

California Volume I

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California Volume 1

PREFACE TO THE SEVENTH EDITION

The staff of the Data Standards and Quality Control (DSQC) Unit of the California Cancer Registry would like to present the seventh edition of *Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, Volume I*, revised January 2006. The CCR has switched to a new format for producing Volume I in 2006. The end result is that two versions are available for users. One version is in HTML and is interactive and fully searchable. The other version is a printable, PDF version for downloading. Changes to this document are identified through the use of ***italicized, bolded, maroon-colored font***. We hope that users find the format changes useful and more efficient.

In addition to changes in requirements from the national standard setting agencies for 2006, feedback from hospital registrars and regional registry staff have resulted in modifications and clarifications to this document.

A document summarizing changes for 2006 -- Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, California Cancer Reporting System Standards, Volume I, Summary of Year 2006 Data Changes -- was sent to hospitals and regional registries earlier this year. Another document -- Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, California Cancer Reporting System Standards, Volume I, Changes and Clarifications - 7th Edition - was also sent earlier this year. The first document provided an overview of 2006 data changes. The second document provides a detailed summary of the changes in Volume I, including those related to 2006 data changes.

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, for his technical expertise in transforming this document and Pamela Oakley for making all of the formatting and editing changes.

For reporting facilities in California, please send corrections, comments, and suggestions regarding this manual or requests for additional copies 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 contact the Data Standards and Quality Control Unit at the following address:

California Cancer Registry

Public Health Institute

1700 Tribute Road, Suite 100

This document can be found on CCR's web site at <http://www.ccreal.org>.

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 I. Introduction

Section I.1. Reporting Cancer Statistics

Section 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, or listing, 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 Section of the Department of Health Services (DHS), 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 33 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 Department of Health Services 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.

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 Department of Health Services, 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 informed consent is received from the patient. Section 100330 of the code states:

All records of interviews, written reports and statements procured by the state [D]epartment [of Health Services] 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. A regional registry may modify this policy on the recommendation of its advisory committee representing local medical care facilities and physicians, provided that strict procedures are developed to prevent the disclosure of confidential data about patients.

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.)

I.1.5 Casefinding

The foundation of the State's cancer reporting system is the hospital, and a key to successful registration is a 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.

One component of the State's cancer reporting system is the periodic determination of the vital status and condition of registered patients (see Part VII, Follow up). Case finding should therefore include an identification system for patients who are readmitted to the hospital or are treated on an outpatient basis, whether for the reported cancer or another condition.

Reporting

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). 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 are no longer to be reported to the California Cancer Registry. (Note: Some regional registries have elected not to implement this change. Contact your regional registry with questions about their reporting requirements.)

Beginning 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.

Examples

A patient with active cancer is admitted to the reporting facility with a myocardial infarction and no work up or treatment is done for the cancer. The case does not need to be reported.

A patient admitted to Hospital A with a diagnosis of cancer is sent to Hospital B for a bone scan due to equipment failure at Hospital A. The case must be reported by Hospital A, but does not need to be reported by Hospital B.

A patient with active cancer is admitted to the reporting facility due to a motor vehicle accident and no work up or treatment is done for the cancer. The case does not need to be reported.

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

1. 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.
2. 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.
3. 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.

4. 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.
5. 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.
6. 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's Disease, and leukemia, but excluding basal cell and squamous cell carcinoma of the skin." 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.

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 reportable neoplasms annually. A tumor must be reported if it is diagnosed as cancer by any physician (including a pathologist or radiologist), surgeon, or dentist. (For rules on reportability of neoplasms see Section II.1.)

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). The CCR provides personal computer software, called CNExT (see Section I.2), for preparing the abstracts in accordance with reporting requirements. Although the CNExT abstracting system is emphasized in this manual, the codes and definitions apply to any method of reporting in the California system. Before the introduction of CNExT, data were entered manually on a form called the Confidential Report of Neoplasm. If in doubt about how certain fields should be filled in, the regional registry should be contacted. For use of a computerized abstracting system other than CNExT, consult the system's manual or contact the vendor.

Whatever 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.

The order in which the registrar enters data is up to the individual, except for required identification procedures in CNEXT. Many experienced registrars prefer to fill in the section on diagnostic procedures first, because the various reports contain much of the information needed for key fields. But whatever the order, every required field 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. In most instances, the required number of digits or characters is specified by lines or dots at the bottom of the field. Always start at the left.

I.1.6.4 Entering Dates

When a date is requested, enter the number of the month, then the day, then the four-digit year. On the screen, the fields for the month, day, and year are separated by slashes. 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 Task Force of the American Joint Committee on Cancer. *Collaborative Staging Manual and Coding Instructions*. Version 1.0 Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004, NIH Publication Number 04-5496.

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

Percy, C., VanHolten, V., and Muir, C., eds. *International Classification of Diseases for Oncology*. 2d ed. Geneva: World Health Organization, 1990.

SEER (Surveillance, Epidemiology, and End Results Program). *SEER Extent of Disease—1988 Codes and Coding Instructions*. 3rd ed. [Bethesda]: National Institutes of Health, National Cancer Institute, 1998. NIH Pub. No. 98-1999.

SEER (Surveillance, Epidemiology, and End Results Program). *Summary Staging Guide for the Cancer Surveillance, Epidemiology and End Results Reporting (SEER) Program*. [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, April 1977, reprinted July 1986.

SEER (Surveillance, Epidemiology, and End Results Program). *SEER*Rx Version 1.00. The Cancer Registrar's Interactive Antineoplastic Drug Database*. [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, 2005 (applicable for cases diagnosed January 1, 2005 forward).

SEER (Surveillance, Epidemiology, and End Results Program). *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*. 3d ed. [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, 1994 (applicable for cases diagnosed prior to January 1, 2005).

AJCC (American Joint Committee on Cancer). *Manual for Staging of Cancer*. 6th ed. New York: Springer-Verlag, 2002.

C/NET Solutions. *CNExT User Manual*. [Berkeley]: Public Health Institute, CNEXT Project.

References that are very helpful, although not necessary, for abstracting and coding include:

ACoS (American College of Surgeons Commission on Cancer). *Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data Standards (FORDS)*. Chicago: American College of Surgeons Commission on Cancer, January 2003, revised for 2004.

California Cancer Registry. *California Cancer Registry Inquiry System*.

SEER (Surveillance, Epidemiology, and End Results Program). *SEER Inquiry System: Resolved Questions*.

SEER (Surveillance, Epidemiology, and End Results Program). *SEER Program: Comparative Staging Guide for Cancer*. [Bethesda]: National Institutes of Health, National Cancer Institute, 1993. NIH Pub. No. 93-3640.

SEER (Surveillance, Epidemiology, and End Results Program). *The SEER Program Coding and Staging Manual 2004*, 4th ed. [Bethesda]: National Institutes of Health, National Cancer Institute, 2004. NIH Pub. No. 04-5581.

Shambaugh, E., ed-in-chief. *SEER Program: Self-Instructional Manual for Cancer Registrars*. [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. 2d ed, 1993. NIH Pub. No. 93-1263

Book Seven-Statistics and Epidemiology for Tumor Registrars. 1994.

World Health Organization. *International Classification of Diseases for Oncology*. Geneva: World Health Organization, 1976.

Percy, C., and VanHolten, V. *International Classification of Diseases for Oncology*. 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 workups. 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 computerized 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

Although the American College of Surgeons (ACoS) does not require hospitals to abstract non-analytic cases, a population based registry like California's must record all cases, regardless of place of diagnosis or class of case. For definitions of non-analytic and analytic cases and class of case, see Section III.3.5. The CCR therefore requires that non-analytic cases--classes 3, 4, 5, 7, 8, and 9—be abstracted and submitted to the regional registry.

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

1. Leukemia diagnosed 5/87 in San Francisco, in remission since 6/87, now adm. for treatment of relapse.
2. Colon cancer dx'd 1 year PTA. Now has widespread mets, adm. 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.

For a Class 3 case, CNExT can automatically enter the codes for UNKNOWN or NONE in those fields listed below. Any of the following fields that have been left blank are automatically filled in as shown:

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Field	Code
ADDRESS AT DIAGNOSIS-NO. AND STREET	UNKNOWN
ADDRESS AT DIAGNOSIS—ZIP	99999
BIRTHPLACE	999
DIAGNOSTIC CONFIRMATION	9
FIRST COURSE OF TREATMENT, AT THIS HOSPITAL	00 or 0
FIRST COURSE OF TREATMENT, SUMMARY FIELDS	99 or 9
LAST FOLLOW UP HOSPITAL	0000999999
MARITAL STATUS	9
RACE	99
RADIATION TO CNS	9
RADIATION/SURGERY SEQUENCE	0
REASON FOR NO SURGERY	9
RELIGION	99
SPANISH SURNAME/ORIGIN	9

STAGE AT DIAGNOSIS	9
TUMOR STATUS	9

I.2 CNE_xT

To facilitate the compilation and reporting of cancer data, the CCR has developed a computerized system that enables hospital registrars to enter the required information on personal computers. Called CNE_xT, the system provides reporting hospitals with a number of advantages over the old method of entering data manually on the Confidential Report of Neoplasm forms:

- Many codes are entered automatically.
- On-line help manuals from the California Cancer Registry - Volume I, NAACCR, SEER, and the ACoS FORDS.
- Prompts on the screen help registrars enter information correctly.
- Any case can be updated easily in a few minutes.
- Edits are performed on each record before it is added to the master file, as a quality control.
- Transmittal of cases and corrections to the regional registry is simplified.
- Lists of patients due for their annual follow-up are generated automatically.
- The reporting hospital has convenient access to data for producing summary reports and statistics, computing survival rates, and responding to requests for information.

The CCR provides CNE_xT software free of charge to reporting hospitals in California, and regional registries provide ongoing and free support for users of the system.

Part II. Reportable Neoplasms

Section II.1. Determining Reportability

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](#)Section II.1.4). Neoplasms described by terms synonymous with in situ are reportable (see [Section V.5.8.1](#)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.

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, and for successful use of the data by 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.

II.1.2.1 Metastasis.

Be careful to distinguish metastatic lesions from new primaries. Metastasis is the dissemination of tumor cells from the primary site to a remote part of the body. The new lesion is not a primary tumor. Again, the 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. If a patient has two or more independent primary tumors—that is, multiple neoplasms—each one must be abstracted and reported. (For definitions and rules, see Sections II.1.3 and V.1.)

Single and Multiple Primaries

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. For determining histology, remember that differences in histologic type are based on the first three digits of the histology code except for lymphatic and hematopoietic cancers.

II.1.3.1 Single Primaries.

Under the rules, 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 Sections V.1 and 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.

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:

Paired Sites

Breast Ductal and Lobular Carcinomas

Lymphomas, Leukemias, Multiple Myeloma--Subsequent Diagnoses

Other Single and Multiple Primaries

II.1.3.3 Paired Sites

(See Section V.2 for discussion of laterality.) 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:

1. Bilateral ovarian primaries of the same histologic type, diagnosed within two months of each other.
2. Bilateral retinoblastomas.
3. Bilateral Wilms' tumors.

II.1.3.4 Breast Ductal and Lobular Carcinomas.

Prepare a single abstract for certain combinations of ductal and lobular carcinomas occurring in the same breast within two months of each other (see Section V.1 for coding the primary site). ICD-O-2 has assigned morphology 8522 to this combination. Code as follows:

- Infiltrating duct carcinoma (8500/3) and lobular carcinoma (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's Disease.

Enter code 8543/3 for a combination of intraductal carcinoma (8500/2) and Paget's 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. 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-3 table in Appendix R. If both diagnoses are prior to January 1, 2001, use the ICD-O-2 table below.

(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 disease¹ (9650-9667)

(2) Malignant lymphoma, NOS² (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 lymphoma³ (9591-9595, 9670-9686, 9688, 9690-9698, 9702-9717)
- Hodgkin's disease³ (9650-9667)
- True histiocytic lymphoma (9723)
- Plasmacytoma³ 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 lymphoma² (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, NOS¹ (9590)

Non-Hodgkin's lymphoma¹ (9591-9595, 9670-9686, 9688, 9690-9698, 9702-9717)

True histiocytic lymphoma (9723)

Plasmacytoma³ 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)

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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)

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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 lymphoma² (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 disease³ (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 disease³ (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 lymphoma² (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, NOS² (9590, 9591)
Non-Hodgkin's lymphoma^{1, 2} (9592-9595, 9670-9688, 9690-9698, 9702-9717)
Mycosis fungoides or Sezary's disease¹ (9700, 9701)
True histiocytic lymphoma (9723)
Leukemia, NOS (9800)
Acute leukemia, NOS (9801)
Chronic leukemia (9803)
Lymphocytic leukemia¹ (9820-9828)
Plasma cell leukemia¹ (9830)
Lymphosarcoma cell leukemia¹ (9850)
Hairy cell leukemia¹ (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)

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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:

Plasmacytoma³ 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)

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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 leukemias¹ (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.1.3.7-8 Single and Multiple Primaries, Other

II.1.3.7 Kaposi's Sarcoma.

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

II.1.3.8 Familial Polyposis.

Prepare one abstract when multiple independent carcinomas of the colon-or the colon and rectum-are reported for a patient with familial polyposis. Code the primary site as C18.9 and the histology as 8220/3.

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):

8000-8004 Neoplasms, malignant, NOS, of the skin

8010-8045 Epithelial carcinomas of the skin

8050-8082 Papillary and squamous cell carcinomas of the skin

8090-8110 Basal cell carcinomas of the skin

II.1.4.1 Exceptions.

Note the following exceptions:

Genitalia. Report all carcinomas of the external genital organs, including the vulva, scrotum, and penis (ICD-O-2 site codes C51.9, C63.2, and C60.9).

ACoS Requirements. Hospitals may include other sites to comply with the requirements of the American College of Surgeons or the hospital's cancer committee. However, these should not be reported to the regional registry.

II.1.4.2 Reportable Skin Tumors.

All other malignant tumors of the skin, such as adnexal carcinomas (e.g., carcinomas of the sweat gland, sebaceous gland, ceruminous gland, and hair follicle), adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumor must be reported regardless of site. Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in 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.

II.1.6.1 Reportable.

Report the tumor if any of the following terms is used:

Apparently (malignant)

Appears to*

Comparable with*

Compatible with (a malignancy)*

Consistent with (a malignancy)

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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. *

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 should 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. NRHD 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, see Section VI.7.

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 still requires 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)

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.

Reportable Terminology. For non-malignant brain and CNS primaries, the terms "tumor" and "neoplasm" are diagnostic and reportable. 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. In order to be reportable, there must be a corresponding ICD-0-3 histology code for any CNS tumor related diagnosis.

II.1.9.2 Determining Multiple Primaries. Determining the number of primaries for non-malignant CNS tumors requires a review of the following:

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 rubric. 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 groupings to determine same histology for non-malignant brain tumors

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 single primary
- If same site and same histology and laterality is both sides then separate primaries

Counting Non-Malignant Primaries

Same 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	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	NA	1	1	1	2*	2*	2*
M	M	< 2	2*	2*	2*	2*	2*	2*
M	B	2 +	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	NA	2**	2**	2**	2	2	2
M	M	< 2	2	2	2	2	2	2
M	B	2 +	2	2	2	2	2	2

B = Benign/borderline tumor

M = Malignant tumor

II.1.9.3 Date of Diagnosis. Since 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.

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.

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.

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

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.

II.1.9.8. Staging.

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

Section II.1, Determining Reportability

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
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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

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

Section II.2. Abstracting: Preliminary Procedures

Section 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. Before abstracting a case, use CNExT's Name Search function to ascertain whether the patient already has an accession number. If the patient does not, an accession number must be assigned. (NOTE: On some screens CNExT displays the accession and sequence numbers as an eleven-digit accession/sequence number, while on others the numbers appear in separate fields. Registrars using the manual form should consult the regional registry about assigning accession and sequence numbers.)

II.2.1 Year First Seen

A request for the year first seen appears on the Abstract New Case screen. 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. Assigned 1993 as the year first seen for this primary.

II.2.2 CNExT Generated Numbers

After the first year seen is entered, a nine-digit accession number and two-digit sequence number generated by CNExT appears on the screen. If needed, the numbers can be changed by entering numbers over the suggested values. CNExT will display an error message if you enter a duplicate number.

II.2.3 Accession Number

If a patient had another tumor that was recorded in the hospital's registry, enter the accession number assigned at that time. If this is the first report by the hospital for the patient, use the nine-digit accession number generated by CNExT. Or the hospital may

assign its own accession number in place of CNExT's. The first four digits represent the year first seen for the patient (see Section II.2.1). The last five digits represent the approximate chronological order of the abstracts prepared for that year.

Examples

1. 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.
2. 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.

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

- ..

- 35 THIRTY-FIFTH OF THIRTY-FIVE 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, borderline ovarian tumors and 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 1/1/2003 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, first see Section V.5, Stage at Diagnosis; then, if necessary, Section V.4, Extent of Disease; then, Section V.3.5, Grade and Differentiation. If none reveals 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 00 or 60, one tumor only.

III.1.2.5 Other Tumors

Record on the Remarks screen (see Section VIII.1) 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

Section III.1. Registry Information

Section III.1, Registry Information

Registry Information fields are primarily for identification and document control by the regional registry.

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. If the initials are unknown, enter XXX.

III.1.2 Suspense Flag

When adding a new case in CNExT, choose from the four options for suspense flag: potential, initiated, non-reportable, or historic. CNExT automatically edits the abstract to make sure all required entries have been made, and a message lists omissions. When a case passes edits, you have the option of setting the case to complete or holding it for further treatment information. When completed, the abstract is placed in a queue for transmission to the regional registry.

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

The year first seen, accession number, and sequence number for the case (see Sections II.2.1, II.2.3, and II.2.4, respectively) are displayed.

Enter corrections by highlighting, then typing over the old number(s).

III.1.4 Reporting Hospital

Enter the reporting hospital's CCR assigned code or the hospital's name. In CNExT, select the hospital from the Reporting Hospital drop-down list. *Reporting facilities by code or alphabetic listing can be found on the CCR web site at:*

http://www.ccrca.org/edits/CA_Hosp_Codes_by_code.pdf

http://www.ccrca.org/edits/CA_Hosp_Codes_by_name.pdf

III.1.5 CNExT Automatic Entries

The following fields on CNExT (under Registry/Activity History) are entered automatically by the system:

Date Case First Entered

Date Case Completed (appears when case becomes complete)

Coding Procedure (designates the set of codes and rules used to abstract and edit the case.)

Date Case Last Changed

Source Of Change

Follow up Last Changed

Tumor Record Number

Sequence Number

Vendor Version

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.

Section III.2. Patient Information

Name

Section III.2, Patient Identification

III.2.1 Name

The CCR and regional registries rely on patient identification information for matching data in the abstract with data about the patient from other sources. It is imperative, therefore, that hospitals use the same rules for entering names, dates, and other information

Enter the patient's last name, first name, middle name, maiden name, and any known alias. Begin at the far left of each field, and do not enter any 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. (On the Contact screen-see Section VII.3-names may be entered in order, and with prefixes and suffixes, suitable for addressing correspondence.)

III.2.1.1 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.

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.

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.2.1.5-6 Alias

III.2.1.5 Alias Last Name.

In the Alias Last Name Field enter up to 15 characters of:

- 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 of:

- An alias (also known as, or AKA) first name used by the patient.

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 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

2. Religious name: Sister Mary Anthony

Secular name: Smith (first name unknown)

Report as: (last name) Smith

(first name) Sister

(alias) Anthony

3. 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. The CCR would prefer that this field be used to capture such name suffixes as Jr, Sr, III, IV and that MD, PhD not be entered. They can be used, but will be stripped off at the regional 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 not available, this field may be left blank.

III.2.2 Medical Record Number

Enter the medical record number assigned to the patient at the reporting 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, leave the field blank or enter a code meaningful to the hospital. This field should not be left blank. When entering a number, always start in the first space. 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

Leave the field blank.

III.2.4 Phone Number (Patient)

This field is to be used for entering the patient's current telephone number including the area code. If there is no phone, enter all 0's. If the phone number is unknown, leave blank. When the telephone number is changed during follow up, this field should be updated with the most current telephone number. (CNExT automatically keeps this field consistent with the Contact #1 (Patient) telephone number.)

Address at Diagnosis**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 current address. (The patient's current mailing address is entered on the Contact screen for follow up purposes.) 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 regional registries use automated data processing methods that reject non-standard entries. The data are used for grouping cases by geographical 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

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."

A new 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.2.5.2 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"). Certain abbreviations may be used (consult the regional registry for acceptable abbreviations). 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.2.5.2 Data Entry, State

For states in the U.S. and Canadian provinces, enter the standard two letter Postal Service abbreviation. (California is CA. For other states, U.S. Territories and Canadian provinces, see Appendix B.) For U.S. Territories with a postal abbreviation, such as Guam (GU), use the abbreviation or if no postal abbreviation enter "ZZ," not applicable. If the residence was in the U.S. or Canada, but the state or province is unknown, or the place of

residence is unknown, enter "ZZ." For residents of countries other than the U.S. and Canada, and the country is known, enter "XX". For residents of countries other than the U.S. and Canada, and the country is unknown, enter "YY".

III.2.5.2 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. If the patient resided outside the U.S. or Canada at time of diagnosis and the zip code is unknown, enter 8's in the entire field. 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.2.5.2 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 the codes used. CNExT automatically supplies the code if the county's name is entered.) Consult maps or reference works as needed to determine the correct county. Enter code 000 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). If residence was in a foreign country, enter the country and CNExT will supply the code. (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.2.6 Marital Status

Studies have shown a correlation between marital status and the incidence and sites of cancer, and that these patterns are different among races. So that further analyses can be carried out to identify high risk groups, report the patient's marital status at the time of first diagnosis. Use the following codes:

- 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

III.2.8 Religion

Enter the code for the patient's religion or creed, or enter the name of the religion and CNEXT automatically provides the code. CNEXT currently defaults this field to 99. 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

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- 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

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- 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 BAHAI
- 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; VODOO
- 92 SHAMANISM
- 93 OTHER TRADITIONAL OR NATIVE RELIGION
- 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.

Race and Ethnicity

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 different ethnic groups generate hypotheses for researchers to investigate. 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.

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

Scenarios Demonstrating Conflicting Race Information:

A Name: June Hashimoto

Race: White

Birthplace: Unknown

Marital Status: Single

B Name: Bob Nguyen

Race: White

Birthplace: Mexico

C Name: Robert Jackson

Race: Mexican

Birthplace: California

D Name: Moon Smith

Race: Japanese

Birthplace: California

Marital Status: Married

E Name: Maria Tran

F Name: Carlos Johnson

Race: White

Race: Black

Birthplace: Spain

Ethnicity: Hispanic

Marital Status: Separated

Marital Status: California

G Name: Arlene Thompson

Race: Filipino

Birthplace: California

Marital Status: Divorced

A text statement indicating patient’s race, i.e., “Pt is Japanese”, is required for conflicting types of cases. This information must be entered in either the physical exam or remarks text fields.

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 continue to document race in the physical exam or remarks fields.

Remember to search beyond the facesheet 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 have been 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. 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.

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.

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.

1. 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 Editing Guidelines below for further instructions.
2. If a person's race is a combination of white and any other race(s), code to the appropriate other race(s) first and code white in the next race field.

3. 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).

Examples: 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.

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

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].

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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.

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

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.

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.

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

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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).

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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
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 of population. Included are people whose native tongue is Spanish, who are nationals of a

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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 Hispanic 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. 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

1. A woman whose married surname is Gonzales but who is stated to be of Japanese origin should be coded 0.
2. A patient who is stated to be South American but does not have a Spanish surname should be coded 4, South or Central American.
3. 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.2.10 Birth Date

When recording a patient's date of birth, enter the month first, then the day, then the year (see Section I.1.6.4). Always use two digits for the month and day, and four digits for the year. If the month or day has one digit, enter 0 before the number. 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. If the year is not known, enter 9999 and also code the month and day as

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unknown. If the record only states the patient's age, calculate the year by subtracting the age from the diagnosis date. 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 calculated automatically by CNExT if the birth date and diagnosis date are entered.

entry available

Section III.2, Patient Identification

III.2.12 Birthplace

Enter the name of the state, territory, or country where the patient was born. CNExT automatically enters the code. If the birth place is in the United States, but the state is not known, enter 000. If the place of birth is not known, enter 999.

[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 or regional registry 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. Enter—

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 a research study(ies), this flag should remain set to 0. Code 1 - Hospital First Notified - would be entered. Codes 2 and 3 are for regional and

central registry use. The regions will share this information with each other during routine case sharing between the regions. 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. CNExT 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

Section III.3. Case Identification

Section III.3, Case Identification

III.3 Case Identification

While some of the data reported on the Case Identification screen are only for identification and document control, the [Date of Diagnosis](#) 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. (The previously entered Year First Seen [see Section II.2.1 [Section II.2.1](#)] is displayed on the screen and can be corrected by typing over the old numbers.)

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 (see Section I.1.6.4 for entering dates):

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.

III.3.2 Dates of Inpatient Admission and Inpatient Discharge

Enter the dates of the 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 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

1. 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.

2. 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.)

3. 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.3.3.1 Coding.

Enter the month, then the day, then the year. Enter "99" for any unknown part of the date. Day must be entered as unknown if month is unknown. If the year is not known, enter "99999999".

III.3.3.2 Vague Dates.

Following are coding procedures for vague dates:

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, approximate a date when the exact date cannot be determined. It is preferable to approximate a month or year than to 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.3.4 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, code 7 - Pathology Report Only and code 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:

- Patient who elected to be treated elsewhere.
- 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:
 - Patient diagnosed in a physician's office** and admitted to the reporting hospital for all or part of the first course of therapy.
 - 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.
 - Patient diagnosed at reporting hospital who refused treatment.
 - Patient diagnosed at reporting hospital but was not treatable due to age, advanced disease, an unrelated medical condition, or other reason.
 - Specific treatment recommended but not given at reporting hospital, unknown whether given elsewhere.
 - 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:
 - Patient diagnosed at another hospital but not treated until admission to the reporting hospital, regardless of interval between diagnosis and treatment.
 - 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.
 - 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:
 - Patient diagnosed and first course of therapy completed elsewhere, later admitted to the reporting hospital with disease.
 - Unable to determine whether or not treatment given at the reporting hospital was part of the first course of therapy.
 - 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 performed 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 types 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. The field is preset to code 10 when CNEXT is installed at a cancer reporting facility. To enter a different code, type over the 10. The codes are:

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

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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.

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. CNExT left fills this 10 character field with zeros. *The following links on CCR web site list the code numbers of all facilities in California and some out of state facilities:*

http://www.ccrca.org/edits/CA_Hosp_Codes_by_code.pdf

http://www.ccrca.org/edits/CA_Hosp_Codes_by_name.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. CNExT users may leave blank when first entering a case, and CNExT will prefill with 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 can now be 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. ***Go to the CCR web site for the lists codes:***

http://www.ccrca.org/edits/CA_Hosp_Codes_by_code.pdf

http://www.ccrca.org/edits/CA_Hosp_Codes_by_name.pdf

CNExT left fills this 10-character field with zeros. 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. CNExT users may leave blank when first entering a case, and CNExT will prefill with zeros. ***Ten-digit codes for VA facilities can now be 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 numbers. The codes are based on the physicians' California license numbers. As new physicians who treat cancer patients join the hospital staff, they should be added to the roster, with their license 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 have been expanded to nine characters. The CCR, CNExT, and MDLOOK only use eight 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. The same instructions apply for dentists. For osteopaths, enter the entire eight-character code including a leading O (alpha character). The following are examples:

Physician - A00023456 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.

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 if it cannot be determined who the attending physician is, 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. The second field is to be used to enter the referring physician, the third field is to be used for coding the surgeon, the fourth field is to be used for coding the medical oncologist, and the fifth field is to be used for coding the radiation oncologist. The last two fields may be used to code any other physician. The following physician has its 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, however, 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
-

III.3.15 Discovered By Screening (NEW)

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 (defaults to 9). This item is an existing optional data item in CNExT as part of the Department of Defense Data Set. This item 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

Section IV.1. Diagnostic Procedures Performed

IV.1 Diagnostic Procedures Performed

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. ***Reporting diagnostic procedures is optional for non-analytic cases, however a brief statement of the patient's history and reason for the present admission is required. Enter the statement in the Physical Exam text area.*** (See Section III.3.5 for definitions of analytic and non-analytic cases.) 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.

See also:

IV.1.1 General Instructions

IV.1.2 Physical Examination

IV.1.3 X-ray/scans

IV.1.4 Scopes

IV.1.5 Laboratory Tests

IV.1.6 Operative Findings

IV.1.7 Pathology

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. The date of diagnosis entered on the Case Identification screen and on the Cancer ID screen (see Section III.3.3). If the medical records indicate that the case was actually first diagnosed on a different date, make the correction by typing over the date shown in the Date of Diagnosis field.

*It is acceptable to continue into another text field with free space available if text limits have been reached. However, it is important to note into which field the text is continued. A unique non-alpha numeric symbol (such as an * or #) may be used 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 re-use symbols that indicate a continuation.*

IV.1.1.1 Location.

Record where the tumor is located in the primary site, such as the lobe, quadrant, etc.

IV.1.1.2 Size.

When a pathology report describes tumor size as invasive with a minor component of in situ, then code the total tumor size. 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 <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, focal should be coded 999.

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

- o focal adenocarcinoma in 5% of specimen - TS 999

Although the SEER EOD rules state to always code the size of the tumor, not the size of the polyp, ulcer, or cyst, 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.

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.

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 date(s) of the patient's physical examination(s) 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

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, note 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

Note 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 (see Section IV.2), unless more specific information is given in the cytogenetic report. Subcategories of acute myeloid leukemia are described according to cytogenetic abnormalities. If these abnormalities are included in a laboratory report, they take precedence in coding histologic type. The chromosome study or cytogenetic and molecular biological data results can be recorded here. Enter "none" if no pertinent laboratory tests were performed.

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 (see Section VI.2.1-9), record pertinent findings. Note tumor size, if given, and any statements about observed nodes, even if they are not involved.

IV.1.7 Pathology

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. (For details about microscopic diagnoses, see Section IV.2; for grade and differentiation, see Section V.3.5). Also enter the dates, source of specimen(s), pathology report number, size of the largest tumor, and other details needed to:

- Describe the location of the primary site or sub-site and laterality of the primary tumor (see sections V.1 and V.2 for discussions of site and laterality).

- Record the histologic diagnosis and identify the appropriate ICD-O-3 code (see sections V.3.2 and 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.

IV. 1.7.1 Pathology Report Number - Biopsy/FNA

Record the pathology report number for the first positive biopsy or fine needle aspirate (FNA) performed at your facility. This field may be left blank if biopsy/FNA was not performed or the results were negative.

IV.1.7.2 Pathology Report Number - Surgery

Record the surgical pathology report number for the first definitive surgical resection performed at your facility on the patient's cancer. This should be recorded whether there was cancer present or not in the surgical specimen. This field may be left blank if definitive surgery was not performed.

***Pathology Report Number - Biopsy/FNA and Pathology Report Number - Surgery** need not be entered in the text field if there is only one pathology report, or if it is clear from the information recorded which number belongs to which specimen.

Record pathology report numbers in the text field for all additional pathology reports (including outside pathology, if available).

Do not record pathology report numbers from autopsies in these fields.

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, 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 should be studied to determine what methods were used to confirm the diagnosis

of cancer, and the most conclusive method should be coded in the confirmation field. Since 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 with 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. But do not use code 6 if visualization or palpation during surgery or endoscopy is confirmed by a positive histology or cytology report.

7 RADIOGRAPHY WITHOUT MICROSCOPIC CONFIRMATION

Includes all diagnostic radiology, scans, ultrasound, and other imaging technologies not confirmed by a positive histologic or cytologic report or by direct visualization.

8 CLINICAL DIAGNOSIS ONLY (Other than 5, 6, or 7)

Cases diagnosed by clinical methods other than direct visualization and/or palpation during surgery, endoscopy, or gross autopsy, if not confirmed microscopically.

9 UNKNOWN WHETHER OR NOT MICROSCOPICALLY CONFIRMED

(Death Certificate Only cases are included in code 9.)

Part V. Tumor Data

Section V.1. Primary Site

Section V.1, Primary Site

One of the major concerns of the CCR is the identification of the original (primary) site of a tumor -- not the 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.

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

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

A principal way of determining how many primary tumors a patient has is the identification of separate sites (for further discussion of primaries, see Sections II.1.2 and 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. 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.

Example

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. The 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. For diagnoses referring to regions and ill defined sites of the body, such as "head," "thorax," "abdomen," "pelvis," "upper limb," "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. 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
- 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 on the CCR

website: <http://www.ccrca.org>. Click on Registrar Resources, then Data Standards and Quality Control Memorandums, go to 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.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

Code numbers for recording laterality are:

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- 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 (not 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

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- 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

Beginning with cases diagnosed 1/1/2004 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. ***Beginning with cases diagnosed 1/1/2004 forward, all other non-paired sites, including unknown primaries, must be coded to 0.*** Prior to 1/1/2004, completion of this field was optional for sites not listed in Section V.2.2.

Section V.3. Histology, Behavior, and Differentiation

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), and (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

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.

Cases diagnosed prior to January 1, 2001, should 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 on the report, 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. 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. It is always appropriate to ask for advice about coding from a pathologist or clinician familiar with the case. (Be sure to document the physician's answer to your query in a text field.)

V.3.3.1 Sources for Determining Histology.

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 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 (see Section II.1.3). 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. However, 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.

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

- (1) Predominantly lobular with a ductal component. Use the combination code for lobular and ductal carcinoma.
- (2) 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

- (1) Adenocarcinoma (8140/3) of the sigmoid colon with mucin-producing features. Code as mucin-producing adenocarcinoma (8481/3).
- (2) Invasive carcinoma, probably squamous cell type. Code as squamous cell carcinoma (8070/3), because it is more specific than carcinoma, NOS (8010/3).
- (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.

Example

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.

Example

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 (see Section II.1.3 for criteria), apply the following rules:

- 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.3.3.4 Unspecified Malignancies.

For such unspecific terms as "malignant tumor," "malignant neoplasm," and "cancer," enter the code for neoplasm (8000). Do not use the code for a clinically malignant tumor that has not been microscopically confirmed (9990). (For diagnostic confirmation, see Section IV.2.) If a diagnosis is based only on a cytology report stating "malignant cells," use code 8001 (malignant cells, NOS).

V.3.3.5 Metastatic Site.

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.3.3.6 Lymphoma Codes.

Lymphomas present some unique coding difficulties because of the complexity of the classification and the variety of terminologies in use. The following rules will be helpful in choosing the correct ICD-O-3 code for the histologic type:

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- Terminology from the WHO Classification of Hematopoietic Neoplasms (Table 13, pp. 16-18 in ICD-O-3) is preferred over older terminology.
- In the new classification, 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 digit 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.
- Avoid using non specific or unclassified lymphoma terms if there are specific diagnoses that can be coded.
- 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.

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 also Section II.1.3.6 for rules about reporting lymphoma and leukemia.)

V.3.5.8 Bloom-Richardson Grade for Breast Cancer

Beginning with breast cancer cases diagnosed January 1, 1996, the Bloom-Richardson grading system may be used.

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:

1. degree of tumor tubule formation
2. tumor mitotic activity
3. 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

(low power scanning (X100), find most mitotically tumor area, proceed to high power (x400))

<10 mitoses in 10 high-power fields	1
-------------------------------------	---

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>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:

1. Bloom-Richardson scores 3-9
2. Bloom-Richardson grade (low, intermediate, high)
3. Nuclear grade
4. Terminology (well diff, mod diff...)
5. 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

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. Computers used by the CCR and regional registries to edit data submitted by hospitals reject these combinations, and the data must be corrected. Disallowed combinations are of two types—those involving the first four digits of the histology field (morphology code), and 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. The regional registry will provide 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

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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

C76._ 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 Extent of Disease

The ten-digit Extent of Disease (EOD) code has five components: (1) size of the tumor (three digits), (2) extent to which the primary tumor has spread (two digits), (3) lymph node involvement (one digit), (4) number of nodes found positive in a pathological examination of regional lymph nodes (two digits), and (5) 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).

Beginning with cases diagnosed January 1, 1994, Extent of Disease coding will be required for all California reporting facilities, and all EOD fields are to be coded. (Blanks will not be allowed.) 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 will be 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.

Tumor Size, [number of] Regional Nodes Positive, and [number of] Regional Nodes Examined are also required items for hospitals with ACoS approved programs. Please 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 timeframe for assigning codes have been added. In addition, rules for coding have been revised. Please 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 will be effective through 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.5 Stage at Diagnosis

While Extent of Disease is a detailed description of the spread of the disease from the site of origin, stage is a grouping of cases into broad categories—for example, localized, regional, and distant. 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. It is also used by some of the regional registries and a good many hospital registrars. A new Summary Staging Guide will be used with cases diagnosed on or after January 1, 2001. 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-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 sections V.3.4.3 and 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 SEER Extent of Disease Code Manual, 3rd Edition, 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.

A field for recording other staging systems, such as Duke's, is available in CNEXT.

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 (see also 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

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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 (see Section V.3.4) is 2.

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.

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). But 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, stage 1 (localized) may be used. 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" nodules—that is, lesions secondary to the primary one—might not be localized. Refer to the *Summary Staging Guide* 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 (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).

Some 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 axillary 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 regional 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 (sometimes stated in the record as Stage II—see sections V.5.6 and 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 code 2 of the EOD -- Lymph Nodes field, assume those lymph nodes are involved. Mediastinal lymph nodes > 1 cm are considered enlarged.

Section V.6. Tumor Markers

V.6 Tumor Markers

See also:

V.6.1 Tumor Marker 1

V.6.2 Tumor Marker 2

V.6.3 Tumor Marker 3

V.6.4 Tumor Marker California-1

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 requires 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.

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker - Tumor Marker -California 1(Her2/neu) is still a required data item for the CCR and will continue to be collected in its designated field.

V.6.1 Tumor Marker 1

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: < 1,000 NG/ML (S1)
- 5 RANGE 2: 1,000 - 10,000 NG/ML (S2)
- 6 RANGE 3: > 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.

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

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an antigen antibody reaction. If immunostaining results are available, use them to code Estrogen Receptor Status.

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker- Tumor Marker -California 1(Her2/neu) is still a required data item for the CCR and will continue to be collected in its designated field.

V.6.2 Tumor Marker 2

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: < 5,000 mIU/ml (S1)
- 5 RANGE 2: 5,000 - 50,000 mIU/ml (S2)
- 6 RANGE 3: > 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.

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.

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker- Tumor Marker -California 1(Her2/neu) is still a required data item for the CCR and will continue to be collected in its designated field.

V.6.3 Tumor Marker 3

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

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- 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

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker- Tumor Marker -California 1(Her2/neu) is still a required data item for the CCR and will continue to be collected in its designated field.

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). 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

Section V.7. AJCC Staging and Other ACoS Items

V.7 AJCC Staging and Other ACoS Items

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 regional registry and then sent on 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

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), and M (distant metastasis). For those sites not included in the AJCC Manual for Staging of Cancer, the Summary Staging Guide for Surveillance Epidemiology 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. Fill in the digits from left to right, leaving the second digit blank if there is no entry for it.

V.7.3 TNM Stage Basis

TNM Basis indicates the nature of the information on which AJCC staging is based. The *Manual for Staging of Cancer* provides specific recommendations about which information should be used for each type of staging at each primary site. This field has been prefilled for clinical and pathological staging. It only need be completed for Other TNM using the following codes:

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)

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

M1b Lung metastases

M1c Visceral metastasis at any site associated with an elevated serum lactic dehydrogenase (LDH).

V.7.5 AJCC Stage Group (Clinical and Pathological)

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,	99

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

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. This includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 or later. For patients twenty years of age and older, this field would be coded 88 - not applicable. Use code 99 for pediatric leukemia cases. For cases diagnosed

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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. This includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 and later. For patients twenty years of age and older, this field must be coded 88. 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

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- 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-analytical 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 is to be followed. In addition, there is a new definition for leukemias (see Section VI.1.1). Use old 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. (Enter, for example, "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.

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). CCR has adopted the SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd ed. (1994) as its official list of cancer drugs. Consult the manual to identify which drugs constitute cancer directed treatment. (New drugs might not appear in the manual. Include them if they meet the definition of cancer directed treatment here in Section VI.1.2.)

>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 (see Section VI.2 for coding each surgery field), code a summary of the entire first course of treatment. 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. For the convenience of the abstractor, CNExT always displays a 00 in a non-surgery field so that no data entry is required if no treatment of that type was provided. If treatment was administered, type over the 00 when entering the code.

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).

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 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.

Section VI.2. First Course of Treatment: Surgery

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, 1996, the surgery field was separated into three fields: one for surgery of the primary site, one for diagnostic, staging or palliative procedures, and one for reconstructive surgery.

Beginning with cases diagnosed January 1, 1998, new surgery codes, definitions, and fields from the American College of Surgeons have 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.

Beginning with cases diagnosed January 1, 2003, the surgery codes, definitions, and fields have been reformulated again. Surgical Approach, Number of Regional Lymph Nodes Examined, and Reconstructive Surgery have been dropped, and all remaining fields except Surgery of the Primary Site now have a simplified coding scheme; Surgery of the Primary Site has been assigned new site-specific codes, and Reconstructive Surgery has been folded into the Surgery to the Primary Site codes. Again, CNExT converted the codes for older cases to match the new coding scheme. The fields are:

Surgery of the Primary Site

Scope of Regional Lymph Node Surgery

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Surgical Margins

Treatment Hospital

In addition to the new surgery codes from the ACoS, the CCR is requiring that hospitals record multiple surgical procedures performed on a patient. To this end, each of the surgery fields have space to code up to three procedures. There are also three date fields and three fields for entering the code for the treatment hospital.

Cases diagnosed prior to January 1, 2003, must be coded in three new fields using the codes from ROADS. They are:

Surgical Procedure of Primary Site 98-02

Scope of Regional Lymph Node Surgery 98-02

Surgical Procedure/Other Sites 98-02

Note: These fields are to be left blank for cases diagnosed January 1, 2003 and later.

Effective with cases diagnosed January 1, 2004, the CCR requires completion of the surgical procedure at this hospital fields:

Surgery of the Primary Site At This Hospital

Scope of Regional Lymph Nodes At This Hospital

Surgery of Other/Distant Sites At This Hospital

These fields are computed by CNEXT using the procedure and treatment hospital number fields. Facilities not using CNEXT are to enter the code for each of these fields.

[Click here for Codes](#)

[Click here for Codes](#)

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
-

VI.3 First Course of Treatment: Radiation

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.

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.

The field "Radiation Therapy at this Hospital" will no longer be required 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:

Au¹⁹⁸ gold

Co⁶⁰ cobalt

Cr³²PO₄ phosphocol

CrPO₄ chromic phosphate

Cs cesium

I¹²⁵ iodine

I¹³¹ iodine

Ir¹⁹² iridium

P³² phosphorus

Pb²¹⁰ lead

Ra²²⁶ radium

Rn²²² radon

Ru¹⁰⁶ ruthenium

Sr⁹⁰ strontium

Y⁹⁰ 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.

I.3.2 Radiation 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.

The field "Radiation Therapy at this Hospital" will no longer be required by the CCR beginning with cases diagnosed 1/1/2003.

- 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. As stated previously, software conversion of these two fields will generate the Radiation Therapy Summary field.

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. As noted above, this data item and Radiation - Boost RX Modality will be converted to generate the RX Summ - Radiation.

There is no corresponding "At this Hospital" field. 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)

California Volume I

- 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.

*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 field. As noted above, this data item and Radiation - Regional RX Modality will be converted to generate the RX Summ - Radiation. There is no corresponding "At this Hospital" field. 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 OR 3-D THERAPY
- 40 PROTONS
- 41 STEREOTACTIC RADIOSURGERY, NOS
- 42 LINAC RADIOSURGERY
- 43 GAMMA KNIFE
- 50 BRACHYTHERAPY, NOS
- 51 BRACHYTHERAPY, INTRACAVITARY, LDR
- 52 BRACHYTHERAPY, INTRACAVITARY, 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.

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, a new code - 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

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 Site(s), Distant Site(s), or Distant Lymph Node(s) fields) and radiation, use codes 2–9. For all other cases, use code 0.

Section VI.4. First Course of Treatment: Chemotherapy

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. 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: <http://seer.cancer.gov/tools/seerrx/>***

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 DUE TO CONTRAINDICATIONS.
- 85 CHEMOTHERAPY NOT ADMINISTERED BECAUSE THE PATIENT DIED.
- 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

entry available

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

Section VI.5. First Course of Treatment: Hormone Therapy

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. 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: <http://seer.cancer.gov/tools/seerrx/>***

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 dessicated 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

NAACCR *Data Standards and Data Dictionary* entries available

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.

*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: <http://seer.cancer.gov/tools/seerrx/>*

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 has been modified. Codes for transplants and endocrine procedures have been removed and are coded in a separate field called RX Summ - Transplnt/Endocr . The length of this field has been changed from 1 to 2 characters. The codes for reason for no immunotherapy (BRM) given have been incorporated into this scheme. A conversion will be required.

Use the following codes for recording immunotherapy in the Summary field. Use codes 00-87 for recording immunotherapy in the At This Hospital 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.

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 is 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. A conversion will be required for cases prior to January 1, 2003 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 will be requiring this field in order to provide consistency; i.e., all of the other treatment fields except radiation have a hospital-level field.

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.

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.

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.

Section VI.9. Protocol Participation

Beginning with cases diagnosed January 1, 2001, the CCR requires that this field be collected and transmitted to the regional registry and to the CCR. CNExT already includes this data item although it may not have been collected by all facilities in the past. 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 Trails Support Unit]
 - 16- National Trials
50
 - 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 regional registry. 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 cases of carcinoma in situ of the cervix, or non analytic cases, the CCR will not expect to receive follow-up information for such cases. Information entered in the CNExT follow-up information fields is transmitted automatically to the regional registry.

The CCR requires follow-up on all benign and borderline CNS tumors as well as borderline ovarian tumors.

Beginning with cases diagnosed January 1, 2006 forward, the CCR no longer requires follow-up on class 0 cases. Follow-up is still required for class 0 cases diagnosed prior to 2006. This is consistent with the CoC follow-up requirement change for 2006.

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 a contact with the patient in the form of direct response to a letter or phone call to the patient or other contact, a report by the patient's physician, readmission to the hospital as an inpatient or outpatient, or a 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

Information must be current. Currency is defined as contact with the patient within 15 months of the date the follow up is reported. 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. Otherwise, follow-up may be shared without a signed agreement as long as the source is not disclosed. However, 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.

Section VII.2. Follow-Up Data Items

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, not 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

This field has been added for patients with multiple primaries. Enter the date of the last information obtained on the primary (tumor) being followed.

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. The CNEXT codes are:

- 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 that do not have CNEXT may use another coding system or scale adopted by the hospital's cancer committee.

This item is not required by the CCR.

Last Type of Follow-Up

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

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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

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

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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

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- 21 COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES FILE
- 22 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
- 23 COMPUTER MATCH WITH HMO FILE
- 24 COMPUTER MATCH WITH VOTER REGISTRATION FILE
- 25 NATIONAL DEATH INDEX
- 26 COMPUTER MATCH WITH STATE DEATH TAPE
- 27 DEATH MASTER FILE (SOCIAL SECURITY)
- 29 COMPUTER MATCH, OTHER OR NOS
- 30 OTHER SOURCE
- 31 TELEPHONE CALL TO ANY SOURCE
- 32 SPECIAL STUDIES
- 33 EQUIFAX
- 34 ARS (AIDS REGISTRY SYSTEM)
- 35 COMPUTER MATCH WITH DISCHARGE DATA
- 36 OBITUARY

- 37 COMPUTER MATCH WITH CHANGE OF ADDRESS SERVICE
- 38 TRW
- 39 REGIONAL REGISTRY FOLLOW-UP LIST

Follow-up obtained by central (state) registry from:

- 40 LETTER TO A PHYSICIAN
- 41 TELEPHONE CALL TO ANY SOURCE
- 50 CMS (CENTER FOR MEDICARE & MEDICAIDE 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

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- 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

VII.2.7 Last Follow-up Hospital

Enter the ten-digit code (beginning with 4 leading zeros) 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:

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- 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)

* Enter code 7 to suppress routine generation of follow-up letters, but only when all leads have been exhausted. The case will still be counted as "lost" in the CNEXT Follow Up Success Worksheet (see *CNEXT User Manual*), and the hospital is still responsible for following the patient. If code 7, 8, or 9 is used, or if the field is left blank, CNEXT will not select the case for follow-up processing. 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 number 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.)

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 submitted to the regional registry.

Recurrence Information

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 UNKNOWN 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

For the convenience of the hospital, CNExT provides three lines of text area on Screen F for recording information useful in following the patient. Information entered on the line labeled "FU Letter Remarks" can be printed on a follow up letter. Use of the Follow-Up Remarks fields is optional, and information entered there is not sent to the regional registry.

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

Please refer to the CNExT Supplemental Data Manual for instructions in the use of the Follow-up Resources screen. These fields allow the user to customize how follow-up is to be done, e.g., requesting the medical record, writing the patient, etc. The screen may be left blank if the patient is dead.

VII.3.2 Contact #1

In the Contact #1 fields, enter 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), and 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. (CNExT automatically keeps this consistent with the Current Telephone Number field.) Use the 50 character remarks field to record any information that might be useful when the next follow up letter is generated. Information in all Contact #1 fields except the Remarks field is transmitted to the regional registry.

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

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

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. If there is no final diagnosis in the medical record, leave this field blank.

VIII.1.1 Required Data Items

Certain required data must be recorded on the Remarks screen:

- 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 - see Section VII.3.2).

VIII.1.2 Confidential Remarks

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

Additional confidential text information may be recorded in the More Remarks area. The text in this area will not be transmitted or recorded on the CNExT abstract.

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 regional registry.

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

Section IX.1. Transmittal of Case Information

IX.1 Transmittal of Case Information

The method of transmitting abstracted information to the regional registry varies with each reporting facility. Facilities can either mail diskettes, use a modem to 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. For facilities using CNExT software, there is an option allowing them to perform this function before transmitting a file to their regional registry.

Paper or hard copy 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.

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

Alias First Name

Alias Last Name

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

Date of Chemotherapy

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 Other Therapy

Date of Radiation Therapy

Date of Surgery

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

Discovered by Screening

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

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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

Name Suffix

Number of Regional Lymph Nodes

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/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 - Summary

Sequence Number - Hospital

Sex

Site - Primary (ICD-O-2)

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Social Security Number

Social Security Number Suffix

Spanish/Hispanic Origin

Summary Stage

Summary Stage 2000

Surgical Procedure/Other Site at This Hospital

Surgical Procedure/Other Site - Summary

Surgery of Primary Site at This Hospital

Surgery of Primary Site - Summary

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 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

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

When one of the above fields is changed in an abstract that has already been transmitted, CNExT automatically creates a correction record and places it in a file for transmittal. (See the CNExT Online Help Manual for transmittal instructions.) When the new data are entered, CNExT displays a request for the reason for the correction. 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 to the regional registry as 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. Access CNExT's Update Case function to 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 more than once. Also 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. When a case is deleted from the hospital's registry, CNExT generates a deletion record for transmittal to the regional registry. (See the CNExT Online Help Manual for transmittal instructions.) When the case is deleted, CNExT displays a request for the reason for the deletion. Enter an explanation in the text field displayed on the screen.

Example

After a case of "probable lymphoma" had been reported, the patient was referred to a specialty center where additional workup and repeat biopsies were performed. The final diagnosis was changed to "atypical lymphocytic infiltrates," and physicians decided to follow the patient closely but not treat the condition. Since the patient is now deemed not to have cancer, delete the case from the hospital's registry. CNExT automatically creates a deletion record to be used to notify the regional registry, and requests the reason for the deletion. Enter a statement such as "Patient referred to XYZ University, where DX changed to 'atypical lymphocytic infiltrates.' No treatment given. Patient will be followed closely."

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 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.

Regional registries use computer edits to assess the quality of data submitted. The CCR provides a standard set of edits for regions, and many of the same edits are performed on CNExT 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 standards specify that, for computerized data, all submitted codes must be valid as described in this manual and all cases must pass the interfield edits specified in *Cancer Reporting in California: Data Standards for Regional Registries and California Cancer Registry* (California Cancer Reporting System Standards, Vol.3). Data submitted via CNExT automatically meet these standards.

The CCR's software 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. Many hospital registry software programs also contain these over-ride flags. See Appendix T for a list of these over-rides. Please follow the instructions provided by your hospital software vendor for using these flags.

In addition to computer edits to assess accuracy, regional registries perform visual editing on 100% of the abstracts submitted by hospital registries. Feedback is routinely provided to hospitals on visual editing.

Beginning January 1, 2000, the California Cancer Registry implemented visual editing standards. The purpose of these standards is to provide consistency in the visual editing process and to quantify the accuracy of cancer data from cancer reporting facilities.

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Initially, thirteen data items were included in this standard. They are as follows:

- County of Residence at Diagnosis
- Sex
- Race
- Spanish/Hispanic Origin
- Date of Diagnosis
- Diagnostic Confirmation
- Site/Subsite*
- Laterality (only paired sites listed in Volume I)
- Histology
- Tumor Size
- EOD - Extension (for prostate--count as one discrepancy)*
- EOD - Lymph Node Involvement
- Number of Regional Nodes Positive/Examined*

*Counted as one discrepancy

The visual editing accuracy rate for the thirteen data items was established at 97%. These data items were selected because they affect the overall quality for data usage. 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.

Non-analytic cases are included in the accuracy rate. The regions visually edit them, although not as extensively as analytic cases. Review is limited to verifying that there is supporting documentation to validate the coded data field.

Beginning July 1, 2001, the CCR's Regional Registries began visual editing treatment data items in addition to tumor data items. A total of nineteen treatment data items were added to the list of data items to be visually edited. One discrepancy will be counted for each treatment modality grouping. For example, a discrepancy in Date of Hormone Therapy and a discrepancy in Hormone Therapy would be counted as only one discrepancy.

These data items will be included in the semi-annual accuracy rate using a phased approach. For the period July 1, 2001 to December 31, 2001, visual editing of treatment

items will not be included in calculating accuracy rates, but they will be tracked and feedback will be provided to hospital registrars. Beginning in January, 2005, discrepancies in treatment fields will be counted towards the overall facility accuracy rate, and will be reported in the six-month accuracy rates.

In July 2004, Collaborative Staging fields will be added to the list of data items visually edited by the regional registries. Discrepancies will be counted in a facility's accuracy rate beginning July 1, 2005.

Another method of assessing accuracy is to reabstract cases in the hospitals. A sample of cases from each facility is reabstracted by specially 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.