CANCER REPORTING IN CALIFORNIA: ABSTRACTING AND CODING PROCEDURES FOR HOSPITALS
California Cancer Reporting System Standards, Volume I

SUMMARY OF YEAR 2010 DATA CHANGES

This document provides a summary of data changes for 2010 for hospitals, abstracting vendors, and regional registry data collectors. The changes to Volume I will be available in June. This document is divided into sections – Additions (New Data Items) and Changes (Revised Data Items).

ADDITIONS (New Data Items):

Grade Path Value
Describes the actual grade according to the grading system in *Grade Path System*.

Rationale: This item records the numeric grade reported in the pathology report. This item supplements but does not replace *Grade/Differentiation.*

Codes:
1 - Grade I or 1
2 - Grade II or 2
3 - Grade III or 3
4 - Grade IV or 4
Blank – No two, three or four grade system is available; Unknown

Field length: 1 character

Grade Path System
Indicates whether a two, three or four grade system was used in the pathology report.

Rationale: This item is used to show whether a two, three or four grade system was used in the pathology report to describe the grade. This item is used in conjunction with *Grade Path Value.*

Codes:
2 - Two-grade system
3 - Three-grade system
4 - Four-grade system
Blank – No two, three or four grade system is available; Unknown

Field length: 1 character

Lymph-vascular Invasion

Indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels with the primary tumor as noted microscopically by the pathologist.
Note: CCR requires this data item be collected for Penis and Testis only

Rationale: Lymph-vascular invasion is an indicator of prognosis. This field is used by the CS algorithm to map AJCC T for some primary sites.

Codes:
0 – Absent/Not Identified
1 – Present/Identified
8 - Not applicable
9 – Unknown/Indeterminate

Field length: 1 character

RX Sum--Treatment Status

This data item is a summary of the status of all treatment modalities.

Rationale: This variable provides a yes/no summary of whether treatment has been given, including an option that indicates active surveillance (watchful waiting).

Codes:
0 - No treatment given
1 - Treatment given
2 - Active surveillance (watchful waiting)
9 - Unknown if treatment given

Field length: 1 character

Date Case Initiated

This generated data item records the date the electronic abstract is initiated in the reporting facility's cancer registry database. This is a new NAACCR data item and replaces former CCR data item, *Date First Entered.*

Codes: Use the standard date format YYYYMMDD

Field length: 8 characters

CS Mets at Dx Bone

Identifies the presence of distant metastatic involvement of bone at time of diagnosis.
Note: This includes only bone, not the bone marrow.

Rationale: The presence of metastatic bone disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes:
0 - No
1 - Yes
8 - Not applicable
9 - Unknown

Field length: 1 character

CS Mets at Dx Brain

Identifies the presence of distant metastatic involvement of the brain at time of diagnosis.
Note: This includes only the brain, not spinal cord or other parts of the central nervous system.

Rationale: The presence of metastatic brain disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes:
0 - No
1 - Yes
8 - Not applicable
9 - Unknown

Field length: 1 character

CS Mets at Dx Liver

Identifies the presence of distant metastatic involvement of the liver at time of diagnosis.

Rationale: The presence of metastatic liver disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes:
0 - No
1 - Yes
8 - Not applicable
9 - Unknown

Field length: 1 character

CS Mets at Dx Lung
Identifies the presence of distant metastatic involvement of the lung at time of diagnosis.
Note: This includes only the lung, not pleura or pleural fluid.

Rationale: The presence of metastatic lung disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes:
0 - No
1 - Yes
8 - Not applicable
9 - Unknown

Field length: 1 character

CS Site-Specific Factors 7 to 25
Identifies additional information or prognostic factors that have an effect on stage or survival.

Rationale: Site-specific factors are used to record additional staging information to derive TNM and/or SEER Stage codes for particular site-histology schema.

Codes: The CCR will require the Site Specific Factors required by SEER. The required SSFs are those collected under CSv1, those needed to derive AJCC or SEER Summary Stage, plus a few SSFs considered clinically relevant. Some of the original SSFs 1-6 that were required have been made Obsolete and will no longer be required. For prostate, CS SSF4 (Apex Involvement) is not required for cases diagnosed 2010+; however, it continues to be required for cases diagnosed prior to 2010. Use code "988" [not applicable] for SSFs not collected for a specific-schema. For site-specific codes, please reference http://cancerstaging.org/cstage/manuals/index.html.

Field length: 3 characters

CS Version Input Current
This item indicates the version of CS input fields after they have been updated or recoded. This data item is recorded the first time the CS input fields are entered and should be updated each time the CS input fields are modified.

Rationale: Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

Codes:
Digits 1 and 2 Major version number
Digits 3 and 4 Minor version number
Digits 5 and 6 Less significant changes

Field length: 6 characters

Derived AJCC-7 T
Derived AJCC-7 T Descript
Derived AJCC-7 N
Derived AJCC-7 N Descript
Derived AJCC-7 M
Derived AJCC-7 M Descript
Derived AJCC-7 Stage Grp

These items are the derived 7th Edition AJCC staging elements from coded fields using the CS algorithm.

Rationale: *Derived AJCC TNM and Stage Group* can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Codes: See the most current version of the Collaborative Stage Data Collection System Manual and Coding Instructions (http://cancerstaging.org/cstage/manuals/index.html).

Field length: 2 characters for Derived T, N, M, and Stage Group; 1 for Derived T, N, M Descripts

Path Reporting Fac ID 1-5
Identifies the pathology facility that produced the report. Use the National Provider Identifier (NPI) if available. This data item replaces CCR data item, DX RX Report Facility ID.

Field length: 25 characters

Path Report Numbers 1-5
Unique sequential number assigned by a laboratory to the corresponding pathology report for the case. This data item replaces CCR data item, DX RX Report Number.

Field length: 8 characters

Path Date Spec Collect 1-5
Records 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, DX RX Report Date.

Field length: 14 characters

Path Report Type 1-5

This item reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry. This data item replaces CCR data item, DX RX Report Type. Data in the current DXRX Report Type field will be converted to the new codes.

Codes:
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

Field length: 2 characters

DATE FLAGS

Explains why there is no appropriate value in the corresponding date field.

Rationale: The format used to transmit dates has been modified for interoperability with other electronic data systems. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software, these changes may be transparent to registrars.

Field length: 2 characters

Date of Birth Flag

Codes:
12   Date of birth cannot be determined
Blank   Full or partial date recorded

Date of Diagnosis Flag

Codes:
12   Date of diagnosis cannot be determined
Blank Full or partial date recorded

Date of Multiple Tumors Flag

Codes:
11   Multiple tumors not collected for this site/histology
12   Date cannot be determined, but known to be multiple primary
15   Single primary
Blank Full or partial date recorded

Date Conclusive DX Flag

Codes:
10   Unknown if based on ambiguous terminology
11   Date cannot be determined, diagnosed originally or within 60 days using unambiguous terminology
12   Date cannot be determined, diagnosed using ambiguous terminology, conclusively diagnosed > 60 days later
15   Diagnosed using ambiguous terminology, no conclusive diagnosis followed
Blank Full or partial date recorded

Date of 1st Contact Flag

Codes:
12   Date of first contact cannot be determined
Blank Full or partial date entered

Date of Inpt Adm Flag

Codes:
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

Date of Inpt Disch Flag

Codes:
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

RX Date--Surgery Flag

Codes:
10   Unknown whether surgical procedure performed
11   No surgical procedure performed
12   Date cannot be determined for surgery performed during first course
Blank Full or partial date recorded

RX Date--Radiation Flag

Codes:
10   Unknown whether radiation was given
11   No radiation planned or given
12   Date cannot be determined for radiation received during first course
15   Radiation is planned; start date is not yet available
Blank Full or partial date recorded

RX Date--Chemo Flag

Codes:
10   Unknown whether 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

RX Date--Hormone Flag

Codes:
10   Unknown whether 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

RX Date--BRM Flag

Codes:
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

RX Date--Other Flag

Codes:
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

Date of Initial RX Flag

Codes:
10   Unknown if therapy administered
11   Therapy not administered
12   Therapy was administered but date is unknown
Blank   Full or partial date recorded

RX Date--DX/Stg Proc Flag

Codes:
10   Unknown whether a surgical diagnostic or staging procedure was performed
11   No surgical diagnostic or staging procedure was performed
12   Date cannot be determined for surgical diagnostic or staging performed
Blank   Full or partial date recorded

Date of Last Contact Flag

Codes:
12   Date cannot be determined
Blank   Full or partial entered

RX Date Mst Defin Srg Flag

Codes:
10   Unknown whether any surgery was performed
11   No surgical procedure performed
12   Date cannot be determined, but patient did received first course surgery
Blank   Full or partial date recorded

RX Date Systemic Flag

Codes:
10   Unknown whether any systemic therapy was given
11   No systemic therapy planned or given
12   Date cannot be determined for systemic therapy received during first course
15   Systemic therapy is planned; start date is not yet available
Blank   Full or partial date recorded

Date Surg Proc 1 Flag

Codes:
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

Date Surg Proc 2 Flag

Codes:
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

Date Surg Proc 3 Flag

Codes:
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

RX Date--Transplnt/Endocr Flag

Codes:
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

CHANGES (Revised Data Items):

Class of Case

Class of Case divides cases into two groups - analytic and nonanalytic. Analytic cases (codes 00-22) are those required to be abstracted because of the facility's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and treatment. Treatment and outcome reports may be limited to analytic cases. Nonanalytic cases (codes 30-49 and 99) may be abstracted by the facility to meet central registry requirements or in response to a request by the facility's cancer program. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.

Rationale:

Class of Case reflects the facility's role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program's Reference Date.

Codes:

00   Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere

10   Initial diagnosis AND part or all first course treatment or a decision not to treat done at the reporting facility, NOS

11   Initial diagnosis by staff physician AND part of first course treatment was done at the reporting facility

12   Initial diagnosis by staff physician AND all first course treatment or a decision not to treat was done at the reporting facility

13   Initial diagnosis AND part of first course treatment was done at the reporting facility

14   Initial diagnosis AND all first course treatment or a decision not to treat was done at the reporting facility

20   Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS

21   Initial diagnosis elsewhere AND part of treatment was done at the reporting facility

22   Initial diagnosis elsewhere AND all treatment was done at the reporting facility

Patient appears in person at reporting facility

30   Initial diagnosis and all first course treatment elsewhere AND reporting facility
      participated in diagnostic workup (for example, consult only, staging workup
      after initial diagnosis elsewhere)
31   Initial diagnosis and all first course treatment elsewhere AND reporting facility
      provided in-transit care
32   Diagnosis AND all first course treatment provided elsewhere AND patient
      presents at reporting facility with disease recurrence or persistence
33   Diagnosis AND all first course treatment provided elsewhere AND patient
      presents at reporting facility with disease history only
34   Type of case not required by CoC to be accessioned (for example, a benign colon
      cancer) having initial diagnosis AND part or all of first course treatment by
      reporting facility
35   Case diagnosed before program's Reference Date, having initial diagnosis AND
      part or all of first course treatment by reporting facility
36   Type of case not required by CoC to be accessioned (for example, a benign colon
      tumor) having initial diagnosis elsewhere AND all or part of first course treatment
      by reporting facility.
37   Case diagnosed before program's Reference Date, having initial diagnosis AND a
      all or part of first course treatment by facility.
38   Initial diagnosis established by autopsy at the reporting facility, cancer not
      suspected prior to death.

Patient does not appear in person at reporting facility

40   Diagnosis AND all first course treatment given at the same staff physician's
      office
41   Diagnosis and all first course treatment given in two or more different staff
      physician offices
42   Non-staff physician or non-CoC approved clinic or other facility, not part of
      reporting facility, accessioned by reporting facility for diagnosis and/or treatment
      by that entity (for example, hospital abstracts cases from an independent radiation
      facility)
43   Pathology or other lab specimens only
49   Death certificate only
99   Case not required by CoC to be abstracted of unknown relationship to facility (not
      for use by CoC approved cancer programs for analytic cases.)

Field Length: Changed from 1 to 2 characters

CS Extension
Added new codes.

Codes: See the most current version of the Collaborative Stage Data Collection System Manual and Coding Instructions (http://cancerstaging.org/cstage/manuals/index.html).

Field Length: Changed from 2 to 3 characters

CS Lymph Nodes
Added new codes.

Codes: See the most current version of the Collaborative Stage Data Collection System Manual and Coding Instructions (http://cancerstaging.org/cstage/manuals/index.html).

Field Length: Changed from 2 to 3 characters

CS Mets at Dx
Added site/histology-specific codes.

Codes: See the most current version of the Collaborative Stage Data Collection System Manual and Coding Instructions (http://cancerstaging.org/cstage/manuals/index.html).

Diagnostic Confirmation
Added code 3 effective with 2010 diagnoses, only for hematopoietic and lymphoid neoplasms 95903-99923.

Code:
  3   Positive histology PLUS –
         Positive immunophenotyping AND/OR positive genetic studies

Laterality
Added code 5 for 2010 forward.

Codes:
5   Paired site, midline tumor

Race 1-5
Retired Code 09 – Asian Indian or Pakistani. These cases were converted to new code 15.
Added the following codes.

Codes:
13   Kampuchean (Cambodian)
15   Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16   Asian Indian
17   Pakistani

Site-Specific Surgery Codes – Brain
Added codes 21, 22, 30 for 2010 and forward.

Code:
21   Subtotal resection of tumor, lesion or mass in brain
22   Resection of tumor of spinal cord or nerve
30   Radical, total, gross resection of tumor, lesion or mass in brain

TNM Edition Number
Added code 7 for 2010 and forward.

7   Seventh Edition (published 2009)

RX Summ--Systemic Sur Seq
Revised definition of Code 0.

Code:
0   No systemic therapy and/or surgical procedures; unknown if surgery and/or systemic therapy given.

CS Version Original
Changed from CS Version 1st

CS Version Derived
Changed from CS Version Latest

Derived AJCC-6 T
Changed from AJCC

Derived AJCC-6 T Descript
Changed from AJCC

Derived AJCC-6 N
Changed from AJCC

Derived AJCC-6 N Descript
Changed from AJCC

Derived AJCC-6 M
Changed from AJCC

Derived AJCC-6 M Descript
Changed from AJCC

Derived AJCC-6 Stage Group
Changed from AJCC

DATE FORMAT CHANGES:

Date of Birth/Birthdate
Date of Diagnosis
Date of Conclusive DX
Date of Multiple Tumors
Date of 1ˢᵗ Contact
Date of Inpatient Adm
Date of Inpatient Disch
RX Date--Radiation
RX Date--Chemo
RX Date--Hormone
RX Date--BRM
RX Date--Other
Date of Initial RX--SEER
RX Date--DX/Stg Proc
RX Date--Most Definitive Surg
RX Date--Systemic

Uses new date format of CCYYMMDD, or CCYYMM, or CCYY

Rationale: The format used to transmit dates has been modified for interoperability with other electronic data systems. Registry software may display dates in the traditional manner or in the interoperable format, and therefore, these changes may be transparent to registrars.

FIELD LENGTH CHANGES:

Addr at DX--No & Street
Length changed from 40 to 60

Addr at DX—Supplementl
Length changed from 40 to 60

Addr at DX – City
Length changed from 20 to 50

Addr Current--No & Street
Length changed from 40 to 60

Addr Current—Supplementl
Length changed from 40 to 60

CS Extension
Length changed from 2 to 3

CS Lymph Nodes
Length changed from 2 to 3

Follow Up Contact—Name
Length changed from 30 to 60

Follow Up Contact--No & St
Length changed from 40 to 60

Follow Up Contact—City
Length changed from 20 to 50

Follow Up Contact—Suppl
Length changed from 40 to 60

Name—Last
Length changed from 25 to 40

Name—First
Length changed from 14 to 40

Name--Middle
Length changed from 14 to 40

Name—Alias
Length changed from 15 to 40

Name--Maiden
Length changed from 15 to 40

RX Text—Surgery
Length changed from 150 to 1000

RX Text--Radiation (Beam)
Length changed from 150 to 1000

RX Text--Radiation Other
Length changed from 150 to 1000

RX Text—Chemo
Length changed from 200 to 1000

RX Text—Hormone
Length changed from 200 to 1000

RX Text—BRM
Length changed from 100 to 1000

RX Text—Other
Length changed from 100 to 1000

Text--DX Proc—PE
Length changed from 200 to 1000

Text--DX Proc--X-ray/Scan
Length changed from 250 to 1000

Text--DX Proc—Scopes
Length changed from 250 to 1000

Text--DX Proc--Lab Tests
Length changed from 250 to 1000

Text--DX Proc—Op
Length changed from 250 to 1000

Text--DX Proc—Path
Length changed from 250 to 1000

Text--Primary Site
Length changed from 40 to 100

Text--Histology Title
Length changed from 40 to 100

Text--Staging
Length changed from 300 to 1000

Text—Remarks
Length changed from 250 to 1000

Text--Place of Diagnosis
Length changed from 50 to 60

Text--Usual Occupation
Length changed from 40 to 100

Text--Usual Industry
Length changed from 40 to 100

TNM Clin T
Length changed from 2 to 4

TNM Clin N
Length changed from 2 to 4

TNM Clin M
Length changed from 2 to 4

TNM Clin Stage Group
Length changed from 2 to 4

TNM Path T
Length changed from 2 to 4

TNM Path N
Length changed from 2 to 4

TNM Path M
Length changed from 2 to 4

TNM Clin Stage Group
Length changed from 2 to 4