CANCER REPORTING IN CALIFORNIA: ABSTRACTING AND CODING PROCEDURES FOR HOSPITALS

California Cancer Reporting System Standards, Volume I

Changes And Clarifications – 7th Edition
July 2003

Please replace the 6th Edition of Volume I with the 7th Edition dated July 2003, with the exception of Appendix R - Definitions of Single and Subsequent Primaries for Hematologic Malignancies, Based on ICD-O-3 Single versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases and Appendix S - DSQC Memos From January 2000 Forward. These appendices have not been reprinted for the 7th Edition of Volume I, thus the current copies need to be retained. DSQC memos can be downloaded from the CCR web site at: www.ccrcal.org, click on Registrar Resources and then click on Data Standards and Quality Control Memorandums.

Change bars identify most changes to the document. An earlier document, *Summary of Year 2003 Data Changes*, dated February 11, 2003, summarized new 2003 data changes. This document includes a brief summary of those changes and additional changes and clarifications to instructions in Volume I. The changes are as follows:

SECTION	CHANGE
I.1.3	**State Cancer Reporting Requirements** Added a section indicating that it is the reporting facilities responsibility to inform the patient that cancer is reportable. References the Patient Information Sheet found in Appendix J.
I.1.6.2	**Reporting Methods** References Appendix U - Data Items and Their Required Status. This table was previously found in Section I.3.
I.1.6.4	**Entering Dates** Entering a year now includes 4 digits, not 2 as stated previously.
I.1.6.5	**Coding Sources** Revises references to the AJCC Manual for Staging of Cancer, the ACoS FORDS Manual, the CCR Inquiry System, Version 2002.1

SECTION	CHANGE
I.1.7	**Reporting by Non-Hospital Treatment Centers** References Appendix U - Data Items and Their Required Status. This table was previously found in Section I.3.
I.2	**CNExT** Replaces the ACoS ROADS reference to the ACoS FORDS Manual in the on-line help files. **Illustrations I.1, I.2, and I.3 have been removed.** The abstract forms have changed and no longer resemble the examples.
II.1.7	**Pathology Only, Tumor Board Only, and Consultation Only Cases** Clarifies that *abstract* reporting is not required for malignancies diagnosed by the pathology department as a result of slide reviews, tumor board presentation consultation only or consultation only cases. Facilities are required to notify the regional registry of these cases however.
II.1.9	**Intracranial/CNS Tumors** Adds a statement regarding the staging of these cases.
II.1.10	**Borderline Ovarian Tumors** Adds a list of reportable borderline ovarian tumors with terms and morphology codes. A statement regarding the staging of these cases is also added.
II.2	**Abstracting Preliminary Procedures** Reflects the nine-digit accession number and the eleven-digit accession and sequence number.
II.2.3	**Accession Number** Reflects the nine-digit accession number, beginning with the four-digit accession year.
II.2.4	**Sequence Number** Reflects the new sequence codes for malignant and in situ behavior tumors in the 00-35 range and code 99. Separate new codes for benign and uncertain behavior CNS tumors, borderline ovarian tumors and cases reportable by agreement utilize codes in the 60-88 range. Note: Alphabetic codes are no longer allowed.

SECTION	CHANGE
III.2	**Last Name** Adds a statement indicating if a patient has no last name or the name cannot be determined, enter NLN.
III.2.5.2	**Data Entry** The street address was expanded to 40 characters. There is also a new field "Patient Address at Diagnosis Supplemental", which provides the ability to record additional address information such as a name of a facility or apartment complex. Use up to 40 characters for this field. There is a reference to Appendix C, which lists the Canadian provinces.
III.2.9	**Race and Ethnicity** The race and ethnicity section now includes the content of DSQC Memo # 2002-06 regarding race code documentation.
III.2.14	**Patient No Research Contact Flag** Adds code 4, Out of State Case, Not for Research. This code is generated from the CCR and identifies that the case has been shared from another state and that this case cannot be given to researchers without approval of that state registry.
III.3.2	**Dates of Inpatient Admission and Inpatient Discharge** Clarifies the dates of inpatient admission and discharge to the *reporting* facility for the most definitive surgery.
III.3.5	**Class of Case** Beginning with cases diagnosed 1/1/2003, adds code 7 - Pathology Report Only and code 8 - Death Certificate Only. Code 8 is only used by central registries. Code 9 no longer includes Death Certificate Only cases.
III.3.9	**Payment Source (Primary and Secondary) and Payment Source Text** The CCR adopted the codes and definitions used by the ACoS. Since the new CoC codes are using code 50 that had been used for County Funded, NOS, it is necessary to assign a new code. The new code for County Funded, NOS, is 60. Code 60 will be moved into code 31 - Medicaid on future calls for data.

SECTION	CHANGE
III.3.10	**Hospital Referred From** This field is now a 10-character field (formerly 15 characters).
III.3.10	**Hospital Referred From** This field is now a 10-character field (formerly 15 characters).
III.3.12.2	**Entering Codes** Clarifies that code 99999999 is to be used when there is no attending physician, or if it cannot be determined who the attending physician is, or the attending physician is unknown or the *license number is not assigned*. Use the following codes for Surgeon, Radiation Oncologist, and Medical Oncologist when applicable: Surgeon: 00000000 No surgery and no surgical consultation performed 88888888 Non-surgeon performed procedure Radiation Oncologist: 00000000 No radiation therapy or radiation therapy consult performed 88888888 Non-radiation therapist performed the procedure Medical Oncologist: 00000000 No chemotherapy or chemotherapy consult was performed 88888888 Non-medical oncologist gave systemic therapy
IV.1.1.2	**Size** Adds information regarding tumor size for combined in situ/invasive tumor (DSQC Memo #2000-11). Adds information regarding the terms focus, focal and foci as they pertain to tumor size (DSQC Memo #2000-06). Adds if an ulcerated mass is pathologically confirmed to be malignant, it is acceptable to code the size of tumor based on the size of the mass in the absence of a more precise tumor size description (SINQ 20021027).

SECTION	CHANGE
IV.2	**Diagnostic Confirmation - No Microscopic Confirmation** Adds to Code 5 - "Although an elevated PSA is non-diagnostic of cancer, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup; record as code 5".
V.1.1	**ICD-O Coding** Adds a note: For cases with unknown date of diagnosis collected 1/1/2001 and after, use ICD-O-3 to code site, histology, behavior and grade.
V.1.4	**Special Conditions** Under "Melanoma", adds the following: Unless it is stated to be a recurrent or metastatic melanoma, record each melanoma as a separate primary when any of the following apply: ♦ The occurrences are more than two months apart ♦ The fourth character of the ICD-O topography code for skin (C44._) is different ♦ The first three digits of the ICD-O-3 morphology code are different ♦ An in situ melanoma is followed by an invasive melanoma ♦ The occurrences are within the same sub-site code, but different lateralities or different trunk sides, such as chest and back Under "Colon", adds information from DSQC Memo #2000-04, regarding using the colonoscope measurement to establish colon subsite designation.
V.3.3.3	**Variations in Terminology** The example for (4) was changed to "Tubular carcinoma (8211/3) and medullary carcinoma (8510/3). Code as medullary carcinoma (8510/3).

SECTION	CHANGE
V.3.3.7	**Special Cases** Adds the following: **Mucinous Adenocarcinoma** - the tumor must be at least 50% mucinous, mucin-producing, or signet ring to be coded to the specific histology. Code mucinous adenocarcinoma arising in a villous adenoma and mucinous adenocarcinoma arising in a villous glandular polyp to 8480/3, mucinous adenocarcinoma (DSQC Memo #2003-01). **T-Cell Large Granular Lymphocytic Leukemia -** Pathologic confirmation is required for a diagnosis of T-cell large granular lymphocytic leukemia and these cases should be reported with a behavior code of /3. Do not report cases with a behavior of /1. (Rationale provided in the section).
V.3.4.2	**In Situ Coding** Adds that CIN III cases are not reportable to the CCR effective with cases diagnosed 1/1/96. Prostate Intraepithelial Neoplasia (PIN III) cases are not reportable to the CCR.
V.3.5.3	**Variations in Terms for Degree of Differentiation** Adds information regarding how to code in a three and a two grade system. For a three grade system, refer to the following codes: **Term** **Code** Low Grade 2 Medium Grade 3 High Grade 4 In a two grade system, refer to the following codes: **Term** **Code** Low 2 High 4
V.3.5.6	**Gleason's Score** Adds an exception to Gleason's score 7: If the pathology report states that the tumor is moderately to poorly differentiated and Gleason's score is reported as 7, assign tumor grade code 3 (SINQ 20010117).

SECTION	CHANGE
V.4	**Extent of Disease** Adds the statement "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."
V.5	**Stage of Diagnosis** Ignore the change bars on page 99, as there were no changes to this page.
V.5.13	**Special Rules for Lymph Nodes** Adds the following statement: 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.
V.7.1	**The TNM System** 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. Adds: For a list of these sites, please refer to the AJCC Manual for Staging of Cancer, 6th Edition. (This sentence replaces the former reference to Appendix P, which is no longer in this document).
V.7.4	**TNM Staging Elements** Adds the following codes: N3A N3B N3C Clarifies that M1 and M1A are 2 separate entities.
V.7.6	**TNM Coder** Change in codes: Code 3 Pathologist and managing physician Code 7 Staging assigned at another facility Code 8 Case is not eligible for staging

SECTION	CHANGE
V.7.8	**TNM Edition** All codes are now 2 digit fields. Adds code 06 Sixth Edition
V.7.9	**Pediatric Stage System** Adds code 16 Children's Oncology Group (COG)
V.7.11	**Distant Metastasis** This section has been deleted, as this data item is no longer supported by the ACoS and was not required by the CCR.
V.7.12	**Screening or Biopsy Procedures** This section has been deleted, as this data item is no longer supported by the ACoS and was not required by the CCR.
VI.1	**First Course of Treatment: General Instructions** Adds a paragraph stating there are 2 fields for each first course treatment modality, "Treatment Summary" and "At this Facility". The differences between the two fields are also described.
VI.1.3.1	**Codes** Clarifies that the reason no fields have been incorporated into each treatment modality field. Most treatment codes have 2-digits now. Unknowns are coded with 9's (formerly unknowns were coded with X's).
VI.3.3	**Text** Adds a Note: There is no text field for bone marrow transplant and endocrine procedures. Record the text information regarding bone marrow transplants and endocrine procedures in the immunotherapy text field.
VI.1.3.4	**Treatment Refused** Adds "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."
VI.1.3.5	**No Treatment** Clarifies that summary treatment fields are now 2-digit fields.
VI.1.3.6	**Unknown if Treated** Clarifies that summary treatment fields are now 2-digit fields. When surgery is recommended but not known whether given, use code 8.

SECTION	CHANGE
VI.2	**First Course of Treatment: Surgery Introduction** Clarifies that beginning with cases diagnosed 1/1/2003, the surgery codes, definitions and fields have been reformulated again. The following fields have been deleted: Surgical Approach, Number of Regional Lymph Nodes Examined and Reconstructive Surgery. Surgery of the Primary Site has been assigned new site-specific codes. All remaining surgery fields now have a simplified coding scheme. Reconstructive surgery has been incorporated into the Surgery of the Primary Site codes. Cases diagnosed prior to 1/1/2003, must be coded in three new fields. They are: ♦ Surgical Procedure of Primary Site 98-02 ♦ Scope of Regional Lymph Node Surgery 98-02 ♦ Surgical Procedure/Other Sites 98-02
VI.2.1	**Surgery of the Primary Site** Clarifies that for codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is unavailable. Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix Q. Refer to Appendix Q-1 for cases diagnosed prior to January 1, 2003. Refer to Appendix Q-2 for cases diagnosed on or after January 1, 2003.
VI.2.2	**Scope of Regional Lymph Node Surgery** Starting with cases diagnosed January 1, 2003, forward, RX Summ-Scope of Regional LN Surg will not be coded according to site. A single digit-coding scheme for all sites will be used. The three procedure fields will continue to be coded for 2003 forward cases. The codes for Scope of Regional Lymph Node are as follows: 0 None 1 Biopsy or aspiration of regional lymph node, NOS 2 Sentinal lymph node biopsy 3 Number of regional nodes removed unknown or not stated, regional nodes removed, NOS

SECTION	CHANGE
	4 1-3 Regional lymph nodes removed 5 4 or more lymph nodes removed 6 Sentinal lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated 7 Sentinal lymph node biopsy and code 3, 4 or 5 at different times 9 Unknown or not applicable Cases diagnosed prior to January 1, 2003, are to be coded in a new field, Scope of Regional LN 98-02. Refer to Appendix Q-1 for these codes. For Unknown Primary, Hematopoietic/Reticuloendothelial/Immunoproliferative/Myelopro lifera-tive Disease Primaries, Lymphoma, Brain and Primaries of Ill-Defined Sites, use code 9.
VI.2.3	**Number of Regional Lymph Nodes Examined** Refers to Appendix Q-1 for these codes for cases diagnosed prior to January 1, 2003. Effective with cases diagnosed on or after January 1, 2003, the fields for Rx Summ-Reg LN Examined and Rx Hosp-Reg LN Examined are no longer required by the CCR and the CoC. Information regarding the number of lymph nodes has been incorporated into the scope fields. **However, the summary field for cases diagnosed prior to January 1, 2003, must continue to be coded.** For Unknown Primary, Hematopoietic/Reticuloendothelial/Immunoproliferative Disease Primaries, Lymphoma, Brain and Primaries of Ill-Defined Sites, use code 99.
VI.2.4	**Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Nodes** Starting with cases diagnosed January 1, 2003 forward, this field and its' corresponding procedure fields will not be coded according to site. It will be coded using a single scheme for all sites. The new codes are as follows:

SECTION	CHANGE
	0 None 1 Non-primary surgical procedure performed 2 Non-primary surgical procedure to other regional sites 3 Non-primary surgical procedure to distant lymph node(s) 4 Non-primary surgical procedure to distant site(s) 5 Combination of codes 2, 3 or 4 9 Unknown Cases diagnosed prior to January 1, 2003 are to be coded in the new field, Surgery Other 98-02. Refer to Appendix Q-1 for these codes. This field is for all procedures that do not meet the definition of Surgery of Primary Site or Scope of Regional Lymph Nodes.
VI.2.5	**Date of Surgery** Clarifies that the surgical procedures for this date field include Surgery of the Primary Site, Scope of Regional Lymph Node Surgery or Surgery of Other Regional/Distant Sites. Beginning with cases diagnosed January 1, 2003 forward, a new data item, Rx Date - Most Definitive Surgery of the Primary Site, is required by the CCR. Since the CCR is already collecting multiple procedure fields, this data item will be generated. The generated data item will identify the date for the most definitive surgical procedure of the primary site from the three procedure fields.
VI.2.7	**Surgical Margins** This field is not required by the CCR effective with cases diagnosed January 1, 2000, but is required by the ACoS. For cases diagnosed prior to January 1, 2003, please refer to Appendix Q-1. For cases diagnosed after January 1, 2003, please refer to the FORDS Manual.
VI.2.8	**Reconstructive Surgery - Immediate** This field is no longer required by the CCR or the CoC beginning with cases diagnosed January 1, 2003. Information with regards to reconstruction has been incorporated into the Surgery of the Primary Site field. The old field has been retained and cases diagnosed prior to January 1, 2003 must continue to be coded. For these codes, refer to Appendix Q-1.

SECTION	CHANGE
VI.2.9	**Section # Formerly used for Surgical Approach** This field was not required by the CCR and is no longer supported by the ACoS in 2003, thus this section was removed.
VI.2.9	**Reason For No Surgery** Reason for No Surgery only applies to the Surgery of the Primary Site field, not Scope of Regional Lymph Nodes Surgery or Surgery Other Regional/Distant Sites. Effective with cases diagnosed January 1, 2003, a new code has been added (code 5 - patient died). In addition, the definitions for codes 1, 2, 6, and 9 have been modified as follows: 1 Surgery of the primary site not performed because it was not part of the planned first course treatment 2 Surgery of the primary site not performed because of contraindications due to patient risk factors (comorbid conditions, advanced age, etc.) 5 Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery 6 Surgery of the primary site was recommended but not performed. No reason was noted in the patient's record 9 Not known if surgery of the primary site was recommended or performed; death certificate only and *autopsy only cases*.
VI.2.10	**Diagnostic or Staging Procedures** Beginning with cases diagnosed January 1, 2003 forward, this field does not include palliative treatment/procedures. Palliative treatment/procedures are recorded in a separate field. The CCR does not require that palliative treatment/procedures be recorded but the CoC does require this data item. Consult the FORDS Manual for instructions regarding the palliative procedure field. Two notes are also added to this section as follows: NOTE: Removal of fluid (paracentesis and thoracentesis) even if cancer cells are present is not a surgical procedure. Do not code brushings, washings, or hematologic findings (peripheral blood smears). These are not considered surgical procedures. NOTE: If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (incisional biopsy of primary site).

SECTION	CHANGE
	Do not code the following items in this field: ♦ Surgical procedures, which aspirate, biopsy or remove regional lymph nodes to diagnose or stage disease in this data item. Use the Scope of Regional Lymph Node Surgery to code these procedures. (Do not record the date of surgical procedures, which aspirate, biopsy or remove regional lymph nodes in the data item Date of Surgical Diagnostic and Staging Procedure). ♦ Excisional biopsies with clear or microscopic margins in this data item. Use the data item Surgical Procedure of Primary Site to code these procedures. ♦ Palliative surgical procedures
VI.2.10	**Diagnostic or Staging Procedure Codes** References to palliative procedures have been removed in this section.
VI.2.11	**Date of Diagnostic or Staging Procedure** References to palliative procedures have been removed in this section. In addition to valid dates, the following codes have been added: 00000000 No diagnostic procedure preformed, autopsy only case 99999999 Unknown if any surgical diagnostic or staging procedure was performed; date unknown, or death certificate only case
VI.3	**First Course of Treatment: Radiation** Effective with cases diagnosed January 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 "Radiation at this Hospital" field will no longer be required by the CCR beginning with cases diagnosed January 1, 2003.

SECTION	CHANGE
VI.3.2	**Radiation Codes** Effective with cases diagnosed January 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 "Radiation at this Hospital" field will no longer be required by the CCR beginning with cases diagnosed January 1, 2003. Effective 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 conversions of these two fields will generate the Radiation Therapy Summary field.
VI.3.3	**Radiation - Regional RX Modality** This is a new field. 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 field and the RX Boost RX Modality will be converted to generate the RX Summ - Radiation. There is no corresponding "At this Hospital" field. The codes for this field are as follows: 00 No radiation treatment 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) 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

SECTION	CHANGE

41 Stereotactic Radiosurgery, NOS
42 Linac Radiosurgery, NOS
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
80* Combination Modality, Specified
85* Combination Modality, NOS
98 Other, NOS
99 Unknown

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 of the first course of treatment. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to the ACoS documents: Volume II, ROADS, and the Data Acquisition Manual rules and **should not** be used to record regional radiation for cases diagnosed on or after January 1, 2003.

VI.3.4 **Radiation - Boost RX Modality**

This is a new field. 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 field and Radiation - Regional RX Modality will be converted to generate the RX Summ - Radiation. There is no corresponding "At this Hospital" field. The codes for this field are as follows:

00 No boost treatment
20 External beam, NOS
21 Orthovoltage
22 Cobalt-60, Cesium-137
23 Photons (2-5 MV)

SECTION	CHANGE

24	Photons (6-10 MV)
25	Photons (11-19 MV)
26	Photons (>19)
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, NOS
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

IV.3.5 **Date of Radiation Therapy**

Each treatment modality will now have it's own date field section. If radiation therapy was not administered, enter 0's. If radiation therapy was known to have been given but the date is not known, enter 9's. Codes, in addition to valid dates, include the following:

00000000	No radiation therapy administered, autopsy only case
88888888	Radiation therapy is planned as part of first course 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	Unknown whether any radiation therapy was administered; the date is unknown, or the case was identified by death certificate only.

SECTION	CHANGE
IV.3.6	**Reason For No Radiation** Modifications have been made to codes 1, 2, 5, 6 and 9 as follows: 1 Radiation treatment not performed because it was not part of planned first course treatment 2 Radiation contraindicated because of other conditions or other patient risk factors 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 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.
IV.4.2	**Chemotherapy Codes** The length of this field has changed from 1 to 2 characters. The codes for reason no chemotherapy given have been incorporated into this scheme. The codes are as follows: 00 None, chemotherapy was not part of the planned first course of therapy 01 Chemotherapy, NOS 02 Single agent chemotherapy 03 Multi-agent chemotherapy 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 physician, but was not administered as part of first course therapy. No reason was stated in patient record. 87 Chemotherapy was not administered, it was recommended by the physician but was refused by the patient, the patient's family member or guardian. The refusal was noted in the patient's record. 88 Chemotherapy was recommended, but it is unknown if it was administered 99 It is unknown whether a therapeutic agent(s) was recommended or administered because it is not stated in the patient's record; death certificate only.

SECTION	CHANGE

VI.4.3 **Date of Chemotherapy**

Record the date on which chemotherapy began at any facility as part of first course treatment. If chemotherapy is known to have been administered, but the date is unknown, enter 9's. Codes, in addition to valid dates include:

00000000	No chemotherapy administered; autopsy only case
88888888	Chemotherapy is planned as part of first course treatment, but had not been started at time of the most recent follow-up, the date should be revised at the next follow-up.
99999999	Unknown whether any chemotherapy was administered; the date is unknown, or the case was identified by death certificate only.

VI.5.2 **Hormone (Endocrine) Surgery**

This data item is now coded in the new "Transplant/Endocrine Procedure" field, Section VI.7.

VI.5.3 **Hormone (Endocrine) Radiation**

This data item is now coded in the new "Transplant/Endocrine Procedure" field, Section VI.7.

VI.5.4 **Hormone Therapy Codes**

The length of this field has changed from 1 to 2 characters. The codes for reason no hormone therapy given have been incorporated into this scheme. The codes are as follows:

00	None, hormone therapy was not part of the planned first course of therapy
01	Hormone therapy administered
82	Hormone therapy was not recommended/administered due to contraindications
85	Hormone therapy not administered because the patient died
86	Hormone therapy was not administered, it was recommended by the physician, but was not administered as part of first course therapy. No reason was stated in patient record.
87	Hormone therapy was not administered, it was recommended by the physician but was refused by the patient, the patient's family member or guardian. The refusal was noted in the patient's record.

SECTION	CHANGE
	88 Hormone therapy was recommended, but it is unknown if it was administered 99 Unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.
VI.5.5	**Date of Hormone Therapy** Record the date on which hormone therapy began at any facility as part of first course treatment. If hormone therapy is known to have been administered, but the date is unknown, enter 9's. Codes, in addition to valid dates include: 00000000 No hormone therapy administered; autopsy only case 88888888 Hormone therapy is planned as part of first course treatment, but had not been started at time of the most recent follow-up, the date should be revised at the next follow-up. 99999999 Unknown whether any hormone therapy was administered; the date is unknown, or the case was identified by death certificate only.
VI.6.1	**Immunotherapy Agents** Adds "Interferon" to the list.
VI.6.2	**Immunotherapy Codes** Effective with cases diagnosed January 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/Endcr. The length of this field has been changed from 1 to 2 characters. The codes for reason no immunotherapy (BRM) given has been incorporated into this scheme. A conversion will be required. Please note a correction to the statement "Use codes 0-9 for recording immunotherapy in the At This Hospital Field," should state "Use codes *01-87* for recording immunotherapy in the At This Hospital Field." Codes for this field include:

SECTION	CHANGE

00	None, immunotherapy was not part of the planned first course of therapy
01	Immunotherapy administered as part of first course treatment
82	Immunotherapy was not recommended/administered due to contraindications
85	Immunotherapy not administered because the patient died
86	Immunotherapy was not administered, it was recommended by the physician, but was not administered as part of first course therapy. No reason was stated in patient record.
87	Immunotherapy was not administered, it was recommended by the physician but was refused by the patient, the patient's family member or guardian. The refusal was noted in the patient's record.
88	Immunotherapy was recommended, but it is unknown if it was administered
99	Unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

VI.6.3 **Date of Immunotherapy**

Record the date on which immunotherapy began at any facility as part of first course treatment. If immunotherapy is known to have been administered, but the date is unknown, enter 9's. Codes, in addition to valid dates include:

00000000	No immunotherapy administered; autopsy only case
88888888	Immunotherapy is planned as part of first course treatment, but had not been started at time of the most recent follow-up, the date should be revised at the next follow-up.
99999999	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**

This is a new field to 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. A conversion will be required for cases diagnosed prior to January 1, 2003 using both the Rx Summ - BRM (Immunotherapy) and Rx Summ - Hormone

SECTION	CHANGE
	fields. Although the CoC did not add a corresponding "At this Hospital" field, the CCR is requiring this field in order to provide consistency, since all the other treatment modalities (except radiation) have a hospital-level field. NOTE: There is no text field for the transplant/endocrine procedures. Record the text information regarding transplants and endocrine procedures in the immunotherapy text field.
VI.7.1	**Transplant/Endocrine Codes** Use the following codes to record transplant/endocrine procedures in the Summary field. Use codes 10-87 to record transplant/endocrine procedures in the At This Hospital field. Codes for this field include: 00 No transplant or endocrine procedure was performed as part of the planned first course of therapy 10 A bone marrow transplant procedure was administered, but the type is 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 10, 11, 12 or 20) 82 Hematologic transplant and/or endocrine surgery/radiation therapy not recommended/administered due to contraindications 85 Hematologic transplant and/or endocrine surgery/radiation therapy not administered because the patient died 86 Hematologic transplant and/or endocrine surgery/radiation therapy was not administered, it was recommended by the physician, but was not administered as part of first course therapy. No reason was stated in patient record. 87 Hematologic transplant and/or endocrine surgery/radiation therapy was not administered, it was recommended by the physician but was refused by the patient, the patient's family member or guardian. The refusal was noted in the patient's record. 88 Hematologic transplant and/or endocrine surgery/radiation therapy was recommended, but it is unknown if it was administered

SECTION	CHANGE
	99 Unknown whether hematologic transplant and/or endocrine surgery/radiation therapy was recommended or administered because it is not stated in patient record. Death certificate only.
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 first course treatment. If the procedure is known to have been performed, but the date is unknown, enter 9's. Codes, in addition to valid dates include: 00000000 No transplant or endocrine therapy administered; autopsy only case 88888888 Transplant or endocrine therapy is planned as part of first course treatment, but had not been started at time of the most recent follow-up, the date should be revised at the next follow-up. 99999999 Unknown whether any transplant or endocrine procedure was administered; the date is unknown, or the case was identified by death certificate only.
VI.8	**First Course of Treatment: Other Therapy** This treatment modality section was formerly Section VI.7. Previously, Section VI.8 described Subsequent Treatment. Since the Subsequent Treatment field is no longer supported by the ACoS, this section was removed.
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 is known to have been performed, but the date is unknown, enter 9's. Codes, in addition to valid dates include: 00000000 No other therapy administered; autopsy only case 99999999 Unknown whether other therapy was administered; the date is unknown, or the case was identified by death certificate only.

SECTION	CHANGE
VI.9	**Protocol Participation** This field has a new section number (formerly Section VI.8) in Volume I. The following new codes are also added: 13 Veteran's Administration 14 COG (Children's Study Group) 15 CTSU (Clinical Trials Support Group) 16-50 National Trials
VII.2.12	**Recurrence Information** The distant recurrence sites field (formerly section VII.2.12.3) has been removed and incorporated into the Type of First Recurrence field. As a reminder, this data item is optional for reporting to the CCR, but required by the ACoS. New codes to the Type of First Recurrence field includes: 40 Distant recurrence, insufficient information to use codes 46-62 46 Distant recurrence of an in situ tumor 51 Distant recurrence of invasive tumor in the peritoneum only 52 Distant recurrence of an invasive tumor of the lung only 53 Distant recurrence of an invasive tumor in the pleura only 54 Distant recurrence of an invasive tumor in the liver only 55 Distant recurrence of an invasive tumor in bone only 56 Distant recurrence of an invasive tumor in the CNS only 57 Distant recurrence of an invasive tumor in the skin only 58 Distant recurrence of an invasive tumor in lymph node(s) only 59 Distant systemic recurrence of an invasive tumor only 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 70 Never disease freed 89 Disease has recurred, but the type of recurrence is unknown 99 Unknown whether the disease has recurred or if the patient was ever disease free See this section for additional new code information.

SECTION	CHANGE
VII.3	**Contact Name/Address File** A supplemental field has been added, providing the ability to record additional address information such as the name of a place or facility. This supplemental field is 40 characters in length.
VII.3.2	**Contact #1** Expanded the current street address or post office box to 40 characters. In the Patient Address Current--Supplemental field provides the ability to record additional address information such as the name of a place or facility. The supplemental field is limited to 40 characters.
VII.3.3	**Contact #2-3** A supplemental field has been added, providing the ability to record additional address information such as the name of a place or facility. This supplemental field is 40 characters in length.
VIII.1.1	**Remarks: Required Data Items** Adds statement to the race documentation requirement, "Race of patient when coded as "Other" *or if there is conflicting race information"*
VX.1.2	**Corrections** Adds the new data fields to the list of fields in which corrections and the reason they were entered must be sent to the regional registry.
Appendix B	**Postal Abbreviations for State and Territories of the United States** **Canadian Province/Territory** Updates list to reflect new codes.
Appendix C	**Codes for States and Territories of the United States** **Canadian Province/Territory** Updates list to reflect new codes.
Appendix D.1 & D.2	**Codes for Countries** Updates list to reflect new codes.
Appendix F.1 & F.2	**California Hospital Codes** Updates list to reflect new codes
Appendix H	**Summary of Codes** Updates codes and title changes.

SECTION	CHANGE
Appendix J	**Patient Information Sheet** Adds confidentiality citations referencing the California Health and Safety Code, Civil Code, Government Code and Federal Law.
Appendix M.1 & M.2	**Common Acceptable Abbreviations** Updates list to reflect additional abbreviations.
Appendix N	**ICD-O-3 Codes to be Considered One Primary Site When Determining Multiple Primaries** Replaces references to ICD-O-2 with ICD-O-3. Updates revisions to the list.
Appendix P	**General Summary Stage** Deleted from this document, instead, reference is made to the AJCC Manual for Staging of Cancer, 6th Edition.
Appendix Q.1 & Q.2	**Surgery Codes** Appendix Q.1 is referenced for cases diagnosed prior to January 1, 2003. Appendix Q.2 is referenced for cases diagnosed on or after January 1, 2003. Appendix Q.1 and Q.2 each has a Table of Contents for their respective section. Appendix Q.2 contains notations and guidelines from SEER.
Appendix U	**Table of Data Items and Their Required Status** This table was formerly Section I.3 in the front of this document. The table has been simplified with the elimination of the "Transmitted from Region to CCR" column. Updates revisions to the table.