Cancer Reporting in California

California Cancer Reporting System Standards, Volume I: Abstracting and Coding Procedures

Eighteenth Edition

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Preface to the Eighteenth Edition

The staff of the Cancer Informatics and IT Systems Unit of the California Cancer Registry (CCR) present the eighteenth edition, of Cancer Reporting in California: Abstracting and Coding Procedures, Volume I, dated October 2018.

The extensive changes for 2018 include being presented in PDF format, the implementation of the 2018 new and revised Prognostic Data Items, the 2018 version of the Solid Tumor Rules (formerly named Multiple Primary and Histology Rules), the 2018 SEER Summary Stage and SEER EOD Manuals, as well as the Commission on Cancer's STORE Manual (formerly named FORDS). All of the 2018 data changes are requirements from national standard setting agencies and were not initiated by the California Cancer Registry.

Please refer to the document titled "Cancer Reporting in California: Abstracting and Coding Procedures, California Cancer Reporting System Standards, Volume I, Changes and Clarifications –18th Edition, October 2018", for page, data field, or formatting updates and revisions. This document will provide a detailed summary of the revision or clarification to Volume I in the 2018 version and is posted to the CCR web site.

I want to acknowledge Mary Brant, CTR as the lead for the revision of Volume I for 2018, as well as Donna Hansen, CTR for providing mentorship and guidance. Thank you also to the following Quality Control Unit staff for their review, suggestions and assistance in revising this document: Jenna Mazreku, CTR, Marilyn Scocozza, CTR, and Ben Wormeli. In addition, I would like to thank the Greater Bay area Cancer Registry, the Cancer Registry of Greater California, and the Los Angeles County Cancer Surveillance Program, for your continued contributions to the success of Volume I.

Reporting facilities in California should direct any corrections, comments, and suggestions regarding this document to their regional registry. The regional registry will send/forward this information to the CCR. If individuals or facilities that are not part of the California reporting system need copies of Volume I, they may download the PDF from the California Cancer Registry website.

Thank you for your continued commitment to ensure that the CCR data is of the highest quality. The data you provide remains the cornerstone of the California Cancer Registry.

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Part I. Introduction

Part I of Volume I introduce the user to the role of the cancer registry, the California Cancer Registry, as well as state cancer reporting requirements. Included in the state requirements are: confidentiality, casefinding, reporting by both hospital and non-hospital facilities, and cases diagnosed and treated elsewhere.

I.1 Reporting Cancer Statistics

The systematic gathering of information about the incidence of cancer in designated populations is an indispensable tool in the struggle to contain the disease. With access to reliable statistics on the occurrence of several types of cancer, the people affected, the treatment provided, and other epidemiological factors, researchers and public health officials are better able to identify problems and evaluate remedies. Findings from such studies include possible environmental influences on the development of neoplasms, the susceptibility of certain ethnic and social groups to particular neoplasms, the need for oncology services in various locales, and the appropriateness of diagnostic and therapeutic procedures.

I.1.1 Role of the Cancer Registry

Many California hospitals have had their own cancer registries since the 1950's in accordance with guidelines established by the American College of Surgeons (ACS) and its requirements for accreditation of oncology services. The main purpose of a hospital registry is to provide physicians with the data needed to maintain quality of care through peer review and to compare performance with recognized standards. However, a more comprehensive level of reporting is required by state law and that level is supported by the California Cancer Registry and its statewide database system, Eureka DMS.

I.1.2 The California Cancer Registry

Information from hospital registries and other reporting sources is gathered by the California Cancer Registry (CCR) primarily for use in epidemiological research and for monitoring the occurrence of cancer in the state. A unit in the Chronic Disease Surveillance and Research Branch of the California Department of Public Health, the CCR was established in 1947 as a pilot study to determine the feasibility of basing a central registry on data reported by hospitals. The study was successful, and the registry gradually expanded its coverage from nine hospitals to thirty-six, most of which were in the San Francisco Bay area and Los Angeles County. As a result, valuable statistics were developed about the survival of cancer patients. However, since the data did not apply to a defined segment of the population, it was not possible to calculate the incidence of cancer. A section covering the population of Alameda County was therefore added to the registry in 1960. When the National Cancer Institute (NCI) undertook its Third National Cancer Survey in 1969, the population-based registration was extended to the entire San Francisco-Oakland Standard Metropolitan Statistical Area (SF-O SMSA) consisting of Alameda, Contra Costa, Marin, San Francisco, and San Mateo counties. Support for the SF-O SMSA registration was subsequently provided by the NCI's Surveillance, Epidemiology and End Results (SEER) Program. Established in 1973, SEER is among the largest population-based registries in the Western world, covering approximately 73 million people in eleven designated regions of the United States.

Expansion of the registration to the SF-O SMSA produced several important benefits. It strengthened the DHS's ability to estimate the incidence of cancer in California, ascertain risk factors in the occurrence of the disease, study variations in risks among different ethnic groups and social classes, identify changes in the incidence of various forms of cancer in subgroups of the population, and study long-term changes in the interrelationship of incidence, early diagnosis, treatment, length of survival, and mortality for a greater understanding of cancer. In addition, it greatly increased the number of cases available to researchers for epidemiological studies of human cancer and its relationship to the environment, genetics, cancer in varied species, and other fields. Because of these benefits, the CCR's coverage was extended to the State's entire population, which now totals over 37 million people.

I.1.3 State Cancer Reporting Requirements

The State of California has specific cancer reporting requirements. An overview of California's Health and Safety Code and related information is outlined below.

Provisions of the California Health and Safety Code enacted in 1985 (Sections 103875 and 103885) mandate the establishment of a statewide system of cancer reporting. The purpose of the system is to *conduct a Program of epidemiological assessments of the incidence of cancer*, with a view to identifying cancer hazards to the public health and their remedies. Under the code, *any hospital or other health care facility that diagnoses or treats cancer patients within an area designated as a cancer reporting area shall report each case of cancer to the department or the authorized representative of the department.*

The Official California Code of Regulations implement the state statutes and have the same force of law as court decisions or legislation, is located on the Reporting Legislation and Regulation page on the California Cancer Registry website.

Guidelines:

- Diagnoses of borderline and benign primary intracranial and central nervous system (CNS) tumors are also reportable, as well as Newly Reportable Hematopoietic Diseases (NRHD), see Hematopoietic and Lymphoid Neoplasm. This applies to cases diagnosed January 1, 2001 and forward.
- It is the reporting facility's responsibility to inform patients that their cancer diagnosis has been reported to the California Cancer Registry as required by regulations that govern the cancer reporting law. A Patient Information Sheet has been developed by the California Department of Public Health, which may be used to inform patients. Refer to Appendix F - Patient Information Sheet.

  Note: A reporting facility may modify this information sheet, if they so choose.

I.1.4 Confidentiality

The California Health and Safety Code stipulates that the identity of patients whose cases are reported to the CCR must be held in the strictest confidence. Information that could be used to identify a patient may not be released to or discussed with anyone other than authorized personnel at the reporting facility or other reporting sources, unless prior informed consent is received from the patient. Section 100330 of the code states:

> All records of interviews, written reports and statements procured by the state Department of Public Health or by any other person, agency or organization acting jointly with the state department, in connection with special morbidity and mortality studies shall be confidential insofar as the identity of the individual patient is concerned and shall be used solely for the purposes of the study. The furnishing of such information to the state or its authorized representative, or to any other cooperating individual, agency or organization in any such special study, shall not subject any person, hospital, sanitarium, rest home, nursing home, or other organization furnishing such information to any action for damages.

Guidelines:

- The CCR also has a policy of maintaining the confidentiality of any information that could be used to identify the caseload of a specific facility or physician.
- Under certain circumstances, confidential information may be released for research purposes without the patient's consent.
    - Legal provisions for these exceptions to the rules of confidentiality are contained in the Information Practices Act, Civil Code 1798.24. Refer to Appendix F for a sample Patient Information Sheet, for use in notifying patients that cancer is reportable.
- For more information regarding the CCR's confidentiality policy, refer to the CCR web site: http://www.ccrcal.org.

I.1.5 Casefinding

Casefinding (case ascertainment): The process of identifying eligible cases through review of sources documents and case listings. Comprehensive casefinding includes investigating all diagnostic and therapeutic services to look for active cancer cases. Casefinding covers a range of cases that need to be accessed to determine whether they are reportable or not.

Although exact procedures might vary from reporting facility to reporting facility, they ordinarily involve careful monitoring of the records kept by the departments that usually provide diagnostic and treatment services to patients with cancer.

Guidelines:

- Refer to Appendix G for the current ICD-10 casefinding lists.
    - Current and previous casefinding lists are also available on the SEER website: http://seer.cancer.gov.
    - Use the casefinding lists to screen prospective reportable cancer cases.
    - A casefinding list is NOT the same as a reportable list.
    - The casefinding lists are used to identify cases seen at the reporting facility with benign or malignant tumors and/or conditions, which are reportable to the CCR. This aids in the prevention of missed cases.

I.1.5.1 Casefinding Procedures

Registrars must rely on several sources of documentation to identify all cancer cases diagnosed and/or treated at the facility. More than one type of documentation is generally needed to capture all of the required information for each patient.

Guidelines:

- Investigate every department or area where a patient might be seen or treated to identify eligible cases.
    - Sources differ depending on the facility type, services provided, and size.
    - Facility registries should limit the number of casefinding personnel to those who are familiar with the reportable diagnoses. This helps to ensure complete casefinding.

      Note: Other Standard Setters such as the American College of Surgeons (ACS) and/or the facility's cancer committee may require registrars to report certain cases in addition to what the CCR requires.
- Effective communication skills are essential in the casefinding process. Registrars will likely interact with other facility staff while looking for and obtaining information on eligible cases.
    - Explain the purpose to departments and requests for information.
    - Describe the nature of cancer case reporting and the function of the state registry. Underscoring:
        - How accurate, timely and complete data collected at the provider level benefits the public, facility and patient with cancer.
        - How cooperation of ancillary departments involved in cancer care is critical to achieve maximum casefinding results.
    - Open communication extends to the relationships that registrars have among themselves, with fellow members of the cancer committee and with their regional registry representatives.
        - Regional registry representatives serve as liaisons between the CCR and the reporting facility.
        - Registrars are encouraged to contact their regional registry representative when questions and concerns arise.

I.1.5.2 Casefinding Sources

The hospital and non-hospital departments listed below identify the areas within a facility where eligible cases might be found. Not all facilities contain the departments listed.

Guidelines:

- Include all casefinding sources when searching for reportable cases.
- Each of the following departments are potential sources for finding eligible cancer cases:
    - Laboratory
    - Health Information Management/Medical Records
    - Other departments used in Casefinding
        - Outpatient, Clinic and Ambulatory Care Services/Surgery
        - Oncology-Related Services
        - Staff Physician's Offices
        - Long-Term Care Facility/Skilled Nursing Facility
        - Hospice
        - Emergency Department (ED)

I.1.5.2.1 Casefinding - Laboratory

The laboratory department is generally the primary casefinding source for eligible cases to be included in the registry database. Personnel who are knowledgeable in cancer case reporting must review Pathology reports, including histology, cytology, hematology, bone marrow, and autopsy findings.

Guidelines:

- Ways to accomplish the review of all laboratory reports:
    - Manually review every report to identify eligible cases.
    - If the pathology reports are computerized, the registrar can request a list.
- Pathology reports, including histology, cytology, hematology, bone marrow, and autopsy findings.
    - Since pathologic studies are made for most patients suspected of having cancer, most reportable cases can be found by reviewing or obtaining copies of reports with positive or indicative diagnoses.
- The pathology department may have distinct divisions with subspecialties such as dermatopathology, eye pathology, oral pathology, GYN pathology and/or pediatric bone marrow pathology.
    - Each division should be reviewed for reportable cases of cancer.
- Experience demonstrates that trained registry personnel perform the most complete and accurate screening of pathology reports.
    - A registrar should audit the findings to ensure casefinding is complete in the event someone outside the registry reviews the pathology reports.

I.1.5.2.2 Casefinding - Health Information Management (HIM)/ Medical Records

The secondary source of cancer casefinding is the HIM/Medical Records Department, especially through the Disease Index. The Disease Index is usually a list run periodically that is either hard copy or in an electronic format. It is typically in medical record or ICD-O code order. The value of the Disease Index cannot be overemphasized.

Guidelines:

- Disease indexes (See Appendix G - Codes for Casefinding, for applicable ICD-10-CM codes used in health information/medical record departments).
- The index should include the patient name, medical record number, and ICD diagnosis codes.
    - Supplementary information may include admission and/or discharge dates, length of stay, ICD codes for the associated disease and procedures, and the physician's name and/or license/ID number.
    - When requesting the Disease Index, the cancer registrar should specify the reportable ICD cancer codes to identify pertinent inpatient and outpatient visits.
    - Not every reportable case has a positive histological diagnosis at every facility.
        - Regularly, a case is histologically diagnosed at one hospital or in a physician's office and the patient is admitted to another facility for treatment.
- Surgery reports.
- Health Information Management/Medical Records Departments can also be a source of information associated with discharges, specifically discharges following a death (death log). Regular review of all hospital deaths reduces the likelihood of Death Certificate Only (DCO) cases in the future.

I.1.5.2.3 Casefinding - Other Sources

Other sources of eligible case ascertainment include inpatient/outpatient departments such as staff physician offices, clinics (ambulatory care/surgery), oncology-related services (diagnostic imaging), emergency departments, long-term care, and hospice facilities. Casefinding procedures should be established for eligible cases.

Guidelines:

- Other facilities and/or departments with potential sources for finding eligible cancer cases:
    - Outpatient, Clinic and Ambulatory Care Services/Surgery
        - Disease Index
        - Daily facility and clinic discharges
        - Surgery and visit logs
        - Billing form copies (contain both diagnosis and ICD codes)
    - Oncology-Related Services
        - Radiation therapy logs
        - Nuclear medicine logs
        - Radiology logs, including logs of scans
        - Radiation and chemotherapy appointment books/logs
    - Staff Physician's Offices
        - Disease Index
    - Long-Term Care Facility/Skilled Nursing Facility
        - Admissions and discharges
    - Hospice
        - Monitor admissions to facility hospice units for casefinding purposes. Collect eligible cases where:
            - Palliative or comfort care is provided.
            - Active cancer cases whether patients have been diagnosed and/or have received treatment at the facility or not.
    - Emergency Department (ED)
        - ED logs
        - Death Certificates

I.1.5.3 Casefinding - Audits

Periodic casefinding audits are strongly encouraged for every reporting facility to confirm that every eligible case is identified and reported.

Guidelines:

- Develop a system of internal review.
    - Speak with other facility registrars or their field representatives for ideas.
- When significant changes occur in the annual reporting total average, look for changes in services and/or staffing.
- Address fluctuations in reporting totals with regional representatives as soon as they are noted.

I.1.5.4 Casefinding for Follow-Up

To meet the requirements of the State's cancer reporting system, it is necessary to periodically determine the vital status and condition of registered patients. One method of obtaining this information is through the casefinding process.

Guidelines:

- Reporting facilities must have a systematic method of identifying patients who are re-admitted to the facility or who are treated on an outpatient basis, whether for the reported cancer or for another condition.
    - This information can be used to update patient's vital status and condition.
    - Regular review of all hospital deaths reduces the likelihood of Death Certificate Only (DCO) cases in the future.

Refer to Follow-Up Information for additional follow-up information.

I.1.6 Reporting

The reporting facility must report every reportable case first seen as an inpatient or outpatient, either with evidence of cancer or for cancer-directed treatment, on or after the date that mandatory reporting was declared for the region (the region's reference date). Refer to the Regional Registry Reference Date Guide for the specific date when mandatory reporting began in each region.

A **Full Abstract** is required for any reportable case diagnosed and/or treated at the reporting facility (analytic cases) and for most nonanalytic cases. For the list of required data items included in a full abstract, see the California Cancer Reporting Systems Standards, Volume II, and the associated Volume II Appendices for data item requirements. Each regional registry may establish alternative reporting mechanisms for use when an abstract is not prepared.

Cases Not Reportable:

- Hospice only
- Patients receiving long-term therapy with a history of cancer, but no current evidence of cancer.
- Cancer Conference (Tumor Board) presentation only
- Consult Only (See Pathology and Consultation Only Cases for exceptions)
- Catheter placement for cancer therapy only*
- Patients receiving transient care*

***Note:** Regional Registries may request notification via an alternate reporting mechanism to remain informed of these types of cases.*

Essentially, Class 33, 40 and 41 are not reportable to the CCR. Class 32 is to be reported through a full abstract. Registry is to notify their Region of Class 31 cases. Additionally, Class 43 is reportable through a CMR. See Class of Case for definitions.

REQUIRED METHOD OF REPORTING TO THE CCR		
Class of Case	**Required by CCR**	**Reporting Method**
Analytic Cases		
Initial Diagnosis at Reporting Facility		
00	Yes	Abstract
10	Yes	Abstract
11	Yes	Abstract
12	Yes	Abstract
13	Yes	Abstract
14	Yes	Abstract

Initial Diagnosis at Reporting Facility		
20	Yes	Abstract
21	Yes	Abstract
22	Yes	Abstract
Non-Analytic Cases		
Patient appears in person at Reporting Facility; Both initial diagnosis and Treatment Elsewhere		
30	Yes	Abstract
31	Yes*	**Notify**
32	Yes	Abstract
33	No	NR
34	Yes	Abstract
35	Yes	Abstract
36	Yes	Abstract
37	Yes	Abstract
38	Yes	Abstract
Patient does NOT appear in person at Reporting Facility		
40	No	NR
41	No	NR
42	Yes	Abstract
Regional Registry Responsibility ONLY		
43	Yes	Abstract
49	Yes	Abstract

Key to Reporting Method:

Abstract – Full abstract required

NR – Not Reportable

Notify – Notify Regional Registry

I.1.6.1 Definition of Cancer

Cancer is defined by the California Health and Safety Code for registry purposes, as "all malignant neoplasms, regardless of the tissue of origin, including malignant lymphoma, Hodgkin disease, and leukemia, but excluding basal cell and squamous cell carcinoma of the skin."

Guidelines:

- Benign and uncertain behavior intracranial and central nervous system (CNS) tumors became reportable along with newly reportable histologies published in ICD-O-3. This applies to cases diagnosed January 1, 2001 and forward.
- The CCR establishes an official list of reportable neoplasms annually.
- A reportable cancer or tumor must be reported to the CCR if it is diagnosed by any physician/health care practitioner, including:
    - Pathologist
    - Radiologist
    - Surgeon
    - Dentist
    - Podiatrist
    - Any other healthcare practitioner diagnosing or providing treatment for cancer patients.

      Examples:

        - Physician Assistant (PA)
        - Nurse Practitioner (NP)
- Carcinoma In-situ (including squamous cell and adenocarcinoma) of the cervix and CIN III (cervical intraepithelial neoplasia, grade III) are no longer reportable to the CCR. This applies to cases diagnosed January 1, 1996 and forward.

I.1.6.2 Abstracting Cancer Data

Information about cancer cases is reported to the CCR in the form of abstracts, which summarize pertinent information about individual cases. (See the California Cancer Reporting Systems Standards, Volume II, and the associated Volume II Appendices for data item requirements. If in doubt about how certain fields should be completed, the regional registry should be contacted.

Guidelines:

- Whatever reporting software is used, rules for entering data must be followed precisely.
- The text summaries required for the sections on diagnostic procedures and treatment should be as concise as possible.
- Every required data item must be completed, and the entries must be accurate, concise, and clear.
- Coded fields **must** be supported by text documentation on the abstract.
    - Information which does not require supporting text:
        - Date of Birth (DOB) (unless the patient is 100 years of age or older). Refer to Age at Diagnosis.
        - Social Security Number (SSN)
        - Medical Record Number (MRN)
        - Comorbidities
        - Secondary Diagnosis

I.1.6.3 Entering Dates

Dates transmitted between facility registries and central registries 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. Consult your software vendor for specific data entry instructions.

- **Traditional dates** are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. In 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. An allowable date must contain the year.

Description	Traditional Date	Interoperable Date	Date Flag
Full date known	MMDDCCYY	CCYYMMDD	Blank
Month and year known	MM99CCYY	CCYYMMbb	Blank
Year only known	9999CCYY	CCYYbbbb	Blank
Unknown date	99999999	bbbbbbbb	10, 11, 12, or 15*

b= blank

* Allowable date flag values

Coding Instructions:

- **Vague Dates:** Enter an approximate date when the exact date cannot be determined. At a minimum, a year of diagnosis is required for all analytic cases (Class of Case 00-22). The year of diagnosis must be known or estimated and cannot be blank or unknown. The date of first cancer directed therapy may be used as the date of diagnosis, if the therapy was initiated before definitive confirmation of the diagnosis. Documentation must be provided for the basis of the estimated date.
- **Approximate Dates:** At a minimum, a year of diagnosis is required for all analytic cases (Class of Case 00-22). Use the date treatment was started if the patient receives a first course of treatment before a definitive diagnosis. Documentation must be provided for the basis of the estimated date. Use the following coding procedures for estimating dates relating to diagnosis.
- **Estimating Year:** *Use whatever information is available to calculate the year*. Enter the year of admission when there is no basis for estimation.

Terms	Code To
Couple of years ago	Two years ago
Few years ago	Three years ago

- **Estimating Month:** *Use whatever information is available to calculate the month*. Leave the month blank if there is no basis for approximation.

Terms	Code To
Recently	Enter the month and year of admission, and unknown ("99" or leave blank depending on your registry software) for the day. If patient was admitted during the first week of a month, enter the previous month
Several months ago	Assume the case was first diagnosed three months before admission with the day unknown when the patient was not previously treated or if a course of treatment started elsewhere was continued at the reporting facility
Spring	Enter as April
Summer	Enter as July
Fall or Autumn	Enter as October
Winter	Enter as December or January based on available information i.e. end/beginning of year
Early in the year	Enter as January
Middle of the year	Enter as July
End of the year	Enter as December
Late in the year	Enter as December

I.1.6.4 Date Format and Date Flag Guide

Dates transmitted between facility registries and central registries changed to improve the interoperability or communication of cancer registry data with other electronic record systems.

Coding Instructions:

- Registry software may display dates in the traditional manner or in the interoperable format. Consult your software vendor for specific data entry instructions.
- Depending on the registry software, the date flag codes may be applied in the background and may not apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, the date flags are used to explain the reason the date field is blank.
    - **Traditional dates** are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. In 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. An allowable date must contain the year.

Description	Traditional Date	Interoperable Date	Date Flag
Full date known	MMDDCCYY	CCYYMMDD	Blank
Month and year known	MM99CCYY	CCYYMMbb	Blank
Year only known	9999CCYY	CCYYbbbb	Blank
Unknown date	99999999	bbbbbbbb	10, 11, 12, or 15*

b= blank

* Allowable date flag values

Refer to the Date Flag Guide for the allowable values for each date flag field.

I.1.7 Reporting by Non-Hospital Treatment Centers

Not all abstracting requirements apply to freestanding radiation therapy centers and other cancer treatment centers that are not part of hospitals and do not have inpatient facilities. Usually, patients seen at these facilities have been hospitalized elsewhere previously, and the treatment center is not the primary source for detailed information about their diagnostic work-ups. However, case reports from such facilities afford a quality check on the hospitals' reports and, even more important, provide data that complete the information about the patient's first course of treatment. Without these reports, statewide data on patterns of care would not be accurate or clinically useful.

Guidelines:

- When submitting abstracts, treatment centers must provide complete patient identification and treatment information, but they are not required to fill in text fields for diagnostic procedures that were performed elsewhere. See Text – Diagnostic Procedures Performed for additional information.
- Recording stage is also important. When planning treatment, the radiation therapist often performs the most thorough assessment of stage available for the case.
- The treatment center's abstract must be prepared in the same electronic format used by other facilities.
- See the California Cancer Reporting Systems Standards, Volume II, and the associated Volume II Appendices for data item requirements.

I.1.8 Cases Diagnosed and Treated Elsewhere

Reporting requirements for cases diagnosed and treated elsewhere are less stringent than those for other cases. The reporting facility's medical record often does not contain the required data, or contains only secondhand data.

CCR Expectations:

- The CCR requires that most non-analytic cases be abstracted and submitted.
    - For definitions of non-analytic, analytic cases and class of case, see Class of Case.
    - For instruction on how the case should be submitted, see Reporting.
- Report any information included in the medical record, but it is not necessary to obtain missing information, although a facility may choose to do so.
- Text information about diagnostic procedures limited to a brief statement of the patient's history and the reason for the present admission must be included.
- Enter the statement in the physical exam text area.
- Even though information for many required data fields might not be available, all the fields must be completed.
- If necessary, enter the codes for UNKNOWN or NONE.

Part II. Reportable Neoplasms

Part II of volume I contains the CCR Reportability Guide, information on how to identify primary tumors, ambiguous terminology, what to do with path or consult only cases, hematopoietic neoplasms, and benign/borderline and CNS tumor reporting. Additionally, abstracting accession and sequence number instructions are also included.

II.1 CCR Reportability Guide - Reportable

Refer to the reportability guide below for information on specific histologies and sites for tumors that are reportable to the CCR.

2018 ICD-O-3 histology coding changes: Updates include new and revised histology terms, codes, and behaviors for cases diagnosed January 1, 2018 and forward. Please see the 2018 ICD-O-3 – Coding tables.

Note: The 2018 ICD-O-3 Update Table includes the histology changes from the ICD-O-3 Histology Code Crosswalk for 2015 through 2017.

IMPORTANT REMINDER:

Check the 2018 ICD-O-3 Update Table first to determine if the histology is listed. If the histology is not included in the update, then review the Solid Tumor Rules (MP/H), ICD-O-3 and/or Hematopoietic and Lymphoid Database.

Coding Instruction:

- If a case has a reportable histology for 2018 forward and was diagnosed with that histology prior to 2018:
    - Do not go back and report for 2017 because the histology was not reportable then. Report the date of diagnosis when case first became reportable in 2018.

Reportable Diagnoses

- Invasive malignancies (behavior /3)
- In-situ malignancies (behavior /2)
    - The following terms indicate in-situ behavior and are reportable:

General Reportable Terms Indicating In-situ Behavior
Bowen's disease (excluding skin)
Confined to epithelium (does not extend beyond base membrane)
Ductal carcinoma in-situ, (DCIS) (any site)
Intracystic, Intraepidermal (NOS), Intrasquamous, In-situ
Intraepithelial neoplasia grade III, not otherwise specified (NOS)
Involvement up to, but not including basement membrane
Lobular carcinoma in-situ (LCIS)
No stromal invasion

Non-infiltrating; Non-invasive
Squamous intraepithelial neoplasia grade III (SIN III) (excluding cervix and skin sites coded to C44_), dx 01/01/2014 +
Papillary, non-infiltrating or intraductal
Pre-invasive
Site-Specific Terms Indicating In-situ Behavior
Anus – Anal Intraepithelial Neoplasia grade III (AIN III), dx 01/01/2001 + High grade squamous intraepithelial invasion (HGSIL or HSIL), dx 01/01/2018 +
Breast • Ductal intraepithelial neoplasia grade III (DIN III), dx 01/01/2001+ • Lobular intraepithelial neoplasia grade III (LIN III), dx 01/01/2016 + • Lobular neoplasia grade III (LN III), dx 01/01/2016 + • Lobular, non-infiltrating
Breast, Colon, Rectum • Stage 0 (excluding Paget's disease) confined to lamina propria
Gallbladder – High grade biliary intraepithelial neoplasia grade III (BiIN III), 01/01/2018 +
Larynx – Laryngeal intraepithelial neoplasia grade III (LIN III), dx 01/01/2001 +
Pancreas – Pancreatic intraepithelial neoplasia grade III (PanIN III), dx 01/01/2004 +
Penis • Penile intraepithelial neoplasia grade III (PeIN III), dx 01/01/2001 + • Queyrat's erythroplasia
Skin • Clark's level I (melanoma; limited to epithelium) • Hutchinson's melanotic freckle, not otherwise specified (NOS) • Lentigo maligna • Precancerous melanosis
Vagina – Vaginal intraepithelial neoplasia grade III (VAIN III), dx 01/01/1992 + High grade squamous intraepithelial invasion (HGSIL or HSIL) 01/01/2018 +
Vulva – Vulvar intraepithelial neoplasia grade III (VIN III), dx 01/01/1992 + High grade squamous intraepithelial invasion (HGSIL or HSIL) 01/01/2018 +

NOTE: Terms without reportability dates have been reportable since the region's reference date.

- Carcinoid Tumors, NOS
- Severe or high-grade dysplasia, documented as being synonymous with carcinoma.
- Malignant perivascular epithelioid cell tumor (PEComa), dx 01/01/2018 +
- Benign and borderline **Intracranial and/or Central Nervous System** (CNS) tumors, dx 01/01/2001 +

- Sites C70-C70.9, C71.0-C71.9, C72.0-C72.9, C75.1-C75.3, behaviors /0 or /1
- Hemangioma, NOS (9210/0) and Cavernous hemangioma (9121/0)

  Note: For cavernous sinus hemangioma, code site to C70.0 cerebral meninges
- Lhemitte-Duclos disease is synonymous with dysplastic gangliocytoma per WHO classification of CNS tumors, dx 01/01/2018 +

Standard Setter Differences:

- CCR reportability date for benign brain tumors is 2001. This included benign schwannoma's. In 2004, benign brain tumors (including schwannoma's) became required for collection by SEER and CDC registries as well.
- Juvenile astrocytoma is coded as borderline in ICD-O-3; North America registries report as (9421/3). (Per ICD-O-3 Errata dated 5/22/2001).

- All **Hematopoietic and lymphoid** neoplasms as outlined in the following link: http://seer.cancer.gov/seertools/hemelymph are reportable.
- **Gastrointestinal stromal tumors (GIST):**
  - Reportable when:
    - Documented as being in-situ
    - Documented as NOS with multiple foci, lymph node involvement, or metastasis
    - Patient is undergoing treatment as if it is malignant
- **Liver** - Report liver cases with an LR-5 or LR-5V based on the 2014 American College of Radiology Definitions, https://nrdr.acr.org/lirads.
- **Ovary:**
  - Site C56.9
    - Noninvasive low grade (Micropapillary) serous carcinoma (MPSC) of ovary, dx 01/01/2018 +

      Notes:

      1. Assign code 8460/2, applying the ICD-O-3 matrix concept to this non-invasive carcinoma.
      2. Noninvasive can be used as a synonym for in-situ, ICD-O-3 behavior code /2. See page 66 in ICD-O-3.
- **Pancreas:**
  - Sites C25.0-C25.9, dx 01/01/2015 +
    - Neuroendocrine tumor of the pancreas when the diagnosis is insulinoma (8240/3 or 8151/3)
    - Cystic pancreatic endocrine neoplasm (CPEN) (8150/3)

- Cystic pancreatic endocrine specified as neuroendocrine tumor, grades 1 and 2 (8240/3)
- Solid pseudopapillary neoplasm of pancreas (8452/3)
- Non-invasive mucinous cystic neoplasm (MCN) of pancreas with high-grade dysplasia (8470/2)

Note: Term high-grade dysplasia replaces term mucinous cystadenocarcinoma, non-invasive.

- **Pituitary:**
  - Site C75.1
    - Rathke pouch tumor (9350/1), dx 01/01/2001 +

    Note: Rathke cleft cyst and Rathke pouch tumor are different conditions. Rathke cleft cyst is not reportable.
- **Testis:**
  - Sites C62.0-C62.9, dx 01/01/2015 +
    - Mature teratoma of the testes in adult.

      Notes: Adult, defined as post puberty.

      Do not report if it is unknown whether patient is pre- or post-pubescence.
- **Thymoma:**
  - Reportable when:
    - Documented as NOS with multiple foci, lymph node involvement, or metastasis.
- **Thyroid:**
  - Site C73.9 (8343/3), dx 01/01/2017 +
    - Non-invasive follicular thyroid neoplasm with papillary like nuclear features is a synonym for encapsulated follicular variant of papillary thyroid carcinoma.
- **Skin:**
  - Sites C44.0-C44.9
    - Basal and squamous cell carcinoma of the skin of the genital organs (vagina, clitoris, labium, vulva, prepuce, penis, and scrotum).
    - Adnexal carcinomas (e.g., carcinomas of the sweat gland, sebaceous gland, ceruminous gland, and hair follicle), adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumors are reportable regardless of site.
    - Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in skin.
      - For additional information regarding lip reportability, please see: Q-Tips - Cancer of the Lip & Reportability.

II.1.1 CCR Reportability Guide - Non-Reportable or Historically Reportable

Refer to the reportability guide below for information on specific histologies and sites for tumors that are either not reportable of historically reportable to the CCR.

Non-Reportable or Historically Reportable Diagnoses

- **Skin:**
  - Sites C44.0-C44.9, histologies (8000-8110) has always been non-reportable.
    - Basal cell carcinomas of the skin
    - Epithelial carcinomas of the skin
    - Papillary carcinomas of the skin
    - Squamous cell carcinomas of the skin
    - Squamous intraepithelial neoplasia III (8077) arising in the perianal skin (C445), dx 01/01/2018 +
    - **Early or evolving melanoma of any type is NOT reportable, dx 01/01/2018 +**

      Note: This includes both invasive and in situ melanomas; early or evolving are **not** reportable.
- **Cervix:**
  - Sites C53.0-C53.9, behavior /2 was reportable before 1996
    - Carcinoma in-situ of the cervix (CIS) (including squamous cell & adenocarcinoma)
    - Cervical intraepithelial neoplasia grade III (CIN III).
    - Cervical intraepithelial neoplasia with severe dysplasia (CIN III)
- **Borderline Ovarian:**
  - Site C56.9, histologies (8442/1, 8451/1, 8462/1, 8472/1, and 8473/1)
    - Not reportable 01/01/2016 +
      - Reportable with behavior /1 between 01/01/01 through 12/31/2015
      - Reportable with behavior /3 before 01/01/2001
- **Prostate:**
  - Site C61.9, histology (8148/2) has always been non-reportable.
    - Prostatic intraepithelial neoplasia, grade III (PIN III)
- **Appendix:**
  - Site C18.1, histology (8240/1), OBSOLETE beginning 01/01/2015
    - Carcinoid tumors, NOS of the appendix

- **Liver** – Do not report cases based only on an LI-RADS category LR-4
- **Lymphoma in-situ**, behavior /2 has always been non-reportable
- **Renal Pelvis, ureters, urinary bladder part of urethra** – Papillary urothelial neoplasm of low malignant potential (PUNLMP) are not reportable
- **Urine Cytology –** Positive for malignancy, dx 01/01/2013 +
- **Venous angioma/Venous hemangioma** - Venous angiomas are NOT reportable wherever they arise. The primary site for venous hemangioma arising in the brain is blood vessel (C490). The combination of 9122/0 (Venous hemangioma) and C490 is not reportable.

  Note: This is a venous abnormality, previously referred to as venous angiomas and currently referred to as developmental venous anomalies (DVA).
- **Historic – Newly Reportable Hematopoietic Diseases (NRHD)**
  - Click the link above, for cases 01/01/2001 to 01/01/2010

II.2 Determining Reportability

Reportable cases are cases that the registry is required to collect and report.

Guidelines:

- Every reporting facility must report all cases, inpatient or outpatient, admitted on or after the regional registry's reference date with a neoplasm classified in the morphology section of ICD-O-3 (International Classification of Diseases for Oncology, Third Edition, 2000) as malignant or in-situ, including those discovered at an autopsy.
    - The only exceptions are certain carcinomas of the skin. See the CCR Reportability Guide – Reportable.
- Neoplasms described by terms synonymous with in-situ are reportable. See In-Situ Coding for a list of these terms.
- Benign and uncertain behavior intracranial and central nervous system (CNS) tumors became reportable along with newly reportable histologies published in ICD-O-3. This applies to cases diagnosed January 1, 2001 and forward.
- Other benign neoplasms are not reportable.
- For a list of reportable and non-reportable neoplasms, refer to the morphology section of ICD-O-3.

II.2.1 Identifying the Primary Neoplasm and Single or Multiple Tumors

A primary neoplasm is the original lesion, as compared to a tumor that has developed because of metastasis or extension. A patient might have many lesions that developed from one tumor or different tumors that developed independently.

Coding Instructions:

- For cases or tumors diagnosed January 1, 2018 and forward, refer to the 2018 Solid Tumor Rules Manual.
- Code the primary site to the location of the transplanted organ when a malignancy arises in a transplanted organ.
- See Terms and Definitions for types of transplants.
- Do not use the Solid Tumor Rules Manual to determine reportability, stage or to assign grade.
- For hematopoietic and lymphoid cases diagnosed January 1, 2018 and forward, please refer to the SEER Hematopoietic and Lymphoid Neoplasm Database.
- Kaposi's sarcoma (9140/3) is to be reported only once.
- For additional information on historical manual references, refer to Appendix S - Historical Coding and Staging Manual Requirements for CCR.

II.2.2 Ambiguous Diagnostic Reportable Terms

Physicians sometimes use vague or ambiguous terms to describe a tumor when its behavior is uncertain. This occurs primarily when there is no histologic diagnosis.

The terms listed below are reportable when they are used with a term such as cancer, carcinoma, sarcoma, etc.

Ambiguous Terms for Reportability

REPORTABLE TERMS		
Ambiguous Terminology Considered as Diagnostic of Cancer ***Exception:*** *If the cytology is reported as "suspicious" and neither a positive biopsy nor a physician's clinical impression supports the cytology findings, do not consider as diagnosis of cancer.*	Apparent(ly) (malignant) Appears to* Comparable with* Compatible with (a malignancy)* Consistent with (a malignancy) Favor (s) (a malignancy) Malignant appearing*	Most likely (malignant) Presumed (malignant) Probable (malignancy) Suspect (ed) (malignancy) Suspicious (of malignancy) Typical (of/for malignancy)

*Effective for cases diagnosed January 1, 1988 and forward.

Coding Instructions:

- Use this list as a reference of last resort.
- The only reportable ambiguous terms are those listed above. Ambiguous terms not on this list would not be considered reportable and should not be abstracted.
- The registrar should determine malignancy from the resources available for all cases where there is a clear statement of malignancy. In those cases, the ambiguous terminology list would not be applicable.
- Ambiguous terms may be located in any source document, such as pathology, operative, radiology, or clinical reports. This does not include tumor marker reports.
- Do not report a case when cytology, biopsy, excision, resection, or physician's statement proves the ambiguous diagnosis is not reportable.
- Do not substitute synonyms such as "supposed" for presumed or "equal" for comparable. Do not substitute "likely" for "most likely."
- There may be other ambiguous modifying words such as "mildly" suspicious. In general, ignore these modifiers and/or adjectives and accept the reportable ambiguous term.
- Report the case when there are reportable and non-reportable ambiguous terms within the medical record.
- Report the case when there is a single report and it has a reportable term and a term not listed on the reportable list.

- Do not report if the original source document used a non-reportable ambiguous term and later documents refer to a history of cancer.
- If cytology is reported as "suspicious," DO NOT interpret this as a diagnosis of cancer. Abstract the case if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.
    - FNA "suspicious" for cancer cannot be used for the date of diagnosis without a physician statement or other indication of malignancy.
        - Text must document the physician statement of malignancy referencing the date of the suspicious cytology as date of diagnosis.
        - In the absence of a documented physician statement as outlined above, if an FNA "suspicious" for cancer is followed by a definitive procedure such as a tissue biopsy, surgery, scan or other procedure confirming the cancer, the date of the procedure would be the date of diagnosis.
    - In addition, a cytologically confirmed case with a negative biopsy must be evaluated carefully. If the biopsy rules out the presence of cancer, do not report the case. However, if a negative biopsy does not rule out the presence of cancer, the case is considered to be cytologically confirmed and is reportable. See Diagnostic Confirmation for further information.
    - A urine cytology positive for malignancy is reportable. Report these cases when they are encountered. This is effective with cases diagnosed 1/1/2013 and forward. Do not implement new/additional casefinding methods to capture these cases.

      Exception: When a subsequent biopsy of a urinary site is negative, do not report the case.
    - Code the primary site to C689 in the absence of any other information.
    - As always, **do not** report cytology cases with ambiguous terminology.

Benign and borderline primary intracranial and CNS tumors:

- Use the above "Ambiguous Terms for Reportability" list to identify benign and borderline primary intracranial and CNS tumors that are reportable.
- If any of the reportable **ambiguous terms precede** either the word "**tumor**" or the word "**neoplasm**", report the case.

II.2.3 Pathology and Consultation Only Cases

Abstract reporting by facilities is not mandatory for reportable cases diagnosed by the pathology department based on slides or specimens submitted from outside the reporting facility and cases seen for consultation only. However, the facility must notify the regional registry about these types of cases in order to verify that all reportable cases in the population have been recorded.

Coding Instructions:

- It is sometimes difficult to identify a consultation only case, especially at a large teaching facility. As a guideline, the CCR recommends determination of who is ultimately responsible for treatment decisions and follow-up of the patient.
    - If the consulting facility is responsible for treatment decisions or follow-up, an abstract is required.
    - If the consulting facility is confirming a diagnosis made elsewhere, rendering a second opinion, or recommending treatment to be delivered and managed elsewhere, an abstract is not required, although the regional registry must be notified.

Note: When in doubt about whether to report the case, contact your regional registry for guidance.

II.2.4 Hematopoietic and Lymphoid Neoplasm

Reportable hematopoietic diseases diagnosed January 1, 2010 and forward, use the current Hematopoietic Database and Manual to abstract hematopoietic cases.

- Manual: https://seer.cancer.gov/tools/heme
- Database: https://seer.cancer.gov/seertools/hemelymph

LYMPHATIC & HEMATOPOIETIC DISEASES---SUBSEQUENT DIAGNOSES **For reportability rules of hematopoietic and lymphoid neoplasms, refer to the Hematopoietic and Lymphoid Neoplasm Database and Coding Manual.**		
DATE DIAGNOSIS YEAR		
1st Primary	**2nd primary**	**Reference**
Prior to 2001	Prior to 2001	SEER Hematopoietic Manual & Database
2001--2009	2001--2009	See Archived Volume I – Use case year of diagnosis to determine which volume I to choose SEER Hematopoietic Manual & Database
Prior to 2001	2001-2009	See Archived Volume I – Use case year of diagnosis to determine which volume I to choose SEER Hematopoietic Manual & Database
2010	2010	SEER Hematopoietic Manual & Database
Prior to 2010	2010	SEER Hematopoietic Manual & Database

II.2.5 Benign/Borderline Brain and CNS Tumors

In determining whether a Benign/Borderline Brain and CNS are reportable, the basic criterion is a diagnosis of cancer by a physician, surgeon, or dentist, even if it is not pathologically confirmed.

Reportability:

Note: There is a standard setter difference in reportability dates for Benign/Borderline Brain and CNS Tumors.

- California Cancer Registry began collecting the following cases January 1, 2001 and forward.
    - ***Benign Schwannoma:**
        - Reportable for cases diagnosed January 1, 2004 and forward for sites C72.2-C72.5
        - Expanded for cases diagnosed January 1, 2011 and forward to include site C72.0
- National implementation began with cases diagnosed on January 1, 2004 and forward.
    - In 2002, Public Law 107-260 required the National Program of Cancer Registries (NPCR) to expand their primary brain tumor data collection to include tumors of benign and uncertain behavior. This began with cases diagnosed January 1, 2004 and forward.

Any tumor with a behavior code of 0 or 1 will be collected for the following site codes based on ICD-O-3:

- 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) ***(above)**
- Cauda equina (C72.1)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

- Juvenile astrocytomas/pilocytic astrocytomas should continue to be reported as 9421/3.
- Only benign brain tumor cases with a diagnosis year of 2001 forward are required to be reported to the CCR.

Guidelines:

- For vague and ambiguous diagnostic terms, see Ambiguous Diagnostic Reportable Terms.

- A positive pathology report takes precedence over any other report or statement in a patient's chart.
- In case of doubt about the reportability of a tumor, contact the reporting facility's regional registry for advice.
- Do not report benign brain tumor cases with an unknown year of diagnosis, unless it is known that the year of diagnosis is 2001 forward. Apply the rules under the Vague Dates section to determine a date of diagnosis if it is known that the benign brain case was diagnosed after 2001.

Reportable Terminology

- To be reportable, there must be a corresponding ICD-0-3 histology code for any CNS tumor related diagnosis.
    - The terms "tumor" and "neoplasm" are diagnostic and reportable for non-malignant brain and CNS primaries.
    - The terms "mass" and "lesion" are not reportable for non-malignant brain and CNS primaries, but may be used for initial casefinding purposes.
    - The terms "hypodense mass" or "cystic neoplasm" are not reportable even for CNS tumors.

Benign Schwannoma *(above)

- Per SEER instruction, we are to report Benign Schwannomas (9560/0) of the spinal cord (C72.0) and of the cranial nerves (C72.2 - C72.5); therefore, these are both reportable to the CCR. Benign Schwannomas occurring anywhere else such as the peripheral nerves or peripheral nerve roots are not reportable to the CCR.
- Report spinal (Schwannoma) tumors (C72.0) when the tumor arises within the spinal dura or spinal nerve roots, or when they are stated to be “intradural” or “of the nerve root.” DO NOT report tumors that arise in peripheral nerves. Peripheral nerves are the portion of the nerve extending beyond the spinal dura.
- The cranial nerves (C72.2 – C72.5) are composed of twelve pairs of nerves that emanate from the nervous tissue of the brain. Cranial nerves are sometimes referred to by their number, such as the 8th cranial nerve, instead of the vestibulocochlear nerve.

To assist registrars with identifying reportable benign Schwannoma tumors, the cranial nerve numbers, names and their ICD-O-3 topography codes are listed below:

Cranial Nerve Description	Associated ICD-O-3 Code
I	Olfactory (C72.2)
II	Optic (C72.3)
III	Oculomotor (C72.5)
IV	Trochlear (C72.5)

V	Trigeminal (C72.5)
VI	Abducens (C72.5)
VII	Facial (C72.5)
VIII	Vestibulocochlear (auditory and vestibular nerve, acoustic nerve) (C72.4)
IX	Glossopharyngeal (C72.5)
X	Vagus (C72.5)
XI	Accessory (C72.5)
XII	Hypoglossal (C72.5)

Example of a reportable Schwannoma:

- Vestibular Schwannoma, also known as acoustic neuroma (C72.4 M-9560/0)

Note: Registrars are not expected to go back and review Schwannoma cases already submitted to the CCR.

References: SEER and CDC

- For more information see: http://www.cdc.gov/cancer/npcr/training/btr/clarification.htm.
- For historical information, see: Data Collection of Primary Central Nervous System Tumors.

II.2.5.1 Date of Diagnosis for Benign/Borderline Brain and CNS Tumors

As the CCR began reporting benign brain and CNS tumors prior to national reporting implementation, there are two sets of rules for establishing the Date of Diagnosis for benign and malignant brain tumors.

Coding Instructions:

- Record the date a recognized medical practitioner states the patient has a reportable tumor, whether that diagnosis was made clinically or pathologically. If a clinical diagnosis, do not change the date of diagnosis/when there is a subsequent tissue diagnosis. This pertains to cases diagnosed January 1, 2004 and forward.
- For **non-analytic** cases (Class of Case 30-99): All attempts should be made to determine or estimate the date/year of diagnosis.
    - If no information about the date or at least year of diagnosis is available:
        - Use the date of admission /1st contact and apply the applicable coding instructions.

    Example:

    A CT scan done 4/1/04 states brain tumor. The patient has surgery on 4/5/04 and a biopsy reveals an astrocytoma. The date of diagnosis is 4/1/04.

- Use the most definitive source of diagnostic confirmation as the date of diagnosis. This pertains to cases diagnosed January 1, 2001 to December 31, 2003.

    Example:

    A CT scan done 2/1/03 states brain tumor. The patient has surgery on 2/5/03 and a biopsy reveals an astrocytoma. The date of diagnosis is 2/5/03.

II.2.5.2 Malignant Transformation - Brain and CNS Tumors

Malignant transformation occurs when a benign or borderline tumor transforms into a malignancy.

Coding Instructions:

- Create a new case abstract when a benign or borderline tumor transforms into a malignancy.
    - For cases or tumors diagnosed January 1, 2018 and forward, refer to the 2018 Solid Tumor Rules Manual.
- Do NOT create a second abstract and do NOT change the original histology code when a benign tumor transforms to a borderline tumor.

II.2.5.3 WHO Grade - Benign/Borderline Brain and CNS Tumors

CNS WHO classifications use a grading scheme that is a "malignancy scale" ranging across a wide variety of neoplasms, rather than a strict histologic microscopic grading system, that can be applied equally to all tumor types. The WHO Grade is collected for reportable non-malignant Brain and CNS tumors in the 2018 Grade data items.

Guidelines:

- WHO Classifications:
    - WHO Grade I generally describe non-malignant or benign tumors.
    - WHO Grade II generally describes a malignant tumor, but it can describe a non-malignant tumor depending on histologic type.
        - Refer to the most current **Solid Tumor Rules 2018: Non-Malignant CNS** "*Instructions for identifying and Assigning Behavior*" to determine whether WHO Grade 2 neoplasms are non-malignant or malignant. Use the appropriate set of rules.
    - WHO Grade III and IV describe malignant tumors.

Coding Instructions:

- Refer to the most current Grade Coding Instructions and Tables for coding instructions.
- When the WHO Grade is not documented for reportable non-malignant Brain and CNS tumors, refer to the following:
    - The WHO Grading system for selected tumors of the CNS as noted in the **AJCC 8th edition Chapter 72,** Brain and Spinal Cord, **Table 72.2**.
    - The **Solid Tumor Rules 2018: Non-Malignant CNS** *WHO Grade of Select CNS Neoplasms*.
- If the histology for a reportable non-malignant Brain or CNS tumor is not listed in AJCC Table 72.2, or the Non-Malignant CNS Solid Tumor Rules Table 1, code Grade to 9.

For historical information, see: Data Collection of Primary Central Nervous System Tumors.

II.3 Abstracting - Accession and Sequence Number

Each patient in a reporting facility's cancer registry is identified by a permanent nine-digit accession number and each of the patient's primary tumors is identified by a different two-digit sequence number. The accession number remains the same in every abstract prepared by the reporting facility for the patient, but the sequence number is different.

II.3.1 Year First Seen

Year first seen is the year the patient was first seen for this reportable primary.

Coding Instructions:

- Enter the four-digit year during which the patient was first seen at the reporting facility for diagnosis or treatment of the neoplasm reported in this abstract. For patients seen at the end of the year, use the year of diagnosis as the year first seen for this primary.

  Example:

  - A patient is admitted to the reporting facility in December 1992 and is diagnosed in January 1993.
    - Assign 1993 as the year first seen for this primary.

II.3.2 Accession Number

This data item identifies the patient and the tumor. Each patient entered in a reporting facility registry is assigned a unique accession number, and each primary diagnosed for that patient is assigned a sequence number. The accession number never changes and is never reassigned, even if a patient is removed from the registry. The accession number may be auto-generated by some abstracting vendors.

Coding Instructions:

- The first four digits of the accession number represent the year the patient was first seen at the reporting facility. See Year First Seen.
- The last five digits represent the approximate chronological order of the abstracts prepared for that year.
- Each facility abstract must contain an accession number and each patient can only have one accession number.
    - Check to see if the patient already has an accession number, then use that number when it is available.
    - Assign an accession number only when the patient did not have one assigned previously.

      Examples:

        - If the patient was admitted or the tumor was diagnosed on February 11, 2005, the first four digits are 2005. If the abstract for the reported tumor was the 285th prepared for 2005, the accession number is 200500285.
        - Two abstracts are being prepared for a patient with one primary tumor diagnosed in 2004 and another in 2006. The first four digits of the accession number are 2004 and the next five represent the abstract's place in the chronological order of cases reported for 2004. The same accession number must be used for the second and subsequent abstracts. (However, the year first seen for the first tumor is 2004 and for the second it is 2006).

II.3.3 Sequence Number

Sequence refers to the chronological position of a patient's primary tumor among all the reportable tumors occurring during the patient's lifetime, whether they exist at the same or separate times and whether or not they are entered in the reporting facility's registry.

Coding Instructions:

- If two or more reportable neoplasms are diagnosed at the same time, the lowest sequence number is assigned to the diagnosis with the worst prognosis.

  Example:

  A patient's medical record shows a history of three primary malignant (reportable) tumors in the past and two simultaneously diagnosed recent malignant tumors, one of which is the subject of this report, for a total of five malignancies. The stage of the tumor being reported is regional, whereas the stage of the second of the multiple tumors is localized, a better prognosis. Assign sequence number 04 to the tumor being reported. The number for the second multiple primary is 05.

- If more tumors are diagnosed before the report is submitted, the sequence number must be updated if it was originally coded as 00 or 60, designating a single tumor.
- If no difference in prognosis is evident, the decision is arbitrary.
- Use numeric sequence codes in the range of 00-35 to indicate reportable neoplasms of malignant or in-situ behavior. Cases of juvenile astrocytomas, diagnosed prior to 1/1/2001, but entered after 1/1/2003 also use a sequence code in the 00-35 range. This applies to cases diagnosed January 1, 2003 and forward.
- A primary, non-malignant tumor of brain or CNS sites diagnosed on or after 1/1/07 is reportable.
  - Sequence numbers must be in the range of 60-87
- Sequencing of non-malignant tumors does not affect sequencing of malignant tumors and vice versa.
  - A malignancy (sequence 00) will remain as 00 even if followed by a non-malignant tumor (sequence 60-87)

    Example:

    First tumor, benign meningioma, sequence 60

    Second tumor, astrocytoma, sequence 00

- For Newly Reportable Hematopoietic Diseases (NRHD):
  - If the original hematopoietic disease was not reportable at the time of diagnosis, do not include it in the sequencing.

Note: Alphabetic sequence codes are no longer allowed.

- In the remarks area, record the following information regarding subsequent reportable tumors/ primary sites:
  - Enter the tumor # (first, second, third primary in relation to this one).

- Name of site
- Histology, and
- Diagnosis date

Example:

You currently abstract a breast case however the patient had a previous squamous cell cancer of the lung diagnosed January 20, 2000.

Your text should state: #1 – Lt Lung SCC, dx – 1/20/00

Codes for Tumors with Invasive and In-situ Behavior:

Code	Description
00	One primary malignancy
01	First of two or more primaries
02	Second of two or more primaries
59	59th or higher of 59 or more primaries
99	Unspecified in-situ / invasive sequence number or unknown

Codes for Benign and Uncertain Behavior CNS Tumors and Cases Reportable by Agreement:

Code	Description
60	One benign or borderline tumor reportable by agreement
61	1st of 2 or more benign or borderline tumors
62	2nd of 2 or more benign or borderline tumors
87	27th of 27 or more tumors
88	Unspecified benign, borderline, tumor of uncertain behavior and reportable by agreement Sequence number

II.3.4 Other Tumors/Primaries

In the remarks text field, record other reportable tumors/primary sites that the patient has or has had.

Coding Instruction:

- In the Remarks area, record the following information regarding subsequent reportable tumors/ primary sites:
    - Enter the tumor # (First, second, third primary in relation to this one).
    - Name of Site
    - Histology, and
    - Diagnosis date

      Example:

      You currently abstract a breast case however the patient had a previous squamous cell cancer of the lung diagnosed January 20, 2000.

      Your text should state: #1 – Lt Lung SCC, dx – 1/20/00.

Part III. Identification

Part III of Volume I is comprised of the sub-sections identifying the registry, the patient, and the case. Included in each subsection are detailed instructions on coding facility specific items, patient demographics, and case specific items such as date of diagnosis or class of case, to name a couple.

III.1 Registry Information

This includes reporting facility specific data items such as the reporting facility identification number, abstractor, and ACS approval flag fields. The information is used by the reporting facility and regional registries for facility specific identification purposes.

III.1.1 Abstractor

Enter the abstractor's initials, beginning in the left most space. If there are fewer than three initials, leave the trailing spaces blank.

Coding Instructions:

- Each reporting facility must submit a list of names and initials of all abstractors in their facility, including temporary staff beginning in January 2007.
- Changes to this list must be submitted to the region when specified abstractors no longer create abstracts at the facility, or when new abstractors are added.

III.1.2 Reporting Facility

Enter the reporting facility's CCR assigned reporting facility code or the facility's name.

Coding Instructions:

- Refer to the most current California Reporting Facility Codes lists, located on the CCR website https://www.ccrcal.org/learn-about-ccr/, Registrar Resources, Reporting Cancer in California, Volumes I-IV.
    - Lists are presented in both alphabetical and code order.

III.1.3 CoC Accredited Flag

The CoC Accredited Flag is assigned at the point and time of data abstraction to label an abstract being prepared for an analytic cancer case at a facility accredited by the Commission on Cancer (CoC). This data item is required by the CCR for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Hospital Registries:
    - Assign the code that reflects the CoC accreditation at the time the case is abstracted.
    - The flag may be defaulted by the registry's software or manually entered by the abstractor.

Codes:

Code	Description
0	Abstract prepared at a facility WITHOUT CoC accreditation of its cancer program
1	ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 10-22)
2	NON-ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 30-43 and 99, plus code 00 which CoC considers analytic but does not require to be staged)
BLANK	Not applicable; DCO

III.2 Patient Information

This section contains instructions on how to collect patient specific demographic information.

III.2.1 Name

Follow the guidelines below for entering the patient's name. Accurate patient information is important for matching data in the abstract with data about the patient received from other sources.

Reporting facilities must use the same rules for entering names, dates, and other information. Although reporting facility systems may have different name-related data entry requirements, the CCR requires the following information and formatting for patient name.

Coding Instructions:

- Enter the patient's last name, first name, middle name, maiden name, and any known alias.
- For entering alias names see, Entering Names.
- Begin at the far left of each field.
- Avoid using only uppercase/capitals.
- Spaces, hyphens and apostrophes are allowed. **Do not use any other punctuation**.

  Example:

  A patient with the name "St. James" should be entered in either one of the following ways:

  - St James
  - St-James
  - St'James
  - Saint James

  o However, you choose to enter the name, with a space, hyphen, apostrophes, or spelled out, all efforts should be made to keep all similar name entries consistent.
- Do not enter the gender or marital status-Mr., Mrs., Miss, Ms.-or similar forms of address in other languages before the name. For religious order names, see Religious Names.
- Spell out abbreviated names (e.g., Robt. = Robert).
- If the patient is a child under the age of 18, living with his/her parent(s) or guardian(s), record the name(s) of the parent(s) or guardian(s) in the remarks text field.

III.2.1.1 Entering Names

The patient's name is used by reporting facilities as a patient identifier.

Coding Instructions:

- Each name field is 40 characters in length.
  - If more than 40 characters, enter only the first 40.
  - Spaces, hyphens and apostrophes are allowed.
  - Do not use other punctuation.
- **Last Name**
  - Enter the patient's entire last name.
  - If the patient has no last name, enter NLN (Examples: Prince or Madonna).
  - If the name cannot be determined or is unknown, enter “UNKNOWN” or “Unknown.”
  - If a patient's last name has changed, enter the current last name in the Last Name field and move the original name to the Alias field.
- **Maiden Name**
  - Enter a woman's maiden name, if known, even if it has been entered in the Last Name field.
  - Leave the field blank if maiden name is not known.
- **Alias Last Name**
  - An alias (also known as, or AKA) surname used by the patient, certain religious order names (See Religious Names), or the first part of a Chinese name that might appear as a last name on another report. (For example, Sun Yat sen might appear elsewhere as Sun, Yat sen or Yat sen Sun).
  - The spelled-out version of a name containing the word Saint.
  - Leave the field blank if there is no alias last name.
  - Do not enter a maiden name in the Alias Last Name field.
- **First Name**
  - Enter the patient's entire first name.
  - If a woman uses her husband's full name (e.g., Mrs. John Smith), try to learn her first name.
  - If the patient has no first name, enter NFN.
  - If the name cannot be determined or is unknown, enter “UNKNOWN” or “Unknown.”

    Note: CCR coding instructions for unknown first name differs from SEER and STORE. For this data item, CCR follows the NPCR coding instructions to pass NPCR submission edits.

    - If the patient's first name is not a common male or female name or it is ambiguous with regard to gender, include a statement in the Remarks field confirming the patient's gender.

- **Alias First Name**
    - Enter the alias (also known as, or AKA) first name used by the patient.
    - Leave the field blank if there is no alias first name.
- **Middle Name**
    - Enter the patient's middle name or middle initial.
    - Leave the space blank if there is no middle name or initial or if it is not known.

III.2.1.2 Religious Names

Please use the following instructions as when entering religious names.

Coding Instructions:

- Do not enter religious designations like Sister, Brother, or Father unless the patient's secular name is unknown.
- If the secular name is known, enter the last name of the religious name under Alias Last Name.
- When the religious name only is known, enter the last name under Last Name, the designation under First Name, and the religious first name under Middle Name.

  Examples:

  - Religious name: Sister Mary Anthony and Secular name: Jane Smith

    Report as:

    (last name) Smith

    (first name) Jane

    (alias) Anthony

  - Religious name: Sister Mary Anthony and secular name: Smith (first name unknown)

    Report as:

    (last name) Smith

    (first name) Sister

    (alias) Anthony

  - Religious name: Sister Mary Anthony and secular name: unknown

    Report as:

    (last name) Anthony

    (first name) Sister

    (middle name) Mary

III.2.1.3 Name Suffix

A name suffix is a title that would follow the name in a letter such as Jr, Sr, III, or IV. It is frequently a generation identifier. It helps to distinguish between patients with the same name.

Coding Instructions:

- Do not use punctuation.
- Leave blank if the patient does not have a name suffix.
- Do not use this field to record suffixes such as MD or PhD.

III.2.1.4 Mother's First Name

Enter the pediatric patient's mother's first name in this field.

Coding Instructions:

- Enter up to 40 characters in the Mother's First name field.
- Include the hyphen or apostrophe in a name, but do not enter any other non-alphabetic characters.
- If this name is not available, this field may be left blank.

III.2.2 Medical Record Number

Enter the medical record number assigned to the patient at the reporting facility. For facilities using a serial numbering system, enter the latest number assigned at the time of abstracting. (This will not be updated).

Coding Instructions:

- Medical record numbers can be alphanumeric and should be right justified.
- Do not use punctuation or leave a blank space. Enter leading zeroes that are part of the number.
- If a patient has not been assigned a medical record number at the time the abstract is prepared, certain other identifying numbers may be entered.

  Examples:

  - Some facilities enter the log number assigned by the radiation therapy department, preceded by the letters RT, for patients who do not have a medical record number but are receiving radiation therapy.
  - For outpatients who are not admitted and not seen in the radiation therapy department, the assigned number can be preceded with the letters OP.
  - If a number is not assigned, enter a code meaningful to the facility. This field should not be left blank.
- An alternate medical record number, such as the patient's record number at the next follow-up facility, may be entered for the convenience of the facility performing the follow-up. The Alternate Medical Record Number field should usually be changed if the Next Follow-Up Facility field is changed. The item is not required, and is not transmitted to the CCR.

III.2.3 Social Security Number

A patient's full social security number is critical for the identification of multiple reports of the same cancer so that they are not counted as separate cases.

Coding Instructions:

Two fields are provided:

- **Nine-character field for the number:**
  - Enter the patient's 9-digit social security number (SSN).
  - Make every effort to ascertain the patient's own number. Enter it and its suffix in the fields provided.
  - If the patient's own number cannot be determined, enter whatever number (including its suffix) available from the medical record.
  - Do not combine the suffix from one number with a different number.
  - If the social security number is not known, enter 9's.
  - Military facilities use the sponsor's social security number plus a numeric prefix as the clinic number or Medical Record Number. Disregard such a number when entering the social security number and suffix, but enter it in the Medical Record Number field when appropriate.
  - The following values are not allowed:
    - First three digits cannot be 000 or 666
    - Fourth and fifth digits cannot be 00
    - Last four digits cannot be 0000
    - First digit cannot be 9 (except for 999999999)

      Examples:

      Social security number from face sheet: 111-22-3333

      Medicare claim number: 123-45-6789B

      Enter 111-22-3333

      Social security number from face sheet: 222-33-4444D5

      No other numbers recorded in chart

      Enter 222-33-4444D5

      Social security number from face sheet: not recorded

      Clinic record number at Air Force facility: 30-333-44-5555

      Enter 999-99-9999

- **Two-character field for a suffix:**

- The suffix for a patient's social security number was historically used to show the relationship of the patient to the bearer of the SSN entered (e.g. spouse).
- If the suffix is only one character, leave a trailing blank space in the Suffix field.
- A Medicare claim number with a suffix indicating the patient's relationship to the wage earner or primary beneficiary/claimant, or both. (The suffix A, for example, indicates that the patient is the wage earner or primary beneficiary/claimant and the social security number is the patient's).
- When there is no suffix, leave the two-character field blank.

III.2.4 Medicare Beneficiary Identifier (MBI)

Enter the Medicare Beneficiary Identifier assigned to the patient. The MBI is a randomly generated identifier that does not include a SSN or any personal identifiable information. The MBI is a step to minimize the risk of identity theft for Medicare beneficiaries and to reduce opportunities for fraud. The Medicare Beneficiary Identifier is required if available by the CCR for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Enter the 11-character Medicare Beneficiary Identifier randomly assigned to the patient by Medicare.
- The Medicare Beneficiary Identifier:
    - Consists of numbers and upper-case letters
    - Entered **without** dashes

Codes (in addition to MBI):

Code	Description
BLANK	Not Available, Non-Medicare Patient, Not Applicable, or Unknown

III.2.5 Phone Number (Patient)

This field is to be used for entering the patient's current telephone number including the area code.

Coding Instructions:

- Update this field with the most current telephone number, when follow-up indicates that the telephone number has been changed.
- Enter all 0's, if there is no phone.
- Enter all 9’s, if the phone number is unknown.

III.2.6 Address at Diagnosis

The address at diagnosis field is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer cluster concerns and other epidemiological studies. The main purpose of the address field is to identify the patient's residence at the time the cancer was first diagnosed, not the patient's current address.

- Every effort should be made to determine the correct address.
- Rules for determining residency are based on those used by the U.S. Department of Commerce for the 1990 Census of Population.
- It is important to follow the rules exactly, because the central registry uses automated data processing methods that reject non-standard entries. The data are used for grouping cases by geographic area.

Coding Instructions:

- Enter the address of the patient's usual residence on the date of the initial diagnosis. See, Date of Diagnosis for definition of date of diagnosis.
- Usual residence is where the patient lives and sleeps most of the time and is not necessarily the same as the legal or voting residence.
- Do not record a temporary address, such as a friends or relatives.
- If both a street address and a P.O. Box are given, use the street address.
- For military personnel and their families living on base, the address is that of the base. For personnel living off base, use the residence address. For details about military personnel assigned to ships and about crews of merchant vessels, see Appendix D - Determining Residency of Military Personnel.
- Address is that of the institution for the following:
    - Incarcerated individuals
    - Nursing home, convalescent or rest home patients
    - Physically handicapped, mentally challenged or mentally ill residents of homes, schools, hospitals or wards
    - Long-term residents of other hospitals such as Veterans Administration (VA) hospitals
- Use the current address of a college student. However, for children in boarding schools below the college level enter the parents' address.
- If the case is nonanalytic (See, Class of Case for criteria), use the address at admission unless there is a documented reason to suspect that the patient resided elsewhere at the time of diagnosis. If there is such an indication, record what is known of the address at diagnosis.
- If the patient is homeless or transient with no usual residence:

- Enter the street, city and zip code as unknown but code county of residence to the county where the reporting facility is located and code the state to California.
- Document that the patient is “Homeless” or “Transient” in the Address at Diagnosis – Supplemental field.

Note: Coding address information for homeless/transient patients in this manner is important from a research perspective. Attempting to code otherwise would be incorrect in California and would skew cluster investigations.

- Persons with more than one residence (snowbirds) are considered residents of the place they designate as their residence at the time of diagnosis if their usual residence cannot be determined.

III.2.6.1 Number and Street at DX

Enter the patient's street number and street name at diagnosis.

Coding Instructions:

- Use up to 60 characters for the street address.
- The allowable character values that may be entered are:
  - Letters
  - Numbers
  - Spaces
  - The ***ONLY*** special characters allowed are:
    - Number symbol (#)
    - Slash (/)
    - Hyphen (-)
    - Period (.)
- House numbers must precede the street name.
- Insert a single space between each component in the street address (e.g., "NEW MONTGOMERY STREET").
- Direction (e.g., North, West) and street types (e.g., Avenue, Road) may be abbreviated (e.g., N MAIN ST). However, do not abbreviate a direction that is the name of a street (e.g., 123 NORTH ST).
- Use intersection addresses (e.g., "FOURTH AND MAIN"), post office box numbers, and building names (e.g., "HOTEL NEW HAMPSHIRE") only if an exact address is not available in the medical record, business office, or elsewhere.
- Place a unit designation directly after the house number (e.g., "139A MAIN ST") or after the street name (e.g., "106 CHURCH STREET 1ST FLOOR," "36 EASTERN CIRCLE APT A").
- If the address contains more than 60 characters, omit the least essential elements, such as the apartment or space number.
  - Do not omit elements needed to locate the address in a census tract, such as house number, street, direction or quadrant, and street type.
- Abbreviate as needed, using the standard address abbreviations listed in the List of Acronyms/Abbreviations published by the U.S. Postal Service.
- If the address cannot be determined, enter the word "UNKNOWN."
- The **Address at Diagnosis - Supplemental** field provides the ability to record additional address information such as the name of a place or facility (i.e., a nursing home or name of an apartment complex) at the time of diagnosis.
  - If the patient is stated to be "Homeless" or "Transient", enter "HOMELESS" or "TRANSIENT" in this field.

- Use up to 60 characters for this field.
- 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.

III.2.6.2 City at DX

Enter the patient’s city of residence.

Coding Instructions:

- Keep spaces in names consisting of more than one word, but do not use punctuation (e.g., "LOS ANGELES," "SAN FRANCISCO," "ST PAUL"). A maximum of 50 characters and spaces.
- If a patient's usual place of residence at the time of diagnosis was in a foreign country, enter the name of the city in the foreign country.
- Enter the word "UNKNOWN" if the city where the patient lived cannot be determined.

III.2.6.3 State at DX

The State at Diagnosis data item identifies the patient's state of residence at time of diagnosis.

Coding Instructions:

- For states in the U.S. and provinces in Canada, enter the standard two-letter Postal Service abbreviation.

  Example:

  California is CA

- For other states, U.S. Territories and Canadian provinces see, Appendix B - Postal Abbreviations for States and Territories of the United States.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.

Guidelines:

- Use U.S. Postal Service abbreviations 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.
- Do not update this data item if the patient's state or residence changes.

III.2.6.4 ZIP at DX

The data field Zip at DX identifies the postal code of the patient's address at diagnosis.

Coding Instructions:

- Enter the five-digit or nine-digit U.S. postal zip code or the proper postal code for any other country.
    - When entering only five digits, leave the last spaces blank.
- Enter 8's in the entire field, if the patient resided outside the U.S. or Canada at time of diagnosis and the zip code is unknown.
- To obtain an unknown zip code, consult the U.S. Postal Service National Zip Code and Post Office Directory, published by the U.S. Postal Service, or phone the local post office.
- If the code cannot be determined and it is a U.S. or Canadian resident, enter 9's in the entire field.

III.2.6.5 County at DX

County at DX documents the county the patient lived in at the time of diagnosis.

Coding Instructions:

- For California residents, enter the code for the county of residence at the time of diagnosis. Some abstracting software will automatically enter the code if the county name is entered.
- Consult maps or reference works as needed to determine the correct county. If your software vendor provides FIPS codes for this data field, see Appendix L.1 and L.2 for code conversions.
- Required California county codes in Alpha or Numerical order can be accessed in the links below:
    - Appendix H - Codes for California Counties
- For foreign residents, enter the country of residence in this field. This information will also be captured in the "Address at Diagnosis - Country" field (see Country at DX).
- Enter code CAN for Canada, NOS, or the specific code for the known Canadian province.
    - Canadian province codes are listed in Appendix B - Postal Abbreviations for States and Territories of the United States.
- For non-United States, use the country of residence.
    - Appendix C - Codes for Countries.

III.2.6.6 Country at DX

Country at DX documents the country the patient lived in at the time of diagnosis.

Coding Instructions:

- Enter the three-digit Country Code for the country in which the patient lived at the time of cancer diagnosis.
- Blanks are not allowed for this field.
- Appendix C - Codes for Countries.

III.2.7 Marital Status

Incidence of cancer and sites of cancer have shown correlations to marital status. These patterns are also different among races. Thus, this data item is very important to researchers for the reportable neoplasm.

Definition:

Common Law Marriage: A couple living together for a period of time and declaring themselves as married to friends, family, and the community, having never gone through a formal ceremony or obtained a marriage license.

Coding Instruction:

- Report the patient's marital status at the time of first diagnosis for the reportable neoplasm.

Codes:

Code	Description
1	Single (never married, including only marriage annulled)
2	Married (including common law)
3	Separated
4	Divorced
5	Widowed
6	Unmarried or Domestic Partner (same sex or opposite sex, registered or unregistered, NOT including common law)
9	Unknown

III.2.8 Sex

This field documents the sex (gender) of the patient.

Definitions:

Intersex: A person born with ambiguous reproductive or sexual anatomy; chromosomal genotype and sexual phenotype other than XY-male and XX-female.

Transsexual: A person who has undergone (or is in the process of) surgical alteration to achieve gender opposite to their sex at birth, i.e. surgically altered gender.

Transgender/Transgendered person: A person who identifies with or expresses a gender identity that differs from the one that corresponds to the person's sex at birth.

Coding Instructions:

- Enter the appropriate code for the patient's gender using the table below.
- Code the natal sex (sex at birth) when known over transsexual or transgender, NOS.
- Assign code 3 for:
    - Intersexed (persons with sex chromosome abnormalities)
    - Hermaphrodite

      Note: Hermaphrodite is an outdated term.
- Assign code 4 for transsexuals/transgender/transgendered with unknown natal sex and primary site is not C510-C589 or C600-C639.
- Codes 5 and 6:
    - Have priority over codes 1 and 2.
    - May be used for cases diagnosed prior to 2015.
- Assign code 5 for transsexuals who are natally male or transsexuals with primary site of C600-C639.
- Assign code 6 for transsexuals who are natally female or transsexuals with primary site of C510-C589.

When patient's gender is unknown:

- Code to 1 when primary site is C600-C639.
- Code to 2 when Primary site is C510-C589.
- Code to 9 for primary sites not included above.

- **The CCR requires text documentation to support the sex field code.**

Codes:

Code	Description
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD). The word hermaphrodite formally classified under this code is an outdated term
4*	Transsexual/Transgender/Transgendered, NOS
5	Transsexual/Transgender/Transgendered, natal male
6	Transsexual/Transgender/Transgendered, natal female
9	Unknown

III.2.9 Religion

This field captures the patient's religion or creed.

Coding Instructions:

- Enter the code for the patient's identified religion.
    - Appendix E - Codes for Religions
- Use code 99 if the religion is not stated.
- These codes and definitions were added for religion, effective with cases diagnosed January 1, 1998 and forward.
- Religion codes prior to 1998 were converted.

III.2.10 Race and Ethnicity

Race and ethnicity are defined by specific physical, hereditary and cultural traditions, not necessarily by birthplace, place of residence, or citizenship. 'Origin' is defined by the Census Bureau as the heritage, nationality group, lineage, or in some cases, the country of birth of the person or the person's parents or ancestors before their arrival in the United States.

Beginning with cases diagnosed January 1, 2000, four race fields were added to the data set in addition to the existing race field. These four fields were added so patients who belong to more than one racial category can be coded with multiple races, consistent with the 2000 Census.

Coding Resources:

- All resources in the facility, including the medical record, face-sheet, physician and nursing notes, photographs, and any other sources, must be used to determine race. If a facility does not print race in the medical record but does maintain it in electronic form, the electronic data must also be reviewed.
- Photographs of patients may be used but **only** with extreme caution. Photographs are often misleading and unreliable.
    - Use this source only when all other options are exhausted and there is no conflicting information.
    - If a photograph is used, documentation **must** be present in the abstract text explaining the use of the photograph.

Guidelines:

1. Code the patient's stated race, if possible. See Appendix O - Race and Nationality. It consists of the “Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" for guidance.

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

   Exception Example:

   The person's race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 Japanese because it is more specific than 96 Asian, NOS.
2. If the patient's race is determined based on the races of relatives, there is no priority for coding race, other than to list the non-white race(s) first.
3. If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of a race category.

   Examples:

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

- 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.

4. If race is unknown or not stated in the medical record and birth place is recorded, in some cases race may be inferred from the nationality. See Appendix O - Race and Nationality. It consists of the "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" to identify nationalities from which race codes may be inferred.

   Example:

   Record states: "This native of Portugal." Code race as 01 White per the Appendix W.

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

   Guideline Exception Example:

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

5. Use of patient name in determining race:

   - Do not code race from name alone, especially for females with no maiden name given.
   - In general, a name may be an indicator of a racial group, but should not be taken as the only indicator of race.
   - A patient name may be used to identify a more specific race code.
   - A patient name may be used to infer Spanish ethnicity or place of birth, but a Spanish name alone (without a statement about race or place of birth) cannot be used to determine the race code.

   Example:

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

6. 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.

   Example:

   Miss Sabrina Fitzsimmons is a native of Brazil. Code race as 01 White per Appendix O.

   Note: Race and ethnicity are coded independently.

7. Code 03 should be used for any person stated to be Native American or [western hemisphere] Indian, whether from North, Central, South, or Latin America.

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

   - In the cancer record Race 1 through Race 5 are coded as 99 Unknown.

- The death certificate states race as black. Change cancer record for Race 1 to 02 Black and Race 2 through Race 5 to 88.

Coding Instructions:

- Use Codes for Race Field for instructions on how to code the appropriate race of the patient.
- All race fields must be coded. This applies to cases diagnosed after January 1, 2000 and forward.

  Note: Per 2004 SEER guidelines, races previously coded to 09 – Asian Indian were to be coded to 96 - Other Asian. For consistency, the CCR created a new code, code 90 for Other South Asian that includes Bangladeshi, Bhutanese, Nepalese, Sikkimese, Sri Lankan (Ceylonese). Cases are converted from 90 to 96 for Calls for Data.
- Cases with conflicting information, that lack supporting text documentation, will be returned as queries and counted as discrepancies.
  - Outlined below are examples of when text documentation would be required.
  - A text statement indicating patient's race, i.e., "Pt is Japanese", is required for conflicting types of cases. Such remarks must be entered in either the physical exam or remarks text fields.

  Examples:

  Note: These examples are not intended to demonstrate all possible scenarios.

  Scenarios Demonstrating Conflicting Race Information:

A.	Name:	June Hashimoto	B.	Name:	Bob Nguyen
	Race:	White		Race:	White
	Birthplace:	Unknown		Birthplace:	Mexico
	Marital Status:	Single			
C.	Name:	Robert Jackson	D.	Name:	Moon Smith
	Race:	Mexican		Race:	Japanese
	Birthplace:	California		Birthplace:	California
				Marital Status:	Married

E.	Name:	Maria Tran	F.	Name:	Carlos Johnson
	Race:	White		Race:	Black
	Birthplace:	Spain		Ethnicity:	Hispanic
	Marital Status:	Separated		Marital Status:	California

- Use Codes 01 – 97 (Specific Race Fields).
- Code 88 (No Further Race Documented) is not to be used for coding the first race field (Race 1). It may only be used to document Race fields 2 through 5 when there are less than five races identified.
- Code 98 (Other) is **not** to be used if the Face Sheet states "other" or "other race." **
    - Code 98 is to be used only in the event a specified race is identified with no corresponding CCR/SEER Race code.
    - It is encouraged to use 99 before considering the use of code 98.
    - If the only information available is “other” or “other race”, carefully review the medical record in search of a specific race. If no other information is available to code a specific race, use code 99.
    - **Do NOT code** a patient stated to be Hispanic or Latino as 98 Other Race in Race 1 and 88 in Race 2 through Race 5.
- Use code 99 in the following scenarios:
    - Race code 99 is entered in the Race 1 field code 99 must be entered in the remaining race fields (Race 2 through Race 5).
    - Information about the patient's race or races is not given in any portion of the medical record.
- When the patient’s race is reported differently by two or more sources within the medical record, code race using the following sources in the following priority order:
    - The patient’s self-declared identification.
    - Documentation in the medical record.
        - Dictated reports
        - Nurses’ notes
    - Death Certificate
- If the patient has multiple tumors, each tumor must have the same race codes assigned to each abstract.
    1. If a person's race is a combination of Hawaiian and any other race(s), code Race 1 as 07 Hawaiian and code the other races in Race 2, Race 3, Race 4, and Race 5 as appropriate.

2. If a person's race is a combination of white and any other race(s), code to the appropriate other race(s) first and code white in the next race field.
3. Code ONLY the specific race when both a specific race code and a non-specific race code apply (DO NOT CODE 96, 97, or 98 for “multi-racial”:
    a. Codes 04 – 17, 90* take priority over code 96
    b. Codes 16 – 17 takes priority over code 15
    c. Codes 20 – 32 takes priority over code 97
    d. Codes 01**-32, 90*, and 69-97 take priority over code 98

    *California uses code 90 too (Other South Asian, Bangladeshi, Bhutanese, Nepalese, Sikkimese, and Sri Lankan – changed to 96 for submissions).

    **Unlike SEER, California gives code 01 priority over 98

    Example:

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

- Code race in order stated when no other priority applies.

III.2.10.1 Codes for Race Field

Enter the most appropriate code for a patient's race(s) or ethnicity. See Race and Ethnicity for coding instructions.

Codes:

Code	Description
01	WHITE*
02	BLACK
03	AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
04	CHINESE
05	JAPANESE
06	FILIPINO
07	HAWAIIAN
08	KOREAN
09	FORMERLY ASIAN INDIAN OR PAKISTANI, RETIRED EFFECTIVE 1/1/10. See replacement codes 15-17
10	VIETNAMESE
11	LAOTIAN
12	HMONG
13	KAMPUCHEAN (CAMBODIAN)
14	THAI
15	ASIAN INDIAN OR PAKISTANI, NOS
16	ASIAN INDIAN
17	PAKISTANI
20	MICRONESIAN, NOS
21	CHAMORRO
22	GUAMANIAN, NOS
25	POLYNESIAN, NOS
26	TAHITIAN
27	SAMOAN
28	TONGAN
30	MELANESIAN, NOS
31	FIJI ISLANDER
32	NEW GUINEAN
88	NO FURTHER RACE DOCUMENTED (Do not use for coding the first race field)

90	OTHER SOUTH ASIAN, INCLUDING BANGLADESHI, BHUTANESE, NEPALESE, SIKKIMESE, SRI LANKAN (CEYLONESE)
96	OTHER ASIAN, INCLUDING BURMESE, INDONESIAN, ASIAN, NOS AND ORIENTAL, NOS
97	PACIFIC ISLANDER, NOS
98	OTHER
99	UNKNOWN

*The following are some of the ethnic groups included in the White category:

- Afghan
- Albanian
- Algerian
- Arabian
- Armenian
- Australian
- Austrian
- Bulgarian
- Caucasian
- Central American*
- Cuban**
- Cypriot
- Czechoslovakian
- Dominican**
- Egyptian
- Greek
- Gypsy
- Hungarian
- Iranian
- Iraqi
- Israeli
- Italian
- Jordanian
- Latino
- Lebanese
- Mexican*
- Moroccan
- Palestinian
- Polish
- Portuguese
- Puerto Rican**
- Romanian
- Russian
- Saudi Arabian
- Slavic
- Slovene
- South American*
- Spanish
- Syrian
- Tunisian
- Turkish
- Yugoslavian

* Unless specified as Indian (code 03)

** Unless specified as Black (code 02)

III.2.10.2 Spanish/Hispanic Origin

This data item is used to identify patients with Spanish/Hispanic surname or of Spanish origin. Persons of Spanish or Hispanic surname/origin may be of any race.

Coding Instructions:

- Coding Spanish/Hispanic Origin is independent of coding race. A person of Spanish descent might be described as white, black, or some other race.
- Use **all** information to determine the Spanish/Hispanic Origin, including:
    - The ethnicity stated in the medical record.
        - Self-reported information takes priority over other sources of information.
    - Death Certificate
    - Birthplace
    - Information about life history and/or language spoken.
    - Last name or maiden name found on a list of Spanish/Hispanic names.
- Use Code 6, Spanish, NOS when:
    - There is more than one ethnicity/origin (multiple codes).

      Example: Mexican (code 1) and Cuban (code 3).
    - There is no hierarchy among the codes 1-5 or 8.
- Assign code 7 for the following scenarios:
    - When the only evidence of the patient's Hispanic origin is a surname or maiden name and there is **no** evidence that the patient is **not** Hispanic.
    - See Appendix J - Spanish Surnames.
- Portuguese, Brazilians, and Filipinos are not presumed to be Spanish or non-Spanish.
    - Assign code 7 when the patient's name is on the Spanish Surnames list **and** they are Portuguese, Brazilian, or Filipino.
    - Assign code 0 when the patient's name does **not** appear on the Spanish Surnames list **and** they are Portuguese, Brazilian, or Filipino.
- Use code 9 for death certificate only (DCO) cases when Spanish/Hispanic origin is unknown.

Codes:

Code	Description
0	NON-SPANISH, NON-HISPANIC
1	MEXICAN (including Chicano, NOS)
2	PUERTO RICAN
3	CUBAN

4	SOUTH OR CENTRAL AMERICAN (except Brazilian)
5	OTHER SPECIFIED SPANISH ORIGIN (includes European; excludes DOMINICAN REPUBLIC for cases diagnosed on or after January 1, 2005)
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 (only evidence of person's Hispanic origin is surname or maiden name, and there is no contrary evidence that the person is not Hispanic) **
8	DOMINICAN REPUBLIC (for cases diagnosed on or after January 1, 2005)
9	UNKNOWN WHETHER SPANISH OR NOT

III.2.11 Date or Birth

This data field captures the month, day, and year of the patient's birth.

Coding Instructions:

- Enter the 8-digit date of birth
    - Consult with your software vendor for specific data entry instructions.
- See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates.
- Document the patient's age in either the physical exam or remarks text field.
    - Include text verification in the remarks text field when the patient is 100 years or older.

III.2.11.1 Date of Birth Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
12	Date of Birth cannot be determined
Blank	Full or partial date recorded

III.2.12 Age at Diagnosis

This data field captures the age of the patient at the time of diagnosis.

Coding Instructions:

- Age at First Diagnosis is a required field. Usually, the Age at First Diagnosis is calculated and generated by the abstracting software.
- If the Age at First Diagnosis is not calculated and generated by the abstracting software, calculate the age and enter it into this field.
- Document the patient's age in either the physical exam or remarks text field.
    - Include text verification in the remarks text field when the patient is 100 years or older.

III.2.13 Birthplace - Country

The Birthplace – Country field is intended to collect information on the patient's country of birth.

Coding Instructions:

- Enter the three-digit Country Code for the Country in which the patient was born.
- Blanks are not allowed for this field.
- Appendix C - Codes for Countries.

III.2.13.1 Birthplace - State

Birthplace - State is a two-digit field that is intended to collect information on the patient's birth state.

Coding Instruction:

- Enter the abbreviation of the State or Territory in which the patient was born. Refer to Appendix B - Postal Abbreviations for States and Territories of the United States.

III.2.14 Occupation and Industry

Because the identification of occupational cancer is an important aspect of cancer research, every effort should be made to record the occupation and the industry in which the patient works or worked, regardless of whether the patient was employed at the time of admission.

Guidelines:

- Ideally, the information should pertain to the longest held job (other than housework performed in the patient's home).
- Review all admissions in the patient's medical record, including those before the diagnosis of cancer, and record the best information available. It is not necessary to request parts of the medical record predating diagnosis solely to determine occupation and industry, but review all admissions in the parts pulled for abstracting.
- Good sources of information include admission and discharge summaries, face sheets, history and physical examination reports, oncology consultation reports, and health and social history questionnaires the patient has completed.
- The CCR will code the occupation and industry using the United States Bureau of the Census occupation and industry classifications.

Please refer to http://www.cdc.gov/niosh/docs/2011-173/

III.2.14.1 Occupation

The usual (longest-held) occupation and industry of workers can reveal the national cancer burden by industry and occupation. Such information can also be used to help discover jobs that may have a high risk for cancer or other diseases and for which prevention efforts can be concentrated (or targeted).

Coding Instructions:

- Enter any available information about the kind of work performed (e.g., television repairman, chemistry teacher, bookkeeper, construction worker) associated with the longest held occupation. This field may contain up to 100 characters.
- Avoid the use of abbreviations where possible.
- If the patient is not employed, try to determine the longest held occupation.
- Do not enter a term such as "homemaker", "student", "retired", "unemployed", or "disabled" unless no other information can be obtained.
- If no information is available, enter "NR" (not recorded). Do not leave this field blank.

Refer to http://www.cdc.gov/niosh/docs/2011-173/.

III.2.14.2 Industry

The usual (longest-held) occupation and industry of workers can reveal the national cancer burden by industry and occupation. Such information can also be used to help discover jobs that may have a high risk for cancer or other diseases and for which prevention efforts can be concentrated (or targeted).

Coding Instructions:

- Enter any available information about the industry associated with the longest held occupation (e.g., automotive repair, junior high school, trucking, house construction), up to 100 characters.
- If the chart identifies the employer's name but does not describe the industry, enter the employer's name (and city if available).
- If only an abbreviation is given for the industry or employer (e.g., PERS, USD, or FDIC), record it even if it's meaning is not known (avoid the use of abbreviations where possible).
- If no information is available, enter "NR" (not recorded). Do not leave this field blank.

Refer to http://www.cdc.gov/niosh/docs/2011-173/.

III.2.14.3 Occupation and Industry - Children

Occupation and Industry specific information is required to be entered in the abstract for children as well as adults. Follow the instructions below for Occupation and Industry if the patient is under 18 years of age.

Coding Instructions:

- Enter "Child" in the Occupation field when the patient is a child.
    - This field is left justified
- Record any information available about the occupations of the parents and the industries in which they are employed.
- Record the occupation and industry of both parents if the information is in the medical record.
    - If there is not enough room, however, give priority to the father's occupation and industry.
    - Precede information about a parent with "FA" (father) or "MO" (mother).

      Examples:

        - Patient is 10 years old. Father is a field engineer with an oil company. Mother is an artist (NOS). Complete the Occupational and Industry fields as follows:

          Occupation: Child - FA: field engineer MO: artist

          Industry: FA: oil industry
        - Patient is 14 years old. Father's occupation is not recorded. Mother is a biology professor at a university. Complete the Occupational and Industry fields as follows:

          Occupation: Child - MO: biology professor

          Industry: MO: University

Refer to http://www.cdc.gov/niosh/docs/2011-173/.

III.2.15 Patient - No Research Contact Flag

This flag is to be set to code 1, 2, or 3 if there is documentation on the medical record or if the cancer registry has been contacted by the patient or the patient's physician saying that they do not want to be included in research studies. Cases coded to 4 or 5 should **not** be contacted for research studies.

Coding Instructions:

- If there is no information with regard to the patient's not wanting inclusion in one or more research studies, this flag should remain set to 0.
- This flag is not to be set for patients not wanting to be contacted during routine annual follow-up.
- The purpose of code 4 is to notify CCR and its regional registries that a case has been shared from another state and that this case cannot be given to researchers without approval of that state registry.
- This is a required data item and cannot be blank.

Codes:

Code	Description
0	No flag: There no information regarding the patient not wanting inclusion in one or more research studies
1	Hospital/Reporting Facility first notified
2	Region first notified - For regional and central registry use
3	CCR first notified - For regional and central registry use
4	Out of state case, not for research - is generated by the CCR
5	VA case, not for research - is generated by the CCR

III.2.16 Height

Document the patient's height in this field. This data item is required if available for cases diagnosed January 1, 2011 and forward.

Coding Instructions:

- Different tumors for the same patient may have different values.
- The patient's height should be collected from source records once for each cancer.
- Height should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's reporting facility medical record or physician office record.
- The height entered should be that listed at or around the time of diagnosis.
- If no height was listed on the date of diagnosis, please use the height recorded on the date closest to the date of diagnosis and before treatment was started.
- Entered as 2-digit number and measured in inches (note that 1 foot=12 inches).

  Example:

  Patient is stated to be 6 feet 1 inch (6`1") tall. Enter 73 into this field.
- Code "98" for 98 inches or greater.
- Code "99" for unknown height.
- All inches' values should be rounded to the nearest whole number; values with decimal place x .5 and greater should be rounded up (e.g., 62.5 inches would be 63 inches).
- Exhaust all potential sources for height before using code "99" ("unknown").
- Leaving this field blank is not permitted and code "99" should be used to reflect unknown height. The CDC will use the volume of cases coded to "99" to help determine the availability of information related to height in the medical record.
- Use the Height Conversion Table below to convert to inches:

Height Conversion Table
Feet (ft) / Inches (in) / Centimeters (cm)

Feet/Inches	Total Inches	Centimeters
1' 6"	18"	46
1' 7"	19"	48
1' 8"	20"	51
1' 9"	21"	53
1' 10"	22"	56
1' 11"	23"	58
2'	24"	61
2' 1"	25"	64
2' 2"	26"	66

Feet/Inches	Total Inches	Centimeters
3' 3"	39"	99
3' 4"	40"	102
3' 5"	41"	104
3' 6"	42"	107
3' 7"	43"	109
3' 8"	44"	112
3' 9"	45"	114
3' 10"	46"	117
3' 11"	47"	119

Feet/Inches	Total Inches	Centimeters
5'	60"	152
5' 1"	61"	155
5' 2"	62"	157
5' 3"	63"	160
5' 4"	64"	163
5' 5"	65"	165
5' 6"	66"	168
5' 7"	67"	170
5' 8"	68"	173

2' 3"	27”	69
2' 4"	28”	71
2' 5"	29”	74
2' 6"	30”	76
2' 7"	31”	79
2' 8"	32”	81
2' 9"	33”	84
2' 10"	34”	86
2' 11"	35”	89
3'	36”	91
3' 1"	37”	94
3' 2"	38”	97

4'	48”	122
4' 1"	49”	124
4' 2"	50”	127
4' 3"	51”	130
4' 4"	52”	132
4' 5"	53”	135
4' 6"	54”	137
4' 7"	55”	140
4' 8"	56”	142
4' 9"	57”	145
4' 10"	58”	147
4' 11"	59”	150

5' 9"	69”	175
5' 10"	70”	178
5' 11"	71”	180
6'	72”	183
6' 1"	73”	185
6' 2"	74”	188
6' 3"	75”	191
6' 4"	76”	193
6' 5"	77”	195
6' 6"	78”	198
6' 7"	79”	201
6' 8"	80”	203

III.2.17 Weight

Document the patient's weight at diagnosis in this field. This data item is required if available for cases diagnosed January 1, 2011 and forward.

Coding Instructions:

- Entered as 3-digit numbers and measured in pounds (note that 1 kg = 2.2 pounds).

  Example:

  Patient is documented as 195. Enter 195 into this field.

- Code "999" for unknown weight.
- All pound values should be rounded to the nearest whole number; values with decimal place x.5 and greater should be rounded up (e.g., 155.5 pounds would be 156 pounds).
- Patients with a weight of less than 100 pounds should be recorded with a leading 0.
- Exhaust all potential sources for weight before using code "999" ("unknown").
- Leaving this field blank is not permitted and code "999" should be used to reflect unknown weight. The CDC will use the volume of cases coded to "999" to help determine the availability of information related to weight in the medical record.

Guidelines:

- Different tumors for the same patient may have different values.
- The patient's weight should be collected from source records once for each cancer.
- Weight should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's reporting facility medical record or physician office record.
- The weight entered should be that listed on the date of diagnosis.
- If no weight was listed on the date of diagnosis, please use the weight recorded on the date closest to the date of diagnosis and before treatment was started.
- Use the Weight Conversion Table below to convert to pounds:

Weight Conversion Table
Kilograms (kg) / Pounds (lb.)

Kilograms	Pounds	Kilograms	Pounds	Kilograms	Pounds	Kilograms	Pounds
1	2	43	95	85	187	127	280
2	4	44	97	86	190	128	282
3	7	45	99	87	192	129	284
4	9	46	101	88	194	130	287
5	11	47	104	89	196	131	289
6	13	48	106	90	198	132	291
7	15	49	108	91	201	133	293
8	18	50	110	92	203	134	295

9	20	51	112	93	205	135	298
10	22	52	115	94	207	136	300
11	24	53	117	95	209	137	302
12	26	54	119	96	212	138	304
13	29	55	121	97	214	139	306
14	31	56	123	98	216	140	309
15	33	57	126	99	218	141	311
16	35	58	128	100	220	142	313
17	37	59	130	101	223	143	315
18	40	60	132	102	225	144	317
19	42	61	134	103	227	145	320
20	44	62	137	104	229	146	322
21	46	63	139	105	231	147	324
22	49	64	141	106	234	148	326
23	51	65	143	107	236	149	328
24	53	66	146	108	238	150	331
25	55	67	148	109	240	151	333
26	57	68	150	110	243	152	335
27	60	69	152	111	245	153	337
28	62	70	154	112	247	154	340
29	64	71	157	113	249	155	342
30	66	72	159	114	251	156	344
31	68	73	161	115	254	157	346
32	71	74	163	116	256	158	348
33	73	75	165	117	258	159	351
34	75	76	168	118	260	160	353
35	77	77	170	119	262	161	355
36	79	78	172	120	265	162	357
37	82	79	174	121	267	163	359
38	84	80	176	122	269	164	362
39	86	81	179	123	271	165	364
40	88	82	181	124	273	166	366
41	90	83	183	125	276	167	368
42	93	84	185	126	278	168	370

III.2.18 Tobacco Use

These fields record the patient's past or current use of tobacco.

Coding Instructions:

There are four separate fields for Tobacco Use. The fields are:

1. Tobacco Use Cigarette
2. Tobacco Use Other Smoke
3. Tobacco Use Smokeless
4. Tobacco Use NOS

- Tobacco use should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats or Nursing Assessment section, or other available source from the patient's reporting facility medical record or physician office record.
- Electronic cigarettes are NOT to be coded in this data item.
- The collection of Tobacco Use will be divided into three types of tobacco products and when tobacco use is indicated, but type is not specified:
    - Cigarette smoking
    - Smoking tobacco products other than cigarettes (e.g., pipes, cigars, kreteks)
    - Smokeless tobacco products (e.g., chewing tobacco, snuff, etc.).
    - Tobacco, NOS
- Use code 0 if the medical record indicates "None," ("Never Used").
- Use code 9 (Unknown/not stated/no smoking specifics provided) if the medical record only indicates "No," rather than "Never used."
- The CDC will use the volume of cases coded to "9" to help determine the availability of information related to tobacco use in the medical record.

Codes:

Code	Description
0	Never used
1	Current user (i.e., "current user" as of date of diagnosis) *(added July 2011)*
2	Former user, quit within one year of the date of diagnosis
3	Former user, quit more than one year prior to the date of diagnosis
4	Former user, unknown when quit
9	Unknown/not stated/no smoking specifics provided

III.2.19 Source Comorbidity

This data item is intended to record the data source from which comorbidities/ complications was collected.

Note: Source Comorbidity does not include data sources reflecting Secondary Diagnosis.

Coding Instruction:

- If comorbidities/complications are coded, then the source comorbidity data field must be coded.

Codes:

Code	Description
0	No comorbid condition or complication identified / not applicable
1	Collected from facility face sheet

III.3 Case Identification

While some of the data reported on the Case Identification screens are only for identification and document control, the Date of Diagnosis serves as the basis for computing incidence, survival, and other statistics. Accurate recording of the date of the first diagnosis of a reportable neoplasm is especially important.

III.3.1 Date of First Contact

Per SEER Clarification, effective January 1, 2012 and forward, date of first contact is the admission date when the patient was an inpatient or an outpatient at the reporting facility for:

- Work-up of suspected cancer:

  Example:

  Patient has a suspected cancer. As an inpatient for work-up or first-course treatment, the date of first contact is the date of admission to the facility.

- Any part of the first-course treatment for known cancer:

  Example:

  A patient is diagnosed elsewhere and was seen for preliminary planning for radiation. The patient is sent elsewhere for surgery and does not return for radiation until after a lengthy recovery. The date of first contact is the date the patient returned for radiation treatment. The date of the radiation work-up is not the date of first contact.

- Class of Case change from non-analytic to analytic:

  Example:

  The patient comes in for a consult only (class 30) and subsequently all or part of first course of treatment is given at your facility. The date of first contact is updated to the date when the case became analytic.

- Patients admitted for other causes:
  - When cancer is an incidental finding for patients admitted as an inpatient at the reporting facility for another condition, the date of first contact is the date the cancer was first suspected.
  - Autopsy-only cases
  - Date of first contact is date of death

Coding Instructions:

- **Inpatient:** Enter the first date of admission as an inpatient for the reportable neoplasm, or the actual date when the diagnosis of a reportable neoplasm was made during the inpatient admission to the reporting facility.
- **Outpatient:** Enter the date first diagnosed, treated, or seen as an outpatient for the reportable neoplasm.

See Entering Dates, Date Format and Date Format Guide and Class of Case, for further information on coding and entering dates. Consult with your software vendor for specific data entry instructions.

III.3.1.1 Date of First Contact Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
12	Date of first contact cannot be determined
Blank	Full or partial date recorded

III.3.2 Dates of Inpatient Admission and Inpatient Discharge

Enter the dates of "Inpatient Admission and Inpatient Discharge" to the reporting facility for the most definitive surgery.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates. Consult with your software vendor for specific data entry instructions.

Coding Instructions:

- Use the inpatient admission and discharge dates for any other cancer-directed therapy when the patient does not have surgery.
- Use the dates of inpatient admission and discharge for diagnostic evaluation when the patient has not had cancer-directed therapy.

III.3.2.1 Date of Inpatient Admission Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	No information, unknown if an inpatient
11	Patient was never an inpatient
12	Patient was inpatient but the date is unknown
Blank	Full or partial date recorded

III.3.2.2 Date of Inpatient Discharge Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	No information, unknown if an inpatient
11	Patient was never an inpatient
12	Patient was inpatient but the date is unknown
Blank	Full or partial date recorded

III.3.3 Date of Diagnosis

This field captures the month day and year of the patient's diagnosis. It serves as the basis for computing incidence, survival, and other statistics. Accurate recording of the date of the first diagnosis of a reportable neoplasm is especially important.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates. Consult your software vendor for specific data entry instructions.

Coding Instructions:

- Enter the date a physician, surgeon, or dentist first stated that the patient has cancer, whether the diagnosis was ever confirmed microscopically or not. The rule applies even if the cancer was confirmed at a later date and whether the diagnosis was made at the reporting facility or before admission or not.
- When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis. See Ambiguous Diagnostic Reportable Terms for a list.
    - However, if upon clinical and/or pathologic review of a previous condition it is determined that the patient had the tumor at an earlier date, enter that date (that is, backdate the diagnosis). For cases diagnosed at autopsy, enter the date of death. If diagnosis date is not known, see Approximation for additional instructions.
- For **analytic** cases, a completely unknown date of diagnosis is no longer allowed for all analytic cases (Class of Case 00-22). Effective for all cases identified/first seen 1/1/2010 and forward.
    - At a minimum, the year of diagnosis is required for all analytic cases.
    - The year of diagnosis must be known or estimated and cannot be blank or unknown.
    - For instructions on determining a date of diagnosis, refer to Vague Dates or Approximation, and DSQC Memo #2011-04.
    - Text documentation must be provided for the basis of the estimated date.
- For **non-analytic** cases (Class of Case 30-99): All attempts should be made to determine or estimate the date/year of diagnosis.
    - If no information about the date or at least year of diagnosis is available:
        - Use the date of admission /1st contact year as the date of diagnosis and apply the applicable coding instructions.
- 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.

III.3.3.1 Date of Diagnosis Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.
- The date of diagnosis flag should only be used for non-analytic case with an unknown month and year of diagnosis.

Codes:

Code	Description
12	Date of Diagnosis cannot be determined
Blank	Full or partial date recorded

III.3.3.2 Vague Dates

Vague dates refer to those occasions where incomplete or vague date information exists in the medical record. This instruction directs abstractors on how to enter vague dates.

Coding Instructions:

- Enter an approximate date when the exact date cannot be determined.
- At a minimum, a year of diagnosis is required for all analytic cases (Class of Case 00-22).
- The year of diagnosis must be known or estimated and cannot be blank or unknown.
- The date of first cancer directed therapy may be used as the date of diagnosis, if the therapy was initiated before definitive confirmation of the diagnosis.
- Text documentation **must** be provided for the basis of the estimated date.

III.3.3.3 Approximation

Date information is sometimes expressed in the medical record giving an idea of an approximate date. This instruction directs abstractors on how to approximate dates.

Coding Instructions:

- At a minimum, a year of diagnosis is required for all analytic cases (Class of Case 00-22).
- Use the date treatment was started if the patient receives a first course of treatment before a definitive diagnosis.
- Text documentation **must** be provided for the basis of the estimated date.

Estimating Year

- Use whatever information is available to calculate the year.
- Code the year of admission when there is no basis for estimation.

Terms	Code To
Couple of years ago	Two years ago
Few years ago	Three years ago

Estimating Month

- Use whatever information is available to calculate the month.
- Leave the month blank if there is no basis for approximation.

Terms	Code To
Recently	Enter the month and year of admission, and unknown ("99") for the day. If patient was admitted during the first week of a month, enter the previous month
Several months ago	Assume the case was first diagnosed three months before admission with the day unknown when the patient was not previously treated or if a course of treatment started elsewhere was continued at the reporting facility
Spring	Enter as April
Summer	Enter as July
Fall or Autumn	Enter as October
Winter	Enter as December or January based on available information i.e. end/beginning of year
Early in the year	Enter as January
Middle of the year	Enter as July
End of the year	Enter as December
Late in the year	Enter as December

III.3.4 Place of Diagnosis

If the case was not first diagnosed at the reporting facility, enter whatever is known about the place of diagnosis:

Scenario	Instruction
Another Reporting Facility	Enter the facility's name, the city, and the state
Physician Only	Enter physician's name and address. If the physician is on the reporting facility's medical staff, also enter "Staff Physician"
Reporting Facility and Physician Unknown	Enter name of city, state, or country where diagnosis was first made
No Information Available	Enter "unknown"

III.3.5 Class of Case

Class of Case is divided into two basic categories: Analytic and Nonanalytic.

- **Analytic cases** (codes 00-22) are grouped according to the location of diagnosis and first course of treatment. Analytic cases are required to be reported to the CCR by all facilities. These cases are included in treatment and survival analyses.
- **Nonanalytic cases** include codes 30-49 and 99. The CCR requires that specific nonanalytic cases be abstracted by the reporting facility.
- **Class of Case change from non-analytic to analytic:**

  Example:

  The patient comes in for a consult only (class 30) and subsequently all or part of first course of treatment is given at your facility. The date of first contact is updated to the date when the case became analytic.

- Patients admitted for other causes:

For specific reportability requirements, see Reporting.

A facility's Cancer Committee may also direct reporting of nonanalytic cases. Nonanalytic cases are not required to be abstracted by the CoC and are not included in treatment and survival analyses.

Codes:

Code	Description
Analytic Classes of Case	
Initial Diagnosis at Reporting Facility	
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere ***Example:*** • *Patient was diagnosed with squamous cell carcinoma of the tonsil by biopsy at reporting facility; underwent surgical resection at another facility.* ***Note***: *Beginning in 2010, Class of Case 00 includes cases diagnosed by the facility that are treated in staff or non-staff physician' offices, as well as cases when it is known that the patient went elsewhere for treatment. Facility Referred To,* ***MUST*** *be documented.* ***Note:*** *Use Class of Case 10 if there is no information about whether or where the patient was treated.* ***Note:*** *Use Class of Case 14 if the patient received no treatment, either because the patient refused recommended treatment, or a decision was made not to treat.*
10	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS ***Note:*** *Use Class of Case 10 if there is no information about whether or where the patient was treated.* ***Example:*** • *Homeless patient is diagnosed by biopsy at reporting facility; facility was unable to discover whether the patient actually received any treatment elsewhere*.

11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility ***Example:*** • *Patient was diagnosed by a physician with admitting privileges, received neoadjuvant radiation at another facility, and underwent surgical resection at the reporting facility.*
12	Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility
13	Initial diagnosis and part of the first course treatment was done at the reporting facility AND part of first course treatment was done elsewhere ***Example:*** • *Breast cancer was diagnosed and treated with surgery at the reporting facility. Radiation was given at the facility across the street with which the reporting facility has an agreement.*
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility ***Note:*** *Use Class of Case 14 if the patient received no treatment, either because the patient refused recommended treatment, or a decision was made not to treat.*
Initial Diagnosis Elsewhere, Facility Involved in First Course Therapy	
20	Initial diagnosis elsewhere AND part or all 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 the first course treatment was done elsewhere ***Example:*** • *Definitive or repeat biopsy following initial FNA or biopsy performed elsewhere.*
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility
Non-Analytic Classes of Case	
Patient Appears in Person at Reporting Facility; Both Initial Diagnosis and Treatment Elsewhere	
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup ***Examples:*** • *Consult Only* • *Treatment planning only* • *Staging workup after initial diagnosis elsewhere*
31	Initial diagnosis and all first course treatment provided elsewhere AND reporting facility provided in-transit care or facility provided care that facilitated treatment elsewhere ***Examples:*** • *Patient receiving transient care to avoid interrupting therapy initiated elsewhere (equipment failure at the reporting facility or while vacationing).* • *Catheter placement for cancer therapy*
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence ***Examples:*** • *Patient with active disease admitted for other medical condition(s)* • *Patient expires in the ER with lung metastases* • *After treatment failure, patient is admitted for supportive care*

33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only ***Example:*** • *A patient admitted that does not have active disease* ***Note:*** *Not required to be reported to the CCR*
34	Type of case not required by CoC to be accessioned AND initial diagnosis AND part or all of first course treatment by reporting facility Cases required to be reported and followed by the **CCR** in this category include: • Benign and borderline intracranial/CNS tumors diagnosed 1/1/2001 - 12/31/2003 only ***Note:*** *For cases diagnosed on or after 1/1/04 when these diagnoses became nationally reportable, use Class of Case codes 00-22*. • Intraepithelial neoplasia grade III tumors as follows: o Anus (AIN III) cases, diagnosed 1/1/2001 forward o Vagina (VAIN III) cases, diagnosed 1/1/1992 forward o Vulva (VIN III) cases, diagnosed 1/1/1992 forward • Borderline ovarian tumors diagnosed 1/1/2001 through 12/31/2015 ***Note:*** *Effective 1/1/2010, active follow-up is no longer required for borderline ovarian cases diagnosed 1/1/2001 forward.*
35	Cases diagnosed before program's Reference Date AND initial diagnosis AND part or all of first course treatment by reporting facility ***Note:*** *Reportable to the CCR for cases diagnosed on or after 1/1/1988, or the regional registry reference date if earlier. See Reporting for additional instructions.*
36	Type of case not required by CoC to be accessioned AND initial diagnosis elsewhere AND part or all of first course treatment by reporting facility Cases required to be reported and followed by the **CCR** in this category include: • Benign and borderline intracranial/CNS tumors diagnosed 1/1/2001 - 12/31/2003 only ***Note:*** *For cases diagnosed on or after 1/1/04 when these diagnoses became nationally reportable, use Class of Case codes 00-22*. • Intraepithelial neoplasia grade III tumors as follows: o Anus (AIN III) cases, diagnosed 1/1/2001 forward o Vagina (VAIN III) cases, diagnosed 1/1/1992 forward o Vulva (VIN III) cases, diagnosed 1/1/1992 forward • Borderline ovarian tumors diagnosed 1/1/2001 through 12/31/2015 ***Note:*** *Effective 1/1/2010, active follow-up is no longer required for borderline ovarian cases diagnosed 1/1/2001 forward.*
37	Cases diagnosed before program's Reference Date AND initial diagnosis elsewhere AND part or all of first course treatment by reporting facility ***Note:*** *Reportable to the CCR for cases diagnosed on or after 1/1/1988, or the regional registry reference date if earlier. See Reporting for additional instructions.*
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death ***Note:*** *If the patient is suspected to have a malignancy, confirmed at autopsy, code to Class of Case 14.*
Patient Does Not Appear in Person at Reporting Facility	
40	Diagnosis AND all first course treatment given at the same staff physician's* office

41	Diagnosis AND all first course treatment given in two or more different offices of physicians with admitting privileges.
42	Non-staff physician, clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity ***Example:*** • *Reporting facility abstracts cases from an independent radiation facility.*
43	Pathology or other lab specimens only ***Note:*** *If a pathology specimen is submitted by a physician's office to be read at the reporting facility, notification to the regional registry is required* ***Class 43 is to be*** *Used by CCR/ Regional registries only*
49	Death certificate only - ***Class 49 is to be*** *Used by CCR/ Regional registries only*
Unknown Relationship to Reporting Facility	
99	Nonanalytic case of unknown relationship to facility

*A staff physician is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there.

For further information, please see the current STORE Manual.

III.3.6 Type of Reporting Source

Type of Reporting Source codes the source documents used to abstract the majority of information on the tumor being reported.

Coding Instructions:

- Codes 3, 6 and 7 are only used with the following Class of Case codes:
  - Class 43 (Path Only) – code 3
  - Class 38 (Autopsy Only) – code 6
  - Class 49 (Death Certificate Only) – code 7
- Codes 4 and 5 must be used with the following reporting facilities:
  - 0000999996, 0000000803 or specific Physician# – code 4
  - 0000000804 or specific Nursing Home# – code 5
- Codes are arranged in the order of the precedence of the sources, with a hospital record first.
- Code this field in the following priority order: 1, 2, 8, 4, 3, 5, 6, and 7.
- Enter code 1 for reporting source and code 2 for type of admission For Class 40 and 41 cases.

Codes:

Code	Description
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, hospital or private (e.g., pathology specimen only)
4	PRIVATE MEDICAL PRACTITIONER
5	NURSING HOME, CONVALESCENT HOSPITAL, OR HOSPICE
6	AUTOPSY ONLY (neoplasm discovered and diagnosed for the first time as a result of an autopsy - see Class of Case)
7	DEATH CERTIFICATE ONLY
8	OTHER HOSPITAL OUTPATIENT UNITS/SURGERY CENTERS

III.3.7 Type of Admission

This field represents the type(s) of admission the patient had at the reporting facility.

Codes:

Code	Description
1	Inpatient Only
2	Outpatient Only
3*	Tumor Board Only
4*	Pathology Specimen Only
5	Inpatient and Outpatient
6	Inpatient and Tumor Board
7	Outpatient and Tumor board
8	Inpatient, Outpatient and Tumor Board
9	Unknown (may appear in archival files but is not entered by hospitals)

*See Reporting, Required Method of Reporting Guide

III.3.8 Casefinding Source

This two-digit field indicates the source that identified the case.

Coding Instructions:

- Determine where the case was first identified, and enter the appropriate code. However, 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 cancer reporting facility (codes 10-29), code the earliest source of identifying information.
- If a death certificate, private 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 abstracted**.
- If the regional registry or CCR identifies a case and asks a reporting facility to abstract it, the regional registry or CCR **must** specify the appropriate code to be used in the field.
- If a case was identified through the Death Clearance process at the regional registry, the hospital **must** use code 80 when abstracting the case.

Codes:

Code	Description
Case first identified at cancer reporting facility:	
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, code 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 cancer reporting facility:	

30	PHYSICIAN INITIATED CASE
40	CONSULTATION ONLY OR PATHOLOGY ONLY REPORT (not abstracted by reporting hospital)
50	PRIVATE 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 FOLLOW BACK (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 of a regional registry or the CCR)
99	UNKNOWN

III.3.9 Payment Source (Primary and Secondary) and Payment Source Text

These data items identify the patient's insurance status at the time of initial diagnosis. It consists of three fields:

- Primary source of payment
- Secondary source of payment
- 40-character alphanumeric field for collecting the specific name of the payment source (i.e., Foundation Health Plan, Blue Shield, etc.).

Coding Instructions:

- The primary payment source and text fields are required and may not be left blank.
- Record the primary payer from the information available at diagnosis.
- Enter the secondary payment source if it is available in the medical record.
- When multiple insurances are listed:
    - Code the first mentioned as the primary, and the second as secondary.
    - Code the closest to the date of diagnosis when there are multiple admissions and/or multiple physician encounters.
- When the primary payer at diagnosis is unknown, record the information available during the initial treatment period.
- Assign code 2 when the only information is "self-pay".
- Assign code 10 for prisoners when no further information is available.
- Codes 28-HMO and 29-PPO are California specific codes that are converted to code 20-Managed Care for submission to standard setting agencies. This was effective with 2004 cases.
- Code 89-County Funded, NOS is a California specific code that is converted to code 31-Medicaid for submission to standard setting agencies. This was effective with 2006 cases.

Codes:

Code	Label	Definition
01	NOT INSURED	Patient has no insurance and is declared a charity write-of
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 reporting facility. Type of insurance plan not coded as 20
28	HMO	California specific code
29	PPO	California specific code
31	MEDICAID	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than described in code 35
35	MEDICAID ADMINISTERED THROUGH A MANAGED CARE PLAN	Patient is enrolled in Medicaid through a Managed Care program (for example, HMO or PPO). The Managed Care plan pays for all incurred costs
60	MEDICARE WITHOUT SUPPLEMENT, MEDICARE, NOS	Federal government funded insurance for persons who are 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
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 reporting facility 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 SERVICES	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
89	COUNTY FUNDED, NOS	California specific code
99	INSURANCE STATUS UNKNOWN	It is unknown from the patient’s medical record whether or not the patient is insured

III.3.10 Reporting Facility Referred From

The CCR assigned reporting facility code for the facility or agency that has referred the patient to your facility.

Coding Instructions:

- Refer to the most current California Reporting Facility Codes lists, located on the CCR website https://www.ccrcal.org/learn-about-ccr/, Registrar Resources, Reporting Cancer in California, Volumes I-IV.
    - Lists are presented in both alphabetical and code order.
- If the diagnosis was made before admission (diagnosed PTA), enter the CCR assigned reporting facility code for the other facility at which the patient was previously seen for the disease.

III.3.11 Reporting Facility Referred To

The CCR assigned reporting facility code for the facility or agency that your reporting facility has referred the patient to.

Coding Instructions:

- Refer to the most current California Reporting Facility Codes lists, located on the CCR website https://www.ccrcal.org/learn-about-ccr/, Reporting Cancer in California, Volumes I-IV.
    - Lists are presented in both alphabetical and code order.
- If the patient is seen at another reporting facility or other facility for specialized cancer treatment or any other cancer-related reason after admission to the reporting facility, enter the facility's name or CCR assigned reporting facility code.

III.3.12 Physicians

Each reporting facility must maintain its own roster of physicians and their code or NPI numbers. The non-NPI numbers codes are based on the physicians' California license numbers.

As physicians who treat cancer patients join the reporting facility's staff, they must be added to the roster with their license or NPI numbers. If the license number is unavailable, assign a temporary number, beginning it with the letter X to differentiate it from regular codes. When the license number becomes available, update the files as soon as possible.

III.3.12.1 Physician License Numbers

Enter the physician's license number.

Coding Instructions:

- Enter the California State **physician's** license number.
    - These are eight characters in length and the first character is always an alpha character.
    - License numbers less than eight characters insert zero(s) after the first alpha character.

      Example:

      Physician - A23456 would be entered A0023456
- For **dentists**, the same instructions apply.

  Example:

  Dentist - D00056789 would be entered D0056789
- For **osteopaths**, add a leading O (alpha character) and then enter the entire eight-character code.
    - It is important to note that the first character of the osteopath license is an alpha character and the third character is a zero.
    - For handling a nine-character number, drop the first zero after O2.

      Example:

      Osteopath - O20A4422 would be entered O20A4422 or for nine-digit O20A44222 would be entered O2A44222
- **Out-of-state license numbers**:
    - The first character must be an X.
    - If this number is less than seven characters, insert zeros between the X and the license number.

III.3.12.2 Entering Physician NPI Codes

Enter the physician NPI code in the respective field, if available. This is effective with cases diagnosed January 1, 2007 and forward. See Appendix P - National Provider Identifier (NPI) codes for further details.

Coding Instructions:

- The managing physician field may not be blank.
- Use the following codes for Surgeon, Radiation Oncologist, and Medical Oncologist.
- Additional Physicians are designated by their role in the case, i.e. referring, consulting, and other. See Follow-Up Physician for further instructions.
- If there is no managing physician, or the managing physician cannot be determined, the code for "unknown physician" or "license number not assigned" (99999999) must be entered.
- If the managing physician is the same as another physician, (i.e., the medical oncologist) the license number must be entered in both places.

Codes:

Code	Description
Surgeon	
00000000	No surgery and no surgical consultation performed
88888888	Non - surgeon performed procedure
99999999	Physician is unknown or an identification number is not assigned
Radiation Oncologist	
00000000	No radiation therapy or radiation therapy consult performed
99999999	Physician is unknown or an identification number is not assigned
Medical Oncologist	
00000000	No chemotherapy or chemotherapy consult was performed
99999999	Physician is unknown or an identification number is not assigned

III.3.13 Secondary Diagnosis 1 - 10

Secondary Diagnosis data fields 1-10 are designed to capture the patient's preexisting or secondary diagnosis, factors influencing health status, and/or complications during the admission to the reporting facility for the treatment of cancer using ICD-10-CM codes. These factors may affect treatment decisions and influence outcomes. These data fields were developed to capture ICD-10-CM, which can be up to 7 characters in length and have a different structure than ICD-9-CM.

Note: ICD-10-CM were implemented October 1, 2015.

Coding Instructions:

- Use the Secondary Diagnosis 1 – 10 fields when your facility begins using ICD-10-CM. Only ICD-10-CM codes are allowed in these fields.
- Data collection of Secondary Diagnosis fields 1 - 10 is required by the CCR if available, and is required from CoC facilities.
- These fields are left justified. DO NOT add additional characters, such as 0's if the ICD-10-CM code is less than 7-characters.
- If ICD-9-CM was initially used in the patient record for a case and then the ICD-10-CM was subsequently used, code the relevant ICD-9-CM codes in Comorbidities and Complications and the relevant ICD-10-CM codes in Secondary Diagnoses. Do not attempt to convert between versions.
- If multiple ICD-10-CM codes are available to enter into these fields, use the Secondary Diagnosis fields in order beginning with Secondary Diagnosis 1 and use the other nine (9) fields in order, using as many as needed.
- If there is a secondary diagnosis that is stated in the medical record but is not coded, do not attempt to code the condition.

  Example:

  If diabetes is mentioned in the medical record and it is not coded in the medical record do not attempt to code the condition in ICD-10-CM or fill in these fields.
- Code the secondary diagnoses in the sequence in which they appear in the discharge summary or recorded by the billing department.
- Report the secondary diagnoses for this cancer using the following priority rules:
  1. Surgically treated patients:
     a. Following the most definitive surgery of the primary site
     b. Following other non-primary site surgeries
  2. Non-surgically treated patients:
     a. Following the first treatment encounter/episode
  3. In cases of non-treatment:
     a. Following the last diagnostic/evaluative encounter
- If no ICD-10-CM secondary diagnoses were documented, code 0000000 in the field Secondary Diagnosis #1 and leave the remaining fields blank.

- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining blank.
- For cases or tumors diagnosed January 1, 2018 and forward, refer to the STandards for Oncology Registry Entry (STORE) Manual for coding instructions.

  Note: For ICD-10-CM codes there is an assumed decimal between the third and fourth characters.

III.3.14 Comorbidities and Complications

Comorbidities and Complications data fields 1-10 are designated to capture the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's admission to the reporting facility for the treatment of the cancer using ICD-9-CM codes. These factors may affect treatment decisions and influence outcomes.

Note: ICD-10-CM were implemented October 1, 2015.

Coding Instructions:

- ONLY ICD-9-CM codes are allowed in this field. ICD-10-CM codes are to be coded in the data item Secondary Diagnosis 1-10. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Although data collection for these fields is required by the CCR if available, Comorbidity/Complications 1-10 will be collected from CoC facilities.
- If a comorbid condition is stated in the medical record but is not coded, do not attempt to code the condition in ICD-9-CM or ICD-10-CM.

  Example:

  If diabetes is mentioned in the medical record and it is not coded in the medical record do not attempt to code the condition in ICD-10-CM or fill in these fields.
- Code the comorbid conditions in the sequence in which they appear in the discharge summary or recorded by the billing department.
- Report the comorbid conditions for this cancer using the following priority rules:
  1. Surgically treated patients:
     a. Following the most definitive surgery of the primary site
     b. Following other non-primary site surgeries
  2. Non-surgically treated patients:
     a. Following the first treatment encounter/episode
  3. In cases of non-treatment:
     a. Following the last diagnostic/evaluative encounter
- If no ICD-9-CM comorbid conditions were documented, then code 00000 in the field Comorbidities and Complications #1 and leave the remaining fields blank.
- If fewer than 10 ICD-9-CM comorbid conditions are listed, then code the diagnoses listed, and leave the remaining fields blank.
- For cases or tumors diagnosed January 1, 2018 and forward, refer to the STandards for Oncology Registry Entry (STORE) Manual for coding instructions.
- **Note:** For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-

V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters. For ICD-10-CM codes, there is an assumed decimal between the third and fourth characters.

III.3.15 ICD Revision - Comorbidities and Complications

This item indicates the coding system from which the *Comorbidities and Complications* codes are provided. This data item is not required by the CCR, but it is required for ACS approved facilities.

Coding Instructions:

- ICD Revision Comorbidities and Complications are to be recorded for patients diagnosed January 1, 2006 and forward.
    - ICD-10-CM is allowable for cases diagnosed 2011 and 2012 only.
    - For cases diagnosed January 1, 2013 and forward, code 1 is no longer allowed.

Codes:

Code	Description
0	No secondary diagnosis reported
1	ICD - 10
9	ICD - 9
Blank	Comorbidities and Complications not collected

III.3.16 Discovered by Screening

This item is required if available by the CCR. This field has been added for tracking which cancer cases were first diagnosed via screening programs. If this information is not available, the field may be left blank. It is an existing optional data item as part of the Department of Defense Data Set and will be collected and transmitted from facilities completing the Department of Defense Data Set.

Codes:

Code	Description
0	No (discovered by some other method such as symptomatic patient)
1	Routine screening exam (e.g. routine screening mammogram in asymptomatic patient)
2	Reporting facility screening program (targeted to a particular cancer)
3	State-sponsored screening program
4	Nationally-sponsored screening program
5	Other type of screening (e.g., American Cancer Society screening project)
9	Unknown if via screening (default)

Part IV. Diagnostic Procedures

Part IV of Volume I contain coding instructions for diagnostic procedures. This includes physical examination, X-Rays and scans, scopes, laboratory results, operative and pathologic findings and staging procedures. This section also includes directions regarding diagnostic confirmation.

IV.1 Text - Diagnostic Procedures Performed

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 length of the text fields are 1000 characters.

Text Documentation Instructions:

- Report results for all analytic cases and for autopsy only (class 38) cases.
- Reporting diagnostic procedures is optional for non-analytic cases; however, record a brief statement of the patient's history and the reason for the present admission in the Physical Exam text area.
- Coded fields must be supported by text documentation on the abstract.
    - Information which does not require supporting text:
        - Date of Birth (DOB) (unless the patient is 100 years of age or older) See Age at Diagnosis.
        - Social Security Number (SSN)
        - Medical Record Number (MRN)
        - Comorbidities
        - Secondary Diagnosis
- Record text in a consistent, organized manner.
- Use standard medical abbreviations when possible.
    - See Appendix I - Common Acceptable Symbols and Abbreviations.
- Use phrases not complete sentences. Separate phrases using either periods (.) or semi-colons (;).
- Avoid using only uppercase/capitals in text documentation.
- Do not leave field blank. Record “None”, NR, or NA when information is missing from the medical record or there is not pertinent information.
- Enter text documentation in the following order, chronologically by date:
    - Enter date
        - Use either a slash (/) or hyphen (-) to separate month, day, and year.
    - Name of Exam
    - Results and other pertinent **cancer related** findings (negative as well as positive).
- Enter text documentation that supports the following data items, when appropriate:

Data Item Name

Date of Diagnosis
Primary Site
Laterality
Histology (92-00) ICD-O-2
Behavior (92-00) ICD-O-2
Histologic Type ICD-O-3
Behavior Code ICD-O-3
Grade Data Items
Collaborative Stage variables
Diagnostic Confirmation
RX Hosp--Dx/Stg Proc
RX Hosp--Surg Prim Site
RX Hosp--Scope Reg LN Sur
RX Hosp--Surg Oth Rg/Dis
RX Summ--Dx/Stg Proc
RX Summ--Surg Prim Site
RX Summ--Scope Reg LN Sur
RX Summ--Surg Oth Reg/Dis
SEER Summary Stage 2000
SEER Summary Stage 1977
Regional Nodes Positive
Regional Nodes Examined
RX Date Surgery
Reason for No Surgery
RX Summ--Surg/Rad Seq
RX Summ--Systemic/Sur Seq
Summary Stage 2018
AJCC TNM Data Items
Directly-assigned EOD Data Items
Site-specific SSDI Data Items

For additional information regarding recording text, please see:

- Q-Tips – Recording Information in Text Fields

IV.1.1 Text - Physical Examination

Enter findings from the physical examination performed by the physician.

Text Documentation Instructions:

- Use standard medical abbreviations when possible. See Appendix I for common acceptable abbreviations.
- Use phrases not complete sentences. Separate phrases using either periods (.) or semi-colons (;).
- Avoid using only uppercase/capitals in text documentation.
- Record both the information and the source of the information.

  Example:

  Race (white per face sheet)
- The following demographics may be entered in either the physical exam or remarks text fields:
  - Age
    - Include text verification in the remarks text field when the patient is 100 years or older.
  - Race
    - Include text verification for the race of patient in the remarks text field, when coded as "Other" or if there is conflicting race information. See Race and Ethnicity.
  - Hispanic Origin
  - Sex
- Record the date of the patient's physical examination.
  - Use either a slash (/) or hyphen (-) to separate month, day, and year.
- Results and other pertinent **cancer related** findings (negative as well as positive).
- Enter text documentation that supports the following data items, when appropriate:

Data Item Name
Date of Diagnosis
Primary Site
Laterality
Histologic Type ICD-O-3
Grade Data Items
Collaborative Stage variables
Diagnostic Confirmation
RX Hosp--Surg Prim Site

RX Hosp--Scope Reg LN Sur
RX Hosp--Surg Oth Rg/Dis
RX Summ--Surg Prim Site
RX Summ--Scope Reg LN Sur
RX Summ--Surg Oth Reg/Dis
SEER Summary Stage 2000
SEER Summary Stage 1977
Regional Nodes Positive
Regional Nodes Examined
RX Date Surgery
Reason for No Surgery
RX Summ--Surg/Rad Seq
RX Summ--Systemic/Sur Seq
Summary Stage 2018
AJCC TNM Data Items
EOD Data Items
Site-specific SSDI Data Items

IV.1.2 Text - X-Ray/Scans

Document X-Ray/Scan findings in this text field to capture relevant positive and negative findings on imaging or scans performed.

Text Documentation Instructions:

- Use standard medical abbreviations when possible. See Appendix I for common acceptable abbreviations.
- Enter "none" if no X-rays or scans were performed.
- Use phrases not complete sentences. Separate phrases using either periods (.) or semi-colons (;).
- Avoid using only uppercase/capitals in text documentation.
- Enter findings from the X-rays, computerized axial tomography (CT or CAT scans), magnetic resonance imaging (MRI), echosonography, and other imaging used to diagnose or stage the cancer in the following order:
    - Record dates of the image
        - Use either a slash (/) or hyphen (-) to separate month, day, and year.
        - If there are multiple procedures, record in chronological order.
        - For multiple procedures performed on the same date, record the date once and separate procedures with a period (.) or semi-colon (;).
    - Name of exam (i.e. CT Abdomen/Pelvis), MRI Brain).
    - Enter the findings, positive and negative results, including:
        - A description of the primary tumor and whether it is multi-focal
        - Location of the primary tumor
        - Tumor size
        - Laterality
        - Extent to which the tumor has spread:
            - Spread within the organ of origin
            - Invasion to other tissues or adjacent organs and lymph nodes by direct extension
            - Involvement or non-involvement of lymph nodes
            - Distant disease or metastasis
                - Involvement of distant sites including distant lymph nodes
- Enter text documentation that supports the following data items, when appropriate:

Data Item Name
Date of Diagnosis
RxSumm--Dx/Stg Proc

Primary Site
Laterality
Histology (92-00) ICD-O-2
Histologic Type ICD-O-3
Collaborative Stage variables
SEER Summary Stage 2000
SEER Summary Stage 1977
Summary Stage 2018
AJCC TNM Data Items
EOD Data Items
Site-specific SSDI Data Items

IV.1.3 Text - Scopes

In the Scopes section of the abstract, record information for all scopes performed as part of the initial work-up of diagnosis.

Text Documentation Instructions:

- Use standard medical abbreviations when possible. See Appendix I for common acceptable abbreviations.
- Use phrases not complete sentences. Separate phrases using either periods (.) or semi-colons (;).
- Avoid using only uppercase/capitals in text documentation.
- Enter the date and type of procedure performed, such as laryngoscopies, sigmoidoscopies, mediastinoscopies, colonoscopies, and other endoscopic procedures.
    - Use either a slash (/) or hyphen (-) to separate month, day, and year.
- Record any pertinent positive and negative results, including:
    - A description of the primary tumor and whether it is multifocal
    - Tumor Size
    - Extent to which the tumor has spread
    - Involvement of lymph nodes
- Include mention of biopsies, washings, and other procedures performed during the examination. All results obtained from these procedures must be entered in the Text – Pathology Section.
- Enter "none" if no endoscopic examination was performed.
- Enter text documentation that supports the following data items, when appropriate:

Data Item Name
Date of Diagnosis
RX Summ--Dx/Stg Proc
Diagnostic Confirmation
Primary Site
Laterality
Histology (92-00) ICD-O-2
Histologic Type ICD-O-3
Collaborative Stage variables
SEER Summary Stage 1977
SEER Summary Stage 2000
RX Hosp--Surg Prim Site
RX Date Surgery

Summary Stage 2018
AJCC TNM Data Items
EOD Data Items
Site-specific SSDI Data Items

IV.1.4 Text - Laboratory Tests

Enter the findings from the laboratory tests or procedures used in establishing the diagnoses of neoplasms or metastases, such as serum protein electrophoresis for multiple myeloma or Waldenstrom's macroglobulinemia, serum alpha-fetoprotein (AFP) for liver cancer, and other tumor marker studies.

Text Documentation Instructions:

- Documentation for this text field should include:
    - Date of test
        - Use either a slash (/) or hyphen (-) to separate month, day, and year.
    - Test type
    - Test value (with range)
    - Interpretation (elevated, borderline, or normal)
- Enter the name of the test to identify the test.
- Use standard medical abbreviations when possible. See Appendix I for common acceptable abbreviations.
- Use phrases not complete sentences. Separate phrases using either periods (.) or semi-colons (;).
- Avoid using only uppercase/capitals in text documentation.
- Record T-and B-cell marker studies on leukemia's and lymphomas, but enter hematology reports for leukemia and myeloma under Pathology.
- In leukemia cases where both bone marrow and chromosomes are analyzed, the bone marrow results take precedence in coding histologic type, unless more specific information is given in the cytogenetic report. See Diagnostic Confirmation for additional information.
- Subcategories of acute myeloid leukemia are described according to cytogenetic abnormalities. If these abnormalities are included in a laboratory report, they take precedence in coding histologic type.
- Record chromosome study or cytogenetic and molecular biological data results here. Enter "none" if no pertinent laboratory tests were performed.
- Use the term "none" if no laboratory tests were performed.
- Enter text documentation that supports the following data items, when appropriate:

Data Item Name
Primary Site
Grade Data Items
Diagnostic Confirmation
Collaborative Stage variables
Date of Diagnosis

Summary Stage 2018
AJCC TNM Data Items
EOD Data Items
Site-specific SSDI Data Items

IV.1.5 Text - Operative Findings

Enter findings from operative procedures performed during the diagnosis or treatment of the cancer.

Text Documentation Instructions:

- Use standard medical abbreviations when possible. See Appendix I for common acceptable abbreviations.
- Use phrases not complete sentences. Separate phrases using either periods (.) or semi-colons (;).
- Avoid using only uppercase/capitals in text documentation.
- Record pertinent observations of the surgeon (what is seen/felt/palpated) during the surgical procedure.
- Record pertinent positive and negative results of diagnostic surgical procedures, such as biopsies, dilation and curettage (D & C), and laparotomy, as well as definitive surgery findings entered under treatment, Surgery Introduction - First Course of Treatment and its subsections for additional information. Essential information to include is:
    - Record dates and names of the operative procedures
        - Use either a slash (/) or hyphen (-) to separate month, day, and year.
    - Location of the primary tumor
    - Tumor Size
    - A description of the primary tumor and whether it is multi-focal
    - Extent to which the tumor has spread
    - Residual tumor size
    - Involvement or non-involvement of lymph nodes
    - Enter "**none**" if no operations were performed
- Enter text documentation that supports the following data items, when appropriate:

Data Item Name
Date of Diagnosis
RX Summ--Dx/Stg Proc
Diagnostic Confirmation
Primary Site
RX Hosp--Dx/Stg Proc
RX Summ--Surg Prim Site
Collaborative Stage variables
SEER Summary Stage 1977
SEER Summary Stage 2000

Reason for No Surgery
Summary Stage 2018
AJCC TNM Data Items
EOD Data Items
Site-specific SSDI Data Items

IV.1.6 Text - Pathology Findings

In this text field, enter the details needed to describe the information from the pathology or cytology reports.

Text Documentation Instructions:

- Use standard medical abbreviations when possible. See Appendix I for common acceptable abbreviations.
- Use phrases not complete sentences. Separate phrases using either periods (.) or semi-colons (;).
- Avoid using only uppercase/capitals in text documentation.
- Text information that supports the Path Report Identifier Data Items (1-5) should be recorded here, identifying each report by using the R1- R5 designation.
    - Each path report must be identified in the text field as R1 - R5 with R1 referencing Path Report 1, R2 referencing Report 2, etc.
    - If additional space is necessary, continue the text documentation in the Text - Staging field.
- If there is a pathology report, all the Path Report Identifier Data Item fields must be completed. See Pathology Report Identifier Data Items for further instructions.
    - If the medical record only includes "hearsay" information or the physician only refers to a report finding, but there is no report in the medical record, do not complete the Path Report fields, but include the information in the text field.
- Record dates and names of the operative procedures.
    - Use either a slash (/) or hyphen (-) to separate month, day, and year.
- Describe the location of the primary site, sub-site, and/or the laterality of the primary tumor. See Primary Site and Laterality.
- Record the histologic diagnosis. See ICD-O Morphology – Histology, Behavior, and Differentiation.
- Describe multiple tumors and multiple sites of origin.
- Document the extent of disease and stage at diagnosis.
- Describe the number of lymph nodes examined and the number positive for cancer.
- Determine the method of diagnosis or confirmation.
- Identify all specimens examined microscopically.
- Record all tumor related gross (non-microscopic) and microscopic cytologic and histologic finding whether positive or negative, and include differentiation.
- Record margin status. Including any site-specific margins such as circumferential resection margin (CRM) for colorectal primaries.
- Staging only by the pathologist is recorded in this field.

    - Staging by other physicians should be recorded in the *Text-Staging* field.
- If additional space is needed, continue the pathology text in any other available text field and indicate which text field the text is extending to.
- For details about microscopic diagnoses, see Diagnostic Confirmation.
- See Grade and Differentiation.
- Enter text documentation that supports the following data items, when appropriate:

Data Item Name
Date of Diagnosis
Primary Site
Laterality
Histologic Type ICD-O-3
Grade Data Items
Collaborative Stage variables
Diagnostic Confirmation
RX Hosp--Surg Prim Site
RX Hosp--Scope Reg LN Sur
RX Hosp--Surg Oth Rg/Dis
RX Summ--Surg Prim Site
RX Summ--Scope Reg LN Sur
RX Summ--Surg Oth Reg/Dis
SEER Summary Stage 2000
SEER Summary Stage 1977
Regional Nodes Positive
Regional Nodes Examined
RX Date Surgery
Reason for No Surgery
RX Summ--Surg/Rad Seq
RX Summ--Systemic/Sur Seq
Summary Stage 2018
AJCC TNM Data Items
Directly-assigned EOD Data Items
Site-specific SSDI Data Items

IV.1.6.1 Pathology Report Identifier Data Items

The following data items have replaced the DXRX Report Identifiers as of January 1, 2010.

Coding Instructions:

- Path Reporting Facility ID (1-5)
    - This data item identifies the pathology facility that produced the report.
- Refer to the most current California Reporting Facility Codes lists, located on the CCR website https://www.ccrcal.org/learn-about-ccr/, Registrar Resources, Reporting Cancer in California, Volumes I-IV.
    - Lists are presented in both alphabetical and code order.
    - Enter the reporting facility's CCR assigned reporting facility code.
    - This data item replaces CCR data item, DXRX Report Facility ID, and is required.
- Path Report Numbers (1-5)
    - This data item is a unique sequential number assigned by a laboratory to the corresponding pathology report for the case.
    - This data item replaces CCR data item, DXRX Report Number, and is required.
- Path Date Specimen Collected (1-5)
    - This data item collects the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.
    - This data item replaces CCR data item, DXRX Report Date, and is required.
    - Enter the date and, if available, the time the specimen was collected.
- Path Report Type (1-5)
    - This data item describes the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.
    - This data item accommodates information for only one path report.
    - If additional path reports were prepared, enter the path report type(s) in Path Report Type 2 through Path Report Type 5.
    - This data item is required by the CCR.
- Consult your software vendor for specific data entry instructions.

Codes:

Code	Description
01	Pathology
02	Cytology
03	Gyn Cytology

04	Bone Marrow (biopsy/aspirate)
05	Autopsy
06	Clinical Laboratory Blood Work, NOS
07	Tumor Marker (p53, CD’s Ki, CEA, HER2/neu, etc.)
08	Cytogenetics
09	Immunohistochemical Stains
10	Molecular Studies
11	Flow Cytometry, Immunophenotype
98	Other
99	Unknown

IV.1.7 Text - Staging

The text field for staging is used to document additional staging and diagnostic workup information **not** already entered in other text fields.

Text Documentation Instructions:

- Use standard medical abbreviations when possible. See Appendix I for common acceptable abbreviations.
- Use phrases not complete sentences. Separate phrases using either periods (.) or semi-colons (;).
- Avoid using only uppercase/capitals in text documentation.
- The following information should be entered in chronological order by date.
    - Date(s) of procedure(s), including clinical procedures that provided information for assigning stage.
        - Use either a slash (/) or hyphen (-) to separate month, day, and year.
    - Type of procedure performed
    - Findings used for staging purposes
    - **Do not** repeat information from other text fields
- Staging by physicians (other than the pathologist) may be recorded in this field.
    - Record the type of physician recording the stage (Managing MD, Radiation Oncologist, Registrar and MD, etc.).
    - Staging by the pathologist should be recorded in the Text-Pathology Findings field.
- Enter text documentation that supports the following data items, when appropriate:

Data Item Name
RxDate Dx/Stg Proc
Collaborative Stage variables
SEER Summary Stage 1977
SEER Summary Stage 2000
Regional Nodes Positive
Regional Nodes Examined
RX Hosp--Surg Prim Site
RX Summ--Surg Prim Site
RX Hosp--Scope Reg LN Sur
RX Summ--Scope Reg LN Sur
RX Hosp--Surg Oth Rg/Dis
RX Summ--Surg Oth Reg/Dis

Mult Tum Rpt as One Prim
Laterality

IV.2 Diagnostic Confirmation

Records the best method used to confirm the presence of the cancer being reported. The best method could occur at any time throughout the entire course of the disease. It is not limited to the confirmation at the time of initial diagnosis. The most conclusive method should be coded in the confirmation field.

Coding Instructions:

- Medical records must be studied to determine what methods were used to confirm the diagnosis of cancer.
- As the confirmation field covers the patient's entire medical history, **the best method could occur at any time throughout the entire course of the disease. It is not limited to the confirmation at the time of initial diagnosis.**
- Coding for the confirmation field is in the order of the conclusiveness of the method **with the lowest number taking precedence over other codes** even when there are multiple diagnostic methods.
- Use code 1 if the microscopic diagnosis is based on:
    - Tissue specimens from fine needle aspirate, biopsy, surgery, autopsy, or D&C
    - Bone marrow aspiration and/or biopsy
- Use code 2 if the microscopic diagnosis is based on:
    - Examination of cells (instead of tissue).

      Examples: Include but is not limited to: sputum, vaginal, and cervical smears; bronchial washings or brushings; prostatic or breast secretions; gastric, spinal, peritoneal or pleural fluid; urinary sediment.
    - Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.
- Use code 4 if the diagnosis is documented as microscopically confirmed, but the type of confirmation is not known.
- Use code 5 if the diagnosis is based on laboratory tests or tumor marker studies that are clinically diagnostic for the specific cancer.
- Use code 6 if the diagnosis is **only** based on:
    - Surgeons operative report from a surgical exploration or endoscopy, when no tissue was examined.

      Examples: Mediastinoscopy, peritoneoscopy, or colonoscopy.
    - Gross autopsy findings, without cytologic or tissue confirmation.
- Use code 7 when the only confirmation of malignancy is diagnostic imaging.

  Examples: CT or MRI scans.
- Use code 8 when the diagnosis is made by any clinical method not mentioned in the previous codes.
    - This code is used when the only confirmation of disease is the physician's clinical diagnosis.

- Use code 9 if it is unknown if the diagnosis was confirmed microscopically.

Codes:

Code	Description
Microscopic Confirmation	
1	POSITIVE HISTOLOGY Use for microscopic confirmation based on biopsy, including punch biopsy, needle biopsy, bone marrow aspiration, curettage, and conization Code 1 includes: 1. Microscopic examination of frozen section specimens and surgically removed tumor tissue, whether taken from the primary or a metastatic site 2. Leukemia only: Records a positive blood count (CBC or peripheral blood) 3. Cancers first diagnosed as a result of an autopsy or previously suspected and confirmed in an autopsy if microscopic examination is performed on the autopsy specimens
2	POSITIVE CYTOLOGY, NO POSITIVE HISTOLOGY Cytologic diagnoses based on microscopic examination of cells, rather than tissue 1. Do not use code 2 if cancer is ruled out by a histologic examination 2. Included is sputum, cervical, and vaginal smears; fine needle aspiration from breast or other organs; bronchial brushings and washings; tracheal washings; prostatic secretions; gastric, spinal, or peritoneal fluid; and urinary sediment, or urine cytology Also, include diagnoses based on paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid
CODE 3 is ONLY used for Hematopoietic and Lymphoid Neoplasms (9590/3-9992/3)	
3	POSITIVE HISTOLOGY PLUS Positive immunophenotyping AND/OR positive genetic studies Code 3 is used when the following conditions are met: 1. Genetic testing and/or immunophenotyping are described in the Hematopoietic Database "Definitive Diagnostic Method", AND 2. Genetic testing and/or immunophenotyping were done, AND 3. Genetic testing and/or immunophenotyping were positive (proved the type of neoplasm being coded) Flow cytometry is a test for immunophenotyping and also for genetic testing. It is coded for hematopoietic and lymphoid neoplasms using the directions above
4	POSITIVE MICROSCOPIC CONFIRMATION, METHOD NOT SPECIFIED Cases with a history of microscopic confirmation, but no information about whether based on examination of tissue or cells
No Microscopic Confirmation	
5	POSITIVE LABORATORY TEST OR MARKER STUDY Clinical diagnosis of cancer based on certain laboratory tests or marker studies that are clinically diagnostic for cancer Examples are the presence of alpha-fetoprotein (AFP) for liver cancer and an abnormal electrophoretic spike for multiple myeloma or Waldenstrom's macroglobulinemia Although an elevated PSA is nondiagnostic of cancer, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5
6	DIRECT VISUALIZATION WITHOUT MICROSCOPIC CONFIRMATION Includes diagnoses by visualization and/or palpation during surgical or endoscopic exploration, or by gross autopsy Do not use code 6 if visualization or palpation during surgery or endoscopy is confirmed by a positive histology or cytology report

7	RADIOGRAPHY WITHOUT MICROSCOPIC CONFIRMATION Includes all diagnostic radiology, scans, ultrasound, and other imaging technologies not confirmed by a positive histologic or cytologic report or by direct visualization
8	CLINICAL DIAGNOSIS ONLY (Other than 5, 6, or 7) Cases diagnosed by clinical methods other than direct visualization and/or palpation during surgery, endoscopy, or gross autopsy, if not confirmed microscopically
9	UNKNOWN WHETHER OR NOT MICROSCOPICALLY CONFIRMED (Death Certificate Only cases are included in code 9)

Part V. Tumor Data

Part V of Volume I contain instructions and guidelines on coding tumor related data items. The type of items in this section are primary site, laterality, histology, coding and staging systems, and pediatric stating.

V.1 Primary Site

Primary site is the anatomic position of where the primary tumor developed. It is essential to identify the original (primary) site of a tumor rather than a metastatic (secondary) site.

Coding Instructions:

- Resources for coding primary site are:
    - ICD-O-3 (International Classification of Diseases for Oncology, Third Edition, 2000) is used for Topography and Morphology coding instructions.
        - The Primary Site field codes are found in the Topography section. In the Index, the site is indicated by a four-character code. The first character is always a “C”, followed by three numbers.
        - The first two numerical digits stand for the primary site (organ, tissue, or structure). The third digit identifies the subsite of the primary site.

          Examples:

            - A computerized axial tomographic (CT or CAT) scan of a patient's chest revealed a large malignancy in the upper lobe of the left lung. The correct ICD-O-3 code is therefore C34.1, which should be entered C341.
            - The site cardia of the stomach (the part of the stomach at the opening of the esophagus) is listed in the Index for the ICD-O-3 under "cardia" or "stomach, cardia" as T-C16.0, which should be entered C160.
    - 2018 Solid Tumor Rules is used for selected primary site coding instructions.
- Identify the primary site by careful scrutiny of all reports in the patient's medical record.
    - Where information in the record is conflicting, statements in the pathology report generally take precedence over other statements.
    - If the record does not provide a clear answer, ask the patient's physician.
- If the only information available is the secondary site, then it should be reported in accordance with the instructions in Section Primary Site – Site-Specific Special Conditions.
- Record the site in which the primary tumor originated, even if it extends onto/into an adjacent subsite.
- Code the site of the invasive tumor when there is an invasive and an in-situ tumor in different subsites of the same anatomic site.
- Code a transplanted organ to the primary site the organ is grafted to.
- When the medical record does not contain enough information to assign a primary site:
    - Code unknown primary (C809) in the absence of any information when the physician is not able to identify a primary site.

- Use the NOS code for the organ system or ill-defined site (C760-C768) when there are two or more possible primary sites documented and they are within the same system.
- Assign C148 when there is an unknown head and neck primary for Diagnosis Dates through December 31, 2017.
- Assign C760 (Head, Neck, Face NOS) when there is an unknown head and neck primary with unknown subsite for cases diagnosed 01/01/2018+.

- For additional information regarding Unknown Primary, please see:
  - Q-Tips - Before You Code Primary Site as Unknown C809
  - Q-Tips - Recording Information in Text Fields
- Code the last digit of the primary site code to '8' when a **single tumor** overlaps an adjacent subsite(s) of an organ and the point of origin cannot be determined.

  Exception: Skin Cancers – Assign the site code for where the bulk of the tumor is or where the epicenter is. Do **not** use code C448.
- Code the last digit of the primary site 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.
- In the absence of any additional information, assign the codes listed for these primary sites:

Codes:

Primary Site	ICD-0-3 Code
Anal margin	C445
Anal verge	C211
Angle of the stomach	C162
Angular incisura of stomach	C163
Book-leaf lesion (mouth)	C068
Colored / lipstick portion of the upper lip	C000
Cutaneous leiomyosarcoma	C44_
Distal conus	C720
Edge of tongue	C021
Frontoparietal (brain)	C718
Gastric angular notch (incisura)	C163
Glossotonsillar sulcus	C109
Infrahilar area of lung	C349
Incisura, incisura angularis	C163
Leptomeninges	C709
Masticatory space	C069

Melanoma, NOS	C449
Nail bed. Thumb	C446
Pancreatobiliary space	C269
Parapharyngeal space	C490
Perihilar bile duct	C240
Testis, descended post orchiopexy	C621

V.1.1 Identification of Separate Sites

For cases or tumors diagnosed January 1, 2018 and forward, refer to the 2018 Solid Tumor Rules Manual.

Coding Instructions:

- Tumor recurrences only relate to the organ of origin. Metastatic tumors in regional and distant sites are not considered tumor recurrences when applying the Solid Tumor Rules.
- When determining multiple primaries for solid tumors, do not use a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary.
- Use the Solid Tumor Rules as written unless a pathologist compares (slide review) the present tumor to the "original" tumor and states that this tumor is a recurrence of a cancer from the previous primary.

V.1.2 Indefinite and Metastatic Sites

This instruction discusses how to code specific categories in instances where a specific primary site cannot be identified.

Coding Instructions:

- Assign codes from the following categories **only** when the primary site cannot be identified exactly:
    - **NOS** (not otherwise specified) subcategory when a subsite or tissue of an organ is not specifically listed in ICD-O-3.
        - Do not use NOS if a more descriptive term is available.
- Use **Codes C76.0 - C76.8** for diagnoses referring to regions and ill-defined sites of the body, such as "head", "thorax", "abdomen", "pelvis", "upper limb," and "lower limb."
    - These sites typically contain several types of tissue (e.g., bone, skin, soft tissue), which might not be specified on the diagnostic statement.
    - If the tissue in which the tumor originated can be identified, use a more specific site code.
- Use **Code C80.9** when the primary site is not known and the only information available is the metastatic or secondary site.

V.1.3 Primary Site - Site-Specific Special Conditions

For cases or tumors diagnosed January 1, 2018 and forward, refer to the 2018 Solid Tumor Rules Manual.

For hematopoietic and lymphoid cases diagnosed January 1, 2018 and forward, please refer to the SEER Hematopoietic and Lymphoid Neoplasm Database.

Site-Specific Special Conditions Coding Instructions:

SKIN:

- Assign the site code for where the bulk of the tumor is or where the epicenter is. Do **not** use code C448.

  Melanoma

  - If the primary site is unknown, assume the primary site is the skin and enter C449.
  - Unless it is stated to be a recurrent or metastatic melanoma, record each melanoma as a separate primary when any of the following apply:
    - The occurrences are more than two months apart.
    - The fourth character of the ICD-O topography code for skin (C44._) is different.
    - The first three digits of the ICD-O-3 morphology code are different
    - An in-situ melanoma is followed by an invasive melanoma.
    - The occurrences are within the same sub-site code, but have a different laterality or a different trunk side, such as chest and back.

  Kaposi's Sarcoma

  - Code the primary site as the site in which the tumor arises. If Kaposi's sarcoma arises in the skin and another site simultaneously, or if no primary site is stated, code the primary site as skin (C44._).

BREAST:

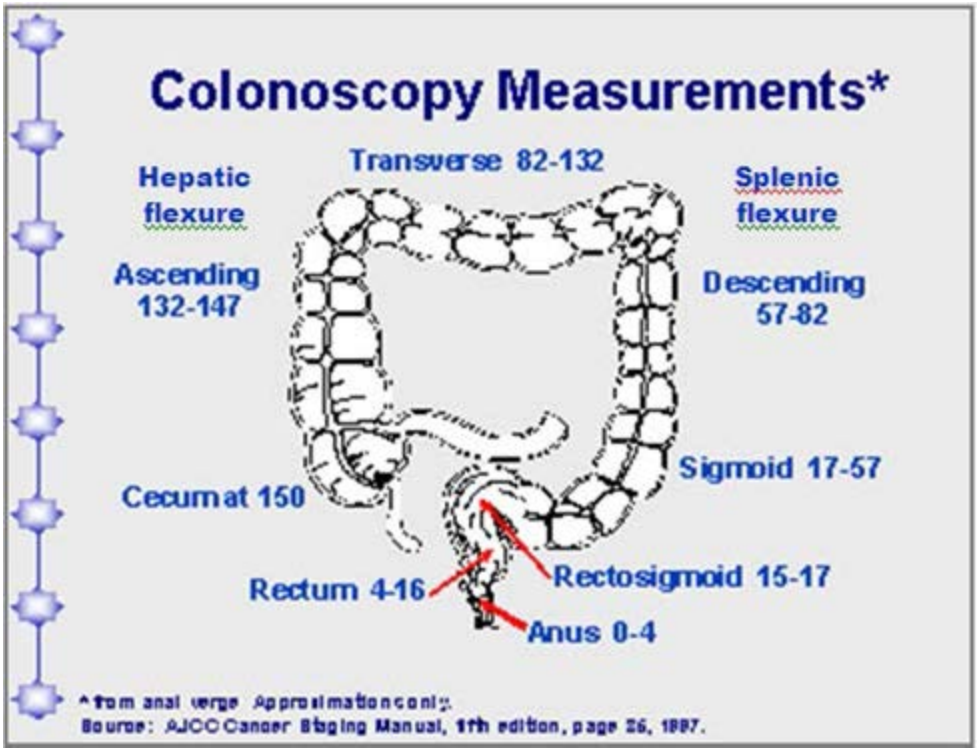
Subareolar/Retroareolar Tumor

- Code as the central portion of the breast (C50.1), which indicates that the tumor arose in the breast tissue beneath the nipple, but not in the nipple itself.

COLON:

Determining Subsite

- If there is no other information given regarding subsite except for the measurement given in the colonoscopy, the measurement may be used to assign subsite. If the colonoscopy measurement is used to assign a specific subsite, the CCR's standard reference is the colon diagram:



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- If there is conflicting information in the medical record with regard to subsite and there is no surgical resection, code the subsite as stated by the physician. If there is a surgical resection, code the subsite as stated in the operative report or a combination of the operative report and the pathology report.

Familial Polyposis

- When multiple carcinomas arising in familial polyposis involve multiple segments of the colon or the colon and rectum, code the primary site as colon, NOS (C18.9).

OTHER:

Neuroblastoma

- Code neuroblastomas of ill-defined sites for the most likely site in each case. (Adrenal medulla is a common site). If the location of the primary tumor is unknown, code as connective, subcutaneous, and other soft tissue, NOS (C49.9).

Angiosarcoma

- Code C422 (spleen) for angiosarcoma of the spleen
- Code C50_ (breast) for angiosarcoma of the breast. Although angiosarcoma originates in the lining of the blood vessels, when it arises in the breast, there is a poorer prognosis than many other breast tumors.

V.1.4 Uncertain Primary Site

Vague or ambiguous terms are sometimes used by physicians when indicating the primary site of a tumor. Interpretation of terms in this context is like their interpretation in a diagnosis of cancer itself. See Ambiguous Diagnostic Reportable Terms for additional information.

Interpret the following terms as an indication of the primary site:

- Apparently (malignant)
- Appears to
- Comparable with
- Compatible with (a malignancy)
- Consistent with (a malignancy)
- Favor (a malignancy)
- Malignant appearing
- Most likely (malignant)
- Presumed (malignant)
- Probable (malignancy)
- Suspect or suspected (malignancy)
- Suspicious (of malignancy)
- Typical (of/for malignancy)

Coding Instructions:

- Ambiguous terms not listed above are NOT considered indication of primary site.
- Ambiguous terms may be located in any source document, such as pathology, operative, radiology, or clinical reports. This does not include tumor marker reports.
- Do not substitute synonyms such as “supposed” for presumed or “equal” for comparable. Do not substitute “likely” for “most likely.”

Benign and borderline primary intracranial and CNS tumors:

- Use the above terms list to identify benign and borderline primary intracranial and CNS primary tumors.
- Ambiguous terms **not** listed above are NOT considered indication of primary site.
- If any of the reportable **ambiguous terms precede** either the word “**tumor**” or the word “**neoplasm**”, it is considered an indication of a primary site.

V.2 Laterality

Laterality describes the side of a paired organ or the side of the body on which the reportable tumor originated, which is not captured in topographic codes. This field applies only to the primary site. Its main purpose is to identify the origin of the tumor.

Coding Instructions:

- Laterality must be coded for all paired sites. See Laterality - Paired Sites for additional information.
    - Laterality may be coded for non-paired sites other than those required: for example, thyroid.
- Code 0 is appropriate for non-paired sites, not otherwise specified.
    - Primary Site is unknown (C809)
- Metastatic bilateral involvement is not coded for laterality.
- Assign code 3 if the laterality is not known but the tumor is confined to a single side of the paired organ.
- Code 4 should not be used for bilateral primaries for which separate abstracts are prepared or when the side of origin is known, and the tumor has spread to the other side.

  Example:

  A left ovarian primary with metastases to the right ovary is code 2, rather than code 4.
- Assign code 5 when the tumor originates in the midline of a paired organ or site (effective with 1/1/2010 dx).

  Example:
  Patient has an excision of a melanoma located above the umbilicus.
- All primary brain and CNS tumors diagnosed prior to January 1, 2004 are coded: Laterality 0 (not a paired site).
- Site code C70.0, C71.0-C71.4, C72.2 diagnosed January 1, 2004 and forward require a laterality codes 1-5, or 9.
- All other CNS/brain subsites of C70, C71, and C72 are coded: Laterality 0 (not a paired organ) regardless of the date of diagnosis. All pituitary and pineal gland and craniopharyngeal duct tumors (C75.1-3) are coded Laterality = 0 (not a paired site).
- Assign code 9 when the neoplasm originated in a paired site and the laterality is unknown AND there is no statement that only one side of the paired organ is involved.
- **The CCR requires text documentation to support the laterality code**

Codes:

Laterality Code	Description
0	Not a paired site
1	Right side origin of primary
2	Left side origin of primary
3	One side only involved, but right or left side origin not specified
4	Both sides involved, but origin unknown (including bilateral ovarian primaries of the same histologic type, diagnosed within two months of each other; bilateral retinoblastomas; and bilateral Wilms' tumors)
5	Paired site, midline tumor (effective with 1/1/2010 dx)
9	Paired site, but no information available concerning laterality

V.2.1 Laterality - Paired Sites

This section identifies the sites that are considered paired. The ICD-O-3 site codes listed below are sites for which laterality must be entered. The requirement includes any subsite, except those specifically noted. See Laterality for specific laterality coding.

Site Codes and Description:

Code	Description
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity-*excluding nasal cartilage, nasal septum*
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus–*excluding carina*
C34.1-C34.9	Lung
C38.4	Pleura, NOS
C40.0	Upper limb long bones, scapula
C40.1	Upper limb short bones
C40.2	Lower limb long bones
C40.3	Lower limb short bones
C41.3	Rib, clavicle—*excluding sternum*
C41.4	Pelvic bones—*excluding sacrum, coccyx, symphysis pubis*
C44.1	Eyelid skin
C44.2	External ear skin
C44.3	Skin of other and unspecified parts of face
C44.5	Trunk skin
C44.6	Upper limb and shoulder skin
C44.7	Lower limb and hip skin
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 adnexa
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

V.3 ICD-O Morphology - Histology and Behavior

The morphology code indicates the type of cell that has become neoplastic (histology) and its biologic activity (behavior).

2018 ICD-O-3 histology coding changes: Updates include new and revised histology terms, codes, and behaviors for cases diagnosed January 1, 2018 and forward. Please see the 2018 ICD-O-3 – Coding tables.

Note: The 2018 ICD-O-3 Update Table includes the histology changes from the ICD-O-3 Histology Code Crosswalk for 2015 through 2017.

IMPORTANT REMINDER:

Check the 2018 ICD-O-3 Update Table first to determine if the histology is listed. If the histology is not included in the update, then review the Solid Tumor Rules (MP/H), ICD-O-3 and/or Hematopoietic and Lymphoid Database.

Definitions:

- **Histology** identifies the specific cell type of the tumor. Specific cell lines come from different tissues and are extremely important information for the diagnosis and treatment of the disease. For cases or tumors diagnosed January 1, 2018 and forward, refer to the 2018 Solid Tumor Rules Manual.

  Examples:

  - **Adenocarcinoma:** is typically a cancer that begins in glandular (secretory) cells. Glandular cells are found in tissue that lines certain internal organs and makes and releases substances in the body, such as mucus, digestive juices, or other fluids. Most cancers of the breast, pancreas, lung, prostate, and colon are adenocarcinomas.
  - **Squamous cell carcinoma:** Cancer that begins in squamous cells. Squamous cells are thin, flat cells that look like fish scales, and are found in the tissue that forms the surface of the skin, the lining of the hollow organs of the body, and the lining of the respiratory and digestive tracts. Most cancers of the anus, cervix, head and neck, and vagina are squamous cell carcinomas (also called epidermoid carcinoma).
  - **Melanoma:** A form of cancer that begins in melanocytes (cells that make the pigment melanin). It may begin in a mole (skin melanoma), but can also begin in other pigmented tissues, such as in the eye or in the intestines.
  - **Sources for Determining Histology:**
    - For solid tumors diagnosed January 1, 2018 and forward, refer to the 2018 Solid Tumor Rules Manual.
    - For hematopoietic and lymphoid cases diagnosed January 1, 2018 and forward, please refer to the SEER Hematopoietic and Lymphoid Neoplasm Database.

For additional information on site-specific histology coding, please see:

- Q-Tips - Inflammatory Breast Cancer
- Q-Tips - Papillary Carcinoma Coding Guideline – Cases dx 2007- 2017

- **Behavior** indicates whether a tumor is malignant or benign, or uncertain whether benign or malignant.

Coding Instructions:

- The CCR has adopted the ICD-O-3 (*International Classification of Diseases for Oncology, Third Edition*) as its official morphology code system for all cases diagnosed January 1, 2001 forward.
- Enter the appropriate morphology code.

V.3.1 Histologic Type

Histology is the study of the minute structure of cells, tissues, and organs in relation to their functions. It is primarily through histological analysis that neoplasms are identified. Determination of the correct histology code can be one of the most difficult aspects of abstracting. Training and experience are essential for development of the ability to assign the correct code. The rules are taken from the SEER Program. They provide guidance, but no set of rules can cover all situations.

Coding Instructions:

For cases or tumors diagnosed January 1, 2018 and forward, refer to ICD-O-3 the 2018 Solid Tumor Rules Manual, ICD-O-3 and/or the SEER Hematopoietic and Lymphoid Neoplasm Database.

V.3.2 Unspecified Malignancies

Unspecified malignancies are those malignancies in which a specific histologic type has not been identified.

Coding Instructions:

- Enter the code for neoplasm (8000) for unspecific terms such as "malignant tumor," "malignant neoplasm", and "cancer."
- Use code 8001 (malignant cells, NOS), if a diagnosis is based only on a cytology report stating, "malignant cells."

See Diagnostic Confirmation for additional information.

V.3.3 Behavior

The Behavior Code describes the malignant potential of the tumor. Codes range from /0-benign to /3-malignant (invasive). The fifth digit of the morphology code is the Behavior Code.

Coding Instructions:

- Intracranial and CNS tumor with behavior codes /0-benign or /1-borderline are reportable for cases diagnosed 1/1/2001 forward.
- Code behavior from CT scan, MRI or PET scans when there is no tissue diagnosis (no pathology or cytology report). Code the behavior as indicated on the scan.
    - Do not use WHO grade to code behavior.
- Clinical evidence alone is not sufficient to identify behavior as in-situ. A behavior code of /2-in-situ must be based on pathologic examination.

  Note: If Diagnostic Confirmation is Clinical (8), then behavior cannot be /2-in-situ.
- Behavior codes of /6 or /9 per ICD-0-3 are **NOT** reportable. An edit error will be received when attempting to enter /6 or /9 for behavior.
- Code /3-malignant when malignant metastasis is identified.
    - ***Examples*** *shown below are representative and are not intended to represent all possible scenarios:*
        - GIST tumor where lymph nodes are positive for malignancy, or
        - Atypical Thymoma with malignant metastasis in one lymph node
- Code behavior as /3-malignant if any portion of the primary tumor is invasive, regardless of how limited (i.e., microinvasion).
    - ***Example*** *below is representative and not intended to represent all possible scenarios:*
        - Intraductal carcinoma of the breast with focal areas of invasion
- The pathologist has the final decision on the behavior of the tumor. The applicable ICD-0-3 code may indicate /3-malignant behavior, however, the pathologist may indicate the specimen is /2-in-situ. Code the /2 behavior per the pathologist's findings. The reverse scenario also applies.
- Re-Code the behavior as malignant /3 when metastases are attributed to a tumor originally thought to be in-situ.
- Do not code in-situ behavior with a primary site that is unknown or ill-defined. A behavior code of /2-in-situ combined with any of the following primary sites will result in an error:
    - C26.9 Gastrointestinal tract, NOS
    - C39.9 Ill-Defined sites within respiratory system
    - C55.9 Uterus, NOS
    - C57.9 Female genital tract, NOS

- C639 Male genital organs, NOS
- C68.9 Urinary system, NOS
- C72.9 Nervous system, NOS
- C75.9 Endocrine gland, NOS
- C76.__ Other and ill-defined sites
- C80.9 Unknown primary site

Codes:

Code	Description
/0*	Benign
/1*	Uncertain whether benign or malignant
	Borderline Malignancy (except cystadenomas in the range 844-849)
	Low Malignant Potential
/2	Carcinoma in-situ (see In-situ Coding for synonyms)
/3	Malignant, Primary Site (includes microinvasion)
/6	Malignant, Metastatic Site, Malignant, secondary site -- Reportable behavior but enter code 3 (Code 6 NOT Used by Cancer Registries)
	Malignant, Secondary Site
/9**	Malignant, uncertain whether primary or metastatic site

Benign and borderline Brain and CNS tumors are reportable to CCR for cases diagnosed 1/1/2001 forward.

V.3.3.1 In-Situ Coding

The term "in-situ" means a tumor that meets all microscopic criteria for malignancy, except invasion of basement membrane. For further discussion of "in-situ", see Terms Indicating In-Situ for Staging.

"In-situ" behavior can be determined only by pathologic examination and not by clinical evidence alone. If a tumor is classifiable as "in-situ" according to the time period rules for stage at diagnosis, code the tumor as "in-situ." In other words, a behavior code of 2, "in-situ" corresponds to a stage code of 0, "in-situ" and vice versa. Computer and visual edits will verify that the codes in these two fields correspond. Do not interpret terms like "approaching in-situ" or "very close to in-situ" as "in-situ."

Reportable terms indicating "in-situ" behavior include:

General Reportable Terms Indicating In-situ Behavior
Bowen's disease (excluding skin)
Confined to epithelium (does not extend beyond base membrane)
Ductal carcinoma in-situ, (DCIS) (any site)
Intracystic, Intraepidermal (NOS), Intrasquamous, In-situ
Intraepithelial neoplasia grade III, not otherwise specified (NOS)
Involvement up to, but not including basement membrane
Lobular carcinoma in-situ (LCIS)
No stromal invasion
Non-infiltrating; Non-invasive
Squamous intraepithelial neoplasia grade III (SIN III) (excluding cervix and skin sites coded to C44_), dx 01/01/2014 +
Papillary, non-infiltrating or intraductal
Pre-invasive
Site-Specific Terms Indicating In-situ Behavior
Anus – Anal Intraepithelial Neoplasia grade III (AIN III), dx 01/01/2001 + High grade squamous intraepithelial invasion (HGSIL or HSIL), dx 01/01/2018 +
Breast • Ductal intraepithelial neoplasia grade III (DIN III), dx 01/01/2001+ • Lobular intraepithelial neoplasia grade III (LIN III), dx 01/01/2016 + • Lobular neoplasia grade III (LN III), dx 01/01/2016 + • Lobular, non-infiltrating
Breast, Colon, Rectum • Stage 0 (excluding Paget's disease) confined to lamina propria
Gallbladder – High grade biliary intraepithelial neoplasia grade III (BiIN III), 01/01/2018 +
Larynx – Laryngeal intraepithelial neoplasia grade III (LIN III), dx 01/01/2001 +

Pancreas – Pancreatic intraepithelial neoplasia grade III (PanIN III), dx 01/01/2004 +
Penis • Penile intraepithelial neoplasia grade III (PeIN III), dx 01/01/2001 + • Queyrat's erythroplasia
Skin • Clark's level I (melanoma; limited to epithelium) • Hutchinson's melanotic freckle, not otherwise specified (NOS) • Lentigo maligna • Precancerous melanosis
Vagina – Vaginal intraepithelial neoplasia grade III (VAIN III), dx 01/01/1992 + High grade squamous intraepithelial invasion (HGSIL or HSIL), dx 01/01/2018 +
Vulva – Vulvar intraepithelial neoplasia grade III (VIN III), dx 01/01/1992 + High grade squamous intraepithelial invasion (HGSIL or HSIL), dx 01/01/2018 +

Note: Terms without reportability dates have been reportable since the region's reference date.

Not Reportable (Reminder)

As a reminder, carcinoma "in-situ" (including squamous cell and adenocarcinoma) of the cervix and Cervical Intraepithelial Neoplasia, CIN III, are not reportable effective with cases diagnosed January 1, 1996 and forward.

Prostatic Intraepithelial Neoplasia (PIN III), morphology code 8148/2 is also not reportable to the CCR.

V.4 Grade and Differentiation

Grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin).

- For cases diagnosed 2018+ grade is coded in three separate data items:
  - Grade Clinical
  - Grade Pathological
  - Grade Post-therapy
- Grade was captured in a single data item for cases prior to 2018. See Archived Volume I for coding case for cases diagnosed prior to 2018.
  - Use case year of diagnosis to determine which volume I to choose.
- Cell lineage indicator/grade for hematopoietic lymphoid neoplasms are NO LONGER COLLECTED for cases with DX date 2018+.

See Grade - General Information for further grade coding guidelines.

Grade questions should be directed to CAnswer Forum at: http://cancerbulletin.facs.org/forums/.

Refer to the most current Grade Coding Instructions and Tables for coding instructions.

V.4.1 Grade - General Information

2018 Grade is captured in three new fields which is separate from the previous single grade data field (pre 2018 cases). Grade Clinical, Grade Pathological, and Grade Post-Therapy are required by the CCR for cases diagnosed January 1, 2018 and forward.

For additional information on historical manual references, refer to Appendix S – Historical Coding and Staging Manual Requirements for CCR.

Guidelines:

- Refer to the most current Grade Coding Instructions and Tables for coding instructions.
- Cell lineage indicator/grade for hematopoietic lymphoid neoplasms are NO LONGER COLLECTED for cases with DX date 2018+.

  ONLY EXCEPTION: Ocular Adnexa Lymphoma AJCC Chapter 71. AJCC has defined a grading system for the follicular histologies.

  - Applicable sites: C441, C690, C695, C696
  - Applicable histologies for above: 9690/3, 9691/3, 9595/3, 9698/3
  - Grade for all other histologies collected in AJCC Chapter 71 is coded as 9
- Classification of grade now varies by tumor site and/or histology.
- Three new grade data items reflect the points in time in the patient's work-up care when grade may be assessed:
  - **Grade Clinical** – Record the grade of a solid primary tumor before any treatment, including surgical resection, systemic therapy, radiation therapy or neoadjuvant therapy.

    Note: Not all surgical procedures are treatment.

    Examples: Grade determined from a TURBT, TURB, or endoscopic biopsies would be collected as clinical grade.
  - **Grade Pathological** – Record the grade of a solid primary tumor that has been surgically resected, and patient has NOT had neoadjuvant treatment.
    - The tumor must meet the surgical resection requirements in the AJCC Manual for pathological stage.
    - Pathological grade may include the grade from clinical workup, as all information from diagnosis (clinical staging) through the surgical resection is used for pathological grade.

      Note: Not all surgical procedures meet the requirements for pathological grade or pathological stage (i.e., TURB or TURP).
  - **Grade Post-Therapy** – Record the grade of a solid primary tumor that has been resected following neoadjuvant therapy.
    - The tumor must meet the surgical resection requirements for yp pathological stage in the AJCC Manual to assign the post-therapy grade.

- Neoadjuvant therapy **must** meet applicable guidelines or standards, and not be that given for variable or unconventional reasons as noted in the AJCC Manual.
- This data item corresponds to the yp staging period only.

V.4.1.1 Grade - Clinical

Grade Clinical records the grade of a solid tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). This data item is required by the CCR for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Refer to the most current Grade Coding Instructions and Tables for coding instructions.
    - **Always** check the site-specific Clinical Grade tables (in the document link above) for additional information.
- Clinical grade is recorded for cases where a histological (microscopic) exam is done and tissue is available, and grade is recorded.
    - Includes: FNA, biopsy, needle core biopsy, etc.
- Clinical grade **must not** be blank.
- Code the highest grade from the primary tumor assessed during the clinical time frame.
- Use Code 9 (unknown) when:
    - Grade is not documented
    - Clinical grade/staging is not applicable

      Example: cancer is an incidental finding during surgery for another condition
    - Grade checked “not applicable” on CAP Protocol (if available) and no other grade information is available.
    - If there is only one grade available and it cannot be determined if it is clinical or pathological, assign it as a clinical grade and code unknown (9) for pathological grade, and blank for post-therapy grade.

V.4.1.2 Grade - Pathological

Grade Pathological records the grade of a solid tumor that has been resected and for which no neoadjuvant therapy was administered. This data item is required by the CCR for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Refer to the most current Grade Coding Instructions and Tables for coding instructions.
    - **Always** check the site-specific Pathological Grade tables (in the document linked above) for additional information.
- Pathological grade is recorded for cases where a surgical resection has been done.
- Pathological grade **must not** be blank.
- Assign the highest grade from the primary tumor.
    - Use the grade that was identified during the clinical time frame for both clinical grade and pathological grade if the clinical grade is higher than the grade identified on the surgical resection specimen.
- Code 9 (unknown) when:
    - Grade is not documented
    - No resection of the primary site performed
    - Neoadjuvant therapy followed by a resection. See Grade - Post-Therapy.
    - Clinical case only. See Grade - Clinical.
    - Grade checked “not applicable” on CAP Protocol (if available) and no other grade information is available.
    - There is only one grade available and it cannot be determined if it is clinical or pathological.

V.4.1.3 Grade - Post-Therapy

Grade Post-Therapy records the grade of a solid tumor that has been resected following neoadjuvant therapy. This data item is required by the CCR for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Refer to the most current Grade Coding Instructions and Tables for coding instructions.
    - **Always** check the site-specific Post-Therapy Grade tables (in the document linked above) for additional information.
- Leave **BLANK** when:
    - No neoadjuvant therapy given
    - Clinical or pathological case only
    - There is only one grade available and it cannot be determined if it is clinical, pathological, or post-therapy.
- Assign the highest grade from the resected primary tumor assessed **after** the completion of neoadjuvant therapy only.
    - Clinical grade information may never be used in assigning post-therapy grade.
- Code 9 (unknown) when:
    - Surgical resection is done after neoadjuvant therapy and grade is not documented.
    - Grade checked “not applicable” on CAP Protocol (if available) and no other grade information is available.

V.5 Tumor Size

Three data items were added in 2016 to collect information on tumor size of the solid, primary tumor at various points in the diagnosis and treatment of the reportable neoplasm. These data fields are: Tumor Size-Clinical, Tumor Size-Pathological and Tumor Size-Summary. These data fields are independent from one another and have specific, unique coding instructions. Refer to each separate tumor size data item for the specific corresponding coding instructions.

V.5.1 Tumor Size Clinical

This data item records the size of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant) and is essential for treatment decision making and prognosis determination for many types of cancer.

Coding Instructions:

- Code the tumor size from the largest invasive component of the primary tumor measured on physical exam, imaging, or other diagnostic procedures performed before any form of treatment.
- Code the largest tumor size from all information available within four months of the date of diagnosis, in the absence of disease progression when no treatment is administered.
- Tumor size from imaging/radiographic techniques can be used to code clinical size when there is not more specific size information from a biopsy or operative report. It should be taken as a lower priority, but over a physical exam.
    - Code the largest size in the record, regardless of the imaging technique, when there is a difference in reported tumor size among imaging and radiographic reports, unless the physician specifies the imaging that is most accurate.
    - Record the size from an incisional biopsy. Use the clinical guideline for TNM to determine if the biopsy was done during the clinical timeframe. **Use the source that gives you the best size and take the largest size.**

      NOTE: An incisional biopsy that removed the whole tumor is actually an excisional biopsy. Record tumor size from an excisional biopsy in Tumor Size – Pathologic.
- Code the size of the largest invasive tumor, or the largest in-situ tumor if all tumors are in-situ, when the tumor is multi-focal or when multiple tumors are reported as a single primary.
- Code the size of the primary tumor, not the size of the polyp, ulcer, cyst or distant metastasis.
    - However, if the tumor is described as a “cystic mass”, and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.
- Code the size of the primary tumor before neoadjuvant (preoperative) treatment.

  Example:

  Patient has a 2.8 cm mass in the hypopharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathological size of tumor after total resection is 3.2 cm. Record clinical tumor size as 028 (28 mm).
- Record tumor size only in millimeters (mm). Convert to millimeters when the size of tumor is measured in centimeters.
- Tumor size is the largest dimension of the tumor, not necessarily the depth or thickness of the tumor.

- Tumor size noted in a resection operative report is a clinical tumor size, and not a Pathological tumor size.
- Check the Clinical History/Clinical Impression/Clinical Information section of the pathology report for information on the clinical size of the tumor.

  Tumor Size Less than or Greater than:

  - Record the tumor size as 1 mm less when tumor size is reported as "less than x mm" or "less than x cm."

    Examples:

    - Code as 009 when stated <10 mm; or 009 when stated as <1 cm.
    - Code 001 when stated as less than 1 mm.
  - Record the tumor size as 1 mm more when tumor size is reported as "more than x mm" or "more than x cm."

    Example:

    - Code as 010 when stated > 9 mm; or 011 when stated as > 1 cm.
  - When size stated is between 2 sizes, for example, "between 3 and 4 cm", code to the midpoint: 3.5.

  Rounding:

  - Round tenths of millimeters in the 1-4 range down to the nearest whole millimeter.
  - Round tenths of millimeters in the 5-9 range up to the nearest whole millimeter when tumor size is greater than 1 millimeter.

    Examples:

    - Lung cancer described as 4.5 millimeters in size. Round up to 5 mm and code as 005.
    - Cancer in a polyp described as 2.3 millimeters in size. Round down to 2 mm and code as 002.
- Tumor size code 999 is used when size is unknown or not applicable.
- Sites/Morphologies where tumor size is not applicable are listed here:
  - Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms (histology codes 9590-9992).
  - Kaposi Sarcoma
  - Melanoma Choroid
  - Melanoma Ciliary Body
  - Melanoma Iris
  - Unknown primary site (C809)
- **The CCR requires text documentation to support the Tumor Size Clinical code.**

Codes:

Code	Description
000	No mass/tumor found
001	1 mm or described as **less than** 1 mm (0.1 cm or less than 0.1 cm)
002-988	Exact size in millimeters (2 mm to 988 mm) (0.2 cm to 98.8 cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given
998-Site-Specific Codes	Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9) **If no size is documented:** Circumferential: Esophagus (C15.0 C15.5, C15.8 C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9) Diffuse: Breast (C50.0 C50.6, C50.8 C50.9)
999	Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; The only measurement(s) describes pieces or chips; Not applicable

V.5.2 Tumor Size Pathological

This data item records the size of a solid primary tumor that has been resected. It is an important prognostic indicator and is valuable for both clinical practice and for research on surgically treated patients for most cancers.

Coding Instructions:

- Code the tumor size from the largest invasive component of the primary tumor measured at surgical resection when the surgery is administered as first course treatment.
- Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.
- The Pathological tumor size is recorded from the surgical resection specimen when surgery (including after neoadjuvant therapy) is administered as part of the first course of treatment.
- Use final diagnosis, microscopic or gross examination, in that order, when only a pathology report is available.
- Do not add the size of pieces or chips together to create a whole.
- Code the size from the synoptic report (CAP protocol) when there is a discrepancy among the various sections of the pathology report.

  Example:

  Chest x-ray shows 2.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 1.8 cm. Record tumor size as 018 (18mm).
- Record the size of the invasive component, even if it is smaller, when both in-situ and invasive components are measured.
- Code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis.
- Record the size of the entire tumor from the operative report or pathology report when the size of the invasive component is not given.
- Record the size as stated for purely in-situ lesions.
- Disregard microscopic residual or positive margins.
- Code the size of the largest invasive tumor, or the largest in-situ tumor when the tumor is multi-focal or multicentric.
- Tumor size noted in a resection operative report is a clinical tumor size, not a Pathological tumor size.
- Tumor size is the largest dimension of the tumor, not necessarily the depth or thickness of the tumor.
- Record tumor size only in millimeters (mm). Convert to millimeters when the size of tumor is measured in centimeters.

Tumor Size Less than or Greater than:

- Record the tumor size as 1 mm less when tumor size is reported as “less than x mm” or “less than x cm.”

  Examples:

  - Code as 009 when stated <10 mm; or 009 when stated as < 1 cm.
  - Code 001 when stated as less than 1 mm.

- Record the tumor size as 1 mm more when tumor size is reported as “more than x mm” or “more than x cm.”

  Example:

  - Code as 010 when stated > 9 mm; or 011 when stated as > 1 cm.

- When size stated is between 2 sizes, for example, “between 3 and 4 cm”, code to the midpoint: 3.5.

Rounding:

- Round tenths of millimeters in the 1-4 range down to the nearest whole millimeter.
- Round tenths of millimeters in the 5-9 range up to the nearest whole millimeter when tumor size is greater than 1 millimeter.

  Examples:

  - Lung cancer described as 6.5 millimeters in size. Round up to 7 mm and code as 007.
  - Cancer in a polyp described as 1.3 millimeters in size. Round down to 1 mm and code as 001.

- Code 999 is used when size is unknown or not applicable.
- Sites/morphologies where tumor size is not applicable are listed here:
  - Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms (Histology codes 9590-9992)
  - Kaposi Sarcoma
  - Melanoma Choroid
  - Melanoma Ciliary Body
  - Melanoma Iris
  - Unknown primary site (C809)
- **The CCR requires text documentation to support the Tumor Size Pathological code.**

Codes:

Code	Description

000	No mass/tumor found
001	1 mm or described as less than 1 mm (0.1 cm or less than 0.1 cm)
002-988	Exact size in millimeters (2 mm to 988 mm) (0.2 cm to 98.8 cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given
998-Site-Specific Codes	Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9) **If no size is documented:** Circumferential: Esophagus (C15.0 C15.5, C15.8 C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9) Diffuse: Breast (C50.0 C50.6, C50.8 C50.9)
999	Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; No excisional biopsy or tumor resection done; The only measurement(s) describes pieces or chips; Not applicable

V.5.3 Tumor Size Summary

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen. Tumor size is one indication of the extent of disease and is therefore used by clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Coding Instructions:

- Tumor size is the diameter of the tumor, not the depth or thickness of the tumor.
- All measurements should be in millimeters (mm).
- Use tumor size measurement from the surgical resection specimen, when no pre-surgical treatment is administered.
    - If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report.
    - If only a path text report is available, use: final diagnosis, microscopic, or gross examination, in that order.
    - Microscopic residual or positive surgical margins should be disregarded when coding tumor size. The status of primary tumor margins may be recorded in a separate data field.
- If neoadjuvant therapy was followed by surgical resection, do not record the size from the pathological specimen. Instead code the largest tumor size prior to neoadjuvant treatment.
- If no surgical resection, record the size prior to any other form of treatment
    - Code the largest tumor measurement in the following priority order:
        - Imaging
        - Physical exam
        - Other diagnostic procedures
    - Priority of imaging/radiographic techniques should be taken as low priority, over a physical exam.
        - If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.
- Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis.
    - However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.
- Record the size of the invasive component, if given.
    - If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

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

- Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.
- Record the size as stated for purely in-situ lesions.
- Multifocal/multicentric tumors: If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor or if all the tumors are in-situ, code the size of the largest in-situ tumor.
- Use Code 999 in the following situations:
  - Neoadjuvant (preoperative) therapy was administered and pretreatment tumor size is unknown.
  - Sites/morphologies where tumor size is not applicable.
    - Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms (histology codes 9590-9992)
    - Kaposi Sarcoma
    - Melanoma Choroid
    - Melanoma Ciliary Body
    - Melanoma Iris
  - Pieces or chips are the only measurement provided
- Recording 'less than'/ 'greater than' Tumor Size:
  - If tumor size is reported as less than x mm or less than x cm, the reported tumor size should be 1 mm less; for example, if size is < 10 mm, code size as 009.
  - If tumor size is reported as more than x mm or more than x cm, code size as 1 mm more; for example, if size is > 10 mm, size should be coded as 011.
  - If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two.
- Rounding decimals: Round the tumor size only if it is described in fractions (decimals) of millimeters.
  - If the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000).
  - If tumor size is greater than 1-millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter.
  - Round tenths of millimeters in the 5-9 range up to the nearest whole millimeter.
  - Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point one space to the right, converting the measurement to millimeters).

Examples:

- Breast tumor described as 6.5 millimeters in size. Round up Tumor Size as 007.
- Cancer in polyp described as 2.3 millimeters in size. Round down Tumor Size as 002.
- Focus of cancer described as 1.4 mm in size. Round down as 001.

- **The CCR requires text documentation to support the Tumor Size Summary code.**

Codes:

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm (0.1 cm or less than 0.1 cm)
002-988	Exact size in millimeters (2 mm to 988 mm) (0.2 cm to 98.8 cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given
998-Site-Specific Codes	Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9) **If no size is documented:** Circumferential: Esophagus (C15.0 C15.5, C15.8 C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9) Diffuse: Breast (C50.0 C50.6, C50.8 C50.9)
999	Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; No excisional biopsy or tumor resection done; The only measurement(s) describes pieces or chips; Not applicable

V.6 Mets at Diagnosis Bone, Brain, Liver, Lung, Distant Lymph Nodes, and Other

The following data items record the specific site(s) of metastatic disease present at diagnosis. Each field identifies whether bone, brain, distant lymph nodes, liver, lung or other discontinuous or distant metastatic site(s) are involved.

Coding Instructions:

- Metastatic involvement may be single (one focus of metastatic disease) or multiple (multiple foci of metastatic disease in the same site or multiple sites). Information may be clinical or pathologic.
- Code these fields for metastasis even if the patient had neoadjuvant (preoperative) systemic therapy, unless it is determined to be disease progression.
- These fields should be coded for all solid tumors, Kaposi's sarcoma, Lymphoma's, Unknown primary site and Other and Ill-defined primary sites.
    - Code this field for Lymphomas of **all sites** for the histologies (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 8927, and 9737).
- In the data field for each site, enter the code that demonstrates involvement of that site.

V.6.1 Mets at Diagnosis - Bone

The Mets at Diagnosis – Bone data item captures whether bone is an involved metastatic site at the time of diagnosis.

Coding Instructions:

- Code information about bone metastasis only (discontinuous or distant) to the bone identified at the time of diagnosis.

  Note: Bone marrow involvement is NOT coded in this field. See Mets at Diagnosis – Other.

- Metastatic involvement may be single (one focus of metastatic disease) or multiple (multiple foci of metastatic disease in the same site or multiple sites).
- Information regarding bone involvement may be clinical or pathologic.
- Code this field for bone metastasis even if the patient had neoadjuvant (preoperative) systemic therapy, unless it is determined to be disease progression.
- Code bone involvement in this field for all solid tumors, including Kaposi's sarcoma and Other Ill-defined primary sites (includes unknown primary site) and the following hematopoietic schemas.
  - Lymphoma Ocular Adnexa 00710
  - Lymphoma (excluding CLL/SLL) 00790
  - Lymphoma CSS/SLL) 00795
  - Mycosis Fungoides 00811
  - Primary Cutaneous Lymphoma (excluding MF and SS) 00812
- Assign the code that best describes whether the case has bone metastasis at diagnosis.
  - Use code 0 when the medical record indicates:
    - No distant (discontinuous) metastases at all.
    - Clinical or pathological statement that there is no bone metastasis.
    - Imaging reports that are negative for bone metastasis.
    - The patient has distant (discontinuous) metastasis but bone is not mentioned as an involved site.
  - Use code 1 when the medical record confirms:
    - The patient has distant (discontinuous) metastasis and the bone is mentioned as involved.
    - Bone is the primary and there is metastasis in a different bone(s).

      Note: Do not code as 1 when bone is the primary with multifocal bone involvement of the same bone.
    - The patient is diagnosed with an unknown primary (C80.9) and bone is mentioned as a distant metastatic site.
  - Use code 8 (Not applicable) for the following:

- Any case coded to primary site C420, C421, C423 or C424
- Plasma Cell myeloma 00821
- Plasma cell Disorders 00822
- HemeRetic 00830

o Use code 9 when the patient is known to have distant metastasis, but it cannot be determined whether the distant metastasis include bone.

Note: For additional information on schemas and schema IDs, see the SSDI Manual, Appendix A.

Codes:

Code	Description
0	None; no bone involvement
1	Yes, distant bone metastasis
8	Not Applicable
9	Unknown whether bone is an involved metastatic site Not documented in patient record

V.6.2 Mets at Diagnosis - Brain

The Mets at Diagnosis – Brain data item captures whether the brain is an involved metastatic site at the time of diagnosis.

Coding Instructions:

- Code information about brain metastasis only (discontinuous or distant) to the brain identified at the time of diagnosis.

  Note: Spinal cord involvement is NOT coded in this field. See Mets at Diagnosis – Other.

  Metastatic involvement may be single (one focus of metastatic disease) or multiple (multiple foci of metastatic disease in the same site or multiple sites).

- Information regarding brain involvement may be clinical or pathologic.
- Code this field for brain metastasis even if the patient had neoadjuvant (preoperative) systemic therapy, unless it is determined to be disease progression.
- Code brain involvement in this field for all solid tumors, including Kaposi's sarcoma and Other Ill-defined primary sites (includes unknown primary site) and the following hematopoietic schemas.
  - Lymphoma Ocular Adnexa 00710
  - Lymphoma (excluding CLL/SLL) 00790
  - Lymphoma CSS/SLL) 00795
  - Mycosis Fungoides 00811
  - Primary Cutaneous Lymphoma (excluding MF and SS) 00812
- Assign the code that best describes whether the case has brain metastasis at diagnosis.
  - Use code 0 when the medical record indicates:
    - No distant (discontinuous) metastases at all.
    - Clinical or pathological statement that there is no brain metastasis.
    - Imaging reports that are negative for brain metastasis.
    - The patient has distant (discontinuous) metastasis but brain is not mentioned as an involved site.
  - Use code 1 when the medical record confirms:
    - The patient has distant (discontinuous) metastasis and the brain is mentioned as involved.
    - The patient is diagnosed with an unknown primary (C80.9) and brain is mentioned as a distant metastatic site.
  - Use code 8 (Not applicable) for the following:
    - Any case coded to primary site C420, C421, C423 or C424
    - Plasma Cell myeloma 00821
    - Plasma cell Disorders 00822

- HemeRetic 00830

- Use code 9 when the patient is known to have distant metastasis, but it cannot be determined whether the distant metastasis include brain.

Note: For additional information on schemas and schema IDs, see the SSDI Manual, Appendix A.

Codes:

Code	Description
0	None; no brain involvement
1	Yes, distant brain metastasis
8	Not Applicable
9	Unknown whether brain is an involved metastatic site Not documented in patient record

V.6.3 Mets at Diagnosis - Liver

The Mets at Diagnosis – Liver data item captures whether the liver is an involved metastatic site at the time of diagnosis.

Coding Instructions:

- Code information about liver metastasis only (discontinuous or distant) to the liver identified at the time of diagnosis.
- Metastatic involvement may be single (one focus of metastatic disease) or multiple (multiple foci of metastatic disease in the same site or multiple sites).
- Information regarding liver involvement may be clinical or pathologic.
- Code this field for liver metastasis even if the patient had neoadjuvant (preoperative) systemic therapy, unless it is determined to be disease progression.
- Code liver involvement in this field for all solid tumors, including Kaposi's sarcoma and Other Ill-defined primary sites (includes unknown primary site) and the following hematopoietic schemas.
    - Lymphoma Ocular Adnexa 00710
    - Lymphoma (excluding CLL/SLL) 00790
    - Lymphoma CSS/SLL) 00795
    - Mycosis Fungoides 00811
    - Primary Cutaneous Lymphoma (excluding MF and SS) 00812
- Assign the code that best describes whether the case has liver metastasis at diagnosis.
    - Use code 0 when the medical record indicates:
        - No distant (discontinuous) metastases at all.
        - Clinical or pathological statement that there is no liver metastasis.
        - Imaging reports that are negative for liver metastasis.
        - The patient has distant (discontinuous) metastasis but liver is not mentioned as an involved site.
    - Use code 1 when the medical record confirms:
        - The patient has distant (discontinuous) metastasis and the liver is mentioned as involved.
        - The patient is diagnosed with an unknown primary (C80.9) and liver is mentioned as a distant metastatic site.
    - Use code 8 (Not applicable) for the following:
        - Any case coded to primary site C420, C421, C423 or C424
        - Plasma Cell myeloma 00821
        - Plasma cell Disorders 00822
        - HemeRetic 00830

- Use code 9 when the patient is known to have distant metastasis, but it cannot be determined whether the distant metastasis include liver.

Note: For additional information on schemas and schema IDs, see the SSDI Manual, Appendix A.

Codes:

Code	Description
0	None; no liver involvement
1	Yes, distant liver metastasis
8	Not Applicable
9	Unknown whether liver is an involved metastatic site Not documented in patient record

V.6.4 Mets at Diagnosis - Lung

The Mets at Diagnosis – Lung data item captures whether lung is an involved metastatic site at the time of diagnosis.

Coding Instructions:

- Code information about lung metastasis only (discontinuous or distant) to the lung identified at the time of diagnosis.

  Note: Pleural or pleural fluid involvement is NOT coded in this field. See Mets at Diagnosis – Other.

- Metastatic involvement may be single (one focus of metastatic disease) or multiple (multiple foci of metastatic disease in the same site or multiple sites).
- Information regarding lung involvement may be clinical or pathologic.
- Code this field for lung metastasis even if the patient had neoadjuvant (preoperative) systemic therapy, unless it is determined to be disease progression.
- Code lung involvement in this field for all solid tumors, including Kaposi's sarcoma and Other Ill-defined primary sites (includes unknown primary site) and the following hematopoietic schemas.
  - Lymphoma Ocular Adnexa 00710
  - Lymphoma (excluding CLL/SLL) 00790
  - Lymphoma CSS/SLL) 00795
  - Mycosis Fungoides 00811
  - Primary Cutaneous Lymphoma (excluding MF and SS) 00812
- Assign the code that best describes whether the case has lung metastasis at diagnosis.
  - Use code 0 when the medical record indicates:
    - No distant (discontinuous) metastases at all.
    - Clinical or pathological statement that there is no lung metastasis.
    - Imaging reports that are negative for lung metastasis.
    - The patient has distant (discontinuous) metastasis but lung is not mentioned as an involved site.
  - Use code 1 when the medical record confirms:
    - The patient has distant (discontinuous) metastasis and the lung is mentioned as involved.
    - Lung is the primary and there is metastasis in the contralateral lung.

      Note: Do not code as 1 when lung is the primary with multifocal lung involvement of the same lung.
    - The patient is diagnosed with an unknown primary (C80.9) and lung is mentioned as a distant metastatic site.
  - Use code 8 (Not applicable) for the following:

- Any case coded to primary site C420, C421, C423 or C424
- Plasma Cell myeloma 00821
- Plasma cell Disorders 00822
- HemeRetic 00830

o Use code 9 when the patient is known to have distant metastasis, but it cannot be determined whether the distant metastasis include lung.

Note: For additional information on schemas and schema IDs, see the SSDI Manual, Appendix A.

Codes:

Code	Description
0	None; no lung involvement
1	Yes, distant lung metastasis
8	Not Applicable
9	Unknown whether lung is an involved metastatic site Not documented in patient record

V.6.5 Mets at Diagnosis - Distant Lymph Node(s)

The Mets at Diagnosis – Distant Lymph Node(s) data item captures whether distant lymph node(s) are an involved metastatic site at the time of diagnosis.

Coding Instructions:

- Use AJCC TNM to determine regional verses distant lymph nodes.

  Note: Regional lymph nodes are NOT coded in this field.

- Code information about distant lymph node(s) metastasis only (discontinuous or distant) to distant lymph node(s) identified at the time of diagnosis.
- Metastatic involvement may be single (one focus of metastatic disease) or multiple (multiple foci of metastatic disease in the same site or multiple sites).
- Information regarding distant lymph node involvement may be clinical or pathologic.
- Code this field for distant lymph node metastasis even if the patient had neoadjuvant (preoperative) systemic therapy, unless it is determined to be disease progression.
- Code distant lymph node involvement in this field for all solid tumors, including Kaposi's sarcoma and Other Ill-defined primary sites (includes unknown primary site) and the following hematopoietic schemas.
    - Lymphoma Ocular Adnexa 00710
    - Lymphoma (excluding CLL/SLL) 00790
    - Lymphoma CSS/SLL) 00795
    - Mycosis Fungoides 00811
    - Primary Cutaneous Lymphoma (excluding MF and SS) 00812
- Assign the code that best describes whether the case has distant lymph node metastasis at diagnosis.
    - Use code 0 when the medical record indicates:
        - No distant (discontinuous) metastases at all.
        - Clinical or pathological statement that there is no distant lymph node metastasis.
        - Imaging reports that are negative for distant lymph node metastasis.
        - Lymph nodes are involved, but there is no indication they are regional or distant.
        - The patient has distant (discontinuous) metastasis but distant lymph node(s) are not mentioned as an involved site.
    - Use code 1 when the medical record confirms:
        - The patient has distant (discontinuous) metastasis and the distant lymph node(s) are mentioned as involved.
    - Use code 8 (Not applicable) for the following:
        - Any case coded to primary site C420, C421, C423 or C424

- Plasma Cell myeloma 00821
- Plasma cell Disorders 00822
- HemeRetic 00830

o Use code 9 when the patient is known to have distant metastasis, but it cannot be determined whether the distant metastasis include distant lymph node.

Note: For additional information on schemas and schema IDs, see the SSDI Manual, Appendix A.

Codes:

Code	Description
0	None; no distant lymph node involvement
1	Yes, distant lymph node metastasis
8	Not Applicable
9	Unknown whether distant lymph node(s) are involved metastatic site Not documented in patient record

V.6.6 Mets at Diagnosis - Other

The Mets at Diagnosis – Other data item captures any type of distant involvement not captured in the bone, brain, liver, lung, and distant lymph node fields where metastasis has occurred at the time of diagnosis.

Coding Instructions:

- Code information about other metastasis only (discontinuous or distant) to other sites identified at the time of diagnosis.

  Note: Do not code this field for bone, brain, liver, lung, or distant lymph node metastasis.

- Metastatic involvement may be single (one focus of metastatic disease) or multiple (multiple foci of metastatic disease in the same site or multiple sites).
- Information regarding other involvement may be clinical or pathologic.
- Code this field for other metastasis even if the patient had neoadjuvant (preoperative) systemic therapy, unless it is determined to be disease progression.
- Code other involvement in this field for all solid tumors, including Kaposi's sarcoma and Other Ill-defined primary sites (includes unknown primary site) and the following hematopoietic schemas.
  - Lymphoma Ocular Adnexa 00710
  - Lymphoma (excluding CLL/SLL) 00790
  - Lymphoma CSS/SLL) 00795
  - Mycosis Fungoides 00811
  - Primary Cutaneous Lymphoma (excluding MF and SS) 00812
- Assign the code that best describes whether the case has other metastasis at diagnosis.
  - Use code 0 when the medical record indicates:
    - No distant (discontinuous) metastases at all.
    - Clinical or pathological statement that there is no other metastasis.
    - Imaging reports that are negative for other metastasis.
    - The patient has distant (discontinuous) metastasis but other sites are not mentioned as an involved site.
  - Use code 1 when the medical record confirms:
    - The patient has distant (discontinuous) metastasis in any sites (other than bone, brain, liver, lung, or distant lymph node(s).
    - Lymphomas with bone marrow involvement (Stage IV disease).

      Note: Do not include lymphomas or lymphoma/leukemias where the primary site is coded to C421 (bone marrow).
    - The patient is diagnosed with an unknown primary (C80.9) and other is mentioned as a distant metastatic site.
  - Use code 2 when the medical record confirms:

- The patient has carcinomatosis (carcinomatosis is a condition in which cancer is spread widely throughout the body, or, in some cases, to a relatively large region of the body).

  Note: It is possible to have carcinomatosis and have metastatic disease to a specific organ.

- If a patient has metastatic disease to a site other than bone, brain, liver, lung, or distant nodes **and** carcinomatosis, assign code 2 for carcinomatosis. Code 2 for carcinomatosis takes priority.

o Use code 8 (Not applicable) for the following:

- Any case coded to primary site C420, C421, C423 or C424
- Plasma Cell myeloma 00821
- Plasma cell Disorders 00822
- HemeRetic 00830

o Use code 9 when the patient is known to have distant metastasis, but it cannot be determined whether the distant metastasis include other.

Note: For additional information on schemas and schema IDs, see the SSDI Manual, Appendix A.

Codes:

Code	Description
0	None; no other metastasis
1	Yes, distant metastasis in known site(s), other than bone, brain, liver, lung or distant lymph nodes **Note:** Includes bone marrow involvement for lymphoma
2	Generalized metastasis such as carcinomatosis
8	Not Applicable
9	Unknown whether any other metastatic site or generalized metastasis Not documented in patient record

V.7 Lymphovascular Invasion

Lymphovascular invasion identifies the presence or absence of tumor cells within blood vessels, lymphatic channels (not lymph nodes) or surrounding tissue within the primary tumor as noted microscopically by the pathologist. Lymphovascular invasion (LVI) includes lymphatic, vascular, and lympho-vascular invasion is an indicator of prognosis.

Coding Instructions:

- Lymphovascular Invasion status is required by the CCR for all sites when available.
    - LVI is required by the CCR for primary sites penis (C60.0; C60.8-C609.) and testis (C62.0-C62.1) for cases diagnosed 1/1/2010 and forward.
- Code from pathology report(s). If not available, code the absence or presence of lymphovascular invasion as described in the medical record.
    - The primary source of this information is the College of American Pathologists (CAP) synoptic report or checklist. If the CAP is not available, code this data item from the pathology report or a physician's statement within the medical record, in that order of priority.
    - Perineural invasion is **not** coded in this field.
    - Information to code this field can be taken from any specimen (biopsy or resection) from the primary tumor.
    - Use code 8 (not applicable) for benign/borderline brain and CNS tumors.
    - For cases treated with neoadjuvant therapy, refer to table below to code this field. However, if documentation in the medical record indicates information that conflicts with this table, code lymphovascular invasion with the documentation in the medical record.

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

- Use code 0:
    - When the pathology report indicates no lymphovascular invasion.

- Purely in-situ carcinoma, which biologically has no access to lymphatic or vascular channels below the basement membrane.

- Use code 1, when the pathology report indicates lymphovascular invasion (or one of its synonyms) is present.

Synonyms for Lymphovascular Invasion
Angiolymphatic invasion
Blood vessel invasion
Lymph vascular emboli
Lymphatic invasion
Lymphvascular invasion
Vascular invasion

- Use code 8 for the following schema/ID's:
  - Adnexa Uterine Other 00558
  - Biliary Other 00278
  - Brain 00721
  - Cervical Lymph Nodes, Occult Head and Neck 00060
  - CNS Other 00722
  - Conjunctiva 00650
  - Cutaneous Carcinoma Head and Neck 00150
  - Digestive Other 00288
  - Endocrine Other 00778
  - Eye Other 00718
  - Fallopian Tube 00553
  - Genital Female Other 00559
  - Genital Male other 00598
  - HemeRetic 00830
  - Ill-Defined Other 99999
  - Intracranial Gland 00723
  - Kaposi Sarcoma 00458
  - Lacrimal Gland 00690
  - Lacrimal Sac 00698
  - Lymphoma 00790
  - Lymphoma (CLL/SLL) 00795
  - Lymphoma Ocular Adnexa 00710
  - Melanoma Head and Neck 00140

- Middle Ear 00119
- Mycosis Fungoides (MF) 00811
- NET Adrenal Gland 00770
- Ovary 00551
- Pharynx Other 00118
- Plasma Cell Disorder 00822
- Plasma Cell Myeloma 00821
- Pleural Mesothelioma 00370
- Primary Cutaneous Lymphoma (excluding MF and SS) 00812
- Primary Peritoneal Carcinoma 00552
- Respiratory Other 00378
- Retinoblastoma 00680
- Sinus Other 00128
- Skin Other 00478
- Trachea 00358
- Urinary Other 00638
- Schemas other than Penis 00570 and Testis 00590 if the registry has opted not to collect

Note: For additional information on schemas and schema IDs, see the SSDI Manual, Appendix A.

- Use code 9 when:
  - There is no microscopic examination of a primary tissue specimen.
  - The primary site specimen is a cytology or fine needle aspiration.
  - The biopsy is only a very small tissue sample.
  - It is not possible to determine whether lymphovascular invasion is present.
  - The pathologist states the specimen is insufficient to determine lymphovascular invasion.
  - Lymphovascular invasion is not mentioned in the pathology report.
  - Primary site is unknown.
- This field is to be left blank for cases diagnosed before 2010.

Codes:

Code	Description
0	Lymphovascular invasion not present (absent)/Not identified.
1	Lymphovascular invasion present/identified.
2	Lymphatic and small vessel invasion only (L).

3	Venous (large vessel) invasion only (V).
4	BOTH lymphatic and small vessel AND venous (large vessel) invasion
8	Not Applicable.
9	Unknown if lymphovascular invasion present; Indeterminate; not mentioned in path report.

V.8 Terms Indicating In-situ for Staging

Certain terms indicate an in-situ stage. Also, see In-Situ Coding for Reportable terms indicating "in-situ" behavior.

General Terms Indicating In-situ Behavior
Bowen's disease (excluding skin)
Confined to epithelium (does not extend beyond base membrane)
Ductal carcinoma in-situ, (DCIS) (any site)
Intracystic, Intraepidermal (NOS), Intrasquamous, In-situ
Intraepithelial neoplasia grade III, not otherwise specified (NOS)
Involvement up to, but not including basement membrane
Lobular carcinoma in-situ (LCIS) **
No stromal invasion
Non-infiltrating; Non-invasive
Squamous intraepithelial neoplasia grade III (SIN III) (excluding cervix and skin sites coded to C44_), dx 01/01/2014 +
Papillary, non-infiltrating or intraductal
Pre-invasive
Site-Specific Terms Indicating In-situ Behavior
Anus – Anal Intraepithelial Neoplasia grade III (AIN III), dx 01/01/2001 + High grade squamous intraepithelial invasion (HGSIL or HSIL), dx 01/01/2018 +
Breast • Ductal intraepithelial neoplasia grade III (DIN III), dx 01/01/2001+ • Lobular intraepithelial neoplasia grade III (LIN III), dx 01/01/2016 + (LCIS) ** • Lobular neoplasia grade III (LN III), dx 01/01/2016 + ** • Lobular, non-infiltrating
Breast, Colon, Rectum • Stage 0 (excluding Paget's disease) confined to lamina propria
Gallbladder – High grade biliary intraepithelial neoplasia grade III (BiIN III), 01/01/2018 +
Larynx – Laryngeal intraepithelial neoplasia grade III (LIN III), dx 01/01/2001 +
Pancreas – Pancreatic intraepithelial neoplasia grade III (PanIN III), dx 01/01/2004 +
Penis • Penile intraepithelial neoplasia grade III (PeIN III), dx 01/01/2001 + • Queyrat's erythroplasia

Skin • Clark's level I (melanoma; limited to epithelium) • Hutchinson's melanotic freckle, not otherwise specified (NOS) • Lentigo maligna • Precancerous melanosis
Vagina – Vaginal intraepithelial neoplasia grade III (VAIN III), dx 01/01/1992 + High grade squamous intraepithelial invasion (HGSIL or HSIL), dx 01/01/2018 +
Vulva – Vulvar intraepithelial neoplasia grade III (VIN III), dx 01/01/1992 + High grade squamous intraepithelial invasion (HGSIL or HSIL), dx 01/01/2018 +

**** Staging of these data items differ by standard setter.** Please see:

- AJCC Cancer Staging Manual for TNM staging clarifications
- Extent of Disease 2018 General Instructions for staging instructions
- Summary Stage 2018 Manual for staging instructions

V.9 Stage at Diagnosis

Stage at Diagnosis is the established extent of disease determined after the diagnostic/staging workup for a new cancer.

Guidelines:

- Include pertinent findings from autopsy reports if the patient dies within four months of the diagnosis of cancer.
- Exclude data about progression of disease since the time of the original diagnosis.
    - **Progression of Disease:** Any regional or distant metastasis known to have developed after the stage at diagnosis was established.

      Examples:

        - Prostate biopsy 1/10/15 is diagnostic of Adenocarcinoma. There is no suspicion of and/or evidence of disease beyond the prostate. On 2/28/15 the patient underwent a Radical prostatectomy. He was seen again on 4/28/15 complaining of hip pain. On 5/1/15 Bone scan reveals bony metastases.

          The subsequent findings of bony mets, even though within four months from diagnosis would be excluded when coding stage at diagnosis.
        - A patient is undergoing first course treatment and then develops new symptoms or is not responding to treatment, and upon investigation is found to have disease progression.

          The progression of disease would be excluded when coding the stage at diagnosis.
    - Documentation of treatment failure and/or disease progression signifies the end of the first course of treatment.
- Sometimes stage may be stated incorrectly in the medical record due to a typographical, transcription, or similar error. If the stage recorded in one report is clearly contradicted in another, query the physician or the registry's medical consultant. Do not code stage based on information that appears to be inaccurate.

V.9.1 Staging Requirements 2014-2018

Staging requirements have evolved over the past four years. This page provides a view of the changes at a glance.

Guidelines:

- Methods commonly used to determine stage are the American Joint Committee on Cancer (AJCC) TNM staging system, SEER Summary Stage, SEER Extent of Disease, Site-Specific Data Items, and Collaborative Stage:
    - **AJCC TNM:** Used in the clinical setting by physicians to define spread of disease to make appropriate treatment decisions, determine prognosis, and measure end results. Refer to the most current AJCC Cancer Staging Manual for coding instructions.
    - **SEER Summary Stage:** Used by Epidemiologists and researchers where cases are grouped into standardized and simplified broad categories to ensure consistent definitions over time. Refer to the most current SEER Summary Stage Manual for coding instructions.
    - **SEER Extent of Disease:** Reflects a combination of clinical and pathologic information. Permits staging of all cancer types. Allows calculation of a combined "best" stage. Refer to the most current SEER Extent of Disease General Instructions for coding.
    - **Site-Specific Data Items:** Consist of additional prognostic factors or schema discriminators, which are cancer site-specific. Some are used in combination with staging systems variables to determine or derive a stage.
        - Refer to the most current Site-Specific Data Items Manual for coding instructions.
        - See, Appendix Q – Index to Site-Specific Data Items (SSDIs) for the CCR requirement for Schema Discriminators 1-3.
    - **Collaborative Stage:** Collection of Collaborative Stage data items and/or Site-Specific Factors were in effect from January 1, 2004 through December 31, 2017.

*Staging Requirements 2014-2018					
Staging System Data/Collection	**2014**	**2015**	**2016**	**2017**	**2018**
AJCC TNM 8th Edition Clinical & Path Stage Directly Coded	N/A				• Required from CoC facilities only
SEER 2018 Extent of Disease (EOD) Directly Coded	N/A				• Required from ALL facilities
Summary Stage 2018 Directly Coded	N/A				• Required from ALL facilities

Site-Specific Data Items (SSDIs) only per CCR Appendix Q	N/A			• Required from ALL facilities as required by CCR Appendix Q*
AJCC TNM 7th Edition Clinical & Path Stage Directly Coded	• As available from ALL facilities	• Required from CoC facilities • As Available from non-CoC	• Required from ALL facilities	N/A
Summary Stage 2000 Directly Coded	N/A	• Required from ALL facilities		N/A
CS SITE-SPECIFIC FACTORS only per CCR Appendix Y*	N/A		• CS SITE-SPECIFIC FACTORS as required by CCR Appendix Y*	N/A
Collaborative Stage	• CS Stage 02.05 required from ALL facilities		N/A	
Summary Stage 2000 Derived	• Required from ALL facilities	N/A		

***** See Archived Volume I – Use case year of diagnosis to determine which volume I to choose.

V.10 AJCC 8th Edition

The American Joint Committee on Cancer (AJCC) released the AJCC Cancer Staging Manual, 8th Edition in October 2016. AJCC Staging is required by CoC-accredited facilities for all cases diagnosed January 1, 2018 and forward.

AJCC Cancer Staging questions should be directed to the CAnswer Forum at: http://cancerbulletin.facs.org/forums.

Refer to the most current AJCC Cancer Staging Manual for specific disease site chapters and staging instructions.

V.10.1 AJCC TNM Staging General Information

The 2018 AJCC TNM staging data fields are separate from the pre-2018 TNM clinical and pathological stage items. AJCC Staging is required by CoC-accredited facilities for all cases diagnosed January 1, 2018 and forward.

For additional information on historical manual references, refer to Appendix S – Historical Coding and Staging Manual Requirements for CCR.

Guidelines:

- Refer to the most current AJCC Cancer Staging Manual for specific disease site chapters and staging instructions.
- Three stage classifications are defined by AJCC TNM 8th edition staging and include:
    - Clinical staging
    - Pathological staging
    - Post-therapy staging
- Data items within each stage classification include:

Clinical Stage	Pathological Stage	Post-Therapy Stage
AJCC TNM Clin T	AJCC TNM Path T	AJCC TNM Post-Therapy T
AJCC TNM Clin T Suffix	AJCC TNM Path T Suffix	AJCC TNM Post-Therapy T Suffix
AJCC TNM Clin N	AJCC TNM Path N	AJCC TNM Post-Therapy N
AJCC TNM Clin N Suffix	AJCC TNM Path N Suffix	AJCC TNM Post-Therapy N Suffix
AJCC TNM Clin M	AJCC TNM Path M	AJCC TNM Post-Therapy M
AJCC TNM Clin Stage Group	AJCC TNM Path Stage Group	AJCC TNM Post-Therapy Stage Group

V.10.1.1 AJCC TNM Clinical

Clinical stage classification describes a point in time in the care of the cancer patient. It is assigned by the managing physician based on data from all relevant sources. Clinical Stage includes information from the date of diagnosis until the start of definitive treatment (surgery, systemic or radiation therapy, active surveillance, or palliative care), to one of the following points in time, whichever is shortest:

- To within 4 months after diagnosis **OR**
- To the date cancer progression is identified before the end of the 4-month window.

  Note: Only data on disease extent known before observed progression is included in the clinical stage.

The AJCC staging data items listed below are required by CoC-accredited facilities for all cases diagnosed January 1, 2018 and forward.

Data Item Name
AJCC TNM Clin T
AJCC TNM Clin T Suffix
AJCC TNM Clin N
AJCC TNM Clin N Suffix
AJCC TNM Clin M
AJCC TNM Clin Stage Group

Coding Instructions:

- Refer to the most current AJCC Cancer Staging Manual for specific disease site chapters and staging instructions.
- Clinical stage classification is based on findings from physical exam, patient history, imaging done prior to treatment, as well as biopsies of the primary site, regional nodes, and distant metastatic sites.
- For the following categories, clinical stage is obtained from various places in the medical record, specifically:
  - **Clinical T category:**
    - Clinical history, symptoms, physical exam, labs, imaging, endoscopy, biopsy, and surgical exploration without resection.
  - **Clinical N category:**
    - Physical exam, imaging, FNA or core needle biopsy, and from a sentinel node biopsy.
  - **Clinical M category:**
    - Clinical history, physical exam, imaging, FNA or biopsy.

AJCC Clinical T and N Suffix:

- Enter the detailed site-specific codes for the clinical T & N category as defined by AJCC.

cT Suffix Codes:

Code	Description
(m)	Multiple synchronous tumors OR For thyroid differentiated and anaplastic only, Multifocal tumor
(s)	For thyroid differentiated and anaplastic only, Solitary tumor
BLANK	No information available; not recorded

cN Suffix Codes:

Code	Description
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only
BLANK	No suffix needed or appropriate; not recorded

AJCC Clinical Stage Group:

- Assigned by the managing physician based on data from all relevant sources.
- Stage group is assigned using the T, N, and M categories as well as non-anatomic factors such as prognostic factors and/or Site-Specific Data Items (in some instances).
- Enter the detailed site-specific clinical stage group as defined by the AJCC.

Clinical Stage Group Codes (in addition to those published in the AJCC Cancer Staging Manual)

Code	Description
88	Not applicable, no code assigned for this case in the current AJCC Staging Manual
99	Unknown, not staged

V.10.1.2 AJCC TNM Pathological

Pathological stage classification describes a point in time in the care of the cancer patient. Pathological stage includes information from the date of diagnosis (including clinical stage), the surgeon's operative findings of disease extension of involvement (even if not microscopically proven), and/or negative clinical findings, and the pathology report from the resected specimen.

The AJCC staging data items listed below are required by CoC-accredited facilities for all cases diagnosed January 1, 2018 and forward.

Data Item Name
AJCC TNM Path T
AJCC TNM Path T Suffix
AJCC TNM Path N
AJCC TNM Path N Suffix
AJCC TNM Path M
AJCC TNM Path Stage Group

Coding Instructions:

- Refer to the most current AJCC Cancer Staging Manual for specific disease site chapters and staging instructions.
- Includes all surgical observations of disease extent even if not microscopically confirmed.
- Is based on combination of all information and not only on resected specimen pathology report. Therefore, the pathologist cannot assign the final stage.
- The following categories must meet the following criteria:
    - **Pathological T category:**
        - **Must** meet the definitive surgical treatment specified in the specific disease site chapter of the AJCC Manual.
    - **Pathological N category:**
        - Microscopic assessment of at least one node is required for pN.
        - Can use all positive nodes to assign pN category.
            - Physician interpretation of positive palpated or imaged regional nodes are included in pN, in addition to those microscopically examined.
        - If lymph node(s) biopsied during clinical workup (cN) and patient has a surgical resection without further lymph node assessment, include the cN node status (pos/neg) in assigning pN.

          Example:

          Axillary lymph node biopsy during clinical workup for breast cancer was **negative** (cN0). At lumpectomy, no further regional lymph nodes were assessed.

- Assign **pN0** in pathological stage (because at least one lymph node was microscopically examined).
- If clinical lymph node biopsy had been **positive** (cN1), it would be coded as a pN1 in pathological stage.

o **Pathological M category:**

- Pathological M is category pM1 if based on biopsy proven involvement/metastasis.
- Pathological M category can be cM1 if based on clinical physical exam and/or imaging shows evidence of metastasis.

  Note: cM1 is only used in the pathological M stage classification if the patient underwent surgical resection meeting AJCC criteria.
- Pathological M category "pM0" is NOT a valid category.

AJCC Pathological T and N Suffix:

- Enter the detailed site-specific codes for the pathological T & N category as defined by AJCC.

pT Suffix Codes:

Code	Description
(m)	Multiple synchronous tumors OR For thyroid differentiated and anaplastic only, Multifocal tumor
(s)	For thyroid differentiated and anaplastic only, Solitary tumor
BLANK	No information available; not recorded

pN Suffix Codes:

Code	Description
(sn)	Sentinel node procedure without resection of nodal basin
(f)	FNA or core needle biopsy without resection of nodal basin
BLANK	No suffix needed or appropriate; not recorded

AJCC Pathological Stage Group:

- Assigned by the managing physician based on data from all relevant sources.
- Stage group is assigned using the T, N, and M categories as well as non-anatomic factors such as prognostic factors and/or Site-Specific Data Items (in some instances).
- Enter the detailed site-specific pathological stage group as defined by the AJCC.

Pathological Stage Group Codes (in addition to those published in the AJCC Cancer Staging Manual)

Code	Description
88	Not applicable, no code assigned for this case in the current AJCC Staging Manual
99	Unknown, not staged

V.10.1.3 AJCC TNM Post-Therapy

Post-therapy stage classification describes a point in time in the care of the cancer patient. Post-therapy stage includes information from the surgical resection of the primary tumor after completion of any neoadjuvant therapy (systemic or radiation therapy).

Note: Information from the clinical diagnostic timeframe is excluded.

The AJCC staging data items listed below are required by CoC-accredited facilities for all cases diagnosed January 1, 2018 and forward.

Data Item Name
AJCC TNM Post -Therapy T
AJCC TNM Post-Therapy T Suffix
AJCC TNM Post-Therapy N
AJCC TNM Post-Therapy N Suffix
AJCC TNM Post-Therapy M
AJCC TNM Post-Therapy Stage Group

Coding Instructions:

- Refer to the most current AJCC Cancer Staging Manual for specific disease site chapters and staging instructions.
- Leave all elements BLANK when post-therapy stage is not applicable.
- Post-therapy stage classifications include:
    - **ycClinical:**
        - Includes physical exam, imaging, or bx assessment after primary neoadjuvant systemic or radiation therapy is completed and before planned 1st course surgical treatment.
        - Note: the ycClinical stage is NOT the same timeframe as the Clinical (diagnostic) Stage timeframe.
    - **ypPathological:**
        - Includes all information from the ycClinical staging (if done), as well as, the surgeon's operative findings, and the pathological findings from the 1st course surgical resection specimen after neoadjuvant therapy.
- Enter the detailed site-specific codes for the postneoadjuvant therapy categories T, N, and M as defined by AJCC.

AJCC Post-Therapy T and N Suffix:

- Enter the detailed site-specific codes for the Post-Therapy T & N category as defined by AJCC.

Post-Therapy T Suffix Codes:

Code	Description

(m)	Multiple synchronous tumors OR For thyroid differentiated and anaplastic only, Multifocal tumor
(s)	For thyroid differentiated and anaplastic only, Solitary tumor
BLANK	No information available; not recorded

Post-therapy N Suffix Codes:

Code	Description
(sn)	Sentinel node procedure without resection of nodal basin
(f)	FNA or core needle biopsy without resection of nodal basin
BLANK	No suffix needed or appropriate; not recorded

AJCC Post-Therapy Stage Group:

- Assigned by the managing physician based on data from all relevant sources.
- Stage group is assigned using the T, N, and M categories as well as non-anatomic factors such as prognostic factors and/or Site-Specific Data (in some instances).
- Enter the detailed site-specific post-therapy stage group as defined by the AJCC.
    - **Assignment of a Post-therapy Stage Group is not applicable to all cancer sites.**
        - Do not assign a post-therapy Stage Group for breast cancers. Assign the T, N and M categories as appropriate, and assign Stage Group as 99.
        - Some AJCC 8th Ed chapters have a specific Post-Therapy Stage group table which CAN be used to assign as stage group. Esophagus is an example.
        - In general, if there is only 1 stage group table within an AJCC Chapter, it is used to calculate the clinical, pathological and post-therapy stage groups, unless there is an exception. Review the appropriate AJCC Chapter for specific directions.

Post-Therapy Stage Group Codes (in addition to those published in the AJCC Cancer Staging Manual)

Code	Description
88	Not applicable, no code assigned for this case in the current AJCC Staging Manual
99	Unknown, not staged

V.10.2 AJCC TNM Edition Number

AJCC TNM Edition Number identifies the Cancer Staging Manual edition used to code the AJCC TNM Stage.

Coding Instructions:

- Record the edition of the AJCC Cancer Staging Manual that was used for TNM staging.
- The TNM Edition field may not be left blank.

Codes:

Code	Description
00	Not staged
01	First edition
02	Second edition
03	Third edition
04	Fourth edition
05	Fifth edition
06	Sixth edition
07	Seventh edition
08	Eighth Edition
88	Not applicable (cases do not have an AJCC staging scheme and staging was not done)
99	Unknown

V.10.3 AJCC - Ambiguous Terms for Disease Extension

AJCC TNM staging does not define ambiguous terminology nor mandate how words should be interpreted.

Guidelines:

How to interpret words for cancer involvement:

- Review clinician's statements
- Treatment choices may indicate clinician's impression
- Review and analyze entire case
    - Physical exam
    - Medical history of all other disease
    - Symptoms
    - Imaging
    - Lab tests
    - Diagnostic procedures
    - All other variable information
- Judgement call based on all aspects of patient's care

Note: For CoC facilities as a reference of last resort with respect to tumor spread for staging purposes, please see STORE - Ambiguous Terms Describing Tumor Spread.

V.11 Extent of Disease (EOD)

Extent of Disease (EOD) 2018 is a data collection system which has three data items: EOD Primary Tumor, EOD Regional Nodes, and EOD Mets. EOD 2018 is required by the CCR to be collected for every site and histology combination for cases diagnosed January 1, 2018 and forward.

Extent of Disease questions should be directed to ask a SEER Registrar at: https://seer.cancer.gov/registrars/contact.html.

Refer to the most current Extent of Disease 2018 General Instructions for coding instructions and SEER*RSA for rules and site-specific codes and coding structures.

V.11.1 EOD General Information

The 2018 Extent of Disease is separate from the previous version. EOD Primary Tumor, EOD Regional Nodes, and EOD Mets are required by the CCR for cases diagnosed January 1, 2018 and forward.

For additional information on historical manual references, refer to Appendix S - Historical Coding and Staging Manual Requirements for CCR.

Guidelines:

- Refer to the most current Extent of Disease 2018 General Instructions for coding instructions and SEER*RSA for rules and site-specific codes and coding structures.
- Three main EOD data items:
    - EOD Primary Tumor
    - EOD Regional Nodes
    - EOD Mets
- **Always** check the site-specific EOD 2018 schemas for exceptions and/or additional information.
- EOD is based on a combined clinical and operative/pathological assessment for ALL sites.
    - Gross observations at surgery are particularly important when all malignant tissue cannot be, or was not removed.
        - In the event of a disagreement between pathology and operative reports regarding excised tissue, priority is given to the pathology report.
- EOD should include all available information within four months of diagnosis in the absence of disease progression or upon completion of surgery(ies) during the first course of treatment, whichever is longer.
- Review clinical information carefully to accurately determine the extent of disease. Clinical information such as description of skin involvement for breast cancer and lymph nodes for any site, can change the EOD Stage.
    - If the operative/pathological information disproves the clinical information, use the operative/pathological information.
- Information for EOD from a surgical resection after neoadjuvant treatment may ONLY be used if the extent of disease is greater than the pre-treatment clinical stage.
- Exclude disease progression, including metastatic involvement, known to have developed after the initial stage workup, when coding EOD fields.
- Autopsy reports are used in coding EOD just as pathology reports. Apply the same rules for inclusion and exclusion.
- Death Certificate only (DCO) cases
    - Code the following for DCO's, unless more specific codes can be assigned
        - EOD Primary Tumor: 999

        - EOD Regional Nodes: 999
        - EOD Mets: 99
- TNM information may be used to code EOD 2018 when it is the only information available.
- When there is a discrepancy between the T, N, M information and the documentation in the medical record.
    - Access the physician to resolve the discrepancy, when possible. Otherwise, use the medical record documentation to assign EOD.
- EOD schema-specific guidelines take precedence over the general guidelines. Always read the information pertaining to the specific primary site or histology schema.

V.11.1.1 EOD - Primary Tumor

EOD Primary Tumor is part of the EOD 2018 data collection system and is used to classify contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. This data item is required by the CCR for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Refer to the most current Extent of Disease 2018 General Instructions for coding instructions and SEER*RSA for rules and site-specific codes and coding structures.
- **Always** check the site-specific EOD 2018 schemas for exceptions and/or additional information.
- Enter the code for farthest documented direct contiguous extension of the primary tumor.
    - If an involved organ or tissue is not specifically mentioned in the code descriptions, approximate the location from listed structures in the same anatomic area and assign the appropriate code based on that information.
- **EOD Primary Tumor codes are hierarchical** except for code 800.
- The "Localized, NOS" code is ONLY to be used after an exhaustive search for more specific information.
- Pathological findings take priority over clinical findings.
    - Assign the highest code representing the greatest extension pathologically.
    - Assign the highest code representing the greatest extension clinically, when there is no pathology.
        - Imaging takes precedence over physical examination.
    - If the extension is positive based on the imaging and/or physical exam, but is confirmed to be negative on the pathological exam, code the EOD Primary Tumor based on the pathological findings.
- **Neoadjuvant therapy -** When a patient receives preoperative systemic therapy (chemotherapy/immunotherapy) or radiation:
    - Code the clinical information if that is the furthest documented extension.
    - **OR** Code the post-neoadjuvant extension if the post-neoadjuvant surgery shows a more extensive disease (i.e., disease was greater than at clinical presentation).
- Use code 000 when:
    - Medical record indicates tumor is in-situ.
        - Exception: For some schemas, e.g., Breast, there may be multiple categories of in-situ codes. Use the schema-specific instructions and codes.
    - In-situ tumors which have nodal or metastatic involvement:
        - In the event of an in-situ tumor with nodal or metastatic involvement, assign EOD Primary tumor as in-situ and code the EOD Regional Nodes

and/or EOD Mets appropriately. **This is a change from previous version of EOD and Summary Stage.**

- **Discontinuous or distant mets:** Discontinuous/distant metastasis are usually coded in the EOD Mets field.
    - Some exceptions include: Mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, where discontinuous mets in the pelvis or abdomen are coded in EOD Primary Tumor.
        - For some schemas, such as breast, lung, and kidney, direct (contiguous) extension to certain specific sites is listed under EOD Mets.
            - If the structure involved by direct extension is NOT listed in the EOD Primary Tumor categories, look for it in the EOD Mets.
            - If the specific structure involved by direct extension is not listed in either data item, assign the highest known contiguous extension code in EOD Primary Tumor.
- Use code 800 when there is no evidence of the primary tumor (occult primary).
- Use code 999:
    - When there is no information on primary tumor extent.
    - By default, for death certificate only (DCO) cases; however, assign the appropriate EOD Primary Tumor code when specific primary tumor extension information is available on a DCO.
- Document choice of EOD Primary Tumor code in text. It is strongly recommended that the assessment of the primary tumor extension be documented, as well as the choice of the EOD Primary Tumor code in a related STAGE text field on the abstract. While primary tumor extension can be found in a variety of places, it is most commonly found in a pathology and/or operative report.

Codes:

Code	Description
000	In-situ, intraepithelial, noninvasive, non-infiltrating
	SCHEMA-SPECIFIC CODES WHERE NEEDED
800	No evidence of primary tumor
999	Unknown; extension not stated Primary tumor cannot be assessed Not documented in patient record Death Certificate

V.11.1.2 EOD - Regional Nodes

EOD Regional Nodes is part of the EOD 2018 data collection system and is used to classify the regional lymph nodes involved at the time of diagnosis. This data item is required by the CCR for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Refer to the most current Extent of Disease 2018 General Instructions for coding instructions and SEER*RSA for rules and site-specific codes and coding structures.
- **Always** check the site-specific EOD 2018 schemas for exceptions and/or additional information.
- Regional lymph nodes are listed for each schema.
- Enter the code for the specific involved regional lymph node chain(s) farthest from the primary site.
- **EOD Regional Nodes are hierarchical** except for code 800.
    - Usually, regional lymph nodes in the chain(s) closest to the primary site typically have lower codes, while nodes further away from the primary or in a further lymph node chain have higher codes. Although, there are some exceptions due to lymph node drainage patterns.
    - If a lymph node chain is not listed, check:
        - SEER*RSA – Abstractor Nodes
        - Hematopoietic Manual, Appendix C
        - An anatomy textbook
        - ICD-O-3
        - Medical Dictionary
    - If the named lymph node chain or its synonym cannot be found in the above resources and are not listed in regional nodes, code involved node(s) in EOD Mets.

      Coding tip for lymph nodes: If it is not possible to determine if a lymph node is regional or distant, check the scheme for a site that is nearby.

      Example:

      If site is esophagus and you are unable to determine if a listed regional node is regional or distant, check the stomach EOD regional nodes. If the lymph node chain is listed as regional for stomach, assume the named lymph node is not an obscure name for a lymph node chain and that it is probably distant for the esophagus.

- **Pathological findings take priority over clinical findings.**
    - Assign the highest applicable code for lymph node involvement at diagnosis, whether determination was clinical or pathological.
    - If there is a discrepancy between clinical and pathologic information about the same lymph nodes, pathologic information takes precedence (provided no preoperative treatment was administered).

Note: Biopsy of every suspicious lymph node is not necessary to disprove involvement.

- Assign the code representing lymph node involvement at diagnosis pathologically.
- Assign the code representing lymph node involvement at diagnosis clinically, when there is no pathology.
- If the lymph nodes are positive based on the imaging, but are confirmed to be negative on the pathological exam, code the EOD Regional Nodes based on the pathological findings.

  - **Exception:** Assign code 800 ONLY when there is lymph node involvement but no available information regarding the specific nodal chain involved.

- **Solid Tumors – Terms indicating lymph node involvement** (when no specific information as to tissue involved) are recorded as lymph node involvement:
  - Fixed
  - Matted
  - Mass in the hilum, mediastinum, retroperitoneum, and/or mesentery
  - The following terms should be ignored for solid tumors unless there is a statement of involvement by the clinician or the patient was treated as though regional lymph nodes were involved.
    - Palpable
    - Enlarged
    - Visible swelling
    - Shotty
    - Lymphadenopathy
  - "Ipsilateral", "homolateral", and "same side: are used interchangeably.
- **Accessible lymph nodes** – Lymph nodes that can be observed, palpated, or examined without instruments such as the regional lymph nodes for breast, oral cavity, salivary gland, skin, thyroid and other organs are considered accessible lymph nodes.
  - Look for the description of the accessible lymph nodes.
  - Code 000 (Negative Regional lymph nodes) when:
    - A statement such as "remainder of examination negative" is made.
    - Clinical evaluation IS mentioned but no mention of positive nodes.
- **Inaccessible lymph nodes** – Lymph nodes within body cavities that in most situations are NOT easily examined by clinical methods such as observation, palpation and physical exam are considered inaccessible. Examples are bladder, colon, corpus uteri, esophagus, kidney, liver, lung, ovary, prostate, and stomach (not an all-inclusive list).
- Code 000 over 999 when **ALL** the following conditions are met:

- No mention of regional nodes involved in the physical exam, the pre-treatment diagnostic testing, or the surgical exploration.
- The patient has localized disease.
- Patient receives (or is offered but refused) standard treatment to the primary site as determined appropriate to the stage of disease by the physician.

- Use code 000 when:
  - Medical record indicates tumor is in-situ.
  - In-situ tumors which have nodal metastatic involvement:
    - In the event of an in-situ tumor with metastatic nodal involvement, assign EOD Primary tumor as in-situ and code the EOD Regional Nodes appropriately positive.
- Direct extension of tumor into regional lymph node is coded as an involved node(s) in EOD Regional Nodes.
- Code as positive regional nodes, when involved nodes are found during sentinel lymph node procedures.
  - The sentinel lymph nodes are the first to receive lymphatic drainage from the primary tumor.
  - If the sentinel lymph node contains metastatic tumor, this indicates other lymph nodes may contain tumor. If it does not contain metastatic tumor, the other lymph nodes are not likely to contain tumor.
- **Isolated Tumor Cells (ITCs)** – ITCs are counted as positive regional nodes (for some schemas). Other schemas count them as negative. See individual schemas to determine how to code ITCs.
- Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid, and rectum: These can occur WITH or WITHOUT regional lymph node involvement.
  - Enter the code according to guidelines in the individual schemas.
  - Tumor nodules in pericolic or perirectal fat without evidence of residual lymph node structures can have one of several aspects of the primary cancer: discontinuous spread, venous invasion with extravascular spread, or a totally replaced lymph node.
  - When there are Tumor Deposits **and** lymph node involvement:
    - Code only the lymph node involvement in EOD Regional Nodes.
    - Code the presence of Tumor Deposits in the SSDI item, Tumor Deposits.
- Use code 800 in the following situations:
  - Lymph node assignment for the EOD schema is based on location (specifically listed lymph nodes) and the only documentation available is that lymph nodes are involved.
  - Lymph node assignment for the EOD schema is based on number and/or size and the only documentation available is that lymph nodes are involved.
  - Stated as “Regional lymph nodes involved”, with no further information on location, number and size.

    - Undefined nodes included with the resected primary site.
        - Nodes may be identified in the operative/pathology report (including the final diagnosis), microscopic or gross description.
    - Lymph nodes that are not specified as regional or distant (LN chain/name and location unknown) should be assumed to be regional nodes.
- Code 888 for the following schemas:
    - Brain
    - CNS Other
    - HemeRetic
    - Ill-Defined Other (includes unknown primary site)
    - Intracranial Gland
    - Lymphoma
        - Primary Cutaneous and Ocular Adnexal Lymphomas have separate schemas from Lymphoma. **Code 888 is invalid for these schemas.** Code the EOD Regional nodes appropriately per medical record findings.
- Use 999 when the medical record:
    - Has no information on regional lymph node involvement and the primary tumor is NOT localized.
    - By default, for death certificate only (DCO) cases; however, assign the appropriate EOD Regional Nodes code when specific regional lymph node involvement information is available on a DCO.
- Document choice of EOD Regional Nodes code in text. It is strongly recommended that the assessment of regional nodes be documented, as well as the choice of the EOD Regional Nodes code in a related STAGE text field on the abstract. While regional node status can be found in a variety of places, it is most commonly found in physical exam, scans, and pathology reports.

Codes:

Code	Description
000	No regional lymph node involvement
	SCHEMA-SPECIFIC CODES WHERE NEEDED
800	Regional lymph node(s), NOS
888	Use for these sites only: Brain; CNS Other; HemeRetic; Ill-Defined Other (includes unknown primary site); Intracranial Gland; Lymphoma; Lymphoma-CLL/SLL, Plasma Cell Myeloma
999	Unknown; regional lymph node(s) not stated Regional lymph node(s) cannot be assessed Not documented in patient record Death Certificate

V.11.1.3 EOD - Mets

EOD Mets is part of the EOD 2018 data collection system and is used to classify the distant site(s) of metastatic involvement at the time of diagnosis. This data item is required by the CCR for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Refer to the most current Extent of Disease 2018 General Instructions for coding instructions and SEER*RSA for rules and site-specific codes and coding structures.
- **Always** check the site-specific EOD 2018 schemas for exceptions and/or additional information.
- Determination of EOD Mets requires ONLY history and physical examination.
- Imaging of distant organs is not required. The registrar can infer solely from the PE, that there is no distant metastasis when there is a lack of extensive workup.
- Use code 00 when:
    - There is no distant metastasis as determined by clinical, radiographic and/or pathological methods.
    - No physical exam, imaging or pathology information is available.
    - There is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastasis.
- Enter the appropriate EOD Mets codes for cases with one or more distant metastasis identified clinically, radiographically, and/or pathologically.
- **EOD Mets are hierarchical** except for code 70.
- The EOD Mets category may include direct extension of the primary tumor into distant organs or tissues for a few schemas, such as Breast, Lung, Kidney, and Ovary.
    - If the structure involved by direct extension is NOT listed in the EOD Primary Tumor categories, look for it in the EOD Mets.
    - If the specific structure involved by contiguous mets is not listed in either data item, assign the highest available code in EOD Primary Tumor.
- **Discontinuous or hematogenous metastasis:** Tumor metastasis known at the time of diagnosis to have indirectly spread (through vascular or lymph channels) to distant nodes or site(s) from the primary site, are coded in the EOD Mets field. Refer to individual schemas for detailed instructions.
- Positive pathological findings **take priority over** clinical findings.
    - Assign the highest code for metastasis at diagnosis pathologically.
    - Assign the highest code for metastasis at diagnosis clinically, with imaging taking priority, when there is no pathology, or the pathology report does not show metastasis.
- Not all possible metastatic sites are listed in each of the schemas. If there is confirmed metastasis that is not listed, assign the highest code as described below:

    - Code 70 is used for all mets (except distant lymph nodes only), for schemas that have only codes 10 (distant lymph nodes) and 70 (all other mets.
    - For schemas where there are additional codes:
        - Use the highest code before code 70, when mets are present that are not specified in any of the other codes.
        - Code 70 in these cases should only be used when the only information is "distant metastasis, NOS," and there is no documentation regarding the specific metastases.
- **Neoadjuvant therapy -** When a patient receives preoperative systemic therapy (chemotherapy/immunotherapy) or radiation:
    - Code the clinical information description that identifies the most extensive metastasis.
    - **OR** if the post-neoadjuvant surgery reveals additional or more extensive disease, code EOD Mets based on the post-neoadjuvant information.
- **Isolated Tumor Cells (ITCs), Circulating Tumor Cells (CTCs), and Disseminated Tumor Cells (DTCs)** – Are small clusters of cells not greater than 0.2 mm in largest dimension found in distant sites such as bone, circulating blood, or bone marrow and have uncertain prognostic significance.
    - **Breast** – Code 5 when a biopsy of distant nodes shows ITCs, CTCs or DTCs detected by IHC or molecular techniques.
    - **Other sites** – ITCs, CTCs or DTCs are coded to 00.
- **In-situ tumors with metastatic involvement:**
        - In the event of an in-situ tumor with metastatic involvement, assign EOD Primary tumor as in-situ and code the EOD Mets as positive.
- Code 88 for the following schemas:
    - HemeRetic
    - Ill-Defined Other (includes unknown primary site)
    - Kaposi Sarcoma
    - Lymphoma
        - Primary Cutaneous and Ocular Adnexal Lymphomas have separate schemas from Lymphoma. **EOD Mets code 88 is invalid for these sites.** Code EOD Mets appropriately per medical record findings.
        - Lymphoma-CLL/SLL
    - Plasma Cell Myeloma
    - Plasmacytosis
- Use 99 ONLY for death certificate only (DCO) cases; however, assign the appropriate EOD Mets code when specific metastatic information is available on a DCO.
    - Code 00 when it is unknown if there are distant metastasis.
- Document choice of EOD Mets code in text. It is strongly recommended that the assessment of distant lymph nodes and/or distant metastasis be documented, as well

as the choice of the EOD Mets code in a related STAGE text field on the abstract. While information on met status can be found in a variety of places, it is most commonly found in physical exam and scans.

Codes:

Code	Description
00	No distant metastasis Unknown if distant metastasis None
	SCHEMA-SPECIFIC CODES WHERE NEEDED
70	Distant Metastasis, NOS
88	Use for these sites only: HemeRetic; Ill-Defined Other (includes unknown primary site); Kaposi Sarcoma; Lymphoma; Lymphoma-CLL/SLL, Plasma Cell Myeloma; Plasmacytomas
99	Death Certificate Only (DCO)

V.11.2 EOD - Prostate Pathological Extension

This data item is used in EOD staging and was previously collected as Prostate, CS SSF#3. The Pathological extension is used to assign pT category for prostate cancer based on the radical prostatectomy specimens. This data items is required by the CCR for cases diagnosed January 1, 2018 and forward.

Guidelines:

- Refer to the Schema specific Summary Stage 2018 and EOD codes/coding instructions and SEER*RSA for rules and site-specific codes and coding structures for coding instructions on this data item.
    - **Always** check the site-specific EOD 2018 schemas for exceptions and/or additional information.
- Only use histologic information from prostatectomy, including simple prostatectomy with negative margins, and autopsy in this field.
    - Information from biopsy of extraprostatic sites are coded in EOD - Primary Tumor.
- Use code 900 when there is not prostatectomy performed within the first course of treatment.
- Limit information in this field to first course of treatment in the absence of disease progression.
- If prostate cancer is an incidental finding during a prostatectomy for other reasons (such as, cystoprostatectomy for bladder cancer), use the appropriate code for the extent of disease found.
- Involvement of the prostatic urethra does not alter the extension code.
- The clinical term which means tumor extends to pelvic sidewall(s) is “Frozen Pelvis.”
    - Use code 700 in the absence of a more detailed statement of involvement.

Codes:

Code	Description
000	In situ: noninvasive; intraepithelial
250	Invasion into (but not beyond) prostatic capsule Intracapsular involvement only No extracapsular extension
300	Confined to prostate, NOS Localized, NOS
350	Bladder neck, microscopic invasion Extraprostatic extension (beyond prostatic capsule), unilateral, bilateral, or NOS WITHOUT invasion of the seminal vesicles

	Extension to periprostatic tissue WITHOUT invasion of the seminal vesicles
400	Tumor invades seminal vesicle(s)
500	Extraprostatic tumor that is not fixed WITHOUT invasion of adjacent structures Periprostatic extension, NOS (unknown if seminal vesicle(s) involved) Extraprostatic extension, NOS (unknown if seminal vesicle(s) involved) Through capsule, NOS
600	Bladder neck, except microscopic bladder neck involvement Bladder, NOS External sphincter Extraprostatic urethra (membranous urethra) Fixation, NOS Levator muscles Rectovesical (Denonvillier's) fascia Rectum Skeletal muscle Ureter(s)
700	Extension to or fixation to pelvic wall or pelvic bone "Frozen pelvis", NOS Further contiguous extension including • Bone • Other organs • Penis • Sigmoid colon • Soft tissue other than periprostatic
800	No evidence of primary tumor
900	No prostatectomy or autopsy performed
950	Prostatectomy performed, but not first course of treatment for example performed after disease progression
999	Unknown; extension not stated Unknown if prostatectomy done Primary tumor cannot be assessed Not documented in patient record

V.11.3 EOD - Ambiguous Terms for Extent of Disease

Registrars will find definitive statements of involvement, most of the time; however, for those situations where involvement is described with non-definitive (ambiguous) terminology, use the guidelines below to interpret and determine the appropriate assignment of EOD 2018.

Guidelines:

- Refer to the most current Extent of Disease 2018 General Instructions for coding instructions and SEER*RSA for rules and site-specific codes and coding structures.
- **Always** check the site-specific EOD 2018 schemas for exceptions and/or additional information.
- Determination of the cancer stage is both a subjective and objective assessment by the physician(s) of how far the cancer has spread.
    - Look at the documentation that the physician used to make informed decisions on how the patient is being treated when it is not possible to determine the extent of involvement because terminology is ambiguous.

      Example: Assign EOD fields based on involvement when the patient was treated as though adjacent organs or nodes were involved.
- Use the following lists to interpret the intent of the clinician **ONLY** when further documentation is not available and/or there is no specific statement of involvement in the medical record.
    - The physician's definitions/descriptions and choice of therapy **have priority over these lists** because individual clinicians may use these terms differently.
- **Terminology in the chapter takes priority over this list:**
    - Some chapters interpret certain words as involvement; such as 'encasing' the carotid artery for a head and neck site or "abutment," "encases," or "encasement" for pancreas primaries.
- **Use the following list only for EOD 2018 or Summary Stage 2018.**
    - This is ***not*** the same list used for determining reportability as published in the SEER Program Manual, Hematopoietic Manual or in Section 1 of the STandards for Oncology Registry Entry (STORE) Manual.
    - This is ***not*** the same list of ambiguous terminology provided in the 2018 Solid Tumors Rules published and maintained by the SEER Program.
    - **Use the following lists as a guide *ONLY when no other information is available.***

INVOLVED	
Adherent	Incipient invasion

Apparent(ly)	Induration
Appears to	Infringe/infringing
Comparable with	Into*
Compatible with	Intrude
Consistent with	Most likely
Contiguous/continuous with	Onto*
Encroaching upon*	Overstep
Extension to, into, onto, out onto	Presumed
Features of	Probable
Fixation to a structure other than primary**	Protruding into (unless encapsulated)
Fixed to another structure**	Suspected
Impending perforation of	Suspicious
Impinging upon	To*
Impose/imposing on	Up to
NOT- INVOLVED	
Abuts	Extension to without invasion/involvement
Approaching	Kiss/kissing
Approximates	Matted (except for lymph nodes)
Attached	Possible
Cannot be excluded/ruled out	Questionable
Efface/effacing/effacement	Reaching
Encased/encasing	Rule out
Encompass(ed)	Suggests
Entrapped	Very Close to
Equivocal	Worrisome

* interpret as involvement whether the description is clinical or operative/pathological

** interpret as involvement of other organ or tissue

V.12 Site-Specific Data Items (SSDIs)

A Site-Specific Data Items (SSDIs) are based on primary site, AJCC chapter, the EOD schema, or the Summary Stage schema. SSDIs have their own data item name and number and can be collected for as many sites, chapters, and/or schemas as needed. **Each Site-Specific Data Item (SSDI) applies only to selected site-specific schemas.**

Site-Specific Data Item SSDI questions should be directed to CAnswer Forum at: http://cancerbulletin.facs.org/forums.

Refer to the most current Site-Specific Data Item (SSDI) Manual for coding instructions and the SSDI Schema List for site-specific codes and coding structures.

V.12.1 SSDI General Information

The Site-Specific Data Items are separate from the pre-2018 Collaborative Stage items. **Each Site-Specific Data Item (SSDI) applies only to selected site-specific schemas.** SSDIs are to be used for cases diagnosed January 1, 2018 and forward.

Resources:

- Please see, Appendix Q – Site Specific Data Items (SSDIs) for CCR requirements.
- Refer to the most current Site-Specific Data Item (SSDI) Manual for coding instructions and the SSDI Schema List for site-specific codes and coding structures.
- For additional information on historical manual references, refer to Appendix S - Historical Coding and Staging Manual Requirements for CCR.

Guidelines:

- SSDIs are to be collected during the initial diagnosis, workup and first course treatment.
- Code SSDIs based on date of diagnosis, not the date the case was abstracted.
- SSDI fields should be blank for schemas where they do not apply.
- Schema ID is derived based on coded values for primary site, histology, and schema discriminator when needed.
- The association between site/histologies and SSDIs are based on:
    - Schema discriminators when needed to determine the correct SSDIs, AJCC chapter, EOD schema, or Summary Stage schema.
        - See, Appendix Q – Index to Site-Specific Data Items (SSDIs) for the CCR requirement for Schema Discriminators 1-3.
    - Data items required to assign stage.
    - Data items currently required by at least one standard setter and listed as registry collection data items in at least one AJCC 8th edition chapter.
    - Certain data items are required by standard setters and not necessarily stage related.
- SSDIs follow the standard definitions of rounding.
    - All SSDIs that have lab values, percentages or measurements are set up to record in the 10ths (one digit after the decimal point).
    - If a lab value, percentage or measurement is recorded in 100ths (two digits after the decimal point), then the last digit must be rounded.
    - The general rounding rules are:
        - If digit is 0-4, round down
        - If digit is 5-9, round up
        - Currently, the only SSDIs that have exceptions to the general rounding rules are:

        - HER2 ISH Single Probe Copy Number
        - HER2 ISH Dual Probe Copy Number
        - HER2 ISH Dual Probe Ratio
- Unless instructions for a specific laboratory test state otherwise, record only test results obtained.
    - Before any cancer-directed treatment is given (neoadjuvant therapy or surgical), AND
    - No earlier than approximately three months before diagnosis AND
    - If multiple lab tests are available, record the highest value
- SSDI format:
    - The character length for each SSDI code is dependent on the highest value recommended by AJCC 8th Edition.
    - SSDI data items for lab values and percentages may include the decimal point in the code.
    - "Not applicable" and "unknown" codes differ based on length of the specific data item.
        - Not applicable codes ALWAYS end in "8"
        - Unknown codes ALWAYS end in "9"

  Note: It is important to reference the SSDI Manual when completing the SSDI data items. Do not rely on registry software coding notes alone. Additional guidelines as well as updated notes and clarifications will only be available in the online manual.

V.13 SEER Site-Specific Factor 1

SEER Site-Specific Factor 1 is reserved for capturing information on human papilloma virus (HPV) status. There is evidence that HPV plays a role in pathogenesis of some cancers. HPV testing may be performed for prognostic purposes; testing may be performed on metastatic sites to aid in determination of the primary site. This data item is required by the CCR for cases diagnosed January 1, 2018 and forward.

NOTE: For information on coding Site-Specific Data Items, see Site-Specific Data Items (SSDIs) and Appendix Q: Index to Site-Specific Data Items (SSDIs).

This data item **only** applies to the schemas:

- **Oropharynx (p16+):** C019, C024, C051-C052, C090-C091, C098-C099, C100, C102-C103, C108-C109, C111
- **Oropharynx (p16-) and Hypopharynx:** C019, C024, C051-C052, C090-C091, C098-C099, C100, C102-C103, C108-C109, C111, C129, C130-C132, C138-C139
- **Lip and Oral Cavity:** C000-C009, C020-C023, C028-C029, C-C031, C039, C040-C041, C048-C049, C050, C058-C059, C060-C062, C068-C069

Coding Instructions:

- Codes 0-7 are hierarchical
  - Use the highest code that applies (0 is highest, 7 is lowest)
- **This data item is only for HPV** status determined by tests designed to detect viral DNA or RNA. Tests based on ISH, PCR, RT-PCR technologies detect the viral DNA or RNA.
- **Do not record the results of IHC p16 expression in this field.**
  - There are several methods for determination of HPV status. The most frequently used test is IHC for p16 expression which is a surrogate marker for HPV infection and is **not** to be recorded in this field.
  - HPV-type 16 refers to **virus type** and is different from p16 overexpression (p16+).
- Record the results of HPV testing performed on pathologic specimens including surgical and cytological (from cell blocks) tissue from the primary tumor or a metastatic site, including lymph nodes.
- Do not record the results of blood tests or serology.
- Leave blank when no applicable test is performed.

Codes:

Code	Description
0	HPV negative for viral DNA by ISH test
1	HPV positive for viral DNA by ISH test

2	HPV negative for viral DNA by PC test
3	HPV positive for viral DNA by PCR test
4	HPV negative by ISH E6/E7 RNA test
5	HPV positive by ISH E6/E7 RNA test
6	HPV negative by RT-PCR E6/E7 RNA test
7	HPV positive by RT-PCR E6/E7 RNA test
8	HPV status reported in medical records as positive or negative but test type is unknown
9	Unknown if HPV test detecting viral DN and or RNA was performed

V.14 STandards for Oncology Registry Entry (STORE)

The American College of Surgeons Cancer (ACS), Commission on Cancer (CoC) released the STandards for Oncology Registry Entry (STORE) in August 2018. The STORE Manual is required for CoC Accredited facilities for cases diagnosed January 1, 2018 and forward.

V.14.1 STORE General Information

The American College of Surgeons Cancer (ACS), Commission on Cancer (CoC) released the STandards for Oncology Registry Entry (STORE) in August 2018. The STORE Manual is required for CoC Accredited facilities for cases diagnosed January 1, 2018 and forward. If non-CoC facilities are collecting data items outlined in the STORE Manual as available, then the STORE Manual should be referenced for coding instructions, particularly in the event coding clarification is not included in Volume I for those data items.

For additional information on historical manual references, to Appendix S - Historical Coding and Staging Manual Requirements for CCR.

Guidelines:

- Refer to the most current STandards for Oncology Registry Entry (STORE) Manual for coding instructions.
- STORE Manual questions should be directed to the CAnswer Forum at: http://cancerbulletin.facs.org/forums.

V.14.2 STORE - Ambiguous Terms Describing Tumor Spread

The purpose of the Ambiguous Terminology list for tumor spread is to help registrars make consistent decisions when wording in the patient record is ambiguous with respect to tumor spread and there is no further information is available from any source.

Guidelines:

- **The first and foremost resource for the registrar for questionable cases is the physician who staged the tumor.** The ideal way to approach abstracting situations when the medical record is not clear is to follow up with the physician.
- When the record is not clear, and the physician is unavailable:
  - Review the medical record closely for the required information.
  - Only use the Ambiguous Terms Describing Tumor Spread list when **NO** other information is available from any resource.
    - If tumor spread can be determined from the resources available, DO NOT use the Ambiguous Terms Describing Tumor Spread list.
  - If the wording in the patient record is ambiguous with respect to tumor spread for stating purposes, **use the following table as a reference of last resort**:

Ambiguous Terms Describing Tumor Spread		
Terms that Constitute Tumor Involvement or Extension		**Terms that *DO NOT* Constitute 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	

V.15 Summary Stage 2018 (SS2018)

Summary Stage is the most basic way of classifying how far a cancer has spread from its point of origin. Summary Stage 2018 is collected for every site and histology combination and is required by the CCR for cases diagnosed January 1, 2018 and forward.

Summary Stage 2018 questions should be directed to ask a SEER Registrar at: https://seer.cancer.gov/registrars/contact.html.

Refer to the most current Summary Stage 2018 Manual for general coding instructions, site-specific coding instructions, and the Complete Summary Stage 2018 manual.

V.15.1 SS2018 General Information

Summary Stage 2018 uses all available information in the medical record; a combination of the most precise clinical and pathological information of the extent of disease. SS2018 is required by the CCR for cases diagnosed January 1, 2018 and forward.

For additional information on historical manual references, refer to Appendix S - Historical Coding and Staging Manual Requirements for CCR.

Guidelines:

- Refer to the most current Summary Stage 2018 Manual for general coding instructions, site-specific coding instructions, and the Complete Summary Stage 2018 manual.
- Six main categories in Summary Stage 2018:

Code	Description
0	In-situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND lymph node involvement
7	Distant site(s)/node(s) involved
8	Benign/borderline*
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death certificate only case

*Applicable for the following SS2018 chapters: Brain, CNS Other, Intracranial Gland.

- Summary Stage chapters apply to ALL Primary sites and histologies.
- Chapter-specific guidelines take precedence over general guidelines.
    - **Always** check the information pertaining to a specific primary site or histology chapter.
- For ALL primary sites and histologies, Summary Stage is based on a combined clinical and operative/pathological assessment.
    - Gross observations at surgery are particularly important when all malignant tissue cannot be, or was not removed.
        - In the event of a disagreement between pathology and operative reports regarding excised tissue, priority is given to the pathology report.
- Summary Stage should include all available information within four months of diagnosis in the absence of disease progression or upon completion of surgery(ies) during the first course of treatment, whichever is longer.
- Review clinical information carefully to accurately determine the extent of disease. Clinical information such as description of skin involvement for breast cancer and lymph nodes for any site, can change the Summary Stage.

    - If the operative/pathological information disproves the clinical information, use the operative/pathological information.
- Assign the greatest Summary Stage from any tumor when multiple tumors are reported as a single primary.
- Information for Summary Stage from a surgical resection after neoadjuvant treatment may ONLY be used if the extent of disease is greater than the pre-treatment clinical stage.
- Exclude disease progression, including metastatic involvement, known to have developed after the initial stage workup, when coding Summary Stage fields.
- Autopsy reports are used in coding Summary Stage just as pathology reports. Apply the same rules for inclusion and exclusion.
- TNM information may be used to code Summary Stage when it is the only information available.
- If there is a discrepancy between the T, N, M information and the documentation in the medical record.
    - Access the physician to resolve the discrepancy, when possible. Otherwise, use the medical record documentation to assign Summary Stage.
- Document choice of Summary Stage assignment in text. It is strongly recommended that the assessment of Summary Stage be documented, as well as the choice of the Summary Stage code in a related STAGE text field on the abstract.
- Death Certificate only (DCO) cases and unknown primaries are coded to “9” for Summary Stage cases; however, assign the appropriate Summary Stage code when specific staging information IS available on a DCO.

V.15.1.1 SS2018 - In-situ (Code 0)

In-situ is the presence of malignant cells within the cell group from which they arose. There is no penetration of the basement membrane of the tissue and no stromal invasion. Generally, a cancer begins in the rapidly dividing cells of the epithelium or lining of an organ and grows from the inside to the outside of the organ. An In-situ cancer fulfills all pathological criteria for malignancy except that it has not invaded the supporting structure of the organ or tissue in which it arose.

Coding Instructions:

- Refer to the most current Summary Stage 2018 Manual for general coding instructions, and site-specific coding instructions.
- Chapter-specific guidelines take precedence over general guidelines.
    - **Always** check the information pertaining to a specific primary site or histology chapter.
- In-Situ diagnosis can only be diagnosed microscopically.
    - If the pathology report indicates an in-situ tumor but there is evidence of positive lymph nodes or distant metastases, code to the regional nodes/distant metastases.
- Organs and tissues that have no epithelial layer cannot be staged as in situ, since they do not have a basement membrane.
- Descriptions pathologists use to describe in-situ cancer:
    - Intracystic
    - Intra-epithelial
    - No penetration below the basement membrane
    - No stromal invasion
    - Non-infiltrating
    - Noninvasive
    - Pre-invasive
- Code 0 is NOT applicable for the following Summary Stage chapters:
    - Bone
    - Brain
    - Cervical Lymph Nodes, Occult Head and Neck
    - CNS Other
    - Corpus Sarcoma
    - Heart, Mediastinum and Pleura
    - HemeRetic
    - Ill-defined other
    - Kaposi Sarcoma

- Lymphoma
- Lymphoma Ocular Adnexa
- Mycosis Fungoides
- Myeloma Plasma Cell Disorder
- Pleural Mesothelioma
- Primary Cutaneous Lymphoma (non-MF and SS)
- Retinoblastoma
- Retroperitoneum
- Soft Tissue

V.15.1.2 SS2018 - Localized (Code 1)

A localized cancer is defined as a malignancy limited to the site of origin, that has not spread farther than the site of origin in which it started. It has infiltrated basement membrane of the epithelium into parenchyma (the functional part of the organ), but there is no spread beyond the boundaries of the organ.

Coding Instructions:

- Refer to the most current Summary Stage 2018 Manual for general coding instructions, site-specific coding instructions, and the Complete Summary Stage 2018 manual.
- Chapter-specific guidelines take precedence over general guidelines.
    - **Always** check the information pertaining to a specific primary site or histology chapter.
- It is typically straightforward to determine if the cancer is localized when:
    - Organs have definite boundaries (such as prostate, testis, or stomach).
    - Sites have a clear line between the organ of origin and the surrounding region (such as breast or bladder).

      Exception: Skin, because it is sometimes difficult to determine where the dermis ends, and subcutaneous tissue begins.
    - It is possible for imaging to determine if the cancer is localized or regional without surgery. However, for many internal organs, it is difficult to determine whether the tumor is localized without surgery.
- It is imperative to know and recognize the names of different structures within the organ (such as lamina propria, myometrium, and muscularis) so invasion or involvement of these structures is interpreted correctly. Misinterpretation can lead to over or under staging.
- Summary Stage uses both clinical and pathological information:
    - Review and read the pathology and operative report(s) for comments on gross evidence of spread, microscopic extension and metastases, as well as physical exam and diagnostic imaging reports for mention of regional or distant disease.
        - The case is not localized if any of these reports provide evidence that the cancer has spread beyond the boundaries of the organ of origin.
        - The case is assumed to be localized if the pathology report, operative report and other investigations show no evidence of spread.
- Code 1 is NOT applicable for the following Summary Stage chapters:
    - Cervical Lymph Nodes and Unknown Primary
    - Ill-defined other

V.15.1.3 SS2018 - Regional (Codes 2-4)

Regional stage can be described as direct extension only, regional lymph node(s) involvement only, or regional by both direct extension and regional lymph node(s) involvement. . There are several codes to describe the different methods of regional tumor spread.

Coding Instructions:

- Refer to the most current Summary Stage 2018 Manual for general coding instructions, site-specific coding instructions, and the Complete Summary Stage 2018 manual.
- Chapter-specific guidelines take precedence over general guidelines.
    - **Always** check the information pertaining to a specific primary site or histology chapter.
- It is important to understand the words used to describe the spread of the cancer and how they are used in staging because clinicians may use some terms differently than cancer registrars.

  Examples:

    - "Local" as in "carcinoma of the stomach with involvement of the local lymph nodes." Local nodes are the first group of nodes to drain the primary site and often are referred to as "regional" nodes. Unless evidence of distant or regional spread is present, such a case should be staged as regional lymph node(s) involved only, assign 3.
    - "Metastases" as in "carcinoma of lung with peribronchial lymph node metastases." Metastases in this sense means involvement by tumor. The name of the involved lymph node will determine whether it is a regional node or distant node. In this case, it would be a regional node. It is important to learn the names of regional nodes for each primary site.

V.15.1.3.1 SS2018 - Regional by Direct Extension Only (Code 2)

Regional by direct extension means there is direct tumor extension beyond the limits of the site of origin. Regional stage by direct extension is perhaps the broadest category as well as the most difficult to properly identify. Although the boundary between localized and regional tumor extension is usually well identified, the boundary between regional and distant spread is not always clear and can be defined differently by physicians in various specialties.

Coding Instructions:

- Refer to the most current Summary Stage 2018 Manual for general coding instructions, site-specific coding instructions, and the Complete Summary Stage 2018 manual.
- Chapter-specific guidelines take precedence over general guidelines.
    - **Always** check the information pertaining to a specific primary site or histology chapter.
- Once there is potential for cancer spread by more than one vascular supply route, cancer becomes regional by direct extension. For example, if the tumor goes outside of the wall and invades another organ, it regional by direct extension.
- Definitions of “regional” differ among specialists:
    - Surgeons define regional as:
        - The area extending from the periphery of an involved organ that lends itself to removal en bloc with a portion of, or an entire organ with outer limits to include at least the first level nodal basin. However, en bloc resection (removal of multiple organs or tissues in one piece at the same time) is not always feasible or may have been shown not to be necessary.

          Example:

          Many clinical trials have shown that lumpectomy or modified radical mastectomy has equivalent survival to the very disfiguring radical mastectomy for treatment of breast cancer.
    - Radiation Oncologists define regional as:
        - Including any organs or tissues encompassed in the radiation field used to treat the primary site and regional lymph nodes.
- Regional by direct extension in:
    - Primary sites which have “walls”, such as the colon or rectum, means there is invasion or extension through the entire wall of the primary organ into surrounding organs and/or adjacent tissue, direct extension or contiguous spread.
    - Primary sites without defined walls, means the tumor has spread beyond the primary site or capsule into adjacent structures.
- Code 2 is NOT to be used when there is both direct extension and regional nodes positive (see code 4).

- Code 2 is not applicable for the following Summary Stage chapters:
    - Cervical Lymph Nodes and Unknown Primary
    - HemeRetic
    - Ill-defined other
    - Myeloma Plasma Cell Disorder

V.15.1.3.2 SS2018 - Regional Lymph Nodes Only (Code 3)

Regional lymph nodes only include nodes that are regional to the primary site. Please see the specific chapter/site in the Summary Stage 2018 Manual for site-specific regional lymph nodes.

Coding Instructions:

- Refer to the most current Summary Stage 2018 Manual for general coding instructions, site-specific coding instructions, and the Complete Summary Stage 2018 manual.
- Chapter-specific guidelines take precedence over general guidelines.
    - **Always** check the information pertaining to a specific primary site or histology chapter.
        - Regional lymph nodes are listed for each chapter/site.
        - Use the following resources to help identify regional lymph nodes when a lymph node chain is not listed in code 3:
            - Appendix I
            - Anatomy textbook
            - ICD-O manual
            - Medical dictionary (synonym)
- If preoperative treatment was **NOT** administered and there is a discrepancy between clinical and pathological information about the same lymph nodes, pathological information takes precedence.
    - It is not necessary to biopsy every lymph node in the suspicious area to disprove involvement. Use the following priority order:
        - Pathology report
        - Imaging
            - If nodes are determined positive based on imaging and then confirmed to be negative on pathological exam, treat the regional nodes as negative when assigning Summary Stage.
        - Physical exam
            - If nodes are determined positive based on physical exam and then confirmed to be negative on pathological exam, treat the regional nodes as negative when assigning Summary Stage.
- **Neoadjuvant (preoperative) treatment** as in systemic therapy (chemotherapy, immunotherapy) or radiation therapy:
    - Code the clinical information if that is the most extensive lymph node involvement documented.
    - Code the regional nodes based on the post-neoadjuvant information when the post-neoadjuvant surgery shows more extensive lymph node involvement.

- **Solid Tumors – Terms indicating lymph node involvement** (when no specific information as to tissue involved) are recorded as lymph node involvement:
    - Fixed
    - Matted
    - Mass in the hilum, mediastinum, retroperitoneum, and/or mesentery
  - The following terms should be ignored for solid tumors unless there is a statement of involvement by the clinician or the patient was treated as though regional lymph nodes were involved.
    - Palpable
    - Enlarged
    - Visible swelling
    - Shotty
    - Lymphadenopathy
- "Ipsilateral", "homolateral", and "same side; these terms are used interchangeably.
- **Accessible lymph nodes** – Lymph nodes that can be observed, palpated, or examined without instruments such as the regional lymph nodes for breast, oral cavity, salivary gland, skin, thyroid and other organs are considered accessible lymph nodes. It is sufficient to determine lymph nodes as negative when:
  - A statement such as "remainder of examination negative" is made.
- **Inaccessible lymph nodes** – Lymph nodes within body cavities that in most situations are NOT easily examined by clinical methods such as observation, palpation and physical exam are considered inaccessible. Bladder, colon, corpus uteri, esophagus, kidney, liver, lung, ovary, prostate, and stomach (not an all-inclusive list). It is sufficient to determine lymph nodes as negative when:
  - The tumor is localized and standard treatment for a localized site is done.
- Code as positive regional nodes, when involved nodes are found during sentinel lymph node procedures.
  - The sentinel lymph nodes are the first to receive lymphatic drainage from the primary tumor.
  - If the sentinel lymph node contains metastatic tumor, this indicates other lymph nodes may contain tumor. If it does not contain metastatic tumor, the other lymph nodes are not likely to contain tumor.
- **Isolated Tumor Cells (ITCs)** – ITCs are counted as positive regional nodes (for some schemas). Other schemas count them as negative. See individual schemas to determine how to code ITCs.
- Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid, and rectum: These can occur WITH or WITHOUT regional lymph node involvement.
  - Enter the appropriate code according to guidelines in the individual schemas.
  - Tumor nodules in pericolic or perirectal fat without evidence of residual lymph node structures can have one of several aspects of the primary cancer:

discontinuous spread, venous invasion with extravascular spread, or a totally replaced lymph node.

    - When there are Tumor Deposits AND lymph node involvement:
        - Code only the lymph node involvement in Summary Stage.

- Code as involved regional nodes when there is direct extension of the primary tumor into a regional lymph node.
- Code as “Regional Lymph Nodes, NOS” when any positive unidentified nodes are included with the resected primary site specimen.
- If the only indication of positive regional lymph node involvement in the record is the physician’s statement of a positive N category from the TNM staging system or a stage from a site-specific staging system, use that information to code regional lymph node involvement.
- Assume distant lymph node(s) are involved when a specific chain of lymph nodes is named, but not listed as regional.
    - Determine if the name is synonymous with a listed lymph node.
- Code 3 is NOT to be used when there is both regional nodes positive AND direct extension (see code 4).
- Code 3 is NOT applicable for the following Summary Stage chapters:
    - Brain
    - CNS Other
    - HemeRetic
    - Ill-Defined Other (includes unknown primary site)
    - Intracranial Gland
    - Lymphoma
        - Primary Cutaneous Lymphoma and Ocular Adnexal Lymphoma have separate chapters from Lymphoma and regional lymph node involvement is assigned in these chapters.

V.15.1.3.3 SS2018 - Regional by BOTH Direct Extension AND Regional Lymph Node(s) Involved (Code 4)

Regional by BOTH Direct Extension and Regional lymph node(s) include direct tumor extension beyond the limits of the site of origin as well as nodes that are regional to the primary site only. Please see the specific chapter/site in the Summary Stage 2018 Manual for site-specific regional lymph nodes.

Coding Instructions:

- Refer to the most current Summary Stage 2018 Manual for general coding instructions, site-specific coding instructions, and the Complete Summary Stage 2018 manual.
- Chapter-specific guidelines take precedence over general guidelines.
    - **Always** check the information pertaining to a specific primary site or histology chapter.
- Use code 4 when tumors have BOTH regional direct extension and have regional lymph node involvement.
- Code 4 is not applicable for the following Summary Stage chapters:
    - Brain
    - Cervical Lymph Nodes and Unknown Primary
    - CNS Other
    - HemeRetic
    - Ill-defined other (includes unknown primary site)
    - Intracranial Gland
    - Lymphoma
        - Primary Cutaneous Lymphoma and Ocular Adnexal Lymphoma have separate chapters from Lymphoma and regional lymph node involvement is assigned in these chapters.
    - Myeloma Plasma Cell Disorder

V.15.1.4 SS2018 - Distant Metastasis (Code 7)

Distant metastases are tumor cells that have broken away from the primary tumor, have travelled to other parts of the body, and have begun to grow at the new location. Distant stage is also called remote, diffuse, disseminated, metastatic, or secondary disease.

Coding Instructions:

- Refer to the most current Summary Stage 2018 Manual for general coding instructions, site-specific coding instructions, and the Complete Summary Stage 2018 manual.
- Chapter-specific guidelines take precedence over general guidelines.
    - **Always** check the information pertaining to a specific primary site or histology chapter.
- Cancer cells can travel from the primary site in any of four ways:
    - Extension from the primary organ beyond adjacent tissue into next organ.

      Example:

      From the lung through the pleura into bone or nerve.
    - Travel in lymph channels beyond the first (regional) drainage area.
    - Hematogenous or blood-borne metastases.
    - Spread through fluids in a body cavity.
        - This type of spread is also called implantation or seeding metastases.
- Common sites of distant spread are:
    - Liver, lung, brain, and bones, but they are not listed specifically for each chapter.

      Example:

      Liver involvement from a primary in the gallbladder. It is likely that this is regional by direct extension rather than distant stage, since the gallbladder is adjacent to the liver.
- Read the diagnostic imaging reports to determine:
    - Involvement of the surface of the secondary organ, which could either be regional by direct (contiguous) extension or distant (if determined to be a discontiguous surface implant).
        - If the tumor is identified growing from one organ onto/through the surface of the secondary organ, then it is contiguous extension.
        - However, if the tumor is only found in the parenchyma of the secondary organ well away from the primary organ, then it is discontinuous mets.
- Hematopoietic, immunoproliferative, and myeloproliferative neoplasms are distant except as noted in the Summary Stage chapter.
- Code 7 is not applicable for the following Summary Stage chapters:
    - Ill-defined other

V.15.1.5 SS2018 - Benign/Borderline (Code 8)

Benign, borderline, and uncertain behavior intracranial and central nervous system (CNS) tumors.

Coding Instructions:

- Refer to the most current Summary Stage 2018 Manual for general coding instructions, site-specific coding instructions, and the Complete Summary Stage 2018 manual.
- Code 8 is for Benign/borderline neoplasms.
    - Benign/borderline neoplasms are collected ONLY for the following chapters:
        - Brain
        - CNS Other
        - Intracranial Gland
- Use code 9 for Summary Stage 2018 when a registry collects other benign/borderline tumors that are not reportable.

  Note: Code 8 (at this time) will NOT be allowed for other sites.

V.15.1.6 SS2018 - Unknown if Extension or Metastatic (Unstaged, Unknown, or Unspecified) (Code 9)

Unknown extension or metastatic involvement is unknown.

Coding Instructions:

- Refer to the most current Summary Stage 2018 Manual for general coding instructions, site-specific coding instructions, and the Complete Summary Stage 2018 manual.
- Chapter-specific guidelines take precedence over general guidelines.
    - **Always** check the information pertaining to a specific primary site or histology chapter.
- Summary Stage must be unknown when- the primary site is unknown (C809).
- Assign 9 very sparingly.
    - If possible, contact the physician to see if there is more information about the case.
- There will be cases for which sufficient evidence is not available to adequately assign a stage.

  Examples:
    - The patient expires before workup is completed
    - A patient refuses a diagnostic or treatment procedure
    - There is limited workup due to the patient's age or a simultaneous comorbid or contraindicating condition
    - Only a biopsy is done and does not provide enough information to assign stage
- Use Code 9:
    - By default, for Death Certificate Only (DCO) cases; however, assign the appropriate Summary Stage when specific staging information is available on a DCO.

V.15.2 SS2018 Ambiguous Terms for Disease Extension

Registrars will find definitive statements of involvement, most of the time; however, for those situations where involvement is described with non-definitive (ambiguous) terminology, use the guidelines below to interpret and determine the appropriate assignment of Summary Stage 2018.

Guidelines:

- Refer to the most current Summary Stage 2018 Manual for general coding instructions, site-specific coding instructions, and the Complete Summary Stage 2018 manual.
- Chapter-specific guidelines take precedence over general guidelines.
    - **Always** check the information pertaining to a specific primary site or histology chapter.
- Determination of the cancer stage is both a subjective and objective assessment by the physician(s) of how far the cancer has spread.
    - Look at the documentation that the physician used to make informed decisions on how the patient is being treated when it is not possible to determine the extent of involvement because terminology is ambiguous.

      EXAMPLE: Assign Summary Stage 2018 based on involvement when the patient was treated as though adjacent organs or nodes were involved.
- Use the following lists to interpret the intent of the clinician **ONLY** when further documentation is not available and/or there is no specific statement of involvement in the medical record.
    - The physician's definitions/descriptions and choice of therapy **have priority over these lists** because individual clinicians may use these terms differently.
- Terminology in the chapter takes priority over this list:
    - Some chapters interpret certain words as involvement; such as 'encasing' the carotid artery for a head and neck site or "abutment," "encases," or "encasement" for pancreas primaries.
- **Use this list only for Summary Stage 2018 *OR* EOD 2018.**
    - This is ***not*** the same list used for determining reportability as published in the SEER Program Manual, Hematopoietic Manual or in Section 1 of the STandards for Oncology Registry Entry (STORE) Manual.
    - This is ***not*** the same list of ambiguous terminology provided in the Solid Tumors Rules published and maintained by the SEER Program.

- **Use the following lists as a guide *ONLY when no other information is available.***

INVOLVED	
Adherent	Incipient invasion
Apparent(ly)	Induration
Appears to	Infringe/infringing
Comparable with	Into*
Compatible with	Intrude
Consistent with	Most likely
Contiguous/continuous with	Onto*
Encroaching upon*	Overstep
Extension to, into, onto, out onto	Presumed
Features of	Probable
Fixation to a structure other than primary**	Protruding into (unless encapsulated)
Fixed to another structure**	Suspected
Impending perforation of	Suspicious
Impinging upon	To*
Impose/imposing on	Up to
NOT- INVOLVED	
Abuts	Extension to without invasion/involvement
Approaching	Kiss/kissing
Approximates	Matted (except for lymph nodes)
Attached	Possible
Cannot be excluded/ruled out	Questionable
Efface/effacing/effacement	Reaching
Encased/encasing	Rule out
Encompass(ed)	Suggests
Entrapped	Very Close to
Equivocal	Worrisome

* interpret as involvement whether the description is clinical or operative/pathological.

** interpret as involvement of other organ or tissue.

V.16 Pediatric Stage

Pediatric staging refers to cancer staging that is specific to pediatric patients, which may differ in some instances from staging of adult cancers. Pediatric Stage includes patients who are younger than twenty (20) years of age.

Common pediatric cancers are often managed using clinical protocols and are treated in pediatric centers. Many pediatric cancers are staged using specialized systems which are histology and tumor site driven per clinical trials.

However, some pediatric cancers can be staged using the AJCC TNM staging system.

Example:

Lymphoma in pediatric patients is staged using the same scheme as that for adults.

Coding Instructions:

- If AJCC staging is used to stage a pediatric case, refer to the most current AJCC Cancer Staging Manual for coding instructions.
- When Summary Stage is used, for cases or tumors diagnosed January 1, 2018 and forward, refer to the SEER Summary Stage Manual for coding instructions.
- In the event another staging system is used, please specify the staging method used.
- Document the stage and method used in the stage text field.

V.16.1 Pediatric Stage Group

Pediatric stage group refers to the stage group assigned for the pediatric cancer. This scheme is to be used for entering the stage for pediatric patients only.

Coding Instructions:

- Pediatric Stage includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 or later.
- Record the stage assigned by the managing provider.
- This scheme is to be used for entering the stage for pediatric patients only.
- Use Code 88 - not applicable, for patients twenty years of age and older.
- Use code 99 for pediatric leukemia cases.

Codes:

Code	Description
1	Stage I
1A	Stage IA (rhabdomyosarcomas & related sarcomas)
1B	Stage IB (rhabdomyosarcomas & related sarcomas)
2	Stage II
2A	Stage IIA (rhabdomyosarcomas & related sarcomas)
2B	Stage IIB (rhabdomyosarcomas & related sarcomas)
2C	Stage IIC (rhabdomyosarcomas & related sarcomas)
3	Stage III
3A	Stage IIIA (liver, rhabdo. & related sarcomas, Wilms')
3B	Stage IIIB (liver, rhabdo. & related sarcomas, Wilms')
3C	Stage IIIC (Wilms' tumor)
3D	Stage IIID (Wilms' tumor)
3E	Stage IIIE (Wilms' tumor)
4	Stage IV
4A	Stage IVA (bone)
4B	Stage IVB (bone)
4S	Stage IVS (neuroblastoma)
5	Stage V (Wilms' tumor/retinoblastoma)
A	Stage A (neuroblastoma)

B	Stage B (neuroblastoma)
C	Stage C (neuroblastoma)
D	Stage D (neuroblastoma)
DS	Stage DS (neuroblastoma)
88	Not Applicable (not a pediatric case)
99	Unstaged, Unknown

V.16.2 Pediatric Protocols

Pediatric protocols refer the specialized systems used to stage pediatric cancers. These systems are based on histologic type and/or primary site.

Coding Instructions:

- Use for pediatric patients **only**.
- Record the staging system used by the managing provider.

Codes:

Code	Description
00	None
01	American Joint Committee on Cancer (AJCC)
02	Ann Arbor
03	Children's Cancer Group (CCG)
04	Evans
05	General Summary
06	Intergroup Ewing's
07	Intergroup Hepatoblastoma
08	Intergroup Rhabdomyosarcoma
09	International System
10	Murphy
11	National Cancer Institute (Pediatric Oncology)
12	National Wilms Tumor Study
13	Pediatric Oncology Group (POG)
14	Reese Ellsworth
15	SEER Extent of Disease
16	Children's Oncology Group (COG)
88	Not Applicable
97	Other
99	Unknown

V.16.3 Staged by - Pediatric Stage

This field identifies the person who assigned the cancer stage.

Coding Instructions:

- This data item is to be used for pediatric cases only diagnosed January 1, 1996 and forward. It identifies the person who staged the case.
- The ACS states that the managing provider is responsible for staging analytical cases.
    - The CCR concurs and feels that this applies to non-analytic cases, also.
- If the staging has not been done by the provider, the registrar does not have to stage the case.
    - Enter 0 for not staged.
- For patients older than twenty (20), enter 0.

Codes:

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

Part VI First Course of Treatment

Part VI of Volume I consist of first course of treatment. Instructions included in this section range from surgery, radiation, chemotherapy, hormone therapy, immunotherapy, transplant/endocrine therapy and other therapy, to the summary of treatment status and protocol participation.

VI.1 Definitions and Guidelines - First Course of Treatment

First course treatment is all treatments administered to the patient after the original diagnosis of cancer in an attempt to destroy or modify the cancer tissue.

IMPORTANT Note: This section applies to all neoplasms (including benign and borderline intracranial and CNS tumors) **except** hematopoietic and neoplasms. For hematopoietic and lymphoid cases diagnosed January 1, 2018 and forward, please refer to the SEER Hematopoietic and Lymphoid Neoplasm Database for information on coding first course treatment for these cases.

Record all cancer directed therapeutic procedures (surgery, radiation, systemic, or other therapy) administered at any facility, whether in a primary or metastatic site, whatever the mode of treatment, and regardless of the sequence and degree of completion of any component part.

Coding Instructions:

These instructions are in hierarchical order:

1. Use the **documented** first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment is **completed** (no matter how long it takes to complete the plan).
2. First course ends when there is documentation of disease progression, recurrence, or treatment failure.
3. When there is no documentation of a treatment plan or progression, recurrence or a treatment failure, first course therapy ends one year after the date of diagnosis. Any treatment given after one year is second course therapy in the absence of a documented treatment plan or a standard of treatment.
4. A patient refuses all treatment modalities and does not change his/her mind within a reasonable time frame, or if the physician opts not to treat the patient, record that there was no treatment in the first course.

   Note: If treatment is given for symptoms/disease progression after a period of "watchful waiting," this treatment is **not** considered part of first course.

   Example:

   A physician and patient choose a "wait and watch" approach to prostate and the patient becomes symptomatic, consider the symptoms to be an indication that the disease has progressed and that any further treatment is not part of first course.

   - The data item RX-Treatment Status was added to summarize the status of all treatment modalities. This data item is a summary of whether

treatment was given, including an option that identifies active surveillance or watchful waiting.

CCR Expectations:

- The CCR expects every reporting facility that has a tumor registry to obtain information about the entire first course therapy from the medical record and, if necessary, the physicians themselves, regardless of where the treatment was administered. If it cannot be determined whether an intended therapy was actually performed, record that it was recommended but it is not known whether the procedure was administered.

  Example:

  Enter "Radiation therapy, recommended; unknown if given"

- Reporting facilities preparing initial case reports for the sole purpose of meeting state mandatory reporting requirements may elect to record only the treatment documented in their medical records.
- Abstractors are provided with two fields to record first course of treatment information.
  - The first treatment field for each modality (except surgery) is known as "Treatment Summary." This field should include any first course treatment administered for that modality, regardless of where it was administered, including treatment administered at the reporting facility.
  - The second treatment field for each modality (except surgery) is known as "Treatment at this reporting facility." This field should only include first course treatment administered at the reporting facility, respective to each modality.
- Referral to an oncologist is considered a recommendation. Registry personnel should follow-up on these cases to determine whether chemotherapy was administered or not, and code accordingly. This applies to cases diagnosed January 1, 2010 and forward. Prior to January 1, 2010, referral did not equal a recommendation.

For additional information regarding recording text, please see:

- Q-Tips - Recording Information in Text Fields
- CCR Knowledge Series - CCR Text Documentation Guidelines

VI.1.1 First Course of Treatment - Special Situations

Listed below are special conditions that may occur and must be considered when coding first course of treatment.

In Utero Diagnoses and Treatment

- Beginning in 2009, the dates of diagnosis and treatment for tumors developed while in utero should reflect the dates on which they occur. In the past, these dates were assigned to the date the baby was born.
- Diagnoses made in utero are reportable if the pregnancy results in a live birth. 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.
- In the absence of documentation of stillbirth, abortion or fetal death, assume there was a live birth and report the case.

Treatment Performed Elsewhere

- Record any part of the first course of treatment administered at another facility before the patient was admitted to the reporting facility or after discharge. Also, record the name of the facility where the treatment was administered.

Coding Instructions:

Leukemia and Hematopoietic Diseases

- For hematopoietic and lymphoid cases diagnosed January 1, 2018 and forward, please refer to the SEER Hematopoietic and Lymphoid Neoplasm Database.

Treatment – Refused

Surgery:

- If the patient or patient's guardian refuses surgery to the primary site:
  - Use code 7 in the Reason for No Surgery field

Treatment Modalities:

- If the patient or patient's guardian refuses any other treatment modality:
  - Use code 87 in the respective treatment field
  - If a treatment that was originally refused was subsequently performed as part of the first course of treatment, enter the appropriate code for the procedure.

No Treatment

- If a patient did not receive any of the treatments described in sections VI.2-VI.8:
    - The surgery summary code would be 00 and all the other treatment summary fields would contain a 00.

      Example:

      The case might be Autopsy only, or the patient might have received only symptomatic or supportive therapy. Explain briefly, why no definitive treatment was given (for example, "terminal," "deferred").
    - If definitive treatment was refused, see Treatment – Refused (above) for coding instructions. A facility that is preparing initial case reports to only meet state mandatory reporting requirements may also use 00 if no treatment is documented in its medical records (code 99 should not be used in this situation).
    - The data item **RX-Treatment Status** was added to summarize the status of all treatment modalities. This data item is a summary of whether treatment was given, including an option that identifies active surveillance or watchful waiting.

  Note: Referral to an oncology specialist is considered a recommendation. Registry personnel should follow up on these cases to determine whether treatment was administered or not, and code accordingly. This applies to cases diagnosed January 1, 2010 and forward.

Treatment - Unknown

- If it is unknown whether or not the patient had treatment:
    - Code 99 or 9 (unknown) should generally be used only for cases in which the first course of treatment is unknown.
    - Enter 99 or 9 for each modality of treatment, leave the treatment date fields blank, and state briefly, why the information is not available.
    - Do not use code 99 or 9 for a component part of the treatment summary.

      Example:

      If surgical resection was performed and it is not known whether chemotherapy was administered, do not enter a 99 in the Chemotherapy field -- use code 00.
    - If specific treatment is recommended, but it is not known whether it was administered, enter a statement to this effect and code the appropriate summary fields for Immunotherapy and Other Therapy with code 88 (code 8 for Surgery) and Treatment at this reporting facility fields with code 00.

  Note: Referral to a specialist is considered a recommendation. Registry personnel should follow up on these cases to determine whether treatment was administered or not, and code accordingly. This applies to cases diagnosed January 1, 2010 and forward.

VI.1.2 First Course of Treatment - Data Entry

Enter codes, dates, and written summaries to reflect the first course of treatment.

Dates

Enter the date treatment was started for each modality.

Coding Instructions:

- For instructions about entering dates, see Entering Dates.
- If the treatment was administered in courses (as in a radiation therapy series) or included different procedures (for example, excisional biopsy and a resection), enter the date the first procedure was performed.
- The Date of Systemic Therapy will be generated from Date of Chemotherapy, Date of Hormone, Date of Immunotherapy, and Date of Transplant/Endocrine Procedures effective with cases diagnosed 1/1/2003 and forward.

Text

Text is the abstractor's supporting documentation obtained from the medical record that validates codes entered in the abstract.

Coding Instructions:

- In the text fields, describe the treatment as briefly as possible.
- If more than one procedure was performed, describe each one in chronological order.
- Indicate where the procedure was performed, unless it was at the reporting facility.
- Enter the reason into the appropriate text field, when treatment has been discontinued.
- If treatment is not performed, record the reason in the text field for that data item.

  Examples:

  - If cancer-directed surgery is not performed, record the reason in the text field for surgery; such as, patient not a surgical candidate.
  - If no chemotherapy was performed, record the reason; such as, patient refused chemotherapy.
- Do not leave a text field blank when information is missing or unknown from the medical record, or when there is no pertinent information. For example,

you could record None, NR, or NA.
Note: There is no text field for bone marrow transplant and endocrine procedures. Record text information regarding bone marrow transplants and endocrine procedures in the immunotherapy text field.

- Enter text documentation that supports the following data items, when appropriate:

Data Item Name
Date 1st Crs RX CoC
Date Initial RX SEER
Phase I Number of Fractions
Phase I Radiation Treatment Modality
Phase II Number of Fractions
Phase II Radiation Treatment Modality
Phase III Number of Fractions
Phase III Radiation Treatment Modality
Rad Boost Dose cGy
Rad Location of RX
Rad Location of RX
Rad Regional RX Modality
Rad Treatment Volume
Rad--No of Treatment Vol
Rad--Regional Dose cGy
Reason No Radiation
Reason for No Surgery
RX Date BRM
RX Date Chemo
RX Date Hormone
RX Date Rad Ended
RX Date Radiation
RX Date Surgery
RX Date Systemic
RX Hosp--BRM
RX Hosp--Chemo
RX Hosp--Hormone
RX Hosp--Radiation
RX Hosp--Scope Reg LN Sur

RX Hosp--Surg Oth Reg/Dis
RX Hosp--Surg Prim Site
RX Summ--BRM
RX Summ--Chemo
RX Summ--Hormone
RX Summ--Palliative Proc
RX Summ--Scope Reg LN Sur
RX Summ--Surg Oth Reg/Dis
RX Summ--Surg Prim Site
RX Summ--Surg/Rad Seq
RX Summ--Surgical Margins
RX Summ--Systemic/Sur Seq
RX Summ--Tranplnt/Endocr
Text--Place of Diagnosis

Codes

Numeric codes summarize each modality of treatment (surgery, radiation, chemotherapy, etc.). For each modality except surgery, code a summary of the entire first course of treatment. See Section Surgery Introduction – First Course of Treatment for coding each surgery field.

Coding Instructions:

- For hematopoietic and lymphoid cases diagnosed January 1, 2018 and forward, please refer to the SEER Hematopoietic and Lymphoid Neoplasm Database.
- Treatment given by a physician on the medical staff of a facility should not be recorded as treatment given at that reporting facility, effective with cases diagnosed January 1, 1998 and forward.
- In the field provided, assign a separate code to that portion of the treatment administered at the reporting facility.
- The codes for the reason no surgery, reason no radiation, reason no chemotherapy and reason no hormone therapy have been incorporated into each respective treatment modality field.
- The codes for surgical procedures have one or two digits.
- Other codes have two digits, with a 00 always meaning no procedure performed for that type of treatment.

- Code all treatment fields to 00 (Not done) when physician decides to do **active surveillance** (**aka watchful waiting**) for a patient who has prostate cancer. The first course of therapy is no treatment. When the disease progresses or the patient becomes symptomatic, any prescribed treatment is second course.
- Cases coded to 00 based on active surveillance **must** also be coded to 2 in the RX Summ-Treatment Status field.
- Code the treatment as first course of therapy if the patient refuses treatment but changes his/her mind and the prescribed treatment is implemented less than one year from the date of diagnosis, AND there is no evidence of disease progression.
- The first course of therapy is **no treatment** when the patient **refuses** treatment. Code the treatment fields to Refused.
    - Keep the refused codes, even if the patient later changes his/her mind and decides to have the prescribed treatment in the following scenario:
        - More than one year after diagnosis, or when there is evidence of disease progression before treatment is implemented.
    - Use code 87 in the respective treatment field if the patient or patient's guardian refuses that modality and record the fact in the text field.
    - If the patient or patient's guardian refuses surgery to the primary site, enter code 7 in the Reason for No Surgery field.

      Note: Prior to January 1, 2010, referral does not equal a recommendation.
- Code all treatment that was started and administered, whether completed or not.
- 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.
- Code the treatments only for the site that is affected when a patient has multiple primaries and the treatment affects only one of the primaries.
- Code the treatment given as first course even if the correct primary is identified later when a patient is diagnosed with an unknown primary.
- 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.

- Code 99 or 9 (unknown) is to be used only for cases in which the first course of treatment is unknown.
    - Enter 99 or 9 for each modality of treatment, leave the treatment date fields blank, and **state briefly why the information is not available.**
- Do not use code 99 or 9 for a component part of the treatment summary.

    Example:

    Surgical resection was performed, and it is not known whether chemotherapy was administered, do not enter a 99 in the Chemotherapy field -- use code 00.
- If specific treatment is recommended, but it is not known whether it was administered, enter a statement to this effect and code the appropriate summary fields for Immunotherapy and Other Therapy with code 88 (code 8 for Surgery) and At This Hospital fields with code 00.

    Note: For cases diagnosed January 1, 2010 and forward, referral to a specialist is considered a recommendation.

VI.2 Surgery Introduction - First Course of Treatment

In abstracting surgical treatment, the total or partial removal (except an incisional biopsy) of tumor tissue must be recorded in the text field, whether from a primary or metastatic site.

Coding Instructions:

- Record procedures that remove normal tissue.

  Example:

  Dissection of non-cancerous lymph nodes if they are part of the first course of treatment.

- Shave or punch biopsies are most often diagnostic. Code as a surgical procedure **only** when the entire tumor is removed, and margins are clear.
- Brushings, washings, aspiration of cells and peripheral blood smears are not considered surgical procedures, but they might have to be recorded as diagnostic procedures. See Text – Diagnostic Procedures Performed for additional information.

VI.2.1 Treatment Facility Number

The CCR assigned reporting facility code for the reporting facility or agency that provided first course treatment.

Coding Instructions:

- Refer to the most current California California Reporting Facility Codes lists, located on the CCR website https://www.ccrcal.org/learn-about-ccr/,Registrar Resources, Reporting Cancer in California, Volumes I-IV.
    - Lists are presented in both alphabetical and code order.
- The fields are to be left blank if no cancer-directed surgery was performed.
- These fields are used in conjunction with each surgical procedure performed.
- If the procedure was performed at the reporting facility, the CCR assigned reporting facility code should be entered.

VI.2.2 Sources for Information (Surgery)

To capture all aspects of a patient's surgical treatment, it is necessary to review multiple sources. This instruction directs abstractors on where to obtain information regarding surgery.

Coding Instructions:

- To ascertain exactly what procedures were performed, read the operative and pathology reports thoroughly. Do not depend on the title of an operative report, because it might be incomplete.
- If the operative report is unclear about what tissue was excised or the operative and pathology reports contain different information, use the pathology report unless there is reason to doubt its accuracy.

VI.2.3 Diagnostic or Staging Procedures

Record surgical procedures performed solely for establishing a diagnosis and or determining stage of disease. If more than one surgical diagnostic or staging procedure was done, record the first one performed.

Surgical diagnostic or staging procedures include:

- Biopsy, incisional or NOS (if a specimen is less than or equal to 1 cm, assume the biopsy to have been incisional unless otherwise specified).
- Only record positive procedures.

  Note: 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 to code these procedures.
- Dilation and curettage for invasive cervical cancer.
- Dilation and curettage for invasive or in-situ cancers of the corpus uteri, including choriocarcinoma.
- Surgery in which tumor tissue is not removed:

  Examples:

  - Bypass surgery—colostomy, esophagostomy, gastrostomy, nephrostomy, tracheostomy, urethrostomy, stent placement.

    Note: Removal of fluid (paracentesis or thoracentesis) even if cancer cells are present is not a surgical procedure. Do not code brushings, washings, or hematologic findings (peripheral blood smears). These are not considered surgical procedures.
  - Exploratory surgery—celiotomy, cystotomy, gastrotomy, laparotomy, nephrotomy, thoracotomy.

    Note: 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).

Coding Instructions:

- This field does not include palliative treatment/procedures. Palliative treatment/procedures are recorded in a separate field. The CCR does not require that palliative treatment/procedures be recorded but the CoC does require this field. Please consult the STandards for Oncology Registry Entry (STORE) Manual for instructions regarding the palliative procedure field. This applies to cases diagnosed January 1, 2003 forward.
- Give priority to:
  - Codes 01-07 over code 09
  - Codes 01-06 over code 07

- Codes in the range 01-06 are hierarchical
- Code microscopic residual disease or no residual disease as surgery of primary site.

  Note: The CCR follows SEER guidelines and requires coding incisional biopsies without residual at re-excision to be coded as an excisional biopsy **only** in the Surgery of Primary Site data field. **COC Facilities:** Please make note in your user defined fields when standards between CoC and CCR differ.

Do Not Code the following information:

- Brushings, washings, cell aspirations and hematologic findings (peripheral smears), as they are NOT considered surgical procedures and should not be coded in the Diagnostic or Staging Procedures field. Code positive brushings, washings and cell aspirations, and hematologic findings (peripheral smears) as cytologic diagnostic confirmation in the Diagnostic Confirmation field.
- Surgical procedures which aspirate, biopsy, or remove regional lymph nodes in effort to diagnose and/or stage disease in this data item. Use the data item Scope of Regional Lymph Node Surgery 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.
- Excisional biopsies with clear or microscopic margins in this data item. Use the data item Surgical Procedure of Primary Site to code these procedures.
- Palliative surgical procedures in this data item.

Codes:

Code	Description
00	No surgical diagnostic or staging procedure
01	Incisional, needle, or aspiration biopsy of other than primary site (code microscopic residual disease or no residual disease as surgery of other regional site[s], distant site[s], or distant lymph nodes[s])
02	Incisional, needle, or aspiration biopsy of primary site
03	Exploratory surgery only (no biopsy)
04	Bypass surgery or ostomy only (no biopsy)
05	Combination of 03 plus 01 or 02
06	Combination of 04 plus 01 or 02
07	Diagnostic or staging procedure, NOS
09	Unknown if diagnostic or staging procedure done

VI.2.3.1 Date of Diagnostic or Staging Surgical Procedures

Enter the date of the earliest surgical diagnostic and/or staging procedure in this field.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates.

Coding Instructions:

- Enter the earliest date in which the diagnostic or staging surgical procedure was administered.
- Record only first course of treatment dates in this field.
- Record the date, diagnostic or staging procedure, and results in the associated text field.

VI.2.3.1.1 Date of Diagnostic or Staging Surgical Procedures Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	Unknown whether a surgical diagnostic or staging procedure was performed
11	No surgical diagnostic or stating procedure was performed
12	Date cannot be determined for surgical diagnostic or staging performed
Blank	Full or partial date recorded

VI.2.4 Surgery of the Primary Site

This field refers to surgical procedures that are performed on the Primary Site. See Appendix K - STORE Surgery Codes for Site-Specific Surgery Codes.

Generally, cancer-directed surgery includes most procedures that involve removal of a structure (those with the suffix "ectomy") and such procedures as:

- Biopsy, excisional (which has microscopic residual disease or no residual disease)
- Biopsy, NOS, that removes all tumor tissue
- Chemosurgery (Moh's technique)
- Conization
- Cryosurgery
- Desiccation and Curettage for bladder and skin tumors
- Electrocautery
- Fulguration for bladder, skin, and rectal neoplasms
- Laser therapy
- Local excision with removal of cancer tissue (including excisional biopsy but excluding incisional biopsy)
- Photocoagulation
- Splenectomy for lymphoma or leukemia
- Surgery removing metastatic malignant tissue
- Transurethral resection (TUR) with removal of tumor tissue of bladder or prostatic tumors

Coding Instructions:

- Enter the procedures in chronological order. If more than three surgical procedures are performed on a patient, the earliest surgery and the most definitive surgery must be included. For codes 00 through 79, the response positions are hierarchical.
    - Code 98 takes precedence over code 00.
    - Use codes 80 and 90 only if more precise information about the surgery is unavailable.
- 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 K - STORE Surgery Codes.
- Do not code pre-surgical embolization of hypervascular tumors with particles, coils or alcohol. These pre-surgical embolizations are typically performed to make the resection of the primary tumor easier.

Example:

Where pre-surgical embolization is used include meningiomas, hemangiomas, paragangliomas, and renal cell metastases in the brain.

- Surgery of the Primary Site consists of three two-character fields which are to be used to record surgeries of the primary site only. If an en bloc resection is performed which removes regional tissue or organs with the primary site(s) part of a specific code definition, it should be coded. An en bloc resection is the removal of organs in one piece at one time.

  Example:

  Patient undergoes a modified radical mastectomy. The breast and auxiliary contents are removed in one piece (en bloc). Surgery would be coded 50 for modified radical mastectomy regardless of whether nodes were found by pathology in the specimen.

- For non-en bloc resections, record the resection of a secondary or metastatic site in the Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s).
- Refer to Appendix K - STORE Surgery Codes for the site-specific surgery codes. They are hierarchical with less specific (NOS) terms followed by more specific terms.

  Examples:

  - 50 Gastrectomy, NOS WITH removal of a portion of esophagus
  - 51 Partial or subtotal gastrectomy
  - 52 Near total or total gastrectomy

- Codes 10-90 have priority over code 99.
- Codes 10-84 have priority over codes 90 and 99.
- Codes 10-79 have priority over codes 80, 90 and 99, where 80 is site-specific surgery, not otherwise specified.
- If surgery removes the remaining portion of an organ, code the total removal of the organ.

  Example:

  - Patient undergoes left thyroid lobectomy (code 21) for goiter and is found to have thyroid cancer on pathologic review. The patient then returns to have the right thyroid lobe removed. The removal of the right lobe results in a total thyroidectomy, therefore code to 50, total thyroidectomy, (not a second lobectomy code 21).

- Biopsies, NOS, which remove all gross tumor or leave only microscopic margins, should be coded to surgery of the primary site. If there is no statement that the initial biopsy was excisional, yet no residual tumor was found at a later resection, assume that the biopsy was excisional.

  Examples:

- The patient had a resection of a stomach remnant and portion of the esophagus at the time of their second procedure.
- The first procedure was a partial gastrectomy, NOS - code 30.

- **Excisional Biopsy:**
  - Record an excisional biopsy as first surgical treatment, whether followed by further definitive surgery or not and whether or not residual tumor was found in a later resection.

    Note: The CCR follows SEER guidelines and requires coding incisional biopsies without residual at re-excision to be coded as an excisional biopsy **only** in the Surgery of Primary Site data field. **COC Facilities:** Please make note in your user defined fields when standards between CoC and CCR differ.
- **Aborted Procedure:**
  - Assign the surgery code(s) that actually represents the extent of the surgical procedure that was carried out when surgery is aborted. If the procedure was cancelled or discontinued before anything took place, assign code 00.
- **Extranodal Lymphomas:**
  - When coding surgery for extranodal lymphomas, use the appropriate code for the extranodal site. For example, use a code for the stomach to code a lymphoma of the stomach.

Notes:

- If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given.
- Referral to a specialist is considered a recommendation. Registry personnel should follow-up on these cases to determine whether treatment was administered or not and code accordingly. This applies to cases diagnosed January 1, 2010 and forward.

VI.2.4.1 Date of Surgery

Enter the date of surgery performed for each surgical procedure. There are three date fields available to be used in conjunction with each definitive procedure performed.

- Procedures for this date field include:
    - Surgery of the Primary Site
    - Scope of Regional Lymph Node Surgery
    - Surgery of Other Regional/Distant Sites
- Record the date, surgical procedure, and results in the associated text field.

Note: These must be entered in chronological order.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates.

VI.2.4.1.1 Date of Surgery Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	Unknown whether any procedure performed
11	No procedure planned or performed
12	Date cannot be determined for procedure performed
Blank	Full or partial date recorded

VI.2.4.2 Surgical Margins of the Primary Site

This field describes the final status of the surgical margins after resection of the primary tumor. It is used in staging, for quality assurance measures, and may be a prognostic factor in recurrence. Surgical margins are required by the CCR to be coded for all primary sites. This applies to cases diagnosed January 1, 2016 and forward.

Coding Instructions:

- 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 1 for involved margins not otherwise specified.
- Code 2 for involved margins seen microscopically but not grossly (cannot be seen by the naked eye).
    - To identify microscopic findings, use the margins section of the CAP protocol or the microscopic description from the pathology report.
- Code 3 for involved margins seen macroscopically (grossly, with the naked eye).
    - To identify macroscopic findings, use the margins section of the CAP protocol or the gross description from the pathology report.
- Code 7 if the pathology report indicates the margin could not be determined.
- Code 8 when no surgery is performed on the primary site.
- Code 9 in the following scenarios:
    - Pathology report makes no mention of the margins.
    - No tissue was sent to pathology.
    - For lymphomas/lymphoid neoplasms with a lymph node primary site.
    - For an unknown or ill-defined primary site.
    - For Hematopoietic, Reticuloendothelial, Immunoproliferative, or Myeloproliferative diseases.

Codes:

Code	Label	Description
0	No residual tumor	All margins are grossly and microscopically negative
1	Residual tumor, NOS	Involvement is indicated, but not otherwise specified
2	Microscopic residual tumor	Cannot be seen by the naked eye
3	Macroscopic residual tumor	Gross tumor of the primary site which is visible to the naked eye

7	Margins not evaluable	Cannot be assessed (indeterminate)
8	No primary surgery site	No surgical procedure of the primary site. Diagnosed at autopsy
9	Unknown of not applicable	It is unknown whether a surgical procedure to the primary site was performed; death certificate-only; for lymphomas with lymph node primary site; an unknown or ill-defined primary; or for Hematopoietic, Reticuloendothelial, Immunoproliferative, or Myeloproliferative disease

VI.2.5 Sentinel Lymph Node Biopsy

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the date of regional node dissection separate from the date of sentinel lymph node biopsy if performed.

Guidelines:

- Sentinel lymph nodes (SLNs) are the first lymph nodes (LNs) to which cancer cells are most likely to spread from the primary tumor.
- Sentinel lymph node biopsy (SLNBx) is a procedure in which a sentinel LN is identified, removed, and examined.
    - By injection of a radioactive tracer substance and/or blue dye near the tumor, sentinel lymph nodes can be identified when they "map" or are described as "hot" from radiotracer uptake, or described "blue" resulting from dye uptake.
    - Usually 1-3 sentinel LNs will be identified, however, non-sentinel LNs may be in very close proximity to SLNs and may need to be excised in the process of dissecting the SLNs.
        - ALL LNs removed in this bundle during the sentinel lymph node procedure are counted and coded in the number of sentinel LNs examined even if the node(s) were described as "non sentinel", "failed to map", and/or did not contain dye or radio tracer.
        - ALL LNs removed in this bundle during the sentinel lymph node procedure and identified as positive by the pathologist, are counted and coded as positive even if the node(s) were described as "non sentinel", "failed to map", and/or did not contain dye or radio tracer.
- A SLN biopsy is performed when lymph nodes (LNs) are clinically negative and may be followed by a full regional lymph node (LN) dissection when:
    - Nodes "fail to map" **OR**
    - SLNs are found to be positive
- Failure to map occurs when no nodes will uptake either the radiotracer substance or the blue dye.
- If a relatively large number of LNs (>5) are removed, more investigation needs to be done.
- READ the operative report to clarify that the procedure was limited to a SLNBx and did not include a full regional LN dissection. This **cannot** be determined from the path report.
- Generally performed for breast and melanoma cancers.

VI.2.5.1 Date of Sentinel Lymph Node Biopsy

Enter the date of the sentinel lymph node(s) biopsy procedure. This data item is required by the CCR for **melanoma of skin and breast cases only** diagnosed January 1, 2018 and forward.

Coding Instructions:

- Enter the date of the sentinel lymph node(s) biopsy procedure performed, and documented in the *Sentinel Lymph Node Examined* data item.
- Record **must** definitively state that the procedure is a sentinel lymph node (SLN) procedure.
    - Dates for lymph node aspiration, fine needle aspiration, fine needle aspiration biopsy, core needle biopsies, and core biopsies are **NOT** to be coded in this field.
- If the SLNBx is either the first **or** only surgical procedure performed, also record this date in the *Date First Surgical Procedure* field.
- If a regional lymph node dissection (RLND) is also performed in addition to/or subsequent to the SLNBx, also record the date of the RLND in the *Date Regional Lymph Node Dissection* data field.
    - If a SLNBx and a RLND are performed on the same date, the dates should be equal/the same.
    - If the RLND is done subsequently (on a later date), after the SLNBx, then dates for each procedure will differ.
- Record the date, procedure, and results in the associated text field(s).

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates.

VI.2.5.1.1 Date of Sentinel Lymph Node Biopsy Flag

This data item is used to explain why there is no appropriate value in the corresponding date field. This data item is required by the CCR for **melanoma of skin and breast cases only** diagnosed January 1, 2018 and forward.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any sentinel lymph node biopsy was performed)
11	No proper value is applicable in this context (for example, no sentinel lymph node biopsy performed; autopsy only cases)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, sentinel lymph node biopsy performed but date is unknown)
Blank	A valid date value is provided; Case was diagnosed prior to January 1, 2018

VI.2.5.2 Sentinel Lymph Nodes Positive

This field records the exact number of sentinel lymph nodes found to contain metastases. This data item is required by the CCR for **melanoma of skin and breast cases only** diagnosed January 1, 2018 and forward.

Coding Instructions:

- Record information **only** about sentinel lymph node procedure in this field.
- If a positive *aspiration* of sentinel lymph node(s) AND a positive sentinel node biopsy are done on the same patient, **record the results of the sentinel node biopsy procedure**.
- Enter the exact number of **sentinel lymph nodes** biopsied/dissected and found to contain **metastasis** by the pathologist.
    - If "non-sentinel" lymph nodes are removed by chance during the sentinel lymph node procedure, which are positive on exam by the pathologist, record the total number of positive nodes from the sentinel lymph node procedure regardless of whether the positive node(s) contained any dye or radiotracer.
- Record the number of **positive sentinel lymph nodes** identified in this data item, and record the *total number of positive regional nodes* (which includes sentinel LNs), in the *Regional Lymph Nodes Positive* data item.
- Sentinel lymph nodes with **mi** (Microscopic or micro mets) are considered **positive**.
- **Breast carcinoma only**:
    - If only positive isolated tumor cells (ITCs) are identified, the sentinel lymph nodes are **negative.**
    - Use code 97 in this data item when a sentinel lymph node biopsy and a regional node dissection are performed **during the same procedure**, and positive **sentinel lymph nodes are documented as present, but the number is unspecified**, AND record the total number of positive regional nodes (which includes any positive sentinel nodes) in the *Regional Lymph Nodes Positive* data field.
- **Cutaneous Melanoma only:**
    - If only positive isolated tumor cells (ITCs) are identified, the sentinel lymph nodes are **positive.**
    - If both a sentinel lymph node biopsy procedure AND a regional lymph node dissection are performed **during the same procedure** record the total number of positive sentinel nodes identified in the sentinel procedure in this data item, AND record the total number of positive regional lymph nodes biopsied/dissected (which includes the number of sentinel nodes documented in this data item) in the *Regional Lymph Nodes Positive* data field.
- The number of positive sentinel lymph nodes should be less than or equal to the total number of regional nodes positive.

- The number of positive sentinel lymph nodes will typically be found in the:
    - Pathology report
    - Radiology Report
    - Documented by the physician
- Determination of the exact number of positive sentinel lymph nodes may require assistance from the managing physician.

Codes:

Code	Description
00	All sentinel nodes examined negative
01-90	Sentinel nodes are positive (code exact number of nodes positive)
95	Positive aspiration of sentinel lymph node(s) was performed
97	Positive sentinel nodes are documented, but the number is unspecified; For breast ONLY: SLN and RLND occurred during the same procedure
98	No sentinel nodes were biopsied
99	It is unknown whether sentinel nodes are positive; not applicable; not stated in patient record

VI.2.5.3 Sentinel Lymph Nodes Examined

This field records the total number of lymph nodes sampled during the sentinel node biopsy and examined by the pathologist. This data item is required by the CCR for **melanoma of skin and breast cases only** diagnosed January 1, 2018 and forward.

Coding Instructions:

- Record the total number of nodes sampled during the sentinel node biopsy procedure and examined by the pathologist.
    - Includes aspiration of SLNs
    - If both sentinel and non-sentinel LNS were sampled during the SLNBx procedure:
        - **Record total number of node(s) examined regardless of status; sentinel, "non-sentinel", positive or negative.**
- Sentinel lymph nodes are also regional nodes. Therefore, if both a sentinel lymph node biopsy procedure is performed AND a regional lymph node dissection (whether on the same date or a subsequent date) is performed, record the total number of sentinel nodes examined in the sentinel procedure in this data item, AND record the total number of regional lymph nodes biopsied/dissected **(which includes the number of sentinel nodes documented in this data item)** in the *Regional Lymph Nodes Examined* data field.
- If both an *aspiration* of sentinel lymph node(s) is done, AND a sentinel node *biopsy* is done on the same patient, **record the results of the sentinel node biopsy procedure.**
- The number of sentinel nodes examined should be equal to or less than the number of regional lymph nodes examined recorded in the *Regional Lymph Nodes Examined* data field.

Codes:

Code	Description
00	No sentinel nodes were examined
01-90	Sentinel nodes were examined (code the exact number of sentinel lymph nodes examined)
95	No sentinel nodes were removed, but aspiration of sentinel node(s) was performed
98	Sentinel lymph nodes were biopsied, but the number is unknown
99	Unknown whether sentinel nodes were examined; not stated in patient record

VI.2.6 Scope of Regional Lymph Node Surgery

This field is used to record surgeries performed on regional lymph nodes. Refer to the most current AJCC Staging Manual for nodes identified as regional by the AJCC. Record the removal of distant lymph node(s) in *Surgical Procedure of Other Reg/Dis site*.

Guidelines:

- Records the removal, biopsy or aspiration (FNA) of regional LNS performed.
    - During the workup as a separate surgical event **OR**
    - At the time of the primary site surgery as either a separate LN surgery or an incidental LN removal as part of the surgical specimen.
- Lymph node dissection (LND) is the removal of multiple lymph nodes.
- Regional LND removes some of the lymph nodes in a tumor area.
- Radical LND attempts to remove the entire group of lymph nodes.
- Use the operative report as the primary coding source to determine if a SLNBx or RLND were performed.
- Do not use the number of LNs removed/examined to determine SLNBx vs RLND.
- Use to code ONLY regional LNs:
    - When two primaries share a common regional ln, code regional node removal for both primaries.
    - Removal of distant LNs is coded in *Surgical Procedure of Other Site.*

Coding Instructions:

Effective January 1, 2012 and forward the following instructions apply:

- Record the farthest regional lymph node removed regardless of involvement with disease.
- There is no minimum number of nodes that must be removed.
    - Record the **cumulative** total of lymph nodes during each first course surgical procedure.
    - If a regional lymph node was aspirated or biopsied, code regional lymph node(s) removed, NOS (1).
        - For counting regional lymph nodes for a core needle biopsy or aspiration followed by a dissection, see Section Special Rules for Counting Lymph Nodes.
- The following instructions should be applied to all surgically treated cases for all types of cancers:

- The treatment of breast and skin cancer is where the distinction between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered.
- For all sites, non-sentinel regional node dissections are typical, and codes 2, 6, and 7 are infrequently used.

- Please reference https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals for additional background on the origin and scope of the issue.
- Use code 0 when:
  - Regional LNs were not removed.
  - RLND performed but **no** LNs were found by the pathologist.
  - Patient is on active surveillance or watchful waiting.
- Use code 1 when:
  - Only bx or FNA of regional LNs performed.
- Use code 2 when the **operative report** states:
  - SLNBx performed.
  - Describes procedure involving radio label and/or dye to ID LNs for removal (also see references to "hot" and/or "blue" LNS).
  - SLNBx attempted but "failed to map" **AND NO** LNs removed (no RLND performed).
  - SLN and additional incidental non-sentinel LNs are removed as part of the SLNBx procedure.

  BREAST Specific:
  - If >5LNs examined, must review operative report to confirm SLNBx only vs. additional ALND:
    - Assign code 2 when:
      - Only SLNBx performed.
      - SLNBx attempted but "failed to map" AND NO LNs removed.
    - Assign code 6 when SLNBx and ALND performed during the **same** surgical procedure.
- Use code 3 when the number of regional LNs removed is unknown, not stated, or are stated as regional LNs removed NOS.
- Use code 4 for 1-3 regional LNs removed.
- Use code 5 for 4 or more regional LNs removed.
- Use code 6 for SLNBx AND regional LND during the same surgical event or the timing is **unknown**.
- Use code 7 for SLNBx and regional LND in **separate** events.

BREAST Specific (codes 3-7):

- Typically, ALND removes at least 7-9 LNS but can remove fewer LNS. Must check op report to confirm ALND only vs additional SLNBx.
    - Assign codes 3, 4, or 5 when only ALND is performed.
    - Assign code 6 if:
        - SLNBx and ALND performed during the **same** surgical event.
        - SLN Bx attempted but "failed to map" AND ALND performed during the **same** surgical event.
    - Assign code 7 if SLNBx and ALND performed during a **separate** surgical event.

Codes:

Code	Label	General Instruction Applying to All Sites	Additional Notes Specific to Breast (C50.x)
		Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.	*Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), an axillary node dissection (ALND), or a combination of both SLNBx and ALND. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a ALND.*
0	No regional lymph node surgery	No regional lymph node surgery	

1	Biopsy or aspiration of regional lymph node(s)	Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed. If additional procedures were performed on the lymph nodes, use the appropriate code 2-7	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7
2	Sentinel Lymph Node Biopsy	• The operative report states that a SLNBx was performed • Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination • When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6	• If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND) • Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items *Regional Lymph Nodes Examined* (NAACCR Item #830) and *Regional Lymph Nodes Positive* (NAACCR Item #820)

3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	• The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure) • Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7) • Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only • Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes were examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7) • Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event	Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7)
4	1-3 regional lymph nodes removed		
5	4 or more regional lymph nodes removed		

6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	• SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known • Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only • Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6	• Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed
7	Sentinel node biopsy and code 3, 4, or 5 at different times	• SLNBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events • Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only	• Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a SLNBx plus an ALND was performed
9	Unknown or not applicable	• The status of regional lymph node evaluation should be known for surgically treated cases (i.e., cases coded 19-90 in the data item *Surgery of Primary Site* [NAACCR Item #1290]). Review surgically treated cases coded 9 in *Scope of Regional Lymph Node Surgery* to confirm the code	

- Starting with cases diagnosed January 1, 2003 forward, RX Summ, Scope of Reg LN Surg is not to be coded according to site. It is coded using a single scheme for all sites. The three procedure fields must continue to be coded for 2003 forward cases.

The codes for Scope of Regional LN's are as follows:

Code	Description
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 NODE REMOVED, NOS Sampling or dissection of regional lymph node(s) and the number of nodes is unknown or not stated. The procedure is not specified as sentinel node biopsy
4	1-3 REGIONAL LYMPH NODES REMOVED Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy
5	4 OR MORE REGIONAL LYMPH NODES REMOVED Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy
6	SENTINEL NODE BIOPSY AND CODE 3, 4, OR 5 AT SAME TIME, OR TIMING OUT 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 was 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; primaries of the brain, meninges, spinal cord, cranial nerves and other part of the CNS (including the pituitary gland, craniopharyngeal duct, and pineal gland), or for leukemia/lymphoma histologies, hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease

VI.2.6.1 Date of Regional Lymph Node Dissection

Records the date non-sentinel regional lymph node dissection (RLND) was performed. This data item can be used to more accurately assess the date of regional node dissection separate from the date of sentinel lymph node biopsy if performed. This data item is required by CoC-accredited facilities for all cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Enter the date of the non-sentinel, regional lymph node dissection performed, and documented in the *Regional Lymph Nodes Examined* data item.
- For Breast and Melanoma cases:
    - If both a sentinel lymph node biopsy (SLNBx) was done and then a subsequent, separate RLND, record the RLND in this data item, and record the date of the SLNBx procedure in the *Date of Sentinel Lymph Node Biopsy* data item.
        - If a SLNBx and a RLND are performed on the same date, the dates should be equal/the same.
        - If the RLND is done subsequently (on a later date), than the SLNBx, then dates for each procedure will differ.
- For all other cases, record the date of the regional lymph node dissection in this data item.
- Record the date, procedure, and results in the associated text field(s).

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates.

VI.2.6.1.1 Date of Regional Lymph Node Dissection Flag

This data item is used to explain why there is no appropriate value in the corresponding date field. This data item is required by CoC-accredited facilities for all cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any regional lymph node dissection was performed)
11	No proper value is applicable in this context (for example, no regional lymph node dissection was performed; autopsy only cases
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, regional lymph node dissection was performed but date is unknown)
Blank	A valid date value is provided; Case was diagnosed prior to January 1, 2018

VI.2.6.2 Regional Lymph Nodes Positive

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

Note: Effective with cases diagnosed January 1, 2016 and forward, the AJCC definition takes precedence if the definition of regional nodes differs between the current AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual.

Coding Instructions:

- **This field is based on pathologic information only**.
- Record information **only** about regional lymph nodes in this field.
- This field is to be recorded regardless of whether the patient received preoperative treatment.
- This field collects the cumulative count of lymph nodes found to be positive by pathologic examination.
    - From all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.
- Tumors which are truly in situ cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed.
- Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in regional nodes positive when there are positive nodes in the resection.
- If the positive aspiration or core biopsy is from a regional node in a different node region then the regional lymph node chain surgically removed, include the node in the count of regional nodes positive.
- If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of regional nodes positive.
- If there is a discrepancy regarding the number of positive lymph nodes, **use information in the following priority**:
    - final diagnosis
    - synoptic report (also known as CAP protocol or pathology report checklist)
    - microscopic
    - gross
- If there are multiple primary cancers with different histologic types in the same organ, and the pathology report just states the number of nodes positive:

    - First, try to determine the histology of the metastases in the nodes and code the nodes as positive for the primary with that histology.
- If no further information is available, code the nodes as positive for all primaries.
- When Isolated Tumor Cells (ITCs) for all primary sites *except cutaneous melanoma and Merkel cell carcinoma of skin* are identified, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size).
    - Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs).
    - If the path report indicates that nodes are positive, but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.
    - For cutaneous melanoma and Merkel cell carcinoma, count nodes with ITCs as positive lymph nodes.
- Code 95 is used when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
    - Use code 95 when a positive lymph node is aspirated and there are no surgically resected lymph nodes.
    - Use code 95 when a positive lymph node is aspirated, and surgically resected lymph nodes are negative.
- Code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology.
    - Code 97 includes positive lymph nodes diagnosed by either cytology or histology.
    - Avoid using *Regional Nodes Positive* code 97 if possible, even if this means slightly undercounting the number of nodes positive.
- Code 98 may be used in several situations.
    - When the assessment of lymph nodes is clinical only.
    - When no lymph nodes are removed and examined.
    - When a “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
    - **If *Regional Nodes Positive* is coded as 98, *Regional Nodes Examined* is usually coded 00**.
- Code 99 is used if it is unknown whether regional lymph nodes are positive.
    - For the following primary sites and histologies, the *Regional Nodes Positive* data field is always coded as 99:
        - Placenta
        - Brain and Cerebral Meninges

- Other Parts of Central Nervous System
- Intracranial Gland
- Hodgkin and non-Hodgkin Lymphoma
- Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
- Myeloma and Plasma Cell Disorders
- Other and Ill-Defined Primary Sites
- Unknown Primary Site

Codes:

Code	Description
00	All nodes examined negative
01-89	1 to 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node(s)
97	Positive nodes - number unspecified
98	No nodes examined
99	Unknown whether nodes are positive; not applicable; not documented in patient record

VI.2.6.3 Regional Lymph Nodes Examined

This field records the total number of regional lymph nodes that were removed and examined by the pathologist.

Note: Effective with cases diagnosed January 1, 2016 and forward, the AJCC definition takes precedence if the definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual.

Coding Instructions:

- Record information **only** about regional lymph nodes in this field.
- **This field is based on pathologic information only**.
- This field is to be recorded regardless of whether the patient received preoperative treatment.
- Record the total number of regional lymph nodes removed and examined by the pathologist.
    - The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
    - Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in *Regional Nodes Examined* data item.
    - If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of *Regional Nodes Examined* data item.
    - If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of *Regional Nodes Examined*.
    - When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use code 98.
- If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority:
    - final diagnosis
    - synoptic report (also known as CAP protocol or pathology report checklist)
    - microscopic
    - gross
- Code 00 may be used in several situations.
    - When the assessment of lymph nodes is clinical.
    - When no lymph nodes are removed and examined.

    - When a “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
    - **If *Regional Nodes Examined* is coded 00, *Regional Nodes Positive* is coded as 98**.
- Code 95 is used when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
- Code 96 is used if the number of nodes removed by biopsy is not known.
    - Use code 96 when a limited number of nodes are removed but the number is unknown. A lymph node “sampling” is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection.
- Code 97 is used when:
    - More than a limited number of lymph nodes are removed, and the number is unknown. A lymph node “dissection” is the removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, or lymph node stripping.
    - If both a lymph node sampling and a lymph node dissection are performed, and the total number of lymph nodes examined is unknown.
- Code 98 when neither the type of lymph node removal procedure nor the number of lymph nodes examined is known.
- Code 99 is used if it is unknown whether nodes were removed or examined.
    - For the following schemas, the *Regional Nodes Examined* data field is always coded as 99:
        - Placenta
        - Brain and Cerebral Meninges
        - Other Parts of Central Nervous System
        - Intracranial Gland
        - Hodgkin and non-Hodgkin Lymphoma
        - Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
        - Myeloma and Plasma Cell Disorders
        - Other and Ill-Defined Primary Sites
        - Unknown Primary Site

Note: Effective with cases diagnosed on or after January 1, 2003, the fields for *Rx Summ-Reg LN Examined* and *Rx Hosp-Reg LN Examined* are no longer required by the CCR and

the CoC. Information regarding the number of lymph nodes has been incorporated into the scope fields.

Codes:

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

VI.2.7 Special Rules for Counting Lymph Nodes

Special rules for counting regional lymph nodes, gives guidance as to what to do when a core needle biopsy or aspiration is followed by a dissection.

Coding Instructions:

- Add 1 to the number of regional lymph nodes positive and examined when the core biopsy or aspiration is *positive* for metastases, **and** the lymph node dissection does not include the area where the core biopsy or aspiration was done, **and** that lymph node was a regional lymph node for the primary site.

  Example:

  Patient with breast cancer has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. **Code *Regional Nodes Positive* as 04 and *Regional Nodes Examined* as 09 because the supraclavicular lymph node is a regional lymph node for breast, but in a different lymph node chain.**

  Notes:

  - Do not add 1 to regional lymph nodes positive if the biopsy or aspiration was negative for metastases.
  - Do not add to the count of regional lymph nodes examined or positive when the area biopsied or aspirated is *included* in the dissection.

- If the location of the lymph node that is aspirated or biopsied is unknown, assume it was part of the lymph node chain surgically removed, and do not add it to the count of *Regional Nodes Examined*.

  Example:

  Records indicate a lymph node core biopsy was performed at another facility and 7 of 14 regional lymph nodes were positive at the time of resection. **Code *Regional Nodes positive* as 07 and *Regional Nodes Examined* as 14.**

VI.2.8 Surgery of Other Regional Sites, Distant Sites, or Distant Lymph Nodes

This field refers to the surgical removal of sites other than the primary site. There are three one-character fields to be used to record removal of tissue other than the primary tumor or organ of origin. This would not include an en bloc resection.

Coding Instructions:

- RX Summ - Surg Oth Reg/Dis and its corresponding procedure fields are not coded according to site. Rather, they are coded using a single scheme for all sites. This applies to cases diagnosed January 1, 2003 and forward.
- Code the removal of non-primary site tissue, which the surgeon may have suspected to be involved with malignancy even if the pathology was negative.

  Example:

  The patient has an excisional biopsy of a hard palate lesion removed from the roof of the mouth and a resection of a metastatic lung nodule during the same procedure. Code the resection of the lung nodule as 4 (distant site).

- Do not code the incidental removal of tissue for reasons other than malignancy.

  Example:

  During a colon resection, the surgeon noted that the patient had cholelithiasis and removed the gallbladder. Do not code removal of the gallbladder.

- Procedures are to be entered in chronological order.
- If no surgery was performed of other regional or distant sites or distant lymph nodes, leave the fields blank.
- Codes 1-5 have priority over codes 0 and 9.
- Use code 1:
  - If any surgery is performed to treat tumors of Unknown or Ill-defined Primary sites or for hematopoietic/reticuloendothelial/immunoproliferative disease.
  - When the involved contralateral breast is removed for a single breast cancer.
- Use code 2 for sites that are regional.
- Use code 4 for sites that are distant.
- Do not code tissue or organs such as appendix that were removed incidentally, and the organ was not involved with cancer.
- Record the date, surgical procedure, and results in the associated text field.

  Note: Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer. The incidental removal of the appendix, gallbladder etc., during abdominal surgery, for example.

Codes:

Code	Description
0	NONE No surgical procedure of nonprimary site
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

VI.2.9 Surgery of Synchronous Primaries

Synchronous Primaries are multiple histologically distinct tumors diagnosed simultaneously. Outlined below are surgical coding instructions for synchronous primaries.

Coding Instruction:

- If multiple primaries are excised at the same time, enter the appropriate code for each site.

  Examples:

  - A total abdominal hysterectomy was performed for a patient with two primaries, one of the cervix and one of the endometrium.
    - Code each site as having had a total abdominal hysterectomy.
  - A total colectomy was performed on a patient with multiple primaries in several segments of the colon.
    - Code total colectomy for each of the primary segments.

VI.2.10 Systemic Therapy with Surgery Sequence

This field documents the sequence in which systemic therapy and surgical procedures were performed as part of the first course of treatment.

Coding Instructions:

- This data item is required by the CCR to be coded for all primary sites. This applies to cases diagnosed January 1, 2006 and forward.
- Use codes 2-9 for systemic therapy sequence with surgery if the first course of treatment includes codes for any of the following:
    - Surgery of the primary site
    - Scope of regional lymph node surgery
    - Surgery of other regional(s), distant site(s), or distant lymph node(s)
    - Systemic therapy
- Use code 0 for all other cases

Codes:

Code	Description
0	No systemic therapy and /or surgical procedures; unknown if surgery and/or systemic therapy given
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery **Note:** At least two courses of systemic therapy must be given to assign code 4
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before and/or after surgery
7	Surgery both before and after systemic therapy
9	Sequence unknown

VI.2.11 Reason for No Surgery of the Primary Site

Record the reason the patient did not have surgery to the primary site. Reason for No Surgery only applies to the Surgery of the Primary Site field, not Scope of Regional Lymph Node Surgery or Surgery Other Regional/Distant Sites.

Coding Instructions:

- If surgery of the primary site was performed, enter 0.
- Enter code 1 for the following scenarios:
    - For sites where "Surgery of the Primary Site" is coded to 00 or 98 (hematopoietic included).
    - Cases where the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include surgery of the primary site.
    - If the option of “no treatment” was accepted by the patient.
- The following applies to cases diagnosed January 1, 2003 and forward:
    - Code 5 - Surgery not performed because patient died was added
    - Definitions for codes 1, 2, and 6 were modified
- Patient’s decision not to pursue surgery is not a refusal of surgery when:
    - The patient has discussed surgery with their physician, and then decides to pursue no treatment.

      Note: Discussion does not equal a recommendation.

Codes:

Code	Description
0	Surgery of the primary site performed
1	Surgery of the primary site not performed because it was not part of the planned first course treatment
2	Surgery of the primary site not performed because of contraindications due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery (code added in 2003)
6	Surgery of the primary site was recommended but not performed. No reason was noted in the patient's record
7	Surgery of the primary site was recommended but refused by the patient, family member or guardian. The refusal is noted in the patient's record
8	Surgery of the primary site was recommended but unknown if performed. Further follow-up is recommended

9	Not known if surgery of the primary site was recommended or performed; death certificate only; diagnosed at autopsy

VI.3 Radiation Therapy - First Course of Treatment

The new “phase” terminology replaces the traditional terms of “regional” and “boost.” The initial phase (Phase I) is frequently referred to as the initial plan and a subsequent (Phase II) may be referred to as the boost or cone down. A new phase begins when there is a change in the target volume of a body site, treatment fraction size, modality, or treatment technique. To accommodate this, three phases of radiation can now be documented.

Coding Instructions:

- Document the date, name or chemical symbol, as well as method of administration of any radiation therapy that is directed to tumor tissue in the appropriate text field, even if given prophylactically.
    - This includes the administration of any radioactive material given orally, intracavitary, or by intravenous injection.

    Exceptions:

    - Radiation for hormonal effect, such as irradiation of non-cancerous endocrine glands is not coded.
    - Irradiation of the male breast to prevent gynecomastia is not coded.
- Location of Radiation Treatment is required by the CCR. It identifies the location of the facility in which radiation treatment was administered during first course of treatment. This applies to cases diagnosed 1/1/2008 forward.
- For additional information on coding Radiation Therapy, please see the CoC’s: CTR Guide to Coding Radiation Therapy Treatment in the STORE.

VI.3.1 Types of Radiation

The principal types of radiation therapy are the external administration of radioactive beams, implantation of radioactive material, and the internal administration of radioisotopes by other than implantation.

Radioactive materials include the following:

Symbol	Description
Au^{198}	Gold
Co^{60}	Cobalt
$Cr^{32}PO_4$	Phosphocol
$CrPO_4$	Chromic phosphate
Cs	Cesium
I^{125}	Iodine
I^{131}	Iodine
Ir^{192}	Iridium
P^{32}	Phosphorus
Pb^{210}	Lead
Ra^{226}	Radium
Rn^{222}	Radon
Ru^{106}	Ruthenium
Sr^{90}	Strontium
Y^{90}	Yttrium

VI.3.1.1 External Beam Radiation

Radiation is classified as beam when the source of radioactivity is outside the patient, as in a cobalt machine or linear accelerator.

Examples of beam radiation are:

- Betatron
- Brachytron
- Cobalt
- Cyclotron
- Grenz ray
- Helium ion or other heavy particle beam
- Linear accelerator (LINAC)
- MeV
- Neutron beam
- Photon beam
- Proton beam
- Spray radiation
- Stereotactic radiosurgery, such as gamma knife and proton beam
- X-ray

VI.3.1.2 Radioactive Implants

Record the name or chemical symbol and method of administration of any radioactive material administered by implants, molds, seeds, needles, or intracavity applicators.

Coding Instructions:

- The following items are types of Radioactive Implants and should be coded in the Radiation Treatment Modality - Phases I-III fields:
    - Heyman capsules, Fletcher suit, and Fletcher after loader are methods of isotope application.
    - Record High Dose Rate (HDR) and Low Dose Rate (LDR).
    - I-125 treatment for prostate cancer to brachytherapy.
        - Treatment modality to low dose radiotherapy (LDR).
    - Tumor embolization using a radioactive agent or radioactive seeds.

VI.3.2 Date of Radiation Therapy

Enter the date in which radiation therapy for this diagnosis began at any facility as part of the first course treatment.

Coding Instructions:

- Enter the earliest/first date in which radiation was administered.
    - Include date and treatment performed in the corresponding text field.
- Record only first course of treatment dates in this field.
- Date radiation started will typically be found in the radiation oncologist's summary letter for the first course of treatment.
    - Determination of the date radiation started may require assistance from the radiation oncologist.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates. Consult with your software vendor for specific data entry instructions.

VI.3.2.1 Date of Radiation Therapy Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	Unknown whether radiation therapy was given
11	No radiation therapy planned or given
12	Date cannot be determined for radiation therapy received during first course
15	Radiation therapy is planned; start date is not yet available
Blank	Full or partial date recorded

VI.3.3 Radiation Phases I-III General Information

Radiation is commonly delivered in more than one phase. Typically, initial treatment is delivered to the primary tumor, draining lymph nodes or tumor bed in Phase I. The subsequent boost(s) may occur to tumor bed, lymph nodes, etc., with same or alternate radiation modalities. These are considered Phase II and Phase III.

For additional information on coding Radiation Therapy, please see the Commission on Cancer's: CTR Guide to Coding Radiation Therapy Treatment in the STORE.

VI.3.3.1 Radiation Primary Treatment Volume - Phases I-III

These items identify the primary treatment volume or primary anatomic target delivered to the patient during each phase of radiation during the first course of therapy. This data item should be used to indicate the primary target volume, which might include the primary tumor or tumor bed. The CCR requirement for the Radiation Treatment Volume Phase I, II, and III fields are: Required by CoC-accredited facilities and as available by non-CoC accredited facilities for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Enter the code for radiation given to the primary treatment volume in the appropriate phase I, II, and III fields.
- 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.
- A new phase begins when there is a clinically meaningful change in the target volume, fraction size, modality, or treatment technique.
- Usually the phase breakdown is as follows:
    - Phase I – Initial plan

      Note: Phase I, may include primary tumor bed and associated draining lymph node regions. In this situation:
        - Code the radiation to the primary tumor bed in this data item.
        - Code the radiation to the draining lymph nodes in the *Radiation to Draining Lymph Nodes* data item.
    - Phase II and/or III – Boost or cone down.
- Only use codes 01 – 09 when the lymph nodes are the primary target.
    - When the primary treatment volume is lymph nodes, draining lymph nodes are not targeted; therefore use code 88 to record *Phase 1 Radiation to Draining Lymph Nodes.*

Code Order:

Code	Label	Description
00	No radiation treatment	Radiation therapy was not administered to the patient; Diagnosed at autopsy
01	Neck lymph node regions	The primary treatment is directed at the lymph node regions of the neck. Example situations include treatment of lymphoma or lymph node recurrence (in the absence of primary site failure) following definitive surgery of the primary tumor. If radiation to the neck lymph nodes includes the supraclavicular region use code 03

02	Thoracic lymph node regions	Radiation therapy is directed to some combination of hilar, mediastinal, and supraclavicular lymph nodes without concurrent treatment of a visceral organ site. Example situations include mantle or mini-mantle for lymphomas, and treatment of lymphatic recurrence after complete surgical excision of a thoracic primary. Note that the supraclavicular region may be part of a head and neck lymph node region. Use code 03 for treatments directed at neck nodes and supraclavicular nodes with a head and neck primary. Use code 04 if supraclavicular lymph nodes are part of breast treatment
03	Neck and thoracic lymph node regions	Treatment is directed to lymph nodes in the neck and thoracic region without concurrent treatment of a primary visceral tumor. This code might apply to some mantle or mini-mantle fields used in lymphoma treatments for lymphatic recurrences following definitive treatment for tumors of the head and neck or thoracic regions
04	Breast/ Chestwall lymph node regions	Radiation is directed primary to some combination of axillary, supraclavicular, and/or internal mammary lymph node sites WITHOUT concurrent treatment of the breast or chest wall. If the breast AND lymph nodes are being treated, then code the Primary Treatment Volume to Breast (codes 40 or 41) and Breast/chest wall lymph nodes (code 04) in Radiation to Draining Lymph Nodes
05	Abdominal lymph nodes	Treatment is directed to some combination of the lymph nodes of the abdomen, including retro-crural, peri-gastric, peri-hepatic, portocaval and para-aortic nodes. Possible situations might include seminoma, lymphoma, or lymph node recurrence following surgical resection of the prostate, bladder or uterus
06	Pelvic lymph nodes	Treatment is directed to some combination of the lymph nodes of the pelvis, including the common, internal and external iliac, obturator, inguinal and peri-rectal lymph nodes. This might be done for lymphoma or lymph node recurrence following definitive surgery for a pelvic organ
07	Abdominal and pelvic lymph nodes	Treatment is directed to some combination of lymph nodes in both the abdomen and pelvis. This code includes extended fields (“hockey stick”, “dog-leg”, “inverted Y”, etc.) utilized to treat seminomas and lymphomas or recurrence of a solid tumor.
09	Lymph node region, NOS	This category should be used to code treatments directed at lymph node regions that are not adequately described by codes 01-07
10	Eye/orbit/optic nerve	Treatment is directed at all of a portion of the eye, orbit and/or optic nerve
11	Pituitary	Treatment is directed at the pituitary gland
12	Brain	Treatment is directed at all the brain and its meninges (“whole brain”)
13	Brain (Limited)	Treatment is directed at one or more sub-sites of the brain but not the whole brain. Chart may describe “SRS”, “Stereotactic Radiosurgery”, ”Gamma Knife”
14	Spinal cord	Treatment is directed at all of a portion of the spinal cord or its meninges
20	Nasopharynx	Treatment is directed at all or a portion of the nasopharynx

21	Oral Cavity	Treatment is directed at all or a portion of the oral cavity, including the lips, gingiva, alveolus, buccal mucosa, retromolar trigone, hard palate, floor of mouth and oral tongue
22	Oropharynx	Treatment is directed at all or a portion of the oropharynx, including the soft palate, tonsils, base of tongue and pharyngeal wall
23	Larynx (glottis) or hypopharynx	Treatment is directed at all or a portion of the larynx and/or hypopharynx
24	Sinuses/Nasal tract	Treatment is directed at all or a portion of the sinuses and nasal tract, including the frontal, ethmoid, sphenoid and maxillary sinuses
25	Parotid or other salivary glands	Treatment is directed at the parotid or other salivary glands, including the submandibular, sublingual and minor salivary glands
26	Thyroid	Treatment is directed at all or a portion of the thyroid. Code this volume when the thyroid is treated with I-131 radioisotope
29	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the head and neck, but the primary sub-site is not a head and neck organ identified by codes 20-26 or it is an “unknown primary”
30	Lung or bronchus	Treatment is directed at all or a portion of the lung or bronchus
31	Mesothelium	Treatment is directed to all or a portion of the mesothelium. This code should be used for mesothelioma primaries, even if a portion of the lung is included in the radiation field
32	Thymus	Treatment is directed to all or a portion of the thymus
39	Chest/lung (NOS)	The treatment is directed at a primary tumor of the chest, but the primary sub-site is unknown or not identified in codes 30-32. For example, this code should be used for sarcomas arising from the mediastinum
40	Breast - whole	Treatment is directed at all the intact breast. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy
41	Breast - partial	Treatment is directed at a portion of the intact breast but not the whole breast. The chart may have terms such as “Mammosite”’ “interstitial (seed) implant)”, or “(accelerated) partial breast irradiation.” Consider the possibility of partial breast irradiation when “IMRT” is documented in the record
42	Chest wall	Treatment encompasses the chest wall (following mastectomy)
50	Esophagus	Treatment is directed at all or a portion of the esophagus. Include tumors of the gastro-esophageal junction
51	Stomach	Treatment is directed at all or a portion of the stomach
52	Small bowel	Treatment is directed at all or a portion of the small bowel
53	Colon	Treatment is directed at all or a portion of the colon
54	Rectum	Treatment is directed at all or a portion of the rectum
55	Anus	Treatment is directed at all or a portion of the anus

56	Liver	Treatment is directed at all or a portion of the liver**.**
57	Biliary tree or gallbladder	Treatment is directed at all or a portion of the biliary tree or gallbladder
58	Pancreas or hepatopancreatic ampulla	Treatment is directed at all or a portion of the pancreas or the hepatopancreatic ampulla. Hepatopancreatic ampulla tumors are sometimes referred to as periampullary tumors
59	Abdomen (NOS)	Treatment is directed at a primary tumor of the abdomen, but the primary sub-site is not an abdominal organ defined by codes 50-58 or it is considered to be an “unknown primary.” For example, this code should be used for sarcomas arising from the abdominal retroperitoneum
60	Bladder - whole	Treatment is directed at all the bladder
61	Bladder - partial	Treatment is directed at a portion of the bladder but not the whole bladder
62	Kidney	Treatment is directed at all or a portion of the kidney
63	Ureter	Treatment is directed at all of a portion of the ureter
64	Prostate - whole	Treatment is directed at all the prostate and/or seminal vesicles. Use this code even if seminal vesicles are not explicitly targeted
65	Prostate - partial	Treatment is directed at a portion of the prostate but not the whole prostate
66	Urethra	Treatment is directed at all or a portion of the urethra
67	Penis	Treatment is directed at all or a portion of the penis. Treatments of urethral primaries should be coded as ‘urethra’ (code 66)
68	Testicle or scrotum	Treatment is directed at all or a portion of the testicle and/or scrotum
70	Ovaries or fallopian tubes	Treatment is directed at all or a portion of the ovaries or fallopian tubes
71	Uterus or Cervix	Treatment is directed at all or a portion of the uterus, endometrium or cervix
72	Vagina	Treatment is directed at all or a portion of the vagina. Treatments of urethral primaries should be coded as ‘urethra’ (code 66)
73	Vulva	Treatment is directed at all or a portion of the vulva. Treatments of urethral primaries should be coded as ‘urethra’ (code 66)
80	Skull	Treatment is directed at all or a portion of the bones of skull. Any brain irradiation is a secondary consequence
81	Spine/vertebral bodies	Treatment is directed at all or a portion of the bones of the spine/vertebral bodies, including the sacrum. Spinal cord malignancies should be coded using ‘spinal cord’ (code 14)
82	Shoulder	Treatment is directed at all or a portion of the proximal humerus, scapula, clavicle, or other components of the shoulder complex
83	Ribs	Treatment is directed at all or a portion of the one or more ribs

84	Hip	Treatment is directed at all or a portion of the proximal femur or acetabulum
85	Pelvic bones	Treatment is directed at all or a portion of the bones of the pelvis other than the hip or sacrum
86	Pelvis (NOS, non-visceral)	Treatment is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis
88	Extremity bone, NOS	This treatment is directed at all or a portion of the bones of the arms or legs. This **excludes** proximal femur (hip, code 84). This **excludes** the proximal humerus (Shoulder, code 82)
90	Skin	Treatment is directed at all or a portion of the 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 as a soft tissue site
91	Soft tissue	This category should be used to code primary or metastatic soft tissue malignancies not fitting other categories
92	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
93	Whole body	Treatment is directed to the entire body included in a single treatment
94	Mantle, mini-mantle (obsolete after 2017)	For conversion of historical data only
95	Lower extended field (obsolete after 2017)	For conversion of historical data only
96	Inverted Y (obsolete after 2017)	For conversion of historical data only
97	Invalid historical FORDS value	Conversion to new STORE data item could not take place due to an invalid FORDS volume code
98	Other	Radiation therapy administered; treatment volume other than those previously categorized by codes 01-93
99	Unknown	This category should be used to code treatments for which there is no information available about the treatment volume, or it is unknown if radiation treatment was administered

Label Order:

Label	Code	Definition
Abdomen (NOS)	59	Treatment is directed at a primary tumor of the abdomen, but the primary sub-site is not an abdominal organ defined by codes 50-58 or it is considered to be an “unknown primary.” For example, this code should be used for sarcomas arising from the abdominal retroperitoneum.

Abdominal and pelvic lymph nodes	07	Treatment is directed to some combination of lymph nodes in both the abdomen and pelvis. This code includes extended fields (“hockey stick”, “dog-leg”, “inverted Y”, etc.) utilized to treat seminomas and lymphomas or recurrence of a solid tumor
Abdominal lymph nodes	05	Treatment is directed to some combination of the lymph nodes of the abdomen, including retro-crural, peri-gastric, peri-hepatic, portocaval and para-aortic nodes. Possible situations might include seminoma, lymphoma, or lymph node recurrence following surgical resection of the prostate, bladder or uterus
Anus	55	Treatment is directed at all or a portion of the anus
Biliary tree or gallbladder	57	Treatment is directed at all or a portion of the biliary tree or gallbladder
Bladder - partial	61	Treatment is directed at a portion of the bladder but not the whole bladder
Bladder - whole	60	Treatment is directed at all the bladder
Brain	12	Treatment is directed at all the brain and its meninges (“whole brain”)
Brain (Limited)	13	Treatment is directed at one or more sub-sites of the brain but not the whole brain. Chart may describe “SRS”, “Stereotactic Radiosurgery”, ”Gamma Knife”
Breast - partial	41	Treatment is directed at a portion of the intact breast but not the whole breast. The chart may have terms such as “Mammosite”’ “interstitial (seed) implant)”, or “(accelerated) partial breast irradiation.” Consider the possibility of partial breast irradiation when “IMRT” is documented in the record
Breast - whole	40	Treatment is directed at all the intact breast. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy
Breast/ Chestwall lymph node regions	04	Radiation is directed primary to some combination of axillary, supraclavicular, and/or internal mammary lymph node sites WITHOUT concurrent treatment of the breast or chest wall. If the breast AND lymph nodes are being treated, then code the Primary Treatment Volume to Breast (codes 40 or 41) and Breast/chest wall lymph nodes (code 04) in Radiation to Draining Lymph Nodes
Chest wall	42	Treatment encompasses the chest wall (following mastectomy)
Chest/lung (NOS)	39	The treatment is directed at a primary tumor of the chest, but the primary sub-site is unknown or not identified in codes 30-32. For example, this code should be used for sarcomas arising from the mediastinum
Colon	53	Treatment is directed at all or a portion of the colon
Esophagus	50	Treatment is directed at all or a portion of the esophagus. Include tumors of the gastro-esophageal junction
Extremity bone, NOS	88	This treatment is directed at all or a portion of the bones of the arms or legs. This **excludes** proximal femur (hip, code 84). This **excludes** the proximal humerus (Shoulder, code 82)

Eye/orbit/optic nerve	10	Treatment is directed at all of a portion of the eye, orbit and/or optic nerve
Head and neck (NOS)	29	The treatment volume is directed at a primary tumor of the head and neck, but the primary sub-site is not a head and neck organ identified by codes 20-26 or it is an “unknown primary”
Hemibody	92	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
Hip	84	Treatment is directed at all or a portion of the proximal femur or acetabulum
Invalid historical FORDS value	97	Conversion to new STORE data item could not take place due to an invalid FORDS volume code
Inverted Y (obsolete after 2017)	96	For conversion of historical data only
Kidney	62	Treatment is directed at all or a portion of the kidney
Larynx (glottis) or hypopharynx	23	Treatment is directed at all or a portion of the larynx and/or hypopharynx
Liver	56	Treatment is directed at all or a portion of the liver
Lower extended field (obsolete after 2017)	95	For conversion of historical data only
Lung or bronchus	30	Treatment is directed at all or a portion of the lung or bronchus
Lymph node region, NOS	09	This category should be used to code treatments directed at lymph node regions that are not adequately described by codes 01-07
Mantle, mini-mantle (obsolete after 2017)	94	For conversion of historical data only
Mesothelium	31	Treatment is directed to all or a portion of the mesothelium. This code should be used for mesothelioma primaries, even if a portion of the lung is included in the radiation field
Nasopharynx	20	Treatment is directed at all or a portion of the nasopharynx
Neck and thoracic lymph node regions	03	Treatment is directed to lymph nodes in the neck and thoracic region without concurrent treatment of a primary visceral tumor. This code might apply to some mantle or mini-mantle fields used in lymphoma treatments for lymphatic recurrences following definitive treatment for tumors of the head and neck or thoracic regions
Neck lymph node regions	01	The primary treatment is directed at the lymph node regions of the neck. Example situations include treatment of lymphoma or lymph node recurrence (in the absence of primary site failure) following definitive surgery of the primary tumor. If ration to the neck lymph nodes includes the supraclavicular region use code 03
No radiation treatment	00	Radiation therapy was not administered to the patient. Diagnosed at autopsy

Oral Cavity	21	Treatment is directed at all or a portion of the oral cavity, including the lips, gingiva, alveolus, buccal mucosa, retromolar trigone, hard palate, floor of mouth and oral tongue
Oropharynx	22	Treatment is directed at all or a portion of the oropharynx, including the soft palate, tonsils, base of tongue and pharyngeal wall
Other	98	Radiation therapy administered; treatment volume other than those previously categorized by codes 01-93
Ovaries or fallopian tubes	70	Treatment is directed at all or a portion of the ovaries or fallopian tubes
Pancreas or hepatopancreatic ampulla	58	Treatment is directed at all or a portion of the pancreas or the hepatopancreatic ampulla. Hepatopancreatic ampulla tumors are sometimes referred to as periampullary tumors
Parotid or other salivary glands	25	Treatment is directed at the parotid or other salivary glands, including the submandibular, sublingual and minor salivary glands
Pelvic bones	85	Treatment is directed at all or a portion of the bones of the pelvis other than the hip or sacrum
Pelvic lymph nodes	06	Treatment is directed to some combination of the lymph nodes of the pelvis, including the common, internal and external iliac, obturator, inguinal and peri-rectal lymph nodes. This might be done for lymphoma or lymph node recurrence following definitive surgery for a pelvic organ
Pelvis (NOS, non-visceral)	86	Treatment is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis.
Penis	67	Treatment is directed at all or a portion of the penis. Treatments of urethral primaries should be coded as ‘urethra’ (code 66)
Pituitary	11	Treatment is directed at the pituitary gland
Prostate - partial	65	Treatment is directed at a portion of the prostate but not the whole prostate
Prostate - whole	64	Treatment is directed at all the prostate and/or seminal vesicles. Use this code even if seminal vesicles are not explicitly targeted
Rectum	54	Treatment is directed at all or a portion of the rectum
Ribs	83	Treatment is directed at all or a portion of the one or more ribs
Shoulder	82	Treatment is directed at all or a portion of the proximal humerus, scapula, clavicle, or other components of the shoulder complex
Sinuses/Nasal tract	24	Treatment is directed at all or a portion of the sinuses and nasal tract, including the frontal, ethmoid, sphenoid and maxillary sinuses
Skin	90	Treatment is directed at all or a portion of the 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 as a soft tissue site

Skull	80	Treatment is directed at all or a portion of the bones of skull. Any brain irradiation is a secondary consequence
Small bowel	52	Treatment is directed at all or a portion of the small bowel
Soft tissue	91	This category should be used to code primary or metastatic soft tissue malignancies not fitting other categories
Spinal cord	14	Treatment is directed at all of a portion of the spinal cord or its meninges
Spine/vertebral bodies	81	Treatment is directed at all or a portion of the bones of the spine/vertebral bodies, including the sacrum. Spinal cord malignancies should be coded using ‘spinal cord’ (code 14)
Stomach	51	Treatment is directed at all or a portion of the stomach
Testicle or scrotum	68	Treatment is directed at all or a portion of the testicle and/or scrotum
Thoracic lymph node regions	02	Radiation therapy is directed to some combination of hilar, mediastinal, and supraclavicular lymph nodes without concurrent treatment of a visceral organ site. Example situations include mantle or mini-mantle for lymphomas, and treatment of lymphatic recurrence after complete surgical excision of a thoracic primary. Note that the supraclavicular region may be part of a head and neck lymph node region. Use code 03 for treatments directed at neck nodes and supraclavicular nodes with a head and neck primary. Use code 04 if supraclavicular lymph nodes are part of breast treatment
Thymus	32	Treatment is directed to all or a portion of the thymus
Thyroid	26	Treatment is directed at all or a portion of the thyroid. Code this volume when the thyroid is treated with I-131 radioisotope
Unknown	99	This category should be used to code treatments for which there is no information available about the treatment volume, or it is unknown if radiation treatment was administered
Ureter	63	Treatment is directed at all of a portion of the ureter
Urethra	66	Treatment is directed at all or a portion of the urethra
Uterus or Cervix	71	Treatment is directed at all or a portion of the uterus, endometrium or cervix
Vagina	72	Treatment is directed at all or a portion of the vagina. Treatments of urethral primaries should be coded as ‘urethra’ (code 66)
Vulva	73	Treatment is directed at all or a portion of the vulva. Treatments of urethral primaries should be coded as ‘urethra’ (code 66)
Whole body	93	Treatment is directed to the entire body included in a single treatment

VI.3.3.2 Radiation to Draining Lymph Nodes - Phases I-III

These data items identify any draining lymph nodes treated during radiation. The first phase commonly targets both the primary tumor AND draining nodes as a secondary site. This data item indicates the draining LNs, if any, that were radiated during that phase of radiation. The CCR requirement for the Radiation to Draining Lymph Node fields are: Required by CoC-accredited facilities and as available by non-CoC accredited facilities for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Enter the code for radiation given to the draining lymph nodes in the appropriate phase I, II, and III fields.
- Radiation treatment to draining lymph nodes will typically be found in the radiation oncologist's summary letter for the first course of treatment.
    - Determination of the exact draining lymph nodes may require assistance from the radiation oncologist.
- A new phase begins when there is a clinically meaningful change in the target volume, fraction size, modality, or treatment technique.
- Usually the phase breakdown is as follows:
    - Phase I – Initial plan

      Note: Phase I, may include primary tumor bed and associated draining lymph node regions. In this situation:
        - Code the radiation to the draining lymph nodes in this data item.
        - Code the radiation to the primary tumor bed in the *Radiation Primary Treatment Volume* data item.
    - Phase II and/or III – Boost or cone down.
- Use codes 01 – 09 when the lymph nodes are the primary target.
- When the primary treatment volume is lymph nodes, draining lymph nodes are not targeted, therefore, record code 88 in this data item.

Codes:

Code	Description
00	No radiation treatment to draining lymph nodes; Diagnosed at autopsy
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/Chest wall lymph node regions

05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes
08	Lymph node region, NOS
88	Not applicable; Phase I-III Radiation Primary Treatment Volume is lymph nodes
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

VI.3.3.3 Radiation Treatment Modality - Phases I-III

These data items identify radiation modality administered during each phase of radiation treatment delivered during the first course of treatment. Radiation modality reflects whether treatment was external beam, brachytherapy, a radioisotope, or their major subtypes, or a combination of modalities. The Radiation Treatment Modality fields are required by the CCR for cases diagnosed January 1, 2018 and forward.

Historically, the previously named Regional Treatment Modality data field included codes, which described a mixture of modalities, treatment planning techniques and delivery techniques commonly used by Radiation Oncologists. For 2018 implementation, radiation treatment information for Regional Treatment Modality and External Beam Planning Technique will be collected in separate mutually exclusive data items. A separate data item for delivery technique has not been implemented because this information is not consistently reported.

Coding Instructions:

- Enter the code for the radiation treatment **modality** administered in the appropriate phase I, II, and III fields.
- 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 phases and determination of the respective treatment modality may require assistance from the radiation oncologist.
- This data item intentionally does not include reference to various MV energies because this is not a clinically important aspect of technique. A change in MV energy (e.g., 6MV to 12 MV) is not clinically relevant and does not represent a change in treatment technique. It is rare for change in MC energy to occur during any phase of radiation therapy.
- A new phase begins when there is a clinically meaningful change in the target volume, fraction size, modality, or treatment technique.
- Usually the phase breakdown is as follows:
    - Phase I – Initial plan
    - Phase II and/or III – Boost or cone down
- For the purposes of this data item, photons, x-ray, and gamma-rays are equivalent.
- Use code 13 for Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90.
- If this data item is coded to any of the external beam codes (01-06), the *External Beam Radiation Planning Technique* must be recorded in the appropriate phase I, II or III fields.

- If this data item is coded to any of the Brachytherapy or Radioisotope codes (07-16) the code of 88 must be recorded in data item *External Beam Radiation Planning Technique* for the appropriate phase I, II, or III fields.

  Note: Do not code a radioiodine scan in this data item. Only treatment is recorded in this data item.

- Coding instructions for radiation modality based on the type of heavy equipment used for therapy, are located in the CoC's CTR Guide to Coding Radiation Therapy Treatment, Appendix B – Coding Modality for the Heavy Equipment of Modern Radiation Therapy.

Codes:

Code	Description
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, interstitial, LDH
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-223
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Treatment radiation modality unknown; Unknown if radiation treatment administered

VI.3.3.4 Radiation External Beam Planning Technique - Phases I-III

These data items identify the external beam radiation planning technique used to define the target treatment area and/or administer each phase of radiation treatment during the first course of treatment. The Radiation External Beam Planning Technique fields are required by the CCR for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Enter the code for the radiation external planning technique used in the appropriate phase I, II, and III fields.
- Radiation external beam treatment planning technique will typically be found in the radiation oncologist's summary letter for the first course of treatment.
    - Determination of the external beam planning technique may require assistance from the radiation oncologist.
- A new phase begins when there is a clinically meaningful change in the target volume, fraction size, modality, or treatment technique.
- Usually the phase breakdown is as follows:
    - Phase I – Initial plan
    - Phase II and/or III – Boost or cone down
- Code 00 when radiation is **NOT** performed or when diagnosed at autopsy.
- Code 04 for Conformal or 3-D Conformal therapy whenever either is explicitly mentioned.
- Code 05 for Intensity Modulated Therapy (IMT) or Intensity Modulated Radiation Therapy (IMRT).

Codes:

Code	Label	Description
00	No radiation treatment	Radiation therapy was not administered to the patient; Diagnosed at autopsy
01	External beam, NOS	The treatment is known to be external beam, but there is insufficient information to determine the specific planning technique
02	Low energy x-ray/photon therapy	External beam therapy administered using equipment with a maximum energy less than one (1) million volts (MV). Energies are typically expressed in units of kilovolts (kV). These types of treatments are sometimes referred to as electronic brachytherapy or orthovoltage or superficial therapy. Clinical notes may refer to the brand names of low energy x-ray delivery devices, e.g. Axxent®, INTRABEAM®, or Esteya®

03	2-D therapy	An external beam planning technique using 2-D imaging, such as plain film x-rays or fluoroscopic images, to define the location and size of the treatment beams. Should be clearly described as 2-D therapy; This planning modality is typically used only for palliative patients
04	Conformal or 3-D conformal therapy	An external beam planning technique using multiple, fixed beams shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record
05	Intensity modulated therapy	An external beam planning technique where the shape or energy of beam is optimized using software algorithms. Any external beam modality can be modulated but these generally refer to photon or proton beams. Intensity modulated therapy can be described as intensity modulated radiation therapy (IMRT), intensity modulated x-ray or proton therapy (IMXT/IMPT), volumetric arc therapy (VMAT) and other ways. If a treatment is described as IMRT with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning
06	Stereotactic radiotherapy or radiosurgery, NOS	Treatment planning using stereotactic radiotherapy/radiosurgery techniques, but the treatment is not described as Cyberknife of Gamma Knife®. These approaches are sometimes described as SBRT (stereotactic body radiation), SABR (stereotactic ablative radiation), SRS (stereotactic radiosurgery), or SRT (stereotactic radiotherapy). If the treatment is described as robotic radiotherapy (e.g. Cyberknife®) or Gamma Knife®, use stereotactic radiotherapy subcodes below. If a treatment is described as stereotactic radiotherapy or radiosurgery with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning
07	Stereotactic radiotherapy or radiosurgery, robotic.	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which is specifically described as robotic (e.g. Cyberknife®)
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife®	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which uses a Cobalt-60 gamma ray source and is specifically described as Gamma Knife®. This is must commonly used for treatments in the brain
09	CT-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using a CT scan obtained at the treatment machine (online). These approaches are sometimes described as CT-guided online re-optimization or online re-planning. If a treatment technique is described as both CT-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as CT-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used

10	MR-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using and MRI scan obtained at the treatment machine (online). These approaches are sometimes described as MR-guided online re-optimization or online re-planning. If a treatment technique is described as both MR-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as MR-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used
88	Not Applicable	Treatment not by external beam
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

VI.3.3.5 Dose per Fraction - Phases I-III

These data items identify the dose per fraction (treatment session) delivered to the patient in each phase of radiation during the first course of treatment. Radiation therapy is delivered in one or more phases with identified dose per fraction. The unit of measure is centiGray (cGy). The CCR requirement for the Dose per Fraction fields are: Required by CoC-accredited facilities and as available by non-CoC accredited facilities for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Record the actual Phase dose delivered in cGy in the appropriate phase I, II, and III fields.
- Radiation treatment Phase(s) dosage(s) will typically be found in the radiation oncologist's summary letter for the first course of treatment.
    - Determination of the Phase I, II, or III doses of radiation may require assistance from the radiation oncologist.
- A new phase begins when there is a clinically meaningful change in the target volume, fraction size, modality, or treatment technique.
- Usually the phase breakdown is as follows:
    - Phase I – Initial plan
    - Phase II and/or III – Boost or cone down
- Record the **actual dose delivered** (NOT initially prescribed) as documented in the treatment summary.
- For proton therapy:
    - Dosage may occasionally be specified in cGe units (Cobalt Gray Equivalent) rather than cGy.
        - 1cGe = 100 cGy (for the Phase I, II, or III Total Dose multiply cGe by 100).

      Note: Dose is still occasionally specified in "rads." One rad is equivalent to one centi-Gray (cGy).
- Code 99998 when radioisotopes were administered to the patient.
- Code 99999 for Death Certificate Only (DCO) cases.

Codes:

Code	Description
00000	No radiation treatment
00001-99997	Record the actual Phase (I, II, and III) dose delivered in cGy

99998	Not applicable, radioisotopes administered to the patient
99999	Regional radiation therapy was administered but dose is unknown, it is unknown whether radiation therapy was administered; Death Certificate only

VI.3.3.6 Number of Fractions - Phases I-III

These data items identify the number of fractions (treatment sessions) delivered in each phase of radiation during the first course of treatment. The CCR requirement for the Number of Fractions fields are: Required by CoC-accredited facilities and as available by non-CoC accredited facilities for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Record the number of fractions used to deliver radiation in the appropriate phase I, II, and III fields.
- Number of fractions will typically be found in the radiation oncologist's summary letter for the first course of treatment.
    - Determination of the number of fractions (number of treatments) may require assistance from the radiation oncologist.
- A new phase begins when there is a clinically meaningful change in the target volume, fraction size, modality, or treatment technique.
- Usually the phase breakdown is as follows:
    - Phase I – Initial plan
    - Phase II and/or III – Boost or cone down
- Record the **actual** number of fractions **delivered** (NOT initially prescribed) as documented in the treatment summary.
- Count each separate administration of brachytherapy or implants as a single fraction or treatment.
- Code 999 for Death Certificate Only (DCO) cases.

Codes:

Code	Description
000	No radiation treatment
001-998	Number of fractions administered to the patient during each phase (I, II, or III) of radiation therapy
999	Phase I, II, or III radiation therapy was administered, but the number of fractions for each is unknown; It is unknown whether radiation therapy was administered

VI.3.3.7 Total Dose - Individual Phases I-III

These data items identify the total dose delivered in each phase of radiation during the first course of treatment. The CCR requirement for the Total Dose fields are: Required by CoC-accredited facilities and as available by non-CoC accredited facilities for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Record the total dose delivered for each phase in the appropriate phase I, II, and III fields.
- Total dose for each phase (I, II, and/or III) will typically be found in the radiation oncologist's summary letter for the first course of treatment.
    - Determination of the total dose for each phase (I, II, and/or III) may require assistance from the radiation oncologist.
- A new phase begins when there is a clinically meaningful change in the target volume, fraction size, modality, or treatment technique.
- Usually the phase breakdown is as follows:
    - Phase I – Initial plan
    - Phase II and/or III – Boost or cone down
- Record the **total dose delivered in each phase** (NOT initially prescribed) as documented in the treatment summary.
- For proton therapy:
    - Dosage may occasionally be specified in cGe units (Cobalt Gray Equivalent) rather than cGy.
        - 1cGe = 100 cGy (for the Phase I, II, or III Total Dose multiply cGe by 100).

      Note: Dose is occasionally specified as "rads." One rad is equivalent to one centi-Gray (cGy).
- Code 999998 when radioisotopes were administered to the patient.
- Code 999999 for Death Certificate Only (DCO) cases.

Codes:

Code	Description
000000	No radiation treatment; Diagnosed at autopsy
000001-999997	Record the actual total dose (phases I, II, and III) delivered in cGy
999998	Not applicable; radioisotopes administered to the patient
999999	Radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered; Death Certificate Only

VI.3.4 Number of Phases of Rad Treatment to this Volume

This data item identifies the total number of phases administered to the patient during the first course of treatment. A “phase” consists of one or more consecutive treatments delivered to the same anatomic volume with no change in the treatment technique. Although most courses of radiation therapy are completed in one or two phases (historically, the “regional” and “boost” treatments) there are occasions in which three or more phases are used, most typically with head and neck malignancies. The CCR requirement for the Number of Phases of Radiation Treatment to this Volume field is: Required by CoC-accredited facilities and as available by non-CoC accredited facilities for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Record the number of phases administered to the patient during the first course of treatment.
- The number of phases (I, II, and/or III **combined**) will typically be found in the radiation oncologist’s summary letter for the first course of treatment.
    - Determination of the **combined** number of phases may require assistance from the radiation oncologist.

Codes:

Code	Description
00	No radiation treatment
01	1 phase
02	2 phases
03	3 phases
04	4 or more phases
99	Unknown number of phases; Unknown if radiation therapy administered

VI.3.5 Total Dose - Phases Combined

This data item identifies the total radiation dose administered to the patient across all phases during the first course of treatment. The CCR requirement for the Total Dose (phases combined) field is: Required by CoC-accredited facilities and as available by non-CoC accredited facilities for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Record the total dose given in all phases (combined) to the patient during the first course of treatment.
- The total dose (all phases **combined**) will typically be found in the radiation oncologist's summary letter for the first course of treatment.
    - If the total is not documented, add the dose from each phase (I, II, III, or IV or more) and document the total cumulative dose.
    - Doses should ONLY be summed across phases to create a Total Dose when all of the phases were delivered sequentially to the same body site using the same modality and dose-fractionation.
        - Do NOT sum doses across phases if the phases used different treatment fraction sizes or modalities (i.e. external beam in Phase I and brachytherapy in Phase II), OR phases were delivered simultaneously to multiple body sites [different volumes], e.g. simultaneous treatment to multiple metastatic sites, or dose-painting with any other different modality or different fractionation schemes. Use code 999998, Not applicable.
    - Determination of the **combined** number of phases may require assistance from the radiation oncologist.
- For proton therapy:
    - Dosage may occasionally be specified in cGe units (Cobalt Gray Equivalent) rather than cGy.
        - 1cGe = 100 cGy (for Total Dose multiply cGe by 100).

      Note: Dose is occasionally specified as "rads." One rad is equivalent to one centi-Gray (cGy).
- Code 999998 when radioisotopes were administered to the patient.

Codes:

Code	Description
000000	No therapy administered; Diagnosed at autopsy
000001-999997	Record the actual total dose (all phases combined) delivered in cGy

999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered

VI.3.6 Radiation - Regional RX Modality

Record the dominant modality of radiation therapy used to deliver the most clinically significant regional RX Modality dose to the primary volume of interest during the first course of treatment. The CCR requires the collection of this data item for cases diagnosed between January 1, 2003 and December 31, 2017.

Coding Instructions:

- *Radiation - Regional RX Modality* is required to code first course radiation therapy.
- *Radiation - Regional RX Modality* will not be converted to generate *RX Summ-Radiation.*
- If multiple radiation therapy modalities are used to treat the patient, code the dominant modality.
    - In the rare occasion where 2 modalities are combined in a single volume (IMRT photons with an electron "patch" for example), code the appropriate radiation modality item to the highest level of complexity, i.e. the IMRT.
- Referral to a radiation oncologist is considered a recommendation. Follow-up on these cases is required to determine whether radiation was administered or not, and code accordingly. This applies to cases diagnosed January 1, 2010 and forward.
    - Referral does not equal a recommendation for cases diagnosed on or before December 31, 2009.
- Use code 50 when tumor embolization is performed using a radioactive agent or radioactive seeds.
- Use codes 50 or 51 for the use of Cobalt-60 or Cesium-137.
- Use code 53 for I-125 treatment for prostate cancer to brachytherapy, low dose radiotherapy (LDR).

Codes:

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 beam energy in the range of 2-5 MV
24	Photons (6-10 MV)	External beam therapy using a photon producing machine with beam energy in the range of 6-10 MV
25	Photons (11-19 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 11-19 MV
26	Photons (>19 MV)	External beam therapy using a photon producing machine with beam energy of more than 19 MV
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment
28	Electrons	Treatment delivered by electron beam
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in the 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 or radioactive materials not otherwise specified
51	Brachytherapy, intracavitary, LDR	Intracavitary (no direct insertion into tissues) radioisotope 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	Strontium-90
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown
99	Unknown; death certificate only	It is unknown whether radiation therapy was administered; Death certificate only

VI.3.7 Radiation - RX Summ Radiation

Use the following codes for recording radiation therapy in the summary field for cases diagnosed between January 1, 2003 and December 31, 2017.

Coding Instructions:

- This data item **must** be directly coded by the abstractor.
    - *Radiation - Regional RX Modality* will NO LONGER be converted to generate *RX Summ-Radiation*.

      Note: This is different from previous years.
- *Radiation - Regional RX Modality* is required to code first course radiation therapy.
- Radiation to the brain and CNS for lung and leukemia cases is to be coded in *Radiation – Regional RX Modality*.
- See Radioactive Implants for additional information regarding radioactive implants.

Note: CCR does not include codes 7 and 8 in our instructions. We collect this information in the *Reason for No Radiation* Field.

Codes:

Code	Description
0	None
1	Beam Radiation
2	Radioactive Implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS (method or source not specified)
9	Unknown if radiation therapy recommended or given

VI.3.8 Radiation Sequence with Surgery

Code the sequence in which radiation and surgical procedures were performed as part of the first course of treatment.

Coding Instructions:

- Use the appropriate radiation sequence code (2-9) if first course of treatment includes:
    - Surgery of the Primary Site
    - Scope of Regional Lymph Node(s)
    - Surgery of Other Regional Site(s)
    - Distant Site(s)
    - Distant Lymph Node(s)
    - Radiation
- For all other cases, use code 0.

Codes:

Code	Label	Description
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 at least two more after surgery to the primary site; scope of regional lymph node surgery, surgery to other regional 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)

7	Surgery both before and after radiation	Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s)
9	Sequence unknown	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 treatment is not stated in the patient record

VI.3.9 Radiation Treatment Discontinued Early

This field is used to identify patients/tumors whose radiation treatment course was discontinued earlier than initially planned. That is the patients/tumors received fewer treatment fractions (sessions) than originally intended by the treating physician. The CCR requirement for the Radiation Treatment Discontinued field is: Required by CoC-accredited facilities and as available by non-CoC accredited facilities for cases diagnosed January 1, 2018 and forward.

Coding Instructions:

- Enter the code that describes the reason radiation treatment was discontinued early.
- Treatment discontinued early will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- Code 01 when there is no indication that radiation was discontinued or completed early.
- Codes 02-07 are used when there is an indication that radiation therapy was discontinued or was completed early.
- Code 99 is used when therapy is administered, but it is not clear if the treatment course was:
    - Discontinued early
    - Unknown if radiation was administered
    - Death Certificate Only

Codes:

Code	Description
00	No radiation treatment
01	Radiation treatment completed as prescribed
02	Radiation treatment discontinued early - toxicity
03	Radiation treatment discontinued early - contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation etc.)
04	Radiation treatment discontinued early - patient decision
05	Radiation discontinued early - family decision
06	Radiation discontinued early - patient expired
07	Radiation discontinued early - reason not documented
99	Unknown if radiation treatment discontinued; Unknown whether radiation therapy administered; Death Certificate Only

VI.3.10 Location of Radiation Treatment

Records the location of the facility in which radiation treatment was administered during first course of treatment. This applies to cases diagnosed January 1, 2008 and forward.

Coding Instructions:

- Enter the code for the location of the facility in which radiation treatment was administered during first course of treatment.
- Location of radiation treatment will typically be found in the radiation oncologist's summary letter for the first course of treatment.
    - Determination of the location of radiation treatment may require assistance from the radiation oncologist.

Codes:

Code	Label	Description
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, NOS	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 the patient record; or it is unknown whether radiation therapy was administered; Death Certificate Only (DCO)

VI.3.11 Reason for No Radiation

Record the reason the patient did not undergo radiation treatment.

Coding Instructions:

- Include radiation to the brain and central nervous system when coding this field.
- Code 0 if the patient received regional radiation as part of first course therapy.
- Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected a treatment that did not include radiation therapy.
- Code 7 when:
    - Patient refused recommended radiation therapy.
    - Patient refused all recommended treatment.
    - Patient refused all treatment before any treatment was recommended.
- Code 8 when:
    - It is known that the physician recommended radiation, but no further documentation is available to confirm it was performed.
    - Patient was referred to a radiation oncologist.

      Note: Follow up with the specialist or facility to determine if the patient actually had treatment (or not) and change this code as appropriate.
- Code 9 when:
    - The treatment plan offered multiple alternative options, but it is unknown which treatment, if any, was provided.
    - Death Certificate Only (DCO).
- Patient's decision not to pursue radiation therapy is not a refusal of radiation therapy when:
    - The patient has discussed radiation therapy with their physician, and then decides to pursue no treatment.

      Note: Discussion does not equal a recommendation.

Codes:

Code	Description
0	Radiation therapy administered
1	Radiation treatment not administered because it was not a part of the planned first course treatment; Diagnosed at autopsy
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (co-morbid conditions, advanced age, progression of tumor prior to planned radiation, etc.)

5	Radiation treatment not performed because the patient died prior to planned or recommended treatment
6	Radiation treatment was not administered. It was recommended by the patient’s physician, but not performed as part of the first course of treatment. No reason was noted in the patient record
7	Radiation treatment 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 is noted in the patient's record
8	Radiation therapy was recommended, but it is unknown whether it was administered
9	Unknown if radiation was recommended or performed; Death Certificate Only (DCO) cases only

VI.4 Chemotherapy - First Course of Treatment

Chemotherapy includes the use of any chemical to attack or treat cancer tissue, unless the chemical achieves its effect through change of the hormone balance or by affecting the patient's immune system.

Coding Instructions:

- In coding, consider only the agent, not the method of administering it, although the method of administration may be recorded.
- Chemotherapy typically is administered orally, intravenously, or intracavitary, and sometimes topically or by isolated limb perfusion.
- The drugs are frequently given in combinations that are referred to by acronyms or protocols. Do not record the protocol numbers alone.
- Two or more single agents given at separate times during the first course of cancer Two or more single agents given at separate times during the first course of cancer directed therapy are considered a combination regimen.
- The physician may decide to change a drug during the first course of therapy because the patient cannot tolerate the original drug.
    - As long as the substitutions belong to the same group (alkylating, antimetabolites, natural products, targeted therapy, or other miscellaneous), the change in drug is a continuation of the first course of therapy.

      Note: Do not code the new agent as first course of therapy when the original agent is changed to one that is NOT in the same group.
    - Use SEER*Rx to compare the subcategory of each chemotherapy agent to determine whether they belong to the same group (subcategory).
- When chemotherapeutic agents are used as radiosensitizers or radioprotectants, they are given at a much lower dose and do not affect the cancer.
    - Radiosensitizers and radioprotectants are classified as ancillary drugs.

      Note: January 1, 2012 and forward, do not code chemotherapy when documented as being used for radio-sensitization.

      Exception: Cisplatin used for radio-sensitization.
- Code as treatment for both primaries when the patient receives chemotherapy for invasive carcinoma in one breast and the patient also has in situ carcinoma in the other breast.

VI.4.1 Names of Chemotherapeutic Agents

Generic or trade names of the drugs used for chemotherapy must be recorded in the text field.

Coding Instructions:

- Include agents that are in the investigative or clinical trial phase.
- Registrars **must** use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy). This applies to cases diagnosed January 1, 2005 and forward.
    - SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs.
    - The software can be downloaded from the SEER*Rx website.

VI.4.2 Date of Chemotherapy

Enter the date in which chemotherapy began at any facility as part of first course of treatment.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates. Consult with your software vendor for specific data entry instructions.

Coding Instructions:

- Enter the earliest date in which chemotherapy was administered.
    - Include date and treatment performed in the corresponding text fields.
- Record only first course of treatment dates in this field.

VI.4.2.1 Date of Chemotherapy Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	Unknown whether any chemotherapy was given
11	No chemotherapy planned or given
12	Date cannot be determined for chemotherapy received during first course
15	Chemotherapy is planned; start date is not yet available
Blank	Full or partial date recorded

VI.4.3 Chemotherapy Codes

Chemotherapy is a drug treatment that utilizes powerful chemicals to kill fast-growing cancer cells.

Use the following codes for recording chemotherapy in the summary field.

Coding Instructions:

- Use codes 00-87 for recording chemotherapy in the at this facility field.
- Code 00 in the following scenarios:
    - Record shows chemotherapy was not given as first course treatment.
    - No information in the record regarding chemotherapy ***AND***
        - It is known that chemotherapy is not typically performed for this type and/or stage of cancer ***OR***
        - There is no reason to suspect that the patient would have had chemotherapy.
    - The treatment plan offers multiple treatment options and the patient selects a treatment that did not include chemotherapy.
    - Patient's decision not to pursue chemotherapy is not a refusal of chemotherapy when:
        - The patient has discussed chemotherapy with their physician, and then decides to pursue no treatment.

          Note: Discussion does not equal a recommendation.
- Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.
- Code 87 when:
    - Patient refuses chemotherapy
    - Chemotherapy is a typical treatment option for the primary site/histology **AND**
        - Patent made a blanket refusal of all recommended treatment ***OR***
        - Patient refused all treatment before any was recommended
- Code 88 when:
    - Patient referred to an oncologist

      Note: Referral to a medical oncologist is considered a recommendation. This applies to cases diagnosed January 1, 2010 and forward.
    - Insertion of Port-a-Cath

Note: Follow-up on cases coded to 88 is required to determine whether chemotherapy was administered or not, and code accordingly.

Note: Do not code 99 when recording therapy at this facility, if Class of Case is coded to 00, 30, or 31.

Codes:

Code	Description
00	None, chemotherapy was not part of the planned first course of therapy; Diagnosed at autopsy
01	Chemotherapy, NOS
02	Single-agent chemotherapy
03	Multi-agent chemotherapy administered as first course therapy
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age)
85	Chemotherapy not administered because the patient died prior to planned or recommended therapy
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record
88	Chemotherapy was recommended, but it is unknown if it was administered
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record; Death certificate only

VI.5 Hormone (Endocrine) Therapy - First Course of Treatment

Hormone Therapy is a form of systemic therapy that works to add, block or remove hormones from the body to slow or stop the growth of cancer cells. Report the administration of hormones, anti-hormones, or steroids to attack cancer tissue by changing the patient's hormone balance.

Coding Instructions:

- Record surgery performed for hormonal effect (such as castration) and radiation for hormonal effect for breast and prostate cancers only.
- When steroids are combined with chemotherapy, record their use, in addition to reporting the chemotherapy in the chemotherapy section.
- SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs.
    - The software can be downloaded from the SEER*Rx website.

VI.5.1 Hormones

Cancer-directed treatment with hormones and anti-hormones must be coded in the appropriate data field and must always have corresponding text documentation for all sites.

Coding Instructions:

- Report cancer directed use of adrenocorticotropic hormones for treatment of leukemia's, lymphomas, multiple myelomas, and breast and prostate cancers. However, report as hormone therapy any hormonal agent that is given in combination with chemotherapy (e.g., MOPP or COPP) for cancer of any site whether it affects the cancer cells or not.
- For cases diagnosed 1/1/2005 forward, registrars must use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy).
    - SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs.
    - The software can be downloaded from the SEER*Rx website.

VI.5.2 Date of Hormone Therapy

Enter the date in which hormone therapy began at any facility as part of first course of treatment.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates. Consult with your software vendor for specific data entry instructions.

Coding Instructions:

- Enter the earliest date in which hormone therapy was administered.
    - Include date and treatment performed in the corresponding text fields.
- Record only first course of treatment dates in this field.

VI.5.2.1 Date of Hormone Therapy Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	Unknown whether any hormone therapy was given
11	No hormone therapy planned or given
12	Date cannot be determined for hormone therapy received during first course
15	Hormone therapy is planned; start date is not yet available
Blank	Full or partial date recorded

VI.5.3 Hormone Therapy Codes

Use the following codes for recording hormone therapy in the Summary field.

Coding Instructions:

- Use codes 00-87 for recording hormone therapy in the at this facility field.
- The codes for Reason No Hormone have been incorporated into this field.
- For recording therapy at this facility, do not use code 99 if Class of Case is coded to 00, 30, or 31.
- Referral to a medical oncologist is considered a recommendation. Follow-up on these cases is required to determine whether hormone therapy was administered or not, and code accordingly. This applies to cases diagnosed January 1, 2010 and forward.
- Patient's decision not to pursue hormone therapy is not a refusal of hormone therapy when:
    - The patient has discussed hormone therapy with their physician, and then decides to pursue no treatment.

      Note: Discussion does not equal a recommendation.

Codes:

Code	Description
00	None, hormone therapy was not part of the planned first course therapy
01	Hormone therapy administered as first course therapy
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age)
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course 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 the 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

VI.6 Immunotherapy (Biological Response Modifier Therapy) - First Course of Treatment

Immunotherapy/Biological response modifier therapy (BRM) is a generic term covering everything done to the immune system to alter it or change the host response to a cancer (defense mechanism).

Coding Instructions:

- SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs.
    - The software can be downloaded from the SEER*Rx website.

VI.6.1 Immunotherapy Agents

Records the type of immunotherapy administered as first course treatment.

Coding Instructions:

- Cases diagnosed January 1, 2012 and forward, report the following as Immunotherapy:
    - Donor lymphocyte infusion - The lymphocyte donation from the original donor creates an immune reaction to the cancer cells.
- With cases diagnosed January 1, 2005 and forward, registrars must use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy).
    - SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs.
    - The software can be downloaded from the SEER*Rx website.
        - Report the following as immunotherapy:
        - ASILI (active specific intralymphatic immunotherapy)
        - Blocking factors
        - Interferon
        - Monoclonal antibodies*
        - Transfer factor (specific or non-specific)
        - Virus therapy

    Note: Some monoclonal antibodies are used to deliver chemotherapy or radiation agents to the tumor, not to kill the tumor immunologically. Consult SEER*RX to determine how to appropriately code monoclonal antibodies.

VI.6.2 Date of Immunotherapy

Enter the date in which immunotherapy began at any facility as part of first course of treatment.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates. Consult with your software vendor for specific data entry instructions.

Coding Instructions:

- Enter the earliest date in which immunotherapy was administered.
    - Include date and treatment performed in the corresponding text fields.
- Record only first course of treatment dates in this field.

VI.6.2.1 Date of Immunotherapy Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	Unknown whether immunotherapy was given
11	No immunotherapy planned or given
12	Date cannot be determined for immunotherapy received during first course
15	Immunotherapy is planned; start date is not yet available
Blank	Full or partial date recorded

VI.6.3 Immunotherapy Codes

Enter the appropriate code below when coding immunotherapy in the **Summary** field.

Coding Instructions:

- Use codes 00-87 for recording immunotherapy in the at this facility field.
- Immunotherapy agents **must** be recorded in the text field.
- For recording therapy at this facility, do not use code 99 if Class of Case is coded to 00, 30, or 31.
- Referral to a medical oncologist is considered a recommendation. Follow-up on these cases is required to determine whether immunotherapy was administered or not, and code accordingly. This applies to cases diagnosed January 1, 2010 and forward.
- Patient's decision not to pursue immunotherapy is not a refusal of immunotherapy when:
    - The patient has discussed immunotherapy with their physician, and then decides to pursue no treatment.

      Note: Discussion does not equal a recommendation.
- Effective with cases diagnosed 1/1/2003, this data item was modified. Codes for transplants and endocrine procedures were removed and were coded in a separate field called RX Summ - Transplnt/Endocr. The length of this field was changed from 1 to 2 characters. The codes for reason for no immunotherapy (BRM) given were incorporated into this scheme.

Codes:

Code	Description
00	None, immunotherapy was not part of the planned first course of therapy
01	Immunotherapy administered as first course therapy
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e. 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 the 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

VI.7 Transplant/Endocrine - First Course of Treatment

Identifies systemic therapeutic procedures administered as part of the first course of treatment. For reporting purposes, endocrine surgery is defined as the total surgical removal of an endocrine gland (both glands or all of a remaining gland in the case of paired glands).

Coding Instructions:

- Procedures included for transplant/endocrine are:
    - Bone marrow transplants
    - Stem cell harvests
    - Surgical and/or radiation endocrine therapy

VI.7.1 Date of Transplant/Endocrine Procedure

Enter the date in which the transplant/endocrine procedure took place at any facility as part of the first course treatment.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates. Consult with your software vendor for specific data entry instructions.

Coding Instructions:

- Enter the earliest date in which the Transplant/Endocrine procedure was performed.
    - Include date and treatment performed in the corresponding text fields.

      Note: There is no text field for bone marrow transplant and endocrine procedures. Record text information regarding bone marrow transplants and endocrine procedures in the immunotherapy text field.
- Record only first course of treatment dates in this field.

VI.7.1.1 Date of Transplant/Endocrine Procedure Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	Unknown whether transplant/endocrine therapy was given
11	No transplant/endocrine therapy planned or given
12	Date cannot be determined for transplant/endocrine therapy received during first course
15	Transplant/endocrine therapy is planned; start date is not yet available
Blank	Full or partial date recorded

VI.7.2 Transplant/Endocrine Procedures Codes

Record systemic therapeutic procedures administered as part of first course of treatment. For reporting purposes, endocrine surgery is defined as the total surgical removal of an endocrine gland (both glands or all of a remaining gland in the case of paired glands).

Coding Instructions:

- Assign code 10 when the patient has a bone marrow transplant and it is unknown if it is autologous or allogenic (BMT, NOS)
- Use Code 20 for:
    - Allogeneic stem cell transplant
    - Peripheral blood stem cell transplant
    - Umbilical code stem cell transplant (single or double)
- Use Code 88 when:
    - Referral to a specialist for hematologic transplant or endocrine procedures is considered a recommendation.
    - The patient has a bone marrow or stem cell harvest, but it was **not** followed by a rescue or reinfusion as part of the first course treatment.

      Note: Follow-up on cases coded to 88 is required to determine whether a procedure was performed or not. Recode this accordingly. This applies to cases diagnosed January 1, 2010 and forward.
- Patient's decision not to pursue transplant procedure or endocrine therapy is not a refusal of other therapy when:
    - The patient has discussed transplant procedure or endocrine therapy with their physician, and then decides to pursue no treatment.

      Note: Discussion does not equal a recommendation.
- Information on transplants and endocrine procedures was removed from the *Rx Summ-BRM* (Immunotherapy) field and moved to this field. Bone marrow and stem cell procedures are now coded in this field along with endocrine surgery or radiation.
    - Record endocrine surgery for treatment of cancer of the breast or prostate only. The procedures are:
        - Adrenalectomy
        - Hypophysectomy
        - Oophorectomy (breast)
        - Orchiectomy (prostate)
    - If tumor tissue is present in a gland removed in the course of endocrine therapy, record the procedure as surgical treatment also.

- Report any type of radiation directed toward an endocrine gland to affect hormonal balance if:
    - The treatment is for cancers of the breast and prostate.
    - Both paired glands (ovaries, testes, adrenals), or all of a remaining gland have been irradiated.

Notes:

- For recording therapy at this facility, do not use code 99 if Class of Case is coded to 00, 30, or 31.
- Use the following codes for recording transplant/endocrine procedures in the Summary field.
- Use codes 00-87 for recording transplant/endocrine procedures in the "at this facility field."

Codes:

Code	Description
00	No transplant procedure or endocrine therapy was administered as part of the first course therapy
10	A bone marrow transplant procedure was administered, but the type was not specified
11	Bone marrow transplant - autologous
12	Bone marrow transplant - allogeneic Syngeneic bone marrow transplant (identical twin)
20	Stem cell harvest and infusion (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 were not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age)
85	Hematologic transplant and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy
86	Hematologic transplant and/or endocrine surgery/radiation were not administered. It was recommended by the patient's physician, but was not administered as part of the first course therapy. No reason was stated in patient record
87	Hematologic transplant and/or endocrine surgery/radiation were not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered

99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record; Death certificate only

VI.8 Other Therapy - First Course of Treatment

Record the definitive cancer-directed treatment that cannot be assigned to any other category. Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Coding Instructions:

- Hyperbaric oxygen (as adjunct to definitive treatment).
- Hyperthermia (given alone or in combination with chemotherapy, as in isolated heated limb perfusion for melanoma).
- Photophoresis. Used **only** for thin melanoma or cutaneous T-Cell lymphoma (mycosis fungoides).
- PUVA (Psoralen (P) and long-wave ultraviolet radiation (UVA)). **Rarely** used for thin melanoma or cutaneous T-Cell lymphoma (mycosis fungoides).
- UVB Phototherapy for mycosis fungoides is coded to photodynamic therapy under Surgery of Primary Site for skin. See, Appendix K: Skin, for surgery codes.
- Cancer vaccines are still in the experimental phase. Currently, clinical trials use cancer vaccines for brain, breast, colon, kidney, lung, melanoma, and ovary.
- Any experimental drug that cannot be classified elsewhere.
- Double blind clinical trial information where the type of agent administered is unknown and/or there is any use of a placebo. However, after the code is broken, report the treatment under the appropriate category (a correction record should be submitted when the data are available).
- Unorthodox and unproven treatment, such as laetrile or krebiozen.

  Note: Do not code pre-operative embolization of hypervascular tumors with agents such as particles, coils, or alcohol as treatment. These pre-surgical treatments are typically performed to prevent excess bleeding during the resection of the primary tumor.
- 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.

    Note: To report the hematopoietic cases in which a 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 certain hematopoietic diseases **only**.
  - For hematopoietic and lymphoid cases diagnosed January 1, 2018 and forward, please refer to the SEER Hematopoietic and Lymphoid Neoplasm Database for coding instructions regarding specific hematopoietic neoplasms in this item.

Note: Do not collect blood transfusions (whole blood, platelets, etc.) as treatment for any of these diseases. Blood transfusions are used widely to treat anemia and it is not possible to collect this procedure in a meaningful way. This applies to cases diagnosed January 1, 2012 and forward **only**.

VI.8.1 Date of Other Therapy

Enter the date in which Other Therapy began at any facility as part of first course treatment.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates. Consult with your software vendor for specific data entry instructions.

Coding Instructions:

- Enter the earliest date in which other therapy was administered.
    - Include date and treatment performed in the corresponding text fields.
- Record only first course of treatment dates in this field.

VI.8.1.1 Date of Other Therapy Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
10	Unknown whether other therapy was given
11	No other therapy planned or given
12	Date cannot be determined for other therapy received during first course
15	Other therapy is planned; start date is not yet available
Blank	Full or partial date recorded

VI.8.2 Other Therapy Codes

This field captures other therapy administered to the patient as first course treatment.

Coding Instructions:

- Enter the appropriate code below for other therapy administered to the patient.
- Use codes 0-7 for recording other therapy in the at this facility field.
- For recording therapy at this facility, do not use code 9 if Class of Case is coded to 00, 30, or 31.
- Referral to a specialist is considered a recommendation. Follow-up on these cases is required to determine whether treatment was administered or not, and code accordingly. This applies to cases diagnosed January 1, 2010 and forward.
- Patient's decision not to pursue other therapy is not a refusal of other therapy when:
    - The patient has discussed other therapy with their physician, and then decides to pursue no treatment.

      Note: Discussion does not equal a recommendation.

Codes:

Code	Description
0	No other cancer directed therapy except as coded elsewhere; Diagnosed at autopsy
1	Other cancer directed therapy Examples: • Embolization using alcohol as an embolizing agent • Embolization to a site other than the liver where the embolizing agent is unknown • PUVA (psoralen and long-wave ultraviolet radiation) treatments for melanoma • Photophoresis. This treatment is used only for thin melanoma or cutaneous T-cell lymphoma (mycosis fungoides)
2	Other experimental cancer directed therapy (not included elsewhere)
3	Double blind clinical trial, code not yet broken
6	Unproven therapy Cancer therapy administered by nonmedical personnel
7	Patient or patient's guardian refused therapy which would have been coded 1–3 above
8	Other cancer directed therapy recommended, unknown if administered
9	Unknown if other therapy recommended or administered; Death certificate only

VI.9 RX Summary - Treatment Status

This data item is used to summarize the status for all treatment modalities. It is used in conjunction with Date of Initial RX and/or Date of 1st Course RX-CoC and each modality of treatment with their respective date field to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date. Active surveillance (watchful waiting) is also documented. This data item is required by the CCR.

Coding Instructions:

- Assign code 1 when the patient receives treatment collected in ANY of the following fields
    - Surgery of primary site
    - Scope of regional lymph node surgery
    - Surgical procedure of other site
    - Radiation
    - Chemotherapy
    - Hormone Therapy
    - Immunotherapy
    - Hematologic transplant and endocrine procedures
    - Other therapy
- Leave blank for cases diagnosed prior to January 1, 2010

Codes:

Code	Description
0	No treatment given, treatment refused, or physician decides not to treat for any reason such as the presence of comorbidities
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

VI.10 Protocol Participation

This field collects the patient's participation in a Protocol Study.

Coding Instructions:

- The CCR requires that this field be collected and transmitted to the CCR for patient's participation in a protocol study. This is effective with cases diagnosed January 1, 2001 and forward.

Codes:

Code	Description
00	Not applicable
National Protocols	
01	NSABP
02	GOG
03	RTOG
04	SWOG
05	ECOG
06	POG
07	CCG
08	CALGB
09	NCI
10	ACS
11	National Protocol, NOS
12	ACOS-OG
13	VA [Veterans Administration]
14	COG (Children's Oncology Group]
15	CTSU [Clinical Trials Support Unit]
16-50	National Trials
Locally Defined	
51-79	Locally Defined
80	Pharmaceutical
81-84	Locally Defined

85	In-House Trial
86-88	Locally Defined
89	Other
90-98	Locally Defined
99	Unknown

Part VII. Follow-Up

Part IV of Volume I cover patient and tumor follow-up. It provides resources for where to obtain follow-up information while abstracting. There are great guidelines and instructions for collecting data items such as patient contact information, date of last contact, vital status, tumor status, and physician information.

VII.1 Follow-Up Information

A function of the California cancer reporting system is annual monitoring of patients to ascertain survival rates. Therefore, if follow-up information is available before an abstract is submitted, include the follow-up information in the abstract.

Guidelines:

- The CCR now requires facilities to use the Modified Record instead of the former Update/Correction and Follow-Up Records to transmit data modifications for abstracts already submitted as New Case Records. See Modified Record for more information regarding this change.
- Facilities with cancer programs approved by ACS must update follow-up data annually (consult ACS Guidelines for requirements).
    - Re-admission to the facility as an inpatient or outpatient
    - A report by the patient's physician
    - Direct response to a letter or phone call to the patient or other contact person
- Additionally, regional registries may obtain further follow-up information using the following methods:
    - Registrar of voters
    - Welfare agencies
    - Labor unions
    - Religious groups
    - Death certificate
- Annual follow-up is not required for a reporting facility that does not have a tumor registry and is submitting an abstract only to meet state reporting requirements. The CCR does not impose follow-up requirements beyond what a hospital chooses to do for its own purposes.

  Example:

  A reporting facility elects not to follow nonanalytic cases; the CCR will not expect to receive follow-up information for such cases.
- Current status is defined as contact with the patient within 15 months of the date of last reported follow-up. Although current follow up information is preferred, any information, whether current or not, should still be reported.

Site-Specific Follow-up:

- Follow-up is required for the following tumors, although they are categorized in class of case 34 or 36. This applies to cases diagnosed January 1, 2010 and forward.

- Benign and borderline CNS tumors diagnosed between January 1, 2001 and December 31, 2003 (before the national benign and borderline CNS tumor reporting requirement was implemented).
- VIN III
- VAIN III
- AIN III

Shared Follow-Up:

- In those cases, where a patient is being followed by more than one reporting facility, the regional or the central registry may designate a facility responsible for follow-up in an effort to prevent physicians and patients from receiving requests for information from many sources.
- Shared follow-up which discloses the source or name of the facility requires a signed agreement from each participating registry.
- Follow-up may be shared without a signed agreement as long as the source is not disclosed.
- This does not preclude a facility's registry from submission of more current information about its patients. Shared follow-up is instituted only by agreement among participating facilities in a region.

VII.1.1 Required Data - Follow-Up

Some follow-up data items are optional for reporting to the CCR but might be required by the ACS, for shared follow-up involving other institutions, or by the reporting facility for in-house data.

Coding Instructions:

The CCR's required items for follow-up are:

- Date of Last Patient Contact
- Vital Status
- Date Last Tumor Status
- Tumor Status
- Last Follow-up Facility
- Death information

VII.1.2 Sources of Follow-Up Information

Follow-up information must be based on documentation of contact with the patient in one of the following forms:

- Direct response to a letter or phone call to the patient or other contact person
- A report by the patient's physician
- Re-admission to the facility as an inpatient or outpatient
- Death certificate

It might be necessary to trace the patient through such agencies and organizations as the registrar of voters, welfare agencies, labor unions, religious groups, or the Office of the State Registrar for a death certificate.

VII.1.3 Current Status of Follow-Up Information

Current status is defined as contact with the patient within 15 months of the date the follow-up is reported. Although current follow up information is preferred, any information, whether current or not, should still reported.

VII.1.4 Shared Follow-Up

In those cases, where a patient is being followed by more than one reporting facility, the regional or the central registry may designate a facility responsible for follow-up to prevent physicians and patients from receiving requests for information from many sources.

Shared follow-up which discloses the source or name of the facility requires a signed agreement from each participating registry.

Follow-up may be shared without a signed agreement as long as the source is not disclosed.

This does not preclude a facility's registry from submission of more current information about its patients. Shared follow-up is instituted only by agreement among participating facilities in a region.

VII.2 Follow-Up Data Items

Follow-up data items provide information about the outcome of cancers and the results of treatment. A patient's survival time is calculated based on Date of Diagnosis and Date of Last Contact.

VII.2.1 Date of Last Contact (AKA-Date Last Pt FU)

This field captures the date the patient was last seen, heard from, or the date of death. It is important for researchers to calculate survival and outcome studies.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates. Consult with your software vendor for specific data entry instructions.

Coding Instructions:

- Enter the most current date the patient was seen, heard from, or their date of death.
- Enter the date of discharge from the reporting facility when no follow-up information has been received.
- Each abstract submitted on a patient who has multiple primaries, must contain the same date of last contact.
- Do not enter the date the follow-up information was forwarded or received.
- Change this date if new information received is obtained from the patient, a family member, or other non-physician.

  Note: Follow-up information obtained from the physician or other official source documenting the patient's tumor status is to be coded in Date of Last Cancer Status fields.

VII.2.1.1 Date of Last Contact Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
12	Date cannot be determined
Blank	Full or partial date recorded

VII.2.2 Vital Status

This field records the vital status of the patient on the date of last follow-up.

Coding Instructions:

- Enter the code representing whether the patient was still alive on the date of last contact.
- If a patient with more than one primary has died, be sure to record the fact in all the abstracts.

Codes:

Code	Description
0	Dead
1	Alive

VII.2.3 Date of Last Cancer (Tumor) Status

This field captures the date of the last information obtained on the primary cancer (tumor) being followed. It is important because it documents information on each tumor when the patient has multiple.

See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates. Consult with your software vendor for specific data entry instructions.

Coding Instructions:

- Enter the date on which the patient's cancer status was known to be updated.
- Cancer status is based on information from the patient's physician or other official source such as a Death Certificate.
    - Only change this date if new information received is from the physician or other official source.

      Note: Follow-up information obtained from the patient, a family member, or other non-physician is to be coded in the Date of Last Contact fields.
- Cancer status changes if the patient has a recurrence or relapse.
- If there are multiple primaries, this date may be different for each depending on follow-up for each tumor.

VII.2.3.1 Date of Last Cancer (Tumor) Status Flag

This data item is used to explain why there is no appropriate value in the corresponding date field.

Coding Instructions:

- Depending on the registry software, these codes may be applied in the background and may not be apparent to the registrar.
- Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank.

Codes:

Code	Description
12	Date cannot be determined
Blank	Full or partial date recorded

VII.2.4 Cancer (Tumor) Status

This field records the presence or absence of clinical evidence of the patient's cancer (tumor) as of the Date of Last Cancer Status (AKA – Date of Tumor Status). It is important because it can be used to gauge disease-free survival.

Coding Instructions:

- The field applies only to the cancer (tumor) for which the abstract is submitted, regardless of any other cancers (tumors) the patient might have.
- The value may be different for each primary.

Codes:

Code	Description
1	Free - no evidence of this cancer
2	Not free - evidence still exists of this cancer
9	Unknown - status of this cancer is unknown

VII.2.5 Quality of Survival

Enter the code that best characterizes the patient's quality of survival. This item is not required by the CCR.

Coding Instructions:

- Reporting facilities may use another coding system or scale adopted by the facility's cancer committee.

Codes:

Code	Description
0	Normal activity
1	Symptomatic and ambulatory
2	Ambulatory more than 50%, occasionally needs assistance
3	Ambulatory less than 50%, nursing care needed
4	Bedridden, may require hospitalization
8	Not applicable; dead
9	Unknown/Unspecified

VII.2.6 Last Type of Follow-Up

This field captures the type of follow-up a patient has received.

Coding Instructions:

- There are two fields which are to be used to enter the source of the most recent follow-up information about the patient and the patient's tumor:
    - o See Last Type of **Tumor** Follow-Up
    - o See Last Type of **Patient** Follow-Up

VII.2.6.1 Last Type of Tumor Follow-Up

This field is to be used to enter information representing the source of the most up-to-date information on the tumor being followed.

Coding Instruction:

- Reporting facilities ordinarily use the codes 00-15.

Codes:

Code	Description
Follow-up obtained by reporting facility from:	
00	Admission being reported
01	Readmission to reporting facility
02	Follow-up report from physician
03	Follow-up report from patient
04	Follow-up report from relative
05	Obituary
07	Follow-up report from hospice
08	Follow-up report from other facility
09	Other source
11	Telephone call to any source
12	Special studies
14	ARS (AIDS registry system)
15	Computer match with discharge data
Follow-up obtained by regional registry from:	
20	Letter to a physician
22	Computer match with Medicare or Medicaid file
23	Computer match with HMO file
25	National death index
26	Computer match with state death tape
29	Computer match, other or NOS
30	Other source
31	Telephone call to any source
32	Special studies

34	ARS (AIDS registry system)
35	Computer match with discharge data
36	Obituary
Follow-up obtained by central (state) registry from:	
40	Letter to a physician
41	Telephone call to any source
52	Computer match with Medicare or Medicaid file
53	Computer match with HMO file
55	National death index
56	Computer match with state death tape
59	Computer match, other or NOS
60	Other source
Follow-up obtained by reporting facilities usually done by the regional/central registry:	
73	Computer match with HMO file
76	Computer match with state death tape
Additional Codes:	
99	Source unknown

VII.2.6.2 Last Type of Patient Follow-Up

This field is to be used to enter the code representing the source of the most up-to-date information about the patient being followed.

Coding Instruction:

- Reporting facilities ordinarily use codes 00-16.

Codes:

Code	Description
Follow-up obtained by reporting facilities from:	
00	Admission being reported
01	Readmission to reporting facility
02	Follow-up report from physician
03	Follow-up report from patient
04	Follow-up report from relative
05	Obituary
06	Follow-up report from Social Security Administration or Medicare
07	Follow-up report from hospice
08	Follow-up report from other facility
09	Other source
11	Telephone call to any source
12	Special studies
13	Equifax
14	ARS (AIDS registry system)
15	Computer match with discharge data
16	SSDI match
Follow-up obtained by regional registry from:	
20	Letter to a physician
21	Computer match with Department of Motor Vehicles file
22	Computer match with Medicare or Medicaid file
23	Computer match with HMO file
24	Computer match with voter registration file
25	National death index
26	Computer match with state death tape

27	Death master file (Social Security)
29	Computer match, other or NOS
30	Other source
31	Telephone call to any source
32	Special studies
33	Equifax
34	ARS (AIDS registry system)
35	Computer match with discharge data
36	Obituary
37	Computer match with change of address service
38	TRW
39	Regional registry follow-up list
Follow-up obtained by central (state) registry from:	
40	Letter to a physician
41	Telephone call to any source
50	CMS (Center for Medicare & Medicaid Services)
51	Computer match with Department of Motor Vehicles file
52	Computer match with Medicare or Medicaid file
53	Computer match with HMO file
55	National death index
56	Computer match with state death tape
57	Computer match with Medi-Cal
58	Computer match with Social Security death tape
59	Computer match, other or NOS
60	Other source
61	Social Security – SSN
62	Special studies
65	Computer match with OSHPD hospital discharge database
66	Computer match with national change of address file
67	SSA - Epidemiological vital status
68	Property tax linkage
69	State death tape (incremental)
Follow-up obtained by reporting facilities usually done by the regional/central registry:	

73	Computer match with HMO file
76	Computer match with state death tape
Regional Registry (Additional Codes):	
80	Social Security Administration
81	Property tax linkage
82	PROBE360
83	SSDI – Internet
84	E-Path
85	Path labs
86	Patient
87	Relative
Additional Codes:	
99	Source unknown

VII.2.7 Last Follow-Up Facility

The CCR assigned reporting facility code for the reporting facility or agency that provided the most recent follow-up information.

Coding Instructions:

- Refer to the most current California Reporting Facility Codes lists, located on the CCR website https://www.ccrcal.org/learn-about-ccr/,Registrar Resources, Reporting Cancer in California, Volumes I-IV.
    - Lists are presented in both alphabetical and code order.

VII.2.8 Next Type Follow-Up

Record the method of obtaining follow-up information about the patient for the next report.

Codes Instructions:

- If the patient has died, leave the field blank.
- Foreign residents may be followed at the reporting facility's discretion, in which case do not use code 8.

Codes:

Code	Description
0	Submit a request for the patient's chart to the reporting facility's medical records department
1	Send a follow-up letter to the patient's physician
2	Send a follow-up letter to the person designated as the contact for the patient
3	Contact the patient or designated contact by telephone
4	Request follow-up information from another facility
5	Follow-up by a method not described above
6	Send a follow-up letter to the patient
7	Patient presumed lost, stop printing follow-up letters
8	Foreign resident, follow-up discontinued or not initiated*
9	Do not follow-up (except code 8)

VII.2.9 Next Follow-Up Facility

The CCR assigned reporting facility code of the hospital, facility, or agency responsible for the next follow-up of the patient.

Coding Instructions:

- Refer to the most current California Reporting Facility Codes lists, located on the CCR website https://www.ccrcal.org/learn-about-ccr/,Registrar Resources, Reporting Cancer in California, Volumes I-IV.
    - Lists are presented in both alphabetical and code order.

VII.2.10 Follow-Up Physician

Enter the name or code number of the attending physician—not a resident or intern—responsible for the patient. (See Physician License Numbers for instructions about entering codes).

Coding Instructions:

- Enter code 99999999 if there is no Follow-Up Physician.
- Enter code 99999999 if the Follow-Up Physician is "unknown" or "license number not assigned."
- Enter the physician NPI code in the respective field, if it is available. See Appendix P - National Provider Identifier (NOP) Codes for further details.

VII.2.11 Recurrence Information

Recurrence occurs when a patient's primary tumor persisted after a period of complete remission. The following fields must be coded by American College of Surgeons-approved registries. The data items are optional for reporting to the California Cancer Registry.

- Date of First Recurrence
- Type of First Recurrence

Coding Instructions:

- Code only the first recurrence and do not update the fields except to correct data entry errors.
- Enter the date of first recurrence of a primary tumor that recurred after a period of complete remission.
  - See Entering Dates and Date Format and Date Flag Guide for additional information regarding entering dates.
- If the exact date is not known, enter an estimate based on the best available information.
- If the patient was never free of the primary tumor or did not experience a recurrence, leave the field as zeros.

Codes:

Code	Description
00	None, disease free
01	In-situ
06	Recurrence following diagnosis of an in-situ lesion of the same site
10	Local
11	Trocar site
15	Combination of 10 and 11
16	Local recurrence following an in-situ lesion of the same site
17	Combination of 16 with 10, 11, and/or 15
20	Regional, NOS
21	Regional tissue
22	Regional lymph nodes
25	Combination of 21 and 22
26	Regional recurrence following an in-situ lesion of the same site
27	Combination of 26 with 21, 22, and/or 25

30	Any combination of 10, 11, and 20, 21 or 22
36	Any combination of recurrence following an in-situ lesion of the same site with 10, 11, 20, 21 or 22
40	Distant recurrence, and there is insufficient information available to code to 46-62
46	Distant recurrence of an in-situ tumor
51	Distant recurrence of invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascetic fluid
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid
54	Distant recurrence of an invasive tumor in the liver only
55	Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site
56	Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but not the external eye
57	Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site
58	Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site
59	Distant systemic recurrence of an invasive tumor only. This includes leukemia, bone marrow metastasis, carcinomatosis, generalized disease
60	Distant recurrence of an invasive tumor in a single distant site (51-58) and local, trocar and/or regional recurrence (10-15, 20-25, or 30)
62	Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51-59)
70	Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated
88	Disease has recurred, but the type of recurrence is unknown
99	It is unknown whether the disease has recurred or if the patient was ever disease-free

VII.2.12 Place of Death - Country

Place of Death - Country is intended to collect information on the patient's country of death. Consult with your software vendor for possible auto-generation of this data item.

Coding Instructions:

- Enter the code for the Country in which the death occurred.
    - Appendix C - Codes for Countries.
- See also Vital Status.
    - If the patient is alive, this field must be blank.

VII.2.12.1 Place of Death - State

Place of Death - State is intended to collect information on the State of death.

Coding Instructions:

- Enter the abbreviation for the State in which the death occurred. Appendix B - Postal Abbreviations for States and Territories of the United States
- See also Vital Status.
    - If the patient is alive, this field must be blank.

VII.3 Follow-Up Contact Name/Address File

The Contact Name/Address File is for generating follow-up letters to the patient or designated contact(s).

Coding Instructions:

- Space is provided for the name and address of the patient, including state and country, and up to five contacts for information about the patient.
- Enter names and addresses exactly as they are to appear in the heading of the letter, using capital and lower-case letters, punctuation, and special characters like # for number.
- In the Phone field, enter the area code and number without spaces, dashes, or other marks.
- For Country of residence, see Appendix C - Codes for Countries.
- A supplemental field has been added which provides the ability to record additional address information such as the name of a place or facility (i.e., a nursing home or name of an apartment complex). This supplemental field is limited to 60 characters.

VII.3.1 Follow-Up Contact 1

This field captures the person who will be the contact for follow up. This field is usually designated for the patient, however in some circumstances it may be a parent or guardian. It is where patient follow up letters are sent.

Coding Instructions:

- Enter the patient's name and preceding Mr., Mrs., Ms., or followed by Jr. or Sr. (up to 60 characters and spaces).
- Enter the current address information:
    - Street address or post office box (up to 60 characters and spaces).
    - Current city (up to 50 characters and spaces).
- Two-character Postal Service abbreviation for the state (Appendix B - Postal Abbreviations for States and Territories of the United States).
    - Zip code (up to ten characters and spaces).
    - Country code (three characters) if the address is outside the United States. If the patient lives within the United States, this field may be left blank. (See Appendix C - Codes for Countries).
- If the patient is under 18, enter a parent's name and address.
- Addresses in foreign countries may be entered, including foreign postal codes.
- Entry of a telephone number is required for all patients alive at the time the case is abstracted. Include the area code.
- If the telephone number changes at the time of follow-up, it needs to be changed in this field. If there is no phone, enter all 0's.
- In the Patient Address Current--Supplemental field, record the place or facility (i.e., nursing home or name of an apartment complex) of the patient's current usual residence.
    - If the patient has multiple tumors, the address should be the same.
    - Update this data item if a patient's address changes.
    - This supplemental field is limited to 60 characters.

VII.3.2 Follow-Up Contacts 2 - 6

If available in the abstracting software, these follow up contact fields collect the other contacts the patient has listed in their chart (usually on the face sheet). These contacts are not the patient. They are relatives, friends, neighbors, etc.

Coding Instructions:

- Enter the names, addresses, including country, and phone numbers of up to six people designated as contacts for the case.
- The contacts name preceded by Mr., Mrs., Ms., or followed by Jr. or Sr. (up to 60 characters and spaces).
- The current street address or post office box (up to 60 characters and spaces).
- The current city (up to 50 characters and spaces).
- The two-character Postal Service abbreviation for the state (see Appendix B - Postal Abbreviations for States and Territories of the United States).
- The zip code (up to ten characters and spaces).
- The three-character country code.
    - Appendix C - Codes for Countries.
- A supplemental follow-up contact field has been added. This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex.

Notes:

- A supplemental follow-up contact field has been added. This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex.
    - It can be used to generate a follow-up inquiry, and must correspond to the other fields in the follow-up contact address.
    - If the patient has multiple tumors, Follow-Up Contact--Supplemental should be the same.
    - This supplemental field is limited to 60 characters.

Part VIII. Remarks, Final Diagnosis and Extra Reporting Facility Information

Part VIII of Volume I include directives for the data items “Text Remarks” and “Text Final Diagnosis” fields. This section also includes items that are regional specific and facility specific, also called “user data.”

VIII.1 Text - Remarks

Textual information that does not fit into its designated field can be recorded in the Remarks area.

Coding Instructions:

- Use standard medical abbreviations when possible.
  - See Appendix I - Common Acceptable Symbols and Abbreviations
- Use phrases not complete sentences. Separate phrases using either periods (.) or semi-colons (;).
- Avoid using only uppercase/capitals in text documentation.
- Record both the information and the source of the information.

  Example:

  Race (white per face sheet).
- Indicate the name of the field being extended and enter the overflow information.
- The following required data must be recorded in the Remarks section:
  - Other tumors. See Other Tumors/Primaries.
  - Parent or guardian of a child whose case is being reported. (Information about the parent is also entered in the Follow-Up Contact #1 area. See Follow-Up Contacts 2 - 6.
- The following demographics may be entered in either the physical exam or remarks text fields:
  - Age
    - Include text verification in the remarks text field when the patient is 100 years or older.
  - Race
    - Include text verification for the race of patient in the Text-Remarks text field, when coded as "Other" or if there is conflicting race information. See Race and Ethnicity.
  - Hispanic Origin
  - Sex
  - Height, Weight
  - Smoking information to support tobacco codes
- Supplemental information, which cannot be coded numerically but may be useful to clarify unusual circumstances or situations.
  - Patient moved to live with family and will receive additional treatment in another state.

- Record other pertinent information for which there is no designated field.

For additional information regarding recording text, please see Q -Tips - Recording Information in Text Fields.

VIII.1.1 Required Documentation for Data Items - Remarks

The following required data must be recorded in the Remarks section.

Coding Instructions:

- See Other Tumors/Primaries.
- Race of patient, when coded as "Other" or if there is conflicting race information. See Race and Ethnicity.
- Parent or guardian of a child whose case is being reported. See Follow-Up Contact 1 for additional information.

VIII.2 Text - Final Diagnosis

This text field is designated for recording the final diagnosis (FDX) as determined by a recognized medical practitioner.

Coding Instructions:

- This information is ideally found in the discharge summary or progress notes.
- Record the date of the notation and the final diagnosis, including stage if given.
- If there is no final diagnosis in the medical record, please state FDX: NR; do not leave this field blank.
- If the only information available is a pathology report, which has already been recorded, then document “No MD FDX reported” in the FDX field.

For additional information regarding recording text, please see:

- Q-Tips – Recording Information in Text Fields.

VIII.3 Regional Data

Use of the Regional Data fields is determined by the regional registry, which designates the codes to be entered.

VIII.4 Extra Facility Information

The extra facility Information fields (also called user data) are provided for the convenience of the reporting facility, which determines how they are to be used. All the fields may be left blank. The information is not sent to the CCR.

Part IX. Transmittal of Case Information and Quality Control

Part IX of Volume I include information on transmitting new and modified cases to the CCR. The second portion explains quality control areas such as completeness, accuracy, timeliness.

IX.1 Transmittal of Case Information

The process for transmitting cases to the regional registry is specific to each region. Contact your regional registry for regional specific guidelines. General case transmission guidelines are outlined below.

Coding Instructions:

- All cases must be transmitted electronically.
- Cases are to be transmitted via a secure portal.
- Generally, abstracts are submitted when all required information has been entered, usually no later than six months after admission.
- The types of files transmitted include:
    - New case abstracts
    - Modified Record: Includes any changes to the original abstract submitted
    - Deleted cases

Note: Software vendors may have options for direct transmission of the abstract to the Central Registry. If this capability exists, please refer to the vendor for their protocol.

IX.1.1 Timeliness - Transmission

Submit all abstracts per agreement to the regional or central registry.

Guideline:

- Generally, abstracts are submitted when all required information has been entered, usually no later than six months after admission.

IX.1.2 Modified Record

The CCR now requires facilities to use the Modified Record instead of the former Update/Correction and Follow-Up Records to transmit data modifications for abstracts already submitted as New Case Records.

Guidelines:

- The Modified Record, record type M, has the same length (22824 characters) and contains the same fields in the same locations as the New Case Record, record type A.
- The field Follow-up Flag is the only field that has a different requirement status between the two record types.
    - The flag documents if the Modified Record contains updates to fields identified to contain follow-up information.
    - Vendors will be responsible for generating this field using the following guidelines:
        - Generate a flag of 1 in the field Follow-up Flag when an update has been made to any of the following fields:
            - Date of Last Cancer (tumor) Status
            - Date of Last Cancer (tumor) Status Flag
            - Vital Status
            - Date Cancer Status
            - Date Cancer Status Flag
            - Cancer Status
            - Follow-Up Hospital Last
            - Follow-Up Last Type (Patient)
            - Follow-Up Last Type (Tumor)
            - Follow-Up Registry - Next
            - Follow-Up Next Type
            - Physician--Follow-Up
            - Cause of Death
            - Place of Death - State
            - Date Case Last Changed
            - DC State File Number
            - Contact Name
            - Addr Current--No & Street

        - Addr Current--Supplement
        - Addr Current--City
        - Addr Current--State
        - Addr Current--Postal Code
        - Telephone
        - Pat No Contact
        - Follow-Up Contact--Name
        - Follow-Up Contact--Nest
        - Follow-Up Contact--Suppl
        - Follow-Up Contact--City
        - Follow-Up Contact--State
        - Follow-Up Contac--Postal
        - Place of Death--Country
        - Addr Current--Country
        - Follow-up Contact--Country
- Unlike the former Update/Correction record, the Modified Record is designed to allow facilities to submit the current version of an abstract, providing the cumulative updates to all of the fields since the original new case was submitted, rather than sending a separate record for each data item change. The Modified Record can only be used once the reporting facility's registry system has been converted to use the latest NAACCR record version and CCR coding procedure standards.
- The reporting facility changes a data item value with an Update Triggers Modified Record specification of yes in Volume II, Appendix B: Modified Record Layout.
- Although only the above criteria will trigger a Modified Record, all data items in the Modified Record will be sent to the CCR.
    - A Modified Record will only be generated by vendor software after an updated field triggered the record as outlined above and the facility has chosen to generate Modified Record files in the vendor software. This will allow for multiple changes to be sent in the same Modified Record.
    - Hospital Registrars will have these Modified Records generated and included in their monthly transmissions to the CCR as appropriate.
    - Modified Records will now be rejected from the Eureka Database software if they are unable to pass edits, see Volume II, Section III.1 for further details and requirements.

      NOTE: Whenever items change due to the receipt of shared follow-up from the CCR, DO NOT TRIGGER a Modified Record.

IX.1.2.1 Modified Record - Changing Items in an Abstract

Changes or modifications to an abstract already submitted as New Case Records will be submitted as a Modified Record. Some possible reasons for updating an abstract are described in this section.

Coding Instructions:

- The reasons for changes are not limited to first course of treatment.

  Example: Diagnostic Confirmation is a data item that can be changed ANY TIME during the patient's course of disease to a lower code.

- To correct coding or abstracting errors.
- When clarifications or rule changes retroactively affect the data item coded.
- When better information is available at a later date.

  Example: Follow-up on treatment coded as 88 (recommended, unknown if given) and the patient did have treatment. Update the code in the appropriate treatment field, along with supporting text in the associated text field.

- The date of diagnosis is confirmed in retrospect to be earlier than the original date abstracted.
- Updates to an abstract may also be made due to:
  - Visual Editing Discrepancies
  - Recoding Audits
  - Re-Abstracting Audits

IX.1.3 Deletions

Deletions are cases that are to be, or have been deleted from the database.

Coding Instructions:

- Delete any duplicate records if a case is found to have been abstracted and sent to the regional or central registry more than once.
    - Deletions cannot be submitted for a case to be re-abstracted under a new reporting facility if the case was previously abstracted under another reporting source.
- Delete a previously reported case if subsequent evidence disproves the presence of cancer, or if what was thought to be a new primary cancer is later found to be a manifestation of an earlier primary cancer.
- All deletions **must** be reported to the regional or central registry.
    - Mass deletions must be approved by the regional or central registry in advance.

IX.2 Quality Control

The California Cancer Registry (CCR) and regional registries have procedures for assuring the quality of the data produced by the reporting system. Staff from the regional registry visit cancer reporting facilities to perform quality control audits and submit copies of their final reports to the CCR.

The CCR has established uniform standards of quality for facility data in three areas:

- Completeness
- Accuracy
- Timeliness

IX.2.1 Completeness - Quality Control

Completeness is the extent to which all required cases have been reported. The minimum acceptable level of completeness for a reporting facility is 97 percent of expected case counts per year.

IX.2.2 Accuracy - Quality Control

Accuracy is the extent to which the data submitted has been correctly coded and matches the information in the medical record and have been correctly coded. It encompasses accurate abstracting, correct application of coding rules, text documentation to support codes, and correct entry into and retrieval from the computer.

Both Analytic and Non-analytic cases are included in the accuracy rate and are evaluated using various methods:

1. **Visual Editing:**
    - The CCR's regional registries perform visual editing on a percentage of the abstracts submitted by reporting facilities. Feedback is provided to reporting facilities on the results of visual editing.
    - A visual editing accuracy rate was established at 97% in January 2000. This rate applies to cancer reporting facilities and not to individual cancer registry abstractors. The reporting facility is responsible for cancer reporting requirements, not specific individuals; therefore, an accuracy rate reflects the facility's compliance with regulations. Please refer to the CCR web site at: https://www.ccrcal.org/submit-data/cancer-registrars-hospitals-and-facilities/reporting-by-cancer-registrars/#visually-edited-data, for the current list of visually edited data items.
    - Discrepancy Reports are provided to each facility outlining the coding errors identified by visual editors. Facility abstractors are expected to update their database with the corrected codes identified by visual editors, thereby ensuring that future Modified Records will reflect the accurate code(s).
2. **Computer Edits:**
    - Computer edits are also used to assess the quality of data submitted. The CCR provides a standard set of edits for abstracting software. These edits are performed on data at the time of abstracting. The measure used to evaluate accuracy is the percent of a facility's cases that fail an edit. CCR's cases must pass the inter-field edits specified in Cancer Reporting in California: Data Standards for Regional Registries and California Cancer Registry (California Cancer Reporting System Standards, Volume III).
    - The CCR's edit set contains a number of edits that require review. After review and confirmation that the abstracted information is correct, a flag must be set so that repeated review is not necessary, and a case can be set to complete. Please follow the instructions provided by your facility's abstracting software vendor for using these flags.
    - The Central Registry is committed to ensuring high quality data in the database. Business Rules have been implemented in the database to evaluate coded data fields based on pre-determined criteria and then auto-correct miscoded data field(s) based on programmed criteria. These rules

have been developed by CTRs at the Central Registry and have been rigorously tested prior to implementation.

3. Re-Abstracting Audits:

- Another method of assessing accuracy is to re-abstract cases in the facilities. A sample of cases from each facility is re-abstracted by specially trained personnel. The measure used is the number of discrepancies found in related categories of items.

IX.2.3 Timeliness - Quality Control

Timeliness involves how quickly the reporting facility submits a case to a regional registry or central registry after admission of the patient. Regional registries and the central registry monitor the timeliness of data submitted by facilities.

Guidelines:

- The standard established by the CCR is that 97 percent of cases must be received by the regional registry or central registry within six months of admission and 100 percent must be received within 12 months of admission.
- Although every effort should be made to complete cases before they are transmitted to the regional registry or central registry, it is recognized that some cancer cases undergo treatment later than six-months from the date of admission.
- Submit treatment information in a Modified Record as available.

Appendices

The appendices section of Volume I includes resources and supplemental information for the abstractor to access for specific coding. Examples of what is included in the appendices section are items such as postal abbreviations, surgery codes, multiple primary information, and race codes.

To access California Cancer Reporting System Standards, Volume I: Abstracting and Coding Procedures –, please see: https://www.ccrcal.org/submit-data/cancer-registrars-hospitals-and-facilities/reporting-by-cancer-registrars/#