
# CANCER REPORTING IN CALIFORNIA SYSTEM STANDARDS

## ABSTRACTING AND CODING PROCEDURES FOR HOSPITALS

## California Cancer Reporting System Standards

### VOLUME ONE

**Eighth Edition, January 2007**
**Revised, May, 2008**


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**Data Standards and Quality Control Unit**

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# PREFACE TO THE EIGHTH EDITION, REVISED MAY, 2008

The staff of the Data Standards and Quality Control (DSQC) Unit of the California Cancer Registry would like to present the eighth edition, of *Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, Volume I*, revised May 2008. In 2006, the CCR switched to a new format for producing Volume I. Two versions are now available for users. One version is in HTML and is interactive and fully searchable. The other version is a printable, PDF version for downloading. As a reminder, changes to this document are identified through the use of ***italicized, bolded, maroon-colored font***. We have changed our format this year. Instructions on current abstracting and coding rules are now provided first in each section. Instructions on historical rules follow. Most references to software functionality have also been removed, as the purpose of this document is to provide abstracting and coding instructions, regardless of the software used. We hope that users find the format changes useful and more efficient.

The main changes for 2008 are the new Diagnostic and Treatment Report (DxRx Report) data items and the collection of the Collaborative Staging (CS) Evaluation fields. These CS data items are required by SEER for all facilities, not just ACoS approved facilities, beginning with cases diagnosed 1/1/2008 forward.

In addition to changes in requirements from national standard setting agencies for 2008, feedback from hospital registrars and regional registry staff has resulted in modifications and clarifications to this document.

A document summarizing changes for 2008 -- Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, California Cancer Reporting System Standards, Volume I, Summary of Year 2008 Data Changes -- was made available to hospitals and regional registries in October, 2007. The document provides an overview of 2008 data changes. Another document -- Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, California Cancer Reporting System Standards, Volume I, Changes and Clarifications - 8th Edition, Revised May 2008, provides a detailed summary of the changes in Volume I, including those related to 2008 data changes. Both documents will be posted to the CCR web site.

I want to acknowledge Winny Roshala, BA, CTR, for her work in revising this document. In addition, I want to acknowledge Alan Houser, MA, MPH, and Dennis O'Neal for their technical expertise.

For reporting facilities in California, please send corrections, comments, and suggestions regarding this document to your regional registry. They will send this information to our unit. If individuals or facilities that are not part of the California reporting system need copies, they may download Volume I from the California Cancer Registry web site at .

As always, I want to thank you for the contribution you make to the California Cancer Registry and its mission - searching for the causes and cures of cancer.

Nancy C. Schlag, B.S., CTR
Data Standards and Quality Control

# Part 1. Introduction

## 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 different 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

One of the principal mechanisms for collecting epidemiological information is the cancer registry. A registry is the administrative system for maintaining a register, (database) of cancer patients and pertinent data about their condition.  Many California hospitals have had their own cancer registries since the 1950's in accordance with guide lines established by the American College of Surgeons (ACoS) 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.

### I.1.2 The California Cancer Registry

Information from hospital registries and other 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 ***Cancer 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 located in the San Francisco Bay area and Los Angeles County. As a result, valuable statistics were developed about the survival of cancer patients. But 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 36 million people in eleven designated regions of the United States.

Expansion of the registration to the SF-O SMSA produced a number of 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 different 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

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 enable the 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 facility providing therapy to 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." For the sake of efficiency and responsiveness to local needs, responsibility for receiving and evaluating reports from hospitals in designated areas is assigned to regional registries. ***Beginning January 1, 2001, diagnoses of borderline and benign primary intracranial and central nervous system (CNS) tumors are also reportable, as well as borderline ovarian cancer and Newly Reportable Hematopoietic Diseases (NRHD) (see Section II.I.8).***

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. Please refer to Appendix J. 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 hospital or other reporting source, unless prior in formed 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.

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. (See Appendix J for a sample Patient Information Sheet for use in notifying patients that cancer is reportable.)

For more information regarding the CCR's confidentiality policy, please go to the CCR web site:

http://www.ccrcal.org/PDF/CCRDataAccessDisclo_v04.4.pdf

## I.1.5 Casefinding

The foundation of the State's cancer reporting system is the hospital, and a key to successful registration is a casefinding system within the hospital for identifying patients with reportable cancers. Although exact procedures might vary from hospital to hospital, they ordinarily involve careful monitoring of the records kept by the services and departments that usually deal with cancer cases.

### I.1.5.1 Sources

The principal sources for a hospital's identification of cancer patients are:

- Pathology reports, including histology, cytology, hematology, bone marrow, and autopsy findings. Since pathologic studies are made for most patients suspected of having cancer, the majority of reportable cases can be found by reviewing or obtaining copies of reports with positive or indicative diagnoses.
- Daily discharges
- Disease indexes (See Appendix K for applicable ICD-9-CM codes used in medical records departments.)
- Outpatient records
- Surgery reports
- Radiation therapy logs
- Nuclear medicine logs
- Radiology logs, including logs of scans

### I.1.5.2 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. Reporting facilities must have a systematic method of identifying patients who are re-admitted to the hospital or who are treated on an outpatient basis, whether for the reported cancer or for another condition. This information can be used to update the reported patient's vital status and condition.

## I.1.6 Reporting

The hospital must report every case of cancer first seen there 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).

For cases seen in 2007 ***and forward***, the CCR requires that reporting facilities must notify the regional registry of the following cases:

- Patients receiving transient care to avoid interrupting therapy initiated elsewhere (equipment failure at the reporting facility or while vacationing).
- Patients with active cancer who are admitted for other medical conditions.
- Patients seen at a facility for catheter placement for cancer therapy.

- ***Patients who are receiving long term therapy (such as hormone therapy). with a history of cancer but with no current evidence of cancer. Do not report cases with only a history of cancer. The patient must be receiving long term therapy AND have a history of cancer to be reportable via notification to the CCR.***

The CCR minimum requirement is that these cases be reported via Confidential Morbidity Report (CMR) or similar mechanism as designated by the regional registry. If your regional registry requires a full abstract on one or more of these scenarios, please continue with this practice. Consult your regional registry for reporting requirements.

If the case is not found in the CCR database, the reporting facility may be asked to submit a full abstract for the case for incidence reporting, if they haven't already done so. These cases are all considered to be Class 3 cases for the reporting facility.

Although a reporting facility must notify the regional registry of cases fitting the scenarios listed and comply with regional reporting requirements, a reporting facility may choose to submit a full abstract for any of these type of cases seen at their facility.

Historically, effective with cancer cases reported January 1, 1992, patients receiving transient care to avoid interrupting therapy initiated elsewhere (equipment failure at the original facility or while vacationing) and patients with active cancer who are admitted for other medical conditions were no longer to be reported to the California Cancer Registry. (Note: Some regional registries had elected not to implement this change. Contact your regional registry with questions about their reporting requirements.) In January 2006, for those who were required to report a full abstract for cases in which there is no evidence of disease or there is a history of cancer, but the patient is still receiving long term therapy (such as hormone therapy), submit a Confidential Morbidity Report (CMR) form only. A full abstract is no longer required for these cases. If these cases were never reported within your region, continue with this practice. This practice changed in 2007.

A report is required whether or not the case was diagnosed elsewhere previously. However, a report is not required if the case was first seen for cancer at the hospital before the region's reference date and is admitted again after that date. The case of a patient hospitalized at the reporting hospital on the region's reference date must be reported if it is diagnosed as cancer on or after the region's reference date. If in doubt about whether or not to report a case, prepare a report or consult the regional registry.

## Examples

The region's reference date is 1/1/87, and a patient was admitted in February of 1987 with recurrent disease. However, the patient's initial diagnosis and treatment occurred at the reporting hospital in January of 1986.

The case does not need to be reported.

The region's reference date is 6/1/87. A patient was admitted to hospital A in June for part of the first course of treatment. The record states that the patient was diagnosed at hospital B in May of 1987.

Hospital A must report the case.

The region's reference date is 1/1/88, and a patient was admitted in February of 1988 for treatment of a recurrence. The place and date of the original diagnosis are not known.

The case must be reported.

The region's reference date is 1/1/88, and a patient was admitted on 12/29/87 for evaluation. Cancer was diagnosed on 1/5/88, and the patient was discharged on 1/8/88.

The case must be reported.

A biopsy done on 12/30/87 revealed colon cancer. A colectomy was performed on 1/2/88, and the patient was discharged on 1/6/88.

The case does not need to be reported.

The region's reference date is 7/1/88. A patient was admitted on 7/5/88 for resection of a cervix cancer which had been diagnosed by biopsy in a staff physician's office on 6/20/88.

The case must be reported.

## I.1.6.1 Definition of Cancer

Cancer is defined by the 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."

Effective with cases diagnosed January 1, 2001, benign and uncertain behavior intracranial and central nervous system (CNS) tumors become reportable along with newly reportable histologies published in ICD-O-3. Although borderline ovarian tumors changed behavior in ICD-O-3 from /3 (malignant) to /1 (borderline), the CCR will continue to require reporting them. They are to be coded with a behavior code of /1. The CCR establishes an official list of report able neoplasms annually. A tumor must be reported if it is diagnosed as cancer by any physician (including a pathologist or radiologist), surgeon, or dentist.

Effective with cases diagnosed January 1, 1996, 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.

## I.1.6.2 Reporting Methods

Information about cancer cases is reported to the CCR in the form of abstracts, which summarize pertinent information about individual cases (please refer to Appendix U -- Data Items and Their Required Status). If in doubt about how certain fields should be completed, the regional registry should be contacted.

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.

## I.1.6.3 Coding

Much of the information is entered in codes consisting of numbers or characters. Codes ***must*** be supported by text documentation on the abstract.

## I.1.6.4 Entering Dates

Enter the number of the month, then the day, then the four-digit year. Usually, the abstracting software will provide separators such as slashes, dashes, or even separate fields for each part of the date. If the number of a month or day has only one digit (January-September, first-ninth), enter a 0 before the digit. Enter 99 for an unknown month or unknown day. If the year is not known, enter 99 in all the fields (99/99/9999).

## Examples

| | | |
|---|---|---|
| January 1, 2000 | = | 01/01/2000 |
| February 10, 1965 | = | 02/10/1965 |
| December 3, 1951 | = | 12/03/1951 |
| November ?, 1975 | = | 11/99/1975 |
| May 19, 193? | = | 99/99/9999 |

## I.1.6.5 Coding Sources

| **A registry must have certain reference works for coding, in addition to this manual.** | |
|---|---|
| ***Collaborative Staging Manual and Coding Instructions*** | Collaborative Staging Task Force of the American Joint Committee on Cancer. Version 01.04 Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004, NIH Publication Number 04-5496. |
| ***International Classification of Diseases for Oncology (ICD-O)*** | Fritz, A., Percy, C. et al, eds. 3rd ed. Geneva; World Health Organization, 2000. |
| ***International Classification of Diseases for Oncology (ICD-O)*** | Percy, C., VanHolten, V., and Muir, C., eds. 2d ed. Geneva: World Health Organization, 1990. |
| ***Multiple Primary and Histology Coding Rules Manual*** | SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: National Institutes of Health, National Cancer Institute, January 01, 2007. |
| ***SEER Extent of Disease—1988 Codes and Coding Instructions*** | SEER (Surveillance, Epidemiology, and End Results Program). 3rd ed. [Bethesda]: National Institutes of Health, National Cancer Institute, 1998. NIH Pub. No. 98-1999. |
| ***Summary Staging Guide for the Cancer Surveillance, Epidemiology and End Results Reporting (SEER) Program*** | SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, April 1977, reprinted July 1986. |
| ***SEER*Rx Version 1.20. The Cancer Registrar's Interactive Antineoplastic Drug Database*** | SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, 2007 (applicable for cases diagnosed January 1, 2005 forward). |
| ***Self-Instructional Manual for Tumor Registrars: Book 8—*** | SEER (Surveillance, Epidemiology, and End Results Program). 3d ed. [Bethesda]: U.S. Department of Health and Human Services, |

| | |
|---|---|
| ***Antineoplastic Drugs*** | Public Health Services, National Institutes of Health, 1994 (applicable for cases diagnosed prior to January 1, 2005). |
| ***Manual for Staging of Cancer*** | AJCC (American Joint Committee on Cancer). 6th ed. New York: Springer-Verlag, 2002. |
| ***CNExT User Manual*** | C/NET Solutions. [Berkeley]: Public Health Institute, CNExT Project. |
| ***Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data Standards (FORDS)*** | ACoS (American College of Surgeons Commission on Cancer). Chicago: American College of Surgeons Commission on Cancer, January 2003, revised 2007***.*** |
| **Helpful references, although not necessary for abstracting and coding, include the following:** | |
| ***California Cancer Registry Inquiry System*** | California Cancer Registry, California Public Health Institute |
| ***SEER Inquiry System (SINQ): Resolved Questions*** | SEER (Surveillance, Epidemiology, and End Results Program) |
| ***SEER Program: Comparative Staging Guide for Cancer*** | SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: National Institutes of Health, National Cancer Institute, 1993. NIH Pub. No. 93-3640. |
| ***The SEER Program Coding and Staging Manual 2007*** | SEER (Surveillance, Epidemiology, and End Results Program). 4th ed [Bethesda]: National Institutes of Health, National Cancer Institute, 2007. NIH Pub. No. 07-5581 |

***SEER Program: Self-Instructional Manual for Cancer Registrars***

Shambaugh, E., ed-in-chief. [Bethesda]: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, various years.

*Book One-Objectives and Functions of a Tumor Registry*
2d ed, 1980. [New edition is in preparation.]

*Book Two-Cancer Characteristics and Selection of Cases*
3d ed, 1992. NIH Pub. No. 92-993

*Book Three-Tumor Registrar Vocabulary: The Composition of Medical Terms*
2d ed, 1993. NIH Pub. No. 93-1078.

*Book Four-Human Anatomy as Related to Tumor Formation*
2d ed, 1993. NIH Pub. No. 93-2161.

| | |
|---|---|
| | *Book Five-Abstracting a Medical Record: Patient Identification, History, and Examinations*<br>2d ed, 1993. NIH Pub. No. 93-1263<br>*Book Seven-Statistics and Epidemiology for Tumor Registrars*<br>1994 |
| ***International Classification of Diseases for Oncology (ICD-O)*** | World Health Organization**.** Geneva: World Health Organization, 1976. |
| ***International Classification of Diseases for Oncology(ICD-O)*** | Percy, C., and VanHolten, V**.**. Field Trial Edition. Geneva: World Health Organization, 1988. |
| ***U.S. Postal Service National Zip Code & Post Office Directory.*** | |

## I.1.7 Reporting by Non-hospital Treatment Centers

Not all abstracting requirements apply to free-standing 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.

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 Section IV.1). 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, although many of the data fields may be left blank or coded as unknown. Required data are listed in Appendix U.

## I.1.8 Abstracting Requirements for Non-analytic Cases

A population based registry like California's must record all cases, regardless of place of diagnosis or class of case, even though the American College of Surgeons (ACoS) does not require hospitals to abstract non-analytic cases.

Therefore, the CCR requires that non-analytic cases — classes 3, 4, 5, 7, 8, and 9 — be abstracted and submitted. For definitions of non-analytic and analytic cases and class of case, see Section III.3.5.

### I.1.8.1 Autopsy Only Cases

Abstracting requirements for Autopsy Only (Class 5) cases are the same as those for analytic cases.

### I.1.8.2 Class 3, 4, and 9 Cases

Reporting requirements for cases included in classes 3, 4, and 9 are less stringent than those for other cases. The reporting hospital's medical record often does not contain the required data, or contains only second hand data. Report any information included in the medical record, but it is not necessary to obtain missing information, although a hospital 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.

#### Examples

Leukemia diagnosed 5/87 in San Francisco, in remission since 6/87, now admitted for treatment of relapse.

Colon cancer diagnosed 1 year PTA. Now has widespread mets. Admitted for terminal care.

Even though information for many required data fields might not be available, all of the fields must be completed. If necessary, enter the codes for UNKNOWN or NONE.

## I.2 CNExT

***This section was software specific and deleted in 2008.***

# Part II. Reportable Neoplasms

The essential criteria for a reportable tumor is a diagnosis of cancer by a physician, surgeon, or dentist, even if it is not pathologically confirmed.

## II.1 Determining Reportability

Every hospital 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 Section II.1.4). Neoplasms described by terms synonymous with in situ are reportable (see Section V.5.8.1 for a list of terms). Effective with cases diagnosed January 1, 2001, benign and uncertain behavior intracranial and central nervous system (CNS) tumors become reportable along with newly reportable histologies published in ICD-O-3. Although borderline ovarian tumors changed behavior in ICD-O-3 from /3 (malignant) to /1 (borderline), the CCR will continue to require reporting them. 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.1.1 Criterion for Reportability

In determining whether a tumor is reportable, the basic criterion is a diagnosis of cancer by a physician, surgeon, or dentist, even if it is not pathologically confirmed. (For vague and ambiguous diagnostic terms, see Section II.1.6). 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 hospital's regional registry for advice.

***For benign and borderline brain and CNS tumors, 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.***

***See Section*** II.1.9.1 Reportability

## II.1.2 Identifying the Primary Neoplasm

Accurate identification of a patient's primary neoplasm is essential for determination of the extent to which the disease has progressed. It is also imperative for successful use of the data by research scientists and public health officials.

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

Metastasis is the dissemination of tumor cells from the primary site to a remote part of the body. It is important to distinguish metastatic lesions from new primaries. A metastatic lesion is not a primary tumor. Pathologic reports are usually the best source. The term "secondary" is sometimes used for a metastatic lesion. Since the lymphatic system is one of the main routes of metastasis, frequent reference will be found in examinations of the lymph nodes. Occurrence of a lesion in a lymph node ordinarily indicates metastasis.

A separate abstract must be prepared for each primary reportable neoplasm present at the time of admission unless it was previously reported. This would ordinarily exclude a tumor identified only by its history.

For definitions and rules, see Section II.1.3 and Section V.1.

**January 1, 2007 and Forward**

Beginning with cases diagnosed January 1, 2007 forward, the 2007 Multiple Primary and Histology Rules must be used to determine histologic type. Do not apply these rules to cases diagnosed prior to January 1, 2007. Refer to the Multiple Primary and Histology Coding Rules Manual for details and instructions.

http://www.seer.cancer.gov/tools/mphrules/mphrules_manual_01012007.pdf

http://www.seer.cancer.gov/manuals/2004Revision 1/SPM_2004_maindoc.r1.pdf

http://www.seer.cancer.gov/tools/mphrules/mphrules_manual_01012007.pdf

**January 1, 2005 through December 31, 2006**

For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

http://www.seer.cancer.gov/manuals/2004Revision 1/SPM_2004_maindoc.r1.pdf

## II.1.2.1 Metastasis

Metastasis is the dissemination of tumor cells from the primary site to a remote part of the body. It is important to distinguish metastatic lesions from new primaries. A metastatic lesion is not a primary tumor. Pathologic reports are usually the best source. The term "secondary" is sometimes used for a metastatic lesion. Since the lymphatic system is one of the main routes of metastasis, frequent reference will be found in examinations of the lymph nodes. Occurrence of a lesion in a lymph node ordinarily indicates metastasis.

## II.1.2.2 Abstracting Each Primary

A separate abstract must be prepared for each primary reportable neoplasm present at the time of admission unless it was previously reported. This would ordinarily exclude a tumor identified only by its history.

For definitions and rules, see Section II.1.3 and Section V.1.

**January 1, 2007 and Forward**

Beginning with cases diagnosed January 1, 2007 forward, the 2007 Multiple Primary and Histology Rules must be used to determine histologic type. Do not apply these rules to cases diagnosed prior to January 1, 2007. Refer to the Multiple Primary and Histology Coding Rules Manual for details and instructions.

http://www.seer.cancer.gov/tools/mphrules/mphrules_manual_01012007.pdf

http://www.seer.cancer.gov/manuals/2004Revision 1/SPM_2004_maindoc.r1.pdf

http://www.seer.cancer.gov/tools/mphrules/mphrules_manual_01012007.pdf

**January 1, 2005 through December 31, 2006**

For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

http://www.seer.cancer.gov/manuals/2004Revision 1/SPM_2004_maindoc.r1.pdf

## II.1.3 Single and Multiple Primaries

The CCR has adopted the SEER policy for reporting whether lesions are single or multiple primaries. The policy states:

> The determination of how many primary cancers a patient has is, of course, a medical decision, but operational rules are needed in order to ensure consistency of reporting by all

participants. Basic factors include the site of origin, the date of diagnosis, the histologic type, the behavior of the neoplasm (i.e., in situ vs. malignant), and laterality. In some neoplasms, one must be careful since different histologic terms are used to describe progressive stages or phases of the same disease process.

Therefore, for purposes of statewide reporting, the following operational rules take precedence over the physician's determination of the number of primaries. Refer to Section V.1.2 for the rules for determining site.

**January 1, 2007 and Forward**

Beginning with cases and tumors diagnosed January 1, 2007 forward, the CCR requires the use of the 2007 Multiple Primary and Histology Coding Rules. The 2007 Multiple Primary and Histology rules replace all previous multiple primary rules except those for hematopoietic neoplasms.

The rules are effective for cases diagnosed on or after January 1, 2007. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.

If there is a previously diagnosed cancer primary before January 1, 2007, do not change the previous primary based on the new rules. Use the new rules for any new tumor diagnosed after January 1, 2007, to determine if it is an additional primary. Refer to the SEER Multiple Primary and Histology Coding Rules Manual for specific instructions.

Note: Use the 2007 Multiple Primary and Histology rules to determine the number of primaries to be abstracted. Do not use the Multiple Primary and Histology Rules to determine reportability, stage or to assign grade.

**January 1, 2005 through December 31, 2006**

For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

For cases diagnosed prior to January 1, 2005, refer to Sections II.1.3.1-2

## II.1.3.1 Single Primaries

***For cases and tumors diagnosed January 1, 2007 forward, apply the SEER Multiple Primary and Histology Coding Rules.***

For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

For cases diagnosed prior to January 1, 2005, the following are to be considered single primaries:

- A single lesion of one histologic type, even if the lesion crosses site boundaries (for definitions of site boundaries and histologic types. See Section V.1 and Section V.3 respectively.
- A single lesion with multiple histologic types. See Section V.3.3.3 for coding instructions.
- A new cancer with the same histology as an earlier one, if diagnosed in the same site within two months.
- Multiple lesions of the same histologic type, if diagnosed in the same site within two months. Furthermore, if one lesion has a behavior code of in situ and another a malignant behavior code, they are to be reported as a single primary whose behavior is malignant. (For definition of behavior codes, see Section V.3.4.
- Two lesions occurring within two months of each other in a single site are considered a single primary if one is reported as (adeno)carcinoma, NOS, and the other is a more specific type of (adeno)carcinoma. For coding instructions, see Section V.3.3.3.2 .

## II.1.3.2 Multiple Primaries

***For cases and tumors diagnosed January 1, 2007 forward, apply the SEER Multiple Primary and Histology Coding Rules.***

For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

For cases diagnosed prior to January 1, 2005, the following are to be considered separate primaries:

- A new cancer with the same histology and behavior as an earlier one, if diagnosed in the same site after two months, unless stated to be recurrent or metastatic.

*Exception #1*: For bladder cancers with site codes C67.0-C67.9 and morphology codes 8120 8130 and adenocarcinomas of the prostate (C61.9), a single report of the first invasive lesion only is required.

*Exception #2*: If there is an in situ followed by an invasive cancer in the same site more than two months apart, report as two primaries even if noted to be a recurrence. The invasive case must be diagnosed 1/1/95 or later. Effective with cases diagnosed January 1, 1998, and later, this also applies to bladder and prostate sites. For these two sites, the first invasive case must be diagnosed 1/1/98 and later. The purpose of this guideline is to ensure that a case is counted as an incidence case, *i.e.*, invasive, when data are analyzed by the regional and central registry.

- Multiple lesions of different histologic types in the same site, whether occurring simultaneously or at different times. (Note: Different histologic terms are sometimes used to describe progressive stages or phases of the same disease process.)

- Multiple lesions of different histologic types in different sites.

See also:

- Section II.1.3.3 Paired Sites
- Section II.1.3.4 Breast Ductal and Lobular Carcinomas
- Section II.1.3.6 Lymphatic and Hematopoietic Diseases - Subsequent Diagnoses
- Section II.1.3.7 Other Single and Multiple Primaries

## II.1.3.3 Paired Sites

***For cases diagnosed January 1, 2007 forward, apply the SEER Multiple Primary and Histology Coding Rules for determining how many primaries are involved in paired sites.*** See Multiple Primary and Histology Coding Rules (NCI).

For cases diagnosed prior to January 1, 2007, apply the following rules:

If only one histologic type is reported and if both sides of a paired site are involved within two months of diagnosis, ascertain whether the patient has one or two independent primaries. (The determination is generally made by the pathologist.)

- If the record shows one primary, submit one abstract.
- If the record shows two independent primaries, submit two abstracts, one for each side.
- If the record contains no information about the number of primaries, submit two independent abstracts, one for each side. Prepare a single abstract for the following bilateral primaries:
    - Bilateral ovarian primaries of the same histologic type, diagnosed within two months of each other.
    - Bilateral retinoblastomas.
    - Bilateral Wilms' tumors.

## II.1.3.4 Breast Ductal and Lobular Carcinomas

***For cases diagnosed January 1, 2007 forward, apply the Multiple Primary and Histology Coding Rules for determining how many primaries are involved in breast tumors with ductal and lobular carcinoma. See Multiple Primary and Histology Coding Rules (NCI).***

***For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.***

***For cases diagnosed prior to January 1, 2005, apply the following rules:***

Prepare a single abstract for certain combinations of ductal and lobular carcinomas occurring in the same breast within two months of each other. ICD-O-2 has assigned morphology 8522 to this combination.

Code as follows:

| | |
|---|---|
| Infiltrating duct carcinoma (8500/3) and lobular carcinom | (8520/3) -- code 8522/3 |
| Infiltrating duct carcinoma (8500/3) and lobular carcinoma in situ | (8520/2) -- code 8522/3 |
| Intraductal carcinoma (8500/2) and lobular carcinoma | (8520/3) -- code 8522/3 |
| Intraductal carcinoma (8500/2) and lobular carcinoma in situ | (8520/2) -- code 8522/2 |
| Infiltrating duct mixed with other types of carcinoma (*i.e.* - duct and cribriform, mucinous, tubular or colloid carcinoma) | --code 8523/3 |
| Infiltrating lobular mixed with other types of carcinoma | --code 8524/3 |

Prepare separate abstracts for a ductal lesion in one breast and a lobular lesion in the other breast, whether or not they occur within two months of each other.

## II.1.3.5 Intraductal Carcinoma and Paget Disease

***For cases and tumors diagnosed January 1, 2007 forward, refer to the SEER Multiple Primary and Histology Coding Rules to determine how to code breast tumors with intraductal carcinoma and Paget Disease.***

For cases diagnosed prior to January 1, 2007, enter code 8543/3 for a combination of intraductal carcinoma (8500/2) and Paget Disease (8540/3).

## II.1.3.6 Lymphatic and Hematopoietic Diseases - Subsequent Diagnoses

The CCR is concerned with identifying lymphomas and leukemias that are or might be treatment induced, usually as a result of chemotherapy plus radiotherapy or chemotherapy with alkylating agents.

The ICD-O-3 version of the hematopoietic primaries table is very different from the ICD-O-2 version in both format and medical understanding of these diseases. As a result, it is not possible to use the tables interchangeably. The page "Definitions of Single and Subsequent Primaries" in Appendix R explains the reasoning underlying the ICD-O-3 table.

- Use the ICD-O-3 table in Appendix R, if both diseases are diagnosed after January 1, 2001.
- Use the ICD-O-3 table in Appendix R, if the first diagnosis was prior to 2001 and the second diagnosis was after January 1, 2001.

- Use the ICD-O-2 table below, if both diagnoses are prior to January 1, 2001.

(1) Hodgkin's disease (9650-9667).

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma (9591-9595, 9670-9686, 9688, 9690-9698, 9702-9717)

Burkitt's lymphoma (9687)

Mycosis fungoides or Sezary's disease (9700, 9701)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

True histiocytic lymphoma (9723)

Plasmacytoma or multiple myeloma (9731, 9732)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Any leukemia (9800-9940)

Do not report as a subsequent primary:

Malignant lymphoma, NOS (9590)

Hodgkin's disease[1] (9650-9667)

(2) Malignant lymphoma, NOS[2] (9590).

Report as a second or subsequent primary:

Burkitt's lymphoma (9687)

Mycosis fungoides or Sezary's disease (9700, 9701)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

Mast cell tumor (9740, 9741)

Acute leukemia, NOS (9801)

Non-lymphocytic leukemias (9840-9842, 9860 9910)

Myeloid sarcoma (9930)

Acute panmyelosis (9931)

Acute myelofibrosis (9932)

Hairy cell leukemia (9940)

Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:

Malignant lymphoma, NOS (9590)

Non-Hodgkin's lymphoma[3] (9591-9595, 9670-9686, 9688, 9690-9698, 9702-9717)

Hodgkin's disease[3] (9650-9667)

True histiocytic lymphoma (9723)

Plasmacytoma[3] or multiple myeloma (9731, 9732)

Waldenstrom's macroglobulinemia (9761)

Leukemia, NOS (9800)

Chronic leukemia, NOS (9803)

Lymphoid or lymphocytic leukemia (9820-9828)

Plasma cell leukemia (9830)

Lymphosarcoma cell leukemia (9850)

Immunoproliferative disease, NOS (9760)

(3) Non-Hodgkin's lymphoma[2] (9591-9595, 9670-9686, 9688, 9690-9698, 9711-9717).

Report as a second or subsequent primary:

Hodgkin's disease (9650-9667)

Burkitt's lymphoma (9687)

Mycosis fungoides or Sezary's disease (9700, 9701)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

Mast cell tumor (9740, 9741)

Acute leukemia, NOS (9801)

Non-lymphocytic leukemias (9840-9842, 9860-9910)

Myeloid sarcoma (9930)

Acute panmyelosis (9931)

Acute myelofibrosis (9932)

Hairy cell leukemia (9940)

Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:

Malignant lymphoma, NOS[1] (9590)

Non-Hodgkin's lymphoma[1] (9591-9595, 9670-9686, 9688, 9690-9698, 9702-9717)

True histiocytic lymphoma (9723)

Plasmacytoma[3] or multiple myeloma (9731, 9732)

Waldenstrom's macroglobulinemia (9761)

Leukemia, NOS (9800)

Chronic leukemia, NOS (9803)

Lymphoid or lymphocytic leukemia (9820-9828)

Plasma cell leukemia (9830)

Lymphosarcoma cell leukemia (9850)

Immunoproliferative disease, NOS (9760)

(4) Burkitt's lymphoma (9687).

Report as a second or subsequent primary: Specific non-Hodgkin's lymphoma (9593-9594, 9670-9686, 9688, 9690-9698, 9702-9717)

Hodgkin's disease (9650-9667)

Mycosis fungoides or Sezary's disease (9700, 9701)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

True histiocytic lymphoma (9723)

Plasmacytoma or multiple myeloma (9731, 9732)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Acute leukemia, NOS unless specified as Burkitt's type (9801)

Chronic leukemia, NOS (9803)

Chronic lymphocytic leukemia (9823)

Plasma cell leukemia (9830)

Non-lymphocytic leukemias (9840-9842, 9860-9910)

Lymphosarcoma cell leukemia (9850)

Myeloid sarcoma (9930)

Acute panmyelosis (9931)

Acute myelofibrosis (9932)

Hairy cell leukemia (9940)

Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:

Malignant lymphoma, NOS (9590, 9591, 9595)

Lymphosarcoma (9592)

Burkitt's lymphoma (9687)

Burkitt's leukemia (9826)

Lymphoid or lymphocytic leukemia (9820-9822, 9824, 9825, 9827)

(5) Cutaneous and peripheral T-cell lymphomas (9700 9709).

Report as a second or subsequent primary:

Specific non-Hodgkin's lymphoma (9593-9594, 9670-9688, 9690-9698, 9711-9717)

Hodgkin's disease (9650-9667)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

True histiocytic lymphoma (9723)

Plasmacytoma or multiple myeloma (9731, 9732)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Lymphoid or lymphocytic leukemia specified as B-cell (9820-9827)

Plasma cell leukemia (9830)

Non-lymphocytic leukemia (9840-9842, 9860-9910)

Lymphosarcoma cell leukemia (9850)

Myeloid sarcoma (9930)

Acute panmyelosis (9931)

Acute myelofibrosis (9932)

Hairy cell leukemia (9940)

Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:

Malignant lymphoma, NOS (9590, 9591, 9595)

Lymphosarcoma (9592)

Cutaneous and peripheral T cell lymphomas (9700-9709)

Leukemia, NOS (9800)

Acute leukemia, NOS (9801)

Chronic leukemia, NOS (9803)

Lymphoid or lymphocytic leukemia unless specifically identified as B-cell (9820-9828)

(6) Malignant histiocytosis or Letterer-Siwe's disease or true histiocytic lymphoma (9720, 9722, 9723).

Report as a second or subsequent primary:

Specific non-Hodgkin's lymphoma (9592-9594, 9670-9686, 9688, 9690-9698, 9702-9717)

Hodgkin's disease (9650-9667)

Burkitt's lymphoma (9687)

Mycosis fungoides or Sezary's disease (9700-9701)

Plasmacytoma or multiple myeloma (9731, 9732)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Leukemia except hairy cell and leukemic reticuloendotheliosis (9800-9932)

Do not report as a subsequent primary:

Malignant lymphoma, NOS (9590, 9591, 9595)

Malignant histiocytosis or Letterer-Siwe's disease or true histiocytic lymphoma (9720, 9722, 9723)

Hairy cell leukemia (9940)

Leukemic reticulendotheliosis (9941)

(7) Plasmacytoma or multiple myeloma (9731, 9732).

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma (9592-9594,

9670, 9672-9676, 9683, 9685, 9686, 9688, 9690-9697, 9702-9713, 9715-9717)

Hodgkin's disease (9650-9667)

Burkitt's lymphoma (9687)

Mycosis fungoides or Sezary's disease (9700, 9701)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

True histiocytic lymphoma (9723)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

Leukemia except plasma cell (9800-9828, 9840 9941)

Do not report as a subsequent primary:

Malignant lymphoma, NOS (9590, 9591, 9595)

Immunoblastic or large cell lymphoma* (9671, 9680-9682, 9684, 9698, 9714)

Plasmacytoma or multiple myeloma (9731, 9732)

Waldenstrom's macroglobulinemia (9761)

Plasma cell leukemia (9830)

*Occasionally, multiple myeloma develops an immunoblastic or large cell lymphoma phase. Report the case as multiple myeloma and as one primary.

(8) Mast cell tumor (9740, 9741).

Report as second or subsequent primary:

Non-Hodgkin's lymphoma (9590-9594, 9670-9688, 9690-9698, 9702-9717)

Hodgkin's disease (9650-9667)

Mycosis fungoides or Sezary's disease (9700, 9701)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

True histiocytic lymphoma (9723)

Plasmacytoma or multiple myeloma (9731, 9732)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Lymphoid or lymphocytic leukemia (9820-9828)

Chronic lymphocytic leukemia (9823)

Plasma cell leukemia (9830)

Non lymphocytic leukemias (9840 9842, 9860-9880, 9910)

Lymphosarcoma cell leukemia (9850)

Myeloid sarcoma (9930)

Acute panmyelosis (9931)

Acute myelofibrosis (9932)

Hairy cell leukemia (9940)

Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:

Mast cell tumor (9740, 9741)

Leukemia, NOS (9800)

Acute leukemia, NOS (9801)

Chronic leukemia, NOS (9803)

Monocytic leukemia (9890-9894)

Mast cell leukemia (9900)

(9) Immunoproliferative disease, NOS (9760) or Waldenstrom's macroglobulinemia (9761).

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma

(9593-9594, 9673-9677, 9683, 9685-9686, 9688, 9690-9697, 9702-9713, 9715-9717)

Hodgkin's disease (9650-9667)

Burkitt's lymphoma (9687)

Mycosis fungoides or Sezary's disease (9700, 9701)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

True histiocytic lymphoma (9723)

Mast cell tumor (9740, 9741)

Leukemia except plasma cell (9800-9827, 9840-9941)

Do not report as a subsequent primary:

Malignant lymphoma, NOS (9590, 9591, 9595)

Lymphosarcoma (9592)

Malignant lymphoma, lymphocytic (9670, 9672)

Immunoblastic or large cell lymphoma (9671, 9680-9682, 9684, 9698, 9714)

Plasmacytoma or multiple myeloma (9731, 9732)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Plasma cell leukemia (9830)

(10) Leukemia, NOS (9800).

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma[2] (9590-9594, 9670-9688, 9690-9698, 9702-9717)

Hodgkin's disease (9650-9667)

Mycosis fungoides (9700)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

True histiocytic lymphoma (9723)

Plasmacytoma or multiple myeloma (9731, 9732)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Do not report as a subsequent primary:

Sezary's disease[3] (9701)

Any leukemia* (9800 9941)

*Note: Leukemia, NOS (9800) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

(11) Acute leukemia, NOS (9801).

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma (9590-9594, 9670-9688, 9690-9698, 9702-9717)

Hodgkin's disease (9650-9667)

Mycosis fungoides (9700)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

True histiocytic lymphoma (9723)

Plasmacytoma or multiple myeloma (9731, 9732)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Do not report as a subsequent primary:

Sezary's disease[3] (9701)

Any leukemia* (9800 9941)

*Note: Leukemia, NOS (9800) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

(12) Chronic leukemia, NOS (9803).

Report as a second or subsequent primary:

Hodgkin's disease (9650-9667)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

Mast cell tumor (9740, 9741)

Do not report as a subsequent primary:

Non Hodgkin's lymphoma[2] (9590-9594, 9670-9686, 9688, 9690-9698, 9702-9717)

Burkitt's lymphoma (9687)

Mycosis fungoides or Sezary's disease (9700, 9701)

True histiocytic lymphoma (9723)

Plasmacytoma or multiple myeloma (9731, 9732)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Any leukemia* (9800-9941)

> *Note: Leukemia, NOS (9800) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

(13) Lymphocytic leukemia (9820-9828).

Report as a second or subsequent primary:

Hodgkin's disease (9650-9667)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

Plasmacytoma or multiple myeloma (9731, 9732)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Non-lymphocytic leukemia* (9840-9842, 9860-9910)

Myeloid sarcoma* (9930)

Acute panmyelosis* (9931)

Acute myelofibrosis* (9932)

Do not report as a subsequent primary:

Malignant lymphoma, NOS[2] (9590, 9591)

Non-Hodgkin's lymphoma[1,2] (9592-9595, 9670-9688, 9690-9698, 9702-9717)

Mycosis fungoides or Sezary's disease[1] (9700, 9701)

True histiocytic lymphoma (9723)

Leukemia, NOS (9800)

Acute leukemia, NOS (9801)

Chronic leukemia (9803)

Lymphocytic leukemia[1] (9820-9828)

Plasma cell leukemia[1] (9830)

Lymphosarcoma cell leukemia[1] (9850)

Hairy cell leukemia[1] (9940)

Leukemic reticuloendotheliosis (9941)

*If diagnosed within four months of the diagnosis of lymphocytic leukemia, NOS, (9820) or acute lymphocytic leukemia (9821), one of the diagnoses is probably wrong. The case should be reviewed.

(14) Plasma cell leukemia (9830).

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717)

Hodgkin's disease (9650-9667)

Burkitt's lymphoma (9687)

Mycosis fungoides or Sezary's disease (9700, 9701)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

True histiocytic lymphoma (9723)

Mast cell tumor (9740, 9741)

Non-lymphocytic leukemias (9840-9842, 9860-9910)

Myeloid sarcoma (9930)

Acute panmyelosis (9931)

Acute myelofibrosis (9932)

Do not report as a subsequent primary:

Plasmacytoma[3] or multiple myeloma (9731, 9732)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Leukemia, NOS (9800)

Acute leukemia, NOS (9801)

Chronic leukemia, NOS (9803)

Lymphocytic leukemia (9820 9828)

Plasma cell leukemia (9830)

Lymphosarcoma cell leukemia (9850)

Hairy cell leukemia (9940)

Leukemic reticuloendotheliosis (9941)

(15) Lymphosarcoma cell leukemia (9850).

Report as a second or subsequent primary:

Hodgkin's disease (9650-9667)

Mycosis fungoides or Sezary's disease (9700, 9701)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

Mast cell tumor (9740, 9741)

Non-lymphocytic leukemia (9840-9842, 9860-9941)

Do not report as a subsequent primary:

Non-Hodgkin's lymphoma (9590-9595, 9670-9688, 9690-9698, 9702-9717)

True histiocytic lymphoma (9723)

Plasmacytoma or multiple myeloma (9731, 9732)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Leukemia, NOS (9800)

Acute leukemia, NOS (9801)

Chronic leukemia, NOS (9803)

Lymphocytic leukemias (9820 9828)

Plasma cell leukemia (9830)

Lymphosarcoma cell leukemia (9850)

(16) Non-lymphocytic leukemias (9840-9842, 9860-9894, 9910-9932).

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717)

Hodgkin's disease (9650-9667)

Burkitt's lymphoma (9687)

Mycosis fungoides or Sezary's disease (9700, 9701)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

True histiocytic lymphoma (9723)

Plasmacytoma or multiple myeloma (9731, 9732)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Lymphocytic leukemia (9820-9828)

Plasma cell leukemia (9830)

Lymphosarcoma cell leukemia (9850)

Mast cell leukemia (9900)

Hairy cell leukemia (9940)

Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:

Leukemia, NOS (9800)

Acute leukemia, NOS (9801)

Chronic leukemia, NOS (9803)

Non-lymphocytic leukemias[1] (9840-9842, 9860-9894, 9910-9932)

(17) Mast cell leukemia (9900).

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717)

Hodgkin's disease (9650-9667)

Burkitt's lymphoma (9687)

Mycosis fungoides or Sezary's disease (9700, 9701)

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

True histiocytic lymphoma (9723)

Plasmacytoma or multiple myeloma (9731, 9732)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Any other leukemia (9820-9894, 9910-9941)

Do not report as a subsequent primary:

Mast cell tumor (9740, 9741)

Leukemia, NOS (9800)

Acute leukemia, NOS (9801)

Chronic leukemia, NOS (9803)

Mast cell leukemia (9900)

(18) Hairy cell leukemia or leukemic reticuloendotheliosis (9940, 9941).

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717)

Hodgkin's disease (9650-9667)

Burkitt's lymphoma (9687)

Mycosis fungoides or Sezary's disease (9700, 9701)

True histiocytic lymphoma (9723)

Plasmacytoma or multiple myeloma (9731, 9732)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

Any non-lymphocytic leukemias (9800-9804, 9830-9932)

Lymphocytic leukemia (9821-9828)

Do not report as a subsequent primary:

Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

Lymphocytic leukemia, NOS (9820)

Hairy cell leukemia or leukemic reticuloendotheliosis (9940, 9941)

Footnotes

1. Code to the term with the higher histology code.
2. If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, code only as chronic lymphocytic leukemia (9823/3). If chronic lymphocytic leukemia is not confirmed, code only the lymphoma.
3. This is presumably the correct diagnosis. Code the case to this histology.

### II.1.3.7 Single and Multiple Primaries, Kaposi's Sarcoma

Kaposi's Sarcoma (9140/3) is to be reported only once.

## II.1.4 Skin Carcinomas

Basal and squamous cell carcinomas of the skin are not reportable. Specifically, do not report the following histologies occurring in the skin (site codes C44.0-C44.9):

- 8000-***8005*** Neoplasms, malignant, NOS, of the skin
- 8010-***8046*** Epithelial carcinomas of the skin
- 8050-***8084*** Papillary and squamous cell carcinomas of the skin
- 8090-8110 Basal cell carcinomas of the skin

## II.1.5 Cervix

Carcinoma in situ (including squamous cell and adenocarcinoma) of the cervix and cervical intraepithelial neoplasia, grade III (CIN III) are not reportable effective with cases diagnosed January 1, 1996 and later. See Section I.1.6.1.

## II.1.6 Ambiguous Diagnostic Terms

Vague or ambiguous terms are sometimes used by physicians to describe a tumor when its behavior is uncertain. This occurs primarily when there is no histologic diagnosis. Reporting requirements depend on the term used.

### II.1.6.1 Reportable Terms

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)

*Effective with cases diagnosed January 1, 1998 and later.

### II.1.6.2 Non-Reportable Terms *

Do not report the tumor if the only term used is:

Approaching (malignancy)

Cannot be ruled out

Equivocal (for malignancy)

Possible (malignancy)

Potentially malignant

Questionable (malignancy)

Rule out (malignancy)

Suggests (malignancy)

Very close to (malignancy)

Worrisome (for malignancy)

* Without additional information.

Exception: If cytology is reported as "suspicious," do not interpret this as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

If a phrase such as "strongly suggestive" or "highly worrisome" is used, disregard the modifier ("-ly") and refer to the guidelines above regarding the primary term.

## II.1.6.3 Negative Biopsies

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. But if a negative biopsy does not rule out the presence of cancer, the case is considered to be cytologically confirmed and is reportable.

See Section IV.2 for coding diagnostic confirmation.

## II.1.7 Pathology Only, Tumor Board Only, and Consultation Only Cases

Abstract reporting by facilities is not mandatory for malignancies diagnosed by the pathology department on the basis of slides or specimens submitted from outside the hospital, cases seen only by the hospital's tumor board, 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 cancers in the population have been recorded. Regional registries establish alternative reporting mechanisms for use when an abstract is not prepared -- for example, submission of a copy of the pathology report or the DHS's "Confidential Morbidity Report" (CMR form). In the interest of ensuring complete information about the incidence of cancer, the CCR requests hospitals to report a first diagnosis even if the patient is not seen at the hospital (for example, a biopsy performed in a doctor's office). But a confirmation diagnosis -- that is, review of a diagnosis already made at another hospital -- need not be reported.

It is sometimes difficult to identify a consultation only case, especially at a large teaching hospital. As a guideline, the CCR recommends determination of who is ultimately responsible for treatment decisions and follow up of the patient.

If the reporting hospital is responsible, an abstract should be submitted.

If the reporting hospital 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 of the case using one or both of the following methods:

- Submit the patient's pathology report
- Submit a completed Confidential Morbidity Report (CMR) form

When in doubt about whether or not to submit a report, either consult the regional registry or report the case using a CMR form.

## II.1.8 Newly Reportable Hematopoietic Diseases (NRHD)

Newly Reportable Hematopoietic Diseases (NRHD) are defined as any of the myeloproliferative or myelodysplastic diseases that changed behavior from /1 borderline to /3 malignant in ICD-O-3.

Abstract and report only NRHD cases diagnosed 1/1/2001 forward.

If disease is known prior to 2001, do not report the case. NRHD cases diagnosed prior to 1/1/2001 undergoing active treatment at your facility are not reportable cases.

Newly Reportable Hematopoietic Diseases include the following:

CHRONIC MYELOPROLIFERATIVE DISEASES

| | |
|---|---|
| Polycythemia vera | 9950/3 |
| Chronic myeloproliferative disease | 9960/3 |
| Myelosclerosis with myeloid metaplasia | 9961/3 |
| Essential thrombocythemia | 9962/3 |
| Chronic neutrophilic leukemia | 9963/3 |
| Hypereosinophilic syndrome | 9964/3 |

MYELODYSPLASTIC SYNDROMES

| | |
|---|---|
| Refractory anemia | 9980/3 |
| Refractory anemia with sideroblasts | 9982/3 |
| Refractory anemia with excess blasts | 9983/3 |
| Refractory anemia with excess blasts in Transformation | 9984/3 |
| Refractory cytopenia with multilineage Dysplasia | 9985/3 |
| Myelodysplastic syndrome with 5q- syndrome | 9986/3 |
| Therapy-related myelodysplastic syndrome | 9987/3 |

OTHER NEW DIAGNOSES

| | |
|---|---|
| Langerhans cell histiocytosis, disseminated | 9754/3 |
| Acute biphenotypic leukemia | 9805/3 |
| Precursor lymphoblastic leukemia | 983_/3 |

| | |
|---|---|
| Aggressive NK cell leukemia | 9948/3 |
| Chronic neutrophilic leukemia | 9963/3 |
| Hypereosinophilic syndrome | 9964/3 |
| Leukemias with cytogenetic abnormalities | |
| Dendritic cell sarcoma | |
| Other new terms in the lymphomas and leukemias | |

Compare diagnoses to check for transition to another hematopoietic disease. Use the ICD-O-3 Hematopoietic Primaries Table.

For treatment information specific to NRHD, seem Section VI.8.

## II.1.9 Intracranial/CNS Tumors

Although the CCR has required reporting of all intracranial and CNS benign and borderline tumors since 1/1/2001, the National Benign Brain Tumor Cancer Registries Amendment Act, signed into law in October 2002, created Public law 107-260, requiring the collection of benign and borderline intracranial and CNS tumors beginning with cases diagnosed 1/1/2004 forward.

The CCR continues to require that follow up be performed on these cases. Due to this national implementation, several elements of reporting these entities have changed.

### II.1.9.1 Reportability

With the national implementation, any tumor diagnosed on January 1, 2004 or later 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)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

***Note: Benign Schwannomas (9560/0) of the cranial nerves only are reportable to the CCR. Benign Schwannomas occurring in the spinal cord, peripheral nerves or peripheral nerve root are not reportable to the CCR.***

The histology codes (also based on ICD-O-3) have been expanded and are listed in Appendix V for ICD-O-3 Primary Brain and CNS Site/Histology Listing.

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. Do not report benign brain tumor cases with an unknown year of diagnosis, unless you know that the year of diagnosis is 2001 forward. Apply the rules under Section III.3.3.2 - Vague Dates to determine a date of diagnosis if it is known that the benign brain case was diagnosed after 2001.

**Reportable Terminology**

In order 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.

## II.1.9.2 Determining Multiple Primaries

This page contains a discuss of determining the number of primaries.

- Site(s)
- Histologies
- Timing
- Laterality

### Site

Non-malignant CNS tumors are different primaries at the subsite level.

**Examples**

Meningioma of cervical spine dura (C70.1) and separate meningioma overlying the occipital lobe (C70.0, cerebral meninges). Count and abstract as 2 separate primary tumors.

The exception is when one of the primaries has an NOS site code (C__.9), and the other primary is a specific subsite within the same rubic. Meninges, NOS (C70.9) with spinal meninges (C70.1) or cerebral meninges (C70.0). Count as a single primary and code to the specific subsite.

### Histology

Refer to the Histology Groups Table below, using the rules in priority order:

| Histologic Group | ICD-O-3 Histology Code |
|---|---|
| Choroid plexus neoplasms | 9390/0, 9390/1 |
| Ependymomas | 9383, 9394, 9444 |
| Neuronal and neuronal-glial neoplasms | 9384, 9412, 9413, 9442, 9505/1, 9506 |
| Neurofibromas | 9540/0, 9540/1, 9541, 9550, 9560/0 |
| Neurinomatosis | 9560/1 |
| Neurothekeoma | 9562 |
| Neuroma | 9570 |
| Perineuroma, NOS | 9571/0 |

1. If all histologies are in the same histologic grouping or row in the table, then the histology is the same. Histologies that are in the same groupings are a progression, differentiation or subtype of a single histologic category.

## Example

A subependymal giant cell astrocytoma (9384/1) of the cerebrum (C71.0) and a gliofibroma (9442/1) of the Island of Reil (C71.0), count as a single primary.*

2. If the first 3 digits are the same as the first 3 digits of any histology in a grouping or row in the table above, then the histology is the same.

## Example

A ganglioglioma (9505/1) of the cerebellum (C71.6) and a neurocytoma (9506/1) of the cerebellopontine angle (C71.6), count as a single primary.*

*NOTE: If one histology is an NOS and the other is more specific, code the specific histology. If both histologies are NOS or both are specific, code the histology that was diagnosed first.

3. If the first 3 digits are the same but one or both histology codes are not found on the table above, then the histology is considered the same.

**Example**

Clear cell meningioma (9538/1) of the cerebral meninges and a separate transitional meningioma (9537/0) in another part of the same hemisphere, count as a single primary.

4. If the histologies are listed in different groupings in the table, they are different histologies.

5. If the first three digits of the histology code are different, and one or both histologies is not listed in the table above, the histology types are different. Report as 2 primaries.

## Timing

If a non-malignant tumor of the same histology and same site as an earlier one is subsequently diagnosed at any time, it is considered to be the same primary.

## Laterality

Beginning with malignant and benign/borderline CNS tumors diagnosed January 1, 2004 forward, the following sites require a laterality code of 1-4, or 9:

- C70.0 Cerebral meninges, NOS
- C71.0 Cerebrum
- C71.1 Frontal lobe
- C71.2 Temporal lobe
- C71.3 Parietal lobe
- C71.4 Occipital lobe
- C72.2 Olfactory nerve
- C72.3 Optic nerve
- C72.4 Acoustic nerve
- C72.5 Cranial nerve

Laterality is used to determine if multiple non-malignant CNS tumors are counted as multiple primary tumors.

- If same site and same histology and laterality is same side, one side unknown or not applicable, then code single primary
- If same site and same histology and laterality is both sides, then code separate primaries

Counting Non-Malignant Primaries

| Same Histology | | | |
|---|---|---|---|
| Tumor | Timing | Same Site | Different Site |

| 1st | 2nd | (months) | Same side | Other side | Unkn side | Same side | Other side | Unkn side |
|---|---|---|---|---|---|---|---|---|
| B | B | NA | 1 | 2 | 1 | 2 | 2 | 2 |
| B | M | < 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| B | M | 2 + | 2 | 2 | 2 | 2 | 2 | 2 |
| Different Histology | | | | | | | | |
| Tumor | | Timing (months) | Same Site | | | Different Site | | |
| 1st | 2nd | | Same side | Other side | Unkn side | Same side | Other side | Unkn side |
| B | B | NA | 2 | 2 | 2 | 2 | 2 | 2 |
| B | M | < 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| B | M | 2 + | 2 | 2 | 2 | 2 | 2 | 2 |

B = Benign/borderline tumor

M = Malignant tumor

Counting Malignant Primaries

| Same Histology *unless stated to be metastatic or recurrent | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Tumor | | Timing (months) | Same Site | | | Different Site | | |
| 1st | 2nd | | Same side | Other side | Unkn side | Same side | Other side | Unkn side |
| M | M | < 2 | 1 | 1 | 1 | 2* | 2* | 2* |
| M | M | 2 + | 2* | 2* | 2* | 2* | 2* | 2* |
| M | B | NA | 2 | 2 | 2 | 2 | 2 | 2 |
| Different Histology **unless one histology is a specific subtype of the other | | | | | | | | |
| Tumor | | Timing (months) | Same Site | | | Different Site | | |
| 1st | 2nd | | Same side | Other side | Unkn side | Same side | Other side | Unkn side |
| M | M | < 2 | 2** | 2** | 2** | 2 | 2 | 2 |
| M | M | 2 + | 2 | 2 | 2 | 2 | 2 | 2 |
| M | B | NA | 2 | 2 | 2 | 2 | 2 | 2 |

B = Benign/borderline tumor

M = Malignant tumor

## II.1.9.3 Date of Diagnosis

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.

**January 1, 2004 and Forward**
For cases diagnosed January 1, 2004 forward, 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.

### 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.

**January 1, 2001 to December 31, 2003**
For cases diagnosed January 1, 2001 to December 31, 2003, use the most definitive source of diagnostic confirmation as the date of diagnosis.

### 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.1.9.4 Sequence Number

A primary non-malignant tumor of any of the sites specified on or after January 1, 2001 is reportable.

The sequence number for the tumor is in the range 60-87.

The sequencing of non-malignant tumors does not effect the sequencing of malignant tumors and vice versa.

A malignancy (sequence 00) will remain 00 if followed by a non-malignant tumor (sequence 60-87).

### Example

First tumor, benign meningioma, sequence 60.

Second tumor, astrocytoma, sequence 00.

## II.1.9.5 Malignant Transformation

If a benign or borderline tumor transforms into a malignancy, abstract the malignancy as a new primary. If there is a change in WHO grade from a WHO I to a higher WHO grade, abstract as a new primary malignancy. If a malignant CNS tumor transforms into a higher grade tumor, do not change histology or grade and do not abstract as a new primary. This determination is made by the pathologist based on review of slides.

### Example

Non-malignant WHO grade I to malignant WHO grade III.

Complete two abstracts, one for the non-malignant tumor and one for the malignant tumor.

| Situation | Create new abstract? |
|---|---|
| Benign /0 to borderline /1 | No* |
| Benign /0 to malignant /3 | Yes |
| Borderline /1 to malignant /3 | Yes |
| Malignant /3 to malignant /3 | No* |
| WHO Grade I to Grade II, III, or IV | Yes |
| WHO Grade II to III or IV | No* |
| WHO Grade III to IV | No* |

* Abstract as one primary using original histology and note progression in remarks.

## II.1.9.6 Tumor Grade

Always assign code 9 for non-malignant ***brain and CNS*** tumors.

Do not code WHO grade in the 6th digit histology data field.

Code the WHO grade classification as documented in the medical record in Collaborative Staging Site Specific Factor 1, for Brain and other Central Nervous System sites.

- WHO grade I generally describes non-malignant or benign tumors; however, non-malignant tumors should not be coded as Grade I unless WHO grade is specifically stated in the source document.
- WHO grade II generally describes a malignant tumor but it can describe a non-malignant tumor depending on histologic type.
- WHO grade III and IV describe malignant tumors.

For certain types of CNS tumors, no WHO grade is assigned.

***References:***

***http://www.cdc.gov/cancer/npcr/training/pdfs/braintumorguide.pdf***

***http://www.cancerstaging.org/cstage/index.html***

## II.1.9.7 WHO Grade

Code the WHO grade classification as documented in the medical record in Collaborative Staging Site Specific Factor 1, for Brain and other Central Nervous System sites.

- WHO grade I generally describes non-malignant or benign tumors; however, non-malignant tumors should not be coded as Grade I unless WHO grade is specifically stated in the source document.
- WHO grade II generally describes a malignant tumor but it can describe a non-malignant tumor depending on histologic type.
- WHO grade III and IV describe malignant tumors.

For certain types of CNS tumors, no WHO grade is assigned.

***References:***

***http://www.cdc.gov/cancer/npcr/training/pdfs/braintumorguide.pdf***

***http://www.cancerstaging.org/cstage/index.html***

## II.1.9.8 Staging

**January 1, 2004 and Forward**
For intracranial and CNS benign and borderline tumor cases diagnosed January 1, 2004 forward, apply Collaborative Staging.

**January 1, 2001 to December 31, 2003**
For intracranial and CNS benign and borderline tumor cases diagnosed from January 1, 2001 to December 31, 2003, the CCR does not require that these cases be staged. The CCR recommends that these cases be coded as EOD 99 (Unknown). If your registry uses SEER Summary Stage, it is recommended that these cases be coded to 9.

## II.1.10 Borderline Ovarian Tumors

Although borderline ovarian tumors changed behavior in ICD-O-3 from /3 (malignant) to /1 (borderline), the CCR will continue to require reporting them. They are to be coded with a behavior code of /1.

As listed in Appendix 6 of the ICD-O-3 Code Manual, reportable borderline ovarian tumors include the following terms and morphology codes:

| | |
|---|---|
| Serous cystadenoma, borderline malignancy | 8442/1 |
| Serous tumor, NOS, of low malignant potential | 8442/1 |
| Papillary cystadenoma, borderline malignancy | 8451/1 |
| Serous papillary cystic tumor of borderline malignancy | 8462/1 |
| Papillary serous cystadenoma, borderline malignancy | 8462/1 |
| Papillary serous tumor of low malignant potential | 8462/1 |
| Atypical proliferative papillary serous tumor | 8462/1 |
| Mucinous cystic tumor of borderline malignancy | 8472/1 |
| Mucinous cystadenoma, borderline malignancy | 8472/1 |
| Pseudomucinous cystadenoma, borderline malignancy | 8472/1 |
| Mucinous tumor, NOS, of low malignant potential | 8472/1 |
| Papillary mucinous cystadenoma, borderline malignancy | 8473/1 |
| Papillary pseudomucinous cystadenoma, borderline malignancy | 8473/1 |
| Papillary mucinous tumor of low malignant potential | 8473/1 |

***January 1, 2008 and Forward***

***Beginning with the implementation of Collaborative Staging, Version 01.04.00, and for borderline ovarian cases diagnosed on or after January 1, 2008, code CS Extension to 99.***

**January 1, 2004 and Forward**
Apply the Collaborative Staging ovary scheme for cases diagnosed on or after January 1, 2004. Do not use Collaborative Staging Extension code 00 (in situ) for borderline ovarian tumors. Follow-up is required for these cases.

**Prior to January 1, 2004**
For cases diagnosed prior to January 1, 2004, these cases are to be staged according to the ovary scheme in the EOD Manual.

## II.2 Abstracting: Preliminary Procedures

Each patient in a hospital'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 hospital for the patient, but the sequence number is different.

***The first four digits of the accession number usually represents the year first seen for the patient (see Section II.2.1). The last five digits***

***usually represents the approximate chronological order of the abstracts prepared for that year.***

Each 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.

## II.2.1 Year First Seen

Certain abstracting software applications, request Year First Seen.

Enter the four digit year during which the patient was first seen at the reporting hospital 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 hospital in December 1992 and is diagnosed in January 1993.

Assign 1993 as the year first seen for this primary.

## II.2.2 CNExT Generated Accession Numbers

***This section was software specific and deleted in 2008.***

## II.2.3 Accession Number

***This data item identifies the patient and the tumor. Each patient entered in a hospital registry is assigned a unique accession number, and each primary diagnosed for that patient is assigned a sequence number. The first four digits of the accession number usually represents the year first seen for the patient (see Section II.2.1). The last five digits usually represents the approximate chronological order of the abstracts prepared for that year.***

***The accession number never changes. Accession numbers are never reassigned, even if a patient is removed from the registry.***

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.2.4 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 at different times and whether or not they are entered in the reporting hospital's registry. 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. If no difference in prognosis is evident, the decision is arbitrary.

Sequence Codes for Tumors with Invasive and In Situ Behavior:

| | |
|---|---|
| 00 | ONE PRIMARY MALIGNANCY |
| 01 | FIRST OF TWO OR MORE PRIMARIES |
| 02 | SECOND OF TWO OR MORE PRIMARIES |
| 59 | FIFTY-NINTH OR HIGHER OF FIFTY-NINE OR MORE PRIMARIES |
| 99 | UNSPECIFIED IN SITU/ INVASIVE SEQUENCE NUMBER OR UNKNOWN |

Sequence Codes for Benign and Uncertain Behavior CNS Tumors, Borderline Ovarian Tumors and Cases Reportable by Agreement:

| | |
|---|---|
| 60 | ONE BENIGN OR BORDERLINE TUMOR REPORTABLE BY AGREEMENT |
| 61 | FIRST OF TWO OR MORE BENIGN OR BORDERLINE TUMORS |
| 62 | SECOND OF TWO OR MORE BENIGN OR BORDERLINE TUMORS |
| 87 | TWENTY-SEVENTH OF TWENTY-SEVEN OR MORE TUMORS |
| 88 | UNSPECIFIED BENIGN, BORDERLINE, TUMOR OF UNCERTAIN BEHAVIOR AND REPORTABLE BY AGREEMENT SEQUENCE NUMBER |

Effective with cases diagnosed 1/1/2003 forward, 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

Effective with cases diagnosed 1/1/2003 forward, ***reportable*** borderline ovarian tumors, benign and uncertain behavior CNS tumors and cases that are reportable by agreement will be sequenced using numeric codes (60-87).

NOTE: Alphabetic sequence codes are no longer allowed.

For Newly Reportable Hematopoietic Diseases (NRHD), the sequencing begins with cases diagnosed 1/1/2001 forward.

## II.2.4.1 Simultaneous Diagnosis

When two or more of the patient's tumors were diagnosed simultaneously, assign the lowest sequence number to the one with the worst prognosis. To determine worst prognosis you can review the following topics (or entire topic area).

Section V.5

Section V.3.5

Section V.4

If these sections do not reveal the worst prognosis, assign sequence numbers in the order in which the abstracts are prepared.

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.

## II.2.4.2 Updating

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.***

## II.2.5 Other Tumors

In the Remarks area, record the primary sites, histologies, and diagnosis dates of other reportable tumors that the patient had before the diagnosis of the tumor being reported.

# Part III. Identification

## III.1 Registry Information

Registry information fields may be used by reporting facilities or regional registries for local 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. Abstractor initials should clearly reflect the identity of the person abstracting the case.

**January 1, 2007 and Forward**
Beginning in January 2007, each reporting facility must submit a list of names and initials of all abstractors in their facility, including temporary staff. Changes to this list must be submitted to the region as abstractors no longer create abstracts at the facility or when new abstractors are added.

### III.1.2 Suspense Flag

***This section was software specific and deleted in 2008.***

### III.1.3 Year First Seen, Accession Number, and Sequence Number

***This section was software specific and deleted in 2008.***

### III.1.4 Reporting Hospital

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

Reporting facilities by code or alphabetic listing can be found on the CCR web site at:

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-1.7.0.17-Code.pdf

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-1.7.0.17-Alpha.pdf

**January 1, 2007 and Forward**

Beginning with cases diagnosed January 1, 2007, if available, enter the NPI (National Provider Identifier) code that identifies the reporting hospital. See Appendix X for details.

## III.1.5 CNExT Automatic Entries

***This section was software specific and deleted in 2008.***

## III.1.6 ACoS Approved Flag

Enter the status of the hospital's ACoS cancer program approval. The following codes are to be used:

| | |
|---|---|
| 1 | CANCER PROGRAM APPROVED |
| 2 | CANCER PROGRAM NOT APPROVED |

NOTE: Code 1 is also to be used for hospitals who have three-year approval with a contingency or one-year approval.

## III.2 Patient Information

## III.2.1 Name

The CCR relies on patient identification information for matching data in the abstract with data about the patient from other sources. It is imperative, therefore, that reporting facilities use the same rules for entering names, dates, and other information. The CCR requires the following information and formatting for patient name.

**Guidelines for Entering Patient Name:**

- Enter the patient's last name, first name, middle name, maiden name, and any known alias.
- Begin at the far left of each field.
- Do not enter punctuation marks or spaces (except hyphens when part of last names, maiden names, and aliases).
- Use uppercase letters only.
- 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 Section III.2.1.7.)
- Spell out abbreviated names (e.g., Robt. = Robert). However, if a name includes the word Saint (e.g., Saint James), abbreviate Saint and connect it to the rest of the name as one word ("STJAMES"), then enter "SAINTJAMES," without a space, under Alias Last Name (see Section III.2.1.5).
- If the patient is a child under age 18 living with its parent(s) or guardian(s), record the name(s) of the parent(s) or guardian(s) in the Remarks area.

### III.2.1.1 Last Name

Note the following guidelines for entering the patient's last name:

- Enter the patient's entire last name.
- Include the hyphen in a hyphenated name, but do not enter any other non-alphabetic characters.
- If the last name contains more than 25 characters, enter only the first 25.
- If the patient has no last name or the name cannot be determined, enter NLN.
- 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.

### III.2.1.2 First Name

For the first name enter no more than the first 14 letters. 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 or the name cannot be determined, enter NFN.

***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.***

### III.2.1.3 Middle Name

Enter the middle name, up to 14 letters, or middle initial. Leave the space blank if there is no middle name or initial or if it is not known.

### III.2.1.4 Maiden Name

Enter a woman's maiden name, if known, even if it has been entered in the Last Name field.

- Include the hyphen in a hyphenated name, but do not enter any other non-alphabetic characters.
- If the name is longer than 15 characters, enter only the first 15.
- Leave the field blank if maiden name is not applicable or it is not known.

### III.2.1.5 Alias Last Name

Enter up to 15 characters in the Alias Last Name field.

- An alias (also known as, or AKA) surname used by the patient.
- The spelled out version of a name containing the word Saint. Do not leave a blank space between the words.
- Certain religious order names. See Section III.2.1.7.
- 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).

- Include the hyphen in a hyphenated name, but do not enter any other non-alphabetic characters.
- Leave the field blank if there is no alias last name.
- Do not enter a maiden name in the Alias Last Name field, but use the Maiden Name field. See Section III.2.1.4.

## III.2.1.6 Alias First Name

In the Alias First Name Field enter up to 15 characters. Including:

- An alias (also known as, or AKA) first name used by the patient.
- The hyphen in a hyphenated name, but do not enter any other non-alphabetic characters.
- Leave the field blank if there is no alias first name.

## III.2.1.7 Religious Names

Do not enter religious designations like Sister, Brother, or Father unless the patient's secular name is unknown. However, when 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**

1. Religious name: Sister Mary Anthony

Secular name: Jane Smith

Report as: (last name) Smith

(first name) Jane

(alias) Anthony

Religious name: Sister Mary Anthony

Secular name: Smith (first name unknown)

Report as: (last name) Smith

(first name) Sister

(alias) Anthony

Religious name: Sister Mary Anthony

Secular name: unknown

Report as: (last name) Anthony

(first name) Sister

(middle name) Mary

## III.2.1.8 Name Suffix

A name suffix is a title that would follow the name in a letter. It is frequently a generation identifier. It helps to distinguish between patients with the same name.

- Do not use punctuation.
- Leave blank if the patient does not have a name suffix.

Use this field to name suffixes such as as Jr, Sr, III, IV.

Do not use this field to record suffices such as  MD, PhD, as these suffixes will be stripped off at the central registry.

## III.2.1.9 Mother's First Name

Enter the patient's mother's first name in this field. This is to be entered for all patients, not just children. It is 14 characters in length. If this name is not available, this field may be left blank.

## III.2.10 Birth Date

When recording a patient's date of birth note the following:

- Enter the month first, then the day, then the year. See Section I.1.6.4.
- Use two digits for the month and day, and four digits for the year. (mmddccyy)
- Enter 0 before the number, if the month or day has one digit.
- The year is divided into two parts, the century (18-20) and the year.
    - Enter 99 for a month or day that is not known.
    - Enter 9999 and also code the month and day as unknown, if the year is not known.
    - Calculate the year by subtracting the age from the diagnosis date, if the record only states the patient's age.  The codes are:

| | |
|---|---|
| MONTH | 01-12 (January-December) |
| | 99 (unknown) |
| | |
| DAY | 01-31 |
| | 99 (unknown) |
| | |
| CENTURY | 18-20 |
| | 99 (unknown) |
| | |
| YEAR | 00-99 |

| | |
|---|---|
| | 99 (unknown) |

Examples

The date February 5, 1943, is entered 02051943.

If the exact day is not known, the entry is 02991943.

If the month and day are stated, but not the year, the entry is 99999999.

## III.2.11 Age at Diagnosis

***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 calculated and generated by the abstracting software, calculate the age and enter it into this field.***

## III.2.12 Birthplace

Enter the name of the state, territory, or country where the patient was born.

SEER Program Manual entry available

COC Facility Oncology Registry Data Standards (FORDS manual) entry available

NAACCR Data Standards and Data Dictionary entry available

## III.2.13 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. 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.

## III.2.13.1 Occupation

Enter any available information about the kind of work performed (e.g., television repairman, chemistry teacher, bookkeeper, construction worker), up to 40 characters associated with the longest held occupation.

- Avoid the use of abbreviations where possible.
- If an occupation is recorded in the chart without mention of its being the longest held, indicate this with an asterisk next to the entry (e.g., insurance salesman*).
- 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.

## III.2.13.2 Industry

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 40 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 its meaning is not known. However, avoid the use of abbreviations where possible.

If no information is available, enter "NR" (not recorded). Do not leave this field blank.

## III.2.13.3 Children

If the patient is a child, enter "Child" in the Occupation field, beginning in the leftmost space.

Also 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

1. 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

2. 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

## III.2.14 Patient, No Research Contact Flag

This flag is to be set to 1 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.

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.

Code 0 - There is no information with regard to the patient's not wanting inclusion in one or more research studies.

Code 1 - Hospital First Notified - would be entered.

Codes 2 and 3 are for regional and central registry use.

Code 4 - Out of State Case, Not for Research - is generated by the CCR.

The purpose of this code 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. It is not to be set for patients not wanting to be contacted during routine annual follow-up. Please use the Follow-up Switch for this purpose. This is a required data item and cannot be blank. When using CNExT, it will pre-fill with 0. The codes are:

| | |
|---|---|
| 0 | NO FLAG |
| 1 | HOSPITAL FIRST NOTIFIED |
| 2 | REGION FIRST NOTIFIED |
| 3 | CCR FIRST NOTIFIED |
| 4 | OUT OF STATE CASE, NOT FOR RESEARCH |

## III.2.2 Medical Record Number

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

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. For example:

- Some hospitals 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 hospital. This field should not be left blank.
- Medical Records numbers should be left justified.
- Do not use punctuation or leave a blank space. Enter leading zeroes that are part of the number.

## III.2.3 Social Security Number

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

Two fields are provided: a nine-character field for the number and a two-character field for a suffix. If the suffix is only one character, leave a trailing blank space in the Suffix field. The medical record might contain the patient's actual social security number, or 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.) 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) is available from the medical record. Do not combine the suffix from one number with a different number. When not entering a suffix, leave the two character field blank. If the social security number is not known, enter 9’s. (Military hospitals 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. See Section III.2.2 for instructions.)

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 8 or 9 (except for 999999999)

Examples

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

Medicare claim number: 123-45-6789B

Enter 111-22-3333.

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

No other numbers recorded in chart.

Enter 222-33-4444D5.

3. Social security number from face sheet: not recorded

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

Enter 999-99-9999.

## III.2.4 Phone Number (Patient)

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

Enter all 0's, if there is no phone.

Leave blank, if the phone number is unknown.

Update this field with the most current telephone number, when follow-up indicates that the telephone number has been changed.

## III.2.5 Address at Diagnosis

For all population-based registries, it is essential to have accurate statistics on the occurrence of types of cancer in defined geographical areas. The main purpose of the address field, therefore, 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.

## III.2.5.1 Rules

Following are the rules for recording the address:

Enter the address of the patient's *Usual Residence* on the date of the initial diagnosis. See Section III.3.3 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 friend's or relative's.
- 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 E.
- For institutionalized patients, including those who are incarcerated or in nursing, convalescent, or rest homes, the address is that of the institution.
- Use the current address of a college student. But for children in boarding schools below the college level enter the parents' address.
- If the case is class 3 (see Section III.3.5 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 hospital is located and code the state to California.
- 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.2.5.2 Data Entry, Number and Street

When entering number and street, not the following requirements:

- Use up to 40 characters for the street address.
- Only letters, numbers, spaces, and the number symbol (#), slash (/), hyphen (-), comma (,), and period (.) may be entered.
- 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 40 characters, omit the least important 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 *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service. If the address cannot be determined, enter the word "UNKNOWN."

- The field, **Patient Address at Diagnosis Supplemental**, 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. Use up to 40 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.2.5.3 Data Entry, City

Enter a maximum of 20 letters and spaces. Keep spaces in names consisting of more than one word, but do not use punctuation (e.g., "LOS ANGELES," "SAN FRANCISCO," "ST PAUL").

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 can not be determined.

## III.2.5.4 Data Entry, State

For states in the U.S.and provinces in Canada, enter the standard two letter Postal Service abbreviation. (California is CA. For other states, U.S. Territories and Canadian provinces, see Appendix B.)

## III.2.5.5 Data Entry, ZIP

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.2.5.6 Data Entry, County

For California residents, enter the code for the county of residence at the time of diagnosis. Appendix L contains a list of codes used. 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. Enter code ***998*** if the county of residence is not known or if it is a state and is other than California and its name is known.

Enter code 220 for Canada, NOS, or the specific code for the known Canadian province (Canadian province codes are listed in Appendix C).

Country codes are listed in Appendix D.

If the state or country is not known, enter code 999.

Note: To maintain consistency in the CCR database, codes must be entered as described above for state and county/country.

### III.2.5.7 Address Dx City, USPS (NEW)

This data item identifies the city in which the patient resides at the time the reportable tumor is diagnosed. Currently, the data item, City at Diagnosis, allows for up to 20 characters. The data item, Address Dx City, USPS, using the USPS file listing, allows for up to 28 characters. No data entry is required, as it is a generated field.

## III.2.6 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.

Use the following codes to report the patient's marital status at the time of first diagnosis.

1 SINGLE (never married, including only marriage annulled)

2 MARRIED (including common law)

3 SEPARATED

4 DIVORCED

5 WIDOWED

9 UNKNOWN

## III.2.7 Sex

Enter one of the following codes for the patient's sex:

1 MALE

2 FEMALE

3 HERMAPHRODITE/INTERSEXED (persons with sex chromosome abnormalities)

4 TRANSSEXUAL/TRANSGENDERED (persons who desire or plan to undergo or have undergone sex change surgery)

9 UNKNOWN

***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.***

## III.2.8 Religion

Enter the code for the patient's religion or creed.

Use code 99 if the religion is not stated.

| | |
|---|---|
| 01 | NONE |
| 02 | AGNOSTIC |
| 03 | ATHEIST |
| 04 | NONE, AGNOSTIC, ATHEIST (OLD) |
| 05 | CATHOLIC; ROMAN CATHOLIC |
| 06 | CHRISTIAN, NOS; PROTESTANT, NOS |
| PROTESTANT DENOMINATIONS: | |
| 07 | AFRICAN METHODIST EPISCOPAL (AME) |
| 08 | ANGLICAN; CHURCH OF ENGLAND |
| 09 | BAPTIST |
| 10 | COMMUNITY |
| 11 | CONGREGATIONAL |
| 12 | EPISCOPALIAN |
| 13 | LUTHERAN |
| 14 | METHODIST |

| | |
|---|---|
| 15 | PREBYTERIAN |
| 16 | UNITARIAN |
| 17 | PROTESTANT DENOMINATION, OTHER |
| 18 | CHRISTIAN REFORMED |
| 19 | DISCIPLES OF CHRIST |
| 20 | DUTCH REFORMED |
| 21 | FIRST CHRISTIAN |
| 22 | INTERDENOMINATIONAL |
| 23 | MORAVIAN |
| 24 | NON-DENOMINATIONAL |
| 25 | SEAMAN'S CHURCH |
| 26 | TRINITY |
| 27 | UNIVERSAL |
| 28 | PROTESTANT, OTHER |
| ORTHODOX: | |
| 29 | ARMENIAN ORTHODOX |
| 30 | COPTIC |
| 31 | GREEK ORTHODOX |
| 32 | RUSSIAN ORTHODOX |
| 33 | SERBIAN ORTHODOX |
| 34 | LEBANESE MARONITE; MARONITE; ORTHODOX, CHRISTIAN, OTHER; ORTHODOX, CHRISTIAN, NOS |
| CHRISTIAN SECTS: | |
| 35 | JEHOVAH'S WITNESSES |
| 36 | CHRISTIAN SCIENCE |
| 37 | MORMON; LATTER DAY SAINTS |
| 38 | SEVENTH-DAY ADVENTIST |
| 39 | FRIENDS; QUAKER |
| CHRISTIAN SECTS-OTHER: | |
| 40 | AMISH |
| 41 | MENNONITES |
| 42 | APOSTOLIC |

| | |
|---|---|
| 43 | ARMENIAN APOSTOLIC |
| 44 | ASSEMBLIES OF GOD |
| 45 | BRETHREN; BROTHERS |
| 46 | CHRISTIAN APOSTOLIC |
| 47 | CHURCH OF ARMEDIAN |
| 48 | CHURCH OF CHRIST |
| 49 | CHURCH OF GOD |
| 50 | CHURCH OF MESSIANITY |
| 51 | CHURCH OF THE DIVINE |
| 52 | CHURCH OF THE OPEN DOOR |
| 53 | CONGREGATIONAL HOLY; HOLY CONGREGATIONAL |
| 54 | COVENANT |
| 55 | DIVINE SCIENCE |
| 56 | EVANGELICAL |
| 57 | FUNDAMENTAL |
| 58 | FOURSQUARE |
| 59 | FULL GOSPEL |
| 60 | HOLINESS |
| 61 | HOLY INNOCENTS |
| 62 | NAZARENE |
| 63 | NEW APOSTOLIC |
| 64 | PENTECOSTAL |
| 65 | RELIGIOUS SCIENCE |
| 66 | SALVATION ARMY |
| 67 | SCIENCE OF MIND |
| 68 | UNITY |
| 69 | CHRISTIAN SECTS, OTHER |
| 70 | JEWISH |
| 71 | JEWISH ORTHODOX; ORTHODOX JEWISH |
| WESTERN OTHER: | |
| 72 | BAHA'I |

| | |
|---|---|
| 73 | CRICKORIAN; ETHICAL CULTURE; GREGORIAN; LAWSONIAN; MASON; METAPHYSICS; OCCULT; PEACE OF MIND; PEOPLE'S; SELF-REALIZATION; SOCIETY OF LIFE; SPIRITUALIST; THEOSOPHY; TRUTH SEAKER |
| 74 | MOLIKAN; MOLOKAN |
| 75 | WESTERN RELIGION OR CREED, OTHER; WESTERN RELIGION OR CREED, NOS |
| 76 | KO |
| EASTERN RELIGIONS: | |
| 77 | BUDDHIST; ZEN; ZEN BUDDHISM |
| 78 | DROUZE |
| 79 | CONFUCIANISM; TOAISM |
| 80 | JAIN |
| 81 | NATION OF ISLAM |
| 82 | MOSLEM; MUSLIM; MOHAMMEDAN |
| 83 | HINDU |
| 84 | ISLAM |
| 85 | PARSEE; ZOROASTRIAN |
| 86 | SHINTO |
| 87 | SIKH |
| 88 | VEDANTA |
| 89 | ORIENTAL PHILOSOPHY; EASTERN RELIGION, OTHER; EASTERN RELIGION, NOS |
| 90 | AMERICAN INDIAN RELIGIONS; NATIVE AMERICAN TRADITIONAL RELIGIONS |
| 91 | HAITIAN/AFRICAN/BRAZILIAN RELIGIONS, OTHER; SANTORIA; VOODOO |
| 92 | SHAMANISM |
| 93 | OTHER TRADITIONAL OR NATIVE RELIGION |
| ***94*** | ***Scientology*** |
| 98 | OTHER |
| 99 | UNSPECIFIED; UNKNOWN |

Note: Effective with cases diagnosed January 1, 1998, new codes and definitions were added for religion. Religion codes prior to 1998 were converted. The new codes and definitions are to be used for all cases.

## III.2.9 Race and Ethnicity

Race and ethnicity are two of the most important data items to epidemiologists who investigate cancer. Differences in incidence rates among ethnic groups generate hypotheses for research. The National Cancer institute has recognized the need to better explain the cancer burden in racial/ethnic minorities and is concerned with research on the full diversity of the U.S. population. The CCR recognizes the importance of these data items and relies on quality data to assist researchers in identifying and reducing disparities due to race and ethnicity.

The CCR requires that race code documentation must be supported by text documentation for those cases where there is conflicting information. 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.

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 | Separated | | | Marital | California |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Status: | | | | Status: | |
| | | | | | | |
| G | Name: | Arlene Thompson | | | | |
| | Race: | Filipino | | | | |
| | Birthplace: | California | | | | |
| | Marital Status: | Divorced | | | | |

Cases with conflicting information that lack supporting text documentation will be returned as queries and counted as discrepancies.

While race code documentation is only required when there is conflicting information, CCR recognizes the importance of race code documentation and strongly recommends that registrars document race in the physical exam or remarks fields. Remember to search beyond the face-sheet for the most definitive race and/or ethnicity information.

Race and ethnicity are defined by specific physical, heredity and cultural traditions, not by birthplace or place of residence. Beginning with cases diagnosed January 1, 2000, four race fields were added to the data set in addition to the existing race field. These fields were added so that patients who belong to more than one racial category can be coded with multiple races, consistent with the 2000 Census. The codes for all five fields are identical with the exception of Code 88 - No further race documented. Code 88 is not to be used for coding the first race field.

Code 99 is to be used for coding the second through fifth race field if the first race field is unknown. If information about the patient's race or races is not given on the face-sheet of the medical record, the physical examination, history, or other sections may provide race information.

**January 1, 2004 and Forward**

Effective with cases diagnosed January 1, 2004 forward, apply the following SEER race coding guideline:

Race (and ethnicity) are defined by specific physical, heredity and cultural traditions or origins, 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.

1. 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.
2. Record the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. The five race fields allow for the coding of multiple races

consistent with the Census 2000. Rules 2 - 8 further specify how to code Race 1, Race 2, Race 3, Race 4 and Race 5. See the editing guidelines that follow for further instructions. 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.

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

## Example

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

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

## Example

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

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

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

a. Code the patient's stated race, if possible. Refer to Appendix W, "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" for guidance.

## Examples

Patient is stated to be Japanese. Code as 05 Japanese.

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

Patient is described as Arabian. Code as 01 White.

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.

## Examples

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.

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

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

## Example

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

c. 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 described as a black female. Code as 02 Black.

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.

d. 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. Refer to Appendix W "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" to identify nationalities from which race codes may be inferred.

## Examples

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

Record states: "this patient was Nigerian." Code race as 02 Black per the Appendix W.

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

## Examples

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

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

e. Use of patient name in determining race

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

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

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

## Examples

Race reported as Asian, name is Hatsu Mashimoto. Code race as 05 Japanese.

Birthplace is reported as Guatemala and name is Jose Chuicol [name is Mayan]. Code race as 03 Native American.

iv. 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.

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

## Example

Miss Sabrina Fitzsimmons is a native of Brazil.

Code race as 01 White per Appendix W.

Note: Race and ethnicity are coded independently.

6. When the race is recorded as African-American, code race as 02.

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 antemortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.

## Examples

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.

Race 1 is coded in the cancer record as 96 Asian.

Death certificate gives birthplace as China.

Change Race 1 in the cancer record to 04 Chinese and code Race 2 through Race 5 as 88.

For cases diagnosed prior to January 1, 2000, only the first race field is to be completed and patients of mixed parentage are to be classified according to the race or ethnicity of the mother. For cases diagnosed January 1, 2000 and later, this no longer applies. Enter each race given. For cases diagnosed prior to January 1, 2004, no "primary" race is designated, and multiple races may be listed in any order, consistent with the 2000 Census. When any of the race fields are coded as Other Asian - Code 96, Pacific Islander, NOS - Code 97, or Other - Code 98" and a more specific race is given which is not included in the list of race codes, this more specific race must be entered in the Remarks field. (When a patient is described as Asian or Oriental and the birthplace is recorded as a specific Asian country, use the birthplace if possible to assign a more specific code.) If there is no information on race in the medical record, a statement documenting that there is no information must be entered in the Remarks Field.

## III.2.9.1 Codes For Race Field

Enter the most appropriate code for a patient's race(s) or ethnicity:

| | |
|---|---|
| 01 | WHITE |
| 02 | BLACK |
| 03 | AMERICAN INDIAN, ALEUTIAN, OR ESKIMO |
| 04 | CHINESE |

| | |
|---|---|
| 05 | JAPANESE |
| 06 | FILIPINO |
| 07 | HAWAIIAN |
| 08 | KOREAN |
| 09 | ASIAN INDIAN, PAKISTANI |
| 10 | VIETNAMESE |
| 11 | LAOTIAN |
| 12 | HMONG |
| 13 | KAMPUCHEAN (CAMBODIAN) |
| 14 | THAI |
| 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 |

*Note: these races were previously coded 09 - Asian Indian. Per the new SEER guideline, these cases are coded as 96 Other Asian. For consistency in these codes over time, the CCR created a new code, code 90 for Other South Asian. These cases will be converted from 90 to 96 for calls for data.

## Example

A person of Chinese ancestry born in Thailand and living in Hawaii at the time of diagnosis is to be reported as Chinese (code 04) instead of Thai (code 14) or Hawaiian (code 07).

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**

Eqyptian

Greek

Gypsy

Hungarian

Iranian

Iraqi

Israeli

Italian

Jordanian

Latino

Lebanese

Mexican*

Moroccan

Palestinian

Polish

Portuguese

Puerto Rican**

Rumanian

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.2.9.2 Spanish/Hispanic *Origin

The Spanish/Hispanic Origin field is for identifying patients of Spanish or Hispanic origin or descent. The field corresponds to a question asked in the U.S. census. Included are people whose native tongue is Spanish, who are nationals of a Spanish speaking Latin American country or Spain, and/or who identify with Spanish or Hispanic culture (such as Chicanos living in the American Southwest). Coding is independent of the Race field, since persons of Hispanic origin might be described as white, black, or some other race in the medical record. Spanish origin is not the same as birth in a Spanish language country. Birthplace might provide guidance in determining the correct code, but do not rely on it exclusively. Information about birthplace is entered separately. See Section III.2.12. In the Spanish/Hispanic Origin field, enter one of the following codes:

| | |
|---|---|
| 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 January 1, 2005 forward) |
| 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 |

The primary source for coding is an ethnic identifier stated in the medical record.

If the record describes the patient as Mexican, Puerto Rican, or another specific ethnicity or origin included in codes 1 to 5 or 8, enter the appropriate code whether or not the patient's surname or maiden name is Spanish.

If the patient has a Spanish surname, but the record contains information that he or she is not of His panic origin, use code 0, Non-Spanish. (American Indians and Filipinos frequently have Spanish surnames but are not considered to be of Spanish origin in the sense meant here.)

Enter code 0 for Portuguese and Brazilians, because they are not Spanish.

If the record does not state an origin that can be assigned to codes 1-5 or 8 and there is evidence other than surname that the person is Hispanic, use code 6, Spanish, NOS.

If the record does not state an origin that can be assigned to codes 0-6, base the code on the patient's name, and use code 7, Spanish Surname Only.

Use code 7, Spanish Surname Only, for a woman with a Spanish maiden name or a male patient with a Spanish Surname.

If a woman's maiden name is not Spanish, use code 0, Non-Spanish, Non-Hispanic.

But if her maiden name is not known or not applicable and she has a Spanish Surname, use code 7.

If race is not known (Race code 99), use code 9, Unknown Whether Spanish or Not, ***unless the patient's last name appears on the Spanish surname list, then use code 7, Spanish surname only .***

Code 7, Spanish Surname Only (or code 6, Spanish, NOS, if diagnosed prior to January 1, 1994) may be used for patients whose name appears on the official list of Spanish Surnames, but code 9 is the preferred code.

Examples

A woman whose married surname is Gonzales but who is stated to be of Japanese origin should be coded 0.

A patient who is stated to be South American but does not have a Spanish surname should be coded 4, South or Central American.

A woman is identified as white in the medical record. Her married name is Anderson, and her maiden name is Chavez. Enter code 7, Spanish, Surname Only.

* The instructions in Section III.2.9.2 are effective with cases diagnosed January 1, 1994. Code 7 is effective with January 1, 1994 cases.

** The CCR has adopted the official list of Spanish Surnames from the 1980 U.S. Census, and this list should be used to assign code 7. (See Appendix O.)

## 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

Enter the date the patient was first seen at the reporting hospital with a reportable neoplasm, according to the following.

For Inpatients, enter the first date of admission as an inpatient for the reportable neoplasm, or the date when diagnosis of a reportable neoplasm was made during a long term hospitalization for another condition.

For Outpatients, enter the date first diagnosed, treated, or seen as an out patient for the reportable neoplasm.

See Section I.1.6.4 for entering dates.

## III.3.2 Dates of Inpatient Admission and Inpatient Discharge

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

If the patient does not have surgery, use the inpatient admission and discharge dates for any other cancer-directed therapy.

If the patient has not had cancer-directed therapy, use the dates of inpatient admission and discharge for diagnostic evaluation.

See Section I.1.6.4 for entering dates.

## III.3.3.1 Coding

When entering dates of "Inpatient Admission and Inpatient Discharge", apply the following guidelines:

- Enter the Month, then the Day, then the Year.
- Enter "99" for any unknown part of the date (with the exception of the year, which requires 4 digits).
- Enter Day as unknown, if the month is unknown.
- Enter "99999999" if the year is not known.

## III.3.3.2 Vague Dates

Following are coding procedures for vague dates regarding "Inpatient Admission and Inpatient Discharge".

| | |
|---|---|
| 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 | If the patient was not previously treated or if a course of treatment started elsewhere was continued at the reporting hospital, assume the case was first diagnosed three months before admission with the day unknown. |
| SPRING | Enter as April. |
| SUMMER | Enter as July. |
| FALL | Enter as October. |
| WINTER | Enter as January. |
| MIDDLE OF YEAR | Enter as July. |

## III.3.3.3 Approximation

If possible, enter an approximate date for "Inpatient Admission and Inpatient Discharge" when the exact date cannot be determined. It is preferable to use an approximate month or year rather than enter "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.

## III.3.3 Date of Diagnosis

Enter the date a physician, surgeon, or dentist first stated that the patient has cancer, whether or not the diagnosis was ever confirmed microscopically. The rule applies even if the cancer was confirmed at a later date and whether or not the diagnosis was made at the reporting hospital or before admission.

However, if upon clinical and/or pathological 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 Section III.3.3.3.

Examples

6/4/06. Chest X-ray shows mass in right upper lobe. 6/6/06 Bronchial washings are positive for carcinoma.

The diagnosis date is 6/6/2006, because the term "mass" does not constitute a diagnosis of cancer.

5/20/05. Mammogram-suspicious for carcinoma, left breast, upper outer quadrant. 6/3/05. Fine needle aspiration, left breast—positive for carcinoma.

The date of diagnosis is 5/20/2005, because the term "suspicious" constitutes a presumptive diagnosis of cancer. See Section II.1.6 for vague or ambiguous terms.

7/9/04 Cervical lymph node biopsy shows papillary carcinoma. Review of slides from a thyroidectomy performed in April 2002 reveals foci of papillary carcinoma not diagnosed at the time and now thought to be the primary tumor.

Backdate the diagnosis date to 04/99/2002, the date of the earliest evidence.

## III.3.4 Place of Diagnosis

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

| | |
|---|---|
| ANOTHER HOSPITAL | Enter the hospital's name, the city, and the state. |
| PHYSICIAN ONLY | Enter physician's name and address. If the physician is on the reporting hospital's medical staff, also enter "Staff Physician." |
| HOSPITAL 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

The class code identifies cases that are usually included in the reporting hospital's treatment and survival statistics. For coding class of case, consider the office of a physician on the hospital's medical staff as an extension of the hospital. See Section VI.1.3.1 for instructions for coding treatment given in a staff physician’s office. Class of case is divided into two basic categories, analytic and non-analytic. Analytic cases are those included in treatment and survival analyses, and non-analytic cases are those that are not included. See Section I.1.8 for data required in abstracts for non-analytic cases.

Beginning with cases diagnosed 1/1/2003, codes "7-Pathology Report Only" and "8-Death Certificate Only" were added. Code 8 is only used by central registries. The codes are:

## Analytic

| | |
|---|---|
| 0 | FIRST DIAGNOSED AT REPORTING HOSPITAL SINCE ITS REFERENCE DATE, BUT ENTIRE FIRST COURSE OF THERAPY* GIVEN ELSEWHERE. Although not treated at the reporting hospital or in a staff physician's office, a class 0 case is known to have received treatment. Included are:<br>• Patient who elected to be treated elsewhere.<br>• Patient referred to another facility for any reason, such as lack of equipment, proximity of other facility to patient's residence, financial, social, or rehabilitative considerations. |
| 1 | FIRST DIAGNOSED AT REPORTING HOSPITAL SINCE ITS REFERENCE DATE, AND EITHER (a) RECEIVED ALL OR PART OF FIRST COURSE OF THERAPY* AT THE HOSPITAL, OR (b) WAS NEVER TREATED. Included are:<br>• Patient diagnosed in a physician's office** and admitted to the reporting hospital for all or part of the first course of therapy.<br>• Patient diagnosed but not treated at the reporting hospital and all or part of the first course of therapy was given in the physician's office.<br>• Patient diagnosed at reporting hospital who refused treatment.<br>• Patient diagnosed at reporting hospital but was not treatable due to age, advanced disease, an unrelated medical condition, or other reason.<br>• Specific treatment recommended but not given at reporting hospital, unknown whether given elsewhere.<br>• Patient diagnosed at reporting hospital but not known to have been treated. |
| 2 | FIRST DIAGNOSED AT ANOTHER HOSPITAL AND EITHER (a) RECEIVED ALL OR PART OF THE FIRST COURSE OF THERAPY* AT THE REPORTING HOSPITAL AFTER ITS REFERENCE DATE, OR (b) PLANNING OF THE FIRST COURSE OF THERAPY WAS DONE PRIMARILY AT THE REPORTING HOSPITAL. Included are:<br>• Patient diagnosed at another hospital but not treated until admission to the reporting hospital, regardless of interval between diagnosis and treatment.<br>• Patient diagnosed and surgically treated at another hospital who is then admitted to the reporting hospital for radiation therapy that completes the planned first course of treatment.<br>• Any case the reporting hospital considered to be analytic—i.e., the planning/management decisions were made at the hospital, even if the treatment was actually administered elsewhere, and the follow up care of the patient is the responsibility of the reporting hospital. |

# Non Analytic

| | |
|---|---|
| 3 | FIRST DIAGNOSED AT ANOTHER HOSPITAL AND EITHER (a) ENTIRE FIRST COURSE OF THERAPY* WAS GIVEN ELSE WHERE, (b) WAS NEVER TREATED, or (c) UNKNOWN IF TREATED. Included are:<br>• Patient diagnosed and first course of therapy completed elsewhere, later admitted to the reporting hospital with disease.<br>• Unable to determine whether or not treatment given at the reporting hospital was part of the first course of therapy.<br>• Patient previously hospitalized elsewhere and the reporting hospital was not involved in planning and/or carrying out the first course of therapy. |
| 4 | FIRST DIAGNOSED AT REPORTING HOSPITAL BEFORE ITS REFERENCE DATE. (Class 4 cases are reportable to the regional registry only if the reporting hospital's reference date is later than the regional registry's reference date.) |
| 5 | FIRST DIAGNOSED AT AUTOPSY. Includes incidental finding of cancer at the time an autopsy was per formed at reporting hospital. If there had been a diagnosis of cancer before death, the case is a Class 1 or 2 that was confirmed at autopsy. See Section III.3.3 for rules applicable to determination of date of diagnosis. Use code 5 if the cancer was first discovered at autopsy in a patient with a different admitting diagnosis. |
| 6 | DIAGNOSED AND RECEIVED ALL OF THE FIRST COURSE OF TREATMENT IN A STAFF PHYSICIAN'S OFFICE. (PER THE AMERICAN COLLEGE OF SURGEONS, THESE CASES ARE NON-ANALYTIC AND REPORTABILITY IS OPTIONAL.) |
| 7 | PATHOLOGY REPORT ONLY. PATIENT DOES NOT ENTER THE REPORTING FACILITY AT ANY TIME FOR DIAGNOSIS OR TREATMENT. THIS CATEGORY EXCLUDES CASES DIAGNOSED AT AUTOPSY. |
| 8 | DIAGNOSIS WAS ESTABLISHED BY DEATH CERTIFICATE ONLY. USED BY CENTRAL REGISTRIES ONLY. |
| 9 | PATIENT TREATED AT REPORTING HOSPITAL BUT DATE OF DIAGNOSIS IS UNKNOWN AND CANNOT BE REASONABLY ESTIMATED. |

* See Section VI.1 for definition of first course of treatment.

** If the diagnosing physician is known not to be on the hospital's medical staff (e.g., is from another town), code the case as class 2.

*** These cases are not required. If hospitals choose to collect them, they may do so.

## III.3.6 Type of Reporting Source

A one-digit code represents the source of information about the patient's neoplasm. 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, 7. The codes are:

| | |
|---|---|
| 1 | HOSPITAL INPATIENT/OUTPATIENT OR CLINIC** |
| 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 Section III.3.5) |
| 7* | DEATH CERTIFICATE ONLY |
| 8 | OTHER HOSPITAL OUTPATIENT UNITS/SURGERY CENTERS*** |

* Codes 4, 5, and 7 are not used by hospitals.

** Before 1988, code 2 was used for CLINIC (hospital outpatient or private) before 1988, and thus appears in some older cases.

*** Codes 2 and 8 are to be applied to cases diagnosed 1/1/2006 forward.

****Note: For Class 6 cases, enter code 1 for reporting source and code 2 for type of admission.

## III.3.7 Type of Admission

Enter one of the following codes representing the type(s) of admission at the reporting hospital during the four months after the patient was seen there for the first time.

| | |
|---|---|
| 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) |

*Abstracts are not required for cases with these types of admission.

## III.3.8 Casefinding Source

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.

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 (e.g., CMR)

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

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, enter the code specified by the regional registry or CCR.

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

These data items have been added for hospital-based registrars to collect payment information on their cancer patients at the time of diagnosis. It consists of three fields, one for recording the primary source of payment, one for recording the secondary source of payment, and a 40-character alphanumeric field for collecting the specific name of the payment source, i.e., Foundation Health Plan, Blue Shield, etc.

The primary payment source and text fields are required and may not be left blank.

Enter the secondary payment source if it is available in the medical record.

The CCR has adopted the codes and definitions used by the American College of Surgeons. The codes are the same for both fields and are as follows:

01 NOT INSURED

02 NOT INSURED, SELF PAY

10 INSURANCE, NOS

20 MANAGED CARE

21 PRIVATE INSURANCE: FEE-FOR SERVICE

28 HMO

29 PPO

31 MEDICAID

35 MEDICAID ADMINISTERED THROUGH A MANAGED CARE PLAN

60 MEDICARE/MEDICARE, NOS

61 MEDICARE WITH SUPPLEMENT, NOS

62 MEDICARE - ADMINISTERED THROUGH A MANAGED CARE PLAN

63 MEDICARE WITH PRIVATE SUPPLEMENT

64 MEDICARE WITH MEDICAID ELIGIBILITY

65 TRICARE

66 MILITARY

67 VETERANS AFFAIRS

68 INDIAN/PUBLIC HEALTH SERVICES

89 COUNTY FUNDED, NOS

99 INSURANCE STATUS UNKNOWN

NOTE: For further information regarding these codes, please refer to the table in the FORDS Manual under Primary Payer at Diagnosis.

NOTE: Codes 28-HMO, 29-PPO and 89-County Funded, NOS are California specific codes. Effective with 2004 cases, codes 28-HMO and 29-PPO are converted to code 20-Managed Care, for submission to standard setting agencies. Effective with 2006 cases, code 89-County Funded, NOS, is converted to code 31-Medicaid for submission to standard setting agencies.

## III.3.10 Hospital Referred From

If the diagnosis was made before admission (diagnosed PTA), enter the six-digit code number of the hospital or other facility at which the patient was previously seen for the disease.

January 1, 2007 and Forward

Beginning with cases diagnosed January 1, 2007, if available, enter the NPI (National Provider Identifier) code that identifies the facility that referred the patient to the reporting facility. See Appendix X for details.

The following links on CCR web site list the code numbers of all facilities in California and some out of state facilities:

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-1.7.0.17-Code.pdf

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-1.7.0.17-Alpha.pdf

If the patient was seen in more than one facility before admission, enter the one in which the patient was seen most recently.

If the patient was diagnosed in the office of a physician who is on the reporting hospital's medical staff, and the case is Class 0 or 1, enter 999993, Staff Physician. But if the physician is not on the hospital's medical staff, and the case is Class 2 or 3, enter 999996, Physician Only.

If the patient was not referred, enter zeros.

If it is not known where the patient was diagnosed or most recently seen, enter 999999, Unknown Hospital.

Ten-digit codes for VA facilities are accepted. The 10-digit field is not restricted to 6 digits with 4 leading 0's.

## III.3.11 Hospital Referred To

If the patient is seen at another hospital or other facility for specialized cancer treatment or any other cancer-related reason after admission to the reporting hospital, enter the facility's name or six-digit code number.

January 1, 2007 and Forward

Beginning with cases diagnosed January 1, 2007, if NPI codes are available, enter the NPI (National Provider Identifier) code that identifies the facility to which the patient was referred for further care after discharge from the reporting facility. See Appendix X for details.

The following links on CCR web site list the code numbers of all facilities in California and some out of state facilities:

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-1.7.0.17-Code.pdf

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-1.7.0.17-Alpha.pdf

If the place of treatment is the office of a physician on the hospital's medical staff, enter 999993, Staff Physician.

If it is not known where the patient was subsequently seen, enter 999999, Unknown Hospital.

If the patient is not referred, enter zeros.

Ten-digit codes for VA facilities are accepted. The 10-digit field is not restricted to 6 digits with 4 leading 0's.

## III.3.12 Physicians

Each hospital must maintain its own roster of physicians and their code ***or NPI*** numbers, ***if available***. The non-NPI numbers codes are based on the physicians' California license numbers.

As physicians who treat cancer patients join the hospital 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 License Numbers

State physician's license numbers are nine characters.

For license numbers less than eight characters, insert zero(s) after the first alpha character. For handling a nine-character number, enter the alpha character and drop the first zero.

For dentists, the same instructions apply.

For osteopaths, enter the entire eight-character code including a leading O (alpha character). ***For handling a nine-character number, drop the first zero after O2 for osteopaths.***

Examples

Physician - ***A23456*** would be entered A0023456

Dentist - D00056789 would be entered D0056789

Osteopath - O20A4422 would be entered O20A4422

NOTE: It is important to note that the first character of the osteopath license is an alpha character and the third character is a zero.

You may enter out-of-state license numbers. The first character must be an X. If this number is less than seven characters, insert zeroes between the X and the license number.

## III.3.12.2 Entering Codes

**January 1, 2007 Forward**

Beginning with cases diagnosed January 1, 2007, if available, enter the physician NPI code, in the respective field. See Appendix X for further details.

**First Field** The first field is to be used to enter the attending physician. This field may not be blank.

- If there is no attending physician, or the attending physician cannot be determined, the code for "unknown physician" or "license number not assigned" (99999999) must be entered.
- If the attending physician is the same as another physician, (i.e., the medical oncologist) the license number must be entered in both places.

**Second Field** The second field is to be used to enter the referring physician.

**Third Field** The third field is to be used for coding the surgeon.

**Fourth Field** The fourth field is to be used for coding the medical oncologist.

**Fifth Field** The fifth field is to be used for coding the radiation oncologist.

**Last Fields** The last two fields may be used to code any other physician.

The following physician has his or her own designated field.

Use the following codes for Surgeon, Radiation Oncologist, and Medical Oncologist:

**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 Comorbidity/Complications

Enter the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of the cancer. These factors may affect treatment decisions and influence outcomes.

Although data collection for these fields is not required by the CCR, Comorbidity/Complications 1-10 will be collected from CoC facilities. Comorbidity/Complications fields 7-10 were added in 2006. Refer to the FORDS Manual for instructions.

## III.3.14 ICD Revision, Comorbidities and Complications

This item indicates the coding system from which the *Comorbidities and Complications* (secondary diagnoses) codes are provided. *ICD Revision Comorbidities and Complications* is to be recorded for patients diagnosed on or after January 1, 2006. This data item is not required by the CCR, but it is required for ACoS approved facilities. The CCR will collect this data item from ACoS approved facilities only.

ICD Revision Comorbidity and Complications codes are as follows:

0 No secondary diagnosis reported

1 ICD - 10

9 ICD - 9

Blank Comorbidities and Complications not collected

## III.3.15 Discovered By Screening

This field has been added for the purpose of tracking which cancer cases were first diagnosed via screening programs. If this information is not available, the field may be left blank.

This item 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.

This item is not required by the CCR.

Codes:

0 No (discovered by some other method such as symptomatic patient)

1 Routine screening exam (e.g. routine screening mammogram in asymptomatic patient)

2 Hospital 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

## IV.1 Diagnostic Procedures Performed

The purpose of the information is to provide as complete a description as possible of a patient's tumor and the extent to which it has spread.

Report the results of physical examinations and diagnostic procedures for all analytic cases and for autopsy only (class 5) 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.

## IV.1.1 General Instructions

In the text fields for recording the results of diagnostic examinations, enter all pertinent findings, negative as well as positive, in chronological order. Enter the date first, then the name of each procedure, then the results and other pertinent information. Do not record details unrelated to cancer. Use standard medical abbreviations when possible to save space. See Appendix M for common acceptable abbreviations. Enter text for both site and histology in the fields designated.

It is acceptable to continue into another text field with free space available, if text limits have been reached. However, it is essential to note into which field the text is continued.

Only use the unique non-alpha numeric symbol *, **, ***, etc as the last entry in the originating text field. The same symbol should be the first entry in the new text field to indicate that the text is a continuation from another field. Do not use other symbols to indicate a continuation.

### IV.1.1.1 Location

When recording location as the results of diagnostic examinations, record where the tumor is located in the primary site, such as the lobe, quadrant, etc.

### IV.1.1.2 Size

***For cases diagnosed January 1, 2004 and forward, apply the Collaborative Staging rules for documenting tumor size.***

***For cases diagnosed prior to January 1, 2004, apply the following rules for documenting tumor size:***

When recording size as the results of diagnostic examinations, code the total tumor size when a pathology report describes tumor size as invasive with a minor component of in situ.

For all sites except breast, *minor component* is defined as: less than 5%, foci of tumor or stated as "minor component". According to the expanded breast EOD tumor size codes, minimal tumor is described as less than 25%.

When interpreting the terms focus, focal, and foci as they pertain to tumor size, focus and foci are microscopic descriptions and are coded 001 when no other information is available. Focal refers to an area of involvement and is coded 999.

## Examples

Examples of diagnoses from pathology reports followed by the correct tumor size:

- Focal adenocarcinoma - TS 999
- Microfocus of adenocarcinoma - TS 001
- Multiple foci of adenocarcinoma in specimen - TS 001
- Multifocal adenocarcinoma in specimen TS - 999
- Microscopic focus of adenocarcinoma in multiple fragments - TS 001
- Focal adenocarcinoma in chips - TS 999
- Focal adenocarcinoma in 5% of specimen - TS 999

SEER EOD rules state to always code the size of the tumor, not the size of the polyp, ulcer, or cyst. However, if an ulcerated mass is pathologically confirmed to be malignant, it is acceptable to code the size of tumor based on the size of this mass in the absence of a more precise tumor size description.

## IV.1.1.3 Extension

***For cases diagnosed January 1, 2008 forward, apply the Collaborative Staging rules and guidelines for documenting tumor extension.***

***For cases diagnosed prior to January 1, 2004, apply the following rules for documenting tumor extension:***

When recording extension as the results of diagnostic examinations, enter details about the direct extension to other organs or structures, and any mention of probable involvement of a distant site. Among the terms sometimes used to indicate tumor involvement are "organomegaly," "visceromegaly," "ascites," "pleural effusion", "masses," and "induration."

## IV.1.1.4 Lymph Nodes

***For cases diagnosed January 1, 2008 forward, apply the Collaborative Staging rules and guidelines for documenting lymph node involvement.***

***For cases diagnosed prior to January 1, 2004, apply the following rules for documenting lymph node involvement:***

When lymph node as the results of diagnostic examinations, the physician's statement about the possibility of tumor involvement of lymph nodes is especially important.

Record terms used in describing the palpability and mobility of accessible lymph nodes-such as "discrete," "freely movable," "slightly fixed," "matted," "attached to deep structures." Identify nodes as specifically as possible, including the number, size, and whether they are ipsilateral, contralateral, or bilateral. Size is particularly important for head, neck, and breast tumors.

## IV.1.2 Physical Examination

Record the dates of the patient's physical examinations and all findings about the presence or absence of neoplasm, particularly the location of the primary tumor, its size, the extent to which it has spread, and involvement of lymph nodes.

## IV.1.3 X-Ray/Scans

When recording X-Rays or Scans, enter dates and pertinent positive and negative results of X-rays, computerized axial tomography (CT- or CAT-scans), magnetic resonance imaging (MRI), echosonography, and other imaging.

If a metastatic series is reported, record the results of each study in the series. Enter a description of the primary tumor, including size, location, and whether or not multi-focal.

Enter "none" if no X-rays or scans were performed.

## IV.1.4 Scopes

Record dates and positive and negative findings of laryngoscopies, sigmoidoscopies, mediastinoscopies, and other endoscopic procedures.

Include mention of biopsies, washings, and other procedures performed during the examinations, but enter their results in the Pathology section.

Record size of an observed lesion, if given.

Enter "none" if no endoscopic examination was performed.

## IV.1.5 Laboratory Tests

Enter dates, names, and results of 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.

Record T-and B-cell marker studies on leukemias 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 Section IV.2.

Subcategories of acute myeloid leukemia are described according to cytogenetic abnormalities. If these abnormalites are included in a laboratory report, they take precedence in coding histologic type.

The chromosome study or cytogentic and molecular biological data results can be recorded here. Enter "none" if no pertinent laboratory tests were performed.

Document the date, ***test type,*** value and interpretation (elevated, borderline or normal) of any pertinent tumor markers or lab tests in the lab text field.

## IV.1.6 Operative Findings

Record dates, names, and relevant findings of diagnostic surgical procedures, such as biopsies, dilation and curettage (D & C), and laparotomy.

For definitive surgery entered under treatment , record pertinent findings. See Sections VI.2.1 through VI.2.9.

Record tumor size, if given, and any statements about observed nodes, even if they are not involved.

## IV.1.7 Pathology

***Beginning in 2008 and forward, record the text for each pathology report type (see the DxRx Report Type listing, IV_3_4 DxRx Report Type 1-5) in the Path Text field. If additional space is necessary, continue the text documentation in the Text - Staging field. Each DxRx report must be identified in the text field as R1 - R5 with R1 referencing DxRx Report 1, R2 referencing Report 2, etc.***

***Examples for documenting DxRx Reports in the pathology text field:***

***R1 - Colon bx: Adenoca***

***R2 - Colon resection: Adenoca, extramural extension into serosa, 2/10 LN's***

***In the pathology text area, enter the source of specimen(s), size of the largest tumor, and other details needed per the following list:***

- Describe the location of the primary site or sub-site and laterality of the primary tumor. See Section V.1 and Section V.2 for discussions of site and laterality.

- Record the histologic diagnosis and identify the appropriate ICD-O-3 code. See Section V.3.2 and Section V.3.3).
- Describe multiple tumors and multiple sites of origin.
- Document the extent of disease (see Section V.4) and stage at diagnosis (see Section V.5).
- 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 findings (see Section V.3.3), whether positive or negative, and include differentiation. ***If additional text space is needed, continue the pathology text in the Staging Text field.***

For details about microscopic diagnoses, see Section IV.2.

For grade and differentiation, see Section V.3.5.

***If there is a pathology report, all the DxRx fields must be completed. 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 DxRx fields, but include the information in the text field.***

***Enter the facility ID number, dates, report types, and pathology numbers in the DxRx Reports (1-5) fields. See section IV_3 DxRx Reports***

## IV.1.7.1 Pathology Report Number - Biopsy/FNA

***This data item became obsolete with the implementation of DxRx Report Number, January 1, 2008.***

See section IV.3.2 DxRx Report Number1-5.

## IV.1.7.2 Pathology Report Number - Surgery

***This data item became obsolete with the implementation of DxRx Report Number, January 1, 2008.***

See section IV.3.2 DxRx Report Number1-5.

## IV.2 Diagnostic Confirmation

A gauge of the reliability of histologic and other data is the method of confirming that the patient has cancer.

Coding for the confirmation field is in the order of the conclusiveness of the method with the lowest number taking precedence over other codes. The most conclusive method, microscopic analysis of tissue, is therefore coded as 1, while microscopic analysis of cells, the next most conclusive method, is coded as 2.

Medical records must be studied to determine what methods were used to confirm the diagnosis of cancer. The most conclusive method should be coded in the confirmation field. As the confirmation field covers the patient's entire medical history in regard to the primary tumor, follow up data (see Section VII.1) might change the coding. The codes, in the order of their conclusiveness, are:

**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 also includes microscopic examination of frozen section specimens and surgically removed tumor tissue, whether taken from the primary or a metastatic site. In addition, positive hematologic findings regarding leukemia and NRHD are coded 1. Cancers first diagnosed as a result of an autopsy or previously suspected and confirmed in an autopsy are coded 1 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.

Do not use code 2 if cancer is ruled out by a histologic examination.

Included are 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.

Also include diagnoses based on paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

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.)

## IV.3 DxRx Report Identifier Data Items (NEW)

In order for the CCR's central data base system (Eureka) to integrate pathology report processing with new case abstract processing, the system needs a way to easily match abstracts to path reports. Five sets of path report identifier data items have been added to the CCR's required data set to allow the documentation of up to five pathology reports that were used as reference reports. These new items include "DxRx" in their names because they are intended to allow documentation of diagnostic and treatment reports. Initially, they will be used to document the types of pathology reports used in abstracting that are listed under DxRx Report Type.

For any existing cases in the database, the fields: DxRx Report Number (1-5) and the DxRx Report Type (1-5) will be filled with data converted from the following fields: Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery. The fields Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery, become obsolete with the implementation of the DxRx Report Identifier fields.

Additional report types that include report numbers, dates, and facility may be added later as they become available. These data items are required by the CCR, effective January 1, 2008. If there is no report, leave the field blank.

Record the text for each pathology report type (see the DxRx Report Type listing, IV_3_4 DxRx Report Type 1-5) in the Path Text field. If additional space is necessary, continue the text documentation in the Text - Staging field. Each DxRx report must be identified in the text field as R1 - R5 with R1 referencing DxRx Report 1, R2 referencing Report 2, etc.

Examples for documenting DxRx Reports in the text field:

R1 - Colon bx: Adenoca

R2 - Colon resection: Adenoca, extramural extension into serosa, 2/10 LN's

If there is a report, all the DxRx fields must be completed. 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 DxRx fields, but include the information in the text field.

## IV.3.1 DxRx Report Facility ID (1-5) (New)

Identifies the facility that produced the reference report, using the CCR reporting source number. Allows for the documentation of up to five facility ID numbers that were used as reference reports. This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report.

Note: Eventually, this may become the NPI number for the facility, but for now we will use the CCR reporting source numbers.

## IV.3.2 DxRx Report Number (1-5) (New)

Enter the filler order number/lab accession number associated with the pathology report specimen or other report type's number uniquely identifying the report for that facility. For cases diagnosed prior to 1/1/2008 and any existing cases in the database, this field will be filled with data converted from the following fields: Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery. This is a 20 character field, that accommodates the documentation of up to five filler order number/lab accession numbers. This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report.

## IV.3.3 DxRx Report Date (1-5) (New)

Identifies the date the specimen associated with a pathology report was collected from the patient, or the most distinguishing report date for other document types.

This 8 character field accommodates the documentation of up to five dates. This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report.

## IV.3.4 DxRx Report Type (1-5) (New)

Identifies the type of report entered as a reference report in the other DxRx fields of the set. This 2 character field allows for the documentation of up to five report types that were used as reference reports. If a biopsy, surgical resection or bone marrow biopsy report also includes results of report types 05-10, code to biopsy, surgical resection or bone marrow biopsy. Use codes 05-10 only if that is the single item result in the report, not as part of the biopsy or resection specimen.

For cases diagnosed prior to 1/1/2008 and any existing cases in the database, DxRx Report Type (1-5) will be filled with data converted from the following fields: Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery. This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report.

**Codes:**

01 Biopsy

02 Surgical resection

03 Bone marrow biopsy

04 Autopsy

05 Cytology

06 Flow Cytometry/Immunophenotype

07 Tumor Marker (p53, CD's Ki, CEA, HER2-neu)

08 Cytogenetics

09 Immunohistochemical stains

10 Molecular studies

88 Other, NOS

## IV.3.5 Text - Staging (New)

This text field can be used to document additional staging and diagnostic workup information. Text information that supports the DxRx Reports data items (1-5) should be listed here, identifying each report by using the R1- R5 designation. Each DxRx report must be identified in the text field as R1 - R5 with R1 referencing DxRx Report 1, R2 referencing Report 2, etc.

As a reminder, record the text for each pathology report type (see the DxRx Report Type listing, IV_3_4 DxRx Report Type 1-5) in the Path Text field. If additional space is necessary, continue the text documentation in the Text - Staging field. DxRx Reports other than Each DxRx report must be identified in the text field as R1 - R5 with R1 referencing DxRx Report 1, R2 referencing Report 2, etc.

This text field was available in the past, but not transmitted to the CCR.

# Part V. Tumor Data

## V.1 Primary Site

It is essential to identify the original (primary) site of a tumor rather than a metastatic (secondary) site.

- 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 V.1.3.

## V.1.1 ICD-O Coding

The Primary Site field codes are found in the topography section of ICD-O*.

In the ICD-O index, the site is indicated by a three-digit number preceded by a "C".

In the topography section, the first two digits stand for the part of the body and the third digit for a specific area in the part. Listings are arranged in the numerical order of the three digits. When entering the code, omit the period following the second digit.

*Beginning with cases diagnosed January 1, 2001, the ICD-O-3 (International Classification of Diseases for Oncology, Third Edition, 2000) must be used for coding primary site. For cases diagnosed prior to January 1, 2001, ICD-O-2 must be used. ICD-O-2 codes will not be allowed for cases diagnosed January 1, 2001 forward.

NOTE: For cases with unknown date of diagnosis collected 1/1/2001 and after, use ICD-O-3 to code site, histology, behavior, and grade.

### Examples

(1) All entries under lung have the first three characters C34, followed by a final digit indicating the subsite:

C34 BRONCHUS AND LUNG

C34.0 Main bronchus
Carina
Hilus of lung

C34.1 Upper lobe, lung
Lingula of lung
Upper lobe, bronchus

C34.2 Middle lobe, lung
Middle lobe, bronchus
C34.3 Lower lobe, lung
Lower lobe, bronchus
C34.8 Overlapping lesion of lung or bronchus
C34.9 Lung, NOS (not otherwise specified)
Bronchus, NOS
Bronchiole
Bronchogenic
Pulmonary, NOS

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-2 code is therefore C34.1, which should be entered C341.

(2) The site cardia of the stomach (the part of the stomach at the opening of the esophagus) is listed in the ICD-O-2 index under "cardia" or "stomach, cardia" as T-C16.0, which should be entered C160.

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.

Examples

The patient has a 5 cm tumor that involves the dorsal surface and anterior 2/3 of the tongue.

Code the primary site to C028 (overlapping lesion of tongue).

Code the last digit of the primary site code to '9' for single primaries, when multiple tumors arise in different subsites of the same anatomic site, unless the subsite is defined in one of the site groups listed in the SEER Site Grouping Table. Refer to the SEER Site Grouping Table in the section entitled "How to Determine Same vs Different Primary Site" to determine the primary site code for specified site groups.

During a TURB, the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).

Patient has an infiltrating duct tumor in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. Code the

primary site as breast, NOS (C509).

See also the following topics for coding rules for Primary Site:

V.1.2 Identification of Separate Sites

V.1.3 Indefinite and Metastatic Sites

V.1.4 Special Conditions

V.1.5 Site-Specific Morphology

V.1.6 Uncertain Diagnoses

## V.1.2 Identification of Separate Sites

**For Cases Diagnosed January 1, 2007 and Forward**

Beginning with cases diagnosed January 1, 2007 forward, the 2007 Multiple Primary and Histology Rules must be used to determine histologic type. Do not apply these rules to cases diagnosed prior to January 1, 2007. Refer to the Multiple Primary and Histology Coding Rules Manual for details and instructions.

**For Cases Diagnosed January 1, 2005 through December 31, 2006**

For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

**For Cases Diagnosed Prior to January 1, 2005**

A principal way of determining how many primary tumors a patient has is the identification of separate sites. For further discussion of primaries, see Section II.1.2 and Section II.1.3).

For colon, rectum, anus, and anal canal, bone, peripheral nerves and autonomic nervous system, connective tissue, and melanoma of skin, each subcategory (4 characters) as delineated in ICD-O-3, is considered to be a separate site.

The site groups shown in Appendix N are each to be considered one site when determining multiples.

For all other sites, each category (3-characters) as delineated in ICD-O-3, is considered to be a separate site.

With cases diagnosed prior to January 1, 2007, if tumors of the same histology occur in more than one subsite within two months of each other, record them as a single primary and code the 9 topographic subcategory. For paired organs, see Section II.1.3.3.

Examples

Independent tumors occurring in the transverse colon (C18.4) and descending colon (C18.6) must be reported separately as different primaries, whatever their histologic types and whether or not they appear within two months of each other.

Base of tongue (C01.9) and border of tongue (C02.1) are considered subsites of the tongue and would be treated as one site-either overlapping lesion of parts of the tongue (C02.8) or tongue, NOS (C02.9).

Report tumors of the same histology appearing in the trigone of the urinary bladder (C67.0) and the lateral wall of the urinary bladder (C67.2) as a single primary and enter code C679.

## V.1.3 Indefinite and Metastatic Sites

Assign codes from the following categories only when the primary site cannot be identified exactly:

**NOS**

Use 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.

**Codes C76.0 - C76.8**

Use these codes 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.

**Code C80.9**

Use this code when the primary site is not known and the only information available is the metastatic, or secondary, site.

## V.1.4 Special Conditions

Special rules apply to the following tumors:

### 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.

### Ductal And Lobular Breast Lesions

See Section II.1.3.5 for a discussion of certain mixed ductal and lobular lesions of the female breast. If these lesions occur in different quadrants of the same breast, the site code is C50.9.

### Melanoma

If the primary site is unknown, assume the primary site is the skin and enter C44.9.

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 different lateralities or different trunk sides, such as chest and back

### 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).

### Lymphoma

Code as an extranodal site, for example, stomach, lung, skin, when there is no nodal involvement of any kind or if it is stated in the medical record that the origin was an extranodal site. If no primary site is given, code as lymph nodes, NOS (C77.9), rather than primary unknown (C80.9)

### Lymphoreticular Process

Code malignant lymphoreticular process as site C42.3, re ticuloendothelial system, NOS. However, for lymphoreticular process further classifiable as myeloproliferative arising in the bone marrow, code site as bone marrow (C42.1). For lymphoreticular process classified as lymphoproliferative arising in the lymph tissue, code site as lymph node, NOS (C77.9).

### Leukemia

Code the primary site as bone marrow, C42.1.

### 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._).

### 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).

### Colon

If there is no other information given regarding subsite except for the measurement given in the colonoscope, the measurement may be used to assign subsite. If the colonoscope measurement is used to assign a specific subsite, the CCR's standard reference is the colon diagram in the *AJCC Cancer Staging Manual, 5th Edition*, page 85. A copy of this diagram is also available in DSQC Memo 2000-04, page 2.

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.

## V.1.5 Site-Specific Morphology

Certain types of neoplasms arise only or usually in certain organs, such as hepatoma (the liver), nephroblastoma (the kidney), retinoblastoma (the retina).

If the diagnosis in the medical record refers only to the histologic type, look it up in the ICD-O-3 index. In instances of site-specific morphology, the index refers to a topographic code. Enter that code if no site is specified in the diagnosis, or if only the metastatic site is given.

Example

The code C22.0 (liver) is given after listings in the ICD-O-3 index for

hepatoma, NOS; hepatoma, benign; hepatoma, embryonal; and hepatoma, malignant.

If the site designated by a physician is different from the site referred to in the ICD-O-3 index, report the site specified by the physician.

## V.1.6 Uncertain Diagnoses

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 Section II.1.6.1).

Interpret the following terms as 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)

Do not interpret the following terms as indication of the primary site:

Approaching (malignancy)

Cannot be ruled out

Equivocal (for malignancy)

Possible (malignancy)

Potentially malignant

Questionable (malignancy)

Rule out (malignancy)

Suggests (malignancy)

Very close to (malignancy)

Worrisome (for malignancy)

## V.1.7 Multiple Primaries Related Data Items

For cases diagnosed January 1, 2007 and forward, apply the 2007 SEER Multiple Primary and Histology Coding Rules to code the following fields:

- Ambiguous Terminology
- Date of Conclusive Diagnosis
- Multiplicity Counter
- Date of Multiple Tumors
- Multiple Tumor Reported as a Single Primary

Leave these fields blank for cases diagnosed prior to January 1, 2007.

For more details and examples, consult the 2007 SEER Multiple Primary and Histology Coding Rules.

## V.1.7.1 Ambiguous Terminology Diagnosis

Beginning with cases diagnosed January 1, 2007 and forward, this data item identifies all cases, including DCO and autopsy only cases which are reportable based only on ambiguous terminology. Ambiguous terms that are considered reportable include the following:

Apparent(ly)

Appears (effective with cases diagnosed 1/1/1998 and later)

Comparable with (effective with cases diagnosed 1/1/1998 and later)

Compatible with (effective with cases diagnosed 1/1/1998 and later)

Consistent with

Favor(s)

Malignant appearing (effective with cases diagnosed 1/1/1998 and later)

Most likely

Presumed

Probable

Suspect(ed)

Suspicious (for)

Typical (of)

Definitions

**Ambiguous terminology** - Terms that have been mandated as reportable when used in a diagnosis. For more details, see Section II.1.6.

### Examples

Clinical: a physician's statement that the patient most likely has lung cancer.

Laboratory tests: A CBC suspicious for leukemia.

Pathology: A prostate biopsy compatible with adenocarcinoma.

**Conclusive terminology** - A clear and definite statement of cancer. The statement may be from a physician (clinical diagnosis); or may be from a laboratory test, autopsy, cytologic findings, and/or pathology.
Ambiguous Terminology Diagnosis Codes:

| Code | Description | Timeframe |
|---|---|---|
| 0 | **Conclusive term.** There was a conclusive diagnosis within 60 days of the original diagnosis. Case was accessioned based on conclusive terminology. Includes all diagnostic methods such as clinical diagnosis, cytology, pathology, etc. | Within 60 days of the date of initial diagnosis. |
| 1 | **Ambiguous term only.** The case was accessioned based only on ambiguous terminology. There was no conclusive terminology during the first 60 days following the initial diagnosis. Includes all diagnostic methods except cytology.Note: Cytology is excluded because registrars are not required to collect cases with ambiguous terms describing a cytology diagnosis. | Not Applicable |
| 2 | **Ambiguous term followed by conclusive term.** The case was originally assigned a code 1 (was accessioned based only on ambiguous terminology). More than 60 days after the initial diagnosis the information is being updated to show that a conclusive diagnosis was made by any diagnostic method including clinical diagnosis, cytology, pathology, autopsy, etc. | 60 days or more after the date of diagnosis |
| 9 | **Unknown term**. There is no information about ambiguous terminology. | Not Applicable |

1. Use Code 0 when a case is accessioned based on conclusive terminology. The diagnosis includes clear and definite terminology describing the malignancy within 60 days of the original diagnosis.

Note: Usually the patient undergoes a diagnostic work-up because there is a suspicion of cancer (ambiguous terminology). For example, a mammogram may show calcifications suspicious for intraductal carcinoma; the date of the mammogram is the date of initial diagnosis. When there is a clear and definite diagnosis within 60 days of that mammogram (date of initial diagnosis) such as the

pathology from an excisional biopsy showing intraductal carcinoma, assign a code 0.

2. Use Code 1 when a case is accessioned based on ambiguous terminology and there is no clear and definite terminology used to describe the malignancy within 60 days of the date of initial diagnosis. The diagnosis may be from a pathology report, a radiology report, an imaging report, or on the medical record.
3. Use Code 2 when a case is accessioned based on ambiguous terminology followed by clear and definite terminology more than 60 days after the initial diagnosis.

4. Follow-back to a physician or subsequent readmission (following the initial 60 days period) may eventually confirm cancer (conclusive cancer term more than 60 days after ambiguous term). Assign Code 2.

5. Leave this data item blank for cases diagnosed prior to 01/01/2007.

Cases accessioned based on ambiguous terminology (Code 1) should be excluded from case selection in research studies. Direct patient contact is not recommended. See 2007 SEER Multiple Primary and Histology Coding Rules.

## V.1.7.2 Date of Conclusive Diagnosis

Enter the date a definite statement of malignancy is made following an initial diagnosis based on ambiguous terminology only.

Record the date of Conclusive Terminology in the month, day, century, year format (MMDDCCYY) with 99 for unknown month or day and 9999 for unknown year.

Leave this field blank for cases diagnosed prior to 01/01/2007.

The date of conclusive diagnosis must be greater than 60 days following the initial (ambiguous terminology only) diagnosis. If the date of conclusive diagnosis is within 60 days of the initial diagnosis, the case does not meet the criteria for ambiguous terminology only, use code 88888888.

Note: If the date of conclusive diagnosis is made after 60 days, change the code for the data item "Ambiguous Terminology" from 1 to 2 and enter the date that the malignancy was described clearly and definitely in Date of Conclusive Terminology.

Codes (in addition to valid dates):

00000000NO CONCLUSIVE DIAGNOSIS MADE

88888888NOT APPLICABLE, INITIAL DIAGNOSIS MADE BY UNAMBIGUOUS TERMINOLOGY

99999999UNKNOWN DATE, UNKNOWN IF DIAGNOSIS BASED ON AMBIGUOUS TERMINOLOGY

http://www.seer.cancer.gov/tools/mphrules/mphrules_manual_01012007.pdf

## V.1.7.3 Multiplicity Counter

Code the number of tumors being abstracted as a single primary at the time of diagnosis or the number of reportable tumors that occur within one year of the original diagnosis reported as a single primary using the 2007 SEER Multiple Primary and Histology Coding Rules. Do not count metastasis. When there is a tumor or tumors with separate single or multiple foci, ignore/do not count the foci.

Change code from 01 to 02 when a second tumor is determined to be the same primary as the first tumor within one year of the initial date of diagnosis. Leave this field blank for cases diagnosed prior to January 1, 2007.

Use code 01 when:

- There is a single tumor in the primary site being abstracted.
- There is a single tumor with separate foci of tumor.
- It is unknown if there is a single tumor or multiple tumors and the multiple primary rules instructed you to default to a single tumor.

Use code 88 for:

- Leukemia
- Lymphoma
- Immunoproliferative disease
- Unknown primary

Use code 99 when:

- The original pathology report is not available and the documentation does not specify whether there was a single or multiple tumors in the primary site.
- The tumor is described as multifocal or multicentric and the number of tumors is not mentioned.
- The tumor is described as diffuse.
- The operative or pathology report describes multiple tumors but does not give an exact number.

Multiplicity Counter Codes:

01 ONE TUMOR ONLY

02 TWO TUMORS PRESENT

03 THREE TUMORS PRESENT

"

"

88 INFORMATION ON MULTIPLE TUMOR NOT COLLECTED/NOT

APPLICABLE FOR THIS SITE

99 MULTIPLE TUMORS PRESENT, UNKNOWN HOW MANY

http://www.seer.cancer.gov/tools/mphrules/mphrules_manual_01012007.pdf

## V.1.7.4 Date of Multiple Tumors

Enter the date used to identify the month, day and year the patient is diagnosed with multiple tumors reported as a single primary using the 2007 SEER Multiple Primary and Histology Coding Rules.

Enter the date in month, day, century, year format (MMDDCCYY) with 99 for unknown month or day and 9999 for unknown year.

Enter the Date of Diagnosis as the Date of Multiple Tumors when multiple reportable tumors are abstracted and reported as a single primary at the time of the initial diagnosis.

Change the code from zeros (00000000) to the date that the second tumor was diagnosed when the second tumor is determined to be the same primary as the first tumor and both are abstracted as a single primary.

Multiple tumors must have the same histology as the original tumor and must be located in the same organ or primary site as the original tumor, using the primary site and histology coding rules.

The Date of Multiple Tumors must occur within one year following the initial/first diagnosis of the reported tumor.

Codes (in addition to valid dates):

00000000SINGLE TUMOR

88888888INFORMATION ON MULTIPLE TUMOR NOT COLLECTED/NOT APPLICABLE FOR THIS SITE

99999999UNKNOWN DATE

http://www.seer.cancer.gov/tools/mphrules/mphrules_manual_01012007.pdf

## V.1.7.5 Type of Multiple Tumors Reported as a Single Primary

Code the type of multiple tumors that are abstracted as a single primary using the 2007 SEER Multiple Primary and Histology Coding Rules.

Multiple tumors found in the same organ or in a single primary site may occur at the time of initial diagnosis or within one year of the initial diagnosis. Ignore metastatic tumors for this data item.

For cases diagnosed on or after January 1, 2007, change this code from 00 to another code when subsequent tumor(s) are determined to be the same primary as the first tumor and are abstracted as a single primary, within one

year of the initial diagnosis. Leave this field blank for cases diagnosed prior to January 1, 2007.

Codes for Type of Multiple Tumors Reported as a Single Primary are as follows:

00 **ALL SINGLE TUMORS.** INCLUDES SINGLE TUMORS WITH BOTH IN SITU AND INVASIVE COMPONENTS

10 **MULTIPLE BENIGN.** AT LEAST TWO BENIGN TUMORS IN SAME ORGAN/PRIMARY SITE. USE THIS CODE FOR REPORTABLE TUMORS IN INTRACRANIAL AND CNS SITES ONLY MAY BE USED FOR REPORTABLE BY AGREEMENT CASES.

11 **MULTIPLE BORDERLINE.** AT LEAST TWO BORDERLINE TUMORS IN THE SAME ORGAN/PRIMARY SITE USE THIS CODE FOR REPORTABLE TUMORS IN INTRACRANIAL AND CNS SITES AND REPORTABLE BORDERLINE OVARIAN TUMORS ONLY MAY BE USED FOR REPORTABLE BY AGREEMENT CASES.

12 **BENIGN AND BORDERLINE.** AT LEAST ONE BENIGN AND AT LEAST ONE BORDERLINE TUMORS IN THE SAME ORGAN/ PRIMARY SITE USE THIS CODE FOR REPORTABLE TUMORS IN INTRACRANIAL AND CNS SITES ONLYMAY BE USED FOR REPORTABLE BY AGREEMENT CASES.

20 **MULTIPLE IN SITU.** AT LEAST TWO IN SITU TUMORS IN THE SAME ORGAN/PRIMARY SITE.

30 **IN SITU AND INVASIVE.** ONE OR MORE IN SITU TUMOR(S)AND ONE OR MORE INVASIVE TUMORS IN THE SAME ORGAN/PRIMARY SITE.

31 **POLYP AND ADENOCARCINOMA.** ONE OR MORE POLYPS WITH EITHER· IN SITU CARCINOMA OR · INVASIVE CARCINOMA AND ONE OR MORE FRANK ADENOCARCINOMA(S) IN THE SAME SEGMENT OF COLON, RECTOSIGMOID, AND/OR RECTUM

32 **FAP WITH CARCINOMA**. DIAGNOSIS OF FAMILIAL POLYPOSIS (FAP) AND CARCINOMA (IN SITU OR INVASIVE) IS PRESENT IN AT LEAST ONE OF THE POLYPS

40 **MULTIPLE INVASIVE.** AT LEAST TWO INVASIVE TUMORS IN THE SAME ORGAN

80 **UNK IN SITU OR INVASIVE.** MULTIPLE TUMORS PRESENT IN THE SAME ORGAN/PRIMARY SITE, UNKNOWN IF IN SITU OR INVASIVE.

88 **NOT APPLICABLE.** INFORMATION ON MULTIPLE TUMORS NOT COLLECTED/NOT APPLICABLE FOR THIS SITE.

99 UNKNOWN

For more details and examples, consult the 2007 SEER Multiple Primary Manual.

## V.2 Laterality

Because topographic codes do not distinguish between the right and left side of a paired site - such as the lung - the location (laterality) of a primary tumor must be recorded. The main purpose is to identify the origin of the tumor.

## V.2.1 Coding (Laterality)

Code numbers for recording laterality are:

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)

9 PAIRED SITE, BUT NO INFORMATION AVAILABLE CONCERNING LATERALITY

Never use code 4 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.

For malignant and benign/borderline brain and CNS tumors, effective with cases diagnosed January 1, 2004 forward, the following sites require a laterality code using codes 1- 4 or 9:

C70.0 Cerebral meninges, NOS

C71.0 Cerebrum

C71.1 Frontal lobe

C71.2 Temporal lobe

C71.3 Parietal lobe

C71.4 Occipital lobe

C72.2 Olfactory nerve

C72.3 Optic nerve

C72.4 Acoustic nerve

C72.5 Cranial nerve, NOS

Midline tumors are coded Laterality = 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).

All primary brain and CNS tumors diagnosed prior to January 1, 2004, are coded Laterality = 0 (not a paired site).

## V.2.2 Principal Paired Sites

Laterality codes of 1, 2, 3, 4, or 9 must be entered for certain parts of the body. The requirement includes any subsite, except those specifically noted. Enter those exclusions as 0 (not a paired site).

ICD-O-3 codes and sites for which laterality codes must be entered are:

C07.9 Parotid gland

C08.0 Submandibular gland

C08.1 Sublingual gland

C09.0 Tonsillar fossa

C09.1 Tonsillar pillar

C09.8 Overlapping lesion of tonsil

C09.9 Tonsil, NOS

C30.0 Nasal cavity-*excluding nasal cartilage, 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

C74.0-C74.9 Adrenal gland

C75.4 Carotid body

## V.2.3 Site Coding Restrictions

**From January 1/1/2004 and Forward**

From January 1, 2004 and forward, the Laterality field must only be coded for sites listed in Volume I, Section V.2.2 and for benign and malignant CNS tumors. All other non-paired sites, including unknown primaries, must be coded to 0.

**Prior to January 1, 2004**

Prior to 1/1/2004, completion of this field was optional for sites not listed in Section V.2.2.

## V.3 Histology, Behavior, and Differentiation

The five digit histology field consists of two parts:

1. The morphology, or cell type, of the primary tumor (first four digits).
2. The tumor's behavior - that is, the degree of malignancy or how the tumor can be expected to eventually behave.

A separate one digit differentiation code represents the grade, or degree of differentiation, of neoplastic tissue-that is, the extent to which cells have the specialized characteristics of a particular tissue or organ.

In general, the less differentiated the cells, the more aggressive the tumor.

## V.3.1 ICD-O

### January 1, 2001 and Forward (ICD-O-3)

The CCR has adopted the ICD-O-3 (*International Classification of Diseases for Oncology*, Third Edition, 2000) Morphology section as its official morphology code system for all cases diagnosed January 1, 2001 forward.

### Prior to January 1, 2001 (ICD-O-2)

Cases diagnosed prior to January 1, 2001, ***must*** be coded using the *International Classification of Diseases for Oncology*, Second Edition, 1990 (ICD-O-2).

Note: Although ICD-O-3 is referenced in coding site and histology throughout this document, unless otherwise noted, these statements apply to ICD-O-2 coding also.

## V.3.2 ICD-O Coding

Coding for the histologic type and behavior consists of the five digits in the morphology section of ICD O. In the ICD-O index the codes are preceded by the letter "M". The first three digits of the ICD-O code represent the histologic type. The fourth digit represents a subtype.

Example

Synovial-Like Neoplasms has the general code 904_. Listed under synovial-like neoplasms are:

9040/3 Synovial sarcoma, NOS

9041/3 Synovial sarcoma, spindle cell

9042/3 Synovial sarcoma, epithelioid cell

9043/3 Synovial sarcoma, biphasic

9044/3 Clear cell sarcoma, except of kidney

Morphology listings in ICD-O also include as the fifth digit the usual behavior code. For circumstances in which other behavior codes are to be entered, see

Section V.3.4. For differentiation codes, see Section V.3.5. When entering the ICD-O code, drop the slash following the fourth digit.

ICD-O-3 contains new morphology terms and synonyms, terms that changed morphology code from ICD-O-2, terms that changed from tumor-like lesions to neoplasms, and terms that changed behavior code. ICD-O-3 also deleted and/or replaced terms.

## V.3.3 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.

***Beginning with cases diagnosed January 1, 2007 and forward, the 2007 SEER Multiple Primary and Histology Rules must be used to determine histologic type. Refer to the Multiple Primary and Histology Coding Rules Manual for details and instructions.***

***For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.***

Ask the regional registry for advice when the rules do not seem to apply to a case or when their application results in a code that seems incorrect. In addition, it is always appropriate to ask for advice about coding from a pathologist or clinician familiar with the case. Document in a text field, every source of information used.

### V.3.3.1 Sources for Determining Histology

***For cases or tumors diagnosed after January 1, 2007, apply the SEER Multiple Primary and Histology Coding Rules to determine histology.***

***For cases or tumors diagnosed prior to January 1, 2007, apply the following guidelines:***

In coding histology, use all pathology reports regarding the tumor. The specimen taken from a resection is usually the most representative, unless all the cancerous material was removed during a biopsy.

An AJCC staging form may also be used if it is signed by a physician.

Other diagnostic procedures or the final clinical diagnosis may be used as the basis for coding histology only if no pathology report is available.

Document on the abstract, in a text field, every source of information used.

## V.3.3.2 Basic Rule

Before attempting to code histology, determine whether the case involves a single primary or multiple primaries. ***For cases diagnosed January 1, 2007 and forward, apply the SEER Multiple Primary and Histology Coding Rules.*** See Section II.1.3.

***For cases diagnosed prior to January 1, 2007, apply the following guidelines:***

Base the code on the best information in the report(s), whatever section it appears in.

If the final diagnosis states a specific histologic type, enter the code for that type.

If the microscopic description or a comment contains a definitive statement of a more specific type (i.e., one with a higher code number), enter the more specific code.

For the hematopoietic diseases, code to the more specific morphology, if that can be determined, which may not be the numerically higher code number. When in doubt which code to use, consult a medical advisor or pathologist.

## V.3.3.3 Variations in Terminology

***For cases diagnosed January 1, 2007 and forward, apply the SEER Multiple Primary and Histology Coding Rules.***

***For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004, pages 7-19 and 84-87.***

***For cases diagnosed prior to January 1, 2005, apply the following guidelines:***

Difficulties in selecting the correct code often occur because different histological terms are used to describe the same tumor in different pathology reports or in different parts of the same report. They might describe the same histology, subtypes of the same histology, the histologies of different parts of the same tumor, or a mixed histology. See Section II.1.3 for rules about whether tumors with mixed histologies are to be considered single or separate primaries.

Various mixed histologies are assigned their own code numbers in ICD O 3. Many of these are found in the index under "Mixed" and "Mixed Tumor," but others are listed under one or the other histologic type. For example, mixed adenocarcinoma and squamous cell carcinoma of the cervix is coded as adenosquamous carcinoma (8560/3) and indexed under "Mixed." However, not all mixed histologies have their own numbers in ICD-O-3.

When coding mixed histologies or tumors described with more than one term, behavior is a key factor (for explanation of behavior codes, see Section V.3.4). Use the following rules.

Single Lesion, Same Behavior

If two histologic types or subtypes existing in the same primary tumor have the same behavior code, select the appropriate morphology code using the following rules in order:

(1) Use a combination code if one exists.

Examples

Predominantly lobular with a ductal component.

Use the combination code for lobular and ductal carcinoma.

Invasive breast carcinoma—predominantly lobular with foci of ductal carcinoma.

Use the combination code for lobular and ductal carcinoma.

(2) If one term appears in ICD-O-3 as an NOS (e.g., "carcinoma" appears as "carcinoma, NOS") and the other is more specific, use the more specific term.

Examples

Adenocarcinoma (8140/3) of the sigmoid colon with mucin-producing features.

Code as mucin-producing adenocarcinoma (8481/3).

Invasive carcinoma, probably squamous cell type.

Code as squamous cell carcinoma (8070/3), because it is more specific than carcinoma, NOS (8010/3).

Adenocarcinoma of prostate, focally cribriform.

Code cribriform carcinoma (8201/3) since it is more specific than adenocarcinoma.

(3) Code the histology of the majority of the tumor if there is no combination code (Rule #1) and neither term is equivalent to an NOS term (Rule #2) in ICD-O-3. Such phrases as "predominantly...", "with features of...", and "...type" indicate that the description applies to the majority of the tumor. Phrases that do not describe the majority of the tumor (e.g., "with foci of...," "areas of...,", "elements of...", "component of...", "pattern...", and "...focus of/focal") are to be ignored when both terms are specific and no combination code exists.

Example

Predominantly leiomyosarcoma associated with foci of well developed chondrosarcoma.

Code as leiomyosarcoma.

(4) If no combination code is available (Rule #1) and one term is not more specific than another (Rule #2) and the majority of the tumor is not indicated (Rule #3), use the term that has the higher histology code in ICD-O-3.

Example

Tubular carcinoma (8211/3) and medullary carcinoma (8510/3).

Code as medullary carcinoma (8510/3).

**Single Lesion, Different Behavior**

If the behavior codes are different, select the morphology code with the higher behavior number.

Examples

Squamous cell carcinoma in situ (8070/2) and papillary squamous cell carcinoma (8052/3).

Code as papillary squamous cell carcinoma (8052/3).

> *Exception:* If the histology of the invasive component is an NOS term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma), use the specific term associated with the in situ component, but enter an invasive behavior code.

Squamous cell carcinoma in situ (8070/2) with areas of invasive carcinoma (8010/3).
Code as squamous cell carcinoma (8070/3).

**Multiple Lesions Considered a Single Primary**

When multiple lesions are considered a single primary, apply the rules that follow. See Section II.1.3 for criteria.

- If one lesion is described with an NOS term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma) and the other with an associated term that is more specific (e.g., large cell carcinoma, mucinous adenocarcinoma, spindle cell sarcoma, respectively), code the more specific term.
- If the histologies of multiple lesions can be represented by a combination code, use that code.
- When both an adenocarcinoma (8140/3) and an adenocarcinoma (in situ or invasive) in a polyp or adenomatous polyp (8210) arise in the same segment of either the colon or rectum, code as adenocarcinoma (8140/3). The same applies to an adenocarcinoma and an adenocarcinoma (in situ or invasive) in a tubulovillous or villous adenoma (8261 or 8263). When both a carcinoma (8010/3) and a carcinoma (in situ or invasive) in a polyp or adenomatous polyp (8210) arise in the same segment of either the colon or rectum, code as carcinoma (8010/3).

## V.3.3.5 Metastatic Site

***Beginning with cases diagnosed January 1, 2007 and forward, the 2007 SEER Multiple Primary and Histology Rules must be used to determine histologic type. Do not apply these rules to cases diagnosed prior to January 1, 2007. Refer to the Multiple Primary and Histology Coding Rules Manual for details and instructions.***

***For cases diagnosed prior to January 1, 2007, apply the following guideline:***

If a histologic or cytologic diagnosis is based only on tissue or fluid from a metastatic site, assume that the primary tumor had the same histology and code the behavior as 3 (malignant, primary site). For explanation of behavior, see Section V.3.4.

## V.3.3.4 Unspecified Malignancies

Enter the code for neoplasm (8000) for unspecific terms such as "malignant tumor," "malignant neoplasm", and "cancer". Do not use the code for a clinically malignant tumor that has not been microscopically confirmed (9990).

Use code 8001 (malignant cells, NOS), if a diagnosis is based only on a cytology report stating "malignant cells.

See also Section IV.2.

## V.3.3.6 Lymphoma Codes

***Beginning with cases diagnosed January 1, 2007 and forward, the 2007 SEER Multiple Primary and Histology Rules must be used to determine histologic type. Refer to the Multiple Primary and Histology Coding Rules Manual for details and instructions.***

***For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.***

***For cases diagnosed prior to January 1, 2005, apply the following guidelines:***

Lymphomas present some unique coding difficulties because of the complexity of the classification and the variety of terminologies in use. cell lymphoma

The following rules will be helpful in choosing the correct ICD-O-3 code for the histologic type:

- Terminology from the WHO Classification of Hematopoietic Neoplasms (Table 13, pp. 16-18 in ICD-O-3) is preferred over older terminology.
- The following terms have equivalent meanings:
  - follicular lymphoma = follicle center cell lymphoma
  - mantle cell lymphoma = mantle zone lymphoma
  - anaplastic large B-cell lymphoma = diffuse large cell lymphoma
- Do not code grade 1, 2 or 3 for follicular lymphoma or Hodgkin's lymphoma in the 6th grade field. The grade refers to the type of cell, not the differentiation.
- If two diagnoses are given, code the more specific term, which may not be the one with the higher code number.
- The terms lymphoma, malignant lymphoma, and non Hodgkin's lymphoma are used interchangeably.
- If there are specific diagnoses that can be coded, avoid using non specific or unclassified lymphoma terms.

- In older classifications, some terms have equivalent meanings. For example:
  - centroblastic = non-cleaved
  - centrocytic = cleaved
  - follicular = nodular
  - histiocytic = large (cell)
  - lymphocytic = small (cell)
  - mixed lymphocytic and histiocytic = mixed small and large (cell)
- When the term "mixed cellularity" is used with non-Hodgkin's lymphoma, it means mixed lymphocytic histiocytic lymphoma.

## V.3.3.7 Special Cases

***Beginning with cases diagnosed January 1, 2007 and forward, the 2007 SEER Multiple Primary and Histology Rules must be used to determine histologic type. Refer to the Multiple Primary and Histology Coding Rules Manual for details and instructions.***

***For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.***

***For cases diagnosed prior to January 1, 2005, apply the following guidelines:***

Note the rules for coding certain special cases.

**Renal Adenocarcinoma**

Code as renal cell carcinoma (8312/3). The word "cell," as used in ICD-O-3, is generally optional and often not found in hospital reports.

**Lymphocytic Lymphoma (small cell type) And Chronic Lymphocytic Leukemia**

When a case is diagnosed in a lymph node(s) or extranodal site or organ, prepare one abstract with the site and histologic type coded as lymphoma.

When a case is diagnosed in the blood or bone marrow and there is no lymph node or organ involvement, prepare one abstract with the site and histologic type coded as leukemia. See Section II.1.3.6 for rules about reporting lymphoma and leukemia.)

Malignant Lymphoreticular Process, code as malignant neoplasm, NOS (8000/3). However:

- For lymphoreticular process further classifiable as myeloproliferative arising in the bone marrow, code as malignant myeloproliferative disease (9960/3).
- For lymphoreticular process classified as lymphoproliferative arising in the lymph tissue, code as malignant lymphoproliferative disease (9970/3).

**(Adeno)carcinoma in a Polyp**

Adenocarcinoma in a polyp should be coded 8210 even if it is stated only in the microscopic description and not in the final diagnosis.

**Adenocarcinoma with Mucin**

The tumor must be at least 50% mucinous, mucin-producing, or signet ring to be coded to the specific histology.

Code mucinous adenocarcinoma arising in a villous adenoma and mucinous adenocarcinoma arising in a villous glandular polyp to 8480/3, mucinous adenocarcinoma.

**T-Cell Large Granular Lymphocytic Leukemia**

Pathologic confirmation is required for a diagnosis of T-cell large granular lymphocytic leukemia and these cases should be reported with a behavior code of /3. Do not report cases with a behavior of /1.

Although T-cell large granular lymphocytic leukemia (code 9831) is a very indolent form of leukemia and therefore assigned a behavior code of /1 in ICD–O–3, the World Health Organization Table 13 on page 17 of the ICD-O-3 lists this entity with a behavior code of /3. Infrequently this entity is symptomatic enough to be confirmed pathologically, thus the CCR requires confirmation for this diagnosis and that these cases be reported with a behavior code of /3.

## V.3.4 Behavior

To code behavior, use the best information in the pathology report, regardless of whether it appears in the microscopic description, final diagnosis, or comments. If an AJCC staging form provides the best information, use it if the form is signed by a physician. ICD-O-3 assigns a behavior code as the fifth digit of the histology number following the slash. For example, in the number 8012/3 for large cell carcinoma, the 3 is the behavior code.

Codes are listed below:

/0* BENIGN

/1* UNCERTAIN WHETHER BENIGN OR MALIGNANT

BORDERLINE MALIGNANCY (except cystadenomas in the range 844-849)

LOW MALIGNANT POTENTIAL

/2 CARCINOMA IN SITU

Intraepithelial

Non-infiltrating

Non-invasive

/3 MALIGNANT, PRIMARY SITE

/6**MALIGNANT, METASTATIC SITE

MALIGNANT, SECONDARY SITE

/9**MALIGNANT, UNCERTAIN WHETHER PRIMARY OR METASTATIC SITE

* Not reportable to the California Cancer Registry, ***except for brain and CNS tumors, beginning with cases diagnosed January 1, 2001.***

** Reportable behavior, but enter code 3.

## V.3.4.1 ICD-O/Pathology Conflicts

If there is a conflict between the behavior code specified by ICD-O for a histologic subtype and the behavior described by a pathologist in the final diagnosis, the pathologic diagnosis generally prevails. ICD-O codes only indicate the usual behavior.

## V.3.4.2 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 Section V.5.8.

"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 (see Section V.5), 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:

AIN III (anal intraepithelial neoplasia, Grade II-III or III)**

Bowen's Disease

DCIS (ductal carcinoma in situ)

DIN 3 (ductal intraepithelial neoplasia 3)**

Clark's level 1 for melanoma (limited to epithelium)

Confined to epithelium

Hutchinson's melanotic freckle

Intracystic, non-infiltrating

Intraductal

Intraepidermal

Intraepithelial

Intrasquamous

Involvement up to but not including the basement membrane

LCIS (lobular carcinoma in situ)

Lentigo maligna

LIN (laryngeal intraepithelial neoplasia)**

Lobular neoplasia, Grade III

No stromal invasion

Non-infiltrating

Non-invasive

Precancerous melanosis

Preinvasive

Queyrat's erythroplasia

Stage 0

VAIN III (vaginal intraepithelial neoplasia, Grade II-III or III)*

VIN III (vulvar intraepithelial neoplasia, Grade II-III or III)*

* Effective with cases diagnosed 1/1/1992 and later
** Effective with cases diagnosed 1/1/2001 and later
All other terms 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 Intaepithelial Neoplasia, CIN III, are not reportable effective with cases diagnosed January 1, 1996 and later. Prostatic Intraepithelial Neoplasia (PIN III), morphology code 8148/2 is also not reportable to the CCR.

## V.3.4.3 Microinvasion

Code a pathologic diagnosis of "microinvasive"--meaning the earliest stage of invasion--as malignant, not "in situ".

For the diagnosis of microinvasive squamous cell carcinoma, a common form of cervical cancer, use the morphology code provided by ICD-O-3, 8076/3.

## V.3.5 Grade and Differentiation

Also see:

- V.3.5.6 Gleason's Score
- V.3.5.7 Lymphomas and Leukemias
- V3.5.8 Bloom-Richard Grade for Breast Cancer
- V.3.5.9 Grading Astrocytomas

Code the grade, or degree of differentiation, as stated in the final pathologic diagnosis.

Do not code as "not stated" if there is a relevant statement in the microscopic description. If there is a difference in grade between two pathologic specimens, code a known grade over an unknown grade.

A grade stated in a histopathology report takes precedence over one stated in a cytology report.

Information on an AJCC staging form may be used if the form is signed by a physician.

If a needle biopsy or excisional biopsy of a primary site has a differentiation given and the excision or resection does not, code the information from the needle/incisional biopsy. If there is no grade provided for the primary site, code as 9, even if a grade is given for a metastatic site.

The codes are:

| | |
|---|---|
| 1 | Grade I<br>grade i<br>grade 1<br>Well differentiated<br>Differentiated, NOS |
| 2 | Grade II<br>grade ii<br>grade 2<br>Moderately differentiated<br>Moderately well differentiated<br>Partially well differentiated<br>Partially differentiated<br>Intermediate differentiation<br>Low grade, NOS |
| 3 | Grade III<br>grade iii<br>grade 3<br>Poorly differentiated<br>Moderately undifferentiated<br>Relatively undifferentiated<br>Slightly differentiated<br>Dedifferentiated<br>Medium grade, NOS |
| 4 | Grade IV<br>grade iv |

| | |
|---|---|
| | grade 4<br>Undifferentiated<br>Anaplastic<br>High grade, NOS |
| 5** | T-Cell<br>T-Precursor |
| 6** | B-Cell<br>Pre B<br>B-Precursor |
| 7** | Null Cell<br>Non-T–Non-B |
| 8** | NK (Natural Killer Cell) |
| 9 | Grade or Differentiation Not Determined or Not Stated |

**Apply to leukemias and lymphomas only. See Section V.3.5.7.

## V.3.5.1 Mixed Differentiation

If a diagnosis indicates different degrees of differentiation in the same neoplasm, enter the code with the highest number, even if it does not represent the majority of the neoplasm. This could include different degrees of differentiation between the biopsy and resection specimens.

Example

The final diagnosis states predominantly grade II, focally grade III.

Code as grade III.

## V.3.5.2 Microscopic Description

If the final pathologic diagnosis states one degree of differentiation, while the microscopic description states another, enter the code for the final diagnosis.

Examples

The microscopic description states moderately differentiated squamous cell carcinoma with poorly differentiated areas. The final diagnosis states moderately differentiated squamous cell carcinoma. Enter code 2 (8070/32).

But if the final pathologic diagnosis does not state the degree of differentiation, code the grade stated in the microscopic description.

The microscopic description states moderately differentiated squamous cell carcinoma with poorly differentiated areas.

The final diagnosis states squamous cell carcinoma. Enter code 3 (8070/33).

## V.3.5.3 Variation in Terms for Degree of Differentiation

Use the higher grade when different terms are used for the degree of differentiation as follows:

| Term | Grade | Code |
|---|---|---|
| Low grade | I-II | 2 |
| Medium grade; intermediate grade | II-III | 3 |
| High grade | III-IV | 4 |
| Partially well differentiated | I-II | 2 |
| Moderately undifferentiated | III | 3 |
| Relatively undifferentiated | III | 3 |

Occasionally a grade is written as "2/3" or "2/4" meaning this is grade 2 of a 3-grade system or grade 2 of a 4-grade system, respectively.

To code in a three grade system, refer to the following codes:

| Histologic Grade | Nuclear Grade | Description | Code |
|---|---|---|---|
| 1/3, or I/III | 1/2, 1/3 | Low Grade | 2 |
| 2/3, or II/III | 2/3 | Medium Grade | 3 |
| 3/3, or III/III | 2/2, 3/3 | High Grade | 4 |

To code in a two-grade system, refer to the following codes:

| Histologic Grade | Description | Code |
|---|---|---|
| 1/2, or I/II | Low Grade | 2 |
| 2/2, or II/II | High Grade | 4 |

## V.3.5.4 In Situ

Medical reports ordinarily do not contain statements about differentiation of in situ lesions. But if a statement is made, enter the code indicated.

## V.3.5.5 Brain Tumors

Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) can sometimes establish the grade of a brain tumor.

If there is no tissue diagnosis, but grade or differentiation is stated in a MRI or PET report, base the grade code on the report.

However, If there is a tissue diagnosis, do not base the grade code on any other source.

## V.3.5.6 Gleason's Score

A special descriptive method, Gleason's Score, is used for prostate cancer. It is obtained by adding two separate numbers to produce a score in the range of 2 to 10. First, a number is assigned to the predominant (primary) pattern (i.e., the pattern that comprises more than half the tumor). Then a number is assigned to the lesser (secondary) pattern, and the two numbers are added to obtain Gleason's Score.

If only one number is stated, and it is 5 or less, assume that it represents the primary pattern. If the number is higher than 5, assume that it is the score. If there are two numbers, add them to obtain the score.

Sometimes, the number 10 is written after Gleason's Score to show the relationship between the actual score and the highest possible score (e.g., Gleason's 3/10 indicates a score of 3).

If a number is not identified as Gleason's, assume that a different grading system was used and code appropriately.

When both grade and Gleason's Score are provided in the same specimen, code the grade. When they are in different specimens, code to the highest grade.

If only Gleason's Score (2-10) is available, convert it to grade according to the following table:

| Gleason's Score | Grade | Code |
|---|---|---|
| 2, 3, 4 | I | 1 |
| 5, 6 | II | 2 |
| 7*, 8, 9, 10 | III | 3 |

* For cases diagnosed January 1, 2004 forward, code Gleason's 7 to grade 3.

* For cases diagnosed prior to January 1, 2003, code Gleason's 7 to grade code 2. The exception, for cases diagnosed prior to January 1, 2003, is if the pathology report states that the tumor is moderately to poorly differentiated and Gleason's score is reported as 7, assign code 3. For cases diagnosed January 1, 2003 forward, code Gleason's 7 to grade 3.

If only the predominant pattern (1-5) is mentioned in the medical record, enter the code as follows:

| Gleason's Pattern | Grade | Code |
|---|---|---|
| 1, 2 | I | 1 |
| 3 | II | 2 |
| 4, 5 | III | 3 |

Effective with prostate cases diagnosed January 1, 2004 forward, the priority order for coding grade of tumor is:

1. Gleason's grade
2. Terminology (well diff, mod diff…)
3. Histologic (grade I, grade II…)
4. Nuclear grade

*Facility Oncology Registry Data Standards* (FORDS manual) entry available

## V.3.5.7 Lymphomas and Leukemias

In ICD-O-3, the WHO Classification of Hematopoietic and Lymphoid Neoplasms is followed. Under this classification, two groups are identified, lymphoid neoplasms and myeloid neoplasms.

Lymphoid neoplasms consist of:

- B-cell, T-cell, NK-cell lymphomas
- Hodgkin’s lymphoma
- Lymphocytic leukemias
- Other lymphoid malignancies

Myeloid neoplasms consist of:

- Myeloproliferative diseases
- Myelodysplastic diseases and syndromes
- Myeloid leukemias
- Acute biphenotypic leukemias

Codes 5 (T-cell), 6 (B-cell), and 7 (Null cell) for lymphomas and leukemias are based on immunological or biochemical test results (marker studies) or on a pathology report. Beginning with cases diagnosed January 1, 1995, T-precursor was added to code 5 and a new code was added - code 8 - NK cell (natural killer cell).

Code any statement of T-cell, B-cell, or Null cell involvement (non-T/non-B is a synonym for Null cell) whether or not marker studies are documented in the medical record. These codes have precedence over those for grades I–IV. If information about T , B , or Null cell codes is unavailable, but a grade (such as well differentiated or poorly differentiated) is given, use the code for the grade.

For lymphomas, do not code the descriptions "high grade," "low grade," or "intermediate grade" in the Grade or Differentiation field. They refer to categories in the Working Formulation of lymphoma diagnoses and not to histologic grade.

Do not code grade 1, 2 or 3 for follicular lymphoma or Hodgkin’s lymphoma in the 6th digit field. The grade refers to the type of cell, not the differentiation.

## V.3.5.8 Bloom-Richardson Grade for Breast Cancer

Beginning with breast cancer cases diagnosed January 1, 1996, the Bloom-Richardson grading system should be used, if available.

Synonyms include: Modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR Grading, BR Grading, Elston-Ellis modification of Bloom-Richardson grading system. This grading scheme is based on three morphologic features as follows:

- Degree of tumor tubule formation
- Tumor mitotic acitivity
- Nuclear pleomorphism of tumor cells (nuclear grade)

Seven possible scores are condensed into three Bloom-Richardson grades. The three grades then translate into well-differentiated (BR low grade), moderately differentiated (BR intermediate grade) and poorly differentiated (BR high grade).

| Tumor tubule formation | Score |
|---|---|
| >75% of tumor cells arranged in tubules | 1 |
| >10% and <75% | 2 |
| <10% | 3 |
| Number of mitoses<br>(low power scanning (X100), find most mitotically tumor area, proceed to high power (x400) | |

| | |
|---|---|
| <10 mitoses in 10 high-power fields | 1 |
| >10 and <20 mitoses | 2 |
| >20 mitoses per 10 high power fields | 3 |
| Nuclear pleomorphism (nuclear grade) | |
| Cell nuclei are uniform in size and shape, relatively small, have dispersed chromatin patterns, and are without prominent nucleoli | 1 |
| Cell nuclei are somewhat pleomorphic, have nucleoli, and are intermediate size | 2 |
| Cell nuclei are relatively large, have prominent nucleoli or multiple nucleoli, coarse chromatin patterns, and vary in size and shape | 3 |

To obtain the final Bloom-Richardson score, add score from tubule formation plus number of mitoses score, plus score from nuclear pleomorphism. The combined score converts to the following BR grade:

| Bloom-Richardson combined scores | Differentiation/BR Grade | ICD-O-3 6th digit |
|---|---|---|
| 3, 4, 5 | Well-differentiated (BR low grade) | 1 |
| 6, 7 | Moderately differentiated (BR intermediate grade) | 2 |
| 8, 9 | Poorly differentiated (BR high grade) | 3 |

There are coding rules and conventions to be used to code breast cancer cases. Use grade or differentiation information from the breast histology in the following order:

- Bloom-Richardson scores 3-9
- Bloom-Richardson grade (low, intermediate, high)
- Nuclear grade
- Terminology (well diff, mod diff…)
- Histologic grade (grade I, grade ii…)

Caution : In this grading system, the terms low, intermediate, and high are codes 1, 2, and 3 respectively. This is an exception to the usual rule for all other grading systems which code "low", "intermediate", and "high" as 2, 3, and 4 respectively. In the Bloom-Richardson system, if grades 1, 2, and 3 are specified, these should be coded 1, 2, and 3 respectively.

| Bloom-Richardson scores | Bloom-Richardson scores | Nuclear Grade | Terminology | Histologic Grade | Code |
|---|---|---|---|---|---|
| 3- 5 points | Low Grade | 1/3, 1/2 | Well Differentiated | (BR low grade) | 1 |
| 6, 7 points | Intermediate Grade | 2/3 | Moderately differentiated | (BR intermediate grade) | 2 |
| 8, 9 points | High Grade | 2/2, 3/3 | Poorly Differentiated | (BR high grade) | 3 |

## V.3.5.9 Grading Astrocytomas

ICD-O-3 rules are to be used for grading astrocytomas. The World Health Organization coding of aggressiveness is reserved for assignment of grade for staging. If there is no information on grade, code as follows:

| **Term** | **ICD-O-3 6th digit** |
|---|---|
| Anaplastic astrocytoma | 4 |
| Astrocytoma (low grade) | 2 |
| Glioblastoma multiforme | 9 |
| Pilocytic astrocytoma | 9 |
| Astrocytoma Grade 1 | 1 |
| Astrocytoma Grade 2 | 2 |
| Astrocytoma Grade 3 | 3 |
| Astrocytoma Grade 4 | 4 |

## V.3.5.10 Fuhrman's Grade for Renal Cell Carcinoma

**January 1, 2004 and Forward**

Effective with cases diagnosed January 1, 2004, the priority order for coding grade for renal cell carcinoma (site code C64.9) is as follows:

1. Fuhrman's grade
2. Nuclear grade
3. Terminology (well diff, moderately diff…)
4. Histologic grade (grade I, grade II…)

Fuhrman's grade is based on 3 parameters:

- Nuclear diameter: in microns
- Nuclear outline: regular or irregular
- Nucleoli (visibility): present or not and at what power (low or high power)

Fuhrman's grade (I-IV) is the sum of the points for all 3 parameters.

These prioritization rules do not apply to Wilm's tumor (morphology code 8960).

## V.3.6 Edits of Primary Site/Histology Codes

Certain combinations of histology and primary site codes indicate errors in coding. The CCR data management system (Eureka) edit data and reject false combinations. False combinations (edit errors) must be corrected before the data management system can store the data and make it available for research.

Disallowed combinations are of two types:

- Those involving the first four digits of the histology field (morphology code).
- Those involving the behavior code (fifth digit of the histology field).

### V.3.6.1 Morphology/Site Codes

Some combinations of morphology and site codes are rejected because another site code more accurately reflects the tissue of origin. For example, a liposarcoma (8850/3) arising in the abdominal wall should be coded as site C49.4, soft tissues of abdomen, instead of C76.2, abdomen, NOS. Contact the regional registry for coding assistance, if required. Following are combinations of morphology and site codes that are rejected:

#### Morphology/Site Code

1. 8090-8096, Basal cell carcinomas, with

    C00._ Lip

    C19.9 Rectosigmoid

    C20.9-C21.8 Rectum and anus

2. 8720-8790, Melanoma, with

    C48.0 C48.8 Retroperitoneum/ peritoneum

    C38.1 C38.8 Pleura and Mediastinum

    C40.0-C41.9 Bone

    C76._ Other and ill-defined sites

3. 8010-8671 Epithelial & with

C38.1-C38.8 Pleura and Mediastinum

specialized gonadal

C40.0-C41.9* Bone tumors

C47.0-C47.9 Peripheral Nerves

C49.0-C49.9 Soft Tissues

C70.0-C72.9 Brain and Other Nervous System

4. 8940–8941, Mixed tumors, with

C38.1 C38.8 Pleura and Mediastinum

C40.0-C41.9* Bone

C47.0-C47.9 Peripheral Nerves

C49.0-C49.9 Soft tissues

C70.0-C71.9 Brain

C72._ Other nervous system

C76._ Other and ill defined sites

*Site C40.0-C41.9 (bone) with histology 8070 (squamous cell carcinoma) is possible.

5. 9250 9340, Bone tumors, with

C30.0-C31.9 Nasal cavity, sinuses

6. 8800-8811, 8813-8831, 8840-8920, 8990-8991, 9040-9044, 9120-9170, 9240-9251, 9540-9560, 9580-9581, Sarcomas and other soft-tissue tumors, with

76._ Other and ill defined sites

7. 9500 Neuroblastoma, NOS with C64.9 Kidney, NOS

## V.3.6.2 Behavior/Site Codes

Do not code in situ behavior with a primary site that is unknown or ill defined. Therefore, if the behavior code is 2 (in situ), the following primary site codes are rejected as errors:

C26.9 Gastrointestinal tract, NOS

Alimentary tract, NOS

Digestive organs, NOS

C39.9 Ill defined sites within respiratory system
Respiratory tract, NOS

C55.9 Uterus, NOS
Uterine, NOS

C57.9 Female genital tract, NOS
Female genital organs, NOS
Female genitourinary tract, NOS
Urethrovaginal septum
Vesicocervical tissue
Vesicovaginal septum

C63.9 Male genital organs, NOS
Male genital tract, NOS
Male genitourinary tract, NOS

C68.9 Urinary system, NOS

C72.9 Nervous system, NOS
Central nervous system
Epidural
Extradural
Parasellar

C75.9 Endocrine gland, NOS

C76._ Other and ill-defined sites

C80.9 Unknown primary site

## V.4 Coding Systems

## V.4.1 Extent of Disease

***Extent of Disease (EOD) coding applied to cases diagnosed prior to January 1, 2004. Collaborative Staging replaced EOD staging with cases diagnosed January 1, 2004 and forward.***

The ten-digit EOD code has five components:

- Size of the tumor (three digits)

- Extent to which the primary tumor has spread (two digits)
- Lymph node involvement (one digit)
- Number of nodes found positive in a pathological examination of regional lymph nodes (two digits)
- Number of regional nodes examined by the pathologist.

In effect, the EOD is a coded descriptive summary of the tumor, including clinical as well as pathologic findings and observations made during surgery. Coding must be supported by textual information entered under Diagnostic Procedures (see Section IV.1).

Extent of Disease coding is required for all California reporting facilities and all EOD fields are to be coded. Blanks will not be allowed. (Beginning with cases diagnosed January 1, 1994.)

Cases diagnosed prior to 1994, may be left blank. SEER area facilities have earlier dates for coding EOD. (Region 8 cases diagnosed January 1, 1988 or later must have EOD coding. Region 1 and Region 9 cases diagnosed January 1, 1992 or later must have EOD coding.)

Beginning with cases diagnosed January 1, 1995, there are different rules for coding prostate cases. The two-month rule for assigning extent of disease codes has been changed to four months and a new extension field has been added for coding cases which undergo prostatectomy.

For cases diagnosed prior to January 1, 1995, the prostate EOD Path Extension field must be left blank.

Tumor Size, number of Regional Nodes Positive, and number of Regional Nodes Examined are required items for hospitals with ACoS approved programs. Refer to the ACoS Facility Oncology Registry Data Standards (FORDS) manual for codes and coding instructions.

Beginning with cases diagnosed January 1, 1998, new codes, new site-specific coding schemes and a new time-frame for assigning codes were added. In addition, rules for coding have been revised. Refer to the SEER Extent of Disease–1988: Codes and Coding Instructions, Third Edition (1998) for detailed codes and instructions.

Cases diagnosed prior to January 1, 1998 are to be coded using previous guidelines and coding schemes.

Note: The EOD Manual contains a new guideline - "Distinguishing Noninvasive and Invasive Bladder Cancer" which is to be implemented for cases diagnosed January 1, 1999 according to instructions from SEER. The CCR is implementing the use of this guideline as a pilot effective with cases diagnosed January 1, 1998.

For breast cancer cases, use the SEER revised breast cancer EOD codes. The revised codes were distributed via DSQC Memo #2002-05, June 12, 2002. These codes were effective through the December 31, 2003 diagnosis year.

With the implementation of Collaborative Staging the Regional Nodes Positive and Examined fields are the same fields for CS and for EOD. However, effective with cases diagnosed January 1, 2004 forward, the codes for Regional Nodes Positive have changed. Cases diagnosed prior to January 1, 2004 will be converted. The new codes are as follows:

| Code | Description |
|---|---|
| 00 | All nodes examined are negative. |
| 01-89 | 1-89 nodes are positive. (Code exact number of nodes positive) |
| 90 | 90 or more nodes are positive. |
| 95 | Positive aspiration of lymph node(s) was performed. |
| 97 | Positive nodes are documented, but the number is unspecified. |
| 98 | No nodes were examined. |
| 99 | It is unknown whether nodes are positive; not applicable; not stated in patient record. |

## V.4.2 Collaborative Staging

***Effective With Cases Diagnosed January 1, 2008 and Forward***

***Although Collaborative Staging has been required by the CCR since 2004, effective with cases diagnosed January 1, 2008 and forward, SEER (and thus the CCR) expanded the requirement to also include the CS Evaluation fields. Thus the following CS fields are required effective with cases diagnosed January 1, 2008 and forward:***

- CS Extension
- CS Lymph Nodes
- Regional Nodes Positive*
- Regional Nodes Examined
- CS Mets at Diagnosis
- CS Site Specific Factor 1
- CS Site Specific Factor 2
- CS Site Specific Factor 3
- CS Site Specific Factor 4
- CS Site Specific Factor 5

- CS Site Specific Factor 6
- CS Tumor Size/Extension Evaluation
- CS Lymph Node Evaluation
- CS Metastasis Evaluation
- Derived AJCC T Descriptor
- Derived AJCC N Descriptor
- Derived AJCC M Descriptor

The CCR has required the collection of the Collaborative Staging fields beginning with cases diagnosed January 1, 2004 forward and for cases with an unknown date of diagnosis first seen at your facility after January 1, 2004, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, Stage Group, Summary Stage 1977, and Summary Stage 2000 (Derived AJCC T, Derived AJCC N, Derived AJCC M, Derived AJCC Stage Group, Derived SS1977, and Derived SS2000) for all cases. These required data items include:

- CS Extension
- CS Lymph Nodes
- Regional Nodes Positive*
- Regional Nodes Examined
- CS Mets at Diagnosis
- CS Site Specific Factor 1
- CS Site Specific Factor 2
- CS Site Specific Factor 3
- CS Site Specific Factor 4
- CS Site Specific Factor 5
- CS Site Specific Factor 6
- CS Tumor Size/Extension Evaluation
- CS Lymph Node Evaluation
- CS Metastasis Evaluation
- Derived AJCC T Descriptor
- Derived AJCC N Descriptor
- Derived AJCC M Descriptor

*Definition changes were made to codes 90-97. See Section V.4.1 for the table of new codes for Regional Nodes Positive.

***For Cases Diagnosed Prior to January 1, 2008***

***The following Collaborative Staging data items are not required by the CCR, but must be submitted from CoC approved facilities:***

- ***CS Tumor Size/Extension Evaluation***
- ***CS Lymph Node Evaluation***
- ***CS Metastasis Evaluation***
- ***Derived AJCC T Descriptor***
- ***Derived AJCC N Descriptor***
- ***Derived AJCC M Descriptor***

***Refer to the Collaborative Staging Manual for coding instructions.***

**Prior to January 1, 2004**

Cases diagnosed prior to January 1, 2004 should continue to use the EOD fields with the exception of the Regional Nodes Positive field.

## V.5 Stage at Diagnosis

Stage at Diagnosis is a grouping of cases into broad categories, for example, localized, regional, and distant. This is different than Extent of Disease which is a detailed description of the spread of the disease from the site of origin.
***Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, Stage Group, Summary Stage 1977, and Summary Stage 2000.***

***For cases seen prior to January 1, 2004, apply the following guidelines:***

In the Stage at Diagnosis field, enter the code that represents the farthest tumor involvement as indicated by all the evidence obtained from diagnostic and therapeutic procedures performed during the first course of treatment or within four months after the date of diagnosis, whichever is earlier. (See Section VI.1 for definitions of first course of treatment and definitive treatment.) Coding must be supported by textual information entered under Diagnostic Procedures (see Section IV.1).

Stage at Diagnosis is not required beginning with cases diagnosed January 1, 1994. Hospitals wishing to do so may continue its use. Cases diagnosed prior to January 1, 1994 must continue to be staged using SEER Summary Staging Guide 1977.

Although Summary Stage is not required by the CCR, it is required by NAACCR and NPCR. This document is available from SEER. The rules for using SEER Summary Stage 1977 and SEER Summary Stage 2000 are as follows:

- Cancer cases diagnosed before January 1, 2001 should be assigned a summary stage according to SEER Summary Stage Guide 1977.
- Cases diagnosed on or after January 1, 2001 should be assigned a stage according to SEER Summary Stage 2000.

## V.5.1 Codes

Always base coding on the site-specific schemes presented in the *Summary Staging Guide for the Cancer Surveillance, Epidemiology and End Results Reporting (SEER) Program,* which is available as a separate publication or as Book 6 of the *Self Instructional Manual for Tumor Registrars* (see Section I.1.6.5).

Instructions in sections V.5.8, V5.9, V5.10, and V.5.11 are provided for guidance only. The codes are:

| | |
|---|---|
| 0 | IN SITU |
| 1 | LOCALIZED |
| 2 | REGIONAL, DIRECT EXTENSION ONLY |
| 3 | REGIONAL, LYMPH NODES ONLY |
| 4 | REGIONAL, DIRECT EXTENSION AND LYMPH NODES |
| 5 | REGIONAL, NOS |
| 7 | DISTANT METASTASES OR SYSTEMIC DISEASE (REMOTE) |
| 9 | UNSTAGEABLE (stage cannot be determined from available information) |
| Blank | NOT DONE |

## V.5.2 Definitions

Terms commonly used to describe stage include:

**Invasion**

Local spread of a neoplasm by infiltration into or destruction of adjacent tissue.

**Microinvasive**

The earliest invasive stage. Applied to cervical cancer, describes a small cancer that has invaded the stroma to a limited extent. The FIGO stage is IA. See Section V.3.4.3 and Section V.5.9.4.

**Direct Extension**

A continuous infiltration or growth from the primary site into other tissue or organs (compare to metastasis).

**Metastasis**

Dissemination of tumor cells in a discontinuous fashion from the primary site to other parts of the body—for example, by way of the circulatory system or a lymphatic system.

**Regional**

Organs or tissues related to a site by physical proximity. Also applies to the first chain of lymph nodes draining the area of the site.

## V.5.3 Ambiguous Terms

Physicians sometimes use ambiguous terms to indicate the involvement of tissue or an organ by a tumor. Refer to the ***Collaborative Staging Manual***, for a list of ambiguous terms.

## V.5.4 Time Period

Report the stage of each case at the time of diagnosis. Consider all diagnostic and therapeutic information obtained during the first course of treatment or within four months after the date of diagnosis, whichever is earlier. This time limitation ensures that the stage recorded is based on the same information that was used to plan the patient's treatment. Exclude progression of the disease since the time of the original diagnosis. See Section VI.1.1 for the analogous rule concerning first course of treatment.

Example

A patient with lung cancer is staged "regional lymph nodes" by the physician on the basis of positive mediastinal lymph nodes and radiation therapy is instituted. Four weeks into the treatment course the patient develops neurological symptoms, and further work–up reveals previously unsuspected brain metastases. The treatment plan is changed to take this new manifestation into account. Since the disease has progressed since the time of original diagnosis, the stage would not be changed to distant

.

## V.5.5 Autopsy Reports

Include pertinent findings from autopsy reports if the patient dies within four months of the diagnosis of the cancer. However, as with other types of information, exclude data about progression of the disease since the time of the original diagnosis.

## V.5.6 Staging by Physician

When a physician has assigned a stage using the TNM, FIGO, Dukes', or any other system, use the information as a guide for coding stage, especially when information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread. For a discussion of TNM, see Section V.7. However, take certain precautions:

- Physicians might use different versions of a staging system at the same time, and a specific designation of stage might have different meanings. To determine the corresponding summary stage code, it is essential to know exactly which version a physician is using.
- Some staging systems (FIGO for example) use clinical information only, whereas CCR's Stage at Diagnosis includes all information, clinical, surgical, and pathological, that falls into the time period. Use the physician's clinical stage if no pathological information is available.

## V.5.7 Contradictory Reports

Sometimes the stage is 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.5.8 In situ (Code 0)

A diagnosis of in situ, which must be based on microscopic examination of tissue or cells, means that a tumor has all the characteristics of malignancy except invasion, that is, the basement membrane has not been penetrated. A tumor that displays any degree of invasion is not classified as in situ.

For example, even if a report states *carcinoma in situ of the cervix showing microinvasion of one area*, the tumor is not in situ and code 0 is incorrect. However, a primary tumor might involve more than one site (for example, cervix and vagina, labial mucosa and gingiva) and still be in situ, as long as it does not show any invasion.

### V.5.8.1 Terms Indicating In Situ

Certain terms indicate an in situ stage. Also see Section V.3.4.2.

AIN (anal intraepithelial neoplasia Grade II-III)**

Bowen's Disease

DCIS (ductal carcinoma in situ)

DIN 3 (ductal intraepithelial neoplasia 3)**

CIN III (cervical intraepithelial neoplasia, grade III)*

Clark's level 1 for melanoma (limited to epithelium)

Confined to epithelium

Hutchinson's melanotic freckle, nos

Intracystic, non infiltrating

Intraductal

Intraepidermal

Intraepithelial

Intrasquamous

Involvement up to but not including the basement membrane

LCIS (lobular carcinoma in situ)

Lentigo maligna

LIN (laryngeal intraepithelial neoplasia)**

Lobular neoplasia, Grade III

No stromal invasion

Non infiltrating

Non invasive

PanIN-III (pancreatic intraepithelial neoplasia III)***

Precancerous melanosis

Preinvasive

Queyrat's erythroplasia

Stage 0

Vaginal intraepithelial neoplasia, Grade III (VAIN III)*

Vulvar intraepithelial neoplasia, Grade III (VIN III)*

* Cases diagnosed January 1992 and later.

** Cases diagnosed January 2001 and later.

***Cases diagnosed January 2004 and later.

## V.5.8.2 Behavior Code

If a tumor is staged in situ, the behavior code is 2. See Section V.3.4.

## V.5.9 Localized (Code 1)

Localized denotes a tumor that is invasive, but is still confined entirely to the organ of origin. For most sites, the tumor might be widely invasive or have spread within the organ, as long as it does not extend beyond the outer limits of the organ and there is no evidence of metastasis to other parts of the body.

## V.5.9.1 Inaccessible Sites

***For cases diagnosed January 1, 2004 and forward, apply the Collaborative Staging rules for inaccessible sites.***

***For cases diagnosed prior to January 1, 2004, apply the following guidelines:***

Clinical diagnosis alone is often insufficient for staging a tumor as localized when the primary site and regional lymph nodes are inaccessible, such as with the esophagus, lung, or pancreas. Without confirmation during surgery or an autopsy, it is usually preferable to code the stage as 9 (unstageable).

Physicians sometimes use ambiguous terms to indicate the involvement of tissue or an organ by a tumor. Refer to the ***Collaborative Staging Manual,*** for a list of ambiguous terms.

Code a case as stage 1, localized, if the physician has staged the case as localized or if clinical reports (such as CT scans) provide enough information to rule out spread of disease.

If surgery has been performed, study the operative report for evidence of direct extension or metastasis. If no such evidence has been found and radiological examination has produced none, classify the tumor as localized.

## V.5.9.2 Vessel and Lymphatic Involvement

Invasion of blood vessels, lymphatics, and nerves within the primary site is a localized stage, unless there is evidence of invasion outside the site.

## V.5.9.3 Multicentric Tumors

Tumors with more than one focus, or starting point, are considered to be localized unless extension beyond the primary site has occurred. But a tumor that has developed "satellite" nodule, that is, lesions secondary to the primary one, might not be localized. Refer to the ***Collaborative Staging Manual*** for rules about satellite lesions.

## V.5.9.4 Microinvasive

Microinvasive, a term used by pathologists to describe the earliest invasive stage, has a precise meaning for cancer of certain sites. Microinvasive cancers are staged as localized, code 1. (Microinvasive squamous cell carcinoma is a common form of cervical cancer, for which ICD-O provides a specific morphology code—8076/3.)

## V.5.10 Regional Stage (Codes 2, 3, 4, 5)

A tumor at the Regional stage has grown beyond the limits of the organ of origin into adjacent organs or tissues by direct extension and/or to regional lymph nodes by metastasis. Neoplasms appearing to be in the regional stage

must be evaluated very carefully to make sure they have not spread any farther.

## Example

A malignant tumor of the stomach or of the gallbladder often passes through the wall of the primary organ into surrounding tissue.

Before coding as regional, make certain that radiological or scan examinations do not reveal metastasis to a lung or bone and that findings during surgery do not include metastasis to the liver or serosal surfaces that are not regional.

Also check progress notes and the discharge summary for any mention of metastasis.

### V.5.10.1 Regional, Direct Extension Only (Code 2)

At times a cancer spreads to surrounding organs or tissue with no involvement of regional lymph nodes. Before assigning code 2 to such a case, make sure that tissue adjacent to the original organ is actually involved. The terms "penetrating" and "extension" are sometimes used to describe spreading within an organ, such as the large intestine or bladder, in which case the stage might still be localized (code 1). The Summary Staging Guide lists organs and structures considered to be regional for each site. Also see Section V.5.3 for interpretation of ambiguous terms.

### V.5.10.2 Regional, Lymph Nodes Only (Code 3)

If a cancer continues to grow after the onset of local invasion, the regional lymph nodes draining the area usually become involved at some point. Enter code 3 if nodal involvement is indicated but there is no other evidence of extension beyond the organ of origin. Words like "local" and "metastasis" appearing in medical records sometimes cause confusion in coding this stage. Failure to recognize the names of regional lymph nodes might lead to incorrect staging. The Summary Staging Guide and the American Joint Committee on Cancer's Manual for Staging of Cancer (see Section I.1.6.5) contain helpful information about the names of nodes.

## Examples

Diagnoses such as "carcinoma of the stomach with involvement of the local lymph nodes" should, lacking further evidence, be considered regional and staged as code 3.

Statements like "carcinoma of the breast with auxiliary lymph node metastasis" and "carcinoma of the stomach with metastasis to perigastric nodes" indicate metastasis to regional nodes and should be staged as code 3.

### V.5.10.3 Bilateral Involvement

Bilateral lymph node metastases are considered regional for primaries on the midline of the body (for example, on the tongue, esophagus, or uterus), and should be coded as 3. But bilateral regional node involvement of primaries that are not on the midline (like the breast) indicates that the cancer has spread to remote tissue (code 7).

### V.5.10.4 Regional, Direct Extension and Lymph Nodes (Code 4)

Enter code 4 when a tumor has metastasized to regional lymph nodes and also has spread to region al tissue via direct extension, but there is no evidence of metastasis to a distant site or distant lymph nodes.

### V.5.10.5 Regional, NOS (Code 5)

If available information states only that a cancer has spread regionally, stage as code 5. Also use code 5 for a nodal lymphoma described as regional which is sometimes stated in the record as Stage II. See Section V.5.6 and Section V.7.5).

## V.5.11 Distant (Code 7)

Enter code 7 for any tumor that extends beyond the primary site by:

- Direct extension beyond adjacent organs or tissues specified as regional in the Summary Staging Guide.
- Metastasis to distant lymph nodes.
- Development of discontinuous secondary or metastatic tumors. (These often develop in the liver or lungs, because all venous blood flows through these organs and the veins are invaded more easily than the thicker walled arteries.)

Code 7 also includes contralateral or bilateral lymph node metastases, if the primary site is not located along the midline of the body (for example, in the breast, lung, bronchus, ovary, testis, kidney). Also included in code 7 are systemic diseases such as leukemia and multiple myeloma.

## V.5.12 Unstageable (Code 9)

If information in medical records is insufficient to assign a stage, enter code 9. Code 9 is required when the primary tumor site is not known. For non-analytic cases (class 3), code 9 is appropriate unless the stage at the time of the initial diagnosis is known.

## V.5.13 Special Rules for Lymph Nodes

Special rules apply to staging lymph nodes:

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

nodes. Any other terms, such as "palpable", "enlarged", "visible swelling", "shotty", or "lymphadenopathy" should be ignored; look for a statement of involvement, either clinical or pathological.

- For lymphomas, any mention of lymph nodes is indicative of involvement.
- For lung primaries, if at mediastinoscopy or x-ray, the description states mass/ adenopathy/ enlargement of any of the lymph nodes listed under ***note 2 of the CS Lymph Nodes instructions in the CS Manual,*** assume those lymph nodes are involved.
- ***For EOD coding (cases diagnosed prior to January 1, 2004),*** mediastinal lymph nodes greater than 1 cm are considered enlarged.

## V.6 Tumor Markers

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 must be collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker - Tumor Marker -California 1(Her2/neu) continues to be a required data item for the CCR and is collected in its designated field.

Document the date, ***type of test,*** value and interpretation (elevated, borderline or normal) of any pertinent tumor markers or lab tests in the lab text field.

Refer to the document: *Recording Tumor Markers in Collaborative Staging System Site-Specific Factors*, on the Collaborative Staging web site.

### *Historical information:*

Three fields are available for collecting information about prognostic indicators referred to as tumor markers. Tumor marker information is currently required on the status of estrogen and progesterone receptors for (ERA and PRA) breast cancers (sites C50.0-C50.9) diagnosed on or after January 1, 1990.

Beginning with January 1, 1996 cases, facilities which collect ACoS data items were allowed to use these fields for other sites. The codes are the same. Please refer to the ROADS Manual for further information.

Beginning with January 1, 1998 diagnoses, the CCR required that tumor markers be collected for prostate -- acid phosphatase (PAP) and prostate specific antigen (PSA) and for testicular cancers -- alpha-feto protein (AFP), human chorionic gonadotropin (hCG), and lactate dehydrogenase (LDH). Ranges for testicular cancer tumor markers have been added in codes 4-6.

Beginning with January 1, 2000 diagnoses, Tumor Marker I may be used to record carcinoembryonic antigen (CEA) for colorectal cancers and CA-125 for ovarian cancers.

## V.6.1 Tumor Marker 1

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 are collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker- Tumor Marker -California 1(Her2/neu) is a required data item for the CCR and will continue to be collected in its designated field.

Document the date, ***type of test,*** value and interpretation (elevated, borderline or normal) of any pertinent tumor markers or lab tests in the lab text field.

Refer to the document: *Recording Tumor Markers in Collaborative Staging System Site-Specific Factors*, on the Collaborative Staging web site.

### *Historical information:*

Use the following codes for ERA for breast cancer cases diagnosed on or after January 1, 1990, PAP for prostate cancer cases and AFP for testicular cancer cases diagnosed after January 1, 1998, and CEA for colorectal cancer cases and CA-125 for ovarian cancer cases diagnosed after January 1, 2000:

| | |
|---|---|
| 0 | TEST NOT DONE (includes cases diagnosed at autopsy) |
| 1 | TEST DONE, RESULTS POSITIVE |
| 2 | TEST DONE, RESULTS NEGATIVE |
| 3 | TEST DONE, RESULTS BORDERLINE OR UNDETERMINED WHETHER POSITIVE OR NEGATIVE |
| 4 | RANGE 1: less than 1,000 NG/ML (S1) |
| 5 | RANGE 2: 1,000 - 10,000 NG/ML (S2) |
| 6 | RANGE 3: greater than 10,000 NG/ML (S3) |
| 8 | TEST ORDERED, RESULTS NOT IN CHART |
| 9 | UNKNOWN IF TEST DONE OR ORDERED; NO INFORMATION (includes death certificate only cases) |

For breast cancer cases diagnosed before January 1, 1990, for prostate and testicular cancers before January 1, 1998, for colorectal and ovarian cancers before January 1, 2000, and for all other sites, enter:

| | |
|---|---|
| 9 | NOT APPLICABLE |

Use codes 0, 1, 2, 3, 8, and 9 for breast, prostate, colorectal, and ovarian cancers.

Use codes 0, 2, 4, 5, 6, 8, and 9 for testicular cancer. ***Do not use code 1 for testicular cancers.***

Record the lowest (nadir) value of AFP after orchiectomy if serial serum tumor makers are done during the first course of treatment.

Do not record the results of tumor marker studies that are not performed on the primary tumor.

Breast tumors too small to evaluate with the conventional estrogen receptor assays might be measured by immunostaining, which is a procedure for identifying antigens in body fluids, in aspirations of tumor masses, or in biopsy specimens. The procedure is based on an antigen antibody reaction. If immunostaining results are available, use them to code Estrogen Receptor Status.

## V.6.2 Tumor Marker 2

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 are collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker- Tumor Marker -California 1(Her2/neu) is a required data item for the CCR and will continue to be collected in its designated field.

Document the date, ***type of test,*** value and interpretation (elevated, borderline or normal) of any pertinent tumor markers or lab tests in the lab text field.

Refer to the document: *Recording Tumor Markers in Collaborative Staging System Site-Specific Factors*, on the Collaborative Staging web site.

***Historical information:***

Use the following codes for the status of PRA for breast cancer cases diagnosed on or after January 1, 1990, and for PSA for prostate cancer cases and hCG for testicular cancer cases for cases diagnosed after January 1, 1998:

| | |
|---|---|
| 0 | TEST NOT DONE (includes cases diagnosed at autopsy) |
| 1 | TEST DONE, RESULTS POSITIVE |
| 2 | TEST DONE, RESULTS NEGATIVE |
| 3 | TEST DONE, RESULTS BORDERLINE OR UNDETERMINED WHETHER POSITIVE OR NEGATIVE |
| 4 | RANGE 1: less than 5,000 mIU/ml (S1) |
| 5 | RANGE 2: 5,000 - 50,000 mIU/ml (S2) |
| 6 | RANGE 3: greater than 50,000 mIU/ml (S3) |
| 8 | TEST ORDERED, RESULTS NOT IN CHART |

| | |
|---|---|
| 9 | UNKNOWN IF TEST DONE OR ORDERED; NO INFORMATION (includes death certificate only cases) |

For breast cancer cases diagnosed before January 1, 1990, for cancers of the prostate and testis before January 1, 1998 and for all other sites, enter:

| | |
|---|---|
| 9 | NOT APPLICABLE |

Use codes 0, 1, 2, 3, 8 and 9 for breast and prostate.

Use codes 0, 2, 4, 5, 6, 8 and 9 for testis. ***Do not use code 1 for testicular cancers.***

Record the lowest (nadir) value of hCG after orchiectomy if serial serum tumor markers are done during the first course of treatment.

Breast tumors too small to evaluate with the conventional progesterone receptor assays might be measured by immunostaining, which is a procedure for identifying antigens in body fluids, in aspirations of tumor masses, or in biopsy specimens. The procedure is based on an antigen antibody reaction. If immunostaining results are available, use them to code Progesterone Receptor Status.

## V.6.3 Tumor Marker 3

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 are collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker- Tumor Marker -California 1(Her2/neu) is a required data item for the CCR and will continue to be collected in its designated field.

Document the date, ***type of test,*** value and interpretation (elevated, borderline or normal) of any pertinent tumor markers or lab tests in the lab text field.

Refer to the document: *Recording Tumor Markers in Collaborative Staging System Site-Specific Factors*, on the Collaborative Staging web site.

***Historical information:***

For testis cases before January 1, 1998 and all other sites, enter:

| | |
|---|---|
| 9 | NOT APPLICABLE |

For testicular cancer cases diagnosed on or after January 1, 1998, record the status of the Lactate Dehydrogenase (LDH) level as follows:

| | |
|---|---|
| 0 | NOT DONE (SX) |
| 2 | WITHIN NORMAL LIMITS (SO) |

| | |
|---|---|
| 4 | RANGE 1 (S1) <1.5 x UPPER LIMIT OF NORMAL FOR LDH ASSAY |
| 5 | RANGE 2 (S2) 1.5 - 10 x UPPER LIMIT OF NORMAL FOR LDH ASSAY |
| 6 | RANGE 3 (S3) >10 x UPPER LIMIT OF NORMAL FOR LDH ASSAY |
| 8 | ORDERED, BUT RESULTS NOT IN CHART |
| 9 | UNKNOWN OR NO INFORMATION |

***Do not use code 1 for testicular cancers.***

## V.6.4 Tumor Marker California-1

Tumor Marker-California-1 is a tumor marker for breast cancer--HER2/neu (also known as c-erbB2 or ERBB2).

Document the date, ***type of test,*** value and interpretation (elevated, borderline or normal) of any pertinent tumor markers or lab tests in the lab text field.

There are currently two FDA-approved tests to determine HER2 status: IHC and FISH

IHC stands for ImmunoHistoChemistry

- The IHC test is used to measure HER2 protein (also called HER2 receptor) overexpression in the tumor sample.
- Interpretation of IHC relies on a qualitative scoring system on a scale of 0 - 3+
- The results can be reported as 0, 1+, 2+, or 3+. If the result is 3+, the cancer is considered HER2 positive.

Using IHC, a tumor biopsy is scored as:

- 0 (negative)
- 1+ (negative)
- 2+ (borderline)
- 3+ (positive) on an IHC test based on the reviewer's interpretation of staining intensity and completeness of membrane staining

FISH stands for Fluorescence in Situ Hybridization

- FISH uses fluorescent probes to "paint" the HER2 genes in a tumor cell, to see if the number of gene copies is normal or not. A normal cell has 2 copies of the HER2 gene.
- If a FISH test detects more than 2 copies of the HER2 gene, it means that the cell is abnormal and is HER2-positive.
- With FISH testing, the results are quantitative instead of qualitative; tumors are interpreted as HER2 "negative" or "positive" by enumberating the HER2/neu gene copy number.

If both the IHC and FISH tests are performed, use the FISH results for coding this field. ***Document the type of test performed.***

The codes are as follows:

| | |
|---|---|
| 0 | TEST NOT DONE (include cases diagnosed at autopsy) |
| 1 | TEST DONE, RESULTS POSITIVE |
| 2 | TEST DONE, RESULTS NEGATIVE |
| 3 | TEST DONE, RESULTS BORDERLINE OR UNDETERMINED WHETHER POSITIVE OR NEGATIVE |
| 8 | TEST ORDERED, RESULTS NOT IN CHART |
| 9 | UNKNOWN IF TEST DONE OR ORDERED; NO INFORMATION (includes death-certificate-only cases) |

For breast cases prior to January 1, 1999 or all other sites, enter:

| | |
|---|---|
| 9 | NOT APPLICABLE |

## V.7 AJCC Staging and Other ACoS Items

***Beginning with cases diagnosed January 1, 2004 and forward, the the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, and Stage Group.***

***Effective with cases diagnosed January 1, 2008 forward, physician-assigned pathologic AJCC staging will no longer be required to be collected by ACoS approved facilities.***

***For cases diagnosed prior to January 1, 2004,*** hospitals with American College of Surgeons (ACoS) approved registries are required to employ the TNM classification system for staging developed by the American Joint Committee on Cancer (AJCC). Clinical and pathological TNM staging are required by ACoS. Other TNM staging is part of their supplementary data set.

The CCR does not require hospitals to report TNM; however, it does request that if TNM (clinical and pathological only) is collected, it be transmitted to the CCR. There are a number of other data items in this section which hospitals may be required to collect either by ACoS or the CCR.

### V.7.1 The TNM System

***Beginning with cases diagnosed January 1, 2004 and forward, the the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, and Stage Group.***

As the AJCC *Manual for Staging of Cancer* explains, the TNM system "is based on the premise that cancers of similar histology or site of origin share similar patterns of growth and extension. The size of the untreated cancer or tumor (T) increases progressively and at some point in time regional lymph node involvement (N) and finally, distant metastases (M) occur."

Because classifications are different for each primary site, and coding for extension depends on precise anatomical identification, the AJCC manual must be referred to for data entry unless the coding is provided by physicians in the medical records. But fundamentally the system consists of assigning appropriate numbers or letters to the three fields:

- T (primary tumor)
- N (nodal involvement)
- M (distant metastasis)

For those sites not included in the AJCC Manual for Staging of Cancer, the Summary Staging Guide for Surveillance Epidemology and End Results Group (SEER) is to be used. For a list of these sites, please refer to *AJCC Manual for Staging of Cancer, Sixth Edition*.

## V.7.2 Data Entry

In entering data, do not include the letters T, N, or M, even though they are part of the code.

## V.7.3 TNM Stage Basis

TNM Basis indicates the nature of the information on which AJCC staging is based. The *AJCC Cancer Staging Manual* provides specific recommendations about which information should be used for each type of staging at each primary site.

The codes are as follows:

| | |
|---|---|
| S* | Surgical evaluative |
| R | Retreatment |
| A | Autopsy |

* Not used in the 3rd or 4th edition of the AJCC manual.

## V.7.4 TNM Staging Elements (Clinical and Pathological)

***Beginning with cases diagnosed January 1, 2004 and forward, the the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, and Stage Group.***

***For cases diagnosed prior to January 1, 2004,*** consult the AJCC manual for detailed information by site for assigning the appropriate numbers to each element for both clinical and pathological TNM elements. Enter only the numbers, not the letter T, N, or M. If only one number follows a T or N, enter it in the first space of the field, leaving the second space blank. Additional spaces have been added so that there are now three spaces available to record the "T" and the "N" and two spaces to record the "M". The TNM codes generally used are:

# T Codes:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| TX | X | | T1A2 | A2 | | T3 | 3 |
| T0 | 0 | | T1B | 1B | | T3A | 3A |
| Ta | A | | T1B1 | B1 | | T3B | 3B |
| Tis | IS | | T1B2 | B2 | | T3C | 3C |
| Tispu | SU | | T1C | 1C | | T4 | 4 |
| Tispd | SD | | T2 | 2 | | T4A | 4A |
| T1mic | 1M | | T2A | 2A | | T4B | 4B |
| T1 | 1 | | T2B | 2B | | T4C | 4C |
| T1A | 1A | | T2C | 2C | | T4D | 4D |
| T1A1 | A1 | | | | Not applicable | | 88 |

# N Codes:

| | | | | | | |
|---|---|---|---|---|---|---|
| NX | X | N1B | 1B | | N2C | 2C |
| N0 | 0 | N1C | 1C | | N3 | 3 |
| N0(i-) | 1- | | | | | |
| N0(i+) | 1+ | | | | | |
| N0(mol-) | M- | | | | | |
| N0(mol+) | M+ | | | | | |
| N1 | 1 | N2 | 2 | | N3A | 3A |
| N1mi | 1M | N2A | 2A | | N3B | 3B |
| N1A | 1A | N2B | 2B | | N3C | 3C |
| | | | | Not applicable | | 88 |

# M Codes:

| | | | | |
|---|---|---|---|---|
| MX | X | | M1A | 1A |
| M0 | 0 | | M1B | 1B |
| M1 | 1 | | M1C | 1C |
| | | Not applicable | | 88 |

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

| | |
|---|---|
| M1a | Nonregional lymph node(s) |
| M1b | Bone(s) |
| M1c | Other site(s) |

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

| | |
|---|---|
| M1a | Skin or subcutaneous tissue or lymph node(s) beyond the regional lymph nodes |
| M1a | Skin or subcutaneous tissue or lymph node(s) beyond the regional lymph nodes |
| M1c | Visceral metastasis at any site associated with an elevated serum lactic dehydrogenase (LDH). |

## V.7.5 AJCC Stage Group (Clinical and Pathological)

***Beginning with cases diagnosed January 1, 2004 and forward, the the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, Stage Group.***

***For cases diagnosed prior to January 1, 2004,*** the AJCC manual contains instructions for coding summaries of TNM staging.

When entering a stage summary code, be sure to include any letter used for the tumor, for example; 3A, 2C. If there is no letter, leave the second digit in the field blank. The codes are:

| | | | |
|---|---|---|---|
| STAGE 0 | 0 | STAGE IIC | 2C |
| STAGE 0A | 0A | STAGE III | 3 |

| | | | |
|---|---|---|---|
| STAGE 0IS | 0S | STAGE IIIA | 3A |
| STAGE I | 1 | STAGE IIIB | 3B |
| STAGE IA | 1A | STAGE IIIC | 3C |
| STAGE IA1 | A1 | STAGE IV | 4 |
| STAGE IA2 | A2 | STAGE IVA | 4A |
| STAGE IB | 1B | STAGE IVB | 4B |
| STAGE IB1 | B1 | STAGE IVC | 4C |
| STAGE IB2 | B2 | OCCULT | OC |
| STAGE IC | 1C | NOT APPLICABLE | 88 |
| STAGE IS | 1S | | |
| STAGE II | 2 | RECURRENT, UNKNOWN, STAGE X | 99 |
| STAGE IIA | 2A | | |
| STAGE IIB | 2B | | |

## V.7.6 TNM Coder (Clinical, Pathological, and Other)

Record the responsible person for performing the TNM staging on the case.

The TNM Coder (Clinical) and TNM Coder (Pathological) are to be used in conjunction with clinical and pathological TNM staging.

These fields will be transmitted to the state registry.

The codes are as follows:

0 NOT STAGED

1 MANAGING PHYSICIAN

2 PATHOLOGIST

3 PATHOLOGIST AND MANAGING PHYSICIAN

4 ANY COMBINATION OF 1, 2 OR 3

5 REGISTRAR

6 ANY COMBINATION OF 5 WITH 1, 2 OR 3

7 STAGING ASSIGNED AT ANOTHER FACILITY

8 CASE IS NOT ELIGIBLE FOR STAGING

9 UNKNOWN IF STAGED

## V.7.7 TNM Edition

Record which edition of TNM staging was used to stage a case. The codes are as follows:

00 NOT STAGED

01 FIRST EDITION

02 SECOND EDITION

03 THIRD EDITION

04 FOURTH EDITION

05 FIFTH EDITION

06 SIXTH EDITION

88 NOT APPLICABLE (cases that do not have an AJCC staging

scheme and staging was not done)

99 UNKNOWN

The TNM Edition field may be left blank.

## V.7.8 Pediatric Stage

This scheme is to be used for the purpose of entering the stage for pediatric patients only.

Pediatric Stage includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 or later.

Use Code 88 - not applicable, for patients twenty years of age and older.

Use code 99 for pediatric leukemia cases.

For cases diagnosed prior to 1996, both pediatric and non-pediatric, this field may be left blank.

Record the stage assigned by the Managing Physician.

The codes are as follows:

| | |
|---|---|
| 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.7.9 Pediatric Stage System

This scheme is to be used for pediatric patients only.

Pediatric Stage includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 or later.

Use Code 88 - not applicable, for patients twenty years of age and older.

For cases diagnosed prior to 1996, both pediatric and non-pediatric, this field may be left blank.

Record in this field the staging system used by the Managing Physician.

The codes are as follows:

| | |
|---|---|
| 00 | NONE |
| 01 | AMERICAN JOINT COMMITTEE ON CANCER (AJCC) |
| 02 | ANN ARBOR |
| 03 | CHILDREN'S CANCER GROUP (CCG) |
| 04 | EVANS |
| 05 | GENERAL SUMMARY |
| 06 | INTERGROUP EWINGS |
| 07 | INTERGROUP HEPATOBLASTOMA |
| 08 | INTERGROUP RHABDOMYOSARCOMA |
| 09 | INTERNATIONAL SYSTEM |
| 10 | MURPHY |
| 11 | NATIONAL CANCER INSTITUTE (Pediatric Oncology) |
| 12 | NATIONAL WILMS' TUMOR STUDY |
| 13 | PEDIATRIC ONCOLOGY GROUP (POG) |
| 14 | REESE-ELLSWORTH |
| 15 | SEER EXTENT OF DISEASE |
| 16 | CHILDREN'S ONCOLOGY GROUP (COG) |
| 88 | NOT APPLICABLE |
| 97 | OTHER |
| 99 | UNKNOWN |

## V.7.10 Pediatric Stage Coder

This data item is to be used for pediatric cases only diagnosed January 1, 1996 and later. It identifies the person who staged the case.

The ACoS states that the managing physician 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 physician, the registrar does not have to stage the case. Enter 0 for not staged.

For patients older than twenty (20), enter 0.

For cases diagnosed prior to 1996, this field may be left blank. The codes are as follows:

| | |
|---|---|
| 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. Treatment

## VI.1 First Course of Treatment: General Instructions

In the treatment section, record all cancer directed therapy administered as part of the first course of treatment. It includes any therapeutic procedure directed at cancer tissue, 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.

Effective with cases diagnosed January 1, 1998, a new definition for first course therapy was to be followed. In addition, note the definition for leukemias in see Section VI.1.1). Use the older definition for cases diagnosed prior to January 1, 1998.

The following rules are to be followed for first course therapy, and they are in the order of precedence:

1. If there is a documented, planned first course of therapy, first course ends at the completion of this treatment plan, regardless of the duration of the treatment plan.
2. If the patient is treated according to a facility's standards of practice, first course ends at the completion of the treatment.
3. If there is no documentation of a planned first course of therapy or standard of practice, first course therapy includes all treatment received before disease progression or treatment failure. If it is undocumented whether there is disease progression/treatment failure and the treatment in question begins more than one year after diagnosis, assume that the treatment is not part of first course.
4. If 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.

If treatment is given for symptoms/disease progression after a period of "watchful waiting," this treatment is not considered part of first course. For example, if a physician and patient choose a "wait and watch" approach to prostate cancer or chronic lymphocytic leukemia 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 CCR expects every hospital 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. (For example, Enter "Radiation therapy, recommended; unknown if given.") Hospitals 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 Hospital." This field should only include first course treatment administered at the reporting facility, respective to each modality.

***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. Reminder: Referral does not equal a recommendation.***

## VI.1.1 Special Situations

Note the rules for certain special situations:

**Treatment Performed Elsewhere** (class 0-2 analytic cases only).

Record any part of the first course of treatment administered at another facility before the patient was admitted to the reporting hospital or after discharge. Also record the name of the facility where the treatment was administered.

**Leukemia**

If a complete or partial remission of leukemia occurs during the first course of therapy for the leukemic process, report all therapy considered to be remission inducing and remission maintaining for the first remission. Disregard all treatment received after the lapse of the first remission. If a remission does not occur during the first course of therapy, record all treatment that attempted to induce the remission. Disregard all treatment which was administered as a subsequent attempt to induce remission.

## VI.1.2 Definitions

Certain treatment terms include:

**Definitive Cancer Treatment**

Therapy that normally modifies, controls, removes, or destroys proliferating tumor tissue, whether primary or metastatic, even if it cannot be considered curative for a particular patient in view of the extent of disease, incompleteness of treatment, apparent lack of response, size of the dose administered, mortality during surgery, or other reason. The term excludes therapy that has no effect on malignant tissue. Procedures administered for the sole purpose of relieving symptoms are therefore not considered to be cancer treatment.

**Cancer Tissue**

Proliferating malignant cells or an area of active production of malignant cells. Some times malignant cells are found in tissue in which they did not originate and are not reproducing. A procedure that removes cancer cells but does not attack a site of proliferation of the cells (thoracentesis, for example) is not considered cancer treatment.

**Palliative**

Ordinarily means (1) non-curative, or (2) alleviation of symptoms. If used for a procedure that is directed toward symptoms only, the therapy is not considered to be treatment (e.g., colostomy, removal of fluid—even if cancer cells are present—to ease pressure, neurosurgery to relieve pain).

**Antineoplastic Drugs**

Applies to medications that prevent the development, maturation, or spread of cancer cells. Included are drugs for chemotherapy (see Section VI.4), hormonal treatment (see Section VI.5), and immunotherapy (see Section VI.6). ***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 Web Site.***

## VI.1.3 Data Entry

Data entry for the treatment provided consists of codes, dates, and written summaries.

## VI.1.3.1 Codes

Number 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 VI.2 for coding each surgery field.

In the field provided, assign a separate code to that portion of the treatment administered at the reporting hospital.

Beginning with cases diagnosed January 1, 1998, treatment given by a physician on the medical staff of a facility should not be recorded as treatment given at that reporting facility.

For cases diagnosed prior to January 1, 1998, treatment given in a staff physician's office should be recorded as if given at the reporting facility.

The codes for surgical procedures have one or two digits.

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.

Other codes have two digits, with a 00 always meaning no procedure performed for that type of treatment.

## VI.1.3.2 Dates

Enter the date treatment was started for each modality. For instructions about entering dates, see Section I.1.6.4. 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. For any type of treatment that is not known to have been given, leave the date field blank. However, if a type of treatment is known to have been given but the date is not known, enter 9's.

The Date of Systemic Therapy will be generated from Date of Chemotherapy, Date of Hormone, Date of Immuno, and Date of Transplant/Endocrine Procedures effective with cases diagnosed 1/1/03.

## VI.1.3.3 Text

In the text field following the Start Date field, describe the treatment as succinctly 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 hospital. The text field may be left blank when the type of treatment was not provided. But if no cancer-directed surgery is performed, record the reason in the text field for surgery.

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.

## VI.1.3.4 Treatment Refused

If the patient or patient's guardian refuses surgery to the primary site, enter code 7 in the Reason for No Surgery field. 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. However, 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.

## VI.1.3.5 No Treatment

If a patient did not receive any of the treatments described in Sections VI.2—VI.7, the surgery summary code would be 00 and all the other treatment

summary fields would contain a 00. For 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 Section VI.1.3.4 for coding instructions. A hospital 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).

***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. Reminder: Referral does not equal a recommendation.***

## VI.1.3.6 Unknown if Treated

In coding treatment, code 99 or 9 (unknown) should generally be used only for class 3 non-analytic cases for which the first course of treatment is unknown. For a discussion of class of case, see Section III.3.5. 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. For 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 At This Hospital fields with code 00.

***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. Reminder: Referral does not equal a recommendation.***

## VI.2 First Course of Treatment: Surgery Introduction

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. Also record procedures that remove normal tissue--for example, dissection of non-cancerous lymph nodes--if they are part of the first course of treatment. (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 Section IV.1.

Beginning with cases diagnosed January 1, 2003, the surgery codes, definitions, and fields were reformulated.

Surgical Approach, Number of Regional Lymph Nodes Examined, and Reconstructive Surgery were dropped and all remaining fields except Surgery of the Primary Site were given a simplified coding scheme;

Surgery of the Primary Site was assigned new site-specific codes

Reconstructive Surgery was folded into the Surgery to the Primary Site codes.

Beginning with cases diagnosed January 1, 1998, new surgery codes, definitions, and fields from the American College of Surgeons were been added. Even though they are effective with 1998 cases, they are to be used for cases diagnosed prior to 1998. CNExT converted surgery codes for cases prior to 1998 to the new codes.

For cases diagnosed January 1, 1996 forward, the surgery field was separated into three fields:

- Surgery of the primary site
- Diagnostic, staging or palliative procedures
- Reconstructive surgery

## VI.2.1 Surgery of the Primary Site

See Appendix Q 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
- Dessication 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
- Tumor embolization (arterial block)

For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is unavailable. 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 Q.

Refer to Appendix Q-1 for cases diagnosed prior to January 1, 2003. Refer to Appendix Q-2 for cases diagnosed on or after January 1, 2003.

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.

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.

Examples

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 Q for the site-specific surgery codes. They are hierarchical with less specific (NOS) terms followed by more specific terms. See the example.

Examples

50 Gastrectomy, NOS WITH removal of a portion of esophagus
51 Partial or subtotal gastrectomy

52 Near total or total gastrectomy

NOTE: 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.

NOTE: If surgery removes the remaining portion of an organ, code the total removal of the organ.

NOTE: Biopsies that remove all gross tumor or leave only microscopic margins should be coded to surgery of the primary site.

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.

The second procedure would be code 52 for a total gastrectomy.

A patient had a lobectomy--code 31--for cancer in August 1998. The remainder of the lung was surgically removed in November 1998.

The second procedure would be code 40--resection of whole lung..

***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. Reminder: Referral does not equal a recommendation.***

## VI.2.2 Scope of Regional Lymph Node Surgery

These three one-character fields are to be used to record surgeries performed on regional lymph nodes. Record the farthest regional lymph node removed regardless of involvement with disease. There is no minimum number of nodes that must be removed. If a regional lymph node was aspirated or biopsied, code regional lymph node(s) removed, NOS (1).

Starting with cases diagnosed January 1, 2003 forward, RX Summ, Scope of Reg LN Surg is not 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:

| | |
|---|---|
| 0 | NONE<br>No regional lymph node surgery. No lymph nodes found in the pathologic specimen.<br>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<br><br>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<br><br>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<br><br>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<br><br>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<br><br>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<br><br>Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5. |
| 9 | UNKNOWN OR NOT APPLICABLE<br><br>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 and central nervous system***, or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease. |

For Unknown Primary, Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease Primaries, Lymphoma, Brain, Meninges, Spinal cord, Cranial Nerves and other part of the CNS ***(including the Pituitary Gland)*** and Primaries of Ill-Defined Sites, use code 9.

Cases diagnosed prior to January 1, 2003 must be coded in a new field, Scope of Regional LN 98-02. Refer to Appendix Q-1 for these codes.

Each site contains a list of nodes which are regional. Any nodes not contained on these lists are distant and should be coded in Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

In Appendix Q-1 for head and neck primaries diagnosed prior to January 1, 2003, the fields are to be used for neck dissections. Codes 2-5 indicate only that a neck dissection procedure was performed. They do not imply that nodes were found during the pathologic examination of the surgical specimen. Code the neck dissection even if no nodes were found in the specimen.

## VI.2.3 Number of Regional Lymph Nodes Examined

Record the number of lymph nodes identified in the pathology report during each surgical procedure of the regional lymph nodes. The codes are the same for all sites. Refer to Appendix Q-1 for these codes, which are to be entered in chronological order. If no regional lymph nodes were identified in the pathology report, leave the field blank even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or if the operative report documents removal of the nodes.

Note: This field is not cumulative. It does not replace or duplicate the "Regional Lymph Nodes Examined" field used in Extent of Disease coding.

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. However, the summary field for cases diagnosed prior to January 1, 2003 must continue to be coded.

Use code 99 for an Unknown Primary Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease Primaries, Lymphoma, Brain ***(including the pituitary gland)*** and Primaries of Ill-Defined Sites.

## VI.2.4 Surgery of Other Regional Sites, Distant Sites, or Distant Lymph Nodes

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 be an en bloc resection. See example #1. 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. Do not code the incidental removal of tissue

for reasons other than malignancy. See example #2. These 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.

Starting with cases diagnosed January 1, 2003 forward, 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. The new codes are as follows:

| | |
|---|---|
| 0 | NONE<br>No surgical procedure of nonprimary site |
| 1 | NONPRIMARY SURGICAL PROCEDURE PERFORMED<br>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<br>Resection of regional site. |
| 3 | NONPRIMARY SURGICAL PROCEDURE TO DISTANT LYMPH NODE(S)<br>Resection of distant lymph node(s). |
| 4 | NONPRIMARY SURGICAL PROCEDURE TO DISTANT SITE<br>Resection of distant site. |
| 5 | COMBINATION OF CODES<br>Any combination of surgical procedures 2, 3, or 4. |
| 9 | UNKNOWN<br>It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only. |

NOTE: Use code 1 if any surgery is performed to treat tumors of Unknown or Ill-defined Primary sites (C76.0-76.8, C80.9) or for Hematopoietic/Reticuloendothelial/Immunoproliferative disease (C42.0, C42.1, C42.3, C42.4, or 9750, 9760-9764, 9800-9820, 9826, 9831-9964, 9980-9989).

Cases diagnosed prior to January 1, 2003 are to be coded in a new field, Surgery Other 98-02. Refer to Appendix Q-1 for these codes.

This field is for all procedures that do not meet the definitions of Surgery of Primary Site or Scope of Regional Lymph Nodes.

Example #1

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).

Example #2

During a colon resection, the surgeon noted that the patient had cholelithiasis and removed the gallbladder.

Do not code removal of the gallbladder.

## VI.2.5 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 or Surgery of Other Regional/Distant Sites. These must be entered in chronological order. They are to be left blank if no surgery is performed.

Beginning with cases diagnosed 1/1/2003, Rx Date-Most Definitive Surgery of the Primary Site, is required by the CCR. Since the CCR is already collecting multiple procedure fields, this data item will be generated. The generated data item will identify the date for the most definitive surgical procedure of the primary site from the three procedure fields.

## VI.2.6 Treatment Hospital Number

These fields are used in conjunction with each surgical procedure performed. If the procedure was performed at the reporting facility, the reporting hospital number should be entered. ***Use NPI facility number if available.***

The fields are to be left blank if no cancer-directed surgery was performed.

## VI.2.7 Surgical Margins of the Primary Site

This field is not required by the CCR effective with cases diagnosed January 1, 2000, but it is required by the ACoS. It describes the status of the surgical margins after each resection of the primary tumor.

For cases diagnosed after January 1, 2003, please refer to the FORDS Manual.

For cases diagnosed prior to January 1, 2003, please refer to Appendix Q-1 for the site-specific codes.

## VI.2.8 Reconstructive Surgery - Immediate

Record the procedure in both the Reconstructive Summary and At This Hospital fields and in the surgery text field if it was performed subsequent to surgery as part of the planned first course of therapy. This procedure improves the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies.

Beginning with cases diagnosed, January 1, 2003, this field is no longer required by the CCR or the CoC. Information with regards to reconstruction is incorporated into the Surgery of the Primary Site field.

The old field was retained and cases diagnosed prior to January 1, 2003 must continue to be coded.

For these cases, refer to Appendix Q-1.

## VI.2.9 Reason for No Surgery of the Primary Site

If surgery of the primary site was performed, enter 0.

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.

For sites where "Surgery of the Primary Site" is coded to 00 or 98 (hematopoietic included) use code 1.

Effective with cases diagnosed 1/1/2003, Code 5, *surgery not performed because patient died* was added. Definitions for codes 1, 2, and 6 were modified.

| | |
|---|---|
| 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 |

| | |
|---|---|
| 9 | NOT KNOWN IF SURGERY OF THE PRIMARY SITE WAS RECOMMENDED OR PERFORMED; DEATH CERTIFICATE ONLY AND AUTOPSY ONLY CASES |

## VI.2.10 Diagnostic or Staging Procedures

Record surgical procedures performed solely for establishing a diagnosis and or determining stage of disease. If there is more than one surgical diagnostic or staging procedure, record the first one performed. Some of the procedures should be recorded in the Operative Findings field.

Beginning with cases diagnosed January 1, 2003 forward, 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 *FORDS Manual* for instructions regarding the palliative procedure field.

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)
- 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, for example
- Bypass surgery—colostomy, esophagostomy, gastrostomy, nephrostomy, tracheostomy, urethrostomy, stent placement
- Exploratory surgery—celiotomy, cystotomy, gastrotomy, laparotomy, nephrotomy, thoracotomy

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.

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).

**Do Not Code**:

- 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.

## VI.2.10.1 Diagnostic or Staging Procedure Codes

| | |
|---|---|
| 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 (Code Microscopic residual disease or no residual disease as Surgery 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 |

NOTE: Give priority to:

Codes 01-07 over code 09.

Codes 01-06 over code 07.

The highest code in the range 01-06

## VI.2.11 Date of Diagnostic or Staging Surgical Procedures

Enter the date of the earliest surgical diagnostic and/or staging procedure in this field.

Codes (in addition to valid dates)

| | |
|---|---|
| 00000000 | No diagnostic procedure performed; autopsy only case |
| 99999999 | Unknown if any surgical diagnostic or staging procedure performed; date unknown, or death certificate only case |

## VI.2.12 Sources for Information (Surgery)

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.2.13 Special Rules for Coding Ambiguous Cases (Surgery)

There are specific rules for coding certain ambiguous situations:

**Excision Of Multiple Primaries**

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.

**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. 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.

**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.

## VI.2.14 Systemic Therapy With Surgery Sequence

For cases diagnosed 1/1/2006 forward, code the sequence in which systemic therapy and surgical procedures were performed as part of the first course of treatment.

Use the following codes:

| | |
|---|---|
| 0 | No systemic therapy and /or surgical procedures |
| 2 | Systemic therapy before surgery |
| 3 | Systemic therapy after surgery |
| 4 | Systemic therapy both before and after surgery |
| 5 | Intraoperative systemic therapy |
| 6 | Intraoperative systemic therapy with other therapy administered before or after surgery |
| 9 | Sequence unknown |

If first course of treatment includes (codes 10-90 in Surgery of the Primary Site fields, codes 1-7 in the Scope of Regional Lymph Node Surgery fields, and codes 1-8 in the Surgery of Other Regional(s), Distant Site(s), or Distant Lymph Node(s) fields) and systemic therapy, use codes 2-9. For all other cases, use code 0.

## VI.3 First Course of Treatment: Radiation Therapy

The name or chemical symbol and method of administration of any radiation therapy that is directed toward tumor tissue or given prophylactically must be documented in the text field.

Do not include radiation for hormonal effect, such as irradiation of non-cancerous endocrine glands.

Do not include irradiation of the male breast to prevent gynecomastia.

***For cases diagnosed 1/1/2008 forward, the data item, Radiation Location Treatment is required by the CCR. This data item identifies the location of the facility in which radiation treatment was administered during first course of treatment.***

For cases diagnosed 1/1/2003 forward, the two fields, Radiation - Regional RX Modality and Radiation - Boost RX Modality, are required to code first course radiation therapy. Software conversions of these two fields generate the Radiation Therapy Summary field.

The data item, "Radiation Therapy at this Hospital" was no longer required to be completed by the CCR beginning with cases diagnosed 1/1/2003.

## 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:

$Au^{198}$ 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 Beam (Teletherapy)

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

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. (Heyman capsules, Fletcher suit, and Fletcher after loader are methods of isotope application. Interpret these terms as radioactive implants.)

Record High Dose Rate (HDR) and Low Dose Rate (LDR) Brachytherapy as radioactive implants - Code 2.

## VI.3.1.3 Other Internal Radiation

Record the name or chemical symbol and method of administration of any radioactive material given orally, intracavitarily, or by intravenous injection.

## VI.3.2 Radiation Therapy Summary Codes

The following codes will be generated for recording radiation therapy in the summary field.

Beginning with cases diagnosed 1/1/2003, and any cases entered after the software conversion, two fields, Radiation - Regional RX Modality and Radiation - Boost RX Modality, are required to code first course radiation therapy. Software conversions of these two fields will generate the Radiation Therapy Summary field.

| | |
|---|---|
| 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 |

Beginning with cases diagnosed January 1, 1998, radiation to the brain and central nervous system for lung cancers and leukemias only is to be recorded in the Radiation Summary and Radiation At This Hospital fields. Include prophylactic treatment and treatment of known spread to the CNS.

Beginning with cases diagnosed on or after January 1, 2003 or cases entered after the software conversion, radiation to the brain and CNS for lung and

leukemia cases are to be coded in the Radiation – Regional RX Modality and Radiation – Boost RX Modality fields.

The field "Radiation Therapy at this Hospital" will no longer be required by the CCR beginning with cases diagnosed 1/1/2003.

## VI.3.3 Radiation - Regional RX Modality

Record the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment. The CCR requires the collection of this field. This data item and Radiation-Boost RX Modality are converted to generate the RX Summ-Radiation.

The codes for Radiation-Regional RX Modality are as follows:

| | |
|---|---|
| 00 | NO RADIATION TREATMENT; DIAGNOSED AT AUTOPSY |
| 20 | EXTERNAL BEAM, NOS |
| 21 | ORTHOVOLTAGE |
| 22 | COBALT-60, CESIUM-137 |
| 23 | PHOTONS (2-5 MV) |
| 24 | PHOTONS (6-10 MV) |
| 25 | PHOTONS (11-19 MV) |
| 26 | PHOTONS (>19 MV) |
| 27 | PHOTONS (MIXED ENERGIES) |
| 28 | ELECTRONS |
| 29 | PHOTONS AND ELECTRONS MIXED |
| 30 | NEUTRONS, WITH OR WITHOUT PHOTONS/ELECTRONS |
| 31 | IMRT |
| 32 | CONFORMAL OR 3-D THERAPY |
| 40 | PROTONS |
| 41 | STEREOTACTIC RADIOSURGERY, NOS |
| 42 | LINAC RADIOSURGERY |
| 43 | GAMMA KNIFE |
| 50 | BRACHYTHERAPY, NOS |
| 51 | BRACHYTHERAPY, INTRACAVIATARY, LDR |

| | |
|---|---|
| 52 | BRACHYTHERAPY, INTRACAVIATARY, HDR |
| 53 | BRACHYTHERAPY, INTERSTITIAL, LDR |
| 54 | BRACHYTHERAPY, INTERSTITIAL, HDR |
| 55 | RADIUM |
| 60 | RADIOISOTOPES, NOS |
| 61 | STRONTIUM-89 |
| 62 | STRONTIUM-90 |
| 98 | OTHER, NOS |
| 99 | UNKNOWN; DEATH CERTIFICATE ONLY |

Clarification: Intracavitary use of Cobalt-60 or Cesium-137 should be coded as 50 or 51. (See *FORDS Manual* for code definitions).

There is no hierarchy for this data item. 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.

***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. Reminder: Referral does not equal a recommendation.***

*NOTE: For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to Vol. II, ROADS, and DAM rules and should not be used to record regional radiation for cases diagnosed on or later than January 1, 2003.

## VI.3.4 Radiation - Boost RX Modality

Record the dominant modality of radiation therapy used to deliver the most clinically significant boost dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or IMRT. External beam boosts may consist of two or more successive phases with progressively smaller fields generally coded as a single entity.

The CCR requires the collection of this data item. This data item and Radiation-Regional RX Modality are converted to generate the RX Summ-Radiation.

The codes are as follows:

| | |
|---|---|
| 00 | NO BOOST TREATMENT; DIAGNOSED AT AUTOPSY |
| 20 | EXTERNAL BEAM, NOS |
| 21 | ORTHOVOLTAGE |
| 22 | COBALT-60, CESIUM-137 |
| 23 | PHOTONS (2-5 MV) |
| 24 | PHOTONS (6-10 MV) |
| 25 | PHOTONS (11-19 MV) |
| 26 | PHOTONS (>19 MV) |
| 27 | PHOTONS (MIXED ENERGIES) |
| 28 | ELECTRONS |
| 29 | PHOTONS AND ELECTRONS MIXED |
| 30 | NEUTRONS, WITH OR WITHOUT PHOTONS/ELECTRONS |
| 31 | IMRT |
| 32 | CONFORMAL OR3-D THERAPY |
| 40 | PROTONS |
| 41 | STEREOTACTIC RADIOSURGERY, NOS |
| 42 | LINAC RADIOSURGERY |
| 43 | GAMMA KNIFE |
| 50 | BRACHYTHERAPY, NOS |
| 51 | BRACHYTHERAPY, INTRACAVIATARY, LDR |
| 52 | BRACHYTHERAPY, INTRACAVIATARY, HDR |
| 53 | BRACHYTHERAPY, INTERSTITIAL, LDR |
| 54 | BRACHYTHERAPY, INTERSTITIAL, HDR |
| 55 | RADIUM |
| 60 | RADIOISOTOPES, NOS |
| 61 | STRONTIUM-89 |
| 62 | STRONTIUM-90 |
| 98 | OTHER, NOS |

| | |
|---|---|
| 99 | UNKNOWN; DEATH CERTIFICATE ONLY |

Clarification: Intracavitary use of Cobalt-60 or Cesium-137 should be coded as 50 or 51. (See the FORDS Manual for code definitions).

There is no hierarchy for this data item. If multiple radiation therapy boost modalities are used to treat the patient, code the dominant modality.

***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. Reminder: Referral does not equal a recommendation.***

## VI.3.5 Date of Radiation Therapy

Record the date on which radiation therapy began at any facility as part of the first course treatment.

If radiation therapy was not administered, enter 0's.

If radiation therapy is planned, but had not started at the time the case is transmitted to the regional registry, enter 8's.

If radiation therapy is known to have been given but the date is not known, enter 9's.

Codes (in addition to valid dates)

| | |
|---|---|
| 00000000 | NO RADIATION THERAPY ADMINISTERED; AUTOPSY-ONLY CASE |
| 88888888 | WHEN RADIATION THERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP. FOR CoC APPROVED FACILITIES, THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW-UP. |
| | **NOTE**: THE CCR REQUIRES THE USE OF 8'S IN THIS FIELD FOR CASES UNDERGOING RADIATION THERAPY LATER THAN SIX MONTHS FROM THE DATE OF ADMISSION. See Timeliness Section IX.2.3. |
| 99999999 | WHEN IT IS UNKNOWN WHETHER ANY RADIATION THERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY |

## VI.3.6 Reason for No Radiation

The following codes are to be used to record the reason the patient did not undergo radiation treatment:

| | |
|---|---|
| 0 | RADIATION TREATMENT PERFORMED |
| 1 | RADIATION TREATMENT NOT PERFORMED BECAUSE IT WAS NOT A |

| | |
|---|---|
| | PART OF THE PLANNED FIRST COURSE TREATMENT |
| 2 | RADIATION CONTRAINDICATED BECAUSE OF OTHER CONDITIONS OR OTHER PATIENT RISK FACTORS (CO-MORBID CONDITIONS, ADVANCED AGE, ETC) |
| 5 | RADIATION TREATMENT NOT PERFORMED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED TREATMENT |
| 6 | RADIATION TREATMENT WAS RECOMMENDED BUT NOT PERFORMED. NO REASON WAS NOTED IN THE PATIENT'S RECORD. |
| 7 | RADIATION TREATMENT WAS RECOMMENDED BUT REFUSED BY THE PATIENT, FAMILY MEMBER OR GUARDIAN. THE REFUSAL IS NOTED IN THE PATIENT'S RECORD. |
| 8 | RADIATION RECOMMENDED, UNKNOWN IF DONE |
| 9 | UNKNOWN IF RADIATION RECOMMENDED OR PERFORMED; DEATH CERTIFICATE AND AUTOPSY ONLY CASES |

NOTE: Include radiation to the brain and central nervous system when coding this field.

NOTE: Beginning with cases diagnosed 1/1/2003, Code 5 - radiation not performed because patient died was added. Definitions for codes 1, 2, and 6 were also modified.

## VI.3.7 Radiation Sequence With Surgery

Code the sequence in which radiation and surgical procedures were performed as part of the first course of treatment. Use the following codes:

| | |
|---|---|
| 0 | NOT APPLICABLE treatment did not include both surgery and radiation, or unknown whether both were administered; diagnosed at autopsy |
| 2 | RADIATION BEFORE SURGERY |
| 3 | RADIATION AFTER SURGERY |
| 4 | RADIATION BOTH BEFORE AND AFTER SURGERY |
| 5 | INTRAOPERATIVE RADIATION |
| 6 | INTRAOPERATIVE RADIATION WITH OTHER RADIATION GIVEN BEFORE OR AFTER SURGERY |
| 9 | SEQUENCE UNKNOWN, BUT BOTH SURGERY AND RADIATION WERE GIVEN |

Use codes 2-9 if the first course of treatment includes (codes 10–90 in Surgery of the Primary Site fields, codes 1-7 in the Scope of Regional Lymph Node Surgery fields, and codes 1-8 in the Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) fields) and radiation.

For all other cases, use code 0.

## VI.3.8 Location of Radiation Treatment

Code the location of the facility in which radiation treatment was administered during first course of treatment. ***This data item is required by the CCR, beginning with cases diagnosed January 1, 2008 and forward.*** Use the following codes:

| | |
|---|---|
| 0 | NO RADIATION TREATMENT |
| 1 | ALL RADIATION TREATMENT AT THIS FACILITY |
| 2 | REGIONAL TREATMENT AT THIS FACILITY, BOOST ELSEWHERE |
| 3 | BOOST RADIATION AT THIS FACILITY, REGIONAL ELSEWHERE |
| 4 | ALL RADIATION TREATMENT ELSEWHERE |
| 8 | OTHER, NOS |
| 9 | UNKNOWN |

## VI.4 First Course of Treatment: Chemotherapy

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. 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 intracavitarily, 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 directed therapy are considered to be a combination regimen.

## VI.4.1 Names of Chemotherapeutic Agents

In the text field, the generic or trade names of the drugs used for chemotherapy must be recorded. Include agents that are in the investigative or clinical trial phase.

**January 1, 2005 and Forward**

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 Web Site.

## VI.4.2 Chemotherapy Codes

Use the following codes for recording chemotherapy in the Summary field. Use codes 00-87 for recording chemotherapy in the At This Hospital field.

| | |
|---|---|
| 00 | NONE, CHEMOTHERAPY WAS NOT PART OF THE PLANNED FIRST COURSE OF THERAPY. DIAGNOSED AT AUTOPSY |
| 01 | CHEMOTHERAPY, NOS. |
| 02 | SINGLE-AGENT CHEMOTHERAPY. |
| 03 | MULTIAGENT 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. |

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 0 or 3.

***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. Reminder: Referral does not equal a recommendation.***

## VI.4._3 Date of Chemotherapy

Record the date on which chemotherapy began at any facility as part of first course of treatment.

If chemotherapy was not administered, leave the date field blank.

If chemotherapy is planned, but had not started at the time the case is transmitted to the regional registry, enter 8's.

If chemotherapy is known to have been given but the date is not known, enter 9's.

Codes (in addition to valid dates)

| | |
|---|---|
| 00000000 | NO CHEMOTHERAPY ADMINISTERED; AUTOPSY-ONLY CASE |
| 88888888 | WHEN CHEMOTHERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP. FOR CoC APPROVED FACILITIES. THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW-UP. |
| | **NOTE**: THE CCR REQUIRES THE USE OF 8'S IN THIS FIELD FOR CASES UNDERGOING CHEMOTHERAPY LATER THAN SIX MONTHS FROM THE DATE OF ADMISSION. See Timeliness Section IX.2.3. |
| 99999999 | WHEN IT IS UNKNOWN WHETHER ANY CHEMOTHERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY |

## VI.5 First Course of Treatment: Hormone (Endocrine) Therapy

Report the administration of hormones, antihormones, or steroids to attack cancer tissue by changing the patient's hormone balance. 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.

## VI.5.1 Hormones

Cancer-directed treatment with hormones and antihormones must be documented in the text field for all sites.

Report cancer directed use of adenocorticotrophic hormones for treatment of leukemias, lymphomas, multiple myelomas, and breast and prostate cancers. But 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.

**January 1, 2005 Forward**

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 Web Site.

### VI.5.1.1 Agents for Endometrial and Kidney Tumors

Agents commonly used in the treatment of endometrial cancer and cancer of the kidney include:

Delalutin

Depo Provera

Hydroxyprogesterone

Medroxyprogesterone

Megace

Megestrol acetate

Methyl progesterone

Norethindrone

Norlutate

Norlutin

Progestone

Progesterone

Progestin

Progestoral

Proluton

Provera

### VI.5.1.2 Agents For Thyroid Cancer

Agents commonly used in the treatment of thyroid cancer include:

Cytomel

Levothyroxine

Liothyronine

Proloid

Synthroid

Triiothyronine

Thyroglobulin

Thyroid (extract)

Thyrolar

Thyroxine

TRIT

Thyroid stimulating hormone (TSH) is replacement therapy and not tumor directed. But the administration of thyroid hormone following a thyroidectomy is definitive hormonal treatment, since thyroid extract has a dual role: replacement therapy and inhibition of recurrence and metastasis. Exogenous desiccated thyroid is treatment following both subtotal and total thyroidectomy.

## VI.5.2 Hormone (Endocrine) Surgery

This data item is coded in the "Transplant/Endocrine Procedure" field (Section VI.7). 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). 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.

## VI.5.3 Hormone (Endocrine) Radiation

This data item is coded in the "Transplant/Endocrine Procedure" field (Section VI.7). 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.

## VI.5.4 Hormone Therapy Codes

Use the following codes for recording hormone therapy in the Summary field. Use codes 00-87 for recording hormone therapy at this hospital. The codes for Reason No Hormone have been incorporated into this field.

| | |
|---|---|
| 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 (IE, 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. |

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 0 or 3.

***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. Reminder: Referral does not equal a recommendation.***

## VI.5.5 Date of Hormone Therapy

Record the date on which hormone therapy began at any facility as part of first course of treatment.

If hormone therapy was not administered, leave the date field blank.

If hormone therapy is planned, but had not started at the time the case is transmitted to the regional registry, enter 8's.

If hormone therapy is known to have been given but the date is not known, enter 9's.

Codes (in addition to valid dates)

| | |
|---|---|
| 00000000 | NO HORMONE THERAPY ADMINISTERED; AUTOPSY-ONLY CASE |
| 88888888 | WHEN HORMONE THERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP. FOR CoC APPROVED FACILITIES, THE DATE SHOULD BE REVISED AT THE NEXT |

| | |
|---|---|
| | FOLLOW-UP. |
| | **NOTE**: THE CCR REQUIRES THE USE OF 8'S IN THIS FIELD FOR CASES UNDERGOING HORMONE THERAPY LATER THAN SIX MONTHS FROM THE DATE OF ADMISSION. See Timeliness Section IX.2.3. |
| 99999999 | WHEN IT IS UNKNOWN WHETHER ANY HORMONE THERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY |

## VI.6 First Course of Treatment: Immunotherapy (Biological Response Modifier Therapy)

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).

## VI.6.1 Immunotherapy Agents

Immunotherapy agents must be recorded in the text field.

**January 1, 2005 and Forward**

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 Web Site.

Report the following as immunotherapy:

ASILI (active specific intralymphatic immunotherapy)

Blocking factors

Interferon

Monoclonal antibodies*

Transfer factor (specific or non specific)

Vaccine therapy

Virus therapy

*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 Immunotherapy Codes

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.

Use codes 00-87 for recording immunotherapy in the At This Hospital field.

Use the following codes for recording immunotherapy in the Summary field.

| | |
|---|---|
| 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. |

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 0 or 3.

***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. Reminder: Referral does not equal a recommendation.***

## VI.6.3 Date of Immunotherapy

Record the date on which immunotherapy began at any facility as part of first course of treatment.

If immunotherapy was not administered, leave the date field blank (zeros).

If immunotherapy is known to have been given but the date in not known, enter 9's.

| | |
|---|---|
| 00000000 | NO IMMUNOTHERAPY ADMINISTERED; AUTOPSY-ONLY CASE |
| 88888888 | WHEN IMMUNOTHERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP. THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW-UP. |
| 99999999 | WHEN IT IS UNKNOWN WHETHER ANY IMMUNOTHERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY |

## VI.7 First Course of Treatment: Transplant/Endocrine Procedures

Record systemic therapeutic procedures administered as part of first course of treatment. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. 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.

For cases prior to January 1, 2003, a conversion was required using both the Rx Summ - BRM (Immunotherapy) and Rx Summ - Hormone fields. Although the CoC did not add a corresponding "At this Hospital" field, the CCR required this field in order to provide consistency, since all of the other treatment fields except radiation have a hospital-level field during this time period.

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.

## VI._7.1 Transplant/Endocrine Codes

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 Hospital field.

| | |
|---|---|
| 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 |
| 20 | STEM CELL HARVEST |
| 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. |

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 0 or 3.

***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. Reminder: Referral does not equal a recommendation.***

## VI.7.2 Date of Transplant/Endocrine Procedure

Record the date on which the transplant/endocrine procedure took place at any facility as part of the first course treatment.

If transplant/endocrine procedures were not performed leave the date field blank.

If a transplant/endocrine procedure is known to have been performed but the date is not known, enter 9's.

Codes (in addition to valid dates)

| | |
|---|---|
| 00000000 | NO TRANSPLANT OR ENDOCRINE THERAPY WAS PERFORMED; AUTOPSY-ONLY CASE |
| 88888888 | WHEN TRANSPLANT/ENDOCRINE THERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP. THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW-UP. |
| 99999999 | WHEN IT IS UNKNOWN WHETHER ANY TRANSPLANT/ENDOCRINE THERAPY WAS PERFORMED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY |

## VI.8 First Course of Treatment: Other Therapy

Record definitive, cancer directed treatment that cannot be assigned to any other category, for example:

- Hyperbaric oxygen (as adjunct to definitive treatment).
- Hyperthermia (given alone or in combination with chemotherapy, as in isolated heated limb perfusion for melanoma).
- 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.

For Newly Reportable Hematopoietic Diseases (NRHD) only, specify in the Remarks field and use code 1 "Other Therapy" for the following:

- Transfusions/Plasmapheresis
- Phlebotomy/Blood Removal
- Supportive Care
- Aspirin
- Observation

## VI.8.1 Other Therapy Codes

Use the following codes for recording other therapy in the Summary field. Use codes 0-7 for recording other therapy in the At This Hospital field.

| | |
|---|---|
| 0 | NO OTHER CANCER DIRECTED THERAPY EXCEPT AS CODED ELSEWHERE. DIAGNOSED AT AUTOPSY. |
| 1 | OTHER CANCER DIRECTED THERAPY |
| 2 | OTHER EXPERIMENTAL CANCER DIRECTED THERAPY (not included elsewhere) |
| 3 | DOUBLE BLIND CLINICAL TRIAL, CODE NOT YET BROKEN |
| 6 | UNPROVEN THERAPY |
| 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. |

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 0 or 3.

***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. Reminder: Referral does not equal a recommendation.***

## VI.8.2 Date of Other Therapy

Record the date on which Other Therapy began at any facility as part of first course treatment. If Other Therapy was not administered, leave the date field blank. If Other Therapy was known to have been given, but the date is unknown, enter 9's.

| | |
|---|---|
| 00000000 | NO OTHER THERAPY ADMINISTERED; AUTOPSY ONLY CASE |
| 99999999 | UNKNOWN IF ANY OTHER THERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY. |

## VI.9 Protocol Participation

Beginning with cases diagnosed January 1, 2001, the CCR requires that this field be collected and transmitted to the CCR. The codes are as follows:

| | |
|---|---|
| 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

## VII.1 Follow-Up Information

A very important aspect of the California cancer reporting system is the annual monitoring of patients throughout their lives to ascertain survival rates. If any follow-up information is available before an abstract is submitted, include it in the abstract.

Hospitals with cancer programs approved by ACoS must update follow up data annually (consult ACoS Guidelines for requirements). Obtain the information from medical records (if the patient has been readmitted), the patient's physician, contact letters, and telephone calls. Any follow-up information obtained must be reported to the CCR. ***The CCR also requires follow-up on all benign and borderline CNS tumors as well as borderline ovarian tumors from ACoS approved facilities.***

The CCR does not require follow-up for class 0 cases, diagnosed January 1, 2006 and forward. The CCR requires follow-up for class 0 cases diagnosed prior to 2006. This is consistent with the CoC follow-up requirement change for 2006.

Annual follow-up is not required for a hospital 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. For example, if a hospital elects not to follow non analytic cases, the CCR will not expect to receive follow-up information for such cases.

## VII.1.1 Required Data

Some follow-up data items are optional for reporting to the CCR but might be required by the ACoS, for shared follow-up involving other institutions, or by the reporting hospital for in house data.

The CCR's required items are:

- Date of Last Patient Contact
- Vital Status
- Date Last Tumor Status
- Tumor Status
- Last Follow up Hospital
- 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 hospital 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 Currency of Information

Currency is defined as contact with the patient within 15 months of the date the follow up is reported.

Although current information is preferred, updated information that is not current should still be reported.

## VII.1.4 Shared Follow-Up

In those cases where a patient is being followed by more than one hospital, the regional registry may designate a hospital 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 hospital 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 hospital registry's submission of more current information about its patients. Shared follow up is instituted only by agreement among participating hospitals 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 on the basis of Date of Diagnosis and Date of Last Contact.

## VII.2.1 Date of Last Contact

Enter the date the patient was last seen or heard from or the date of death. Do not enter the date the information was forwarded or received.

If no follow up information has been received, enter the date of discharge from the hospital. Never use the code for unknown year, "9999," and do not leave the field blank. (For instructions about entering dates, see Section I.1.6.4.)

All abstracts submitted for a patient must contain the same Date of Last Contact.

## VII.2.2 Vital Status

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.

The codes are:

0 DEAD

1 ALIVE

## VII.2.3 Date Last Tumor Status

Enter the date of the last information obtained on the primary (tumor) being followed. This field has been added for patients with multiple primaries.

## VII.2.4 Tumor Status

Summarize the best available information about the status of the tumor on the date of last contact. The field applies only to the tumor for which the abstract is submitted, regardless of any other tumors the patient might have.

The codes are:

1 FREE—NO EVIDENCE OF THIS CANCER

2 NOT FREE—EVIDENCE STILL EXISTS OF THIS CANCER

9 UNKNOWN—STATUS OF THIS CANCER 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.

Codes:

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

Reporting hospitals may use another coding system or scale adopted by the hospital's cancer committee.

## VII.2.6 Last Type of Follow-Up

There are two fields which are to be used to enter the source of the most recent follow-up information about the patient:

- Last Type of Tumor Follow-Up
- 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 recent information on the tumor being followed. Reporting hospitals ordinarily use codes from the first of the three following groups, i.e., 00-15, unless instructed otherwise by their regional registry.

Follow-up obtained by hospital from:

00 ADMISSION BEING REPORTED

01 READMISSION TO REPORTING HOSPITAL

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 HOSPITAL

09 OTHER SOURCE

11 TELEPHONE CALL TO ANY SOURCE

12 SPECIAL STUDIES

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

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 hospitals or 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 recent information about the patient being followed. Reporting hospitals ordinarily use codes from the first of the three following groups, i.e., 00-15.

Follow-up obtained by hospital from:

00 ADMISSION BEING REPORTED

01 READMISSION TO REPORTING HOSPITAL

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 HOSPITAL

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

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

***48*** *Research Study Follow Up*

50 CMS (CENTER FOR MEDICARE & MEDICAID SERVICES)

51 COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES FILE

52 CALIFORNIA MEDICAL REVIEW INC

53 COMPUTER MATCH WITH HMO FILE

54 COMPUTER MATCH WITH VOTER REGISTRATION 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 FILE

59 COMPUTER MATCH, OTHER OR NOS

60 OTHER SOURCE

61 SOCIAL SECURITY - SSN

62 SPECIAL STUDIES

65 COMPUTER MATCH WITH OSHPD HOSPITAL DISCHARGE DATA BASE

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 hospitals or 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

Unknown Source

99 SOURCE UNKNOWN

**California Cancer Registry Volume I: Data Standards and Data Dictionary**

**Source:***Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals (California Cancer Reporting System Standards, Vol. I).*

**Updated:** May 43, 2008.

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## VII.2.7 Last Follow-Up Hospital

Enter the ten-digit code (beginning with 4 leading zeros), ***NPI number*** or name of the hospital, facility, or agency that provided the most recent follow-up information. See Appendices F1 and F2 for codes.

## VII.2.8 Next Type Follow-Up

Record the method of obtaining follow-up information about the patient for the next report. If the patient has died, leave the field blank.

The codes are:

0 SUBMIT A REQUEST FOR THE PATIENT'S CHART TO THE REPORTING HOSPITAL'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 HOSPITAL

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)

Foreign residents may be followed at the hospital's option, in which case do not use code 8.

## VII.2.9 Next Follow-Up Hospital

Enter the ten-digit code or ***NPI number if available*** or name of the hospital, facility, or agency responsible for the next follow-up of the patient. See Appendices F1 and F2 for codes.

Leave the field blank if the patient is deceased or not to be followed.

## 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. If a different physician is to receive the next follow-up letter, enter that physician's name or code number. (For instructions about entering codes, see Section III.3.12.1.)

**January 1, 2007 and Forward**

Beginning with cases diagnosed January 1, 2007, if available, enter the physician NPI code, in the respective field. See Appendix X for further details.

## VII.2.11 Alternate Medical Record Number

An alternate medical record number, such as the patient's record number at the next follow-up hospital, may be entered for the convenience of the hospital performing the follow-up. (The Alternate Medical Record Number field should usually be changed if the Next Follow-up Hospital field is changed.) The item is not required, and is not ***transmitted to the CCR.***

## VII.2.12 Recurrence Information

If a patient's primary tumor recurred after a period of complete remission, the Date of First Recurrence and Type of First Recurrence must be coded by American College of Surgeons-approved registries. The data are optional for reporting to the California Cancer Registry. Code only the first recurrence and do not update the fields except to correct data entry errors.

## VII.2.12.1 Date of First Recurrence

Enter the date of first recurrence of a primary tumor that recurred after a period of complete remission. See Section I.1.6.4 for 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.

## VII.2.12.2 Type of First Recurrence

Enter one of the following codes to indicate the type of first recurrence:

| | |
|---|---|
| 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 ASCITIC FLUID. |
| 52 | DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE LUNG ONLY. LUNG INCLUDES THE VISCERAL PLEURA. |

| | |
|---|---|
| 53 | DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE PLEURA ONLY. PLEURA INCLUDES THE PLEURAL SURFACE OF ALL STRUCTURES WITHIN THE THORACIC CAVITY AND/OR POSITIVE PLEURAL FLUID. |
| 54 | DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE LIVER ONLY. |
| 55 | DISTANT RECURRENCE OF AN INVASIVE TUMOR IN BONE ONLY. THIS INCLUDES BONES OTHER THAN THE PRIMARY SITE. |
| 56 | DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE CNS ONLY. THIS INCLUDES THE BRAIN AND SPINAL CORD, BUT NOT THE EXTERNAL EYE. |
| 57 | DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE SKIN ONLY. THIS INCLUDES SKIN OTHER THAN THE PRIMARY SITE. |
| 58 | DISTANT RECURRENCE OF AN INVASIVE TUMOR IN LYMPH NODE ONLY. REFER TO THE STAGING SCHEME FOR A DESCRIPTION OF LYMPH NODES THAT ARE DISTANT FOR A PARTICULAR SITE. |
| 59 | DISTANT SYSTEMIC RECURRENCE OF AN INVASIVE TUMOR ONLY. THIS INCLUDES 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 UNKNON WHETHER THE DISEASE HAS RECURRED OR IF THE PATIENT WAS EVER DISEASE-FREE |

NOTE: The Distant Recurrence Sites field has been removed and incorporated into the Type of First Recurrence field.

## VII.2.13 Death Information

If the patient has died, enter the code for the state or country where the death occurred in the Place of Death field. (The code for California is 097. See Appendices C and D for other codes.) If the patient is still alive, enter 997. Hospitals are not required to complete the Cause of Death field or DC (Death Certificate) File No. field.

To report that a patient has died, make every attempt to find the month and year of death. Approximations are acceptable when all attempts to find the date of death have failed.

## VII.2.14 Follow-Up Remarks

***This section was software specific and deleted in 2008. The information entered here was not transmitted to the CCR.***

## VII.3 Contact Name/Address File

The Contact Name/Address File is for generating follow up letters to the patient or designated contact(s). Space is provided for the name and address of the patient 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. But in the Phone field, enter the area code and number without spaces, dashes, or other marks.

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 40 characters.

## VII.3.1 Follow-Up Resources

***This section was software specific and deleted in 2008.***

## VII.3.2 Contact #

In the Contact #1 fields enter the following:

- The patient's name preceded by Mr., Mrs., Ms., or followed by Jr. or Sr. (up to 30 characters and spaces
- The current street address or post office box (up to 40 characters and spaces
- The current city (up to 20 characters and spaces
- The two character Postal Service abbreviation for the state (see Appendix B for abbreviations
- The zip code (up to ten characters and spaces

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 may be different for subsequent primaries. Update this data item if a patient's address changes. This supplemental field is limited to 40 characters.

## VII.3.3 Contacts #2 through #6

***If available in abstracting software,*** enter the names, addresses, and phone numbers of up to six people designated as contacts for the case.

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--Suppl should be the same. This supplemental field is limited to 40 characters.

# Part VIII. Remarks and Extra Hospital Information

## VIII.1 Remarks *and Final Diagnosis*

Textual information that does not fit into its designated field can be recorded in the Remarks area. Indicate the name of the field being extended and enter the overflow information. Also record other pertinent information for which there is no designated field.

The last two lines of this section are available for recording the final cancer diagnosis (FDX) as determined by a recognized medical practitioner. 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.***

## VIII.1.1 Required Data Items

Certain required data must be recorded in the Remarks section:

Other tumors See Section II.2.5.

Race of patient, when coded as "Other" or if there is conflicting race information. See Section III.2.9.

Parent or guardian of a child whose case is being reported. (Information about the parent is also entered in the Contact #1 area. Section VII.3.2.

## VIII.1.2 Confidential Remarks

***This section is software specific and will be removed after 2008.***

In the Confidential Remarks field, enter sensitive information that is not required by the CCR but which the hospital wants to collect - for example, the patient's history of alcohol or drug abuse, abortions, sexual preference, diagnosis of AIDS or HIV status. The information will not be transmitted with the abstract.

## VIII.1.3 More Remarks

***This section is software specific and will be removed after 2008.***

Additional confidential text information may be recorded in the More Remarks area. The text in this area will not be transmitted.

## VIII.2 Regional Data

Use of the Regional Data fields is determined by the regional registry, which designates the codes to be entered.

## VIII.3 Extra Hospital Information

The Extra Hospital Information fields (also called User Data) are provided for the convenience of the reporting hospital, which determines how they are to

be used. All the fields may be left blank. The information is not sent to the ***CCR***.

## VIII.4 Clinical Indicators

These fields have been added for use by hospitals. There is space to record up to 30 clinical indicators.

## VIII.5 Tumor History

These fields are available for recording the tumor history of the patient for each tumor.

# Part IX. Transmittal of Case Information and Quality Control

## IX.1 Transmittal of Case Information

The method of transmitting abstracted information to the regional registry varies with each reporting facility. Facilities can either send the information electronically or send hard copy abstracts to their regional registry. All electronic data that are mailed or transmitted in any form between cancer reporting facilities and regional registries must be encrypted and password protected.

Paper abstracts should be placed in an envelope that is sealed, marked confidential, and accompanied by a statement on the outside alerting the recipient that the sealed envelope contains confidential information that is intended for the regional registry. The statement should request that if the person who receives the confidential package is not the intended recipient, they should return it to the sender. The sealed, marked envelope with attached statement should then be placed in another envelope and sent by a secure delivery service including U.S. Post Office (first class) or some form of traceable, delivery service.

This policy also pertains to abstracts returned to the facility from the regional registry for inquiries or corrections.

The frequency of transmittals must be arranged between the reporting hospital and the regional registry, but must be quarterly at least. For very large hospitals, monthly or even weekly transmittals might be appropriate to allow an even work flow at the regional registry.

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## IX.1.1 Timeliness

Submit all reports to the regional registry assigned to the reporting hospital. Unless the regional registry requests an immediate report on a patient or patients, do not submit an abstract until all the required information has been entered, but no later than six months after admission of the patient.

## IX.1.2 CORRECTIONS

If errors or omissions are discovered after an abstract has been transmitted, the corrections and the reason they were entered must be sent to the regional registry if any of the following fields is changed.

Accession Number

Address at Diagnosis - City

Address at Diagnosis - No. & Street

Address at Diagnosis - Supplemental

Address At Diagnosis - State

Address At Diagnosis - Zip Code

***Address At Diagnosis City USPS***

Alias First Name

Alias Last Name

Ambiguous Terminology Diagnosis

Behavior Code ICD-O-3

Birth Date

Birthplace

Casefinding Source

Chemotherapy at This Hospital

Chemotherapy Summary

Class of Case

Comorbidity/Complication 1

Comorbidity/Complication 2

Comorbidity/Complication 3

Comorbidity/Complication 4

Comorbidity/Complication 5

Comorbidity/Complication 6
Comorbidity/Complication 7
Comorbidity/Complication 8
Comorbidity/Complication 9
Comorbidity/Complication 10
County of Residence at Diagnosis
CS Tumor Size
CS Tumor Size/Extension Evaluation
CS Extension
CS Lymph Nodes
CS Lymph Node Evaluation
CS Metastasis at Diagnosis
CS Mets at Diagnosis Evaluation
CS Site Specific Factor 1
CS Site Specific Factor 2
CS Site Specific Factor 3
CS Site Specific Factor 4
CS Site Specific Factor 5
CS Site Specific Factor 6
***CS Tumor Size/Ext Evaluation***
***CS Reg Nodes Evaluation***
***CS Mets Evaluation***
Date of Chemotherapy
Date of Conclusive Diagnosis
Date of Diagnosis
Date of Diagnostic or Staging Procedures
Date of First Admission
Date of Hormone Therapy
Date of Immunotherapy
Date of Inpatient Admission
Date of Inpatient Discharge
Date of Most Definitive Surgery
Date of Multiple Tumors

Date of Other Therapy
Date of Radiation Therapy
Date of Surgery
Date of Surgery - Procedure 1
Date of Surgery - Procedure 2
Date of Surgery - Procedure 3
Date of Systemic Therapy
Date of Transplant/Endocrine Procedures
Derived AJCC T
Derived AJCC N
Derived AJCC M
Derived AJCC Stage Group
Derived SS2000
Derived SS1977
Diagnostic Confirmation
Diagnostic or Staging Procedures at This Hospital
Diagnostic or Staging Procedure Summary
Discovered by Screening
***DxRx Report Facility (1-5)***
***DxRx Report Number (1-5)***
***DxRx Report Date (1-5)***
***DxRx Report Type (1-5)***
Extent of Disease - Extension
Extent of Disease - Extension (Path)
Extent of Disease - Lymph Node Involvement
First Name
Histology - Behavior - (ICD-O-2)
Histology - Type - (ICD-O-3)
Histology - Grade/Differentiation
Histology - Type - (ICD-O-2)
Hormone Therapy at This Hospital
Hormone Therapy Summary
Hospital Number (Reporting)

Hospital Referred From
Hospital Referred To
ICD Revision Comorbidities
Immunotherapy at This Hospital
Immunotherapy Summary
Industry - Text
Last Name
Laterality
Maiden Name
Marital Status
Medical Record Number
Middle Name
Mother's First Name
Multiple Tumors Reported as One Primary
Multiplicity Counter
Name Suffix
Number of Regional Lymph Nodes
NPI Hospital Referred From
NPI Hospital Referred To
NPI Following Registry
NPI Physician Managing
NPI Physician Follow-up
NPI Physician Primary Surgeon
NPI Physician Radiation Oncologist
NPI Physician Medical Oncologist
NPI Reporting Facility
Examined - Summary
Occupation - Text
Other Therapy at This Hospital
Other Therapy Summary
Pathology Report Number - Biopsy/FNA
Pathology Report Number - Surgery
Patient No Research Contact Flag

Payment Source (Primary & Secondary)
Payment Source Text (Primary)
Pediatric Stage
Pediatric Stage Coder
Pediatric Stage System
Physicians
Protocol Participation
Race 1
Race 2
Race 3
Race 4
Race 5
Radiation Summary
Radiation - Regional Rx Modality
Radiation - Boost Treatment Modality
***Radiation - Location of RX***
Radiation/Surgery Sequence
Reason No Radiation
Reason for No Surgery
Regional Data
Regional Nodes Examined (Number)
Regional Nodes Positive (Number)
Religion
Scope of Regional Lymph Node Surgery at This Hospital
Scope of Regional Lymph Node Surgery - Procedure 1
Scope of Regional Lymph Node Surgery - Procedure 2
Scope of Regional Lymph Node Surgery - Procedure 3
Scope of Regional Lymph Node Surgery - Summary
Scope of Regional Lymph Node Surgery 98-02
Sequence Number - Hospital
Sex
Site - Primary (ICD-O-2)
Social Security Number

Social Security Number Suffix
Spanish/Hispanic Origin
Summary Stage 1977
Summary Stage 2000
Surgical Procedure/Other Site at This Hospital
Surgical Procedure/Other Site - Procedure 1
Surgical Procedure/Other Site - Procedure 2
Surgical Procedure/Other Site - Procedure 3
Surgical Procedure/Other Site - Summary
Surgical Procedure/Other Site 98-02
Surgery of Primary Site at This Hospital
Surgery of the Primary Site - Procedure 1
Surgery of the Primary Site - Procedure 2
Surgery of the Primary Site - Procedure 3
Surgery of Primary Site - Summary
Surgery of Primary Site 98-02
Surgery Summary - Reconstructive
Systemic/Surgery Sequence
Text-Diagnostic Procedures - Physical Examination
Text-Diagnostic Procedures - X-ray
Text-Diagnostic Procedures - Scopes
Text-Diagnostic Procedures - Tests
Text-Diagnostic Procedures - Operative
Text-Diagnostic Procedures - Pathological
Text-Site
Text-Histology
***Text-Staging***
Text Rx-Surgery
Text Rx-Radiation (Beam)
Text Rx-Radiation (Other)
Text Rx-Chemotherapy
Text Rx-Hormone Therapy
Text Rx-Immunotherapy

Text Rx-Other Therapy

Text-Remarks

Text-Final Diagnosis

TNM Coder (Clinical)

TNM Coder (Path)

TNM Edition

TNM M Code (Clinical)

TNM M Code (Path)

TNM N Code (Clinical)

TNM N Code (Path)

TNM Stage (Clinical)

TNM Stage (Path)

TNM T Code (Clinical)

TNM T Code (Path)

Transplant/Endocrine Procedures at This Hospital

Transplant/Endocrine Procedures- Summary

Treatment Hospital Number - Procedure 1

Treatment Hospital Number - Procedure 2

Treatment Hospital Number - Procedure 3

Tumor Marker 1

Tumor Marker 2

Tumor Marker 3

Tumor Marker-CA-1

Tumor Size

Type of Admission

Type of Reporting Source

Year First Seen

In the text field displayed on the screen, enter an explanation of why the changes are being made. If the only reason is that the regional registry notified the hospital of the change or correction, simply enter the word "REGION" (use capital letters), beginning in the first space of the first line in the field.

| Example |
| --- |

A case has been transmitted as an Primary Unknown (site code C80.9), Carcinoma, NOS (histology 8010/3), and Stage Unknown (code 9), based on

a biopsy of the brain. Four months later, the patient dies and an autopsy reveals that, in fact, the cancer was an oat cell carcinoma of the right upper lobe of the lung that had metastasized widely at diagnosis. Change the site code to C34.1, laterality to code 1, histology to 8042/3, and stage to Distant Metastases, code 7. When the request for the reason for the changes appears, enter a statement such as "Autopsy final DX: oat cell CA, RUL lung, mets to left lung, hilar and mediastinal lymph nodes, brain, and liver."

## IX.1.3 DELETIONS

Delete any duplicate records if a case is found to have been abstracted and sent to the regional registry more than once.

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 registry.

## IX.2 Quality Control

The CCR and regional registries have procedures for assuring the quality of the data produced by the reporting system. Staff from both the regional registry and the CCR visit cancer reporting facilities to perform quality control audits. The CCR has established uniform standards of quality for hospital data in three areas: completeness, accuracy, and timeliness.

## IX.2.1 Completeness

Completeness, the extent to which all required cases have been reported, is assessed by a casefinding audit performed at the reporting facility and by the monitoring of death certificates. The minimum acceptable level of completeness for a reporting facility is 97 percent. See Section II, Reportable Neoplasms, for a discussion of which cases must be abstracted. Descriptions of the protocols and procedures for evaluating completeness are available from the CCR.

## IX.2.2 Accuracy

Accuracy is the extent to which the data submitted match the information in the medical record and have been correctly coded. It encompasses accurate abstracting, correct application of coding rules, and correct entry into and retrieval from the computer.

Accuracy is evaluated using various methods:

- visual editing
- computer edits
- reabstracting audits

The CCR's regional registries perform visual editing on ***a percentage*** of the abstracts submitted by hospital registries.  Feedback is provided to hospitals 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 www.ccrcal.org for the current list of visually edited data items.

Non-analytic cases are included in the accuracy rate. The regions visually edit them, although not as extensively as the analytic cases. Review is limited to verifying that there is supporting documentation to validate the coded data fields.

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 hospital's cases that fail an edit. CCR's cases must pass the interfield edits specified in Cancer Reporting in California: Data Standards for Regional Registres 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. See Appendix T for a list of these over-rides. Please follow the instructions provided by your hospital abstracting software vendor for using these flags.

Another method of assessing accuracy is to reabstract cases in the hospitals. A sample of cases from each facility is reabstracted by speciality trained personnel. The measure used is the number of discrepancies found in related categories of items.

## IX.2.3 Timeliness

Timeliness involves how quickly the reporting hospital submits a case to a regional registry after admission of the patient. Regional registries monitor the timeliness of data submitted by hospitals. The standard set by CCR is that 97 percent of cases must be received by the regional 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, it is recognized that some cancer cases undergo treatment later than six-months from the date of admission. If these or other cases are going to exceed the six-month due date, they must be transmitted without treatment data and this must be documented on the abstract. This treatment information must be submitted later in a correction record. These correction records should not be sent in any later than two months after the six-month deadline, or eight months after the date of admission. If these corrections will be sent in later than eight months because treatment has not been completed, the region must be notified.