identification* in Section I). Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for edits of the type *Primary Site, Morphology-Type.*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

OVERRIDE HISTOLOGY

Item Length: 1
Allowable Values: 1, 2, 3
NAACCR Item #2040
Revised 04/07, 09/08

ACR Required Data Item #315a

Description
Used with the EDITS software to override any of five edits: *Diagnostic Confirmation, Behavior ICDO2 (SEER IF31); Diagnostic Confirmation, Behavior ICDO3* (SEER IF31); *Morphology–Type/Behavior ICDO2 (SEER MORPH)*; *Morphology–Type/Behavior ICDO3 (SEER MORPH);* and/or the edit *Morph (1973-91) ICD-O-1 (SEER MORPH).*

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
I. Edits of the type, *Diagnostic Confirmation, Behavior Code*, differ in the use of ICD-O-2 or ICD-O-3 and check that, for in situ cases (Behavior = 2), *Diagnostic Confirmation* specifies microscopic confirmation (1, 2 or 4). The distinction between in situ and invasive is very important to a registry, since prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissue, i.e. is in situ, is made microscopically, cases coded in situ in behavior should have a microscopic confirmation code. Very rarely, a physician will designate a case noninvasive or in situ without microscopic evidence.

If an edit of the type, *Diagnostic Confirmation, Behavior Code*, gives an error message or warning, check that *Behavior Code* (NAACCR Item #523) and *Diagnostic Confirmation* (NAACCR Item #490) have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

II. Edits of the type, *Morphology–Type/Behavior*, perform the following overrideable check:

- Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since use of the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is in situ or malignant. This edit forces review of these rare cases to verify that they are indeed in situ or malignant.

If a *Morphology-Type/Behavior* edit produces an error or warning message and the case is one in which the 4-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, verify the coding of morphology and that the behavior should be coded malignant or in situ. The registrar may need to consult a pathologist or medical advisor in problem cases.

Exceptions to the above: If year of *Date of Diagnosis* > 2000, then a behavior code of 1 is valid for the following ICD-O-2 histologies and no override flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, 9989. Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472, and 8473.

Note: The *Morphology-Type/Behavior* edits are complex and perform several additional types of checks. No other aspects of their checks are subject to override.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the edits of the types *Diagnostic Confirmation* or *Morph* or *Morphology–Type/Behavior.*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1, 2 or 3 as indicated if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported for edits of the type *Morphology–Type/Behavior*.
2	Reviewed, confirmed as reported for edits of the type *Diagnostic Confirmation, Behavior Code*.
3	Reviewed: conditions 1 and 2 above both apply.

OVERRIDE LEUK, LYMPHOMA

ACR Required Data Item #317a

Item Length: 1
Allowable Values: 1
NAACCR Item #2070
Revised 09/06, 09/08, 01/10

Description
Used with the EDITS software to override edits of the type *Diagnostic Confirmation*, *Histology*.

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
Edits of the type *Diagnostic Confirmation*, *Histology* differ in use of ICD-O-2 (NAACCR Item #420) or ICD-O-3 (NAACCR Item #522) and check the following:

- Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation of direct visualization or clinical, and any leukemia with a diagnostic confirmation of direct visualization.
- For lymphomas, *Diagnostic Confirmation* (NAACCR Item #490) cannot be 6 (direct visualization) or 8 (clinical).
- For leukemia and other hematopoietic neoplasms, *Diagnostic Confirmation* cannot be 6 (direct visualization).

If an edit of the type, *Diagnostic Confirmation*, *Histology*, produces and error or warning message, check that the *Histology* and *Diagnostic Confirmation* items are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in *Diagnostic Confirmation*) for leukemia.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the edits of the type *Diagnostic Confirmation*, *Histology*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

OVERRIDE SITE/BEHAVIOR

ACR Required Data Item #318a

Item Length: 1
Allowable Values: 1
NAACCR Item #2071
Revised 09/06, 09/08

Description
Used with the EDITS software to override the edits of the type *Primary Site, Behavior Code.*

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
Edits of the type, *Primary Site, Behavior*, require review of the following primary sites with a behavior of in situ (ICD-O-2 or ICD-O-3 behavior = 2):

C26.9	Gastrointestinal tract, NOS
C39.9	Ill-defined sites within respiratory system
C55.9	Uterus, NOS
C57.9	Female genital tract, NOS
C63.9	Male genital organs, NOS
C68.9	Urinary system, NOS
C72.9	Nervous system, NOS
C75.9	Endocrine gland, NOS
C76.0-C76.8	Ill-defined sites
C80.9	Unknown primary site

Since the designation of in situ is very specific and almost always requires microscopic confirmation, ordinarily specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being in situ is reliable.

- If a specific in situ diagnosis is provided, try to obtain a more specific primary site. A primary site within an organ system can sometimes be identified based on the diagnostic procedure or treatment given or on the histologic type. If a more specific site cannot be determined, it is usually preferable to code a behavior code of 3. In the exceedingly rare situation in which it is certain that the behavior is in situ and no more specific-site code is applicable, set *Override Site/Behavior* to 1.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for *Primary Site, Behavior* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

OVERRIDE SITE/LAT/MORPH

Item Length: 1
Allowable Values: 1
NAACCR Item #2074
Revised 09/06, 09/08

ACR Required Data Item #319a

Description
Used with the EDITS software to override edit of the type *Laterality, Primary Site, Morph.*

Rationale
Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use
Edits of the type *Laterality, Primary Site, Morph* differ in whether they produce a warning or an error message and in use of ICD-O-2 or ICD-O-3 morphology and do the following:

- If the *Primary Site* (NAACCR Item #400) is a paired organ and *Behavior Code* (NAACCR Item #523) is in situ (2), then *Laterality* (NAACCR Item #410) must be 1, 2, 3 or 5.
- If diagnosis year is less than 1988 and *Histology* (NAACCR Item #522) is greater than or equal to 9590, then no further editing is performed. If diagnosis year is greater than 1987 and *Histology* equals 9140, 9700, 9701, 9590-9980, then no further editing is performed.

The intent of this edit is to force a review of in situ cases for which *Laterality* is coded 4 (bilateral) or 9 (unknown laterality) as to origin.

- In rare instances when the tumor is truly midline and the case was diagnosed prior to 2010 (when midline was coded 9), either change the *Laterality* code to 5 and leave the override blank, or enter code 1 for *Override Site/Lat/Morph.* For cases diagnosed in 2010 or later, *Laterality* must be coded 5 for midline tumors.
- If the rare combination is otherwise confirmed correct, enter code 1 for *Override Site/Lat/Morph.*.

Instructions for Coding
- Leave blank if the EDITS program does not generate an error message for the *Laterality, Primary Site, Morphology* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

COC CODING SYSTEM–CURRENT

Item Length: 2
Allowable Values: 00–08, 99
NAACCR Item #2140
Revised 01/10

ACR Required Data Item #320a

Description
Indicates the Commission on Cancer coding system currently used in the record.
Rationale
Knowledge of the coding system that describes the meaning of the codes currently stored for each case is necessary for interpretation of the coded data. It is also necessary for correct conversion of the record to a different coding system or to a different registry software system. This item differs from *CoC Coding System–Original* (NAACCR Item #2150) if the record has been converted to a more recent coding system.

Instructions for Coding
- All fields in a case record should be coded according to the same Commission on Cancer coding system following record conversion.
- This code does not apply to patient race, primary site, histology, TNM stage and its components, Collaborative Stage, comorbidities and complications, or cause of death. The original coding systems for these items are recorded in other fields.
- This item should be updated every time the record is converted to another coding system.

Code	Label	Definition
00	None	No CoC coding system used.
01	Pre-1988	Pre-1988 version (Cancer Program Manual Supplement)
02	1988	1988 *Data Acquisition Manual*
03	1989	1989 *Data Acquisition Manual*
04	1990	1990 *Data Acquisition Manual*
05	1994	1994 *Data Acquisition Manual*
06	1996	*Standards of the Commission on Cancer Volume II: Registry Operations and Data Standards (ROADS)*
07	1998	*Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)* 1998 Revisions
08	2003	*Facility Oncology Registry Data Standards (FORDS)*
99	Unknown	Unknown coding system.

Examples

Code	Reason
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program and no conversion of the record has occurred since its accession into the registry.
08	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program. In 1989, the registry records were converted to conform to the codes defined in the 1989 *Data Acquisition Manual*. The registry data were subsequently converted in 1996, 1998, and 2003 with the publication of each manual.

Code	Reason
08	A case accessioned in 1997 was coded according to 1996 *Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)*, and subsequently converted to correspond to the coding system expressed in *Facility Oncology Registry Data Standards (FORDS).*
08	A new case was abstracted in 2010 using *Facility Oncology Registry Data Standards* (*FORDS) Revised for 2010.*
99	A case was accessioned in 1989, but it is unknown whether the 1988 or 1989 version of the *Data Acquisition Manual* was used to code the case. The conversion of this record to a more recent coding system is not possible due the uncertainty of its original coding system.

COC CODING SYSTEM–ORIGINAL

ACR Required Data Item #322a

Item Length: 2
Allowable Values: 00–08, 99
NAACCR Item #2150
Revised 01/10

Description
Indicates the Commission on Cancer coding system used to originally code the items.

Rationale
The coding system used when a case is originally coded limits the possible categories that could have been applied to code the case. Because code categories may change over time as new coding systems are developed, this item is used to assist interpretation when cases that may have been coded originally according to multiple coding systems are analyzed.

Instructions for Coding
- All fields in a case record should be coded according to the same Commission on Cancer coding system.
- This code does not apply to patient race, primary site, histology, TNM stage and its components, Collaborative Stage, comorbidities or complications, or cause of death. The original coding systems for these items are recorded in other fields.
- This item must not be changed when the record is converted to another coding system. That information is reflected in the data item *CoC Coding System–Current* (NAACCR Item #2140).
- Code 99 for cases coded prior to 2003 if the correct CoC coding system is not known, or if multiple coding systems were used to code a single case. Ordinarily, it will not be necessary to use code 99 for cases accessioned in 2003 or later.

Code	Label	Definition
00	None	No CoC coding system used.
01	Pre-1988	Pre-1988 version (Cancer Program Manual Supplement)
02	1988	1988 *Data Acquisition Manual*
03	1989	1989 *Data Acquisition Manual*
04	1990	1990 *Data Acquisition Manual*
05	1994	1994 *Data Acquisition Manual*
06	1996	*Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)*
07	1998	*Standards of the Commission on Cancer Volume II: Registry Operations and Data Standards (ROADS)* 1998 Revisions
08	2003	*Facility Oncology Registry Data Standards (FORDS)*
99	Unknown	Original CoC coding system used is not known.

Examples

Code	Reason
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program.
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program. In 1989, the registry records were converted to conform to the codes defined in the 1989 *Data Acquisition Manual*. The registry data were subsequently converted in 1996, 1998, and 2003 with the publication of each manual.
06	A case accessioned in 1997 was coded according to *1996 Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards* (ROADS), and subsequently converted to correspond to the coding rules expressed in *Facility Oncology Registry Data Standards (FORDS).*
99	A case was accessioned in 1989, but it is unknown whether the 1988 or 1989 version of the *Data Acquisition Manual* was used to code the case.

RACE CODING SYSTEM–CURRENT

Item Length: 1
Allowable Values: 1–6, 9
NAACCR Item #170
Revised 01/04, 01/10

ACR Required Data Item #324a

Description
Describes how race is currently coded. If converted, this field shows the system to which it was converted.

Rationale
Race codes (NAACCR Items #160–164) have changed over time. To accurately group and analyze data, it is necessary to record the system used to record the race codes.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	<1988 (1-digit)
3	1988 + (2-digit)
4	1991 + (added codes 20–97) #324b-For code 4, year is 1993 for Arizona.
5	1994 + (added code 14)
6	2000 + (no new codes added, new items *Race #2–Race #5* added)
7	2010 + (added codes 15, 16, and 17; removed 09)
9	Other

RACE CODING SYSTEM–ORIGINAL

ACR Required Data Item #325a

Item Length: 1
Allowable Values: 1–6, 9
NAACCR Item #180
Revised 01/04, 01/10

Description
Describes how race was originally coded.

Rationale
Race #1–#5 codes (NAACCR Items #160–164) have changed over time. Identifying both the original and current coding systems used to code race promotes accurate data grouping and analysis.

Instructions for Coding
- This item is autocoded by the software provider.
- For cases diagnosed on or after January 1, 2010, this data item must be coded 7.

Code	Definition
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	<1988 (1-digit)
3	1988 + (2-digit)
4	1991 + (added codes 20–97) #325b-For code 4, year is 1993 for Arizona.
5	1994 + (added code 14)
6	2000 + (no new codes added, new items *Race #2–Race #5* added)
7	2010 + (added codes 15, 16, and 17; removed 09)
9	Other

SITE CODING SYSTEM–CURRENT

ACR Required Data Item #326a

Item Length: 1
Allowable Values: 1–6, 9
NAACCR Item #450

Description
Describes how the primary site is currently coded. If converted, this field shows the system to which it was converted.

Rationale
This information is used for some data analysis and for further item conversions.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
1	ICD-8 and Manual of Tumor Nomenclature and Coding (MOTNAC)
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

SITE CODING SYSTEM–ORIGINAL

ACR Required Data Item #327a

Item Length: 1
Allowable Values: 1–6, 9
NAACCR Item #460

Description
Describes how the primary site was originally coded.

Rationale
This information is used for some data analysis. Converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
1	ICD-8 and Manual of Tumor Nomenclature and Coding (MOTNAC)
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

MORPHOLOGY CODING SYSTEM–CURRENT

Item Length: 1
Allowable Values: 1–7, 9
NAACCR Item #470
Revised 01/10

ACR Required Data Item #328a

Description
Describes how morphology is currently coded. If converted, this field shows the system to which it was converted.

Rationale
This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
9	Other

MORPHOLOGY CODING SYSTEM–ORIGINAL

Item Length: 1
Allowable Values: 1–7, 9
NAACCR Item #480
Revised 01/04, 01/10, 01/11

ACR Required Data Item #329a

Description
Describes how morphology was originally coded. If later converted, this field shows the original codes used.

Rationale
This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding
- This item is autocoded by the software provider.
- For cases diagnosed on or after January 1, 2010, this data item must be coded 8.

Code	Definition
1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
9	Other

ICD-O-2 CONVERSION FLAG

Item Length: 1
Allowable Values: 0–4, blank
NAACCR Item #1980
Revised 01/04

ACR Required Data Item #330a

Description
Specifies whether or how site and morphology codes were converted to ICD-O-2.

Rationale
This information is used for some data analysis and for further item conversions.

Instructions for Coding
- Codes 0, 1, and 2 are autocoded by the software provider.
- Codes 3 and 4 are manually entered following a review of the automated morphology conversion from ICD-O-1 or ICD-O-3 to ICD-O-2.

Code	Definition
(leave blank)	Not converted.
0	Primary site and morphology originally coded in ICD-O-2.
1	Primary site and morphology converted without review.
2	Primary site and morphology converted with review; morphology machine-converted without review.
3	Primary site machine-converted without review; morphology converted with review.
4	Primary site and morphology converted with review.
5	Morphology converted from ICD-O-3 without review.
6	Morphology converted from ICD-O-3 with review.

ICD-O-3 CONVERSION FLAG

ACR Required Data Item #331a

Item Length: 1
Allowable Values: 0, 1, 3, blank
NAACCR Item #2116
Revised 01/04

Description
Identifies how the conversion of morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Rationale
This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding
- Codes 0 and 1 are autocoded by the software provider.
- Code 3 is manually entered following review of the automated morphology conversion from ICD-O-2 to ICD-O-3.

Code	Definition
(leave blank)	Not converted.
0	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) originally coded in ICD-O-3.
1	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) converted from (Morph–Type&Behav ICD-O-2, NAACCR Item #419) without review.
3	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) converted from (Morph–Type&Behav ICD-O-2, NAACCR Item #419) with review.

TNM EDITION NUMBER

ACR Required Data Item #332a

Item Length: 2
Allowable Values: 00–06, 88, 99
NAACCR Item #1060
Revised 01/04, 01/10

Description
Identifies the edition of the *AJCC Cancer Staging Manual* used to stage the case.

Rationale
AJCC stage and component T, N, and M codes and rules have changed over time. This item enables the analysis of cases grouped by edition number.

Instructions for Coding
This item is autocoded by the software provider.

Code	Label
00	Not staged (cases that have an AJCC staging scheme and staging was not done).
01	First Edition
02	Second Edition
03	Third Edition
04	Fourth Edition
05	Fifth Edition
06	Sixth Edition
07	Seventh Edition
88	Not applicable (cases that do not have an AJCC staging scheme).
99	Staged, but the edition is unknown.

ICD REVISION COMORBIDITIES AND COMPLICATIONS

Not Required by ACR #333a

Item length: 1
Allowable values: 0, 1, 9
NAACCR Item #3165
Added 06/05

Description
This item indicates the coding system from which the *Comorbidities and Complications* (secondary diagnoses) codes are provided.

Rationale
Following the implementation of *FORDS*, it was determined that additional *Comorbidities and Complications* data items were needed.

Instructions for Coding
ICD Revision Comorbidities and Complications is to be recorded for patients diagnosed on or after January 1, 2006.

Code	Definition
0	No secondary diagnosis reported.
1	ICD-10
9	ICD-9

RX CODING SYSTEM–CURRENT

ACR Required Data Item #334a

Item Length: 2
Allowable Values: 00–06, 99
NAACCR Item #1460

Description
Describes how treatment for this case is now coded.

Rationale
This information is used for some data analysis and for further item conversions.

Instructions for Coding
- This item is autocoded by the software provider.
- The *FORDS* manual **must** be used to record treatment for all cases diagnosed January 1, 2003, or later and this item **must** be coded 06.

Code	Definition
00	Treatment data not coded/transmitted, i.e., 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.
07	Treatment data coded according to 2010 SEER manual.
99	Other coding, including partial or nonstandard coding.

DERIVED AJCC–FLAG

ACR Required Data Item #335a

Item Length: 1
Allowable Values: 1, 2
NAACCR Item #3030
Added 01/04, 01/10

Description
Indicates the source data items used to derive AJCC Stage descriptors and Stage Group. It also indicates the target AJCC edition described by the derived AJCC Stage descriptors and Stage Group.

Rationale
AJCC Stage and component T, N, and M codes and rules change over time as does the method of deriving them. This item enables the analysis of cases grouped by coding and derivation version.

Instructions for Coding

Code	Description
(leave blank)	Not derived.
1	AJCC fields derived from Collaborative Stage.
2	AJCC fields derived from EOD (prior to 2004).

DERIVED SS1977–FLAG

Item Length: 1
Allowable Values: 1, 2
NAACCR Item #3040
Revised 01/10

ACR Required Data Item #336a

Description
Indicates the source data items used to derive SEER Summary Stage 1997.

Rationale
The derivation of SS1977 varies over time with the coding rules and codes in use when the components were coded. This item enables the analysis of cases grouped by coding and derivation version.

Instructions for Coding

Code	Description
(leave blank)	Not derived.
1	SS1977 derived from Collaborative Stage.
2	SS1977 derived from EOD (prior to 2004).

DERIVED SS2000–FLAG

Item Length: 1
Allowable Values: 1, 2
NAACCR Item #3050
Added 01/04, 01/10

ACR Required Data Item #337a

Description
Indicates the source data items used to derive SEER Summary Stage 2000.

Rationale
The derivation of SS2000 varies over time with the coding rules and codes in use when the components were coded. This item enables the analysis of cases grouped by coding and derivation version.

Instructions for Coding

Code	Description
(leave blank)	Not derived.
1	SS2000 derived from Collaborative Stage.
2	SS2000 derived from EOD (prior to 2004).

CS VERSION INPUT ORIGINAL
(CS VERSION FIRST)

ACR Required Data Item #338a
For cases diagnosed on or after 1/1/2004.

Item Length: 6
Numeric
NAACCR Item #2935
Revised 01/10

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.

Rationale
Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

Instructions for Coding
This item is autocoded by the software provider.

Codes
CS Version Input Original is a 6-digit code. The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g., 010100).

CS VERSION INPUT CURRENT

ACR Required Data Item #339a
For cases diagnosed on or after 1/1/2010.

Item Length: 6
Numeric
NAACCR Item #2937
New Item 01/2010

Description
This item indicates the version of CS input fields after they have been updated or recoded. This data item is recorded the first time the CS input fields are entered and should be updated each time the CS input fields are modified.

Rationale
Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

Instructions for Coding
This item is autocoded by the software provider.

Codes
CS Version Input Current is a 6-digit code. The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g., 010100).

CS VERSION DERIVED
(CS VERSION LATEST)

ACR Required Data Item #340a
For cases diagnosed on or after 1/1/2004.

Item Length: 6
Numeric
NAACCR Item #2936
Revised 01/10

Description
This data item is recorded the first time the CS output fields are derived and should be updated each time the CS Derived items are recomputed. The CS version number is returned as part of the output of the CS algorithm.

Rationale
The CS algorithm may be re-applied to compute the CS Derived items; for example, when the data are to be used for a special study, transmitted, or when an updated CS algorithm is produced. This item identifies the specific algorithm used to obtain the CS Derived values in the data record.

Instructions for Coding
This item is autocoded by the software provider.

Codes
CS Version Derived is a 6-digit code. The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g., 010100).

OVER-RIDE SS/NODESPOS
ALSO CALLED "COC—Flag—SS/NodesPos"

Item Length: 1
Allowable Codes: 1 or blank
NAACCR Item #1981

ACR Required Data Item

Description
This field is used to indicate that an error message has been reviewed by the registrar and the coding is deemed correct, and is used with the following edits in the NAACCR Metafile of the EDITS software:

Summary Stage, 1977, Regional Nodes Pos (NAACCR)
Summary Stage 2000, Regional Nodes Pos (NAACCR)

Rationale
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, override flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Instructions for Coding
Record the appropriate code or leave blank if there is no error message or if the case has not been reviewed.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

OVER-RIDE SS/TNM-N
ALSO CALLED "COC—Flag—SS/TNM-N"

Item Length: 1
Allowable Codes: 1 or blank
NAACCR Item #1982

ACR Required Data Item

Description
This field is used to indicate that an error message has been reviewed by the registrar and the coding is deemed correct, and is used with the following edits in the NAACCR Metafile of the EDITS software:

Summary Stage 1977, TNM-N (NAACCR)
Summary Stage 2000, TNM-N (NAACCR)

Rationale
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, override flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Instructions for Coding
Record the appropriate code or leave blank if there is no error message or if the case has not been reviewed.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

OVER-RIDE SS/TNM-M
ALSO CALLED "COC—Flag—SS/TNM-M"

Item Length: 1
Allowable Codes: 1 or blank
NAACCR Item #1983

ACR Required Data Item

Description
This field is used to indicate that an error message has been reviewed by the registrar and the coding is deemed correct, and is used with the following edits in the NAACCR Metafile of the EDITS software:

Summary Stage 1977, TNM-M (NAACCR)
Summary Stage 2000, TNM-M (NAACCR)

Rationale
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, override flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Instructions for Coding
Record the appropriate code or leave blank if there is no error message or if the case has not been reviewed.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

OVER-RIDE SEQNO/DXCONF
ALSO CALLED "Seer Flag—SeqNo/DxConf"

For Central Registry Only

Item Length: 1
Allowable Codes: 1 or blank
NAACCR Item #2000

Description
This field is used to indicate that an error message has been reviewed by the registrar and the coding is deemed correct, and is used with the following edits in the NAACCR Metafile of the EDITS software:

Diagnostic Confirm, Seq Num—Central (SEER IF23)

Note: In the SEER Program Coding and Staging Manual 2010, this over-ride is referred to as the Sequence Number/Diagnostic Confirmation Interfield Review (Interfield Edit 23).

Rationale
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, override flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Instructions for Coding
Record the appropriate code or leave blank if there is no error message or if the case has not been reviewed.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

This item for Central Registry Use Only.

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

OVER-RIDE SITE/LAT/SEQNO
ALSO CALLED "Seer Flag—Site/Lat/SeqNo"

ACR Required Data Item

Item Length: 1
Allowable Codes: 1 or blank
NAACCR Item #2010

Description
This field is used to indicate that an error message has been reviewed by the registrar and the coding is deemed correct, and is used with the following interrecord edit from the SEER Program: Verify Same Primary Not Reported Twice for a Person (SEER IR09)

Rationale
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, override flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Instructions for Coding
Record the appropriate code or leave blank if there is no error message or if the case has not been reviewed.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

OVER-RIDE REPORT SOURCE
ALSO CALLED "Seer Flag—Report Source"

Item Length: 1
Allowable Codes: 1 or Blank
NAACCR Item #2050

For Central Registry Only

Description
This field is used to indicate that an error message has been reviewed by the registrar and the coding is deemed correct, and is used with the following edits in the NAACCR Metafile of the EDITS software:

Type of Report Srce(DC), Seq Num—Cent, ICDO2 (SEER IF 04)
Type of Rep Srce(DC), Seq Num—Cent, ICDO3 (SEER IF04)

Note: In the SEER Program Coding and Staging Manual 2010, this over-ride is referred to as the Type of Reporting Source/Sequence Number Interfield Review (Interfield Edit 04).

Rationale
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, override flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Instructions for Coding
Record the appropriate code or leave blank if there is no error message or if the case has not been reviewed.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

OVER-RIDE ILL-DEFINE SITE
ALSO CALLED "Seer Flag—Ill-Define Site"

For Central Registry Use

Item Length: 1
Allowable Codes: 1 or blank
NAACCR Item #2060

Description
This field is used to indicate that an error message has been reviewed by the registrar and the coding is deemed correct, and is used with the following edits in the NAACCR Metafile of the EDITS software:

Seq Num—Central, Prim Site, Morph ICDO2 (SEER IF22)
Seq Num—Central, Prim Site, Morph ICDO3 (SEER IF22)

Note: In the SEER Program Coding and Staging Manual 2010, this over-ride is referred to as the Sequence Number Ill-Defined Site Interfield Review (Interfield Edit 22).

Rationale
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, override flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Instructions for Coding
Record the appropriate code or leave blank if there is no error message or if the case has not been reviewed.

1	Reviewed and confirmed as reported: A second or subsequent primary reported with an ill-defined primary site (C76.0-C76.8, C80.9) has been reviewed and is an independent primary.
Blank	Not reviewed or reviewed and corrected

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

OVER-RIDE SITE/EOD/DX DT
ALSO CALLED "Seer Flag—Site/EOD/Dx Dt"

Item Length: 1
Allowable Codes: 1 or blank
NAACCR Item #2072

Not required by ACR.

Description
This field is used to indicate that an error message has been reviewed by the registrar and the coding is deemed correct, and is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, EOD ICDO2 (SEER IF40)
Primary Site, EOD, ICDO3 (SEER IF40)
Primary Site, CS Extension (SEER IF176)

Note: In the SEER Program Coding and Staging Manual 2010, this over-ride is referred to as the Over-ride Flag for Site/EOD/Diagnosis Date (IF40).

Rationale
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, override flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Instructions for Coding
Record the appropriate code or leave blank if there is no error message or if the case has not been reviewed.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Note: The IF40 edit does not allow localized disease with nonspecific sites, such as mouth, NOS; colon, NOS (except histology 8220); bone, NOS; female genital system, NOS; male genital organs, NOS; and others. This over-ride indicates that the conflict has been reviewed.

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

OVER-RIDE SITE/LAT/EOD
ALSO CALLED "Seer Flag—Site/Lat/EOD"

Not required by ACR.

Item Length: 1
Allowable Codes: 1 or blank
NAACCR Item #2073

Description
This field is used to indicate that an error message has been reviewed by the registrar and the coding is deemed correct, and is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, Laterality, EOD, ICDO2 (SEER IF41)
Primary Site, Laterality, EOD, ICDO3 (SEER IF41)
Primary Site, Laterality, CS Extension (SEER IF177)

Note: In the SEER Program Coding and Staging Manual 2010, this over-ride is referred to as the Over-ride Flag for Site/Laterality/EOD (IF41).

Rationale
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, override flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Instructions for Coding
Record the appropriate code or leave blank if there is no error message or if the case has not been reviewed.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Note: The IF41 edit for paired organs does not allow EOD to be specified as *in situ*, localized, or regional by direct extension if laterality is coded as bilateral, site unknown or laterality unknown. This over-ride indicates that the conflict has been reviewed.

Source:
Thornton M. (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1*, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

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ACR Supplement Page

APPENDIX A

Use the table in this Appendix only for hematologic malignancies diagnosed prior to January 1, 2010. Beginning with diagnoses on that date, use *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB).

Appendix A:
Definitions of Single and Subsequent Primaries for Hematologic Malignancies

Based on ICD-O-3 reportable malignancies, for use with diagnoses 01/01/2001 - 12/31/2009

Cancer registrars are often faced with multiple pathology reports in patients with hematologic malignancies, and the diagnoses reported may require different morphology codes. This is due in part to the fact that more intensive diagnostic study may yield a more specific diagnosis, and in part due to the natural histories of hematopoietic diseases, which may progress from one diagnosis into another.

The following chart, provided to aid the registrar in determining single versus subsequent primaries, employs the following guidelines:

1. "Lymphoma" is a general term for hematopoietic solid malignancies of the lymphoid series. "Leukemia" is a general term for liquid malignancies of either the lymphoid or the myeloid series. While it is recognized that some malignancies occur predominantly (or even exclusively) in liquid or solid form, because so many malignancies can potentially arise as either leukemias or lymphomas (or both), all hematopoietic malignancies are assumed to have this potential.
2. Malignancies of the lymphoid series are considered to be different from those of the myeloid series. Therefore, a lymphoid malignancy arising after diagnosis of a myeloid malignancy (or myelodysplastic or myeloproliferative disorder) would be considered a subsequent primary; however, a myeloid malignancy diagnosed after a previous myeloid malignancy would not count as a subsequent primary. Histiocytic malignancies are considered different from both lymphoid and myeloid malignancies.
3. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma (NHL). Among the NHLs, B-cell malignancies are considered different from T-cell/NK cell malignancies. Therefore, a B-cell malignancy arising later in the course of a patient previously diagnosed with a T-cell malignancy would be considered a subsequent primary; however, a T-cell malignancy diagnosed later in the same patient would not be considered a subsequent primary.
4. The sequence of diagnoses affects whether a diagnosis represents a subsequent primary. In some cases, the order of occurrence of the two diagnoses being compared is a factor in the decision whether the second diagnosis is a new primary.

We gratefully acknowledge the assistance of Drs. Charles Lynch, Charles Platz, and Fred Dick of the University of Iowa. Dr. Tim Cote of the SEER Program, Jennifer Seiffert, MLIS, CTR, and Annette Hurlbut, RHIT, CTR for their assistance with this project.

To use the table, assign the ICD-O-3 code to the first diagnosis and find the row containing that code. Assign the ICD-O-3 code for the second diagnosis and find the column containing that code. In the cell at the intersection of the first diagnosis row and second diagnosis column, a "**S**" symbol indicates that the two diagnoses are most likely the **same** disease process (prepare/update a single abstract) and a "**D**" indicates that they are most likely **different** disease processes (prepare more than one abstract).

Note 1: If one of the two diagnoses is an NOS (not otherwise specified) term and the other is more specific and determined to be the same disease process, code the more specific diagnosis regardless of the sequence. For example, if a diagnosis of non-Hodgkin lymphoma, NOS is followed by a diagnosis of follicular lymphoma, assign the morphology code for the follicular lymphoma.

Note 2: The table "Single versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases" (pages X-X) and the "Complete Diagnostic Terms for Table (based on ICD-O-3)" (page X) display only the ICD-O-3 primary (boldfaced) term associated with the code. Refer to the *International Classification of Disease, Third Edition* (ICD-O-3) for a complete list of related terms and synonyms.

Source: SEER Program, NCI E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 1 SECOND DX ACROSS FIRST DX DOWN		1. 9590 Malig lymphoma, NOS	2. 9591 NHL, NOS	3. 9596 Compos HD/NHL	4. 9650-9667 Hodgkin lymphoma	5. 9670-9671 ML, small B lymph	6. 9673 Mantle cell lymph	7. 9675-9684 ML, diff large B-cell	8. 9687 Burkitt lymphoma	9. 9689,9699 Marg zn, B-cl lym	10. 9690-9698 Follicular lymphoma
1. Malignant lymphoma, NOS	9590	**S**	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	**S**	D	D	S	S	S	S	S	S
3. Composite HD/NHL	9596	S	S	**S**	S	S	S	S	S	S	S
4. Hodgkin lymphoma	9650-9667	S	D	D	**S**	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	S	D	D	**S**	D	S	D	D	D
6. Mantle cell lymphoma	9673	S	S	D	D	D	**S**	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	D	D	S	D	**S**	S	D	S
8. Burkitt lymphoma	9687	S	S	D	D	D	D	D	**S**	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	S	S	D	D	D	D	D	D	**S**	D
10. Follicular lymphoma	9690-9698	S	S	D	D	D	D	S	D	D	**S**
11. Mycos fung, Sezary disease	9700-9701	S	S	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	S	S	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	S	S	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	S	S	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	S	S	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	S	S	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	D	D	S	D	S	D	D	D
21. Waldenstrom macroglob	9761	S	S	D	D	S	D	S	D	D	D
22. Heavy chain disease, NOS	9762	S	S	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	S	S	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	S	D	D	D	D	D	S	D	D
25. Acute biphenotypic leukem	9805	S	S	D	D	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	D	D	D	D	S	D	S
27. BCLL/SLL	9823	S	S	D	D	S	D	S	D	D	D
28. Burkitt cell leukemia	9826	S	S	D	D	D	D	D	S	D	D
29. Adult T-cell leuk/lymph	9827	S	S	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	S	S	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	S	S	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	S	S	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	S	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 2 SECOND DX ACROSS FIRST DX DOWN		11. 9700-9701 MF, Sezary disease	12. 9702-9719 T/NK-cell lymphoma	13. 9727 Precurs lym'blas lymph NOS	14. 9728 Precurs lym'blas lymph B-cl	15. 9729 Precurs lym'blas lymph T-cl	16. 9731-9734 Plasma cell tumors	17. 9740-9742 Mast cell tumors	18. 9750-9756 Histiocytos; LCH	19. 9757-9758 Dendritic cell sarc	20. 9760 Immunoprolif dis
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	D	D	D	S	S
3. Composite HD/NHL	9596	S	S	S	S	S	D	D	D	D	S
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	S
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	**S**	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	**S**	D	D	D	D	D	D	D	S
13. Precurs lym'blas lymph NOS	9727	D	D	**S**	S	S	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	**S**	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	**S**	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	**S**	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	**S**	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	**S**	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	**S**	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	S	D	D	D	**S**
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	S
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	S
23. Immun sm intest disease	9764	D	D	D	D	D	S	D	D	D	S
24. Leuk/Acute leuk, NOS	9800-9801	D	S	S	S	S	D	D	D	D	D
25. Acute biphenotypic leukem	9805	S	S	S	S	S	D	D	D	D	D
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	S	S	S	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	S	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	S	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	D	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 3 SECOND DX ACROSS FIRST DX DOWN		21. 9761 Waldenstrom	22. 9762 Heavy chain dis	23. 9764 Imm sm intest dis	24. 9800-9801 Leuk/Acu leuk NOS	25. 9805 Acute biphenotypic leuk	26. 9820 Lym'cyt leuk, NOS	27. 9823 BCLL/SLL	28. 9826 Burkitt leukemia	29. 9827 Adult T-cell leuk/lym	30. 9832 Prolym leuk, NOS
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	S	S	S	S	D
3. Composite HD/NHL	9596	S	S	S	S	D	S	S	S	S	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	S	S	S	D	D	S
6. Mantle cell lymphoma	9673	D	D	D	D	S	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	S	D	S	S	S	D	D	S
8. Burkitt lymphoma	9687	D	D	D	S	S	S	D	S	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	S	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	S	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	S	S	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	S	S	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	S	S	S	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	S	S	S	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	S	S	S	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	S	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	**S**	D	D	D	D	S	S	D	D	D
22. Heavy chain disease, NOS	9762	D	**S**	S	D	D	S	S	D	D	D
23. Immun sm intest disease	9764	D	S	**S**	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	D	**S**	S	S	D	S	S	D
25. Acute biphenotypic leukem	9805	D	D	D	S	**S**	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	S	S	**S**	S	S	S	S
27. BCLL/SLL	9823	D	D	D	D	S	S	**S**	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	S	S	S	D	**S**	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	S	S	D	D	**S**	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	S	S	D	D	**S**
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	S	S	D	D	S
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	S	S	D	D	S	S
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	S	S	S	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	S	S	S	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	S	S	S	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	S	S	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	S	S	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	S	S	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	S	S	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	S	S	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	S	S	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	S	S	D	D	D	D	D
43. NK-cell leukemia	9948	D	D	D	S	S	S	D	D	D	D
44. Polycythemia vera	9950	D	D	D	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	S	S	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	S	S	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	S	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	S	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	S	S	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	S	S	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	S	S	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 4 SECOND DX ACROSS FIRST DX DOWN		31. 9833 Prolym leuk, B-cell	32. 9834 Prolym leuk, T-cell	33. 9835 Precurs leuk, NOS	34. 9836 Precurs leuk, B-cell	35. 9837 Precurs leuk, T-cell	36. 9840-9910 Myeloid leukemias	37. 9920 Therapy rel AML	38. 9930 Myeloid sarcoma	39. 9931 Acute panmyelosis	40. 9940 Hairy cell leukemia	41. 9945 Chr myelomono leu
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	D	D	S	S	S	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	S	S	S	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	S	S	S	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	S	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	S	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	S	S	S	S	S	S	D	D	S
25. Acute biphenotypic leukem	9805	S	S	S	S	S	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S	D
27. BCLL/SLL	9823	S	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	S	S	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	**S**	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	**S**	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	**S**	S	S	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	**S**	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	**S**	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	**S**	S	S	S	D	S
37. Therapy related AML	9920	D	D	D	D	D	S	**S**	S	S	D	S
38. Myeloid sarcoma	9930	D	D	D	D	D	S	S	**S**	S	D	S
39. Acute panmyelosis	9931	D	D	D	D	D	S	S	S	**S**	D	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	**S**	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	S	S	S	S	D	**S**
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	S	S	S	S	D	S
43. NK-cell leukemia	9948	D	D	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	S	S	S	S	D	S
46. Myelosclerosis	9961	D	D	D	D	D	S	S	S	S	D	S
47. Essen thrombocythem	9962	D	D	D	D	D	S	S	S	S	D	S
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	S	S	S	S	D	S
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	S	S	S	S	D	S
50. Refractory anemias	9980-9986	D	D	D	D	D	S	S	S	S	D	S
51. Therapy related MDS	9987	D	D	D	D	D	S	S	S	S	D	S
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	S	S	S	S	D	S

Codes: S--one primary only; D--presumably a subsequent primary

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

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		42. 9946 Juv myelomono leu	43. 9948 NK-cell leukemia	44. 9950 Polycythemia vera	45. 9960 Chr myeloprolif dis	46. 9961 Myelosclerosis	47. 9962 Ess thrombocythem	48. 9963 Chr neutrophil leu	49. 9964 Hypereosin syndr	50. 9980-9986 Refract anemias	51. 9987 Therapy rel MDS	52. 9989 Myelodys syn NOS
1. Malignant lymphoma, NOS	9590	S	S	D	D	D	D	D	D	D	D	D
2. NHL, NOS	9591	D	D	D	D	D	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	D	D	D	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	D	D	S	S	D	S	S	D	S	S
25. Acute biphenotypic leukem	9805	S	S	D	S	S	D	D	D	S	S	S
26. Lymphocytic leukem, NOS	9820	D	S	D	D	D	D	D	D	D	D	D
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	S	D	D	S	S	S	S	S	D	S	S
37. Therapy related AML	9920	S	D	D	D	S	D	D	D	D	S	S
38. Myeloid sarcoma	9930	S	D	D	S	S	S	S	D	D	S	S
39. Acute panmyelosis	9931	S	D	D	D	S	D	D	D	D	S	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	S	D	D	S	S	D	S	D	D	S	S
42. Juvenile myelomonocy leuk	9946	**S**	D	D	D	S	D	D	D	D	S	S
43. NK-cell leukemia	9948	D	**S**	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	**S**	S	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	**S**	S	S	S	D	D	D	D
46. Myelosclerosis	9961	S	D	D	S	**S**	S	S	D	D	S	S
47. Essen thrombocythem	9962	D	D	D	S	S	**S**	S	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	S	S	**S**	D	D	D	D
49. Hypereosinophilic syndrome	9964	S	D	D	S	S	D	D	**S**	D	D	D
50. Refractory anemias	9980-9986	S	D	D	S	S	D	D	D	**S**	S	S
51. Therapy related MDS	9987	S	D	D	S	S	D	D	D	S	**S**	S
52. Myelodysplastic syndr, NOS	9989	S	D	D	S	S	D	D	D	S	S	**S**

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

COMPLETE DIAGNOSTIC TERMS FOR TABLE (BASED ON ICD-O-3)

1	9590	Malignant lymphoma, NOS
2	9591	Malignant lymphoma, non-Hodgkin, NOS
3	9596	Composite Hodgkin and non-Hodgkin lymphoma
4	9650-9667	Hodgkin lymphoma (all subtypes)
5	9670-9671	Malignant lymphoma, small B lymphocytic
6	9673	Mantle cell lymphoma
7	9675-9684	Malignant lymphoma, diffuse large B-cell
8	9687	Burkitt lymphoma
9	9689, 9699	Marginal zone B-cell lymphoma
10	9690-9698	Follicular lymphoma
11	9700-9701	Mycosis fungoides and Sezary syndrome
12	9702-9719	T/NK-cell non-Hodgkin lymphoma
13	9727	Precursor cell lymphoblastic lymphoma, NOS
14	9728	Precursor B-cell lymphoblastic lymphoma
15	9729	Precursor T-cell lymphoblastic lymphoma
16	9731-9734	Plasma cell tumors
17	9740-9742	Mast cell tumors
18	9750-9756	Histiocytosis/Langerhans cell histiocytosis
19	9757-9758	Dendritic cell sarcoma
20	9760	Immunoproliferative disease, NOS
21	9761	Waldenstrom macroglobulinemia
22	9762	Heavy chain disease, NOS
23	9764	Immunoproliferative small intestinal disease
24	9800-9801	Leukemia, NOS/Acute leukemia, NOS
25	9805	Acute biphenotypic leukemia
26	9820	Lymphoid leukemia, NOS
27	9823	B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
28	9826	Burkitt cell leukemia
29	9827	Adult T-cell leukemia/lymphoma (HTLV-1 positive)
30	9832	Prolymphocytic leukemia, NOS
31	9833	Prolymphocytic leukemia, B-cell type
32	9834	Prolymphocytic leukemia, T-cell type
33	9835	Precursor cell lymphoblastic leukemia, NOS
34	9836	Precursor B-cell lymphoblastic leukemia
35	9837	Precursor T-cell lymphoblastic leukemia
36	9840-9910	Myeloid leukemias
37	9920	Therapy related acute myelogenous leukemia
38	9930	Myeloid sarcoma
39	9931	Acute panmyelosis with myelofibrosis
40	9940	Hairy cell leukemia
41	9945	Chronic myelomonocytic leukemia, NOS
42	9946	Juvenile myelomonocytic leukemia
43	9948	Aggressive NK-cell leukemia
44	9950	Polycythemia vera
45	9960	Chronic myeloproliferative disease, NOS
46	9961	Myelosclerosis with myeloid metaplasia
47	9962	Essential thrombocythemia
48	9963	Chronic neutrophilic leukemia
49	9964	Hypereosinophilic syndrome
50	9980-9986	Refractory anemias
51	9987	Therapy related myelodysplastic syndrome, NOS
52	9989	Myelodysplastic syndrome, NOS

Version 1.01. Codes corrected for terms in rows 7 and 9 on pages 2-5.

APPENDIX B:
Site-Specific Surgery Codes

Note: The histologies specified in this section apply only to cases diagnosed in 2010 or later. Please consult *FORDS: Revised for 2009* for applicable histologies for cases diagnosed prior to that date.

Appendix B-As stated above in red font, consult the *FORDS: Revised for 2009* for applicable histologies for cases diagnosed prior to 2010.

ORAL CAVITY

Lip C00.0–C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0–C02.9, Gum C03.0–C03.9, Floor of Mouth C04.0–C04.9, Palate C05.0–C05.9, Other Parts of Mouth C06.0–C06.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Wide excision, NOS

Code 30 includes:
Hemiglossectomy
Partial glossectomy

40 Radical excision of tumor, NOS
- 41 Radical excision of tumor ONLY
- 42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
- 43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

Codes 40–43 include:
Total glossectomy
Radical glossectomy

Specimen sent to pathology from surgical events 20–43.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 12/4/02, 01/10, 02/10)

PAROTID AND OTHER UNSPECIFIED GLANDS

Parotid Gland C07.9, Major Salivary Glands C08.0–C08.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
- 31 Facial nerve spared
- 32 Facial nerve sacrificed

33 Superficial lobe ONLY
- 34 Facial nerve spared
- 35 Facial nerve sacrificed

36 Deep lobe (Total)
- 37 Facial nerve spared
- 38 Facial nerve sacrificed

40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
- 41 Facial nerve spared
- 42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
- 51 WITHOUT removal of temporal bone
- 52 WITH removal of temporal bone
- 53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)

PHARYNX

Tonsil C09.0–C09.9, Oropharynx C10.0–C10.9, Nasopharynx C11.0–C11.9 Pyriform Sinus C12.9, Hypopharynx C13.0–C13.9, Pharynx C14.0

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Stripping

30 Pharyngectomy, NOS
- 31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
- 32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
- 41 WITH Laryngectomy (laryngopharyngectomy)
- 42 WITH bone
- 43 WITH both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS
- 51 WITHOUT laryngectomy
- 52 WITH laryngectomy

Specimen sent to pathology from surgical events 20–52.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)

ESOPHAGUS

C15.0–C15.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
- 51 WITH laryngectomy
- 52 WITH gastrectomy, NOS
- 53 Partial gastrectomy
- 54 Total gastrectomy
- 55 Combination of 51 WITH any of 52–54

80 Esophagectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)

STOMACH

C16.0–C16.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Gastrectomy, NOS (partial, subtotal, hemi-)
- 31 Antrectomy, lower (distal-less than 40% of stomach)***
- 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:

Partial gastrectomy, including a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS
- 41 Near-total gastrectomy
- 42 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

50 Gastrectomy, NOS WITH removal of a portion of esophagus
- 51 Partial or subtotal gastrectomy
- 52 Near total or total gastrectomy

Codes 50–52 are used for gastrectomy resection when only portions of esophagus are included in procedure.

60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***
- 61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
- 62 Near total or total gastrectomy, in continuity with the resection of other organs***
- 63 Radical gastrectomy, in continuity with the resection of other organs***

Codes 60–63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

80 Gastrectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

COLON

C18.0–C18.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy, NOS
- 28 Polypectomy-endoscopic
- 29 Polypectomy-surgical excision

Any combination of 20 or 26–29 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial colectomy, segmental resection
- 32 Plus resection of contiguous organ; example: small bowel, bladder

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
- 41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
- 51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
- 61 Plus resection of contiguous organ; example: small bowel, bladder

70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

80 Colectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)

RECTOSIGMOID

C19.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
- 31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:
- Anterior resection
- Hartmann operation
- Low anterior resection (LAR)
- Partial colectomy, NOS
- Rectosigmoidectomy, NOS
- Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

50 Total proctectomy

51 Total colectomy

55 Total colectomy WITH ileostomy, NOS
- 56 Ileorectal reconstruction
- 57 Total colectomy WITH other pouch; example: Koch pouch

60 Total proctocolectomy, NOS
  65 Total proctocolectomy WITH ileostomy, NOS
  66 Total proctocolectomy WITH ileostomy and pouch
  Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.

70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration

80 Colectomy, NOS; Proctectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)

RECTUM

C20.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Curette and fulguration

30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 30 include, but are not limited to:

Anterior resection
Hartmann's operation
Low anterior resection (LAR)
Transsacral rectosigmoidectomy
Total mesorectal excision (TME)

40 Pull through WITH sphincter preservation (coloanal anastomosis)

50 Total proctectomy

Procedure coded 50 includes, but is not limited to:

Abdominoperineal resection (Miles Procedure)

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration

80 Proctectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ANUS

C21.0–C21.8

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal Ablation

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

60 Abdominal perineal resection, NOS (APR; Miles procedure)
- 61 APR and sentinel node excision
- 62 APR and unilateral inguinal lymph node dissection
- 63 APR and bilateral inguinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

Specimen sent to pathology from surgical events 20–63.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LIVER AND INTRAHEPATIC BILE DUCTS

C22.0–C22.1

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Alcohol (Percutaneous Ethanol Injection-PEI)
- 16 Heat-Radio-frequency ablation (RFA)
- 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10–17.

20 Wedge or segmental resection, NOS
- 21 Wedge resection
- 22 Segmental resection, NOS
  - 23 One
  - 24 Two
  - 25 Three
  - 26 Segmental resection AND local tumor destruction

30 Lobectomy, NOS
- 36 Right lobectomy
- 37 Left lobectomy
- 38 Lobectomy AND local tumor destruction

50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
- 51 Right lobectomy
- 52 Left lobectomy
- 59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS
- 61 Total hepatectomy and transplant

65 Excision of a bile duct (for an intra-hepatic bile duct primary only)
- 66 Excision of an intrahepatic bile duct PLUS partial hepatectomy

75 Extrahepatic bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events 20–75.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/11)

PANCREAS

C25.0–C25.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

25 Local excision of tumor, NOS

30 Partial pancreatectomy, NOS; example: distal

35 Local or partial pancreatectomy and duodenectomy
- 36 WITHOUT distal/partial gastrectomy
- 37 WITH partial gastrectomy (Whipple)

40 Total pancreatectomy

60 Total pancreatectomy and subtotal gastrectomy or duodenectomy

70 Extended pancreatoduodenectomy

80 Pancreatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)

LARYNX

C32.0–C32.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Stripping

30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
- 31 Vertical laryngectomy
- 32 Anterior commissure laryngectomy
- 33 Supraglottic laryngectomy

40 Total or radical laryngectomy, NOS
- 41 Total laryngectomy ONLY
- 42 Radical laryngectomy ONLY

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)

LUNG

C34.0–C34.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS
12 Laser ablation or cryosurgery
13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
No specimen sent to pathology from surgical events 12–13 and 15.

20 Excision or resection of less than one lobe, NOS
23 Excision, NOS
24 Laser excision
25 Bronchial sleeve resection ONLY
21 Wedge resection
22 Segmental resection, including lingulectomy

30 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
33 Lobectomy WITH mediastinal lymph node dissection
The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

45 Lobe or bilobectomy extended, NOS
46 WITH chest wall
47 WITH pericardium
48 WITH diaphragm

55 Pneumonectomy, NOS
56 WITH mediastinal lymph node dissection (radical pneumonectomy)
The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

65 Extended pneumonectomy
66 Extended pneumonectomy plus pleura or diaphragm

70 Extended radical pneumonectomy
The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

80 Resection of lung, NOS
Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY (Revised 01/04, 01/10, 02/10)

HEMATOPOIETIC/RETICULOENDOTHELIAL/
IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE
C42.0, C42.1, C42.3, C42.4 (with any histology)
or
M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992 **(with any site)**

Code

98 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

Surgical procedures for hematopoietic/reticuloendothelial/immunoproliferative/ myeloproliferative primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

BONES, JOINTS, AND ARTICULAR CARTILAGE C40.0–C41.9
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0–C47.9
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C49.0–C49.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction

No specimen sent to pathology from surgical event 15.

25 Local excision

26 Partial resection

30 Radical excision or resection of lesion WITH limb salvage

40 Amputation of limb
- 41 Partial amputation of limb
- 42 Total amputation of limb

50 Major amputation, NOS
- 51 Forequarter, including scapula
- 52 Hindquarter, including ilium/hip bone
- 53 Hemipelvectomy, NOS
- 54 Internal hemipelvectomy

Specimen sent to pathology from surgical events 25–54.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 8/17/02, 01/10, 02/10)

SPLEEN

Spleen C42.2

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

21 Partial splenectomy

22 Total splenectomy

80 Splenectomy, NOS

Specimen sent to pathology for surgical events 21-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10)

SKIN

C44.0–C44.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
- 31 Shave biopsy followed by a gross excision of the lesion
- 32 Punch biopsy followed by a gross excision of the lesion
- 33 Incisional biopsy followed by a gross excision of the lesion
- 34 Mohs surgery, NOS
- 35 Mohs with 1-cm margin or less
- 36 Mohs with more than 1-cm margin

45 Wide excision or reexcision of lesion or minor (local) amputation with margins more than 1 cm, NOS. Margins MUST be microscopically negative.
- 46 WITH margins more than 1 cm and less than or equal to 2 cm
- 47 WITH margins greater than 2 cm

If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code, 20–36.

60 Major amputation

Specimen sent to pathology from surgical events 20–60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10)

BREAST

C50.0–C50.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS

No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Reexcision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy

A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.

40 Total (simple) mastectomy
- 41 WITHOUT removal of uninvolved contralateral breast
  - 43 With reconstruction NOS
    - 44 Tissue
    - 45 Implant
    - 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast
  - 47 With reconstruction NOS
    - 48 Tissue
    - 49 Implant
    - 75 Combined (Tissue and Implant)

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.

For single primaries only, code removal of the involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) and/or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

If the contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, whether it is done at the time of mastectomy or later.

76 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
  - 53 Reconstruction, NOS
    - 54 Tissue
    - 55 Implant
    - 56 Combined (Tissue and Implant)
- 52 WITH removal of uninvolved contralateral breast
  - 57 Reconstruction, NOS
    - 58 Tissue
    - 59 Implant
    - 63 Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle. If only sentinel lymph nodes are removed, the procedure should be coded as a simple mastectomy.

If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 41 or 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
  - 64 Reconstruction, NOS
    - 65 Tissue
    - 66 Implant
    - 67 Combined (Tissue and Implant)
- 62 WITH removal of uninvolved contralateral breast
  - 68 Reconstruction, NOS
    - 69 Tissue
    - 73 Implant
    - 74 Combined (Tissue and Implant)

70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

80 Mastectomy, NOS

Specimen sent to pathology for surgical events coded 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 05/10, 01/11)

CERVIX UTERI

C53.0–C53.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Laser ablation
- 17 Thermal ablation

No specimen sent to pathology from surgical events 10–17.

20 Local tumor excision, NOS
- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 24 Cone biopsy WITH gross excision of lesion
- 29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

- 25 Dilatation and curettage; endocervical curettage (for in situ only)
- 28 Loop electrocautery excision procedure (LEEP)

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim procedure
- 54 Extended radical hysterectomy

60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
- 61 WITHOUT removal of tubes and ovaries
- 62 WITH removal of tubes and ovaries

70 Pelvic exenteration

71 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

72 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–74.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CORPUS UTERI

C54.0–C55.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electocautery Excision Procedure (LEEP)
- 16 Thermal ablation

No specimen sent to pathology from surgical events 10–16.

20 Local tumor excision, NOS; simple excision, NOS
- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

Any combination of 20 or 24–26 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies).
- 31 WITHOUT tube(s) and ovary(ies)
- 32 WITH tube(s) and ovary(ies)

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 61 Modified radical hysterectomy
- 62 Extended hysterectomy
- 63 Radical hysterectomy; Wertheim procedure
- 64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
- 66 WITHOUT removal of tube(s) and ovary(ies)
- 67 WITH removal of tube(s) and ovary(ies)

75 Pelvic exenteration
- 76 Anterior exenteration
  Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

- 77 Posterior exenteration
  Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

- 78 Total exenteration
  Includes removal of all pelvic contents and pelvic lymph nodes.

- 79 Extended exenteration
  Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–79.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

OVARY

C56.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

17 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 17.

25 Total removal of tumor or (single) ovary, NOS
- 26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
- 27 WITHOUT hysterectomy
- 28 WITH hysterectomy

35 Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- 36 WITHOUT hysterectomy
- 37 WITH hysterectomy

50 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- 51 WITHOUT hysterectomy
- 52 WITH hysterectomy

55 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
- 56 WITHOUT hysterectomy
- 57 WITH hysterectomy

60 Debulking; cytoreductive surgery, NOS
- 61 WITH colon (including appendix) and/or small intestine resection (not incidental)
- 62 WITH partial resection of urinary tract (not incidental)
- 63 Combination of 61 and 62

Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.

70 Pelvic exenteration, NOS
- 71 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

- 72 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

- 73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

- 74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 (Salpingo-)oophorectomy, NOS

Specimen sent to pathology from surgical events 25–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10)

PROSTATE

C61.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures* (NAACCR Item #3250).

Codes

00 None; no surgery of primary site; autopsy ONLY

18 Local tumor destruction or excision, NOS

19 Transurethral resection (TURP), NOS, and no specimen sent to pathology or unknown if sent

Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS
- 14 Cryoprostatectomy
- 15 Laser ablation
- 16 Hyperthermia
- 17 Other method of local tumor destruction

No specimen sent to pathology from surgical events 10–17.

20 Local tumor excision, NOS
- 21 Transurethral resection (TURP), NOS, with specimen sent to pathology
- 22 TURP–cancer is incidental finding during surgery for benign disease
- 23 TURP–patient has suspected/known cancer

Any combination of 20–23 WITH
- 24 Cryosurgery
- 25 Laser
- 26 Hyperthermia

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS; total prostatectomy, NOS
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.

80 Prostatectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 12/4/02, 01/10, 02/10, 1/11)

TESTIS

C62.0–C62.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

12 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 12.

20 Local or partial excision of testicle

30 Excision of testicle WITHOUT cord

40 Excision of testicle WITH cord or cord not mentioned (radical orchiectomy)

80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-99922)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal ablation

No specimen sent to pathology from this surgical event 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Procedures coded 30 include, but are not limited to:
- Segmental resection
- Wedge resection

40 Complete/total/simple nephrectomy–for kidney parenchyma
Nephroureterectomy
Includes bladder cuff for renal pelvis or ureter.

50 Radical nephrectomy
May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter.

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)
The other organs, such as colon or bladder, may be partially or totally removed.

80 Nephrectomy, NOS
Ureterectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)

BLADDER

C67.0–C67.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Intravesical therapy
- 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

No specimen sent to pathology from surgical events 10–16.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Complete cystectomy with reconstruction
- 61 Radical cystectomy PLUS ileal conduit
- 62 Radical cystectomy PLUS continent reservoir or pouch, NOS
- 63 Radical cystectomy PLUS abdominal pouch (cutaneous)
- 64 Radical cystectomy PLUS in situ pouch (orthotopic)

When the procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64)

70 Pelvic exenteration, NOS

71 Radical cystectomy including anterior exenteration

For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

72 Posterior exenteration

For females, also includes removal of vagina, rectum and anus. For males, also includes prostate, rectum and anus.

73 Total exenteration

Includes all tissue and organs removed for an anterior and posterior exenteration.

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10)

BRAIN

Meninges C70.0–C70.9, Brain C71.0–C71.9,

Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0–C72.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code laminectomies for spinal cord primaries.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Tumor destruction, NOS

No specimen sent to pathology from surgical event 10.

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.

20 Local excision of tumor, lesion or mass; excisional biopsy

21 Subtotal resection of tumor, lesion or mass in brain

22 Resection of tumor of spinal cord or nerve

30 Radical, total, gross resection of tumor, lesion or mass in brain

40 Partial resection of lobe of brain, when the surgery can not be coded as 20-30.

55 Gross total resection of lobe of brain (lobectomy)

Codes 30 - 55 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events 20–55.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10)

THYROID GLAND

C73.9

(Except for M9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

13 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 13.

25 Removal of less than a lobe, NOS
- 26 Local surgical excision
- 27 Removal of a partial lobe ONLY

20 Lobectomy and/or isthmectomy
- 21 Lobectomy ONLY
- 22 Isthmectomy ONLY
- 23 Lobectomy WITH isthmus

30 Removal of a lobe and partial removal of the contralateral lobe

40 Subtotal or near total thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

Specimen sent to pathology from surgical events 25–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10)

LYMPH NODES

C77.0–C77.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 15.

25 Local tumor excision, NOS
Less than a full chain, includes an excisional biopsy of a single lymph node.

30 Lymph node dissection, NOS
- 31 One chain
- 32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy
- 41 One chain
- 42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
- 51 One chain
- 52 Two or more chains

60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy (Includes staging laparotomy for lymphoma.)
- 61 One chain
- 62 Two or more chains

Specimen sent to pathology for surgical events 25-62.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ALL OTHER SITES
C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be “debulking”

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.

Specimen sent to pathology from surgical events 20–60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

UNKNOWN AND ILL-DEFINED PRIMARY SITES
C76.0–C76.8, C80.9

(Except for M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code

98 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

APPENDIX C:
FORDS Page Revisions

FORDS: An Evolving Data Manual

Following the initial release of ***FORDS*** in July 2002, the manual has undergone a series of modifications and revisions. All revisions have been made to the online edition of the manual and have been available to registries effective the date of revision.

This edition contains all the necessary documentation to support changes in case reporting to accommodate the standard data item changes implemented in 2011. The changes in the January 2010 release involved so much of this document that they are not itemized here. See ***FORDS: Revised for 2009*** for documentation of changes from 2003 through 2009 (see *http://www.facs.org/cancer/coc/fordsmanual.html* for a link). This appendix now contains changes introduced since the initial January 2010 release of ***FORDS: Revised for 2010***. Spelling and grammar corrections are generally not cited below.

Specific questions regarding these revisions may be directed to the editors of ***FORDS: Revised for 2011***, Jerri Linn Phillips, MA, CTR (jphillips@facs.org), Andrew K. Stewart, MA (astewart@facs.org), or Anna Delev, CTR (adelev@facs.org). All other *FORDS*-related coding questions should be directed to the CAnswer Forum at http://cancerbulletin.facs.org/forums/

CHANGES TO *FORDS* SECTION ONE

2010

CANCER IDENTIFICATION: Primary Site
02/01/2010

Instructions for assigning primary site and morphology codes to hematopoietic and lymphoid tumors now specify “and lymphoid” and designate the applicable histology range as M-9590-9992.

CANCER IDENTIFICATION: Morphology
02/01/2010

Instructions for assigning histology codes now specify they apply to “solid tumors”.

CANCER IDENTIFICATION: Morphology - Grade/Differention
05/01/2010

Deleted breast, prostate and kidney from the 3-grade conversion instructions, because separate instructions exist for them.

FIRST COURSE OF TREATMENT: Surgery
02/01/2010

Second of duplicated “Reason for No Surgery of the Primary Site” deleted from list.

2011

AMBIGUOUS TERMS AT DIAGNOSIS
01/01/2011

Added sentence: Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis. For example, “likely” alone does not constitute a diagnosis.
Exception clarified: If a cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer.

CANCER IDENTIFICATION
01/01/2011

Section coverage clarified: The following instructions apply to Primary Site (NAACCR Item #400), Laterality (NAACCR Item #410), Histology (NAACCR Item #522), Behavior Code (NAACCR Item #523), Grade/Differentiation (NAACCR Item #440), Grade Path Value (NAACCR Item #441) and Grade Path System (NAACCR Item #449).

CANCER IDENTIFICATION: Laterality
01/01/2011

Added sentences: ”Midline” in this context refers to the point where the “right” and “left” sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites can not develop midline tumors. For example, skin of the trunk can have a midline tumor, but the breasts can not.

CANCER IDENTIFICATION: Morphology - Grade/Differention, Grade Path Value, Grade Path System
01/01/2011

Section largely reworded.

CANCER IDENTIFICATION: Revising the Original Diagnosis
01/01/2011

Section clarified by adding the word “grade” to the sentence: Change the primary site, laterality, histology, grade and stage as the information becomes more complete. Also sentence added to first example: If first course surgery was performed, the surgery codes should be reviewed.

FIRST COURSE OF TREATMENT: Radiation
01/01/2011

Added sentence to *Treatment Volume* description: If two distinct volumes are radiated, and one of those includes the primary site, record the radiation involving the primary site in all radiation fields.

TREATMENT, PALLIATIVE, AND PROPHYLACTIC CARE
01/01/2011

Clarified palliative care description: This treatment qualifies the patient as analytic if it is given as part of planned first course treatment.

COMORBIDITIES AND COMPLICATIONS
01/01/2011

Revised section to reflect the fact that ICD-10-CM will be adopted by most United States hospitals during 2011.

CHANGES TO *FORDS* SECTION TWO: PATIENT IDENTIFICATION

2011

Military Record Number Suffix (NAACCR Item #2310)
01/01/2011

Item deleted from **FORDS**

First Name (NAACCR Item #2240)
01/01/2011
Modified instructions: Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation. This field may be updated if the name changes.

Middle Name (NAACCR Item #2250)
01/01/2011
Modified instructions: Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation. This field may be updated if the name changes.

State at Diagnosis (NAACCR Item #80)
01/01/2011
Code for Canada corrected: CD

State -- Current (NAACCR Item #1820)
01/01/2011
Code for Canada corrected: CD

Following Physician (NAACCR Item #2470)
01/01/2011
Item deleted from **FORDS**

Primary Surgeon (NAACCR Item #2480)
01/01/2011
Item deleted from **FORDS**

Physician #3 (NAACCR Item #2490)
01/01/2011
Item deleted from **FORDS**

Physician #4 (NAACCR Item #2500)
01/01/2011
Item deleted from **FORDS**

CHANGES TO *FORDS* SECTION TWO: CANCER IDENTIFICATION

2010

Class of Case (NAACCR Item #610)
05/01/2010
Second sentence in description modified to read: "Analytic cases are grouped according to the location of diagnosis and first course of treatment."
Added "or a decision not to treat" to description of code 22.

Date of Initial Diagnosis (NAACCR Item #390)
02/01/2010

Deleted two sentences from final paragraph: "The *Date of Diagnosis Flag* (NAACCR Item #391) is used to explain why *Date of Diagnosis* is not a known date. See *Date of Diagnosis Flag* for an illustration of the relationships among these items."

Date of Diagnosis Flag (NAACCR Item #391)
02/01/2010

Item deleted. Because *Date of Initial Diagnosis* must always have a year estimated if the exact date is not known, this item will never be used.

Laterality (NAACCR Item #410)
05/01/2010

Changed third bullet to read: "Where the right and left sides of paired sites are contiguous (come into contact) and the lesion is at the point of contact of the right and left sides, use code 5, midline. Note that 'midline of the right breast' is coded 1, right; midline in this usage indicates the primary site is C50.8 (overlapping sites)."

Histology (NAACCR Item #522)
03/10/2010

Deleted exception to sixth bullet for consistency with Multiple Primary and Histology rules.

Date Conclusive DX Flag (NAACCR Item #448)
05/01/2010

Corrected item name (from Date of Conclusive DX Flag).

2011

Class of Case (NAACCR Item #610)
01/01/2011

Added instruction: If the hospital has purchased a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved are staff physicians or not, as with any other physician.
Added clarification to codes 13 and 21: "part of first course treatment was done elsewhere".
Added "treatment plan only" to code 30 examples.
Added to definition of code 31: or hospital provided care that facilitated treatment elsewhere (for example, stent placement)
Added to code 32: (active disease)
Added to code 33: (disease not active)

Facility Referred From (NAACCR Item #2410)
01/01/2011

Item deleted from **FORDS**

Facility Referred To (NAACCR Item #2420)
01/01/2011

Item deleted from **FORDS**

Date of First Contact (NAACCR Item #580)
01/01/2011

Clarified first instruction (added "first course"): Record the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or first course treatment of a reportable tumor.

Added instruction: For analytic cases (Class of Case 00-22), the *Date of First Contact* is the date the patient became analytic. For non-analytic cases, it is the date the patient first qualified for the *Class of Case* that causes the case to be abstracted.

Date of Initial Diagnosis (NAACCR Item #390)
01/01/2011

Clarified instruction: Use the date treatment was started as the date of diagnosis if the patient receives a first course of treatment before a diagnosis is documented.

Modified examples

Grade/Differentiation (NAACCR Item #440)
01/01/2011

Added instruction: Code the grade or differentiation from the pathology report prior to any neoadjuvant treatment. If there is no pathology report prior to neoadjuvant treatment, assign code 9.

Grade Path System (NAACCR Item #449)
01/01/2011

Replaced detailed instructions with: Refer to the current *CS Manual* for coding instructions.

Grade Path Value (NAACCR Item #441)
01/01/2011

Replaced detailed instructions with: Refer to the current *CS Manual* for coding instructions.

Lymph-Vascular Invasion (NAACCR Item #1182)
01/01/2011

Replaced detailed instructions with: Refer to the current *CS Manual* for coding instructions.

Diagnostic Confirmation (NAACCR Item #490)
01/01/2011

Added new first instruction to Solid Tumor instructions: See the section following this one for Coding Hematopoietic or Lymphoid Tumors (9590-9992).

Added sentence to cytology coding instruction: CoC does not require programs to abstract cases that contain ambiguous terminology regarding a cytologic diagnosis.

Ambiguous Terminology Diagnosis (NAACCR Item #442)
01/01/2011

Added instruction: Leave blank for cases diagnosed prior to January 1, 2007.

Date Conclusive DX Flag (NAACCR Item #448)
01/01/2011

Replaced detailed instructions with: Apply the instructions in the current version of *Multiple Primary Histology and Coding Rules* to code this item.

Date of Mult Tumors Flag (NAACCR Item #439)
01/01/2011
Replaced detailed instructions with: Apply the instructions in the current version of *Multiple Primary Histology and Coding Rules* to code this item.

CHANGES TO *FORDS* SECTION TWO: STAGE OF DISEASE AT DIAGNOSIS

2010

Clinical Stage (Prefix/Suffix) Descriptor (NAACCR Item #980)
02/01/2010
Code 4 removed and the following instruction added: "Previous editions of FORDS included a code 4 for y-classification, and a note that it was not applicable for clinical stage. Code 4 has been removed from the list of valid codes".
05/01/2010
Code 6 removed; it was a combination of code 4 (removed 02/10/2010) and another code.

Site-Specific Factor 1 (NAACCR Item #2880)
02/01/2010
BileDuctsIntrahepatic schema added to table.
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Kaposi Sarcoma schema added to table.
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 2 (NAACCR Item #2890)
02/01/2010
BileDuctsIntrahepatic schema added to table.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 3 (NAACCR Item #2900)
02/01/2010
SkinEyelid SSF3 name changed to "Clinical Status of Lymph Nodes".
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 4 (NAACCR Item #2910)
02/01/2010
Added instruction: Prostate SSF4 (Prostate Apex Involvement) does not show on this table, because it is considered obsolete in 2010. However, it is required for cases diagnosed through 2009, as it was required in CSv1, even if it is abstracted in CSv2.
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 5 (NAACCR Item #2920)
02/01/2010
Melanoma Choroid and MelanomaCiliaryBody schema added to table.
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 6 (NAACCR Item #2930)
02/01/2010
SkinEyelid, MelanomaChoroid, and MelanomaCiliaryBody schema added to table.
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 7 (NAACCR Item #2861)
02/01/2010
MelanomaChoroid and MelanomaCiliaryBody schema added to table.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 8 (NAACCR Item #2862)
02/01/2010
SkinEyelid schema added to table.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 9 (NAACCR Item #2863)
02/01/2010
SkinEyelid schema deleted from table.
MelanomaChoroid and MelanomaCiliaryBody schema added to table.
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 10 (NAACCR Item #2864)
02/01/2010
TongueBase, PalateSoft, SkinEyelid, GISTPeritoneum, MelanomaChoroid, and MelanomaCiliaryBody schema added to table.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 11 (NAACCR Item #2865)
02/01/2010
MelanomaChoroid, MelanomaCiliaryBody and MerkelCellVulva schema added to table.
Site C03.1 (Gum, Lower) added to Head and Neck site codes in table footnote.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 12 (NAACCR Item #2866)
02/01/2010
MelanomaChoroid and MelanomaCiliaryBody schema added to table.
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 13 (NAACCR Item #2867)
02/01/2010
MelanomaChoroid and MelanomaCiliaryBody schema added to table.
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 14 (NAACCR Item #2868)
02/01/2010
SkinEyelid schema deleted from table.
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 15 (NAACCR Item #2869)
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 16 (NAACCR Item #2870)
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 17 (NAACCR Item #2871)
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 18 (NAACCR Item #2872)
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 19 (NAACCR Item #2873)
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 20 (NAACCR Item #2874)
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 21 (NAACCR Item #2875)
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 22 (NAACCR Item #2876)
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 23 (NAACCR Item #2877)
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 24 (NAACCR Item #2878)
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 25 (NAACCR Item #2879)
02/01/2010
GISTPeritoneum schema deleted from table.

2011

Clinical M (NAACCR Item #960)
01/01/2011
Added sentence to Rationale: Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries.
Corrected code: 0I+ (was I+), represents M0(i+)

Clinical Stage Group (NAACCR Item #970)
01/01/2011
Revised fourth bullet: If the value does not fill all 4 characters, then record the value to the left and leave the remaining spaces blank.

Clinical Stage (Prefix/Suffix) Descriptor (NAACCR Item #980)
01/01/2011
Corrected Allowable Values: 0-3, 5, 9

Pathologic Stage Group (NAACCR Item #910)
01/01/2011
Revised fifth bullet: If the value does not fill all 4 characters, then record the value to the left and leave the remaining spaces blank.

All CS items
01/01/2011
Changed references from "Collaborative Staging" to "Collaborative Stage"

CS Lymph Nodes Eval (NAACCR Item #2840)
01/01/2011
Changed item name from *CS Reg Nodes Eval* for consistency with Collaborative Stage.

CS Site-Specific Factor 2 (NAACCR Item #2890)
01/01/2011
Added new schema and SSF: MyelomaPlasmaCellDisorder, Durie-Salmon Staging System

CS Site-Specific Factor 3 (NAACCR Item #2900)
01/01/2011
Added new schema and SSF: MyelomaPlasmaCellDisorder, Multiple Myeloma Terminology

CS Site-Specific Factor 10 (NAACCR Item #2864)
01/01/2011
Added new SSF for BileDuctsIntrahep schema: Tumor Growth Pattern

CS Site-Specific Factor 13 (NAACCR Item #2867)
01/01/2011
Added new SSF for Testis: Postorchiectomy Alpha Fetoprotein (AFP) Range

CS Site-Specific Factor 15 (NAACCR Item #2869)
01/01/2011
Added new SSF for Breast: HER2: Summary result of testing
Added new SSF for Testis: Postorchiectomy Human Chorionic Gonadotropin (hCG) Range

CS Site-Specific Factor 16 (NAACCR Item #2870)
01/01/2011
Added new SSF for Testis: Postorchiectomy Lactate Dehydrogenase (LDH) Range

Site-Specific Factor (SSF) 1-25
01/01/2011
Updated 2010 reference in table instructions: For tumors abstracted in CS v02.03 or diagnosed in 2011 …
Corrected histology and/or primary site for applicable schema as shown in the following table. Neither schema names nor the associated SSF names are affected. Only the changed sites and histologies are listed below.

Schema Name	Site	Histology
Head and Neck (all)		8000-8713, 8800-9136, 9141-9582, 9700-9701
Esophagus		8000-8934, 8940-9136, 9141-9582, 9700-9701
EsophagusGEJunction		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701
Stomach		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701
SmallIntestine		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701
Colon		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701
Appendix		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701
Rectum		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701
Liver	C22.1	8170-8175
	C22.0	8000-8157, 8162-8175, 8190-9136, 9141-9582, 9700-9701
CysticDuct		8000-9136, 9141-9582,9700-9701
BileDuctsIntrahepat	C22.0	8160-8161, 8180
	C22.1	8000-8162, 8180-9136, 9141-9582, 9700-9701
BileDuctsPerihilar		8000-9136, 9141-9582, 9700-9701
Lung		8000-9136, 9141-9582, 9700-9701
HeartMediastinum		8000-9136, 9141-9582, 9700-9701
Pleura		8000-9136, 9141-9582, 9700-9701
Bone		8000-9136, 9141-9582, 9700-9701
Skin		8000-8246, 8248-8713, 8800-9136, 9141-9582
SkinEyelid		8000-8713, 8800-9136, 9141-9508, 9510-9514, 9520-9582

Schema Name	Site	Histology
SoftTissue		8000-9136, 9141-9582, 9700-9701
Retroperitoneum		8000-8934, 8940-9136, 9141-9582, 9700-9701
Peritoneum	C48.1-2,8	Male: 8800-8921, 8940-9055, 9120-9136, 9141-9582
		Female: 8580-8589, 8680-8921, 9120-9136, 9141-9582, 9700-9701
Breast		8000-9136, 9141-9582, 9700-9701
Vagina		8000-9136, 9141-9582, 9700-9701
Cervix		8000-9136, 9141-9582, 9700-9701
CorpusAdenosarcoma		8933
CorpusSarcoma		8800-8932, 8934-8974, 8982-9136, 9141-9582
Ovary		8000-9136, 9141-9582, 9700-9701
FallopianTube		8000-9136, 9141-9582, 9700-9701
Placenta		8000-9136, 9141-9582, 9700-9701
Prostate		8000-9136, 9141-9582, 9700-9701
Testis		8000-9136, 9141-9582, 9700-9701
Scrotum		8000-8246, 8248-8713, 8800-9136, 9141-9582
Penis		8000-8246, 8248-8713, 8800-9136, 9141-9582
KidneyParenchema		8000-9136, 9141-9582, 9700-9701
KidneyRenalPelvis		8000-9136, 9141-9582, 9700-9701
Bladder		8000-9136, 9141-9582, 9700-9701
Urethra		8000-9136, 9141-9582, 9700-9701
Conjunctiva		8000-8713, 8800-9136, 9141-9508, 9510-9514, 9520-9582
LacrimalGland		8000-8713, 8800-9136, 9141-9508, 9520-9582, 9700-9701
LacrimalSac		8000-8713, 8800-9136, 9141-9508, 9520-9582, 9700-9701
Brain		8000-9136, 9141-9582, 9700-9701
CNSOther		8000-9136, 9141-9582, 9700-9701
Thyroid		8000-9136, 9141-9582, 9700-9701
IntracranialGland		8000-9136, 9141-9582, 9700-9701
Lymphoma	C00.0-44.0; C44.2-68.9; C69.1-4,8-C80.9	9590-9699, 9702-9729, 9735, 9737-9738
	C00.0-41.9; C42.2-3,5-44.0; C44.2-68.9; C69.1-4,8-C80.9	9811-9818, 9823, 9827, 9837
HemeRetic	C00.0-80.9	9740-9809, 9840-9992
	C42.0,1,4	9811-9818, 9823, 9827, 9837
	C00.0-44.0; C44.2-68.9; C69.1-4,8-C80.9	9733, 9820, 9826, 9231-9836

Derived AJCC-6 Stage Group (NAACCR Item #3000)
01/01/2011

Replaced “M” in final instruction with “Stage Group”

Derived AJCC-7 Stage Group (NAACCR Item #3430)
01/01/2011

Replaced “M” in final instruction with “Stage Group”

CHANGES TO *FORDS* SECTION TWO: FIRST COURSE OF TREATMENT

2010

Approach - Surgery of the Primary Site at This Facility (NAACCR Item #668)
05/01/2010

Changed term "laparoscopic" to "endoscopic" in instructions and codes.
Added new bullet: "If both robotic and endoscopic surgery were used, code to robotic (codes 1 or 2)."

Surgical Margins of the Primary Site (NAACCR Item #1320)
02/01/2010

Changed list of lymphoma histologies to be coded 9 when sited to lymph nodes to "9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971."
Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 9 to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

Scope of Regional Lymph Node Surgery (NAACCR Item #1292)
02/01/2010

Changed list of lymphoma histologies to be coded 9 when sited to lymph nodes to "9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971."
Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 9 to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672)
02/01/2010

Changed list of lymphoma histologies to be coded 9 when sited to lymph nodes to "9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971."
Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 9 to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

Surgical Procedure/Other Site (NAACCR Item #1294)
02/01/2010

Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 1 if treated surgically to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

Surgical Procedure/Other Site at This Facility (NAACCR Item #674)
02/01/2010

Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 1 if treated surgically to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

Number of Treatments to this Volume (NAACCR Item #1520)
05/01/2010
Changed code range for number of treatments to 001-998 (from 091-998).
Changed examples to 3-digit codes (from 2).

Rx Date Rad Ended Flag (NAACCR Item #3221)
02/01/2010
Modified fourth bullet to read "Code 11 if no radiation is planned or given, or if it is not yet completed."
Modified definition of code 11 to read "No proper value is applicable in this context (for example, radiation has not been completed)."
03/01/2010
Above changes were incorrect (NCDB apologizes).
Modified fourth bullet by removing "if it is not yet completed"
Modified definition of code 11 to read "No proper value is applicable in this context (for example, no radiation was administered)."

2011

RX Summ -- Treatment Status (NAACCR Item #1285)
01/01/2011
Added instruction: Use code 0 when treatment is refused or the physician decides not to treat for any reason such as the presence of comorbidities.

Approach - Surgery of the Primary Site at This Facility (NAACCR Item #668)
01/01/2011
Changed term "endoscopic" to "endoscopic or laparoscopic" in instructions and codes.

Radiation Treatment Volume (NAACCR Item #1540)
01/01/2011
Added bullet: If two discrete volumes are treated and one of those includes the primary site, record the treatment to the primary site.
Added example for TBI (total body irradiation).

Regional Treatment Modality (NAACCR Item #1570)
01/01/2011
Added examples for PUVA and I-125

Number of Treatments to This Volume (NAACCR Item #1520)
01/01/2011
Added example for Mammosite®

Radiation/Surgery Sequence (NAACCR Item #1380)
01/01/2011
Clarified that at least two courses of radiation must be given to assign code 4.

Systemic/Surgery Sequence (NAACCR Item #1639)
01/01/2011
Clarified that at least two courses of systemic therapy must be given to assign code 4.

Other Treatment (NAACCR Item #1420)
01/01/2011
Added instruction: Code 1 for PUVA (psoralen and long-wave ultraviolet radiation)

CHANGES TO *FORDS* SECTION TWO: OUTCOMES

2011

Following Registry (NAACCR Item #2440)
01/01/2011
Item deleted from **FORDS.**

CHANGES TO *FORDS* SECTION TWO: CASE ADMINISTRATION

2010

Override Hospseq/Site (NAACCR Item #1988)
02/01/2010
Changed the wording of the second bullet to read "Lymph node primary sites (C77.0-C77.9) for histologies other than lymphomas, or hematopoietic primary sites (C42.0-C42.4) for histologies not in range for hematopoietic diseases. (That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.)"

2011

Morphology Coding System Original (NAACCR Item #480)
01/01/2011
Corrected instruction: For cases diagnosed on or after January 1, 2010, this data item must be coded 8. [Formerly, it said 2000].

CHANGES TO *FORDS* SECTION TWO: APPENDIX B

2010

Section cover page
02/01/2010
Added the following note: "The February 2010 updates changed the histologies that apply to these site-specific surgery codes. Those changes apply only to cases diagnosed in 2010 or later. Please consult *FORDS: Revised for 2009* for applicable histologies for cases diagnosed prior to that date".

Rectum
05/01/2010
Corrected notation to indicate that codes 20-80 (rather than 20-28) send material to pathology.

Lung
02/01/2010
Corrected notation to indicate that codes 20-80 (rather than 20-25) send material to pathology.

Breast
05/01/2010
Changed explanatory note for code 30 to read: "A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction."
Corrected indentation of subcodes under codes 40, 50 and 60.

Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease
02/01/2010
Changed list of included histologies to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

Every site other than Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease
02/01/2010
Changed list of excluded histologies to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

2011

Liver and Intrahepatic Bile Ducts
01/01/2011
Reworded description of code 66: Excision of an intrahepatic bile duct PLUS partial hepatectomy
Reworded description of code 75: Extrahepatic bile duct and hepatectomy WITH transplant

Breast
01/01/2011
Added phrase to mastectomy description: A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.

Added new code 76: Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

Added "41 or" to this sentence about contralateral primaries: The surgical procedure is coded 41 or 51 for the first primary.

Prostate

01/01/2011

Clarified code 19: Transurethral resection (TURP), NOS, and no specimen sent to pathology or unknown if sent
Clarified code 21: Transurethral resection (TURP), NOS, with specimen sent to pathology

CHANGES TO *FORDS* SECTION TWO: APPENDIX D

2011

The “referred to” and “referred from” sections of the table were modified as follows:

Referred To Class of Case 00 [Must have a facility or at least one Physician]	NPI-Inst Referred To	2425
	NPI-Primary Surgeon	2485
	NPI-Physician # 3	2495
	NPI-Physician # 4	2505
Referred From Class of Case 20-22 [Must have a facility or at least one Physician]	NPI-Inst Referred From	2415
	NPI-Primary Surgeon	2485
	NPI-Physician # 3	2495
	NPI-Physician # 4	2505

APPENDIX D:

FORDS Items Required to Be Complete to Enter *Date Case Completed – CoC* for Cases Diagnosed in 2010 or Later

See *Date Case Completed–CoC* (NAACCR Item #2092) for instructions.

Category	FORDS Items	NAACCR Item #
Identification Class of Case 00-22	Addr at DX–City	70
	Addr at DX–State	80
	Addr at DX–Postal Code	100
	County at DX	90
	Date of 1st Contact	580
	Date of 1st Contact Flag	581
	Class of Case	610
	Primary Payer at DX	630
	NPI Archive FIN	3105
	Archive FIN	3100
	Accession Number	500
	Sequence Number	560
	Abstracted By	570
	ICD Revision Comorbidities and Complications	3165
	Comorbidities and Complications # 1	3110
	Comorbidities and Complications # 2	3120
	Comorbidities and Complications # 3	3130
	Comorbidities and Complications # 4	3140
	Comorbidities and Complications # 5	3150
	Comorbidities and Complications # 6	3160
	Comorbidities and Complications # 7	3161
	Comorbidities and Complications # 8	3162
	Comorbidities and Complications # 9	3163
	Comorbidities and Complications # 10	3164
	Override Acsn/Class/Seq	1985
	CoC Coding System - Current	2140
	CoC Coding System - Original	2150
	Vendor Name	2170
	ICD-O-3 Conversion Flag	2116
	Date of Last Contact or Death	1750
	Date of Last Contact Flag	1751
	City/Town – Current	1810
	State – Current	1820
	Postal Code – Current	1830
	Last Name	2230
	First Name	2240
	Middle Name	2250
	Medical Record Number	2300
	Social Security Number	2320
	Patient Address (Number and Street) at Diagnosis	2330
	Patient Address at Diagnosis – Supplemental	2335
	Patient Address (Number and Street) – Current	2350
	Patient Address–Current - Supplemental	2335
	Telephone	2360
Demographic Class of Case 00-22	Race 1	160
	Race 2	161
	Race 3	162

	Race 4	163
	Race 5	164
	Spanish/Hispanic Origin	190
	Sex	220
	Age at Diagnosis	230
	Date of Birth	240
	Date of Birth Flag	241
	Birth Place	250
	Race Coding System – Current	170
	Race Coding System – Original	180
Diagnostic Class of Case 00-22	Date of Diagnosis	390
	Date of Diagnosis Flag	391
	Primary Site	400
	Laterality	410
	Histologic Type ICD-O-3	522
	Behavior Code ICD-O-3	523
	Grade	440
	Grade Path Value	441
	Grade Path System	449
	Diagnostic Confirmation	490
	Ambiguous Terminology DX	442
	Date of Conclusive DX	443
	Date Conclusive DX Flag	448
	Mult Tum Rpt as One Prim	444
	Date of Multiple Tumors	445
	Date of Mult Tumors Flag	439
	Multiplicity Counter	446
	Sequence Number - Hosp	560
	RX Hosp–DX/Stg Proc	740
	Regional Nodes Positive	820
	Regional Nodes Examined	830
	Site Coding System – Current	450
	Site Coding System – Original	460
	Morph Coding System – Current	470
	Morph Coding System – Original	480
	Override HospSeq/DxConf	1986
	Override CoC Site/Type	1987
	Override HospSeq/Site	1988
	Override Site/TNM-StgGrp	1989
	Override Age/Site/Morph	1990
	Override SeqNo/DxConf	2000
	Override Site/Lat/SeqNo	2010
	Override Surg/DxConf	2020
	Override Site/Type	2030
	Override Histology	2040
	Override Leuk, Lymphoma	2070
	Override Site/Behavior	2071
	Override Site/Lat/Morph	2074
Staging Class of Case 10-22	TNM Edition Number	1060
	TNM Path T	880
	TNM Path N	890
	TNM Path M	900
	TNM Path Stage Group	910

	TNM Path Descriptor	920
	TNM Path Staged By	930
	TNM Clin T	940
	TNM Clin N	950
	TNM Clin M	960
	TNM Clin Stage Group	970
	TNM Clin Descriptor	980
	TNM Clin Staged By	990
	Lymph-vascular Invasion	1182
	CS Tumor Size	2800
	CS Extension	2810
	CS Tumor Size/Ext Eval	2820
	CS Lymph Nodes	2830
	CS Lymph Nodes Eval	2840
	CS Mets at DX	2850
	CS Mets Eval	2860
	CS Mets at Dx-Bone	2851
	CS Mets at Dx-Brain	2852
	CS Mets at Dx-Liver	2853
	CS Mets at Dx-Lung	2854
	Site-Specific Factors 1-25 – if required for case	
	Derived SS1977	3010
	Derived SS2000	3020
	Derived AJCC–Flag	3030
	Derived SS1977–Flag	3040
	Derived SS2000–Flag	3050
	CS Version Input Current	2937
	CS Version Original	2935
	CS Version Derived	2936
	Derived AJCC 6 T	2940
	Derived AJCC 6 T Descript	2950
	Derived AJCC 6 N	2960
	Derived AJCC 6 N Descript	2970
	Derived AJCC 6 M	2980
	Derived AJCC 6 M Descript	2990
	Derived AJCC 6 Stage Grp	3000
	Derived AJCC 7 T	3400
	Derived AJCC 7 T Descript	3402
	Derived AJCC 7 N	3410
	Derived AJCC 7 N Descript	3412
	Derived AJCC 7 M	3420
	Derived AJCC 7 M Descript	3422
	Derived AJCC 7 Stage Grp	3430
Hospital-Specific Treatment Class of Case 10-22	RX Hosp–Surg App 2010	668
	Surgical Procedure of Primary Site at This Facility	670
	Scope of Regional Lymph Node Surgery at This Facility	672
	Surgical Procedure / Other Site at This Facility	674
	Chemotherapy at This Facility	700
	Hormone Therapy at This Facility	710
	Immunotherapy at This Facility	720
	Other Treatment at This Facility	730
	Palliative Care at This Facility	3280
	Date of First Course of Treatment	1270

	Date of 1st Crs Flag	1271
	Date of First Surgical Procedure	1200
	RX Date–Surgery Flag	1201
	Date of the Most Definitive Resection of the Primary Site	3170
	RX Date–Mst Defin Srg Flag	3171
	Date of Surgical Discharge	3180
	RX Date–Surg Disch Flag	3181
	Date Radiation Started	1210
	RX Date–Radiation Flag	1211
	Date Radiation Ended	3220
	RX Date–Rad Ended Flag	3221
	Date Systemic Therapy Started	3230
	Date Chemotherapy Started	1220
	RX Date–Chemo Flag	1221
	Date Hormone Therapy Started	1230
	RX Date–Hormone Flag	1231
	Date Immunotherapy Started	1240
	RX Date–BRM Flag	1241
	Date Other Treatment Started	1250
	RX Date–Other Flag	1251
	RX Summ–Treatment Status	1285
	NPI- Managing Physician	2465
	NPI-Following Physician	2475
	NPI-Primary Surgeon	2485
	NPI-Physician # 3	2495
	NPI-Physician # 4	2505
Summary Treatment Class of Case 10, 12, 14, 20, 22	Surgical Procedure of Primary Site	1290
	Scope of Regional Lymph Node Surgery	1292
	Surgical Procedure / Other Site	1294
	Surgical Margins of the Primary Site	1320
	Reason for No Surgery of Primary Site	1340
	Surgical Diagnostic and Staging Procedure	1350
	Palliative Care	3270
	Radiation / Surgery Sequence	1380
	Hematological Transplant and Endocrine Procedures	3250
	Chemotherapy	1390
	Hormone Therapy	1400
	Immunotherapy	1410
	Other Treatment	1420
	Reason for No Radiation	1430
	Rx Coding System–Current	1460
	Regional Dose: cGy	1510
	Number of Treatments to This Volume	1520
	Radiation Treatment Volume	1540
	Location of Radiation Treatment	1550
	Regional Treatment Modality	1570
	Boost Treatment Modality	3200
	Boost Dose: cGy	3210
	Systemic / Surgery Sequence	1639
Referred To Class of Case 00 [Must have a facility or at least one Physician]	NPI-Inst Referred To	2425
	NPI-Primary Surgeon	2485
	NPI-Physician # 3	2495
	NPI-Physician # 4	2505

Referred From Class of Case 20-22 [Must have a facility or at least one Physician]	NPI-Inst Referred From	2415
	NPI-Primary Surgeon	2485
	NPI-Physician # 3	2495
	NPI-Physician # 4	2505

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