

**CANCER REPORTING IN
CALIFORNIA:**

**ABSTRACTING AND CODING
PROCEDURES FOR HOSPITALS**

**CALIFORNIA CANCER REPORTING SYSTEM
STANDARDS**

VOLUME ONE
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California Cancer Registry
Data Standards and Quality Control Unit

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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*, dated July 2003. Change bars have been used to delineate changes to this document. A revision of the sixth edition of the manual, published in October 2001, was necessary due to extensive changes in data item requirements from the American College of Surgeons, Commission on Cancer. Many of these data items are required by NCI's SEER Program, and the State of California is comprised of three SEER registries. In addition, many of the same data items were required by the Center for Disease Control and Prevention's National Program of Cancer Registries of which California is a member state. In addition to changes in requirements, feedback from hospital registrars and regional registry staff have resulted in modifications and clarifications to this document.

A document summarizing changes for 2003 -- *Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, California Cancer Reporting System Standards, Volume I, Summary of Year 2003 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* -- accompanies this document. The first document provided an overview of 2003 data changes. The second document provides a detailed summary of the changes in Volume I, including those related to 2003 data changes.

I want to acknowledge Winny Roshala, BA, CTR for her work in revising this document. In addition, I want to acknowledge other members of the DSQC Unit who assisted with sections of the document-- Dawn Leytem, CTR, Cheryl Tatum, BA, CTR and Lydia Jacobs, CTR and Scott Wood, BA for his technical expertise in 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:

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1700 Tribute Road, Suite 100
Sacramento, CA 95815-4402

This document can be found on CCR's web site at www.ccrca.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

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 guidelines 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

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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:

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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, sanatorium, 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.

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- 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 Section VII, Follow-up Information). Casefinding 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.

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.)

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.

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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) The region's reference date is 1/1/88. A patient was admitted on 12/29/87, and a biopsy done on 12/30/87 revealed colon cancer. A colectomy was performed on 1/2/88, and the patient was discharged on 1/6/88. The case does not need to be reported.
- (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.)

Reporting Cancer Statistics

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 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 9's in all the fields (99/99/9999).

Examples		
January 1, 1988	=	01/01/1988
February 10, 1965	=	02/10/1965
December 3, 1951	=	12/03/1951
November ?, 1975	=	11/99/1975
May 19, 193?	=	99/99/9999

Reporting Cancer Statistics

I.1.6.5 Coding Sources. A registry must have certain reference works for coding, in addition to this manual:

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*. 2nd 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). *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.

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.

California Cancer Registry. *California Cancer Registry Inquiry System*, Version 2002.1.

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.

Reporting Cancer Statistics

SEER (Surveillance, Epidemiology, and End Results Program). *The SEER Program Code Manual*. 3rd ed. [Bethesda]: National Institutes of Health, National Cancer Institute, 1998. NIH Pub. No. 98-2313.

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.

Reporting Cancer Statistics

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, 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.

Reporting Cancer Statistics

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 may be limited to a brief statement of the patient's history and the reason for the present admission. 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.

Section I.2

CNEXT

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 CNEXT, 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.
- 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 CNEXT software 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

Every hospital must report all cases, inpatient or outpatient, admitted on or after the regional registry's reference date with a neoplasm classified in the morphology section of ICD-O-3 (International Classification of Diseases for Oncology, Third Edition, 2000) as malignant or in situ, including those discovered at an autopsy. The only exceptions are certain carcinomas of the skin (see Section II.1.4). Neoplasms described by terms synonymous with in situ are reportable (see Section V.5.8.1 for a list of terms). Effective with cases diagnosed January 1, 2001, benign and uncertain behavior intracranial and central nervous system (CNS) tumors become reportable along with newly reportable histologies published in ICD-O-3. Although borderline ovarian tumors changed behavior in ICD-O-3 from /3 (malignant) to /1 (borderline), the CCR will continue to require reporting them. They are to be coded with a behavior code of /1. 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.

Determining Reportability

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.)

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.)

Determining Reportability

- 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.3.3.3.6.)

II.1.3.2 Multiple Primaries. The following are to be considered separate primaries:

- A new cancer with the same histology 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 lesion only is required.

Exception #2: Effective with cases diagnosed January 1, 1995, 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 and 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.

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 and code the laterality to '4'. If the record shows two independent primaries, submit two independent abstracts, one for each side, and code laterality appropriately. If the record contains no information about the number of primaries, submit one abstract, and code laterality to '4'. Prepare a single abstract for the following bilateral primaries and code the laterality to '4':

- Bilateral ovarian primaries.
- Bilateral retinoblastomas.
- Bilateral Wilms' tumors.

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Bilateral lung cancer cases often present problems in determining whether one or two abstracts should be submitted. Use the following as a guide:

- If a second lung cancer with the same histology is diagnosed in the opposite lung more than two months after the first, abstract as two primaries unless stated to be metastatic.
- If a bilateral lung cancer (regardless of the time frame) has a surgical resection performed on each side, abstract as two primaries.

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.

Determining Reportability

(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)

Determining Reportability

(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)

Determining Reportability

Acute panmyelosis (9931)
Acute myelofibrosis (9932)
Hairy cell leukemia (9940)
Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:

Malignant lymphoma, NOS (9590, 9591, 9595)
Lymphosarcoma (9592)
Burkitt's lymphoma (9687)
Burkitt's leukemia (9826)
Lymphoid or lymphocytic leukemia (9820-9822, 9824, 9825, 9827)

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

Report as a second or subsequent primary:

Specific non-Hodgkin's lymphoma (9593-9594, 9670-9688, 9690-9698, 9711-9717)
Hodgkin's disease (9650-9667)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Lymphoid or lymphocytic leukemia specified as B-cell (9820-9827)
Plasma cell leukemia (9830)
Non-lymphocytic leukemia (9840-9842, 9860-9910)
Lymphosarcoma cell leukemia (9850)
Myeloid sarcoma (9930)
Acute panmyelosis (9931)
Acute myelofibrosis (9932)
Hairy cell leukemia (9940)
Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:

Malignant lymphoma, NOS (9590, 9591, 9595)
Lymphosarcoma (9592)
Cutaneous and peripheral T-cell lymphomas (9700-9709)
Leukemia, NOS (9800)
Acute leukemia, NOS (9801)
Chronic leukemia, NOS (9803)
Lymphoid or lymphocytic leukemia unless specifically identified as B-cell (9820-9828)

Determining Reportability

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

Report as a second or subsequent primary:

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

Hodgkin's disease (9650-9667)

Burkitt's lymphoma (9687)

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

Plasmacytoma or multiple myeloma (9731, 9732)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

Waldenstrom's macroglobulinemia (9761)

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

Do not report as a subsequent primary:

Malignant lymphoma, NOS (9590, 9591, 9595)

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

Hairy cell leukemia (9940)

Leukemic reticulendotheliosis (9941)

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

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma (9592-9594, 9670, 9672-9676, 9683, 9685, 9686, 9688, 9690-9697, 9702-9713, 9715-9717)

Hodgkin's disease (9650-9667)

Burkitt's lymphoma (9687)

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

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

True histiocytic lymphoma (9723)

Mast cell tumor (9740, 9741)

Immunoproliferative disease, NOS (9760)

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

Do not report as a subsequent primary:

Malignant lymphoma, NOS (9590, 9591, 9595)

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

Plasmacytoma or multiple myeloma (9731, 9732)

Waldenstrom's macroglobulinemia (9761)

Plasma cell leukemia (9830)

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

Determining Reportability

(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)

Determining Reportability

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.

Determining Reportability

(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)

Determining Reportability

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

(14) Plasma cell leukemia (9830).

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717)
Hodgkin's disease (9650-9667)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Mast cell tumor (9740, 9741)
Non-lymphocytic leukemias (9840-9842, 9860-9910)
Myeloid sarcoma (9930)
Acute panmyelosis (9931)
Acute myelofibrosis (9932)

Do not report as a subsequent primary:

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)

Determining Reportability

Acute leukemia, NOS (9801)
Chronic leukemia, NOS (9803)
Lymphocytic leukemias (9820-9828)
Plasma cell leukemia (9830)
Lymphosarcoma cell leukemia (9850)

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

Report as a second or subsequent primary:

Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717)
Hodgkin's disease (9650-9667)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Lymphocytic leukemia (9820-9828)
Plasma cell leukemia (9830)
Lymphosarcoma cell leukemia (9850)
Mast cell leukemia (9900)
Hairy cell leukemia (9940)
Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:

Leukemia, NOS (9800)
Acute leukemia, NOS (9801)
Chronic leukemia, NOS (9803)
Non-lymphocytic 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)

Determining Reportability

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 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.

Determining Reportability

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
- 8050-8084 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-3 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)	Most likely (malignant)
Appears to*	Presumed (malignant)
Comparable with*	Probable (malignancy)
Compatible with (a malignancy)*	Suspect or suspected (malignancy)
Consistent with (a malignancy)	Suspicious (of malignancy)
Favor (a malignancy)	Typical (of/for malignancy)
Malignant appearing*	

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

Determining Reportability

II.1.6.2 Non-Reportable. *Do not report the tumor if the only term used is:

Approaching (malignancy)	Questionable (malignancy)
Cannot be ruled out	Rule out (malignancy)
Equivocal (for malignancy)	Suggests (malignancy)
Possible (malignancy)	Very close to (malignancy)
Potentially malignant	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.

Determining Reportability

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

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

Determining Reportability

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.8.

II.1.9 INTRACRANIAL/CNS TUMORS

Effective January 1, 2001, all intracranial and CNS tumors are to be reported including those of benign - /0 and uncertain behavior - /1.

With regard to staging these tumors, the CCR is not requiring that they be staged at this time. We recommend that you code EOD Extension 99 (Unknown) for these cases. If your registry uses SEER Summary Stage, we recommend that you code them to Code 9. The CCR requires that follow up be performed on these cases.

Although juvenile astrocytomas changed from /3 (malignant) to /1 (borderline) in ICD-O-3, the CCR will require that these continue to be collected. The behavior should be coded to /3 (malignant) to allow for the correct assignment of sequence number and to follow SEER guidelines.

II.1.10 BORDERLINE OVARIAN TUMORS

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

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

Serous cystadenoma, borderline malignancy	8442/1
Serous tumor, NOS, of low malignant potential	8442/1
Papillary cystadenoma, borderline malignancy	8451/1

Determining Reportability

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

These cases are to be staged according to the ovary scheme in the EOD manual. Follow-up is required for these cases.

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 last two digits of the 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.

Abstracting: Preliminary Procedures

Examples

(1) If the patient was admitted or the tumor was diagnosed on February 11, 1985, the first two digits are 85. If the abstract for the reported tumor was the 285th prepared for 1985, the accession number is 198500285.

(2) Two abstracts are being prepared for a patient with one primary tumor diagnosed in 1987 and another in 1988. The first four digits of the accession number are 1987, and the next five represent the abstract's place in the chronological order of cases reported for 1987. The same accession number must be used for the second and subsequent abstracts. (However, the year first seen for the first tumor is 87, and for the second it is 88.)

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 TUMOR
61	FIRST OF TWO OR MORE TUMORS
62	SECOND OF TWO OR MORE 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.

Abstracting: Preliminary Procedures

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

II.2.4.1 Simultaneous Diagnosis. When two or more of the patient's tumors were diagnosed simultaneously, assign the lowest sequence number to the one with the worst prognosis. (To determine worst prognosis, 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, one tumor only.

II.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

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

III.1.1 ABTRACTOR

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) are displayed. Enter corrections by typing over the old number(s).

III.1.4 REPORTING HOSPITAL

Enter the reporting hospital's CCR-assigned code (see Appendices F1 and F2) or the hospital's name. In CNExT, select the hospital from the Reporting Hospital drop-down list.

Registry Information

III.1.5 CNExT AUTOMATIC ENTRIES

The following fields in 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 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 Identification

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.

III.2.1 NAME

Enter the patient's last name, first name, middle name, maiden name, and any known alias. Begin at the far left of each field, 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.

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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.

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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, 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.

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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.)

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.)

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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.

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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 (ie, 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.

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.

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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 "XX," 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 "XX." For countries other than the U.S. and Canada, enter "YY".

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.

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.

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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 (persons with sex chromosome abnormalities)
- 4 TRANSEXUAL (persons who have undergone sex-change surgery)
- 9 UNKNOWN

III.2.8 RELIGION

Enter the code for the patient's religion or creed (see Appendix G for codes), 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.

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

III.2.9 RACE AND ETHNICITY

Race and ethnicity are two of the most important data items to epidemiologists who investigate cancer. Differences in incidence rates among 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.

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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
Race: White
Birthplace: Spain
Marital Status: Separated | F. Name: Carlos Johnson
Race: Black
Ethnicity: Hispanic
Birthplace: 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.

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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. No "primary" race is designated, and multiple races may be listed in any order, consistent with the 2000 Census. When any of the race fields are coded as Other Asian - Code 96, Pacific Islander, NOS - Code 97, or Other - Code 98" and a more specific race is given which is not included in the list of race codes, this more specific race must be entered in the Remarks field. (When a patient is described as Asian or Oriental and the birthplace is recorded as a specific Asian country, use the birthplace if possible to assign a more specific code.) If there is no information on race in the medical record, a statement documenting that there is no information must be entered in the Remarks Field.

III.2.9.1 Codes For Race Fields. Enter the most appropriate code for a patient's race(s) or ethnicity:

- 01 WHITE
- 02 BLACK
- 03 AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
- 04 CHINESE
- 05 JAPANESE
- 06 FILIPINO
- 07 HAWAIIAN
- 08 KOREAN
- 09 ASIAN INDIAN, PAKISTANI, SRI LANKAN (CEYLONESE), NEPALESE, SIKKIMESE, BHUTANESE, BANGLADESHI
- 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

Patient Identification

- 31 FIJI ISLANDER
- 32 NEW GUINEAN
- 88 NO FURTHER RACE DOCUMENTED (Do not use for coding the first race field.)
- 96 OTHER ASIAN, INCLUDING BURMESE, INDONESIAN, ASIAN, NOS AND ORIENTAL, NOS
- 97 PACIFIC ISLANDER, NOS
- 98 OTHER
- 99 UNKNOWN

Example

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

Following are some of the ethnic groups included in the White category:

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

* Unless specified as Indian (code 03).

** Unless specified as Black (code 02).

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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 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)
- 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.)**
- 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, 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 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

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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--or 19--) 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 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	18-19 99 (unknown)
YEAR	00-99 99 (unknown)

Patient Identification

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.

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 birthplace is in the United States, but the state is not known, enter 000. If the place of birth is not known, enter 999.

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

Patient Identification

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

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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

While some of the data reported on the Case Identification screen are only for identification and document control, the Date of Diagnosis serves as the basis for computing incidence, survival, and other statistics. Accurate recording of the date of the first diagnosis of a reportable neoplasm is especially important. (The previously entered Year First Seen [see 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 ADMISSION

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 outpatient 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 therapy. If the patient has not had cancer 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.

Case Identification

Examples

(1) 6/4/86. Chest X-ray shows mass in right upper lobe.
6/6/86 Bronchial washings are positive for carcinoma.
The diagnosis date is 6/6/86, because the term “mass” does not constitute a diagnosis of cancer.

(2) 5/20/86. Mammogram—suspicious for carcinoma, left breast, upper outer quadrant.
6/3/86. Fine needle aspiration, left breast—positive for carcinoma.

The date of diagnosis is 5/20/86, because the term “suspicious” constitutes a presumptive diagnosis of cancer. (See Section II.1.6 for vague or ambiguous terms.)

(3) 7/9/86 Cervical lymph node biopsy shows papillary carcinoma. Review of slides from a thyroidectomy performed in April 1984 reveals foci of papillary carcinoma not diagnosed at the time and now thought to be the primary tumor.

Backdate the diagnosis date to 04/99/84, the date of the earliest evidence.

III.3.3.1 Coding. Enter the month, then the day, then the year, using two digits for each. Enter "99" for any unknown part of the date. If the year is not known, the month and day should also be entered as unknown.

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.

Case Identification

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 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 INFOR- MATION 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:

Case Identification

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.

Case Identification

- 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 ELSEWHERE, (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.

Case Identification

- ** 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. If there are several sources, report the one with the lowest code number. The codes are:

- 1 HOSPITAL INPATIENT/OUTPATIENT OR CLINIC**
- 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

- * Codes 4, 5, and 7 are not used by hospitals.
- ** Code 2 was used for CLINIC (hospital outpatient or private) before 1988, and thus appears in some older cases.

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.

Case Identification

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
- 29 OTHER HOSPITAL SOURCE (including clinic, NOS or outpatient department, NOS)

NOTE: Codes 10-29 can be used by cancer-reporting facilities whichever way will best serve them in their casefinding efforts. There is no "correct" code to use.

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
- 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.

Case Identification

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 CAR, HMO, PPO
31	MEDICAID
35	MEDICAID ADMINISTERED THROUGH A MANAGED CARE PLAN
36	MEDICAID WITH MEDICARE SUPPLEMENT
50	MEDICARE
51	MEDICARE WITH SUPPLEMENT
52	MEDICARE WITH MEDICAID SUPPLEMENT
53	TRICARE
54	MILITARY
55	VETERANS AFFAIRS
56	INDIAN/PUBLIC HEALTH SERVICE
60	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 zeroes. (Appendices F1 and F2 contain the code numbers of all facilities in California and some out-of-state facilities.) 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 zeroes. CNExT users may leave blank when first entering a case, and CNExT will prefill with zeroes. If it is not known where the patient was diagnosed or most recently seen, enter 999999, Unknown Hospital.

Case Identification

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 (see Appendix F1 and F2 for codes). CNExT left fills this 10 character field with zeroes. 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 zeroes. CNExT users may leave blank when first entering a case, and CNExT will prefill with zeroes.

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.

Case Identification

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 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 procedure

Medical Oncologist

00000000	No chemotherapy or chemotherapy consult was performed
88888888	Non-medical oncologist gave systemic therapy

NOTE: These fields are to be used for entering physician license numbers only. They are not to be used for entering facilities or physician's groups. There are fields designated for this purpose.

PART IV DIAGNOSTIC PROCEDURES

Section 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. (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.

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 is listed 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.

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. Record dimensions of the tumor as stated by the examiner, whether the measurement is in millimeters, centimeters, or inches, or the size is described in terms of a fruit, nut, or other object. Be sure to specify the unit of measurement. Also note such descriptions as "diffuse," "entire circumference," "widespread."

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.

Diagnostic Procedures

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

- focal adenocarcinoma – TS 999
- microfocus of adenocarcinoma – TS 001
- multiple foci of adenocarcinoma in specimen – TS 001
- multifocal adenocarcinoma in specimen TS – 999
- microscopic focus of adenocarcinoma in multiple fragments – TS 001
- focal adenocarcinoma in chips – TS 999
- focal adenocarcinoma in 5% of specimen – TS 999

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

Diagnostic Procedures

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), but the chromosome study 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 subsite 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 code (see sections V.3.2 and V.3.3).
- Describe multiple tumors and multiple sites of origin.

Diagnostic Procedures

- 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.

Section 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 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.

Diagnostic Confirmation

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

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

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 four-digit number preceded by a T, standing for topography. In the topography section, the first three digits stand for the part of the body and the fourth digit for a specific area in the part. Listings are arranged in the numerical order of the first three digits. When entering the code, omit the period following the third 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. |

Primary Site

Examples

- (1) All entries under lung have the first three digits C34, followed by a fourth 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.

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.

Primary Site

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.1.3.4 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.

Primary Site

Unless it is stated to be a recurrent or metastatic melanoma, record each melanoma as a separate primary when any of the following apply:

- The occurrences are more than two months apart
- The fourth character of the ICD-O topography code for skin (C44. _) is different
- The first three digits of the ICD-O-3 morphology code are different
- An in situ melanoma is followed by an invasive melanoma
- The occurrences are within the same sub-site code, but different lateralities or different trunk sides, such as chest and back

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

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

Lymphoreticular Process. Code malignant lymphoreticular process as site C42.3, reticuloendothelial 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: www.ccrcal.org. Click on Registrar Resources, then Data Standards and Quality Control Memorandums, go to DSQC Memo 2000-04, page 2.

Primary Site

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

Primary Site

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)

Section 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:

- 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).

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). Reporting of laterality is optional for sites other than those listed. ICD-O-3 codes and sites for which laterality codes must be entered are:

C07.9 Parotid gland	C09.8 Overlapping lesion of tonsil
C08.0 Submandibular gland	C09.9 Tonsil, NOS
C08.1 Sublingual gland	C30.0 Nasal cavity— <i>excluding</i>
C09.0 Tonsillar fossa	<i>nasal cartilage, nasal septum</i>
C09.1 Tonsillar pillar	C30.1 Middle ear

Laterality

C31.0	Maxillary sinus	C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C31.2	Frontal sinus	C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C34.0	Main bronchus— <i>excluding carina</i>	C50.0-C50.9	Breast
C34.1-C34.9	Lung	C56.9	Ovary
C38.4	Pleura, NOS	C57.0	Fallopian tube
C40.0	Upper limb long bones, scapula	C62.0-C62.9	Testis
C40.1	Upper limb short bones	C63.0	Epididymis
C40.2	Lower limb long bones	C63.1	Spermatic cord
C40.3	Lower limb short bones	C64.9	Kidney, NOS
C41.3	Rib, clavicle— <i>excluding sternum</i>	C65.9	Renal pelvis
C41.4	Pelvic bones— <i>excluding sacrum, coccyx, symphysis pubis</i>	C66.9	Ureter
C44.1	Eyelid skin	C69.0-C69.9	Eye and adnexa
C44.2	External ear skin	C74.0-C74.9	Adrenal gland
C44.3	Skin of other and unspecified parts of face	C75.4	Carotid body
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		

Section 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

Histology, Behavior, and Differentiation

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.

Histology, Behavior, and Differentiation

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.

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Examples

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

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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

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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). (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:

- 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.

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- 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.)

Malignant Lymphoreticular Process. Code as malignant neoplasm, NOS (8000/3). However, for lymphoreticular process further classifiable as myeloproliferative arising in the bone marrow, code as malignant myeloproliferative disease (9960/3). For lymphoreticular process classified as lymphoproliferative arising in the lymph tissue, code as malignant lymphoproliferative disease (9970/3).

(Adeno)carcinoma in a Polyp. Adenocarcinoma in a polyp should be coded 8210 even if it is stated only in the microscopic description and not in the final diagnosis.

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.

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.

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Although T-cell large granular lymphocytic leukemia (code 9831) is a very indolent form of leukemia and therefore assigned a behavior code of /1 in ICD-O-3, the World Health Organization Table 13 on page 17 of the ICD-O-3 lists this entity with a behavior code of /3. Infrequently this entity is symptomatic enough to be confirmed pathologically, thus the CCR is requiring pathologic confirmation for this diagnosis and that these cases be reported with a behavior code of /3.

V.3.4 BEHAVIOR

To code behavior, use the best information in the pathology report, regardless of whether it appears in the microscopic description, final diagnosis, or comments. If an AJCC staging form provides the best information, use it if the form is signed by a physician. ICD-O-3 assigns a behavior code as the fifth digit of the histology number, following the slash. (For example, in the number 8012/3 for large cell carcinoma, the 3 is the behavior code.) The codes are:

* /0 BENIGN

* /1 UNCERTAIN WHETHER BENIGN OR MALIGNANT
BORDERLINE MALIGNANCY (except cystadenomas in the range 844-849)
LOW MALIGNANT POTENTIAL

/2 CARCINOMA-IN-SITU
Intraepithelial
Non-infiltrating
Non-invasive

/3 MALIGNANT, PRIMARY SITE

** /6 MALIGNANT, METASTATIC SITE
MALIGNANT, SECONDARY SITE

** /9 MALIGNANT, UNCERTAIN WHETHER PRIMARY OR METASTATIC SITE

*Not reportable to the California Cancer Registry

**Reportable behavior, but enter code 3.

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V.3.4.1 ICD-O/Pathology Conflicts. If there is a conflict between the behavior code specified by ICD-O for a histologic subtype and the behavior described by a pathologist in the final diagnosis, the pathologic diagnosis generally prevails. ICD-O codes only indicate the usual behavior.

V.3.4.2 In Situ Coding. The term "in situ" means a tumor that meets all microscopic criteria for malignancy, except invasion of basement membrane. (For further discussion of in situ, see Section V.5.8.) Therefore, in situ behavior can be determined only by pathologic examination, and not by clinical evidence alone. If a tumor is classifiable as in situ according to the time-period rules for stage at diagnosis (see Section V.5), code the lesion as in situ. In other words, a behavior code of 2, in situ, corresponds to a stage code of 0, in situ, and vice versa. Computer and visual edits will verify that the codes in these two fields correspond. Do not interpret terms like "approaching in situ" or "very close to in situ" as in situ. Reportable terms indicating in situ behavior include:

AIN (anal intraepithelial neoplasia Grade II-III)**	LCIS (lobular carcinoma in situ)
Bowen's Disease	Lentigo maligna
DCIS (ductal carcinoma in situ)	LIN (laryngeal intraepithelial neoplasia)**
DIN 3 (ductal intraepithelial neoplasia 3	Lobular neoplasia, Grade III
Clark's level 1 for melanoma (limited to epithelium)	No stromal invasion
Confined to epithelium	Non-infiltrating
Hutchinson's melanotic freckle	Non-invasive
Intracystic, non-infiltrating	Precancerous melanosis
Intraductal	Preinvasive
Intraepidermal	Queyrat's erythroplasia
Intraepithelial	Stage 0
Intrasquamous	VAIN III (vaginal intraepithelial neoplasia, Grade III)*
Involvement up to but not including the basement membrane	VIN III (vulvar intraepithelial neoplasia, Grade III)*

*Cases diagnosed January 1992 and later

**Cases diagnosed January 2001 and later.

All other terms have been reportable since the region's reference date.

As a reminder, carcinoma in situ (including squamous cell and adenocarcinoma) of the cervix and Cervical Intraepithelial Neoplasia, CIN III, are not reportable effective with cases diagnosed January 1, 1996 and later. Prostatic Intraepithelial Neoplasia (PIN III), morphology code 8148/2 is also not reportable to the CCR.

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V.3.4.3 Microinvasion. Code a pathologic diagnosis of "microinvasive"—meaning the earliest stage of invasion—as malignant, not in situ. For the diagnosis of microinvasive squamous cell carcinoma, a common form of cervical cancer, use the morphology code provided by ICD-O-3, 8076/3.

V.3.5 GRADE AND DIFFERENTIATION

Code the grade, or degree of differentiation, as stated in the final pathologic diagnosis. However, do not code as "not stated" if there is a relevant statement in the microscopic description. If there is a difference in grade between two different pathologic specimens, it is better to code a known grade over an unknown grade. A grade stated in a histopathology report takes precedence over one stated in a cytology report. Information on an AJCC staging form may be used if the form is signed by a physician. If a needle biopsy or excisional biopsy of a primary site has a differentiation given and the excision or resection does not, code the information from the needle/incisional biopsy. If there is no grade provided for the primary site, code as 9, even if a grade is given for a metastatic site. The codes are:

- 1 Grade I
 - grade i
 - grade 1
 - Well differentiated
 - Differentiated, NOS

- 2 Grade II
 - grade ii
 - grade 2
 - Moderately differentiated
 - Moderately well differentiated
 - Partially well differentiated
 - Partially differentiated
 - Intermediate differentiation
 - Low grade, NOS

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3 Grade III
grade iii
grade 3
Poorly differentiated
Moderately undifferentiated
Relatively undifferentiated
Slightly differentiated
Dedifferentiated
Medium grade, NOS

4 Grade IV
grade iv
grade 4
Undifferentiated
Anaplastic
High grade, NOS

**5 T-Cell
T-Precursor

**6 B-Cell
Pre-B
B-Precursor

**7 Null-Cell
Non-T-Non-B

**8 NK (Natural Killer Cell)

9 Grade or Differentiation Not Determined or Not Stated

**Apply to leukemias and lymphomas only. See Section V.3.5.7.

V.3.5.1 Mixed Differentiation. If a diagnosis indicates different degrees of differentiation in the same neoplasm, enter the code with the highest number, even if it does not represent the majority of the lesion. This could include different degrees of differentiation between the biopsy and resection specimens.

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Example

The final diagnosis states predominantly grade II, focally grade III. Code as grade III.

V.3.5.2 Microscopic Description. If the final pathologic diagnosis states one degree of differentiation, while the microscopic description states another, enter the code for the final diagnosis.

Example

The microscopic description states moderately differentiated squamous cell carcinoma with poorly differentiated areas. The final diagnosis states moderately differentiated squamous cell carcinoma. Enter code 2 (8070/32).

But if the final pathologic diagnosis does not state the degree of differentiation, code the grade stated in the microscopic description.

Example

The microscopic description states moderately differentiated squamous cell carcinoma with poorly differentiated areas. The final diagnosis states squamous cell carcinoma. Enter code 3 (8070/33).

V.3.5.3 Variation in Terms for Degree of Differentiation. Use the higher grade when different terms are used for the degree of differentiation as follows:

Term	Grade	Code
Low grade	I-II	2
Medium grade; intermediate grade	II-III	3
High grade	III-IV	4
Partially well differentiated	I-II	2
Moderately undifferentiated	III	3
Relatively undifferentiated	III	3

Occasionally a grade is written as "2/3" or "2/4" meaning this is grade 2 of a 3-grade system or grade 2 of a 4-grade system, respectively.

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To code in a three grade system, refer to the following codes:

Term	Code
Low Grade	2
Medium Grade	3
High Grade	4

Tumor grades may also be recorded using a two-grade system, noting a grade as “low” or “high.” Use code 2 for low grade and code 4 for high grade.

V.3.5.4 In Situ. Medical reports ordinarily do not contain statements about differentiation of in situ lesions. But if a statement is made, enter the code indicated.

V.3.5.5 Brain Tumors. Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) can sometimes establish the grade of a brain tumor. If there is no tissue diagnosis, but grade or differentiation is stated in a MRI or PET report, base the grade code on the report. If there is a tissue diagnosis, however, do not base the grade code on any other source.

V.3.5.6 Gleason's Score. A special descriptive method, Gleason's Score, is used for prostate cancer. It is obtained by adding two separate numbers to produce a score in the range of 2 to 10. First, a number is assigned to the predominant (primary) pattern (i.e., the pattern that comprises more than half the tumor). Then a number is assigned to the lesser (secondary) pattern, and the two numbers are added to obtain Gleason's Score.

If only one number is stated, and it is 5 or less, assume that it represents the primary pattern. If the number is higher than 5, assume that it is the score. If there are two numbers, add them to obtain the score.

Sometimes, the number 10 is written after Gleason's Score to show the relationship between the actual score and the highest possible score (e.g., Gleason's 3/10 indicates a score of 3).

If a number is not identified as Gleason's, assume that a different grading system was used and code appropriately.

When both grade and Gleason's Score are provided in the same specimen, code the grade. When they are in different specimens, code to the highest grade.

If only Gleason's Score (2-10) is available, convert it to grade according to the following table:

Histology, Behavior, and Differentiation

Gleason's Score	Grade	Code
2, 3, 4	I	1
5, 6, 7*	II	2
8, 9, 10	III	3

***Exception:** If the pathology report states that the tumor is moderately to poorly differentiated and Gleason's score is reported as 7, assign code 3. (SEER SINQ 20010117)

If only the predominant pattern (1-5) is mentioned in the medical record, enter the code as follows:

Gleason's Pattern	Grade	Code
1, 2	I	1
3	II	2
4, 5	III	3

V.3.5.7 Lymphomas and Leukemias. In ICD-O-3, the WHO Classification of Hematopoietic and Lymphoid Neoplasms is followed. Under this classification, two groups are identified, lymphoid neoplasms and myeloid neoplasms.

Lymphoid neoplasms consist of:

- B-cell, T-cell, NK-cell lymphomas
- Hodgkin's lymphoma
- Lymphocytic leukemias
- Other lymphoid malignancies

Myeloid neoplasms consist of:

- Myeloproliferative diseases
- Myelodysplastic diseases and syndromes
- Myeloid leukemias
- Acute biphenotypic leukemias

Codes 5 (T-cell), 6 (B-cell), and 7 (Null-cell) for lymphomas and leukemias are based on immunological or biochemical test results (marker studies), or on a pathology report. Beginning with cases diagnosed January 1, 1995, T-precursor was added to code 5 and a new code was added - code 8 - NK cell (natural killer cell). Code any statement of T-cell, B-cell, or Null-cell involvement (non-T/non-B is a synonym for Null-cell), whether or not marker studies are documented in the medical record. These codes have precedence over those for grades I-IV. If information about T-, B-, or Null-cell codes is unavailable, but a grade (such as well differentiated or poorly differentiated) is given, use the code for the grade. For lymphomas, do not code the descriptions "high grade," "low grade," or "intermediate grade" in the Grade or Differentiation field. They refer to categories in the Working Formulation of lymphoma diagnoses and not to histologic grade.

Histology, Behavior, and Differentiation

Do not code grade 1, 2 or 3 for follicular lymphoma or Hodgkin's lymphoma in the 6th digit field. The grade refers to the type of cell, not the differentiation.

V.3.5.8 Bloom-Richardson Grade for Breast Cancer Beginning with breast cancer cases diagnosed January 1, 1996, the Bloom-Richardson grading system 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** **Score**

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

 - <10 mitoses in 10 high-power fields 1
 - 10 and <20 mitoses 2
 - 20 mitoses per 10 high power fields 3

- **Nuclear pleomorphism (nuclear grade)** **Score**
 - 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:

Histology, Behavior, and Differentiation

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. Terminology (differentiation; well, moderately, poorly, moderately-well, etc.)
2. Histologic grade [grade i (I), grade ii (II), grade iii (III)]
3. Bloom-Richardson scores (range 3-9, converted to grade)
4. Bloom-Richardson grade (low, intermediate, high)
5. Nuclear grade only

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.

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	Term	ICD-O-3 6th digit
Anaplastic astrocytoma	4	Astrocytoma Grade 1	1
Astrocytoma (low grade)	2	Astrocytoma Grade 2	2
Glioblastoma multiforme	9	Astrocytoma Grade 3	3
Pilocytic astrocytoma	9	Astrocytoma Grade 4	4

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:

Histology, Behavior, and Differentiation

Morphology		Site Code	
1. 8090–8096	Basal cell carcinomas with	C00._ C19.9 C20.9-C21.8	Lip Rectosigmoid Rectum and anus
2. 8720–8790 peritoneum	Melanoma	with C48.0-C48.8 C38.1-C38.8 C40.0-C41.9 C76._	Retroperitoneum/ Pleura and Mediastinum Bone Other and ill-defined sites
3. 8010–8671	Epithelial & specialized gonadal tumors	with C38.1-C38.8 C40.0-C41.9* C47.0-C47.9 C49.0-C49.9 C70.0-C72.9	Pleura and Mediastinum Bone Peripheral Nerves Soft Tissues Brain and Other Nervous System
4. 8940–8941	Mixed tumors	with C38.1-C38.8 C40.0-C41.9 C47.0-C47.9 C49.0-C49.9 C70.0-C71.9 C72._ C76._	Pleura and Mediastinum Bone Peripheral Nerves Soft tissues Brain Other Nervous System Other and ill-defined sites
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

*Site C40.0-C41.9 (bone) with histology 8070 (squamous cell carcinoma) is possible.

Histology, Behavior, and Differentiation

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

Section 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 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.

Section 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.

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 Manual 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 Manual 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.5.12 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

Stage at Diagnosis

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 longer. 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.

Stage at Diagnosis

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.

Stage at Diagnosis

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
- Involvement up to but not including the basement membrane
- LCIS (lobular carcinoma in situ)
- Lentigo maligna
- LIN (laryngeal intraepithelial neoplasia)**
- Lobular neoplasia, Grade III
- No stromal invasion
- Non-infiltrating
- Non-invasive
- Precancerous melanosis
- Preinvasive
- Queyrat's erythroplasia
- Stage 0
- 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.

V.5.8.2 Behavior Code. If a tumor is staged in situ, the behavior code (see Section V.3.4) is 2.

Stage at Diagnosis

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.

Stage at Diagnosis

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) . Sometimes 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

- (1) 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.
- (2) 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.

Stage at Diagnosis

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 Manual*.
- 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.

Stage at Diagnosis

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

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 dehydro-genase (LDH). Ranges for testicular cancer tumor markers have been added in codes 4-6.

Beginning with January 1, 2000 diagnoses, Tumor Marker I may be used to record carcinoembryonic antigen (CEA) for colorectal cancers and CA-125 for ovarian cancers.

V.6.1 TUMOR MARKER 1

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)

Tumor Markers

For breast-cancer cases diagnosed before January 1, 1990, for prostate and testicular cancers before January 1, 1998 and for other sites not mentioned above, 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 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 an antigen-antibody reaction. If immunostaining results are available, use them to code Estrogen-Receptor Status.

V.6.2 TUMOR MARKER 2

Use the following codes for 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 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)

Tumor Markers

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.

V.6.3 TUMOR MARKER 3

- 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: $< 1.5 * N$ (S1)
- 5 RANGE 2: $1.5 - 10 * N$ (S2) NOTE: N = the upper limit of normal
- 6 RANGE 3: $> 10 * N$ (S3)
- 8 TEST ORDERED, RESULTS NOT IN CHART
- 9 UNKNOWN IF TEST DONE OR ORDERED; NO INFORMATION (includes death-certificate-only cases)

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:

Tumor Markers

- 0 NOT DONE (SX)
- 2 WITHIN NORMAL LIMITS (SO)
- 4 RANGE 1 (S1) <1.5 x UPPER LIMIT OF NORMAL FOR LDH ASSAY
- 5 RANGE 2 (S2) 1.5 - 10 x UPPER LIMIT OF NORMAL FOR LDH ASSAY
- 6 RANGE 3 (S3) >10 x UPPER LIMIT OF NORMAL FOR LDH ASSAY
- 8 ORDERED, BUT RESULTS NOT IN CHART
- 9 UNKNOWN OR NO INFORMATION

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 TESTS ORDERED, RESULTS NOT IN CHART
- 9 UNKNOWN IF TEST DONE OR ORDERED, NO INFORMATION (includes death certificate only cases)

For breast cancer cases prior to January 1, 1999 or all other sites, enter:

- 9 NOT APPLICABLE

Section 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. 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 the *AJCC Manual for Staging of Cancer, 6th 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.

AJCC Staging and Other ACoS Items

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	T2	= 2
T0	= 0	T2A	= 2A
Ta	= A	T2B	= 2B
Tis	= IS	T2C	= 2C
Tispu	= SU	T3	= 3
Tispd	= SD	T3A	= 3A
T1	= 1	T3B	= 3B
T1mic	= 1M	T3C	= 3C
T1A	= 1A	T4	= 4
T1A1	= A1	T4A	= 4A
T1A2	= A2	T4B	= 4B
T1B	= 1B	T4C	= 4C
T1B1	= B1	T4D	= 4D
T1B2	= B2	Not applicable	= 88
T1C	= 1C		

N CODES:

NX	= X	N2B	= 2B
N0	= 0	N2C	= 2C
N1	= 1	N3	= 3
N1mi	= 1M	N3A	= 3A
N1A	= 1A	N3B	= 3B
N1B	= 1B	N3C	= 3C
N1C	= 1C	Not applicable	= 88
N2	= 2		
N2A	= 2A		

AJCC Staging and Other ACoS Items

M CODES:

MX	= X	M1B	= 1B
M0	= 0	M1C	= 1C
M1	= 1	Not applicable	= 88
M1A	= 1A		

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 and b. Codes indicate metastases to:

M1a	Skin or subcutaneous tissue or lymph node(s) beyond the regional lymph nodes
M1b	Lung metastasis
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 IIA	= 2A
STAGE 0A	= 0A	STAGE IIB	= 2B
STAGE 0IS	= 0S	STAGE IIC	= 2C
STAGE I	= 1	STAGE III	= 3
STAGE IA	= 1A	STAGE IIIA	= 3A
STAGE IA1	= A1	STAGE IIIB	= 3B
STAGE IA2	= A2	STAGE IIIC	= 3C
STAGE IB	= 1B	STAGE IV	= 4
STAGE IB1	= B1	STAGE IVA	= 4A
STAGE IB2	= B2	STAGE IVB	= 4B
STAGE IS	= 1S	STAGE IVC	= 4C
STAGE II	= 2	NOT APPLICABLE	= 88
		RECURRENT, UNKNOWN, STAGE X	= 99

AJCC Staging and Other ACoS Items

V.7.6 TNM CODER (CLINICAL), (PATHOLOGICAL), AND (OTHER)

Record who was responsible for performing the TNM staging on the case. The TNM Coder (Clinical) and TNM Coder (Pathological) are to be used in conjunction with clinical and pathological TNM staging. These fields will be transmitted to the regional and state registries. CNExT will have the TNM Coder (Other) field available for hospitals, but it will not be transmitted. The codes are as follows:

- 0 NOT STAGED
- 1 MANAGING PHYSICIAN
- 2 PATHOLOGIST
- | 3 PATHOLOGIST AND MANAGING PHYSICIAN
- 4 ANY COMBINATION OF 1, 2 OR 3
- 5 REGISTRAR
- 6 ANY COMBINATION OF 5 WITH 1, 2 OR 3
- | 7 STAGING ASSIGNED AT ANOTHER FACILITY
- 8 CASE IS NOT ELIGIBLE FOR STAGING
- 9 UNKNOWN IF STAGED

V.7.7 TNM EDITION

Record which edition of TNM staging was used to stage a case. The codes are as follows:

- 00 NOT STAGED
- 01 FIRST EDITION
- 02 SECOND EDITION
- 03 THIRD EDITION
- 04 FOURTH EDITION
- 05 FIFTH EDITION
- | 06 SIXTH EDITION
- 88 NOT APPLICABLE (cases that do not have an AJCC staging scheme and staging was not done)
- 99 UNKNOWN

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 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:

AJCC Staging and Other ACoS Items

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
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)

AJCC Staging and Other ACoS Items

88 NOT APPLICABLE
97 OTHER
99 UNKNOWN

V.7.10 PEDIATRIC STAGE CODER

This data item is to be used for pediatric cases only diagnosed January 1, 1996 and later. It identifies the person who staged the case. The ACoS states that the Managing Physician is responsible for staging analytical cases. The CCR concurs and feels that this applies to non-analytic cases, also. If the staging has not been done by the physician, the registrar does not have to stage the case. Enter 0 for not staged. For patients older than twenty (20), enter 0. For cases diagnosed prior to 1996, this field may be left blank. The codes are as follows:

0 NOT STAGED
1 MANAGING PHYSICIAN
2 PATHOLOGIST
3 OTHER PHYSICIAN
4 ANY COMBINATION OF 1, 2 OR 3
5 REGISTRAR
6 ANY COMBINATION OF 5 WITH 1, 2 OR 3
7 OTHER
8 STAGED, INDIVIDUAL NOT SPECIFIED
9 UNKNOWN IF STAGED

PART VI TREATMENT

Section VI.1 First Course of Treatment: General Instructions

In the treatment section, record all cancer treatment administered as part of the first course of therapy. 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.

First Course of Treatment: General Instructions

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.

First Course of Treatment: General Instructions

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

First Course of Treatment: General Instructions

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. They will be filled in with zeros by CNEXT. 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. (See illustration I.1 in Section I.1.) The text field may be left blank when the type of treatment was not provided. But if no cancer 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

First Course of Treatment: General Instructions

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 Introduction

In abstracting surgical treatment, record the total or partial removal (except an incisional biopsy) of tumor tissue, 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)

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.

First Course of Treatment: Surgery Introduction

Cases diagnosed prior to January 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

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
- Transurethral resection (TUR) with removal of tumor tissue of bladder or prostatic tumors

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.

First Course of Treatment: Surgery Introduction

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.

Surgery of the Primary Site consists of three two-character fields which are to be used to record surgeries of the primary site only. If an en bloc resection is performed which removes regional tissue or organs with the primary site as part of a specific code definition, it should be coded. An en bloc resection is the removal of organs in one piece at one time.

Example

Patient undergoes a modified radical mastectomy. The breast and axillary contents are removed in one piece (en bloc). Surgery would be coded 50 for modified radical mastectomy regardless of whether nodes were found by pathology in the specimen.

For non-en bloc resections, record the resection of a secondary or metastatic site in the Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s). Please refer to Appendix Q for the site-specific surgery codes.

Example

50	Gastrectomy, NOS WITH removal of a portion of esophagus
51	Partial or subtotal gastrectomy
52	Near total or total gastrectomy

NOTE: Codes 10-90 have priority over code 99.

Codes 10-84 have priority over codes 90 and 99.

Codes 10-79 have priority over codes 80, 90 and 99, where 80 is site-specific surgery, not otherwise specified.

NOTE: If surgery removes the remaining portion of an organ, code the total removal of the organ.

NOTE: Biopsies that remove all gross tumor or leave only microscopic margins should be coded to surgery of the primary site.

First Course of Treatment: Surgery Introduction

Examples

The patient had a resection of a stomach remnant and portion of the esophagus at the time of their second procedure. The first procedure was a partial gastrectomy, NOS - code 30. The second procedure would be code 52 for a total gastrectomy.

A patient had a lobectomy--code 31--for cancer in August 1998. The remainder of the lung was surgically removed in November 1998. The second procedure would be code 40--resection of whole lung.

Enter the procedures in chronological order. If more than three surgical procedures are performed on a patient, the earliest surgery and the most definitive surgery must be included. The Summary field will be computed automatically by CNExT and will contain the most definitive surgical procedure performed on a patient. If surgery is not performed, the fields may be left blank. They will be filled with 00 by CNExT.

VI.2.2 SCOPE OF REGIONAL LYMPH NODE SURGERY

These three one-character fields are to be used to record surgeries performed on regional lymph nodes. Record the farthest regional lymph node removed regardless of involvement with disease. There is no minimum number of nodes that must be removed. If a regional lymph node was aspirated or biopsied, code regional lymph node(s) removed, NOS (1).

Starting with cases diagnosed January 1, 2003 forward, RX Summ -- Scope of Reg LN Surg will not be coded according to site. It will be coded using a single scheme for all sites. The three procedure fields will continue to be coded for 2003 forward cases. The codes for Scope of Regional LN's are as follows:

- | | |
|---|---|
| 0 | NONE
No regional lymph node surgery. No lymph nodes found in the pathologic specimen.
Diagnosed at autopsy. |
| 1 | BIOPSY OR ASPIRATION OF REGIONAL LYMPH NODE, NOS
Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease. |
| 2 | SENTINEL LYMPH NODE BIOPSY
Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor. |

First Course of Treatment: Surgery Introduction

- 3 NUMBER OF REGIONAL NODES REMOVED UNKNOWN OR NOT STATED;
REGIONAL LYMPH NODE REMOVED, NOS
Sampling or dissection of regional lymph node(s) and the number of nodes is unknown or not stated. The procedure is not specified as sentinel node biopsy.
- 4 1-3 REGIONAL LYMPH NODES REMOVED
Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
- 5 4 OR MORE REGIONAL LYMPH NODES REMOVED
Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
- 6 SENTINEL NODE BIOPSY AND CODE 3,4, OR 5 AT SAME TIME, OR TIMING
OUT NOT STATED
Code 2 was performed in a single surgical event with code 3,4, or 5. Or, code 2 and 3, 4, or 5 was performed, but timing was not stated in patient record.
- 7 SENTINEL NODE BIOPSY AND CODE 3,4, OR 5 AT DIFFERENT TIMES
Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.
- 9 UNKNOWN OR NOT APPLICABLE
It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

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.

Each site contains a list of nodes which are regional. Any nodes not contained on these lists are distant and should be coded in Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

In Appendix Q-1 for head and neck primaries diagnosed prior to January 1, 2003, these fields are to be used for neck dissections. Codes 2-5 indicate only that a neck dissection procedure was done, they do not imply that nodes were found during the pathologic examination of the surgical specimen. Code the neck dissection even if no nodes were found in the specimen.

For Unknown Primary, Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease Primaries, Lymphoma, Brain, and Primaries of Ill-Defined Sites, use code 9.

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VI.2.3 NUMBER OF REGIONAL LYMPH NODES EXAMINED

Record the number of lymph nodes identified in the pathology report during each surgical procedure of the regional lymph nodes. The codes are the same for all sites. Please refer to Appendix Q-1 for these codes. These are to be entered in chronological order. If no regional lymph nodes were identified in the pathology report, leave the field blank even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or if the operative report documents removal of the nodes. CNEXT will fill the fields with 00. The Summary field will be computed automatically by CNEXT. It will contain the number of nodes associated with the highest coded regional lymph node surgery. If no nodes were identified in the specimen from this procedure, then the Summary field will contain 00. NOTE: This field is not cumulative. It does not replace or duplicate the "Regional Lymph Nodes Examined" field used in Extent of Disease coding.

Effective with cases diagnosed on or after January 1, 2003, the fields for Rx Summ-Reg LN Examined and Rx Hosp-Reg LN Examined are no longer required by the CCR and the CoC. Information regarding the number of lymph nodes has been incorporated into the scope fields. However, the summary field for cases diagnosed prior to January 1, 2003 must continue to be coded.

For Unknown Primary Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative 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

There are three one-character fields to be used to record removal of tissue other than the primary tumor or organ of origin. This would not be an en bloc resection. See example #1. Code the removal of non-primary site tissue which the surgeon may have suspected to be involved with malignancy even if the pathology was negative. Do not code the incidental removal of tissue for reasons other than malignancy. See example #2. These procedures are to be entered in chronological order. If no surgery was performed of other regional or distant sites or distant lymph nodes, leave the fields blank. They will be filled with 0 by CNEXT. The Summary field will be computed automatically by CNEXT.

Starting with cases diagnosed January 1, 2003 forward, RX Summ - Surg Oth Reg/Dis 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:

- | | |
|---|---|
| 0 | NONE
No surgical procedure of nonprimary site |
| 1 | NONPRIMARY SURGICAL PROCEDURE PERFORMED
Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant. |

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- | | | |
|---|---|--|
| 2 | NONPRIMARY SURGICAL PROCEDURE TO OTHER REGIONAL SITES
Resection of regional site. | |
| 3 | NONPRIMARY SURGICAL PROCEDURE TO <i>DISTANT LYMPH NODE(S)</i>
Resection of <i>distant lymph node(s)</i> . | |
| 4 | NONPRIMARY SURGICAL PROCEDURE TO DISTANT SITE
Resection of distant site. | |
| 5 | COMBINATION OF CODES
Any combination of surgical procedures 2, 3, or 4. | |
| 9 | UNKNOWN
It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only. | |

Cases diagnosed prior to January 1, 2003 are to be coded in a new field, Surgery Other 98-02. Refer to Appendix Q-1 for these codes.
This field is for all procedures that do not meet the definitions of Surgery of Primary Site or Scope of Regional Lymph Nodes.

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Example #1

The patient has an excisional biopsy of a hard palate lesion removed from the roof of the mouth and a resection of a metastatic lung nodule during the same procedure. Code the resection of the lung nodule as 4 (resection of distant site).

Example #2

During a colon resection, the surgeon noted that the patient had cholelithiasis and removed the gallbladder. Do not code removal of the gallbladder.

VI.2.5 DATE OF SURGERY

Enter the date of surgery performed for each surgical procedure. There are three date fields available to be used in conjunction with each definitive procedure performed. Procedures for this date field include Surgery of the Primary Site, Scope of Regional Lymph Node Surgery or Surgery of Other Regional/Distant Sites. These must be entered in chronological order. They are to be left blank if no surgery is performed. They will be filled in with zeros by CNExT. The Summary field will be computed automatically by CNExT and will contain the earliest date of surgery.

Beginning with cases diagnosed 1/1/2003, 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.2.6 TREATMENT HOSPITAL NUMBER

These fields are to be used in conjunction with each definitive surgery performed. If the procedure was performed at the reporting facility, the hospital number can be filled in using a function key in CNExT. The hospital number for procedures performed at other facilities will have to be entered using autocoding. The fields are to be left blank if no cancer-directed surgery was performed. The Summary field will be computed by CNExT and will contain the treatment hospital number for the most definitive or highest code surgical procedure. The Summary field will be available in CNExT but will not be transmitted to the regions or CCR.

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VI.2.7 SURGICAL MARGINS

This field is not required by the CCR effective with cases diagnosed January 1, 2000, but it is required by the ACoS. It describes the status of the surgical margins after each resection of the primary tumor. For cases diagnosed prior to January 1, 2003, please refer to Appendix Q-1 for the site-specific codes. For cases diagnosed after January 1, 2003, please refer to the FORDS Manual.

VI.2.8 RECONSTRUCTIVE SURGERY - IMMEDIATE

Record the procedure in both the Reconstructive Summary and At This Hospital fields and in the surgery text field if it was performed subsequent to surgery as part of the planned first course of therapy. This procedure improves the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies. 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 cases, refer to Appendix Q-1.

VI.2.9 REASON FOR NO SURGERY

Effective with cases diagnosed 1/1/2003, a new code, Code 5, surgery not performed because patient died has been added and the definitions for codes 1, 2, and 6 have been modified. If surgery of the primary site was performed, enter 0. Reason for No Surgery only applies to the Surgery of the Primary Site field, not Scope of Regional Lymph Node Surgery or Surgery Other Regional/Distant Sites.

- 0 SURGERY OF THE PRIMARY SITE PERFORMED
- 1 SURGERY OF THE PRIMARY SITE NOT PERFORMED BECAUSE IT WAS NOT PART OF THE PLANNED FIRST COURSE TREATMENT
- 2 SURGERY OF THE PRIMARY SITE NOT PERFORMED BECAUSE OF CONTRAINDICATIONS DUE TO PATIENT RISK FACTORS (COMORBID CONDITIONS, ADVANCED AGE, ETC.)
- 5 SURGERY OF THE PRIMARY SITE WAS NOT PERFORMED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED SURGERY
- 6 SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT NOT PERFORMED. NO REASON WAS NOTED IN THE PATIENT'S RECORD
- 7 SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT REFUSED BY THE PATIENT, FAMILY MEMBER OR GUARDIAN. THE REFUSAL IS NOTED IN THE PATIENT'S RECORD.
- 8 SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT UNKNOWN IF PERFORMED

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- 9 NOT KNOWN IF SURGERY OF THE PRIMARY SITE WAS RECOMMENDED OR PERFORMED; DEATH CERTIFICATE ONLY AND AUTOPSY ONLY CASES

VI.2.10 DIAGNOSTIC OR STAGING PROCEDURES

Record surgical procedures performed solely for establishing a diagnosis and or determining stage of disease. If there is more than one surgical diagnostic or staging procedure, record the first one performed. Some of the procedures should be recorded in the Operative Findings field (see Section IV.1.6).

Beginning with cases diagnosed January 1, 2003 forward, this field does not include palliative treatment/procedures. Palliative treatment/procedures are recorded in a separate field. The CCR does not require that palliative treatment/procedures be recorded but the CoC does require this field. Please consult the FORDS Manual for instructions regarding the palliative procedure field.

Surgical diagnostic or staging procedures include:

- Biopsy, incisional or NOS (if a specimen is less than or equal to 1 cm, assume the biopsy to have been incisional unless otherwise specified)
- Dilation and curettage for invasive cervical cancer
- Dilation and curettage for invasive or in situ cancers of the corpus uteri, including choriocarcinoma
- Surgery in which tumor tissue is not removed, for example
- Bypass surgery—colostomy, esophagostomy, gastrostomy, nephrostomy, tracheostomy, urethroscopy, stent placement
- Exploratory surgery—celiotomy, cystotomy, gastrotomy, laparotomy, nephrotomy, thoracotomy

NOTE: Removal of fluid (paracentesis or thoracentesis) even if cancer cells are present is not a surgical procedure. Do not code brushings, washings, or hematologic findings (peripheral blood smears). These are not considered surgical procedures.

NOTE: If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).

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Do Not Code:

- Surgical procedures which aspirate, biopsy, or remove *regional lymph nodes* in effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure*.
- Excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* to code these procedures.
- Palliative surgical procedures in this data item.

VI.2.10.1 Diagnostic or Staging Procedure Codes

- 00 NO SURGICAL DIAGNOSTIC OR STAGING PROCEDURE WAS PERFORMED
- 01 INCISIONAL, NEEDLE, OR ASPIRATION BIOPSY OF OTHER THAN PRIMARY SITE (Code microscopic residual disease or no residual disease as Surgery of Other Regional Site[s], Distant Site[s], or Distant Lymph Nodes[s])
- 02 INCISIONAL, NEEDLE, OR ASPIRATION BIOPSY OF PRIMARY SITE (Code Microscopic residual disease or no residual disease as Surgery of Primary Site)
- 03 EXPLORATORY SURGERY ONLY (no biopsy)
- 04 BYPASS SURGERY OR OSTOMY ONLY (no biopsy)
- 05 COMBINATION OF 03 PLUS 01 OR 02
- 06 COMBINATION OF 04 PLUS 01 OR 02
- 07 DIAGNOSTIC OR STAGING PROCEDURE, NOS
- 09 UNKNOWN IF DIAGNOSTIC OR STAGING PROCEDURE DONE

NOTE: Give priority to:

- Codes 01-07 over code 09.
- Codes 01-06 over code 07.
- The highest code in the range 01-06.

First Course of Treatment: Surgery Introduction

VI.2.11 DATE OF DIAGNOSTIC OR STAGING PROCEDURE

Enter the date of the earliest surgical diagnostic and/or staging procedure in this field.

Codes (in addition to valid dates)

00000000 No diagnostic procedure performed; autopsy only case

99999999 Unknown if any surgical diagnostic or staging procedure performed; date unknown, or death certificate only case

VI.2.12 SOURCES FOR INFORMATION

To ascertain exactly what procedures were performed, read the operative and pathology reports thoroughly. Do not depend on the title of an operative report, because it might be incomplete. If the operative report is unclear about what tissue was excised, or the operative and pathology reports contain different information, use the pathology report unless there is reason to doubt its accuracy.

VI.2.13 SPECIAL RULES FOR CODING AMBIGUOUS CASES

There are specific rules for coding certain ambiguous situations:

Excision Of Multiple Primaries. If multiple primaries are excised at the same time, enter the appropriate code for each site.

Examples

- (1) If a total abdominal hysterectomy was performed for a patient with two primaries, one of the cervix and one of the endometrium, code each site as having had a total abdominal hysterectomy.
- (2) If a total colectomy was performed on a patient with multiple primaries in several segments of the colon, code total colectomy for each of the primary segments.

Excisional Biopsy. Record an excisional biopsy as first surgical treatment, whether followed by further definitive surgery or not and whether or not residual tumor was found in a later resection. If there is no statement that the initial biopsy was excisional, yet no residual tumor was found at a later resection, assume that the biopsy was excisional.

Extranodal Lymphomas. When coding surgery for extranodal lymphomas, use the appropriate code for the extranodal site. For example, use a code for the stomach to code a lymphoma of the stomach.

Section VI.3 First Course of Treatment: Radiation

Record the name or chemical symbol and method of administration of any radiation therapy that is directed toward tumor tissue or given prophylactically. 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:

Au ¹⁹⁸	gold	P ³²	phosphorus
Co ⁶⁰	cobalt	Pb ²¹⁰	lead
CrO ₄ P	chromic phosphate	Ra ²²⁶	radium
Cr ³² PO ₄	phosphocol	Rn ²²²	radon
Cs	cesium	Ru ¹⁰⁶	ruthenium
I ¹²⁵	iodine	Sr ⁹⁰	strontium
I ¹³¹	iodine	Y ⁹⁰	yttrium
Ir ¹⁹²	iridium		

First Course of Treatment: Radiation

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	Linear accelerator (LINAC)
Brachytron	MeV
Cobalt	Neutron beam
Cyclotron	Spray radiation
Grenz ray	Stereotactic radiosurgery, such as
Helium ion	gamma knife and proton beam
or other	X-ray
heavy particle beam	

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^{131} -labeled immunoglobulin is coded both as Radioisotopes and Immunotherapy—see Section VI.6.)

VI.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.

First Course of Treatment: Radiation

- 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

NOTE: Code 6 may appear in old cases that were converted to the 1988 codes. SEER converted old code 2, Other Radiation, to code 6.

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
- 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

First Course of Treatment: Radiation

- 42 LINAC RADIOSURGERY, NOS
- 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
- 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 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
- 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

First Course of Treatment: Radiation

- 32 CONFORMAL OR 3-D THERAPY
- 40 PROTONS
- 41 STEREOTACTIC RADIOSURGERY, NOS
- 42 LINAC RADIOSURGERY, NOS
- 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

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 known to have been given but the date is not known, enter 9's.

- 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. THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW-UP.
- 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)

First Course of Treatment: Radiation

- 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)
- 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

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, record the generic or trade names of the drugs used for chemotherapy. Include agents that are in the investigative or clinical trial phase. See the *SEER Self-Instructional Manual for Tumor Registrars: Book 8*, 3rd ed. (1994) for a comprehensive list of chemotherapeutic agents in use at the time of its publication.

VI.4.2 CHEMOTHERAPY CODES

Use the following codes for recording chemotherapy in the Summary field. Use codes 0-3 for recording chemotherapy in the At This Hospital field.

- 00 NONE, CHEMOTHERAPY WAS NOT PART OF THE PLANNED FIRST COURSE OF THERAPY.
- 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.

First Course of Treatment: Chemotherapy

- 86 CHEMOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE OF THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
- 87 CHEMOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN PATIENT RECORD.
- 88 CHEMOTHERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
- 99 IT IS UNKNOWN WHETHER A CHEMOTHERAPEUTIC AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.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 known to have been given but the date is not known, enter 9's.

- 0000000 NO CHEMOTHERAPY ADMINISTERED; AUTOPSY ONLY CASE
- 8888888 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, THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW UP.
- 9999999 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

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

Report cancer directed treatment with hormones and antihormones 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 Prednisone that is given in combination with chemotherapy (e.g., MOPP or COPP) for cancer of any site. For a list of hormonal agents see *SEER Self Instructional Manual for Tumor Registrars: Book 8*, 3rd ed. (1994).

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	Norlutate
Depo-Provera	Norlutin
Hydroxyprogesterone	Progestone
Medroxyprogesterone	Progesterone
Megace	Progestin
Megestrol acetate	Progestoral
Methyl progesterone	Proluton
Norethindrone	Provera

First Course of Treatment: Hormone Therapy

VI.5.1.2 Agents For Thyroid Cancer. Agents commonly used in the treatment of thyroid cancer include:

Cytomel	Thyroglobulin
Levothyroxine	Thyroid (extract)
Liothyronine	Thyrolar
Proloid	Thyroxine
Synthroid	TRIT
Triiothyronine	

Thyroid stimulating hormone (TSH) is replacement therapy and not tumor directed. But the administration of thyroid hormone following a thyroidectomy is definitive hormonal treatment, since thyroid extract has a dual role: replacement therapy and inhibition of recurrence and metastasis. Exogenous desiccated thyroid is treatment following both subtotal and total thyroidectomy

VI.5.2 HORMONE (ENDOCRINE) SURGERY

| This data item is coded in the "Transplant/Endocrine Procedure" field (Section VI.7). For reporting purposes, endocrine surgery is defined as the total surgical removal of an endocrine gland (both glands or all of a remaining gland in the case of paired glands). Record endocrine surgery for treatment of cancer of the breast or prostate only. The procedures are:

- Adrenalectomy
- Hypophysectomy
- Oophorectomy (breast)
- Orchiectomy (prostate)

If tumor tissue is present in a gland removed in the course of endocrine therapy, record the procedure as surgical treatment also.

First Course of Treatment: Hormone Therapy

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 01-87 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 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.

First Course of Treatment: Hormone Therapy

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 known to have been given but the date is not known, enter 9's.

0000000 NO HORMONE THERAPY ADMINISTERED; AUTOPSY ONLY CASE

8888888 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, THE DATE SHOULD BE REVISED AT TH NEXT FOLLOW UP.

9999999 WHEN IT IS UNKNOWN WHETHER ANY HORMONE THERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

Section 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

In addition to the agents listed in the *SEER Self-Instructional Manual for Tumor Registrars: Book 8*, 3rd ed. (1994), report the following as immunotherapy:

- ASILI (active specific intralymphatic immunotherapy)
- Blocking factors
- Bone marrow transplant
- I¹³¹-labeled immunoglobulin (also code as Radioisotopes)
- Interferon
- Monoclonal antibodies
- Transfer factor (specific or non-specific)
- Vaccine therapy
- Virus therapy

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 0-9 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

First Course of Treatment: Immunotherapy

- 82 IMMUNOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (i.e. COMORBID CONDITIONS, ADVANCED AGE).
- 85 IMMUNOTHERAPY WAS NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.
- 86 IMMUNOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE OF THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
- 87 IMMUNOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN THE PATIENT RECORD.
- 88 IMMUNOTHERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
- 99 IT IS UNKNOWN WHETHER AN IMMUNOTHERAPEUTIC AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.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. If immunotherapy is known to have been given but the date is not known, enter 9's.

- 0000000 NO IMMUNOTHERAPY ADMINISTERED; AUTOPSY ONLY CASE
- 8888888 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.
- 9999999 WHEN IT IS UNKNOWN WHETHER ANY IMMUNOTHERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

Section 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 10-87 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.)

First Course of Treatment: Transplant/Endocrine

- 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 ENDORCRINE SURGERY/RADIATION WERE NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY .
- 86 HEMATOLOGIC TRANSPLANT AND/OR ENDORCRINE 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 ENDORCRINE SURGERY/RADIATION WERE NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN PATIENT RECORD.
- 88 HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
- 99 IT IS UNKNOWN WHETHER HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.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.

- 00000000 NO TRANSPLANT OR ENDOCRINE THERAPY ADMINISTERED; AUTOPSY ONLY CASE
- 88888888 WHEN TRANSPLANT OR 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 OR ENDOCRINE THERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

Section VI.8

First Course Treatment: Other Therapy

Record definitive, cancer directed treatment that cannot be assigned to any other category, for example:

- Tumor embolization (arterial block), if the surgeon's intent is to kill tumor cells.
- 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 |
| 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 |

First Course of Treatment: Other Therapy

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 Trials Support Unit)
 - 16-50 National Trials
- 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

Section 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.

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.

Follow-Up 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.

Section 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

Follow-Up Data Items

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.

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.

VII.2.6.1 Last Type of Tumor Follow-up

This field is to be used to enter information representing the source of the most recent information on the tumor being followed. Reporting hospitals ordinarily use codes from the first of the three following groups, i.e., 00-15, unless instructed otherwise by their regional registry.

Follow-up obtained by hospital from:

- 00 ADMISSION BEING REPORTED
- 01 READMISSION TO REPORTING HOSPITAL
- 02 FOLLOW-UP REPORT FROM PHYSICIAN
- 03 FOLLOW-UP REPORT FROM PATIENT
- 04 FOLLOW-UP REPORT FROM RELATIVE
- 05 OBITUARY
- 07 FOLLOW-UP REPORT FROM HOSPICE
- 08 FOLLOW-UP REPORT FROM OTHER HOSPITAL
- 09 OTHER SOURCE
- 11 TELEPHONE CALL TO ANY SOURCE
- 12 SPECIAL STUDIES
- 14 ARS (AIDS REGISTRY SYSTEM)
- 15 COMPUTER MATCH WITH DISCHARGE DATA

Follow-Up Data Items

Follow-up obtained by regional registry from:

- 20 LETTER TO A PHYSICIAN
- 22 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
- 23 COMPUTER MATCH WITH HMO FILE
- 25 NATIONAL DEATH INDEX
- 26 COMPUTER MATCH WITH STATE DEATH TAPE
- 29 COMPUTER MATCH, OTHER OR NOS
- 30 OTHER SOURCE
- 31 TELEPHONE CALL TO ANY SOURCE
- 32 SPECIAL STUDIES
- 34 ARS (AIDS REGISTRY SYSTEM)
- 35 COMPUTER MATCH WITH DISCHARGE DATA
- 36 OBITUARY

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

- 40 LETTER TO A PHYSICIAN
- 41 TELEPHONE CALL TO ANY SOURCE
- 52 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
- 53 COMPUTER MATCH WITH HMO FILE
- 55 NATIONAL DEATH INDEX
- 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

- 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

Follow-Up Data Items

- 14 ARS (AIDS REGISTRY SYSTEM)
- 15 COMPUTER MATCH WITH DISCHARGE DATA

Follow-up obtained by regional registry from:

- 20 LETTER TO A PHYSICIAN
- 21 COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES FILE
- 22 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
- 23 COMPUTER MATCH WITH HMO FILE
- 24 COMPUTER MATCH WITH VOTER REGISTRATION FILE
- 25 NATIONAL DEATH INDEX
- 26 COMPUTER MATCH WITH STATE DEATH TAPE
- 27 DEATH MASTER FILE (SOCIAL SECURITY)
- 29 COMPUTER MATCH, OTHER OR NOS
- 30 OTHER SOURCE
- 31 TELEPHONE CALL TO ANY SOURCE
- 32 SPECIAL STUDIES
- 33 EQUIFAX
- 34 ARS (AIDS REGISTRY SYSTEM)
- 35 COMPUTER MATCH WITH DISCHARGE DATA
- 36 OBITUARY
- 37 COMPUTER MATCH WITH CHANGE OF ADDRESS SERVICE
- 38 TRW
- 39 REGIONAL REGISTRY FOLLOW-UP LIST

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

- 40 LETTER TO A PHYSICIAN
- 41 TELEPHONE CALL TO ANY SOURCE
- 51 COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES FILE
- 52 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
- 53 COMPUTER MATCH WITH HMO FILE
- 54 COMPUTER MATCH WITH VOTER REGISTRATION FILE
- 55 NATIONAL DEATH INDEX
- 56 COMPUTER MATCH WITH STATE DEATH TAPE
- 57 COMPUTER MATCH WITH MEDI-CAL
- 58 COMPUTER MATCH WITH SOCIAL SECURITY DEATH FILE
- 59 COMPUTER MATCH, OTHER OR NOS
- 60 OTHER SOURCE
- 62 SPECIAL STUDIES
- 65 COMPUTER MATCH WITH OSHPD HOSPITAL DISCHARGE DATA BASE
- 66 COMPUTER MATCH WITH NATIONAL CHANGE OF ADDRESS FILE

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

- 99 SOURCE UNKNOWN

Follow-Up Data Items

VII.2.7 LAST FOLLOW-UP HOSPITAL

Enter the six-digit code or name of the hospital, facility, or agency that provided the most recent follow-up information. (See Appendices F1 and F2 for codes.)

VII.2.8 NEXT TYPE FOLLOW-UP

Record the method of obtaining follow-up information about the patient for the next report. If the patient has died, leave the field blank. The codes are:

- 0 SUBMIT A REQUEST FOR THE PATIENT'S CHART TO THE REPORTING HOSPITAL'S MEDICAL RECORDS DEPARTMENT
- 1 SEND A FOLLOW-UP LETTER TO THE PATIENT'S PHYSICIAN
- 2 SEND A FOLLOW-UP LETTER TO THE PERSON DESIGNATED AS THE CONTACT FOR THE PATIENT
- 3 CONTACT THE PATIENT OR DESIGNATED CONTACT BY TELEPHONE
- 4 REQUEST FOLLOW-UP INFORMATION FROM ANOTHER HOSPITAL
- 5 FOLLOW-UP BY A METHOD NOT DESCRIBED ABOVE
- 6 SEND A FOLLOW-UP LETTER TO THE PATIENT

VII.2.9 NEXT FOLLOW-UP HOSPITAL

Enter the six-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.

Follow-Up Data Items

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 fields 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 blank.

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.

Follow-Up Data Items

- 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, leave the field blank. 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.

Follow-Up Data Items

VII.2.14 FOLLOW-UP REMARKS

For the convenience of the hospital, CNExT provides three lines of text in the Follow-Up area of the abstract for recording information useful in following the patient. Information entered on the line labeled "FU Resource 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.

Section 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 (ie, 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. 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 resources 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 (ie 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.

Contact Name/Address File

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

Section 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.

Section VIII.2 Regional Data

Use of the Regional Data fields is determined by the regional registry, which designates the codes to be entered.

Section 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.

Section VIII.4 Clinical Indicators

These fields have been added for use by hospitals. There is space to record up to 30 clinical indicators.

Section 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

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 should 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.

Transmittal of Case Information

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	Diagnostic or Staging Procedures at This Hospital
Address at Diagnosis - City	Extent of Disease - Extension
Address at Diagnosis - No. & Street	Extent of Disease - Extension (Path)
Address at Diagnosis – Supplemental	Extent of Disease - Lymph Node Involvement
Address At Diagnosis - State	First Name
Address At Diagnosis - Zip Code	Histology - Behavior - (ICD-O-2)
Alias First Name	Histology - Type - (ICD-O-3)
Alias Last Name	Histology - Grade/Differentiation
Behavior Code ICD-O-3	Histology - Type - (ICD-O-2)
Birth Date	Hormone Therapy at This Hospital
Birthplace	Hormone Therapy Summary
Casefinding Source	Hospital Number (Reporting)
Chemotherapy at This Hospital	Hospital Referred From
Chemotherapy Summary	Hospital Referred To
Class of Case	Immunotherapy at This Hospital
County of Residence at Diagnosis	Immunotherapy Summary
Date of Chemotherapy	Industry - Text
Date of Diagnosis	Last Name
Date of Diagnostic or Staging Procedures	Laterality
Date of First Admission	Maiden Name
Date of Hormone Therapy	Marital Status
Date of Immunotherapy	Medical Record Number
Date of Inpatient Admission	Middle Name
Date of Inpatient Discharge	Mother's First Name
Date of Most Definitive Surgery	Name Suffix
Date of Other Therapy	Number of Regional Lymph Nodes Examined - Summary
Date of Radiation Therapy	Occupation - Text
Date of Surgery	Other Therapy at This Hospital
Date of Surgery - Procedure 1	Other Therapy Summary
Date of Surgery - Procedure 2	Pathology Report Number- Biopsy/FNA
Date of Surgery - Procedure 3	Pathology Report Number - Surgery
Date of Systemic Therapy	Patient No Research Contact Flag
Date of Transplant/Endocrine Procedures	
Diagnostic Confirmation	

Transmittal of Case Information

Payment Source (Primary & Secondary)	Procedure 2
Payment Source Text (Primary)	Surgical Procedure/Other Site – Procedure 3
Pediatric Stage	Surgery of Primary Site - Procedure Procedure 1
Pediatric Stage Coder	Surgery of Primary Site - Procedure Procedure 2
Pediatric Stage System	Surgery of Primary Site - Procedure Procedure 3
Physicians	Surgery of Primary Site - Summary
Protocol Participation	Surgery Summary - Reconstructive
Race 1	Text-Diagnostic Procedures – Physical Examination
Race 2	Text-Diagnostic Procedures – X-ray
Race 3	Text-Diagnostic Procedures – Scopes
Race 4	Text-Diagnostic Procedures – Tests
Race 5	Text-Diagnostic Procedures – Operative
Radiation Summary	Text-Diagnostic Procedures – Pathological
Radiation – Regional Rx Modality	Text-Site
Radiation – Boost Treatment Modality	Text-Histology
Radiation/Surgery Sequence	Text Rx-Surgery
Reason No Radiation	Text Rx-Radiation (Beam)
Reason for No Surgery	Text Rx-Radiation (Other)
Regional Data	Text Rx-Chemotherapy
Regional Nodes Examined (Number)	Text Rx-Hormone Therapy
Regional Nodes Positive (Number)	Text Rx-Immunotherapy
Religion	Text Rx-Other Therapy
Scope of Regional Lymph Node Surgery - Summary	Text-Remarks
Scope of Regional Lymph Node Surgery - Procedure 1	Text-Final Diagnosis
Scope of Regional Lymph Node Surgery - Procedure 2	TNM Coder (Clinical)
Scope of Regional Lymph Node Surgery - Procedure 3	TNM Coder (Path)
Sequence Number - Hospital	TNM Edition
Sex	TNM M Code (Clinical)
Site - Primary (ICD-O-2)	TNM M Code (Path)
Social Security Number	TNM N Code (Clinical)
Social Security Number Suffix	TNM N Code (Path)
Spanish/Hispanic Origin	TNM Stage (Clinical)
Summary Stage	
Summary Stage 2000	
Surgical Procedure/Other Site – Summary	
Surgical Procedure/Other Site –	

Transmittal of Case Information

TNM Stage (Path)
TNM T Code (Clinical)
TNM T Code (Path)
Transplant/Endocrine Procedures at
This Hospital
Transplant/Endocrine Procedures-
Summary
Treatment Hospital Number –
Procedure 1
Treatment Hospital Number –
Procedure 2
Treatment Hospital Number –
Procedure 3
Tumor Marker 1
Tumor Marker 2
Tumor Marker 3
Tumor Marker-CA-1
Tumor Size
Type of Admission
Type of Reporting Source
Year First Seen

Transmittal of Case Information

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.

Transmittal of Case Information

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."

Section 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 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.

Quality Control

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.

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

Quality Control

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 2002, discrepancies in treatment fields will be counted towards the overall facility accuracy rate, and will be reported in the six-month accuracy rates.

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.

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APPENDIX A

NEW HISTOLOGY CODES FOR LYMPHOMAS AND LEUKEMIAS

NEW LYMPHOMA TERMS. *Effective for cases diagnosed January 1, 1995, and after.*

<u>ICD-O Code</u>	<u>Term</u>
9673/3	Mantle cell lymphoma (*)
9688/3	T-cell rich B-cell lymphoma
9708/3	Subcutaneous panniculitic T-cell lymphoma
9710/3	Marginal zone lymphoma, NOS
9714/3	Anaplastic large cell lymphoma (ALCL), CD30+ (*)
9715/3	Mucosal-Associated Lymphoid Tissue (MALT) lymphoma
9716/3	Hepatosplenic $\gamma\delta$ (gamma - delta) cell lymphoma
9717/3	Intestinal T-cell lymphoma
	Enteropathy associated T-cell lymphoma

NEW LEUKEMIA TERMS. *Effective for cases diagnosed January 1, 1998, and after.*

The following rules are to be used. They are in priority order:

1. Code the FAB (French-American-British) classification. FAB is implied if the description includes "L" or "M" with a number such as "L2" or M5". If more than one FAB classification is listed, use the NOS code. Example:
 Path: "Acute myelogenous leukemia, probably M1 or M2...."
 Code to 9861/3, Acute myeloid leukemia, NOS
2. If the diagnostic statement lists a specific acute leukemia cell type, code that term. If more than one term is listed, use rules in ICD-O-2.

In addition to these rules, the following information will assist in assigning codes:

- "Maturation" and "differentiation" are synonymous.
- Code "acute non-lymphocytic leukemia" as 9861/3, acute myelogenous leukemia, NOS.
- Code "acute biphenotypic leukemia" or "mixed lineage leukemias" to 9801/3, acute leukemia, NOS.
- Terms equivalent of granulocytic are: myeloblastic, myelocytic, myelogenous, myeloid, non-lymphocytic.
- Terms equivalent to lymphocytic are: lymphoblastic, lymphoid, lymphatic.

<u>ICD-O Code</u>	<u>Term</u>
9821/3	Acute lymphoblastic leukemia, L1 type (*)
	Acute lymphocytic leukemia, L1 type (*)
	Acute lymphoid leukemia, L1 type (*)
	Acute lymphatic leukemia, L1 type (*)
	Lymphoblastic leukemia, L1 type (*)
	FAB L1 (*)

9826/3	FAB L3 (*)
9828/3	Acute lymphoblastic leukemia, L2 type Acute lymphocytic leukemia, L2 type Acute lymphoid leukemia, L2 type Acute lymphatic leukemia, L2 type Lymphoblastic leukemia, L2 type FAB L2
9840/3	FAB M6 (*)
9861/3	Acute myeloid leukemia, NOS (*) Acute myeloblastic leukemia, NOS (*) Acute granulocytic leukemia, NOS (*) Acute myelogenous leukemia, NOS (*) Acute myelocytic leukemia, NOS (*)
9866/3	FAB M3 (*)
9867/3	Acute myelomonocytic leukemia, NOS (*) FAB M4 (*)
9871/3	Acute myelomonocytic leukemia with eosinophils FAB M4E
<u>ICD-O Code</u>	<u>Term</u>
9872/3	Acute myeloid leukemia, minimal differentiation Acute myeloblastic leukemia, minimal differentiation Acute granulocytic leukemia, minimal differentiation Acute myelogenous leukemia, minimal differentiation Acute myelocytic leukemia, minimal differentiation FAB M0
9873/3	Acute myeloid leukemia without maturation Acute myeloblastic leukemia without maturation Acute granulocytic leukemia, without maturation Acute myelogenous leukemia, without maturation Acute myelocytic leukemia, without maturation FAB M1
9874/3	Acute myeloid leukemia with maturation Acute myeloblastic leukemia with maturation Acute granulocytic leukemia, with maturation Acute myelogenous leukemia, with maturation Acute myelocytic leukemia, with maturation FAB M2
9891/3	FAB M5 (*) FAB M5A (*) FAB M5B (*)
9910/3	Megakaryoblastic leukemia, NOS (C42.1) FAB M7

(*) new term(s) for an existing number

APPENDIX B

POSTAL ABBREVIATIONS FOR STATES AND TERRITORIES OF THE UNITED STATES

AL ALABAMA	NE NEBRASKA
AK ALASKA	NV NEVADA
AS AMERICAN SAMOA	NH NEW HAMPSHIRE
AZ ARIZONA	NJ NEW JERSEY
AR ARKANSAS	NM NEW MEXICO
CA CALIFORNIA	NY NEW YORK
CO COLORADO	NC NORTH CAROLINA
CT CONNECTICUT	ND NORTH DAKOTA
DE DELAWARE	MP NORTHERN MARIANA ISLANDS
DC DISTRICT OF COLUMBIA	OH OHIO
FL FLORIDA	OK OKLAHOMA
GA GEORGIA	OR OREGON
GU GUAM	PW PALAU
HI HAWAII	PA PENNSYLVANIA
ID IDAHO	PR PUERTO RICO
IL ILLINOIS	RI RHODE ISLAND
IN INDIANA	SC SOUTH CAROLINA
IA IOWA	SD SOUTH DAKOTA
KS KANSAS	TN TENNESSEE
KY KENTUCKY	TT TRUST TERRITORIES
LA LOUISIANA	TX TEXAS
ME MAINE	UT UTAH
MD MARYLAND	VT VERMONT
MH MARSHALL ISLANDS	VA VIRGINIA
MA MASSACHUSETTS	VI VIRGIN ISLANDS
MI MICHIGAN	DC WASHINGTON, DISTRICT OF
FM MICRONESIA, FERERATED STATE OF	WA WASHINGTON, STATE OF
MN MINNESOTA	WV WEST VIRGINIA
MS MISSISSIPPI	WI WISCONSIN
MO MISSOURI	WY WYOMING
MT MONTANA	XX U.S. NOS, U.S. TERRITORY, NOS
	YY NOT US AND NOT CANADA

CANADIAN PROVINCE/ TERRITORY

AB ALBERTA	NS NOVA SCOTIA
BC BRITISH COLUMBIA	NU NUNAVUT
MB MANITOBA	ON ONTARIO
NB NEW BRUNSWICK	PE PRINCE EDWARD ISLAND
NF NEWFOUNDLAND AND LABRADOR	PQ QUEBEC
NT NORTHWEST TERRITORIES	SK SASKATCHEWAN
	YT YUKON TERRITORIES
	XX CANADA, NOS

APPENDIX C
CODES FOR STATES AND TERRITORIES OF THE
UNITED STATES

ALABAMA	037	NEBRASKA	067
ALASKA	091	NEVADA	085
AMERICAN SAMOA	121	NEW HAMPSHIRE	003
ARIZONA	087	NEW JERSEY	008
ARKANSAS	071	NEW MEXICO	086
CALIFORNIA	097	NEW YORK	011
COLORADO	083	NORTH CAROLINA	025
CONNECTICUT	007	NORTH DAKOTA	054
DELAWARE	017	NORTHERN MARIANA ISLANDS	129
DISTRICT OF COLUMBIA	022	OHIO	043
FLORIDA	035	OKLAHOMA	075
GEORGIA	033	OREGON	095
GUAM	126	PALAU	139
HAWAII	099	PENNSYLVANIA	014
IDAHO	081	PUERTO RICO	101
ILLINOIS	061	RHODE ISLAND	006
INDIANA	045	SOUTH CAROLINA	026
IOWA	053	SOUTH DAKOTA	055
KANSAS	065	TENNESSEE	031
KENTUCKY	047	TEXAS	077
LOUISIANA	073	UTAH	084
MAINE	002	VERMONT	004
MARSHALL ISLANDS	131	VIRGINIA	023
MARYLAND	021	VIRGIN ISLANDS	102
MASSACHUSETTS	005	WASHINGTON, DISTRICT OF	022
MICRONESIA, FEDERATED STATES OF	123	WASHINGTON, STATE OF	093
MICHIGAN	041	WEST VIRGINIA	024
MINNESOTA	052	WISCONSIN	051
MISSISSIPPI	039	WYOMING	082
MISSOURI	063	U.S.A., STATE UNKNOWN	000
MONTANA	056		

CANADIAN PROVINCE/ TERRITORY

ALBERTA	224	NOVA SCOTIA	221
BRITISH COLUMBIA	226	NUNAVUT	227
CANADA, NOS	220	ONTARIO	223
MANITOBA	224	PRINCE EDWARD ISLAND	221
NEW BRUNSWICK	221	QUEBEC	222
NEWFOUNDLAND AND LABRADOR	221	SASKATCHEWAN	224
NORTHWEST TERRITORIES	225	YUKON TERRITORIES	225

APPENDIX D.1 CODES FOR COUNTRIES

(in alphabetical order, includes codes for U.S. states and territories)

ABYSSINIA	585	AZERBAIJAN	633
ADEN	629	AZORES	445
AFARS/ISSAS	583	BAHAMAS	247
AFGHANISTAN	638	BAHRAIN	629
AFRICA, NOS	500	BALEARIC ISL	443
AFRICA-CENTRAL (OTHER WEST)	539	BALTIC REPUBLIC, NOS	463
AFRICA-SUDANESE COUNTRIES	520	BALTIC STATES, NOS	463
AFRICAN COASTAL ISLANDS	580	BANGLADESH	645
ALABAMA	037	BARBADOS	245
ALASKA	091	BARBUDA	245
ALBANIA	481	BASUTOLAND	545
ALBERTA	224	BAVARIA	431
ALGERIA	513	BECHUANALAND	545
AMERICA, NORTH	260	BELARUS	457
AMERICAN SAMOA	121	BELGIUM	433
ANATOLIA	611	BELIZE	252
ANDAMAN ISLANDS	641	BENIN	539
ANDORRA	443	BERMUDA	246
ANGOLA	543	BESSARABIA	456
ANGUILLA	245	BHUTAN	643
ANNAM	665	BIOKO	539
ANTARCTICA	750	BOHEMIA	452
ANTIGUA	245	BOLIVIA	355
ANTILLES	245	BOPHUTHATSWANA	545
ARABIA	629	BORNEO	673
ARABIAN PENINSULA	629	BOSNIA-HERZOGOVINA	453
ARGENTINA	365	BOTSWANA	545
ARIZONA	087	BRAZIL	341
ARKANSAS	071	BRITISH COLUMBIA	226
ARMENIA	633	BRITISH GUIANA	331
ARMENIA TURKISH	611	BRITISH HONDURAS	252
ARUBA	245	BRUNEI	671
ASIA, NOS	600	BULGARIA	454
ASIA-ARAB COUNTRIES, NOS	620	BURKINA FASO	520
ASIA-EAST, NOS	680	BURMA	649
ASIA-MID-EAST, NOS	640	BURUNDI	579
ASIA MINOR, NOS	610	BYELORUSSIA	457
ASIA-NEAR EAST, NOS	610	CABINDA	543
ASIA-SOUTHEAST, NOS	650	CAICOS ISLANDS	245
ASIAN REPUBLICS OF FORMER		CALIFORNIA	097
USSR	634	CAMBODIA	663
ATLAN/CARIB US OTHER	109	CAMEROON	539
ATLANTIC/CARIBBEAN AREA,		CANADA, NOS	220
U.S. POSSESSIONS	100	CANADA-MARITIME PROVINCE	221
AUSTRALIA/AUST NEW GUINEA	711	CANADA-NUNAVUT	227
AUSTRIA	436	CANADA-NW TERR/YUKON	225
AZERBAIDZHAN SSR	633	CANADA-PRAIRIE PROVIINCE	224

Codes for Countries (in alphabetical order)

CANAL ZONE	110	DOMINICA	245
CANARY ISL	443	DOMINICAN REPUBLIC	243
CANTON/ENDERBURY ISL	122	DUTCH EAST INDIES	673
CAPE COLONY	545	DUTCH GUIANA	332
CAPE VERDE ISL	445	EAST AFRICA, NOS	570
CARIBBEAN, NOS	245	EAST GERMANY	431
CARIBBEAN ISL NEC	245	ECUADOR	345
CAROLINE ISL (MICRONESA, FEDERATED STATES OF)	123	EGYPT	519
CARTIER ISLANDS	711	EIRE	410
CAUCASIAN REPUBLICS OF FORMER USSR	633	EL SALVADOR	254
CAYMAN ISLANDS	245	ELLICE ISL	125
CENTRAL AFRICA, NOS	500	ENDERBURY ISL	122
CENTRAL AFRICAN REPUBLIC	539	ENGLAND	401
CENTRAL AMERICA, NOS	250	EQUATORIAL AFRICA	500
CEYLON	647	EQUATORIAL GUINEA	539
CHAD	520	ERITREA	585
CHANNEL ISL	401	ESTONIA	458
CHILE	361	ESTONIAN S.S.R.	458
CHINA, NOS	681	ETHIOPIA	585
CHINA, PEOPLE'S REPUBLIC	682	EUROPE, NOS	499
CHINA, REPUBLIC OF	684	EUROPE-CENTRAL, NOS	499
CHRISTMAS ISLAND	723	EUROPE-EASTERN, NOS	499
CISKEL	545	EUROPE-GERMANIC, NOS	430
COCHIN CHINA	665	EUROPE-MEDITER ILS NEC	490
COCOS ISLANDS	711	EUROPE-OTHER MAINLAND, NOS	470
COLOMBIA	311	EUROPE-ROMANCE LANG, NOS	440
COLORADO	083	EUROPE-SLAVIC, NOS	450
COMOROS	580	FAROE ISLANDS	425
CONGO BELGIAN	541	FALKLAND ISLANDS	381
CONGO BRAZZAVILLE	539	FERNANDO PO	539
CONGO FRENCH	539	FIJI	721
CONGO LEOPOLDVILLE	541	FINLAND	429
CONNECTICUT	007	FLORIDA	035
COOK ISL (NEW ZEALAND)	124	FORMOSA	684
CORSICA	441	FOTUNA	721
COSTA RICA	256	FRANCE/MONACO	441
COTE D'IVOIRE	539	FREE STATE	545
CRETE	471	FRENCH GUIANA	333
CROATIA	453	FUTUNA ISLANDS	721
CUBA	241	GABON	539
CURACAO	245	GALAPAGOS ISLANDS	345
CYPRUS	495	GAMBIA	539
CYRENAICA	517	GAZA STRIP	631
CZECHOSLOVAKIA	452	GEORGIA	033
CZECH REPUBLIC	452	GEORGIA (USSR)	633
DAHOMY	539	GERMANIC COUNTRIES	430
DALMATIA	453	GERMANY	431
DELAWARE	017	GERMAN DEMOCRATIC REPUBLIC	431
DENMARK	425	GERMANY, EAST	431
DJIBOUTI	583	GERMANY, FEDERAL REPUBLIC OF	431
DOBRUJA	449	GERMANY, WEST	431
		GHANA	539

Codes for Countries (in alphabetical order)

GIBRALTAR	485	KAZAKHSTAN	634
GILBERT ISLANDS	122	KENTUCKY	047
GREAT BRITAIN, NOS	400	KENYA	575
GREECE	471	KIRGHIZ SSR	634
GREENLAND	210	KIRIBATI	122
GRENADA	245	KOREA	695
GRENADINES	245	KOREA, NORTH	695
GUADALOUPE	245	KOREA, SOUTH	695
GUAM	126	KUWAIT	629
GUATAMALA	251	KYRGYZ	634
GUERNSEY	401	KYRGYSTAN	634
GUIANA BRITISH	331	LABRADOR	221
GUIANA DUTCH	332	LAOS	661
GUIANA FRENCH	333	LAPLAND, NOS	420
GUINEA-BISSAU	539	LATIN AMERICA, NOS	265
GUINEA PORTUGUESE	539	LATVIAN S.S.R.	459
GUINEA	539	LATVIA	459
GUYANA	331	LEBANON	623
HAITI	242	LEEWARD ISL	245
HAWAII	099	LESOTHO	545
HOLLAND	432	LIBERIA	539
HONDURAS	253	LIBYA	517
HONG KONG	683	LIECHTENSTEIN	437
HUNGARY	475	LINE ISL SOUTHERN	122
ICELAND	421	LITHUANIA	461
IDAHO	081	LITHUANIAN S.S.R.	461
ILLINOIS	061	LOUISIANA	073
INDIA	641	LUXEMBOURG	434
INDIANA	045	MACAO	686
INDO-CHINA, NOS	660	MACAU	686
INDONESIA	673	MACEDONIA	453
IOWA	053	MADAGASCAR	555
IRAN	637	MADEIRA ISL	445
IRAQ	627	MAINE	002
IRAQ-SAUDI ARABIAN NEUTRAL ZONE	620	MALAGASY REPUBLIC	555
IRELAND	410	MALAWI	551
ISLE OF MAN	401	MALAY PENINSULA	671
ISRAEL	631	MALAYSIA/SINGAPORE/BRUNEI	671
ISSAS	583	MALDIVES	640
ITALY/SAN MARINO	447	MALI	520
IVORY COAST (COTE D'IVOIRE)	539	MALTA	491
JAMAICA	244	MANITOBA	224
JAN MAYEN	423	MARSHALL ISL	131
JAPAN	693	MARTINIQUE	245
JAVA	673	MARYLAND	021
JERSEY	401	MASSACHUSETTS	005
JOHNSTON ATOLL	127	MAURITANIA	520
JORDAN	625	MAURITIUS	580
KAMEROON	539	MAYOTTE	580
KAMPUCHEA	663	MEDITERRANEAN ISLANDS, OTHER	490
KANSAS	065	MELANESIA (MELANESIAN ISL)	721
KAZAKH SSR	634		

Codes for Countries (in alphabetical order)

MESOPOTAMIA	610	NORTH AMERICAN ISL, NOS	240
MEXICO	230	NORTH CAROLINA	025
MICHIGAN	041	NORTH DAKOTA	054
MICRONESIA	723	NORTHERN IRELAND	404
MICRONESIAN ISL	723	NORTHWEST TERRITORY	225
MIDWAY ISL	132	NORWAY	423
MINNESOTA	052	NOT US, NOS	998
MIQUELON	249	NOVA SCOTIA	221
MISSISSIPPI	039	NYASALAND	551
MISSOURI	063	OCEANA, NOS	720
MOLDAVIA	456	OHIO	043
MOLDAVIAN S.S.R.	456	OKINAWA	693
MOLDOVA	456	OKLAHOMA	075
MONACO	441	OMAN AND MUSCAT	629
MONGOLIA	691	ONTARIO	223
MONTANA	056	ORANGE FREE STATE	545
MONTENEGRO	453	OREGON	095
MONTSERRAT	245	ORKNEY ISLANDS	403
MORAVIA	452	PACIFIC ISL, NOS	720
MOROCCO	511	PACIFIC ISLANDS, TRUST	
MOZAMBIQUE	553	TERRITORY	123
MYANMAR	649	PAKISTAN EAST	645
NAMIBIA	545	PAKISTAN, NOS	639
NAMPO SHOTO SOUTHERN	133	PAKISTAN WEST	639
NATAL	545	PALAU	139
NAURU	723	PALESTINE ARAB	625
NEBRASKA	067	PALESTINE JEWISH	631
NEPAL/BHUTAN/SIKKIM	643	PALASTINIAN NATIONAL	
NETHERLANDS ANTILLES	245	AUTHORITY-PNA	631
NETHERLANDS	432	PANAMA	257
NEVADA	085	PAPUA	711
NEVIS	245	PARAGUAY	371
NEW BRUNSWICK	221	PENNSYLVANIA	014
NEW CALEDONIA	725	PERSIA	637
NEW ENGLAND	001	PERSIAN GULF STATES, NOS	629
NEW GUINEA, NOS	673	PERU	351
NEW GUINEA AUSTRALIAN	711	PHILIPPINES	675
NEW GUINEA NORTHEAST	711	PHOENIX ISLANDS	122
NEW GUINEA PAPUA	711	PITCAIRN	725
NEW HAMPSHIRE	003	POLAND	451
NEW HEBRIDES	721	POLYNESIA	725
NEW JERSEY	008	POLYNESIA, NOS	720
NEW MEXICO	086	POLYNESIAN ISL	725
NEW YORK	011	PORTUGAL	445
NEW ZEALAND	715	PORTUGUESE GUINEA	539
NEWFOUNDLAND	221	PRINCE EDWARD ISL	221
NICARAGUA	255	PRINCIPE	543
NIGER	520	PUERTO RICO	101
NIGERIA	531	QATAR	629
NIUE	715	QUATAR	629
NORFOLK ISLANDS	711	QUEBEC	222
NORTH AFRICA, NOS	510	REPUBLIC OF SOUTH AFRICA	545
NORTH AMERICA	260		

Codes for Countries (in alphabetical order)

REPUBLIC OF CHINA	684	SOUTHERN LINE ISLANDS	122
REPUBLIC OF IRELAND	410	SPAIN/ANDORRA	443
REUNION	580	SPANISH SAHARA	520
RHODE ISLAND	006	SRI LANKA	647
RHODESIA	547	ST. CHRISTOPHER-NEVIS	245
RHODESIA NORTHERN	549	ST. KITTS	245
RHODESIA SOUTHERN	547	ST. HELENA	580
RIO MUNI	539	ST. LUCIA	249
ROMANIA	449	ST. PIERRE	249
RUANDA	577	ST. VINCENT	245
RUMANIA	449	SUDAN	520
RUSSIA, NOS	455	SUMATRA	673
RUSSIAN FEDERATION		SURINAM	332
(FORMER U.S.S.R.)	455	SVALBARD	423
RUSSIAN S.F.S.R.	455	SWAN ISL	135
RWANDA	577	SWAZILAND	545
RYUKYU ISL (JAPAN)	134	SWEDEN	427
SAHARA	520	SWITZERLAND	435
SAMOA AMERICAN	121	SYRIA	621
SAMOA, WESTERN	725	TADZHIK SSR	634
SAN MARINO	447	TAIWAN	684
SAO TOME	543	TAJKISTAN	634
SARDINIA	447	TANGANYIKA	571
SASKATCHEWAN	224	TANZANIA	571
SAUDI ARABIA	629	TANZANYIKA	571
SCANDANAVIA NOS	420	TENNESSEE	031
SCOTLAND	403	TEXAS	077
SENEGAL	539	THAILAND	651
SERBIA	453	TIBET	685
SEYCHELLES	580	TOBAGO	245
SHETLAND ISLANDS	403	TOGO	539
SIAM	651	TOKELAU ISL (NEW ZEALAND)	136
SICILY	447	TONGA	725
SIERRA LEONE	539	TONKIN	665
SIKKIM	643	TRANS-JORDAN	625
SINGAPORE	671	TRANSKEI	545
SLAVIC COUNTRIES	450	TRANSVAAL	545
SLOVAK REPUBLIC	452	TRANSYLVANIA	449
SLOVAKIA	452	TRINIDAD	245
SLOVENIA	453	TRIPOLI	517
SLAVONIA	453	TRIPOLITANIA	517
SOLOMON ISLANDS	721	TRUCIAL STATES	629
SOMALI REPUBLIC	581	TUNISIA	515
SOMALIA	581	TURKEY	611
SOMALILAND, NOS	581	TURKMEN SSR	634
SOMALILAND FRENCH	583	TURKMENISTAN	634
SOUTH AFRICA, NOS	540	TURKS ISLANDS	245
SOUTH AMERICAN ISLANDS	380	TUVALU ISLANDS	125
SOUTH AMERICA, NOS	300	UGANDA	573
SOUTH CAROLINA	026	UKRAINE/MOLDAVIA	456
SOUTH DAKOTA	055	UKRANIAN S.S.R.	456
SOUTH WEST AFRICA	545	ULSTER	404
SOUTHERN EUROPE, NOS	499		

Codes for Countries (in alphabetical order)

UNION OF SOUTH AFRICA	545	WINDWARD ISLANDS	245
UNITED ARAB EMIRATES	629	WISCONSIN	051
UNITED ARAB REPUBLIC	519	WYOMING	082
UNITED KINGDOM, NOS	400	YEMEN	629
UNITED STATES, NOS	000	YEMEN, SOUTHERN	629
UNKNOWN	999	YEMEN, PEOPLE'S DEMOCRATIC	
UPPER VOLTA	520	REPUBLIC	629
URUGUAY	375	YUGOSLAVIA	453
URUNDI	579	YUKON	225
US, NOS	000	ZAIRE	541
US POSS-ATL/CARIB, NOS	100	ZAMBIA	549
US POSS-PACIFIC	120	ZANZIBAR	571
US-CENTRAL MIDWEST, NOS	060	ZIMBABWE	547
US-MOUNTAIN STATES, NOS	080		
US-NEW ENGLAND, NOS	001		
US-NORTH ATLANTIC, NOS	010		
US-NORTH CENTRAL, NOS	040		
US-NORTH MIDWEST, NOS	050		
US-PACIFIC STATES, NOS	090		
US-SOUTH MID ATLANTIC, NOS	020		
US-SOUTH MIDWEST, NOS	070		
US-SOUTHEASTERN, NOS	030		
USSR, NOS	455		
UTAH	084		
UZBEKISTAN	634		
UZBECK SSR	634		
VANUATU	721		
VATICAN CITY	447		
VENDA	545		
VENEZUELA	321		
VERMONT	004		
VIET NAM	665		
VIETNAM	665		
VIRGIN ISL - US	102		
VIRGIN ISLANDS, BRITISH	245		
VIRGINIA	023		
WAKE ISLAND	137		
WALES	402		
WALLACHIA	449		
WALLIS ISLANDS	721		
WASHINGTON DC	022		
WASHINGTON	093		
WEST AFRICA, FRENCH	530		
WEST AFRICAN COUNTRIES,			
OTHER	539		
WEST BANK	631		
WEST GERMANY	431		
WEST INDIES	245		
WEST INDIES, NOS	245		
WEST VIRGINIA	024		
WESTERN SAHARA	520		
WESTERN SAMOA	725		
WHITE RUSSIA	457		

APPENDIX D.2 CODES FOR COUNTRIES

(In numerical order, includes codes for U.S. states and territories)

000	UNITED STATES, NOS	073	LOUISIANA
000	US NOS	075	OKLAHOMA
001	US-NEW ENGLAND, NOS	077	TEXAS
001	NEW ENGLAND	080	US-MOUNTAIN STATES, NOS
002	MAINE	081	IDAHO
003	NEW HAMPSHIRE	082	WYOMING
004	VERMONT	083	COLORADO
005	MASSACHUSETTS	084	UTAH
006	RHODE ISLAND	085	NEVADA
007	CONNECTICUT	086	NEW MEXICO
008	NEW JERSEY	087	ARIZONA
010	US-NORTH ATLANTIC, NOS	090	US-PACIFIC STATES, NOS
011	NEW YORK	091	ALASKA
014	PENNSYLVANIA	093	WASHINGTON
017	DELAWARE	095	OREGON
020	US-SOUTH MID ATLANTIC, NOS	097	CALIFORNIA
021	MARYLAND	099	HAWAII
022	WASHINGTON DC	100	US POSS-ATL/CARIB, NOS
023	VIRGINIA	101	PUERTO RICO
024	WEST VIRGINIA	102	VIRGIN ISL - US
025	NORTH CAROLINA	109	ATLAN/CARIB US OTHER
026	SOUTH CAROLINA	110	CANAL ZONE
030	US-SOUTHEASTERN, NOS	120	US POSS-PACIFIC
031	TENNESSEE	121	AMERICAN SAMOA
033	GEORGIA	121	SAMOA AMERICAN
035	FLORIDA	122	CANTON/ENDERBURY ISL
037	ALABAMA	122	ENDERBURY ISL
039	MISSISSIPPI	122	GILBERT ISLANDS
040	US-NORTH CENTRAL, NOS	122	LINE ISLANDS, SOUTHERN
041	MICHIGAN	122	SOUTHERN LINE ISLANDS
043	OHIO	122	PHOENIX ISLANDS
045	INDIANA	123	CAROLINE ISL, MICRONESIA (FEDERAL STATES OF)
047	KENTUCKY	124	COOK ISLAND (NEW ZEALAND)
050	US-NORTH MIDWEST, NOS	125	TUVALU (ELLICE ISLANDS)
051	WISCONSIN	126	GUAM
052	MINNESOTA	127	JOHNSTON ATOLL
053	IOWA	129	MARIANA ISL
054	NORTH DAKOTA	131	MARSHALL ISL
055	SOUTH DAKOTA	132	MIDWAY ISL
056	MONTANA	133	NAMPO SHOTO SOUTHERN
060	US-CENTRAL MIDWEST, NOS	134	RYUKYU ISLAND (JAPAN)
061	ILLINOIS	135	SWAN ISL
063	MISSOURI	136	TOKELAU ISLAND (NEW ZEALAND)
065	KANSAS	137	WAKE ISLAND
067	NEBRASKA	139	PALAU
070	US-SOUTH MIDWEST, NOS	200	WESTERN HEMISPHERE, NOS
071	ARKANSAS		

Codes for Countries (in numerical order)

210	GREENLAND	245	WINDWARD ISLANDS
220	CANADA, NOS	246	BERMUDA
221	CANADA-MARITIME PROVINCE	247	BAHAMAS
221	NOVA SCOTIA	249	ST. PIERRE AND MIQUELON
221	NEWFOUNDLAND	250	CENTRAL AMERICA, NOS
221	NEW BRUNSWICK	251	GUATAMALA
221	PRINCE EDWARD ISL	252	BRITISH HONDURAS
221	LABRADOR	252	BELIZE
222	QUEBEC	253	HONDURAS
223	ONTARIO	254	EL SALVADOR
224	CANADA-PRAIRIE PROVINCE	255	NICARAGUA
224	MANITOBA	256	COSTA RICA
224	SASKATCHEWAN	257	PANAMA
224	ALBERTA	260	AMERICA, NORTH
225	CANADA-NW TERR/YUKON	260	NORTH AMERICA, NOS
225	YUKON	265	LATIN AMERICA, NOS
225	NORTHWEST TERRITORY	300	SOUTH AMERICA, NOS
226	BRITISH COLUMBIA	311	COLOMBIA
227	CANADA- NUNAVUT	321	VENEZUELA
230	MEXICO	331	GUYANA
240	NORTH AMERICAN ISL, NOS	331	BRITISH GUIANA
241	CUBA	331	GUIANA BRITISH
242	HAITI	332	SURINAM
243	DOMINICAN REPUBLIC	332	DUTCH GUIANA
244	JAMAICA	332	GUIANA DUTCH
245	CARIBBEAN ISL NEC	333	FRENCH GUIANA
245	ANTILLES	333	GUIANA FRENCH
245	NETHERLANDS ANTILLES	341	BRAZIL
245	VIRGIN ISLANDS, BRITISH	345	ECUADOR
245	MONTserrat	345	GALAPAGOS ISLANDS
245	GUADALOUPE	351	PERU
245	MARTINIQUE	355	BOLIVIA
245	ST. CHRISTOPHER-NEVIS	361	CHILE
245	ST. KITTS	365	ARGENTINA
245	ANGUILLA	371	PARAGUAY
245	GRENADINES	375	URUGUAY
245	TURKS ISLANDS	380	SOUTH AMERICAN ISLANDS
245	CAYMAN ISLANDS	381	FALKLAND ISLANDS
245	ST. VINCENT	400	UNITED KINGDOM, NOS
245	CAICOS ISLANDS	400	GREAT BRITAIN, NOS
245	BARBADOS	401	ISLE OF MAN
245	ANTIGUA	401	ENGLAND
245	ARUBA	401	CHANNEL ISL
245	BARBUDA	401	JERSEY
245	CURACAO	401	GUERNSEY
245	DOMINICA	402	WALES
245	GRENADA	403	SCOTLAND
245	ST. LUCIA	403	SHETLAND ISLANDS
245	TOBAGO	403	ORKNEY ISLANDS
245	TRINIDAD	404	NORTHERN IRELAND
245	WEST INDIES, BRITISH	404	ULSTER
245	LEEWARD ISLANDS	410	IRELAND
245	WEST INDIES, NOS	410	REPUBLIC OF IRELAND

Codes for Countries (in numerical order)

410	EIRE	453	BOSNIA-HERZOGOVINA
420	SCANDANAVIA, NOS	453	CROATIA
420	LAPLAND, NOS	453	DALMATIA
421	ICELAND	453	SERBIA
423	NORWAY	453	MACEDONIA
423	JAN MAYEN	453	MONTENEGRO
423	SVALBARD	453	SLAVONIA
425	DENMARK	453	SLOVENIA
425	FAROE ISLANDS	454	BULGARIA
427	SWEDEN	455	RUSSIAN FEDERATION (FORMER)
429	FINLAND		U.S.S.R
430	EUROPE-GERMANIC, NOS	455	USSR, NOS
431	GERMANY	455	RUSSIA
431	BAVARIA	455	RUSSIA, NOS (RUSSIAN S.F.S.R.)
432	NETHERLANDS	456	UKRAINE/MOLDOVA
432	HOLLAND	456	MOLDAVIA
433	BELGIUM	456	BESSARABIA
434	LUXEMBOURG	456	MOLDAVIAN SSR
435	SWITZERLAND	456	UKRANIAN SSR
436	AUSTRIA	457	BYELORUSSIA
437	LIECHTENSTEIN	457	WHITE RUSSIA
440	EUROPE-ROMANCE LANG, NOS	457	BELARUS
441	FRANCE/MONACO	458	ESTONIA (ESTONIAN SSR)
441	MONACO	459	LATVIA (LATVIAN SSR)
441	CORSICA	461	LITHUANIA (LITHUANIAN SSR)
443	SPAIN/ANDORRA	463	BALTIC REPUBLIC(S), NOS
443	ANDORRA	470	EUROPE-OTHER MAINLAND, NOS
443	CANARY ISL	471	GREECE
443	BALEARIC ISL	471	CRETE
445	PORTUGAL	475	HUNGARY
445	AZORES	481	ALBANIA
445	MADEIRA ISL	485	GIBRALTAR
445	CAPE VERDE ISL	490	EUROPE-MEDITER ILS NEC
447	ITALY/SAN MARINO	491	MALTA
447	SAN MARINO	495	CYPRUS
447	SARDINIA	499	EUROPE, NOS
447	SICILY	499	CENTRAL EUROPE, NOS
447	VATICAN CITY	499	EASTERN EUROPE, NOS
449	RUMANIA	499	NORTHERN EUROPE, NOS
449	ROMANIA	499	SOUTHERN EUROPE, NOS
449	TRANSYLVANIA	499	WESTERN EUROPE, NOS
449	DOBRUJA	500	AFRICA, NOS
449	MOLDAVIA RUMANIA	500	CENTRAL AFRICA, NOS
449	WALLACHIA	500	EQUATORIAL AFRICA, NOS
450	EUROPE-SLAVIC, NOS	510	NORTH AFRICA NOS
451	POLAND	511	MOROCCO
452	CZECHOSLOVAKIA	513	ALGERIA
452	BOHEMIA	515	TUNISIA
452	CZECH REPUBLIC	517	LIBYA
452	MORAVIA	517	CYRENAICA
452	SLOVAKIA	517	TRIPOLITANIA
452	SLOVAK REPUBLIC	517	TRIPOLI
453	YUGOSLAVIA (FORMER)	519	EGYPT

Codes for Countries (in numerical order)

519	UNITED ARAB REPUBLIC	545	FREE STATE (ORANGE FREE STATE)
520	AFRICA-SUDANESE COUNTRIES	545	NATAL
520	BURKINA FASO (UPPER VOLTA)	545	LESOTHO
520	SUDAN	545	CAPE COLONY
520	SAHARA	545	BOTSWANA
520	NIGER	545	BECHUANALAND
520	MAURITANIA	545	BASUTOLAND
520	MALI	545	TRANSKEI
520	CHAD	545	VENDA
520	WESTERN (SPANISH) SAHARA	545	CISKEL
530	WEST AFRICA	545	BOPHUTHATSWANA
530	FRENCH WEST AFRICA, NOS	547	ZIMBABWE
531	NIGERIA	547	RHODESIA SOUTHERN
539	AFRICA-CENTRAL (OTHER WEST)	547	RHODESIA
539	TOGO	549	ZAMBIA
539	SIERRA LEONE	549	RHODESIA NORTHERN
539	SENEGAL	551	MALAWI
539	RIO MUNI	551	NYASALAND
539	PORTUGUESE GUINEA	553	MOZAMBIQUE
539	LIBERIA	555	MADAGASCAR
539	KAMEROON	555	MALAGASY REPUBLIC
539	COTE D'IVOIRE (IVORY COAST)	570	EAST AFRICA, NOS
539	GUINEA	571	TANZANIA
539	GHANA	571	ZANZIBAR
539	GAMBIA	571	TANZANYIKA
539	GABON	571	TANGANYIKA
539	FERNANDO PO	573	UGANDA
539	EQUATORIAL GUINEA	575	KENYA
539	DAHOMEY	577	RWANDA
539	CONGO	577	RUANDA
539	CONGO FRENCH	579	BURUNDI
539	CONGO BRAZZAVILLE	579	URUNDI
539	CENTRAL AFRICAN REPUBLIC	580	AFRICAN COASTAL ISLANDS
539	CAMEROON	580	MAYOTTE
539	BENIN	580	SEYCHELLES
539	GUIANA BISSAU	580	MAURITIUS
539	GUIANA PORTUGUESE	580	REUNION
540	SOUTH AFRICA, NOS	580	COMOROS
541	ZAIRE	580	ST. HELENA
541	CONGO BELGIAN	581	SOMALIA
541	CONGO LEOPOLDVILLE	581	SOMALILAND, NOS
541	CONGO/KINSHASA	581	SOMALI REPUBLIC
543	ANGOLA	583	AFARS/ISSAS
543	SAO TOME	583	SOMALILAND FRENCH
543	PRINCIPE	583	ISSAS
543	CABINDA	583	DJIBOUTI
545	NAMIBIA	585	ETHIOPIA
545	REPUBLIC OF SOUTH AFRICA	585	ABYSSINIA
545	UNION OF SOUTH AFRICA	585	ERITREA
545	TRANSVAAL	600	ASIA, NOS
545	SWAZILAND	610	ASIA-NEAR EAST, NOS
545	SOUTH WEST AFRICA	610	MESOPOTAMIA
		611	TURKEY

Codes for Countries (in numerical order)

611	ANATOLIA	640	MALDIVES
611	ASIA MINOR, NOS	641	ANDAMAN ISLANDS
620	ASIA-ARAB COUNTRIES, NOS	641	INDIA
620	IRAQ-SAUDI ARABIA NEUTRAL ZONE	643	NEPAL/BHUTAN/SIKKIM
621	SYRIA	643	BHUTAN
623	LEBANON	643	SIKKIM
625	JORDAN	645	BANGLADESH
625	PALESTINE ARAB	645	PAKISTAN EAST
625	TRANS-JORDAN	647	SRI LANKA
627	IRAQ	647	CEYLON
629	ARABIAN PENINSULA	649	BURMA
629	YEMEN	649	MYANMAR
629	UNITED ARAB EMIRATES	650	ASIA-SOUTHEAST, NOS
629	SAUDI ARABIA	651	THAILAND
629	QUATAR	651	SIAM
629	QATAR	660	INDO-CHINA, NOS
629	OMAN AND MUSCAT	661	LAOS
629	KUWAIT	663	CAMBODIA
629	BAHRAIN	663	KAMPUCHEA
629	ARABIA	665	VIET NAM
629	ADEN	665	VIETNAM
629	TRUCIAL STATES	665	TONKIN
629	PERSIAN GULF STATES, NOS	665	ANNAM
631	ISRAEL	665	COCHIN CHINA
631	GAZA	671	MALAYSIA/SINGAPORE/BRUNEI
631	WEST BANK	671	SINGAPORE
631	PALESTINE (PALESTINIAN NATIONAL AUTHORITY-PNA)	671	BRUNEI
633	CAUCASIAN REPUBLICS OF FORMER USSR	671	MALAY PENINSULA
633	AZERBAIDZHAN SSR	673	INDONESIA
633	AZERBAIJAN	673	DUTCH EAST INDIES
633	ARMENIA	673	NEW GUINEA, NOS
633	GEORGIA (USSR)	673	SUMATRA
634	OTHER ASIAN REPUBLICS OF FORMER USSR	673	JAVA
634	TURKMEN SSR	673	BORNEO
634	UZBEKISTAN	675	PHILIPPINES
634	TURMENISTAN	680	ASIA-EAST, NOS
634	KAZAKHSTAN	681	CHINA, NOS
634	TAJIKISTAN	682	CHINA, PEOPLE'S REPUBLIC
634	KYRGYSTAN	683	HONG KONG
634	UZBECK SSR	684	TAIWAN
634	KAZAKH SSR	684	CHINA, REPUBLIC OF
634	TADZHIK SSR	684	REPUBLIC OF CHINA
634	KIRGHIZ SSR	684	FORMOSA
637	IRAN	685	TIBET
637	PERSIA	686	MACAU
638	AFGHANISTAN	686	MACAO
639	PAKISTAN NOS	691	MONGOLIA
639	PAKISTAN WEST	693	JAPAN
640	ASIA-MID-EAST, NOS	693	OKINAWA
		695	KOREA
		695	NORTH KOREA
		695	SOUTH KOREA

Codes for Countries (in numerical order)

711	AUSTRALIA/AUST NEW GUINEA
711	NEW GUINEA AUSTRALIAN
711	NEW GUINEA NORTHEAST
711	NEW GUINEA PAPUA
711	PAPUA
711	CARTIER ISLANDS
711	COCOS ISLANDS
711	NORFOLK ISLANDS
715	NEW ZEALAND
715	NIUE
720	PACIFIC ISL, NOS
720	OCEANA, NOS
720	POLYNESIA, NOS
721	MELANESIA (MELANESIA ISLANDS)
721	FIJI
721	VANUATA
721	NEW HEBRIDES
721	SOLOMON ISLANDS
721	FUTUNA ISLANDS
721	FOTUNA
721	WALLIS ISLANDS
723	MICRONESIA (MICRONESIAN ISLANDS)
723	NAURU
723	CHRISTMAS ISLAND
725	POLYNESIA (POLYNESIAN ISLANDS)
725	NEW CALEDONIA
725	TONGA
725	SAMOA, WESTERN
725	PITCAIRN
725	WESTERN SAMOA
750	ANTARCTICA
998	NOT US NOS
999	UNKNOWN

APPENDIX E
RULES FOR DETERMINING RESIDENCY OF
MILITARY PERSONNEL ASSIGNED TO SHIPS AND
CREWS OF MERCHANT VESSELS

Cancer reporting facilities that serve patients in the U.S. Navy or Merchant Marine need detailed rules for determining whether their patients are residents of their region for purposes of cancer reporting. The rules for determining residency are the same as those used by the Census Bureau. The guidelines that follow were adapted from U.S. Department of Commerce publications.

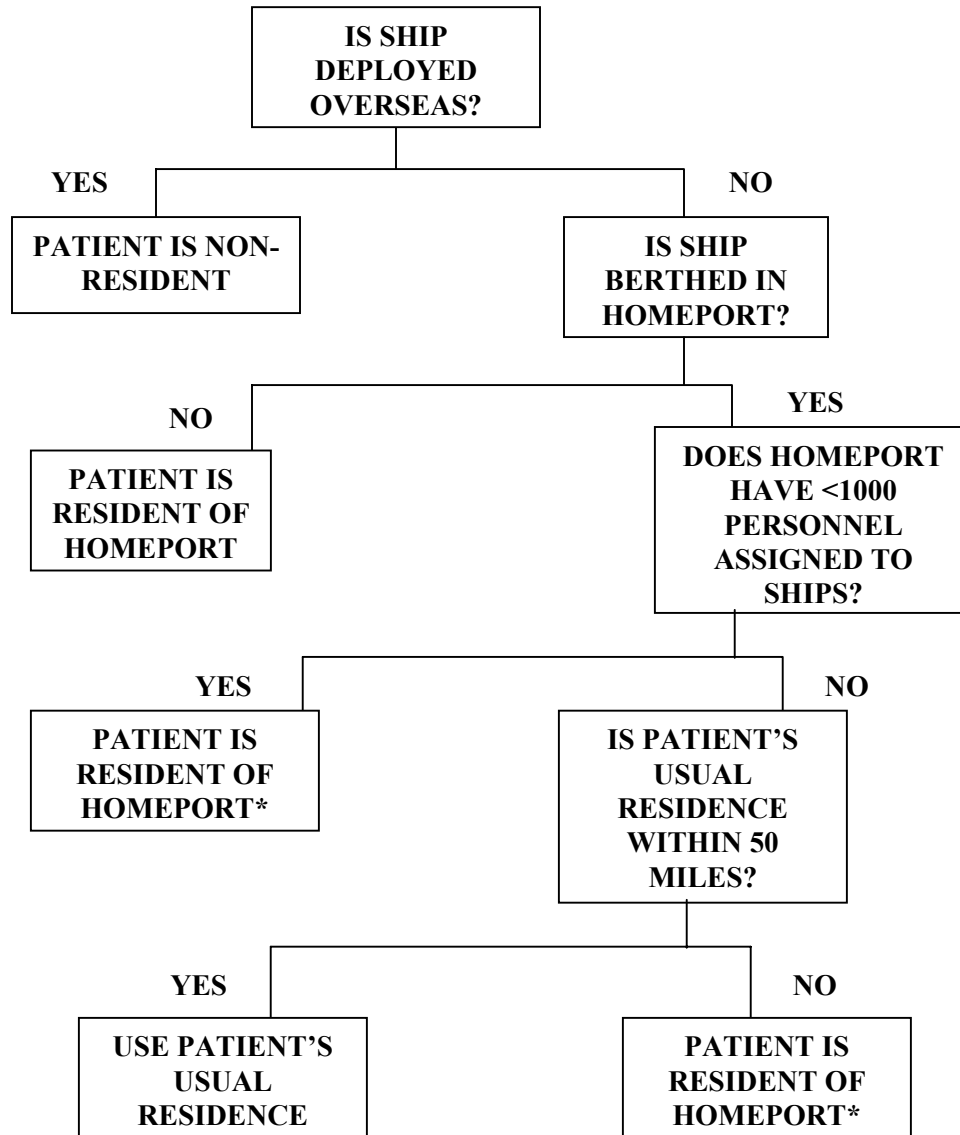
NAVY PERSONNEL

Patients diagnosed with cancer while their ships are deployed overseas are considered overseas residents for cancer-reporting purposes. For ships not deployed overseas, specific rules (shown in the chart below) apply. The Navy assigns a homeport to each of its ships. If a ship that is not deployed overseas is not berthed in its homeport, any crew member diagnosed with cancer is considered a resident of the homeport. If the ship is berthed in its homeport, and the homeport has fewer than 1000 naval personnel assigned to ships, a crew member diagnosed with cancer is considered a resident of the ship. If, however, the homeport has more than 1000 naval personnel assigned to ships and the cancer patient has a usual residence within 50 miles of the homeport, the person's residence is the home, not the ship itself. If the patient's usual residence is more than 50 miles from the homeport, he or she is considered to be a resident of the ship. For patients who are considered residents of a ship, code residence as the ship's homeport unless the homeport is contained in more than one municipality. In that case, code the patient's residence as the municipality immediately adjacent to the dock or pier where the ship is berthed.

CREWS OF MERCHANT VESSELS

Crews of U.S. vessels outside the U.S., or crews of vessels flying a foreign flag, are considered non-residents. If a U.S. vessel is not berthed in a U.S. port but is in territorial waters, and the port of destination is inside the U.S., a crew member diagnosed with cancer is considered a resident of the port of destination. If the destination is outside the U.S., the homeport of the ship is considered the patient's residence. If a U.S. vessel is berthed in a U.S. port at the time of diagnosis, the patient is a resident of that port.

CHART
Summary of Rules for Determining Residency of Navy Personnel
Assigned to Ships



* If homeport is maintained in more than municipality, code patient as resident of the municipality immediately adjacent to the dock or pier where the ship is berthed.

APPENDIX F.1

CALIFORNIA HOSPITAL CODE NUMBERS

(in alphabetical order)

The first two digits of the hospital code number represent the California county code (minus the leading 0) where the hospital or reporting facility is located. Mercy General Sacramento (340947) is in Sacramento County (034).

Hospitals with similar names can be differentiated by the county code. Mission Community Hospital (190524) is in Los Angeles County (019), whereas Mission Community (301262) is in Orange County (030).

There are facilities, which have general names, such as Radiation Therapy Med Grp, but have a specific hospital code number (331155). Therefore, this hospital code number should not be used for another facility with the same name located in a different county.

"OLD" after the hospital name indicates that the hospital number is an inactive reporting source, e.g., hospital closed or merged.

AGNEWS DEVEL CTR	430700	ATASCADERO STATE	400683
AIM 1 COLORECTOL STUDY	000203	ATLANTA SEER	800033
ALABAMA STATE REG	989037	AUBURN FAITH COMM	310791
ALAMEDA COUNTY MED CTR	010737	AUBURN RAD ONC CTR	311010
ALAMEDA HOSPITAL	010735	AUBURN SURGERY CENTER	314010
ALAMEDA RAD ONCOLOGY	010738	AVALON MEMORIAL (OLD)	190044
ALASKA STATE REG	989091	AVALON MUNICIPAL	190045
ALEXIAN BROTHERS (OLD)	430705	AVENAL DISTRICT (OLD)	160681
ALHAMBRA COMMUNITY	190017	BAKERSFIELD COMM RAD (OLD)	150778
ALISAL COMMUNITY (OLD)	270706	BAKERSFIELD COMMUNITY	150775
ALLIANCE COMMUNITY	150775	BAKERSFIELD HEART HOSP	150050
ALTA BATES ALBANY (OLD)	013636	BAKERSFIELD MEM	150722
ALTA BATES/HERRICK	010739	BARLOW	190052
ALTA HOSPITAL DIST	540680	BARSTOW COMMUNITY	361105
ALVARADO COMMUNITY	370652	BARTON MEMORIAL	090793
ALVARADO EAST (OLD)	370749	BAY AREA REG CANCER CTR	070650
ALVARADO MED CTR	370652	BAY HARBOR	190057
AMADOR	030786	BAY MEDICAL CENTER	370658
AMI VALLEY MED CTR	370697	BAY RADIOLOGY MED GRP (OLD)	370660
ANACAPA ADVENTIST (OLD)	560468	BEACH COMMUNITY (OLD)	301109
ANAHEIM GENERAL	301097	BEALE AFB	589990
ANAHEIM MEM OUTPT (OLD)	301761	BEAR VALLEY COMMUN	361110
ANAHEIM MEM WEST (OLD)	301761	BELLFLOWER DOCTORS	190066
ANAHEIM MEMORIAL	301098	BELLWOOD GENERAL	190069
ANAHEIM MEMORIAL EAST	301098	BEN SCHAFFER CA INST	390820
ANGELS	361168	BEVERLY GLEN (OLD)	190078
ANTELOPE VALLEY	190034	BEVERLY HILLS (OLD)	190080
ANTELOPE VALLEY RAD ONC	193005	BEVERLY HILLS MED (OLD)	190488
APPLE VALLEY RAD ONC	361330	BEVERLY HOSPITAL	190081
ARCADIA METHODIST	190529	BEVERLY ONC & IMAGING CTR	193010
ARIZONA CANCER REGISTRY	989087	BIGGS GRIDLEY MEM	040802
ARKANSAS STATE REG	989071	BLOSS MEM DISTRICT (OLD)	240803
ARROWHEAD REG MED CTR	361320	BOYD, DAVID MD OLD	370000
ARROYO GRANDE COMM	400466	BREA COMMUNITY	301126

BREAST CENTER, THE	199997	CIRCLE CITY	331145
BROADWAY VALLEJO (OLD)	481015	CITRUS VALLEY MED CTR	190413
BROOKDALE (OLD)	019997	CITY OF ANGELS MED CTR	190175
BROOKSIDE	070904	CITY OF HOPE	190176
BROOKWOOD	490907	CITY VIEW (OLD)	190178
BROTMAN MED CTR	190110	CLAIREMONT COMMUN (OLD)	370674
BUENA PARK COMMUN (OLD)	301242	CLOVIS COMMUNITY	100005
BUENA PARK DOCTORS OLD	301109	CMRI	000452
BUENAVENTURA MEDCTR	560476	CMS	000450
BURBANK COMMUNITY	190114	COALINGA DISTRICT	100697
CA FDN SN BARBARA RAD CTR	420530	COAST PLAZA MED CTR	190766
CA FOUNDATION SN BARBARA	420530	COASTAL CITIES MRI & ROC	560480
CA GARDENA (OLD)	190312	COASTAL COMMUNITIES	301258
CA PODIATRY (OLD)	380769	COASTAL RAD ONC MED GROUP	560485
CAL ENDOCURIETHER MEDCORP	010745	COLDWATER CANYON	190199
CAL INST FOR MEN	369993	COLLEGE COSTA MESA	301155
CAL MENS COLONY	409990	COLLEGE PARK (OLD)	370683
CALEXICO	130666	COLORADO CENTRAL CA REG	989083
CALIF MED CTR LA	190125	COLUMBIA GOOD SAM SN JOSE	430779
CALIF MED FAC VACAVILLE	485000	COLUMBIA HUNTINGTON BEACH	301209
CALIF MEDICAL FACILITY	485000	COLUMBIA SAN CLEMENTE MED	301325
CALIFORNIA PACIFIC MEDCTR	380920	COLUMBIA SAN JOSE MED CTR	430879
CALVOTER REGISTRATION	000454	COLUMBIA SAN LEANDRO HOSP	013619
CAMARILLO STATE	560681	COLUMBIA SOUTH VALLEY	430924
CAMINO MED GRP	438800	COLUMBIA VALLEY HOSP	361144
CANCER/BLOOD KERN (OLD)	159991	COLUMBIA WEST ANAHEIM MED	301379
CANOGA PARK	190130	COLUMBIA WEST HILLS	190859
CAREUNIT LA (OLD)	190827	COLUSA COMMUNITY	060870
CASA COLINA REHAB	190137	COMMUN CHULA VISTA	370875
CASTLE AFB (OLD)	249990	COMMUNITY HOSP LONG BEACH	190180
CCR	000001	COMMUNITY MED CTR CLOVIS	100005
CEDARS COMP CA CTR	190553	COMMUNITY MED CTR FRESNO	100717
CEDARS-SINAI MED	190555	COMMUNITY MEMORIAL	560473
CENTINELA MAMMOTH	260011	COMMUNITY RAD ONC CTR	362045
CENTINELA MED CTR	190148	COMMUNITY SALINAS (OLD)	270706
CENTRAL VALLEY GENERAL	160787	CONNECTICUT SEER	800007
CENTURY CITY	190155	CONNECTICUT STATE REG	989007
CENTURY COMMUNITY (OLD)	190108	CONTRA COSTA COUNTY	070924
CHABOYA CLINIC	430884	CONTRA COSTA REG MED CTR	070924
CHANNEL ISLANDS (OLD)	560502	CONVALESCENT HOSPITAL	000804
CHANNEL ISLANDS SURGICTR	560475	CORCORAN DISTRICT	160702
CHAPMAN GENERAL	301140	CORCORAN STATE PRISON	169996
CHAPMAN MED CTR	301140	CORNING MEMORIAL (OLD)	520837
CHARTER COMMUNITY	190159	CORONA COMMUNITY (OLD)	331152
CHARTER PACIFIC	190655	CORONA RAD ONC MED CLINIC	331158
CHARTER SUBURBAN	190599	CORONA REGIONAL MED CTR	331145
CHICO COMMUNITY (OLD)	040828	CORONADO	370689
CHICO SURGERY CENTER	044153	CORONER	000802
CHILDRENS HOSP AT MISSION	301150	COSTA MESA MED CTR	301155
CHILDRENS LA	190170	COTTAGE HOSPITAL	420514
CHILDRENS OAKLAND	010776	COVINA VALLEY COMM	190458
CHILDRENS ORANGE	300032	COWELL BERKELEY (OLD)	010799
CHILDRENS SAN DIEGO	370673	COWELL DAVIS (OLD)	571139
CHILDRENS SF (OLD)	380777	CRENSHAW CENTER	190216
CHILDRENS STANFORD	430741	CRYSTAL SPRINGS	410752
CHINESE	382715	DAMERON	390846
CHINO COMMUNITY	361144	DANIEL FREEMAN MAR	190500
CHOPE	410782	DANIEL FREEMAN MEM	190230
CHOWCHILLA DIST	200692	DAVID GRANT USAF	489990
CHRISTIAN MED CTR (OLD)	332172	DAVIES MED CTR	380933
CIGNA CLINICS LA	190665	DC ONLY	000801
CIGNA HOSP LA (OLD)	190661	DEATH CERTIFICATE (STAT)	000456

DEATH CLEARANCE (INCR)	000469	EL CAJON VALLEY OLD	370697
DEL AMO DX CTR	190420	EL CAMINO	430763
DEL PUEBLO (OLD)	190065	EL CENTRO COMMUN	130699
DEL PUERTO (OLD)	500850	EL MONTE COMMUNITY	190352
DELANO REGIONAL MED	150706	EMANUEL MED CTR	500867
DELAWARE STATE REG	989017	ENCINO (OLD)	190280
DELTA MEMORIAL	070934	ENCINO-TARZANA REG MED CT	190517
DESERT	331164	ENDOSCOPY CENTER	514009
DESERT RAD ONCOLOGY	361150	ENLOE MEDICAL CENTER	040962
DESERT RADIATION ONCOLOGY	361150	ENLOE MEMORIAL	040962
DESERT VALLEY	361155	ESCONDIDO SURGICAL CTR	370688
DETROIT SEER	800041	ESKATON AMER RIV	340869
DIGESTIVE DISEASE CENTER	302000	ESTUDILLO CORP	010809
DISTRICT OF COLUMBIA REG	989022	EXETER MEMORIAL	540755
DMV	000451	FAIRCHILD MED CTR	471031
DOCTORS BELLFLOWER	190066	FAIRMONT (OLD)	010811
DOCTORS EAST LA	190256	FAIRVIEW STATE	301781
DOCTORS HAWTHORNE (OLD)	190406	FALLBROOK DISTRICT	370705
DOCTORS LA	190854	FEATHER RIVER	040875
DOCTORS LAKEWOOD	190240	FEATHER RIVER SURG CENTER	514010
DOCTORS LAKEWOOD C (OLD)	190453	FED CORRECT SN PDRO	199993
DOCTORS LODI	390922	FHP FOUNTAIN VLY	300225
DOCTORS LONG BEACH	190477	FHP LA COUNTY MED CTRS	190161
DOCTORS LONG BEACH (OLD)	190478	FHP NOS	999980
DOCTORS MANTECA	392287	FHP ORANGE COUNTY MEDCTRS	300227
DOCTORS MEDICAL CENTER	070904	FHP PHYSICIANS ONLY	999985
DOCTORS MODESTO	500852	FLORIDA STATE REG	989035
DOCTORS MONTCLAIR	361166	FOOTHILL PRESBYTERIAN	190298
DOCTORS OAKLAND (OLD)	019996	FORT IRWIN	369990
DOCTORS PINOLE (OLD)	073449	FORT ORD	279990
DOCTORS SAN PABLO	070904	FORT YUMA IND HOSP	139990
DOCTORS SANTA ANA OLD	301167	FOUNTAIN VALLEY COMM	301175
DOCTORS' SURGERY CENTER	450900	FOUNTAIN VALLEY OP SURG	301170
DOMINGUEZ VALLEY	190242	FOUNTAIN VALLEY REG HOSP	301175
DOMINICAN ST CRUZ	440755	FOWLER MUNICIPAL (OLD)	100714
DOS PALOS MEMORIAL (OLD)	240853	FRANK HOWARD MEM	230949
DOWNEY COMMUNITY	190243	FRANKLIN	380933
DOWNEY RAD ONC MED CLINIC	193020	FRED HUTCHINSON	989992
DRS EAST LA	190256	FREMONT	510882
DRS HAWTHORNE (OLD)	190406	FRENCH LA	190307
DRS LA	190854	FRENCH SF (OLD)	380816
DRS LAKEWOOD	190240	FRENCH SN LUIS OBS	400480
DRS LAKEWOOD CLARK (OLD)	190453	FRESNO COMMUNITY	100717
DRS LODI	390922	FRESNO SURGERY CENTER	100720
DRS LONG BEACH	190477	FRIENDLY HILLS REG OLD	301232
DRS LONG BEACH (OLD)	190478	FROST ST SURG CTR	370710
DRS MANTECA	392287	FULLERTON COMMUN (OLD)	301180
DRS MODESTO	500852	G BAKERSFIELD MEM	150722
DRS MONTCLAIR	361166	GARDEN GROVE MED	301283
DRS OAKLAND (OLD)	019996	GARDEN SULLIVAN (OLD)	382684
DRS PINOLE (OLD)	073449	GARDENA COMMUNITY	190196
DRS SANTA ANA OLD	301167	GARDENA MEMORIAL	190521
E DOHENY EYE FND	199995	GARFIELD MED CTR	190315
EAST BAY (OLD)	071053	GENERAL EUREKA	120981
EAST VALLEY CLINIC	430885	GEORGE AFB	369991
EAST VALLEY MED GRP	190285	GEORGE L MEE MEM	270777
EAST VALLEY PAVILLION	430886	GEORGIA STATE REG	989033
EASTERN PLUMAS	320859	GLENDALE ADV CC (OLD)	190326
EDEN	010805	GLENDALE ADVENTIST	190323
EDWARDS AFB	159990	GLENDALE MEMORIAL	190522
EISENHOWER MED CTR	331168	GLENDORA COMMUNITY	190328

GLENN GENERAL	110889	INLAND RAD THERAPY	361170
GLENN MED CTR	110889	INLAND RADIATION THERAPY	361170
GOLETA VALLEY	420483	INLAND VALLEY REG MED CTR	331239
GOOD SAM BAKERSFIELD	150775	INTERCOMM COVINA	190413
GOOD SAM SAN JOSE	430779	IOWA SEER	800053
GOOD SAM SN CLARA VLY	430779	IOWA STATE REG	989053
GOOD SAMARITAN LA	190392	IRVINE MED CTR	300125
GRANADA HILLS COMM	190348	IRVINE REGIONAL HOSPITAL	300125
GREATER EL MONTE COMMUN	190352	JEROLD R PHELPS COMMUNITY	121031
GREATER SACRAMENTO SURG	341088	JERRY PETTIS MEM	369992
GROSSMONT DIST	370714	JOHN C FREMONT	220733
HAHNEMANN (OLD)	380826	JOHN F KENNEDY MEM	331216
HAMILTON AFB (OLD)	219998	JOHN MUIR MED CTR	070988
HANFORD COMMUNITY	160725	JOHN MUIR MEMORIAL	070988
HARBOR GENERAL	191227	KAISER ANAHEIM	301132
HARBOR VIEW MED OLD	370672	KAISER BAKERSFIELD	150770
HAROLD D CHOPE	410782	KAISER BALDWIN PARK	190425
HAWAII SEER	800099	KAISER BELLFLOWER	190430
HAWAII STATE REG	989099	KAISER CARSON	190135
HAWKINS MEMORIAL	350784	KAISER EL CAJON OLD	370716
HAWTHORNE MEMORIAL	190523	KAISER FONTANA	361223
HAYWARD (OLD)	013637	KAISER FREMONT	014132
HAZEL HAWKINS MEM	350784	KAISER FRESNO	100500
HEALDSBURG GENERAL	490964	KAISER HARBOR CITY	190431
HEALTHCARE TUSTIN	301357	KAISER HAYWARD	010858
HEALTHSOUTH SURG ALHAMBRA	344066	KAISER INGLEWOOD	190433
HEALTHSOUTH SURG FORT SUT	344015	KAISER LA	190429
HEMET VALLEY MED CTR	331194	KAISER MARTINEZ	071010
HENRY MAYO NEWHALL	190949	KAISER NORWALK	190428
HERITAGE	361168	KAISER NOS	999982
HERMOSA BEACH (OLD)	191002	KAISER OAKLAND	010856
HERRICK (OLD)	010844	KAISER PANORAMA	190432
HI DESERT MED CTR	362041	KAISER REDWOOD CITY	410804
HIGHLAND GENERAL (OLD)	010846	KAISER RICHMOND	070991
HILLSIDE (OLD)	370721	KAISER RIVERSIDE	331230
HOAG MEM PRESBYTER	301205	KAISER ROSEVILLE	311015
HOLDERMAN MEMORIAL	281297	KAISER RWC	410804
HOLLYWD PRES/QUEEN ANGELS	190490	KAISER SACRAMENTO	340913
HOLLYWOOD COMMUN	190380	KAISER SAN DIEGO	370730
HOLLYWOOD PRESBY (OLD)	190382	KAISER SAN RAFAEL	210992
HOLY CROSS	190385	KAISER SANTA ROSA	491400
HOME HEALTH	999991	KAISER SANTA TERESA	431506
HOSP DISCHARGE DATA-OSHPD	000465	KAISER SF	380857
HOSPICE	999990	KAISER SN CLARA	430805
HOWARD MEMORIAL	230949	KAISER SO SACTO	340920
HUMANA HUNTINGTON	301209	KAISER SO SF	410806
HUMANA NOS	999981	KAISER SSF	410806
HUMANA SAN LEANDRO	013619	KAISER STOCKTON CLINIC	391020
HUMANA W ANAHEIM	301379	KAISER SUNSET	190429
HUMANA WEST HILLS	190859	KAISER VALLEJO	480989
HUMANA WESTMINSTER (OLD)	301380	KAISER WALNUT CRK	070990
HUMBOLDT COMMUNITY	121031	KAISER WEST LA	190434
HUNTINGTON BEACH MED CTR	301209	KAISER WOODLAND HILLS	190435
HUNTINGTON E VALLEY MED	190328	KANSAS STATE REG	989065
HUNTINGTON MEM	190400	KAWEAH DELTA DIST	540734
HUNTINGTON PARK	190197	KENNETH NORRIS USC	191216
IDAHO STATE REG	989081	KENTFIELD MED	210993
ILLINOIS STATE CA REG	989061	KENTUCKY STATE REG	989047
IMPERIAL VALLEY CANCER CT	130710	KERN MEDICAL CTR	150736
INDIAN VALLEY DIST	320874	KERN REGIONAL CANCER CTR	150740
INDIANA STATE REG	989045	KERN VALLEY	150737
INGLEWOOD WOMENS (OLD)	190412	KINDRED SACRAMENTO	341040

KING-DREW	191230	MANTECA	392287
KINGSBURG GENERAL (OLD)	100745	MARCH AFB	339990
KLAMATH TRINITY (OLD)	120982	MARIAN MEDICAL CTR	420493
KPC GLOBAL MED CTR	361166	MARIN GENERAL	211006
KRANS MEDICAL PARTNERS	193055	MARK TWAIN	050932
LA CO HIGH DESERT	191261	MARSHAL HALE (OLD)	380826
LA CO JAIL HOSP	199996	MARSHALL	090933
LA CO KING-DREW MED	191230	MARSHALL HOSP RAD ONC CTR	090935
LA CO OLIVE VIEW	191231	MARTIN LUTHER KING	191230
LA CO RANCHO AMIGOS	191306	MARTIN LUTHER MED (OLD)	301761
LA CO USC MED	191228	MARYLAND STATE REG	989021
LA COMMUNITY	190198	MARYS HELP	410817
LA HABRA COMMUNITY	301232	MASSACHUSETTS STATE REG	989005
LA MIRADA MED CTR	190449	MATHER AFB	349990
LA PALMA INTERCOMM	301234	MAXICARE MED CTRS	190305
LA VINA FOR RESP	190451	MAYERS MEMORIAL	450936
LAGUNA HONDA REHAB	380865	MAYO CLINIC	989990
LAKE VIEW MED CTR (OLD)	190592	MD ANDERSON	989991
LAKESIDE CLINIC	171300	MD ONLY	999996
LAKESIDE COMMUNITY	171395	MEDI-CAL ELIGIBILITY	000457
LAKESIDE HOSPITAL	331233	MEE MEMORIAL	270777
LAKEWOOD REGIONAL MED CTR	190240	MEM SLOAN KETTERNG	989993
LANCASTER COMMUN	190455	MEMORIAL CERES	500938
LANTERMAN STATE	190588	MEMORIAL LOS BANOS	240924
LAS ENCINAS	190462	MEMORIAL MODESTO	500939
LASSEN COMMUNITY	180919	MEMORIAL SAN LEANDRO	010887
LAUREL GROVE (OLD)	010869	MENDOCINO COAST	231013
LAWRENCE BERK LAB	019989	MENDOCINO COMMUN	231014
LETTERMAN ARMY (OLD)	389995	MENIFEE VALLEY	331235
LINCOLN MED CTR	190468	MERCED COMMUNITY	240942
LINDA VISTA COMMUNITY	190684	MERCY AMERICAN RIVER	340869
LINDSAY MED CTR	540746	MERCY BAKERSFIELD	150761
LITTLE CO MARY	190470	MERCY FOLSOM	341065
LIVINGSTON MED CTR	370735	MERCY GEN SACTO	340947
LIVINGSTON WHEELER	370735	MERCY GEN SANTA ANA	301258
LODI COMMUNITY	390922	MERCY MERCED	240948
LODI MEMORIAL	390923	MERCY MERCED COMMUNITY	240942
LODI OUTPATIENT SURG CTR	394004	MERCY MERCED DOMINICAN	240948
LOMA LINDA COMMUN	361246	MERCY MT SHASTA	470871
LOMA LINDA COMMUN (OLD)	361245	MERCY REDDING	450949
LOMA LINDA UNIV	361246	MERCY SACRAMENTO	340947
LOMPOC DISTRICT	420491	MERCY SACRAMENTO ROC	340948
LOMPOC PENITENTARY	429991	MERCY SAN DIEGO	370744
LONG BEACH	190477	MERCY SAN JUAN	340950
LONG BEACH COMMUN (OLD)	190475	MERCY SAN JUAN ROC	340955
LONG BEACH DOCTORS	190477	MERRITHEW MEMORIAL	070924
LONG BEACH MEM MED	190525	MERRITT	010937
LOS ALAMITOS MED	301248	MERRITT PERALTA MED CTR	010937
LOS ALTOS (OLD)	190482	METHODIST SACTO	340951
LOS AMIGOS	191306	METHODIST SO CALIF	190529
LOS ANGELES COMMUN	190198	METROPOLITAN	190530
LOS BANOS COMMUN	240924	MICHAEL J FAZIO MD SURG	344118
LOS GATOS COMMUN	430743	MICHIGAN CANCER REG	989041
LOS MEDANOS COMMUN	073638	MIDVALLEY	191231
LOS ROBLES REGIONAL	560492	MIDWAY MED CTR	190534
LOS ROBLES SURGICENTER	560495	MIDWOOD COMMUNITY (OLD)	301345
LOUISIANA STATE REG	989073	MILLS MEMORIAL	410742
MAD RIVER COMMUN	121002	MILLS-PENINSULA	410772
MADERA COMMUNITY	201281	MINERS (OLD)	290952
MAINE STATE REG	989002	MINNESOTA STATE REG	989052
MAMMOTH	260011	MISSION	190538

MISSION BAY MEM (OLD)	370746	OAK KNOLL NAVAL	019990
MISSION COMMUNITY	301262	OAK VALLEY DIST	500967
MISSION COMMUNITY HOSP	190524	OAKLAND (OLD)	010902
MISSION HOSP REG MED CTR	301262	OCONNOR CAMPBELL (OLD)	431722
MISSION MED ASSOCIATES	400500	OCONNOR SAN JOSE	430837
MISSION OAKS (OLD)	430915	OHIO STATE REG	989043
MISSION VALLEY MED CTR	331239	OJAI VALLEY COMMUN	560501
MISSION VIEJO RAD ONC GRP	301785	OKLAHOMA STATE REG	989075
MISSISSIPPI STATE REG	989039	ONCOLOGY INSTITUTES	560470
MISSOURI STATE REG	989063	ONCOLOGY THERAPIES INC	370790
MODESTO CITY (OLD)	500954	ONTARIO COMMUNITY	361274
MODOC MED ALTURAS	250956	ORANGE COAST MEM MED CTR	300225
MOJAVE RADIATION ONC CTR	361250	ORANGE CO INST GE&ENDO	302005
MONO GENERAL	261263	ORANGE GROVE HOSP (OLD)	190600
MONROVIA COMMUNITY	190541	OREGON STATE CANCER REG	989095
MONTANA STATE REG	989056	OROVILLE MED CTR	040937
MONTEREY PARK	190547	ORTHOPEDIC	190581
MONTEREY PEN COMM	270744	OXNARD COMMUNITY (OLD)	560502
MONTEREY PENINSULA (OLD)	271118	PACIFIC ALLIANCE MED CTR	190307
MONTEREY PENINSULA SURG	270740	PACIFIC LONG BEACH	190587
MOORE J E LAB (OLD)	019998	PACIFIC MED CTR (OLD)	380929
MORENO VALLEY MED CTR	331245	PACIFIC PRESBYTER (OLD)	380929
MORRIS JOHNSTON MEM	190298	PACIFIC RAD ONCOL	309990
MOTION PICTURE TV	190552	PACIFICA COMMUNITY OLD	301282
MOUNTAINS COMM	361266	PACIFICA OF THE VALLEY	190696
MT DIABLO MED CTR	071018	PALM DRIVE	491338
MT SHASTA COMMUNITY	470871	PALM IMAGING	362046
MT ZION	380895	PALM TUMOR CLINIC	193080
MULLIKIN MED CTR	191320	PALMDALE MED CTR	190595
NAPA STATE	281266	PALO ALTO MED FND	439998
NATIONAL DEATH INDEX	000455	PALO VERDE	331288
NATIVIDAD MEM CTR	270831	PALOMAR MEMORIAL	370755
NAVAL LEMOORE	169990	PAMC	439998
NAVAL LONG BEACH	199990	PANORAMA COMMUNITY	190524
NAVAL OAKLAND	019990	PARADISE VALLEY	370759
NAVAL PENDLETON	379990	PARK VIEW (OLD)	190603
NAVAL SAN DIEGO	379991	PARKVIEW COMMUN	331293
NCOA	000466	PASADENA MED CTR (OLD)	190608
NEBRASKA STATE REG	989067	PATIENTS HOSP OF REDDING	450950
NEEDLES DESERT COMM	361458	PATTON STATE	361315
NEVADA STATEWIDE CA REG	989085	PENINSULA MED CTR	410852
NEVADA, STATE REGISTRY OF	989085	PENNSYLVANIA STATE REG	989014
NEW HAMPSHIRE STATE REG	989003	PERALTA (OLD)	010919
NEW JERSEY STATE REG	989008	PETALUMA VALLEY	490001
NEW MEXICO SEER	800086	PETERSON MED CLINIC (OLD)	560505
NEW MEXICO STATE REG	989086	PHS WINTERHAVEN	139990
NEW YORK STATE REG	989011	PHYSICIAN	000803
NEWHALL COMMUNITY	190559	PHYSICIAN ONLY	999996
NO HOLLYWOOD MED	190654	PHYSICIANS COMMUN (OLD)	010887
NON-HOSPITAL NOS	999995	PICO RIVERA COMMUN	190616
NORTH CAROLINA STATE REG	989025	PINECREST (OLD)	420506
NORTH COAST HEALTHCARE	490907	PIONEER	190619
NORTH COAST REHAB	490907	PIONEERS MEMORIAL	130760
NORTH DAKOTA STATE REG	989054	PLACENTIA-LINDA	301297
NORTH KERN (OLD)	150769	PLASTIC SURG CTR MED GRP	342259
NORTHBAY MED CTR	481357	PLEASANT VALLEY	560508
NORTHERN INYO	141273	PLUMAS DISTRICT	320986
NORTHRIDGE MED CTR	190568	POMERADO	370977
NORTHRIDGE SHERMAN WAY	190810	POMONA VALLEY	190630
NORWALK COMMUNITY	190570	PORT HUENEME ADVENT (OLD)	560468
NOVATO COMMUNITY	212637	PORTERVILLE DEVELOP CTR	541123
NU-MED REGIONAL MED CTR	190860	PORTERVILLE STATE	541123

PRESB INTERCOMMUN	190631	SACRED HEART	160787
PRESBYTERIAN MED (OLD)	380929	SADDLEBACK COMMUNITY	301317
PRESIDIO SAN FRAN (OLD)	389995	SADDLEBACK MEM MED CTR	301317
PROPERTY TAX	000468	SALINAS VALLEY MEM	270875
PROVIDENCE (OLD)	013626	SAMARITAN MED CTR	301325
QUEEN ANGELS/HOLLYWD PRES	190490	SAMUEL MERRITT NO (OLD)	010782
QUEEN OF ANGELS LA (OLD)	190635	SAN ANTONIO COMMUN	361318
QUEEN VALLY NAPA	281047	SAN BENITO DIST	350784
QUEEN VALLEY W COV	190636	SAN BERNARDINO CANCER CTR	362045
RAD ONC CONSULT MED GRP	193086	SAN BERNARDINO CM	361323
RAD ONC CTR HAYWARD (OLD)	010859	SAN BERNARDINO CO	361320
RAD ONC MED GRP SO CALIF	301782	SAN BERNARDINO MT	361266
RAD ONC MED SPECIALISTS	370760	SAN BUENAVENTURA	560473
RAD THERAPY MED GROUP	331155	SAN CLEMENTE GEN	301325
RADIATION MED GRP	370760	SAN DIEGO AMB SURG CTR	370765
RADIATION ONC ASSOCIATES	193085	SAN DIEGO GENERAL (OLD)	370686
RADIATION THERAPY MED GRP	331155	SAN DIEGO PHYSICNS (OLD)	370686
RADIOLOGY MED GRP	370760	SAN DIMAS COMMUN	190673
RALPH K DAVIES	380933	SAN FERNANDO COMM	190676
RANCHO ENCINO	190862	SAN FRANCISCO GEN	380939
RANCHO LOS AMIGOS	191306	SAN GABRIEL COMMUN	190200
RANCHO SPRINGS MED CTR	331350	SAN GABRIEL VALLEY MEDCTR	190200
RECOVERY INN LOS GATOS	430750	SAN GORGONIO MEM HOSP	331326
RECOVERY INN MENLO PARK	410820	SAN GORGONIO PASS	331326
RED BLUFF TUMOR INSTITUTE	522052	SAN JOAQUIN COMMUN	150788
REDBUD COMMUNITY	171049	SAN JOAQUIN GEN	391010
REDDING CANCER RX CTR	450938	SAN JOAQUIN LASER & SURG	394023
REDDING MED CTR	450940	SAN JOSE HEALTH	430879
REDDING SURGERY CENTER	452000	SAN JOSE MED CTR	430879
REDLANDS COMMUNITY	361308	SAN LEANDRO HOSPITAL	013619
REDWOOD MEMORIAL	121051	SAN LUIS MED CLINIC	400500
REG MED CTR OF SAN JOSE	432002	SAN LUIS OBISPO GEN	400511
REGION 1	000101	SAN MATEO COUNTY GENERAL	410782
REGION 10	000110	SAN PEDRO PENINSULA	190680
REGION 2	000102	SAN QUENTIN PR	211167
REGION 3	000103	SAN RAMON REGIONAL MEDCTR	075100
REGION 3 OVARIAN STUDY	000303	SAN VICENTE (OLD)	190681
REGION 4	000104	SANDLEWOOD (OLD)	190379
REGION 5	000105	SANGER	100791
REGION 6	000106	SANSUM MED CLINIC (OLD)	420540
REGION 7	000107	SANTA ANA MED	301314
REGION 8	000108	SANTA BARBARA BREAST (OLD)	420545
REGION 9	000109	SANTA BARBARA MED FDN-OLD	420550
REHAB INST SANTA BARBARA	421167	SANTA BARBARA MEM	421167
RHODE ISLAND STATE REG	989006	SANTA CLARA VALLEY	430883
RIDEOUT MEMORIAL	580996	SANTA CRUZ COMMUN (OLD)	441807
RIDGECREST COMMUN	150782	SANTA CRUZ GENERAL	440886
RIO HONDO MEMORIAL	190651	SANTA CRUZ MED CLINIC	440890
RIVERSIDE COMMUN	331312	SANTA CRUZ RAD ONC MED GR	440894
RIVERSIDE COUNTY REG MED	331313	SANTA FE COMMUNITY	190684
RIVERSIDE GEN UNIV	331313	SANTA MARTA CLINIC	190685
RIVERSIDE KNOLLWD (OLD)	331226	SANTA MONICA MED	190687
RK DAVIES	380933	SANTA MONICA CANCER RX	193090
ROBERT F. KENNEDY	190366	SANTA MONICA MED	190687
ROGUE VALLEY MED CTR	989195	SANTA PAULA MEM	560521
ROSEVILLE COMM	311000	SANTA ROSA COMMUN	490919
ROSEVILLE RAD ONC CTR	311005	SANTA ROSA GENERAL (OLD)	491012
ROSS GENERAL (OLD)	211056	SANTA ROSA MEM	491064
ROSS LOOS MEDICAL (OLD)	190661	SANTA TERESA COMM	431506
SACRAMENTO COMMUN (OLD)	342097	SANTA TERESITA	190691
SACRAMENTO MIDTOWN ENDOSC	344005	SANTA YNEZ VALLEY	420522

SCENIC GENERAL (OLD)	501015	ST BERNARDINE	361339
SCRIPPS CHULA VISTA	370658	ST CATHERINE	410828
SCRIPPS EAST COUNTY OLD	370697	ST DOMINICS	390850
SCRIPPS ENCINITAS	371394	ST ELIZABETH COMM	521041
SCRIPPS GREEN	371256	ST FRANCIS LYNWOOD	190754
SCRIPPS LA JOLLA	370771	ST FRANCIS SF	380960
SEASIDE MED CLINIC	081066	ST FRANCIS SN BARB	420528
SEATTLE SEER	800093	ST HELENA HEALTH	281078
SELMA COMMUNITY	100793	ST JOHNS OXNARD	560529
SELMA DISTRICT	100793	ST JOHNS SN MONICA	190756
SENECA DISTRICT	321016	ST JOSEPH BURBANK	190758
SEQUOIA	410891	ST JOSEPH EUREKA	121080
SERRA MEMORIAL	190696	ST JOSEPH OAK PARK (OLD)	392232
SETON MED CTR COASTSIDE	410828	ST JOSEPH ORANGE	301340
SETON MEDICAL CTR	410817	ST JOSEPH'S SF (OLD)	389994
SF GENERAL	380939	ST JOSEPHS STOCKTN	391042
SHARP CABRILLO	370693	ST JUDE FULLERTON	301342
SHARP CHULA VISTA MED CTR	370875	ST JUDE YORBA LINDA OLD	301169
SHARP HEALTHCARE MURRIETA	331350	ST LOUISE (OLD)	430850
SHARP MARY BIRCH	370690	ST LOUISE CANCER CARE CTR	431500
SHARP MEMORIAL	370694	ST LOUISE REG HOSP (OLD)	430924
SHARP REES STEALY	370695	ST LOUISE REG MED CTR	432001
SHASTA GENERAL (OLD)	451018	ST LUKE PASADENA	190759
SHERMAN OAKS COMM	190708	ST LUKES SF	380964
SHRINERS LA	190712	ST MARY DESERT VLY	361343
SHRINERS SF	380954	ST MARY LONG BEACH	190053
SIERRA COMM FRESNO	100796	ST MARY REG MED CTR	361343
SIERRA KINGS	100797	ST MARYS SF	380965
SIERRA MADRE COMM (OLD)	190714	ST PAULS (OLD)	019999
SIERRA NEVADA MEM	291023	ST ROSE	010967
SIERRA SONORA	552209	ST TERESA RADIATION	391050
SIERRA SURGICENTER	070950	ST VINCENT MED	190762
SIERRA VALLEY DIST	461024	STAFF PHYSICIAN	999993
SIERRA VIEW DIST	540798	STANFORD UNIV	430905
SIERRA VISTA	400524	STANISLAUS MED CTR	501015
SILAS B HAYS ARMY	279990	STUDEBAKER COMMUN	190766
SIMI VALLEY ADVENT	560525	SUMMIT MED CTR	010937
SIMI VALLEY COMMUN (OLD)	560526	SUN CITY CA CLIN	339991
SISKIYOU GENERAL	471031	SURGERY CENTER	192070
SKILLED NURSING FACILITY	999992	SURPRISE VALLEY	250955
SMITH HANNA OLD	370775	SUTTER AMADOR	030786
SN BARBARA BREAST CA (OLD)	420545	SUTTER AUBURN FAITH	310791
SN BARBARA COTTAGE	420514	SUTTER COAST	081066
SO HUMBOLDT COMMUN	121031	SUTTER COAST (OLD)	081070
SOCIAL SECURITY- DEATHS	000458	SUTTER COM YUBA CY (OLD)	511049
SOCIAL SECURITY-SSN	000461	SUTTER COMMUN HOSPITALS	341052
SOLANO SURGERY CENTER	484003	SUTTER DAVIS	571215
SONOMA COUNTY REDWOOD REG	491070	SUTTER GEN SACTO (OLD)	341051
SONOMA STATE	491267	SUTTER LAKESIDE	171395
SONOMA VALLEY	491076	SUTTER MATERN & SURG CTR	440905
SONORA COMMUNITY	551034	SUTTER MED CTR	490919
SOUTH BAY	190734	SUTTER MED CTR SACRAMENTO	341052
SOUTH CAROLINA STATE REG	989026	SUTTER MEM SACTO	341052
SOUTH COAST MED	301337	SUTTER MERCED	240942
SOUTH VALLEY CLINIC	430887	SUTTER NORTH PROCEDURE	514021
SOUTH VALLEY HOSP	430924	SUTTER RAD ONCOLOGY CTR	341055
SOUTHCOAST TUMOR INS (OLD)	370776	SUTTER ROSEVILLE COMM	311000
SOUTHERN INYO	141338	SUTTER SOLANO MED CTR	481094
SOUTHWEST CANCER CARE	370777	SUTTER SURG CTR J ST	344062
SPECIALIST SURGEY CTR	484021	SUTTER SURGERY CENTER	341068
SSA-EVS	000467	SUTTER TRACY COMMUNITY	391056
ST AGNES MED CTR	100899	TAHOE FOREST	291053

TALBERT DESERT SIERRA	710585	VA BRENTWOOD	199992
TALBERT LA CO MED CTRS	190161	VA FRESNO	109999
TALBERT MED GRP NOS	999980	VA LIVERMORE (OLD)	019995
TALBERT ORANGE CO MEDCTRS	300227	VA LOMA LINDA	369992
TALBERT PHYSICIANS ONLY	999985	VA LONG BEACH	199991
TARZANA MED CTR	190517	VA MARTINEZ	079997
TEHACHAPI	150808	VA MATHER	341085
TEMECULA CANCER CTR	331355	VA PALO ALTO (OLD)	439999
TEMPLE COMMUNITY	190784	VA PALO ALTO (VAPAHCS)	439995
TENNESSEE STATE REG	989031	VA RENO (OLD)	989999
TERMINAL ISLAND	199993	VA SACRAMENTO	341085
TERRACE PLAZA MED	190049	VA SAN DIEGO	379992
TEXAS STATE REG	989077	VA SAN FRANCISCO	389992
THOMPSON MEMORIAL MED CTR	190114	VA SEPULVEDA	199994
TORRANCE MEMORIAL	190422	VA W LOS ANGELES	199992
TRACY COMMUNITY	391056	VA WADSWORTH	199992
TRAVIS AFB	489990	VACA VALLEY HOSP	481070
TREATMENT FOLLOW BACK	970000	VALLEJO GENERAL	481094
TRI-CITY	370780	VALLEY CANCER INSTITUTE	193100
TRI-CITY REGIONAL MED CTR	190790	VALLEY CANOG PK (OLD)	190605
TRI-CITY WEST (OLD)	370753	VALLEY CHILDRENS	201819
TRI-VALLEY CASTRO VALLEY	010969	VALLEY CHILDRENS (OLD)	100819
TRI-VALLEY PLEASANTON	010970	VALLEY COMMUNITY	420535
TRINITY GENERAL	531059	VALLEY HEALTH CTR	430888
TULARE DISTRICT	540816	VALLEY LIVERMORE	010983
TUOLUMNE GENERAL	551061	VALLEY MED EL CAJON	370697
TUSTIN HOSP MED CTR	301357	VALLEY MED FRESNO	100822
TWIN CITIES COMMUN	400548	VALLEY PLAZA DOCTORS HOSP	331233
TWIN CITIES SURGICENTER	584003	VALLEY POMONA (OLD)	190314
U PACIFIC DENTAL	389990	VALLEY PRESB MEM	190812
UC DAVIS	341006	VALLEY REG ONC CTR	332173
UC IRVINE	301279	VALLEY TUMOR MED GRP	193104
UC SAN DIEGO	370782	VALLEY VAN NUYS	190810
UC SF MED CENTER	381154	VALLEY VISTA (OLD)	190678
UCD	341006	VALLEY WEST GEN (OLD)	430915
UCI	301279	VAN NUYS COMMUNITY (OLD)	190814
UCLA	190796	VANDENBERG AFB	429990
UCLA HARBOR	191227	VAPA HEALTH CARE SYSTEM	439995
UCMC SAN FRANCISCO	381154	VENCOR	190305
UCSD	370782	VENCOR ONTARIO	361274
UCSF FRESNO	109998	VENCOR SACRAMENTO	341040
UCSF MED CENTER	381154	VENTURA CO MED CTR	560481
UCSF STANFORD HEALTH CARE	381160	VENTURA CO RAD ONC CTR	560482
UKIAH ADVENTIST	231396	VERDUGO HILLS	190818
UKIAH GENERAL (OLD)	231339	VERMONT STATE REG	989004
UKIAH SURGERY CENTER	231350	VESPER SL	010887
UKIAH VALLEY MED	231396	VICTOR VALLEY	361370
UNIVERSITY MED CTR	100822	VILLA VIEW COMMUN	370787
UNKNOWN HOSP	999999	VIRGINIA STATE REG	989023
UNREFERRED PATIENT	000000	VISALIA COMMUNITY	540827
UNSPEC BAY AREA H	999997	VISTA RADIATION	370790
UNSPEC CALIF HOSP	999998	WALNUT CRK RAD GRP	079996
UNSPEC CENTRAL CA HOSP	999987	WARRACK MED CTR	491103
UNSPEC NONCAL HOSP	999994	WASHINGTON CULVER	190847
UNSPEC NORTHERN CA HOSP	999988	WASHINGTON D.C. REG	989022
UNSPEC SOUTHERN CA HOSP	999989	WASHINGTON FREMONT	010987
US FAMILY CARE MED CTR	361166	WASHINGTON STATE REG	989093
USC MEDICAL CENTER	191228	WATSONVILLE COMMUN	440920
USC UNIVERSITY HOSPITAL	191210	WEED ARMY	369990
UTAH SEER	800084	WEST ANAHEIM MED CTR	301379
UTAH STATE REG	989084	WEST COVINA	190857

WEST HILLS REG MED CTR	190859
WEST HOLLYWOOD	190384
WEST PARK	190860
WEST SIDE	150830
WEST SIDE COMMUN (OLD)	241082
WEST VALLEY HOSP & HEALTH	190860
WEST VIRGINIA STATE REG	989024
WESTERN ANAHEIM	301188
WESTERN MED SN ANA	301566
WESTERN TUMOR MED GRP	193110
WESTLAKE COMMUN	190867
WESTSIDE LA	190873
WHEELER	430924
WHILSHIRE ONC MED GRP	193117
WHITE MEMORIAL	190878
WHITTIER MED CTR	190883
WHITTIER ONCOLOGY CLINIC	193113
WISCONSIN CA REPORTING	989051
WOMENS BREAST CTR	301570
WOODLAND MEMORIAL	571086
WOODRUFF COMMUNITY	190891
WOODRUFF GABLES (OLD)	190893
WYOMING STATE REG	989082
X-RAY MED GROUP LA MESA	372000
YOLO GENERAL	571093
YUBA SUTTER RAD ONC CTR	511060

APPENDIX F.2

CALIFORNIA HOSPITAL CODE NUMBERS

(In numerical order)

The first two digits of the hospital code number represent the California county code (minus the leading 0) where the hospital or reporting facility is located. Mercy General Sacramento (340947) is in Sacramento County (034).

Hospitals with similar names can be differentiated by the county code. Mission Community Hospital (190524) is in Los Angeles County (019), whereas Mission Community (301262) is in Orange County (030).

There are facilities, which have general names, such as Radiation Therapy Med Grp, but have a specific hospital code number (331155). Therefore, this hospital code number should not be used for another facility with the same name located in a different county.

"OLD" after the hospital name indicates that the hospital number is an inactive reporting source, e.g., hospital closed or merged.

000000	UNREFERRED PATIENT	010735	ALAMEDA HOSPITAL
000001	CCR	010737	ALAMEDA COUNTY MED CTR
000101	REGION 1	010738	ALAMEDA RAD ONCOLOGY
000102	REGION 2	010739	ALTA BATES/HERRICK
000103	REGION 3	010745	CAL ENDOCURIETHER MED CORP
000104	REGION 4	010776	CHILDRENS OAKLAND
000105	REGION 5	010782	SAMUEL MERRITT NO (OLD)
000106	REGION 6	010799	COWELL BERKELEY (OLD)
000107	REGION 7	010805	EDEN
000108	REGION 8	010809	ESTUDILLO CORP
000109	REGION 9	010811	FAIRMONT (OLD)
000110	REGION 10	010844	HERRICK (OLD)
000203	AIM 1 COLORECTAL STUDY	010846	HIGHLAND GENERAL (OLD)
000303	REGION 3 OVARIAN STUDY	010856	KAISER OAKLAND
000450	CMS	010858	KAISER HAYWARD
000451	DMV	010859	RAD ONC CTR HAYWARD (OLD)
000452	CMRI	010869	LAUREL GROVE (OLD)
000454	CALVOTER REG	010887	PHYSICIANS COMMUN (OLD)
000455	NATIONAL DEATH INDEX	010887	VESPER SL
000456	DEATH CERTIFICATE (STAT)	010887	MEMORIAL SAN LEANDRO
000457	MEDI-CAL ELIGIBILITY	010902	OAKLAND (OLD)
000458	SOCIAL SECURITY-DEATHS	010919	PERALTA (OLD)
000461	SOCIAL SECURITY-SSN	010937	SUMMIT MED CTR
000465	HOSP DISCHARGE DATA-OSHDP	010937	MERRITT
000466	NOCA	010937	MERRITT PERALTA MED CTR
000467	SSA-EVS	010967	ST ROSE
000468	PROPERTY TAX	010969	TRI-VALLEY CASTRO VALLEY
000469	DEATH CLEARANCE (INCR)	010970	TRI-VALLEY PLEASANTON
000801	DC ONLY	010983	VALLEY LIVERMORE
000802	CORONER	010987	WASHINGTON FREMONT
000803	PHYSICIAN	013619	SAN LEANDRO HOSPITAL
000804	CONVALESCENT HOSPITAL	013619	COLUMBIA SAN LEANDRO HOSP

013619	HUMANA SAN LEANDRO	100745	KINGSBURG GENERAL (OLD)
013626	PROVIDENCE (OLD)	100791	SANGER
013636	ALTA BATES ALBANY (OLD)	100793	SELMA COMMUNITY
013637	HAYWARD (OLD)	100793	SELMA DISTRICT
014132	KAISER FREMONT	100796	SIERRA COMM FRESNO
019989	LAWRENCE BERK LAB	100797	SIERRA KINGS
019990	NAVAL OAKLAND	100819	VALLEY CHILDRENS (OLD)
019990	OAK KNOLL NAVAL	100822	UNIVERSITY MED CTR
019995	VA LIVERMORE (OLD)	100822	VALLEY MED FRESNO
019996	DOCTORS OAKLAND (OLD)	100899	ST AGNES MED CTR
019996	DRS OAKLAND (OLD)	109998	UCSF FRESNO
019997	BROOKDALE (OLD)	109999	VA FRESNO
019998	MOORE J E LAB (OLD)	110889	GLENN MED CTR
019999	ST PAULS (OLD)	110889	GLENN GENERAL
030786	SUTTER AMADOR	120981	GENERAL EUREKA
030786	AMADOR	120982	KLAMATH TRINITY (OLD)
040802	BIGGS GRIDLEY MEM	121002	MAD RIVER COMMUN
040828	CHICO COMMUNITY (OLD)	121031	JEROLD R PHELPS COMMUNITY
040875	FEATHER RIVER	121031	SO HUMBOLDT COMMUN
040937	OROVILLE MED CTR	121031	HUMBOLDT COMMUNITY
040962	ENLOE MEDICAL CENTER	121051	REDWOOD MEMORIAL
040962	ENLOE MEMORIAL	121080	ST JOSEPH EUREKA
044153	CHICO SURGERY CENTER	130666	CALEXICO
050932	MARK TWAIN	130699	EL CENTRO COMMUN
060870	COLUSA COMMUNITY	130710	IMPERIAL VALLEY CANCER CT
070650	BAY AREA REG CANCER CTR	130760	PIONEERS MEMORIAL
070904	DOCTORS MEDICAL CENTER	139990	FORT YUMA IND HOSP
070904	DOCTORS SAN PABLO	139990	PHS WINTERHAVEN
070904	BROOKSIDE	141273	NORTHERN INYO
070924	CONTRA COSTA REG MED CTR	141338	SOUTHERN INYO
070924	CONTRA COSTA COUNTY	150050	BAKERSFIELD HEART HOSP
070924	MERRITHEW MEMORIAL	150706	DELANO REGIONAL MED
070934	DELTA MEMORIAL	150722	G BAKERSFIELD MEM
070950	SIERRA SURGICENTER	150722	BAKERSFIELD MEM
070988	JOHN MUIR MED CTR	150736	KERN MEDICAL CTR
070988	JOHN MUIR MEMORIAL	150737	KERN VALLEY
070990	KAISER WALNUT CRK	150740	KERN REGIONAL CANCER CTR
070991	KAISER RICHMOND	150761	MERCY BAKERSFIELD
071010	KAISER MARTINEZ	150769	NORTH KERN (OLD)
071018	MT DIABLO MED CTR	150770	KAISER BAKERSFIELD
071053	EAST BAY (OLD)	150775	GOOD SAM BAKERSFIELD
073449	DOCTORS PINOLE (OLD)	150775	BAKERSFIELD COMMUNITY
073449	DRS PINOLE (OLD)	150775	ALLIANCE COMMUNITY
073638	LOS MEDANOS COMMUN	150778	BAKERSFIELD COMM RAD (OLD)
075100	SAN RAMON REG MEDCTR	150782	RIDGECREST COMMUN
079996	WALNUT CRK RAD GRP	150788	SAN JOAQUIN COMMUN
079997	VA MARTINEZ	150808	TEHACHAPI
081066	SUTTER COAST	150830	WEST SIDE
081066	SEASIDE MED CLINIC	159990	EDWARDS AFB
081070	SUTTER COAST (OLD)	159991	CANCER/BLOOD KERN (OLD)
090793	BARTON MEMORIAL	160681	AVENAL DISTRICT (OLD)
090933	MARSHALL	160702	CORCORAN DISTRICT
090935	MARSHALL HOSP RAD ONC CTR	160725	HANFORD COMMUNITY
100005	COMMUNITY MED CTR CLOVIS	160787	CENTRAL VALLEY GENERAL
100005	CLOVIS COMMUNITY	160787	SACRED HEART
100500	KAISER FRESNO	169990	NAVAL LEMOORE
100697	COALINGA DISTRICT	169996	CORCORAN STATE PRISON
100714	FOWLER MUNICIPAL (OLD)	171049	REDBUD COMMUNITY
100717	COMMUNITY MED CTR FRESNO	171300	LAKESIDE CLINIC
100717	FRESNO COMMUNITY	171395	SUTTER LAKESIDE
100720	FRESNO SURGERY CENTER	171395	LAKESIDE COMMUNITY

180919	LASSEN COMMUNITY	190323	GLENDALE ADVENTIST
190017	ALHAMBRA COMMUNITY	190326	GLENDALE ADV CC (OLD)
190034	ANTELOPE VALLEY	190328	HUNTINGTON E VALLEY MED
190044	AVALON MEMORIAL (OLD)	190328	GLENDORA COMMUNITY
190045	AVALON MUNICIPAL	190348	GRANADA HILLS COMM
190049	TERRACE PLAZA MED	190352	GREATER EL MONTE COMMUN
190052	BARLOW	190352	EL MONTE COMMUNITY
190053	ST MARY LONG BEACH	190366	ROBERT F. KENNEDY
190057	BAY HARBOR	190379	SANDLEWOOD (OLD)
190065	DEL PUEBLO (OLD)	190380	HOLLYWOOD COMMUN
190066	BELLFLOWER DOCTORS	190382	HOLLYWOOD PRESBY (OLD)
190066	DOCTORS BELLFLOWER	190384	WEST HOLLYWOOD
190069	BELLWOOD GENERAL	190385	HOLY CROSS
190078	BEVERLY GLEN (OLD)	190392	GOOD SAMARITAN LA
190080	BEVERLY HILLS (OLD)	190400	HUNTINGTON MEM
190081	BEVERLY HOSPITAL	190406	DOCTORS HAWTHORNE (OLD)
190108	CENTURY COMMUNITY (OLD)	190406	DRS HAWTHORNE (OLD)
190110	BROTMAN MED CTR	190412	INGLEWOOD WOMENS (OLD)
190114	THOMPSON MEMORIAL MED CTR	190413	CITRUS VALLEY MED CTR
190114	BURBANK COMMUNITY	190413	INTERCOMM COVINA
190125	CALIF MED CTR LA	190420	DEL AMO DX CTR
190130	CANOGA PARK	190422	TORRANCE MEMORIAL
190135	KAISER CARSON	190425	KAISER BALDWIN PARK
190137	CASA COLINA REHAB	190428	KAISER NORWALK
190148	CENTINELA MED CTR	190429	KAISER SUNSET
190155	CENTURY CITY	190429	KAISER LA
190159	CHARTER COMMUNITY	190430	KAISER BELLFLOWER
190161	TALBERT LA CO MED CTRS	190431	KAISER HARBOR CITY
190161	FHP LA COUNTY MED CTRS	190432	KAISER PANORAMA
190170	CHILDRENS LA	190433	KAISER INGLEWOOD
190175	CITY OF ANGELS MED CTR	190434	KAISER WEST LA
190176	CITY OF HOPE	190435	KAISER WOODLAND HILLS
190178	CITY VIEW (OLD)	190449	LA MIRADA MED CTR
190180	COMMUNITY HOSP LONG BEACH	190451	LA VINA FOR RESP
190196	GARDENA COMMUNITY	190453	DOCTORS LAKEWOOD C (OLD)
190197	HUNTINGTON PARK	190453	DRS LAKEWOOD CLARK (OLD)
190198	LOS ANGELES COMMUN	190455	LANCASTER COMMUN
190198	LA COMMUNITY	190458	COVINA VALLEY COMM
190199	COLDWATER CANYON	190462	LAS ENCINAS
190200	SAN GABRIEL VALLEY MEDCTR	190468	LINCOLN MED CTR
190200	SAN GABRIEL COMMUN	190470	LITTLE CO MARY
190216	CRENSHAW CENTER	190475	LONG BEACH COMMUN (OLD)
190230	DANIEL FREEMAN MEM	190477	LONG BEACH DOCTORS
190240	DOCTORS LAKEWOOD	190477	LONG BEACH
190240	LAKEWOOD REGIONAL MED CTR	190477	DOCTORS LONG BEACH
190240	DRS LAKEWOOD	190477	DRS LONG BEACH
190242	DOMINGUEZ VALLEY	190478	DRS LONG BEACH (OLD)
190243	DOWNEY COMMUNITY	190478	DOCTORS LONG BEACH (OLD)
190256	DOCTORS EAST LA	190482	LOS ALTOS (OLD)
190256	DRS EAST LA	190488	BEVERLY HILLS MED (OLD)
190280	ENCINO (OLD)	190490	QUEEN ANGELS/HOLLYWD PRES
190285	EAST VALLEY MED GRP	190490	HOLLYWD PRES/QUEEN ANGELS
190298	FOOTHILL PRESBYTERIAN	190500	DANIEL FREEMAN MAR
190298	MORRIS JOHNSTON MEM	190517	ENCINO-TARZANA REG MED CT
190305	VENCOR	190517	TARZANA MED CTR
190305	MAXICARE MED CTRS	190521	GARDENA MEMORIAL
190307	PACIFIC ALLIANCE MED CTR	190522	GLENDALE MEMORIAL
190307	FRENCH LA	190523	HAWTHORNE MEMORIAL
190312	CA GARDENA (OLD)	190524	MISSION COMMUNITY HOSP
190314	VALLEY POMONA (OLD)	190524	PANORAMA COMMUNITY
190315	GARFIELD MED CTR	190525	LONG BEACH MEM MED

190529	METHODIST SO CALIF	190810	NORTHRIDGE SHERMAN WAY
190529	ARCADIA METHODIST	190810	VALLEY VAN NUYS
190530	METROPOLITAN	190812	VALLEY PRESB MEM
190534	MIDWAY MED CTR	190814	VAN NUYS COMMUNITY (OLD)
190538	MISSION	190818	VERDUGO HILLS
190541	MONROVIA COMMUNITY	190827	CAREUNIT LA (OLD)
190547	MONTEREY PARK	190847	WASHINGTON CULVER
190552	MOTION PICTURE TV	190854	DOCTORS LA
190553	CEDARS COMP CA CTR	190854	DRS LA
190555	CEDARS-SINAI MED	190857	WEST COVINA
190559	NEWHALL COMMUNITY	190859	COLUMBIA WEST HILLS
190568	NORTHRIDGE MED CTR	190859	WEST HILLS REG MED CTR
190570	NORWALK COMMUNITY	190859	HUMANA WEST HILLS
190581	ORTHOPEDIC	190860	NU-MED REGIONAL MED CTR
190587	PACIFIC LONG BEACH	190860	WEST VALLEY HOSP & HEALTH
190588	LANTERMAN STATE	190860	WEST PARK
190592	LAKE VIEW MED CTR (OLD)	190862	RANCHO ENCINO
190595	PALMDALE MED CTR	190867	WESTLAKE COMMUN
190599	CHARTER SUBURBAN	190873	WESTSIDE LA
190600	ORANGE GROVE HOSP (OLD)	190878	WHITE MEMORIAL
190603	PARK VIEW (OLD)	190883	WHITTIER MED CTR
190605	VALLEY CANOG PK (OLD)	190891	WOODRUFF COMMUNITY
190608	PASADENA MED CTR (OLD)	190893	WOODRUFF GABLES (OLD)
190616	PICO RIVERA COMMUN	190949	HENRY MAYO NEWHALL
190619	PIONEER	191002	HERMOSA BEACH (OLD)
190630	POMONA VALLEY	191210	USC UNIVERSITY HOSPITAL
190631	PRESB INTERCOMMUN	191216	KENNETH NORRIS USC
190635	QUEEN OF ANGELS LA (OLD)	191227	UCLA HARBOR
190636	QUEEN VALLEY W COV	191227	HARBOR GENERAL
190651	RIO HONDO MEMORIAL	191228	LA CO USC MED
190654	NO HOLLYWOOD MED	191228	USC MEDICAL CENTER
190655	CHARTER PACIFIC	191230	KING-DREW
190661	ROSS LOOS MEDICAL (OLD)	191230	MARTIN LUTHER KING
190661	CIGNA HOSP LA (OLD)	191230	LA CO KING-DREW MED
190665	CIGNA CLINICS LA	191231	LA CO OLIVE VIEW
190673	SAN DIMAS COMMUN	191231	MIDVALLEY
190676	SAN FERNANDO COMM	191261	LA CO HIGH DESERT
190678	VALLEY VISTA (OLD)	191306	LA CO RANCHO AMIGOS
190680	SAN PEDRO PENINSULA	191306	RANCHO LOS AMIGOS
190681	SAN VICENTE (OLD)	191306	LOS AMIGOS
190684	LINDA VISTA COMMUNITY	191320	MULLIKIN MED CTR
190684	SANTA FE COMMUNITY	192070	SURGERY CENTER
190685	SANTA MARTA CLINIC	193005	ANTELOPE VALLEY RAD ONC
190687	SANTA MONICA MED	193010	BEVERLY ONC & IMAGING CTR
190691	SANTA TERESITA	193020	DOWNEY RAD ONC MED CLINIC
190696	PACIFICA OF THE VALLEY	193055	KRANS MEDICAL PARTNERS
190696	SERRA MEMORIAL	193080	PALM TUMOR CLINIC
190708	SHERMAN OAKS COMM	193085	RADIATION ONC ASSOCIATES
190712	SHRINERS LA	193086	RAD ONC CONSULT MED GRP
190714	SIERRA MADRE COMM (OLD)	193090	SANTA MONICA CANCER RX
190734	SOUTH BAY	193100	VALLEY CANCER INSTITUTE
190754	ST FRANCIS LYNWOOD	193104	VALLEY TUMOR MED GRP
190756	ST JOHNS SN MONICA	193110	WESTERN TUMOR MED GRP
190758	ST JOSEPH BURBANK	193113	WHITTIER ONCOLOGY CLINIC
190759	ST LUKE PASADENA	193117	WHILSHIRE ONC MED GRP
190762	ST VINCENT MED	199990	NAVAL LONG BEACH
190766	STUDEBAKER COMMUN	199991	VA LONG BEACH
190766	COAST PLAZA MED CTR	199992	VA W LOS ANGELES
190784	TEMPLE COMMUNITY	199992	VA WADSWORTH
190790	TRI-CITY REGIONAL MED CTR	199992	VA BRENTWOOD
190796	UCLA	199993	FED CORRECT SN PDRO

199993	TERMINAL ISLAND	300125	IRVINE MED CTR
199994	VA SEPULVEDA	300225	ORANGE COAST MEM MED CTR
199995	E DOHENEY EYE FND	300225	FHP FOUNTAIN VLY
199996	LA CO JAIL HOSP	300227	TALBERT ORANGE CO MEDCTRS
199997	BREAST CENTER, THE	300227	FHP ORANGE COUNTY MEDCTRS
200692	CHOWCHILLA DIST	301097	ANAHEIM GENERAL
201281	MADERA COMMUNITY	301098	ANAHEIM MEMORIAL
201819	CHILDRENS HOSP CENTRAL CA	301098	ANAHEIM MEMORIAL EAST
201819	VALLEY CHILDRENS	301109	BUENA PARK DOCTORS OLD
210992	KAISER SAN RAFAEL	301109	BEACH COMMUNITY OLD
210993	KENTFIELD MED	301126	BREA COMMUNITY
211006	MARIN GENERAL	301132	KAISER ANAHEIM
211056	ROSS GENERAL (OLD)	301140	CHAPMAN MED CTR
211167	SAN QUENTIN PR	301140	CHAPMAN GENERAL
212637	NOVATO COMMUNITY	301150	CHILDRENS HOSP AT MISSION
219998	HAMILTON AFB (OLD)	301155	COLLEGE COSTA MESA
220733	JOHN C FREMONT	301155	COSTA MESA MED CTR
230949	FRANK HOWARD MEM	301167	DOCTORS SANTA ANA
230949	HOWARD MEMORIAL	301167	DRS SANTA ANA OLD
231013	MENDOCINO COAST	301169	ST JUDE YORBA LINDA OLD
231014	MENDOCINO COMMUN	301170	FOUNTAIN VALLEY OP SURG
231339	UKIAH GENERAL (OLD)	301175	FOUNTAIN VALLEY REG HOSP
231350	UKIAH SURGERY CENTER	301175	FOUNTAIN VALLEY COMM
231396	UKIAH VALLEY MED	301180	FULLERTON COMMUN (OLD)
231396	UKIAH ADVENTIST	301188	WESTERN ANAHEIM
240803	BLOSS MEM DISTRICT (OLD)	301205	HOAG MEM PRESBYTER
240853	DOS PALOS MEMORIAL (OLD)	301209	HUNTINGTON BEACH MED CTR
240924	MEMORIAL LOS BANOS	301209	COLUMBIA HUNTINGTON BEACH
240924	LOS BANOS COMMUN	301209	HUMANA HUNTINGTON
240942	MERCY MERCED COMMUNITY	301232	FRIENDLY HILLS REG OLD
240942	SUTTER MERCED	301232	LA HABRA COMMUNITY OLD
240942	MERCED COMMUNITY	301234	LA PALMA INTERCOMM
024948	MERCY MERCED DOMINICAN	301242	BUENA PARK COMMUN (OLD)
240948	MERCY MERCED	301248	LOS ALAMITOS MED
241082	WEST SIDE COMMUN (OLD)	301258	COASTAL COMMUNITIES
249990	CASTLE AFB (OLD)	301258	MERCY GEN SANTA ANA
250955	SURPRISE VALLEY	301262	MISSION HOSP REG MED CTR
250956	MODOC MED ALTURAS	301262	MISSION COMMUNITY
260011	MAMMOTH	301279	UC IRVINE
260011	CENTINELA MAMMOTH	301279	UCI
261263	MONO GENERAL	301282	PACIFICA COMMUNITY OLD
270706	ALISAL COMMUNITY (OLD)	301283	GARDEN GROVE MED
270706	COMMUNITY SALINAS (OLD)	301297	PLACENTIA-LINDA
270740	MONTEREY PENINSULA SURG	301314	SANTA ANA MED
270744	MONTEREY PEN COMM	301317	SADDLEBACK MEM MED CTR
270777	GEORGE L MEE MEM	301317	SADDLEBACK COMMUNITY
270777	MEE MEMORIAL	301325	SAN CLEMENTE GEN
270831	NATIVIDAD MEM CTR	301325	COLUMBIA SAN CLEMENTE MED
270875	SALINAS VALLEY MEM	301325	SAMARITAN MED CTR
271118	MONTEREY PENINSULA (OLD)	301337	SOUTH COAST MED
279990	SILAS B HAYS ARMY	301340	ST JOSEPH ORANGE
279990	FORT ORD	301342	ST JUDE FULLERTON
281047	QUEEN VALLEY NAPA	301345	MIDWOOD COMMUNITY (OLD)
281078	ST HELENA HEALTH	301357	TUSTIN HOSPITAL MED CTR
281266	NAPA STATE	301357	HEALTHCARE TUSTIN
281297	HOLDERMAN MEMORIAL	301379	WEST ANAHEIM MED CTR
290952	MINERS (OLD)	301379	COLUMBIA WEST ANAHEIM MED
291023	SIERRA NEVADA MEM	301379	HUMANA W ANAHEIM
291053	TAHOE FOREST	301380	HUMANA WESTMINSTER (OLD)
300032	CHILDRENS ORANGE	301566	WESTERN MED SN ANA
300125	IRVINE REGIONAL HOSPITAL	301570	WOMENS BREAST CTR

301761	ANAHEIM MEM OUTPT (OLD)	340951	METHODIST SACTO
301761	ANAHEIM MEM WEST (OLD)	340955	MERCY SAN JUAN ROC
301761	MARTIN LUTHER MED (OLD)	341006	UC DAVIS
301781	FAIRVIEW STATE	341006	UCD
301782	RAD ONC MED GRP SO CALIF	341040	VENCOR SACRAMENTO
301785	MISSION VIEJO RAD ONC GRP	341051	SUTTER GEN SACTO (OLD)
302000	DIGESTIVE DISEASE CENTER	341052	SUTTER MED CTR SACRAMENTO
302005	ORANGE CO INST GE & ENDO	341052	SUTTER COMMUN HOSPITALS
309990	PACIFIC RAD ONCOL	341052	SUTTER MEM SACTO
310791	SUTTER AUBURN FAITH	341055	SUTTER RAD ONCOLOGY CTR
310791	AUBURN FAITH COMM	341065	MERCY FOLSOM
311000	SUTTER ROSEVILLE COMM	341085	VA SACRAMENTO
311000	ROSEVILLE COMM	341088	GREATER SACRAMENTO SURG
311005	ROSEVILLE RAD ONC CTR	341608	SUTTER SURGERY CENTER
311010	AUBURN RAD ONC CTR	342097	SACRAMENTO COMMUN (OLD)
311015	KAISER ROSEVILLE	342259	PLASTIC SURG CTR MED GRP
314010	AUBURN SURGERY CENTER	344005	SACRAMENTO MIDTOWN ENDOSC
320859	EASTERN PLUMAS	344015	HEALTHSOUTH SURG FORT SUT
320874	INDIAN VALLEY DIST	344062	SUTTER SURGICAL CTR J STREET
320986	PLUMAS DISTRICT	344066	HEALTHSOUTH SURG ALHAMBRA
321016	SENECA DISTRICT	344118	MICHAEL J FAZIO MD SURG
331145	CORONA REGIONAL MED CTR	349990	MATHER AFB
331145	CIRCLE CITY	350784	HAZEL HAWKINS MEM
331152	CORONA COMMUNITY (OLD)	350784	HAWKINS MEMORIAL
331155	RADIATION THERAPY MED GROUP	350784	SAN BENITO DIST
331155	RAD THERAPY MED GROUP	361105	BARSTOW COMMUNITY
331158	CORONA RAD ONC MED CLINIC	361110	BEAR VALLEY COMMUN
331164	DESERT	361144	COLUMBIA VALLEY HOSP
331168	EISENHOWER MED CTR	361144	CHINO COMMUNITY
331194	HEMET VALLEY MED CTR	361150	DESERT RADIATION ONCOLOGY
331216	JOHN F KENNEDY MEM	361150	DESERT RAD ONCOLOGY
331226	RIVERSIDE KNOLLWD (OLD)	361155	DESERT VALLEY
331230	KAISER RIVERSIDE	361166	KPC GLOBAL MED CTR
331233	VALLEY PLAZA DOCTORS HOSP	361166	US FAMILY CARE MED CTR
331233	LAKESIDE HOSPITAL	361166	DOCTORS MONTCLAIR
331235	MENIFEE VALLEY	361166	DRS MONTCLAIR
331239	INLAND VALLEY REG MED CTR	361168	ANGELS
331239	MISSION VALLEY MED CTR	361168	HERITAGE
331245	MORENO VALLEY MED CTR	361170	INLAND RADIATION THERAPY
331288	PALO VERDE	361170	INLAND RAD THERAPY
331293	PARKVIEW COMMUN	361223	KAISER FONTANA
331312	RIVERSIDE COMMUN	361245	LOMA LINDA COMMUN (OLD)
331313	RIVERSIDE COUNTY REG MED	361246	LOMA LINDA UNIV
331313	RIVERSIDE GEN UNIV	361246	LOMA LINDA COMMUN
331326	SAN GORGONIO MEM HOSP	361250	MOJAVE RADIATION ONC CTR
331326	SAN GORGONIO PASS	361266	MOUNTAINS COMM
311350	RANCHO SPRINGS MED CTR	361266	SAN BERNARDINO MT
331350	SHARP HEALTHCARE MURRIETA	361274	VENCOR ONTARIO
331355	TEMECULA CANCER CTR	361274	ONTARIO COMMUNITY
332172	CHRISTIAN MED CTR (OLD)	361308	REDLANDS COMMUNITY
332173	VALLEY REG ONC CTR	361315	PATTON STATE
339990	MARCH AFB	361318	SAN ANTONIO COMMUN
339991	SUN CITY CA CLIN	361320	ARROWHEAD REG MED CTR
340869	MERCY AMERICAN RIVER	361320	SAN BERNARDINO CO
340869	ESKATON AMER RIV	361323	SAN BERNARDINO CM
340913	KAISER SACRAMENTO	361330	APPLE VALLEY RAD ONC
340920	KAISER SO SACTO	361339	ST BERNARDINE
340947	MERCY GEN SACTO	361343	ST MARY REG MED CTR
340947	MERCY SACRAMENTO	361343	ST MARY DESERT VLY
340948	MERCY SACRAMENTO ROC	361370	VICTOR VALLEY
340950	MERCY SAN JUAN	361458	NEEDLES DESERT COMM

362041	HI DESERT MED CTR	370875	COMMUN CHULA VISTA
362045	SAN BERNARDINO CANCER CTR	370977	POMERADO
362045	COMMUNITY RAD ONC CTR	371256	SCRIPPS GREEN
362046	PALM IMAGING	371394	SCRIPPS ENCINITAS
369990	WEED ARMY	372000	X-RAY MED GROUP LA MESA OLD
369990	FORT IRWIN	379990	NAVAL PENDLETON
369991	GEORGE AFB	379991	NAVAL SAN DIEGO
369992	VA LOMA LINDA	379992	VA SAN DIEGO
369992	JERRY PETTIS MEM	380769	CA PODIATRY (OLD)
369993	CAL INST FOR MEN	380777	CHILDRENS SF (OLD)
370000	BOYD, DAVID, MD	380816	FRENCH SF (OLD)
370652	ALVARADO MED CTR	380826	MARSHAL HALE (OLD)
370652	ALVARADO COMMUNITY	380826	HAHNEMANN (OLD)
370658	SCRIPPS CHULA VISTA	380857	KAISER SF
370658	BAY MEDICAL CENTER	380865	LAGUNA HONDA REHAB
370660	BAY RADIOLOGY MED GRP OLD	380895	MT ZION
370672	HARBOR VIEW MED OLD	380920	CALIFORNIA PACIFIC MEDCTR
370673	CHILDRENS SAN DIEGO	380929	PACIFIC MED CTR (OLD)
370674	CLAIREMONT COMMUN (OLD)	380929	PRESBYTERIAN MED (OLD)
370683	COLLEGE PARK (OLD)	380929	PACIFIC PRESBYTER (OLD)
370686	SAN DIEGO GENERAL (OLD)	380933	DAVIES MED CTR
370686	SAN DIEGO PHYSICNS (OLD)	380933	RK DAVIES
370688	ESCONDIDO SURGICAL CTR	380933	FRANKLIN
370689	CORONADO	380933	RALPH K DAVIES
370690	SHARP MARY BIRCH	380939	SAN FRANCISCO GEN
370693	SHARP CABRILLO	380939	SF GENERAL
370694	SHARP MEMORIAL	380954	SHRINERS SF
370695	SHARP REES STEALY	380960	ST FRANCIS SF
370697	SCRIPPS EAST COUNTY OLD	380964	ST LUKES SF
370697	VALLEY MED EL CAJON OLD	380965	ST MARYS SF
370697	AMI VALLEY MED CTR OLD	381154	UC SF MED CENTER
370697	EL CAJON VALLEY OLD	381154	UCSF MED CENTER
370705	FALLBROOK DISTRICT	381154	UCMC SAN FRANCISCO
370710	FROST ST SURG CTR	381160	UCSF STANFORD HEALTH CARE
370714	GROSSMONT DIST	382684	GARDEN SULLIVAN (OLD)
370716	KAISER EL CAJON OLD	382715	CHINESE
370721	HILLSIDE (OLD)	389990	U PACIFIC DENTAL
370730	KAISER SAN DIEGO	389992	VA SAN FRANCISCO
370735	LIVINGSTON MED CTR	389994	ST JOSEPH'S SF (OLD)
370735	LIVINGSTON WHEELER	389995	LETTERMAN ARMY (OLD)
370744	MERCY SAN DIEGO	389995	PRESIDIO SAN FRAN (OLD)
370746	MISSION BAY MEM (OLD)	390820	BEN SCHAFFER CA INST
370749	ALVARADO EAST (OLD)	390846	DAMERON
370753	TRI-CITY WEST (OLD)	390850	ST DOMINICS
370755	PALOMAR MEMORIAL	390922	DRS LODI
370759	PARADISE VALLEY	390922	LODI COMMUNITY
370760	RAD ONC MED SPECIALISTS	390922	DOCTORS LODI
370760	RADIATION MED GRP	390923	LODI MEMORIAL
370760	RADIOLOGY MED GRP	391010	SAN JOAQUIN GEN
370765	SAN DIEGO AMB SURG CTR	391020	KAISER STOCKTON CLINIC
370771	SCRIPPS LA JOLLA	391042	ST JOSEPHS STOCKTN
370775	SMITH HANNA OLD	391050	ST TERESA RADIATION
370776	SOUTHCOAST TUMOR INS (OLD)	391056	SUTTER TRACY COMMUNITY
370777	SOUTHWEST CANCER CARE	391056	TRACY COMMUNITY
370780	TRI-CITY	392232	ST JOSEPH OAK PARK (OLD)
370782	UC SAN DIEGO	392287	MANTECA
370782	UCSD	392287	DOCTORS MANTECA
370787	VILLA VIEW COMMUN	392287	DRS MANTECA
370790	ONCOLOGY THERAPIES INC	394004	LODI OUTPATIENT SURG CTR
370790	VISTA RADIATION	394023	SAN JOAQUIN LASER & SURG
370875	SHARP CHULA VISTA MED CTR	400466	ARROYO GRANDE COMM

400480	FRENCH SN LUIS OBS	430884	CHABOYA CLINIC
400500	MISSION MED ASSOCIATES	430885	EAST VALLEY CLINIC
400500	SAN LUIS MED CLINIC	430886	EAST VALLEY PAVILLION
400511	SAN LUIS OBISPO GEN	430887	SOUTH VALLEY CLINIC
400524	SIERRA VISTA	430888	VALLEY HEALTH CTR
400548	TWIN CITIES COMMUN	430905	STANFORD UNIV
400683	ATASCADERO STATE	430915	VALLEY WEST GEN (OLD)
409990	CAL MENS COLONY	430915	MISSION OAKS (OLD)
410742	MILLS MEMORIAL	430924	ST LOUISE REG HOSP (OLD)
410752	CRYSTAL SPRINGS	430924	COLUMBIA SOUTH VALLEY
410772	MILLS-PENNINSULA	430924	SOUTH VALLEY HOSP
410782	SAN MATEO COUNTY GENERAL	430924	WHEELER
410782	HAROLD D CHOPE	431500	ST LOUISE CANCER CARE CTR
410782	CHOPE	431506	KAISER SANTA TERESA
410804	KAISER REDWOOD CITY	431506	SANTA TERESA COMM
410804	KAISER RWC	431722	OCONNOR CAMPBELL (OLD)
410806	KAISER SO SF	432001	ST LOUISE REG MED CTR
410806	KAISER SSF	432002	REG MED CTR OF SAN JOSE
410817	SETON MEDICAL CTR	438800	CAMINO MED GRP
410817	MARYS HELP	439995	VA PALO ALTO (VAPAHCS)
410820	RECOVERY INN MENLO PARK	439995	VAPA HEALTH CARE SYSTEM
410828	SETON MED CTR COASTSIDE	439998	PALO ALTO MED FND
410828	ST CATHERINE	439998	PAMC
410852	PENINSULA MED CTR	439999	VA PALO ALTO (OLD)
410891	SEQUOIA	440755	DOMINICAN ST CRUZ
420483	GOLETA VALLEY	440886	SANTA CRUZ GENERAL
420491	LOMPOC DISTRICT	440890	SANTA CRUZ MED CLINIC
420493	MARIAN MEDICAL CTR	440894	SANTA CRUZ RAD ONC MED GR
420506	PINECREST (OLD)	440905	SUTTER MATERN & SURG CTR
420514	SN BARBARA COTTAGE	440920	WATSONVILLE COMMUN
420514	COTTAGE HOSPITAL	441807	SANTA CRUZ COMMUN (OLD)
420522	SANTA YNEZ VALLEY	450900	DOCTORS' SURGERY CENTER
420528	ST FRANCIS SN BARB	450936	MAYERS MEMORIAL
420530	CA FOUNDATION SN BARBARA	450938	REDDING CANCER RX CTR
420530	CA FDN SN BARBARA RAD CTR	450940	REDDING MED CTR
420535	VALLEY COMMUNITY	452005	REDDING ENDOSCOPY CENTER
420540	SANSUM MED CLINIC (OLD)	450949	MERCY REDDING
420544	SANSUM SANTA BARBARA MED	450950	PATIENTS HOSP OF REDDING
420545	SANTA BARBARA BREAST (OLD)	451018	SHASTA GENERAL (OLD)
420545	SN BARBARA BREAST CA (OLD)	452000	REDDING SURGERY CENTER
420550	SANTA BARBARA MED FDN (OLD)	461024	SIERRA VALLEY DIST
421167	REHAB INST SANTA BARBARA	470871	MERCY MT SHASTA
421167	SANTA BARBARA MEM	470871	MT SHASTA COMMUNITY
429990	VANDENBERG AFB	471031	FAIRCHILD MED CTR
429991	LOMPOC PENITENTARY	471031	SISKIYOU GENERAL
430700	AGNEWS DEVEL CTR	480989	KAISER VALLEJO
430705	ALEXIAN BROTHERS (OLD)	481015	BROADWAY VALLEJO (OLD)
430741	CHILDRENS STANFORD	481070	VACA VALLEY HOSP
430743	LOS GATOS COMMUN	481094	SUTTER SOLANO MED CTR
430750	RECOVERY INN LOS GATOS	481094	VALLEJO GENERAL
430763	EL CAMINO	481357	NORTHBAY MED CTR
430779	COLUMBIA GOOD SAM SN JOSE	484003	SOLANO SURGERY CENTER
430779	GOOD SAM SN CLARA VLY	484021	SPECIALISTS SURGERY CTR
430779	GOOD SAM SAN JOSE	485000	CALIF MEDICAL FACILITY
430805	KAISER SN CLARA	485000	CALIF MED FAC VACAVILLE
430837	OCONNOR SAN JOSE	489990	TRAVIS AFB
430850	ST LOUISE (OLD)	489990	DAVID GRANT USAF
430879	COLUMBIA SAN JOSE MED CTR	490001	PETALUMA VALLEY
430879	SAN JOSE MED CTR	490907	NORTH COAST HEALTHCARE
430879	SAN JOSE HEALTH	490907	NORTH COAST REHAB
430883	SANTA CLARA VALLEY	490907	BROOKWOOD

490919	SUTTER MED CTR	560508	PLEASANT VALLEY
490919	SANTA ROSA COMMUN	560521	SANTA PAULA MEM
490964	HEALDSBURG GENERAL	560525	SIMI VALLEY ADVENT
491012	SANTA ROSA GENERAL (OLD)	560526	SIMI VALLEY COMMUN (OLD)
491064	SANTA ROSA MEM	560529	ST JOHNS OXNARD
491070	SONOMA COUNTY REDWOOD REG	560681	CAMARILLO STATE
491076	SONOMA VALLEY	571086	WOODLAND MEMORIAL
491103	WARRACK MED CTR	571093	YOLO GENERAL
491267	SONOMA STATE	571139	COWELL DAVIS (OLD)
491338	PALM DRIVE	571215	SUTTER DAVIS
491400	KAISER SANTA ROSA	580996	RIDEOUT MEMORIAL
500850	DEL PUERTO (OLD)	584003	TWIN CITIES SURGICENTER
500852	DOCTORS MODESTO	589990	BEALE AFB
500852	DRS MODESTO	710585	TALBERT DESERT SIERRA
500867	EMANUEL MED CTR	800007	CONNECTICUT SEER
500938	MEMORIAL CERES	800033	ATLANTA SEER
500939	MEMORIAL MODESTO	800041	DETROIT SEER
500954	MODESTO CITY (OLD)	800053	IOWA SEER
500967	OAK VALLEY DIST	800084	UTAH SEER
501015	STANISLAUS MED CTR	800086	NEW MEXICO SEER
501015	SCENIC GENERAL (OLD)	800093	SEATTLE SEER
510882	FREMONT	800099	HAWAII SEER
511049	SUTTER COM YUBA CY (OLD)	970000	TREATMENT FOLLOW BACK
511060	YUBA SUTTER RAD ONC CTR	989002	MAINE STATE REG
514009	ENDOSCOPY CENTER	989003	NEW HAMPSHIRE STATE REG
514010	FEATHER RIVER SURG CTR	989004	VERMONT STATE REG
514021	SUTTER NORTH PROCEDURE	989005	MASSACHUSETTS STATE REG
520837	CORNING MEMORIAL (OLD)	989006	RHODE ISLAND STATE REG
521041	ST ELIZABETH COMM	989007	CONNECTICUT STATE REG
522052	RED BLUFF TUMOR INSTITUTE	989008	NEW JERSEY STATE REG
531059	TRINITY GENERAL	989011	NEW YORK STATE REG
540680	ALTA HOSPITAL DIST	989014	PENNSYLVANIA STATE REG
540734	KAWEAH DELTA DIST	989017	DELAWARE STATE REG
540740	SEQUOIA REG CANCER CTR	989021	MARYLAND STATE REG
540746	LINDSAY MED CTR	989022	DISTRICT OF COLUMBIA REG
540755	EXETER MEMORIAL	989022	WASHINGTON D.C. REG
540798	SIERRA VIEW DIST	989023	VIRGINIA STATE REG
540816	TULARE DISTRICT	989024	WEST VIRGINIA STATE REG
540827	VISALIA COMMUNITY	989025	NORTH CAROLINA STATE REG
541123	PORTERVILLE DEVELOP CTR	989026	SOUTH CAROLINA STATE REG
541123	PORTERVILLE STATE	989031	TENNESSEE STATE REG
551034	SONORA COMMUNITY	989033	GEORGIA STATE REG
551061	TUOLUMNE GENERAL	989035	FLORIDA STATE REG
552209	SIERRA SONORA	989037	ALABAMA STATE REG
560468	ANACAPA ADVENTIST (OLD)	989039	MISSISSIPPI STATE REG
560468	PORT HUENEME ADVENT (OLD)	989041	MICHIGAN CANCER REG
560470	ONCOLOGY INSTITUTES	989043	OHIO STATE REG
560473	COMMUNITY MEMORIAL	989045	INDIANA STATE REG
560473	SAN BUENAVENTURA	989047	KENTUCKY STATE REG
560475	CHANNEL ISLANDS SURGI CTR	989051	WISCONSIN CA REPORTING
560476	BUENAVENTURA MED CTR	989052	MINNESOTA STATE REG
560480	COASTAL CITIES MRI & ROC	989053	IOWA STATE REG
560481	VENTURA CO MED CTR	989054	NORTH DAKOTA STATE REG
560482	VENTURA CO RAD ONC CTR	989056	MONTANA STATE REG
560485	COASTAL RAD ONC MED GROUP	989061	ILLINOIS STATE CA REG
560492	LOS ROBLES REGIONAL	989063	MISSOURI STATE REG
560495	LOS ROBLES SURGICENTER	989065	KANSAS STATE REG
560501	OJAI VALLEY COMMUN	989067	NEBRASKA STATE REG
560502	CHANNEL ISLANDS (OLD)	989071	ARKANSAS STATE REG
560502	OXNARD COMMUNITY (OLD)	989073	LOUISIANA STATE REG
560505	PETERSON MED CLINIC (OLD)	989075	OKLAHOMA STATE REG

989077	TEXAS STATE REG
989081	IDAHO STATE REG
989082	WYOMING STATE REG
989083	COLORADO CENTRAL CA REG
989084	UTAH STATE REG
989085	NEVADA, STATE REGISTRY OF
989085	NEVADA STATEWIDE CA REG
989086	NEW MEXICO STATE REG
989087	ARIZONA CANCER REGISTRY
989091	ALASKA STATE REG
989093	WASHINGTON STATE REG
989095	OREGON STATE REG
989099	HAWAII STATE REG
989195	ROGUE VALLEY MED CTR
989990	MAYO CLINIC
989991	MD ANDERSON
989992	FRED HUTCHINSON
989993	MEM SLOAN KETTERNG
989999	VA RENO (OLD)
999980	TALBERT MED GRP NOS
999980	FHP NOS
999981	HUMANA NOS
999982	KAISER NOS
999985	TALBERT PHYSICIANS ONLY
999985	FHP PHYSICIANS ONLY
999987	UNSPEC CENTRAL CA HOSP
999988	UNSPEC NORTHERN CA HOSP
999989	UNSPEC SOUTHERN CA HOSP
999990	HOSPICE
999991	HOME HEALTH
999992	SKILLED NURSING FACILITY
999993	STAFF PHYSICIAN
999994	UNSPEC NONCAL HOSP
999995	NON-HOSPITAL NOS
999996	PHYSICIAN ONLY
999996	MD ONLY
999997	UNSPEC BAY AREA H
999998	UNSPEC CALIF HOSP
999999	UNKNOWN HOSP

APPENDIX G.1

CODES FOR RELIGIONS

(in numerical order)

01	NONE		
02	AGNOSTIC	35	CHRISTIAN SECTS:
03	ATHEIST	36	JEHOVAH'S WITNESSES
04	*NONE, AGNOSTIC, ATHEIST (OLD)	37	CHRISTIAN SCIENCE
		37	MORMON
05	CATHOLIC	37	LATTER DAY SAINTS
05	*ROMAN CATHOLIC	38	SEVENTH-DAY ADVENTIST
		39	FRIENDS
06	CHRISTIAN, NOS	39	QUAKER
06	PROTESTANT, NOS		
	PROTESTANT DENOMINATIONS:		CHRISTIAN SECTS-OTHER:
07	*AFRICAN METHODIST EPISCOPAL (AME)	40	AMISH
08	ANGLICAN	41	MENNONITES
09	BAPTIST	42	APOSTOLIC
08	CHURCH OF ENGLAND	43	ARMENIAN APOSTOLIC
10	COMMUNITY	44	ASSEMBLIES OF GOD
11	CONGREGATIONAL	45	BRETHREN
12	EPISCOPALIAN	45	BROTHERS
13	LUTHERAN	46	CHRISTIAN APOSTOLIC
14	METHODIST	47	CHURCH OF ARMEDIAN
15	PRESBYTERIAN	48	CHURCH OF CHRIST
16	UNITARIAN	49	CHURCH OF GOD
17	*PROTESTANT DENOMINATION, OTHER	50	CHURCH OF MESSIANITY
18	CHRISTIAN REFORMED	51	CHURCH OF THE DIVINE
19	DISCIPLES OF CHRIST	52	CHURCH OF THE OPEN DOOR
20	*DUTCH REFORMED	53	CONGREGATIONAL HOLY
21	FIRST CHRISTIAN	54	COVENANT
22	INTERDENOMINATIONAL	55	DIVINE SCIENCE
23	MORAVIAN	56	EVANGELICAL
24	NON-DENOMINATIONAL	57	FUNDAMENTAL
25	SEAMAN'S CHURCH	58	FOURSQUARE
26	TRINITY	59	FULL GOSPEL
27	UNIVERSAL	60	HOLINESS
28	PROTESTANT, OTHER	53	HOLY CONGREGATIONAL
	ORTHODOX:	61	HOLY INNOCENTS
29	ARMENIAN ORTHODOX	62	NAZARENE
30	*COPTIC	63	NEW APOSTOLIC
31	GREEK ORTHODOX	64	PENTECOSTAL
34	*LEBANESE MARONITE	65	RELIGIOUS SCIENCE
34	*MARONITE	66	SALVATION ARMY
29	ORTHODOX, ARMENIAN	67	SCIENCE OF MIND
31	ORTHODOX, GREEK	68	UNITY
32	ORTHODOX, RUSSIAN	69	*CHRISTIAN SECTS, OTHER
33	ORTHODOX, SERBIAN		
32	RUSSIAN ORTHODOX	70	JEWISH
33	SERBIAN ORTHODOX	71	*ORTHODOX JEWISH
34	*ORTHODOX, CHRISTIAN, OTHER	71	*JEWISH ORTHODOX
34	*ORTHODOX, CHRISTIAN, NOS		
			WESTERN OTHER:
		72	BAHA'I
		73	CRICKORIAN
		73	ETHICAL CULTURE

Codes for Religion (numerical order)

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

APPENDIX G.2

CODES FOR RELIGIONS

(in alphabetical order)

AFRICAN METHODIST	07	HINDU	83
EPISCOPAL (AME)		HOLINESS	60
AGNOSTIC	02	HOLY CONGREGATIONAL	53
AMERICAN INDIAN RELIGIONS	90	HOLY INNOCENTS	61
AMISH	40	INTERDENOMINATIONAL	22
ANGLICAN	08	ISLAM	84
APOSTOLIC	42	JAIN	80
ARMENIAN APOSTOLIC	43	JEHOVAH'S WITNESS	35
ARMENIAN ORTHODOX	29	JEWISH	70
ASSEMBLIES OF GOD	44	JEWISH ORTHODOX	71
ATHEIST	03	KO	76
BAHA'I	72	LATTER DAY SAINTS	37
BAPTIST	09	LAWSONIAN	73
BRETHREN	45	LEBANESE MARONITE	34
BROTHERS	45	LUTHERAN	13
BUDDHIST	77	MARONITE	34
CATHOLIC	05	MASON	73
CHRISTIAN APOSTOLIC	46	MENNONITES	41
CHRISTIAN, NOS	06	METAPHYSICS	73
CHRISTIAN REFORMED	18	METHODIST	14
CHRISTIAN SCIENCE	36	MOHAMMEDAN	82
CHRISTIAN SECTS, OTHER	69	MOLIKAN	74
CHURCH OF ARMEDIAN	47	MOLOKAN	74
CHURCH OF CHRIST	48	MORAVIAN	23
CHURCH OF ENGLAND	08	MORMON	37
CHURCH OF GOD	49	MOSLEM	82
CHURCH OF MESSIANITY	50	MUSLIM	82
CHURCH OF THE DIVINE	51	NATION OF ISLAM	81
CHURCH OF THE OPEN DOOR	52	NATIVE AMERICAN TRADITIONAL	
COMMUNITY	10		
CONFUCIANISM	79		9
CONGREGATIONAL	11		0
CONGREGATIONAL HOLY	53	RELIGIONS	
COPTIC	30	NAZARENE	62
COVENANT	54	NEW APOSTOLIC	63
CRICKORIAN	73	NON-DENOMINATIONAL	24
DISCIPLES OF CHRIST	19	NONE	01
DIVINE SCIENCE	55	NONE, AGNOSTIC, ATHEIST (OLD)	04
DROUZE	78	OCCULT	73
DUTCH REFORMED	20	ORIENTAL PHILOSOPHY	89
EASTERN RELIGION, NOS	89	ORTHODOX, ARMENIAN	29
EASTERN RELIGION, OTHER	89	ORTHODOX, CHRISTIAN, NOS	34
EPISCOPALIAN	12	ORTHODOX, CHRISTIAN, OTHER	34
ETHICAL CULTURE	73	ORTHODOX, GREEK	31
EVANGELICAL	56	ORTHODOX, JEWISH	71
FIRST CHRISTIAN	21	ORTHODOX, RUSSIAN	32
FOURSQUARE	58	ORTHODOX, SERBIAN	33
FRIENDS	39	OTHER	98
FULL GOSPEL	59	OTHER TRADITIONAL OR NATIVE	93
FUNDAMENTAL	57	RELIGION	
GREEK ORTHODOX	31	PARSEE	85
GREGORIAN	73	PEACE OF MIND	73
HAITIAN/AFRICAN/BRAZILIAN	91	PENTACOSTAL	64
RELIGIONS, OTHER		PEOPLE'S	73

Codes for Religions (in alphabetical order)

PRESBYTERIAN	15	OTHER
PROTESTANT DENOMINATION,	17	
PROTESTANT, NOS	06	
PROTESTANT, OTHER	28	
QUAKER	39	
RELIGIOUS SCIENCE	65	
ROMAN CATHOLIC	05	
RUSSIAN ORTHODOX	32	
SALVATION ARMY	66	
SANTORIA	91	
SCIENCE OF MIND	67	
SEAMAN'S CHURCH	25	
SELF-REALIZATION	73	
SERBIAN ORTHODOX	33	
SEVENTH-DAY ADVENTIST	38	
SHAMANISM	92	
SHINTO	86	
SIKH	87	
SOCIETY OF LIFE	73	
SPIRITUALIST	73	
TAOISM	79	
THEOSOPHY	73	
TRINITY	26	
TRUTH SEEKER	73	
UNITARIAN	16	
UNITY	68	
UNIVERSAL	27	
UNSPECIFIED, UNKNOWN	99	
VEDANTA	88	
VOODOO	91	
WESTERN RELIGION OR CREED,	75	
NOS		
WESTERN RELIGION OR CREED,	75	
OTHER		
ZEN	77	
ZEN BUDDHISM	77	
ZOROASTRIAN	85	

APPENDIX H SUMMARY OF CODES

The codes used for reporting cancer data to the CCR are summarized below. For explanations of the codes and status of data item reportability to the CCR, refer to the sections indicated. Only coded items, not text fields, are listed here.

SECTION ITEM	CODE
REGISTRY INFORMATION	
III.1.1 Abstractor	Three initials of abstractor; flush left, no spaces between initials XXX = unknown
II.2.3 Accession Number	Nine-digit number assigned to patient by hospital tumor registry
II.2.4 Sequence Number	00 ONE PRIMARY MALIGNANCY 01 FIRST OF TWO OR MORE PRIMARIES 02 SECOND OF TWO OR MORE PRIMARIES 10 TENTH OF TEN OR MORE PRIMARIES 11 ELEVENTH OF ELEVEN OR MORE PRIMARIES 99 SEQUENCE UNKNOWN
II.2.1 Year First Seen	Two-digit number assigned by the hospital tumor registry to each registered case
III.1.4 Reporting Hospital	Six-digit number assigned by CCR (see Appendix F); blank if none assigned
III.1.6 ACoS Approved Flag	1 CANCER PROGRAM APPROVED 2 CANCER PROGRAM NOT APPROVED Blank CASES DIAGNOSED BEFORE 1999
PATIENT IDENTIFICATION	
III.2.1 Patient's Name	Uppercase alpha, except single hyphen allowed within last name; maximum of 25 characters for last name, 14 letters for first name, and 14 letters for middle name/initial; no spaces within name; middle name may be blank

III.2.1.4	Maiden Name	Uppercase alpha, except hyphen; first 15 characters of maiden surname; no spaces within name; blank if not applicable
III.2.1.5	Alias Last Name	Uppercase alpha, except hyphen; first 15 characters of alias surname; no spaces within name; blank if not applicable
III.2.1.6	Alias First Name	Uppercase alpha, except hyphen, 15 characters, no spaces within name; blank if not applicable
III.2.1.8	Name Suffix	Alpha; 3 characters; may be left blank
III.2.1.9	Mother's First Name	Alpha; 14 characters; may be left blank
III.2.2	Medical Record No.	Maximum of 12 letters or numbers assigned to patient/admission by reporting hospital, flush left, without special characters or spaces within number; blank if none assigned
III.2.3	Social Security No. and Suffix	Nine-digit number; up to two-character suffix; flush left; blank if unknown; valid suffixes determined by Social Security Administration
III.2.5.2	Number & Street	Maximum of 40 letters, numbers, spaces, and the special characters (#), (/), (-), (.), and (.), flush left; if unknown enter "UNKNOWN"
III.2.5.2	City	Maximum of 20 letters and spaces only; if unknown enter "UNKNOWN"
III.2.5.2	State	Two-letter postal abbreviation (see Appendix B) XX = USA, NOS; CANADA, NOS; UNKNOWN YY = NOT APPLICABLE (i.e., non-USA, or non-Canadian)
III.2.5.2	Zip	Nine-character field for five- or nine-digit postal code, flush left 8's = NON-USA, NON-CANADIAN RESIDENT 9's = UNKNOWN
III.2.5.2	County of Residence	Three-digit code for county at DX in California (see Appendix L); for non-USA or non-Canadian residents, three-digit code for country (see Appendix D) 000 NON-CALIFORNIA RESIDENT; USA, NOS; CALIFORNIA RESIDENT, COUNTY UNKNOWN 999 COUNTRY UNKNOWN

III.2.4 & VII.3.2	Phone	Ten-digit telephone number, including area code; no hyphens; may be blank; enter 0's for no phone
III.2.6	Marital Status	<ul style="list-style-type: none"> 1 SINGLE 2 MARRIED 3 SEPARATED 4 DIVORCED 5 WIDOWED 9 UNKNOWN
III.2.7	Sex	<ul style="list-style-type: none"> 1 MALE 2 FEMALE 3 HERMAPHRODITE 4 TRANSSEXUAL 9 UNKNOWN
III.2.8	Religion	Two-digit code (see Appendix G)
III.2.9.1	Race 1	<ul style="list-style-type: none"> 01 WHITE 02 BLACK 03 AMERICAN INDIAN, ALEUTIAN, OR ESKIMO 04 CHINESE 05 JAPANESE 06 FILIPINO 07 HAWAIIAN 08 KOREAN 09 ASIAN INDIAN, PAKISTANI, SRI LANKAN (CEYLONESE), NEPALESE, SIKKIMESE, BHUTANESE, BANGLADESHI 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 96 OTHER ASIAN, INCLUDING BURMESE, INDONESIAN, ASIAN, NOS AND ORIENTAL, NOS 97 PACIFIC ISLANDER, NOS 98 OTHER 99 UNKNOWN

III.2.9.1 Race 2-5

- 01 WHITE
- 02 BLACK
- 03 AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
- 04 CHINESE
- 05 JAPANESE
- 06 FILIPINO
- 07 HAWAIIAN
- 08 KOREAN
- 09 ASIAN INDIAN, PAKISTANI, SRI LANKAN
(CEYLONESE), NEPALESE, SIKKIMESE,
BHUTANESE, BANGLADESHI
- 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
- 96 OTHER ASIAN, INCLUDING BURMESE,
INDONESIAN, ASIAN, NOS AND ORIENTAL, NOS
- 97 PACIFIC ISLANDER, NOS
- 98 OTHER
- 99 UNKNOWN

III.2.9.2 Spanish Hispanic/Origin

- 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)
 - 6 SPANISH, NOS; HISPANIC, NOS, LATINO, NOS
(evidence that Hispanic cannot be assigned to codes 1-5)
 - 7 SPANISH SURNAME ONLY (only evidence is surname
or maiden name)*
 - 9 UNKNOWN WHETHER SPANISH OR NOT
- *Use Appendix O to code this field.

III.2.10	Birth Date Month	01-12 for January - December 99 = UNKNOWN	
	Day	01-31 99 = UNKNOWN	
	Year	Four-digit year of birth 9999 = UNKNOWN	
III.2.11	Age at Diagnosis	Three-digit age at diagnosis 000 LESS THAN ONE YEAR OLD 999 UNKNOWN AGE	
III.2.12	Birthplace	Three-digit code (see Appendix D)	
III.2.13	Occupation	Four-digit code, U.S. Bureau of the Census 1990 occupation and industry classification; leave blank because entered by regional or central registry	
III.2.13	Industry	Four-digit code (see Occupation, above); leave blank	
III.2.14	Patient No Research Contact Flag	0 NO FLAG 1 HOSPITAL FIRST NOTIFIED 2 REGION FIRST NOTIFIED 3 CCR FIRST NOTIFIED 4 OUT OF STATE CASE, NOT FOR RESEARCH	

CASE IDENTIFICATION

III.3.1	Date of Admission	MMDDYYYY (unknown = 99 or 9999 for unknown year)	
III.3.2	Dates of Inpatient Admission and Inpatient Discharge	MMDDYYYY (unknown = 99 or 9999 for unknown year); may be blank	
III.3.3	Date of Diagnosis	MMDDYYYY (unknown = 99 or 9999 for unknown year)	

III.3.5 Class of Case

ANALYTIC-CODES 0, 1, and 2

- 0 FIRST DIAGNOSED AT REPORTING HOSPITAL SINCE ITS REFERENCE DATE, BUT ENTIRE FIRST COURSE OF THERAPY GIVEN ELSEWHERE
- 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
- 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

NON-ANALYTIC Codes 3-9

- 3 FIRST DIAGNOSED AT ANOTHER HOSPITAL AND EITHER (a) ENTIRE FIRST COURSE OF THERAPY* WAS GIVEN ELSEWHERE, (b) WAS NEVER TREATED, or (c) UNKNOWN IF TREATED
- 4 FIRST DIAGNOSED AT REPORTING HOSPITAL BEFORE ITS REFERENCE DATE
- 5 FIRST DIAGNOSED AT AUTOPSY
- 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

III.3.6	Type of Reporting Source	1	HOSPITAL INPATIENT/OUTPATIENT OR CLINIC
		3	LABORATORY
		*4	PRIVATE MEDICAL PRACTITIONER
		*5	NURSING HOME, CONVALESCENT HOSPITAL, OR HOSPICE
		6	AUTOPSY ONLY
		*7	DEATH CERTIFICATE ONLY

NOTE: Code 2 (Clinic) will still be accepted.

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

III.3.7	Type of Admission	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)

III.3.8	Casefinding Source	Case first identified in cancer-reporting facility:	
		10	REPORTING HOSPITAL, NOS
		20	PATHOLOGY DEPARTMENT REVIEWS
		21	DAILY DISCHARGE REVIEW
		22	DISEASE INDEX REVIEW
		23	RADIATION THERAPY DEPARTMENT/CENTER
		24	LABORATORY REPORTS
		25	OUTPATIENT CHEMOTHERAPY
		26	DIAGNOSTIC IMAGING/RADIOLOGY
		27	TUMOR BOARD
		28	HOSPITAL REHABILITATION SERVICE OR CLINIC
		29	OTHER HOSPITAL SOURCE, INCL. CLINIC, NOS OR OPD, NOS

Case first identified by source other than a cancer-reporting facility:

30	PHYSICIAN-INITIATED CASE
40	CONSULTATION-ONLY OR PATHOLOGY-ONLY REPORT
50	PRIVATE PATHOLOGY LABORATORY REPORT
60	NURSING-HOME-INITIATED CASE
70	CORONER'S-OFFICE RECORDS REVIEW
80	DEATH CERTIFICATE FOLLOW-BACK
85	OUT OF STATE CASE SHARING
90	OTHER NON-REPORTING HOSPITAL SOURCE
95	QUALITY CONTROL REVIEW
99	UNKNOWN

III.3.9	Payment Source Primary and Secondary	01 NOT INSURED 02 NOT INSURED, SELF-PAY 10 INSURANCE, NOS 20 MANAGED CAR, HMO, PPO 31 MEDICAID 35 MEDICAID ADMINISTERED THROUGH A MANAGED CARE PLAN 36 MEDICAID WITH MEDICARE SUPPLEMENT 50 MEDICARE 51 MEDICARE WITH SUPPLEMENT 52 MEDICARE WITH MEDICAID SUPPLEMENT 53 TRICARE 54 MILITARY 55 VETERANS AFFAIRS 56 INDIAN/PUBLIC HEALTH SERVICE 60 COUNTY FUNDED, NOS 99 INSURANCE STATUS UNKNOWN
III.3.10	Hospital Referred From	Six-digit number assigned by CCR (see Appendix F); 0's if not referred
III.3.11	Hospital Referred To	Six-digit number assigned by CCR (see Appendix F); 0's if not referred
III.3.12	Physicians	Eight-digit code based on physician's state license number (7 fields); may enter dentist's and osteopath's license number; may enter out-of-state license but first character must be an X; blank if not applicable; Attending Physician 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.

TUMOR DATA

IV.1.7.1	Pathology Report Number-Biopsy/FNA	Ten-digit, alpha numeric, left justified. Special characters allowed. May be left blank.
IV.1.7.2	Pathology Report Number-Surgery	Ten-digit, alpha numeric, left justified. Special characters allowed. May be left blank.

IV.2	Diagnostic Confirmation	1 POSITIVE HISTOLOGY 2 POSITIVE CYTOLOGY, NO POSITIVE HISTOLOGY 4 POSITIVE MICROSCOPIC CONFIRMATION, METHOD NOT SPECIFIED 5 POSITIVE LABORATORY TEST OR MARKER STUDY 6 DIRECT VISUALIZATION WITHOUT MICROSCOPIC CONFIRMATION 7 RADIOGRAPHY WITHOUT MICROSCOPIC CONFIRMATION 8 CLINICAL DIAGNOSIS ONLY 9 UNKNOWN WHETHER OR NOT MICROSCOPICALLY CONFIRMED	
V.1	Primary Site	Four-digit ICD-O-3 code	
V.2	Laterality	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 9 PAIRED SITE, BUT NO INFORMATION AVAILABLE CONCERNING LATERALITY	
V.3	Histology–Type and Behavior	Five-digit ICD-O-3 code	
V.3.5	Histology– Grade/Diff.	One-digit ICD-O-3 code	

Extent of Disease

EOD items may be blank if not abstracted prior to January 1, 1994. For cases diagnosed 1/1/94 and after, these fields must be coded. For SEER regions, the date is earlier (1/1/88 for Region 8, and 1/1/92 for Region 1 and Region 9). Please refer to SEER Extent of Disease - 1988 Codes and Coding Instructions - for codes.

V.5.1	Stage at Diagnosis	Stage at Diagnosis is not required with cases diagnosed on or after 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. 0 IN SITU 1 LOCALIZED 2 REGIONAL, DIRECT EXTENSIONS ONLY 3 REGIONAL, NODES ONLY 4 REGIONAL, DIRECT EXTENSION AND NODES 5 REGIONAL, NOS 7 DISTANT METASTASES OR SYSTEMIC DISEASE (REMOTE) 9 UNSTAGEABLE; UNKNOWN
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V.6.1	Tumor Marker 1	For breast cancer cases (C50.0-C50.9) diagnosed on or after 1/1/90 and prostate (C61.9) and testicular (C62.0-C62.9) cancer cases diagnosed on or after 1/1/98. For colorectal cancer cases - Carcinoembryonic Antigen (CEA). For ovarian cancer cases - Carbohydrate Antigen 125 (CA-125). Refer to Section V.6.1 for codes.
V.6.2	Tumor Marker 2	For breast cancer cases (C50.0-C50.9) diagnosed on or after 1/1/90 and prostate (C61.9) and testicular (62.0-62.9) cancer cases diagnosed on or after 1/1/98. Refer to Section V.6.2 for codes.
V.6.3	Tumor Marker 3	For testicular cancer cases diagnosed on or after 1/1/98. Refer to Section V.6.3 for codes.
V.6.4	Tumor Marker-CA-1	Her 2/neu tumor marker for breast cancer. Refer to Section V.6.4 for codes.

ACoS Items

V.7.4	TNM-T Code Clinical	Site-specific code, one, two, or three characters (ACoS), flush left
V.7.4	TNM-N Code Clinical	Site-specific code, one, two, or three characters (ACoS), flush left
V.7.4	TNM-M Code Clinical	Site-specific code, two characters (ACoS)
V.7.4	TNM-T Code Pathological	Site-specific code, one, two, or three characters (ACoS), flush left
V.7.4	TNM-N Code Pathological	Site-specific code, one, two, or three characters (ACoS), flush left
V.7.4	TNM-M Code Pathological	Site specific code, two characters (ACoS)
V.7.5	TNM Stage-(Clinical & Pathological)	Site-specific code, one or two characters (ACoS), entered as Arabic (not Roman) numerals; flush left

V.7.6	TNM Coder (Clinical) (Pathological), and (Other) (ACoS)	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
V.7.7	TNM Edition (ACoS)	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

V.7.8	Pediatric Stage	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	00 NONE 01 AMERICAN JOINT COMMITTEE ON CANCER 02 ANN ARBOR 03 CHILDREN'S CANCER GROUP 04 EVANS 05 GENERAL SUMMARY 06 INTERGROUP EWINGS 07 INTERGROUP HEPATOBLASTOMA 08 INTERGROUP RHABDOMYSARCOMA 09 INTERNATIONAL SYSTEM 10 MURPHY 11 NATIONAL CANCER INSTITUTE 12 NATIONAL WILM'S TUMOR SURGERY 13 PEDIATRIC ONCOLOGY GROUP (POG) 14 REESE-ELLSWORTH 15 SEER EXTENT OF DISEASE 16 CHILDREN'S ONCOLOGY GROUP 88 NOT APPLICABLE 97 OTHER 99 UNKNOWN

V.7.10	Pediatric Stage Coder	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

FIRST COURSE OF TREATMENT--SUMMARY

VI.1.3.2	RX Date (start date for each of six treatment types)	MMDDYYYY (blank if none; unknown = 99 or 9999 for unknown year) for each of seven types: surgery, radiation, chemotherapy, hormone/steroid, immunotherapy, transplant/endocrine procedure, and other																		
VI.2.1	Surgery of the Primary Site--Procedures 1-3	See Appendix Q-1 for site-specific codes for cases diagnosed prior to January 1, 2003. For cases diagnosed on or after January 1, 2003, see Appendix Q-2.																		
VI.2.2	Scope of Regional Lymph Node Surgery--Procedures 1-3	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 cases diagnosed on or after January 1, 2003, use the following codes: <table> <tr> <td>0</td> <td>None</td> </tr> <tr> <td>1</td> <td>Biopsy or aspiration of regional lymph node, NOS</td> </tr> <tr> <td>2</td> <td>Sentinel lymph node biopsy</td> </tr> <tr> <td>3</td> <td>Number of regional nodes removed unknown or not stated; regional lymph node removed, NOS</td> </tr> <tr> <td>4</td> <td>1-3 regional lymph nodes removed</td> </tr> <tr> <td>5</td> <td>4 or more regional lymph nodes removed</td> </tr> <tr> <td>6</td> <td>Sentinel node biopsy and code 3,4, or 5 at same time, or timing out not stated</td> </tr> <tr> <td>7</td> <td>Sentinel node biopsy and code 3,4, or 5 at different times</td> </tr> <tr> <td>9</td> <td>Unknown or not applicable</td> </tr> </table>	0	None	1	Biopsy or aspiration of regional lymph node, NOS	2	Sentinel lymph node biopsy	3	Number of regional nodes removed unknown or not stated; regional lymph node removed, NOS	4	1-3 regional lymph nodes removed	5	4 or more regional lymph nodes removed	6	Sentinel node biopsy and code 3,4, or 5 at same time, or timing out not stated	7	Sentinel node biopsy and code 3,4, or 5 at different times	9	Unknown or not applicable
0	None																			
1	Biopsy or aspiration of regional lymph node, NOS																			
2	Sentinel lymph node biopsy																			
3	Number of regional nodes removed unknown or not stated; regional lymph node removed, NOS																			
4	1-3 regional lymph nodes removed																			
5	4 or more regional lymph nodes removed																			
6	Sentinel node biopsy and code 3,4, or 5 at same time, or timing out not stated																			
7	Sentinel node biopsy and code 3,4, or 5 at different times																			
9	Unknown or not applicable																			

VI.2.3	Number of Regional Lymph Nodes Examined—Procedures 1-3	See Appendix Q-1 for site-specific codes
VI.2.4	Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Nodes—Procedures 1-3	<p>Cases diagnosed prior to January 1, 2003 are to be coded in a new field, Surgery Other 98-02. Refer to Appendix Q-1 for these codes. For cases diagnosed on or after January 1, 2003, use the following codes:</p> <ul style="list-style-type: none"> 0 None 1 Nonprimary surgical procedure performed 2 Nonprimary surgical procedure to other regional sites 3 Nonprimary surgical procedure to <i>distant lymph node(s)</i> 4 Nonprimary surgical procedure to distant site 5 Combination of codes 9 Unknown <p>This field is for all procedures that do not meet the definitions of Surgery of Primary Site or Scope of Regional Lymph Nodes.</p>
VI.2.5	Date of Surgery—Procedures 1-3	MMDDYYYY (blank if none; unknown = 99 or 9999 for unknown year)
VI.2.6	Treatment Hospital Number—Procedures 1-3	Six-digit number assigned by CCR (See Appendix F; blank if none assigned)
VI.2.7	Surgical Margins	See Appendix Q-1 for site-specific codes for cases diagnosed prior to January 1, 2003. For cases diagnosed on or after January 1, 2003, refer to the FORDS Manual
VI.2.8	Reconstructive Surgery—Immediate	<p>See Appendix Q-1 for site-specific codes for cases diagnosed prior to January 1, 2003.</p> <p>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 older cases, refer to Appendix Q-1.</p>

VI.2.9	Reason for No Surgery Of The Primary Site	0	SURGERY OF THE PRIMARY SITE PERFORMED
		1	SURGERY OF THE PRIMARY SITE NOT PERFORMED BECAUSE IT WAS NOT PART OF THE PLANNED FIRST COURSE TREATMENT
		2	SURGERY OF THE PRIMARY SITE NOT PERFORMED BECAUSE OF CONTRAINDICATIONS DUE TO PATIENT RISK FACTORS (COMORBID CONDITIONS, ADVANCED AGE, ETC.)
		5	SURGERY OF THE PRIMARY SITE WAS NOT PERFORMED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED SURGERY
		6	SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT NOT PERFORMED. NO REASON WAS NOTED IN THE PATIENT'S RECORD
		7	SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT REFUSED BY THE PATIENT, FAMILY MEMBER OR GUARDIAN. THE REFUSAL IS NOTED IN THE PATIENT'S RECORD.
		8	SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT UNKNOWN IF PERFORMED
		9	NOT KNOWN IF SURGERY OF THE PRIMARY SITE WAS RECOMMENDED OR PERFORMED; DEATH CERTIFICATE ONLY AND AUTOPSY ONLY CASES

VI.2.10.1 Diagnostic or Staging Procedure Codes

00	NO SURGICAL DIAGNOSTIC OR STAGING PROCEDURE
01	INCISIONAL, NEEDLE, OR ASPIRATION BIOPSY OF OTHER THAN PRIMARY SITE
02	INCISIONAL, NEEDLE, OR ASPIRATION BIOPSY OF PRIMARY SITE
03	EXPLORATORY SURGERY ONLY (no biopsy)
04	BYPASS SURGERY OR OSTOMY ONLY (no biopsy)
05	COMBINATION OF 03 PLUS 01 OR 02
06	COMBINATION OF 04 PLUS 01 OR 02
07	DIAGNOSTIC OR STAGING PROCEDURE, NOS
09	UNKNOWN IF DIAGNOSTIC OR STAGING PROCEDURE DONE

VI.2.10	Date Diagnostic and/or Staging Procedure	MMDDYYYY (blank if none; unknown = 99 or 9999 for unknown year)
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VI.3.2	Radiation (Generated field for cases diagnosed on or after January 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
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NOTE: Code 6 may appear in converted cases.

VI.3.3	Radiation- Regional RX Modality	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 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, NOS 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 80 COMBINATION MODALITY, SPECIFIED* 85 COMBINATION MODALITY, NOS 98 OTHER, NOS 99 UNKNOWN
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VI.3.4	Radiation- Boost RX Modality	00 NO BOOST 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 MV) 27 PHOTONS (MIXED ENERGIES)
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- 28 ELECTRONS
- 29 PHOTONS AND ELECTRONS MIXED

- 30 NEUTRONS, WITH OR WITHOUT
PHOTONS/ELECTRONS
- 31 MRT
- 32 CONFORMAL OR 3-D THERAPY
- 40 PROTONS
- 41 STEREOTACTIC RADIOSURGERY, NOS
- 42 LINAC RADIOSURGERY, NOS
- 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 STONTIUM-89
- 62 STONTIUM-90
- 98 OTHER, NOS
- 99 UNKNOWN

VI. 3.5 Date of Radiation
Therapy

- 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. THE DATE SHOULD
BE REVISED AT THE NEXT FOLLOW-UP.

- 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

- 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

VI.3.7 Radiation Sequence With Surgery

- 0 NOT APPLICABLE
- 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

VI.4 Chemotherapy

- 00 NONE, CHEMOTHERAPY WAS NOT PART OF THE PLANNED FIRST COURSE OF THERAPY.
- 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 BECASUE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.	
VI.4.3	Date of Chemotherapy	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, THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW UP.
		99999999	WHEN IT IS UNKNOWN WHETHER ANY CHEMOTHERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.
VI.5.4	Hormone Therapy		
		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 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 COURSE THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
		87	HORMONE THERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICAN, 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. HORMONE THERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
		99	IT IS UNKNOWN WHETHER A HORMONAL AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.5.5	Date Of Hormone Therapy	00000000	NO HORMONE THERAPY ADMINISTERED; AUTOPSY-ONLY
		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, THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW UP.
		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	Immunotherapy (Biological Response Modifier)	00	NONE, IMMUNOTHERAPY WAS NOT PART OF PART OF THE PLANNED FIRST COURSE OF THERAPY
		01	IMMUNOTHERAPY ADMINISTERED AS FIRST COURSE THERAPY
		82	IMMUNOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (i.e. COMORBID CONDITIONS, ADVANCED AGE).
		85	IMMUNOTHERAPY WAS NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.
		86	IMMUNOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE OF THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
		87	IMMUNOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN THE PATIENT RECORD.
		88	IMMUNOTHERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
		99	IT IS UNKNOWN WHETHER AN IMMUNOTHERAPEUTIC AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

VI.6.3 Date of Immunotherapy

- 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 Transplant/ Endocrine Procedures

- 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.

VI.7.2 Date of Transplant/Endocrine Procedure

- 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 ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

VI.8 Other Therapy

- 0 NO OTHER CANCER DIRECTED THERAPY EXCEPT AS CODED ELSEWHERE
- 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

VI.8.2 Date of Other Therapy

- 00000000 NO OTHER THERAPY ADMINISTERED; AUTOPSY ONLY CASE
- 99999999 UNKNOWN IF ANY OTHER THERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

VI.9 Protocol Participation.

00	Not Applicable
National Protocols	
01	NSABP
02	GOG
03	RTOG
04	SWOG
05	ECOG
06	POG
07	CCG
08	CALGB
09	NCI
10	ACS
11	National Protocol, NOS
12	ACOS-OG
13	VA [Veterans Administration]
14	COG [Children's Oncology Group]
15	CTSU [Clinical Trials Support Unit]
16-50	National Trials
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

FIRST COURSE OF TREATMENT GIVEN AT REPORTING HOSPITAL

Fields and codes are the same as for First Course of Treatment–Summary.

FOLLOW-UP

VII.2.1	Date of Last Contact	MMDDYYYY (do not leave blank or code year as unknown)
VII.2.2	Vital Status	0 DEAD 1 ALIVE
VII.2.3	Date of Last Tumor Status	MMDDYYYY (do not leave blank if patient alive; do not code year as unknown)
VII.2.4	Tumor Status	1 FREE-NO EVIDENCE OF THIS PRIMARY CANCER 2 NOT FREE-THIS PRIMARY CANCER STILL EXISTS 9 UNKNOWN

VII.2.5	Quality of Survival	<ul style="list-style-type: none"> 0 NORMAL ACTIVITY 1 SYMPTOMATIC AND AMBULATORY 2 AMBULATORY MORE THAN 50%, OCCASIONALLY NEEDS ASSISTANCE 3 AMBULATORY LESS THAN 50%, NURSING CARE NEEDED 4 BEDRIDDEN, MAY REQUIRE HOSPITALIZATION 8 NOT APPLICABLE; DEAD 9 UNKNOWN/UNSPECIFIED
VII.2.6.1	Last Type of Tumor Follow-Up	<p>Follow-up obtained by hospital from:</p> <ul style="list-style-type: none"> 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 <p>Follow-up obtained by regional registry from:</p> <ul style="list-style-type: none"> 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 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 <p>Follow-up obtained by central (state) registry from:</p> <ul style="list-style-type: none"> 40 LETTER TO A PHYSICIAN 41 TELEPHONE CALL TO ANY SOURCE 52 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE 53 COMPUTER MATCH WITH HMO FILE 55 NATIONAL DEATH INDEX 56 COMPUTER MATCH WITH STATE DEATH TAPE 59 COMPUTER MATCH, OTHER OR NOS 60 OTHER SOURCE

Follow-up obtained by hospitals or facilities
usually done by the regional/central registry:
73 COMPUTER MATCH WITH HMO FILE
76 COMPUTER MATCH WITH STATE DEATH TAPE

99 SOURCE UNKNOWN

May be blank

VII.2.6.2 Last Type of Patient
Follow-Up

Follow-up obtained by hospital from:

- 00 ADMISSION BEING REPORTED
- 01 READMISSION TO REPORTING HOSPITAL
- 02 FOLLOW-UP REPORT FROM PHYSICIAN
- 03 FOLLOW-UP REPORT FROM PATIENT
- 04 FOLLOW-UP REPORT FROM RELATIVE
- 05 OBITUARY
- 06 FOLLOW-UP REPORT FROM SOCIAL SECURITY
ADMINISTRATION OR MEDICARE
- 07 FOLLOW-UP REPORT FROM HOSPICE
- 08 FOLLOW-UP REPORT FROM OTHER HOSPITAL
- 09 OTHER SOURCE
- 11 TELEPHONE CALL TO ANY SOURCE
- 12 SPECIAL STUDIES
- 13 EQUIFAX
- 14 ARS (AIDS REGISTRY SYSTEM)
- 15 COMPUTER MATCH WITH DISCHARGE DATA

Follow-up obtained by regional registry from:

- 20 LETTER TO A PHYSICIAN
- 21 COMPUTER MATCH WITH DEPARTMENT OF
MOTOR VEHICLES FILE
- 22 COMPUTER MATCH WITH MEDICARE OR
MEDICAID FILE
- 23 COMPUTER MATCH WITH HMO FILE
- 24 COMPUTER MATCH WITH VOTER
REGISTRATION FILE
- 25 NATIONAL DEATH INDEX
- 26 COMPUTER MATCH WITH STATE DEATH TAPE
- 27 DEATH MASTER FILE (SOCIAL SECURITY)
- 29 COMPUTER MATCH, OTHER OR NOS
- 30 OTHER SOURCE
- 31 TELEPHONE CALL TO ANY SOURCE
- 32 SPECIAL STUDIES
- 33 EQUIFAX
- 34 ARS (AIDS REGISTRY SYSTEM)
- 35 COMPUTER MATCH WITH DISCHARGE DATA
- 36 OBITUARY
- 37 COMPUTER MATCH WITH CHANGE OF ADDRESS
SERVICE
- 38 TRW
- 39 REGIONAL REGISTRY FOLLOW-UP LIST

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

- 40 LETTER TO A PHYSICIAN
- 41 TELEPHONE CALL TO ANY SOURCE
- 51 COMPUTER MATCH WITH DEPARTMENT OF
MOTOR VEHICLES FILE
- 52 COMPUTER MATCH WITH MEDICARE OR
MEDICAID FILE
- 53 COMPUTER MATCH WITH HMO FILE
- 54 COMPUTER MATCH WITH VOTER
REGISTRATION FILE
- 55 NATIONAL DEATH INDEX
- 56 COMPUTER MATCH WITH STATE DEATH TAPE
- 57 COMPUTER MATCH WITH MEDI-CAL
- 58 COMPUTER MATCH WITH SOCIAL SECURITY
DEATH FILE
- 59 COMPUTER MATCH, OTHER OR NOS
- 60 OTHER SOURCE
- 62 SPECIAL STUDIES
- 65 COMPUTER MATCH WITH OSHPD HOSPITAL
DISCHARGE DATABASE
- 66 COMPUTER MATCH WITH NATIONAL CHANGE
OF ADDRESS FILE

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

- 99 SOURCE UNKNOWN

VII.2.7 Last Follow-Up Hospital A six-digit number assigned by CCR (see Appendix F);
blank if unknown

VII.2.8 Next Type of Follow-Up

- 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

May be blank

VII.2.9 Next Follow-Up Hosp. A six-digit number assigned by CCR (see Appendix F);
blank if unknown

Recurrence Information

The fields may be blank if recurrence information is not collected.

VII.2.12.1	Recurrence Date	MMDDYY (99 = unknown 9999 for unknown year); leave blank if no recurrence or patient never free
VII.2.12.2	Recurrence Type	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.

Death Information

VII.2.13	Place of Death	Three-digit code (see Appendix C and D); blank if patient is alive or died in California
VII.2.13	Cause of Death	Four-digit ICD code; not coded by hospitals
VII.2.13	DC State File Number	Six-digit number; not entered by hospital

APPENDIX J PATIENT INFORMATION SHEET

CCR suggests the following statement be used by hospitals and physicians in notifying their patients that cancer is a reportable disease:

CALIFORNIA CANCER REPORTING SYSTEM PATIENT INFORMATION SHEET

California Department of Health Services (CDHS) is mandated under state law (Health and Safety Code, Section 103885) to gather information on the amount and type of cancer occurring throughout the state. The purpose of the law is to help identify preventable causes of cancer.

For the system to be useful, it must obtain complete and accurate counts of all new cancers that occur. Therefore the new law requires hospitals and physicians to notify the appropriate regional registry of each new case of cancer.

The information collected is confidential under California Health and Safety Code Sections 100330 and 103885, Civil Code, Sections 56.05 and 1798, Government Code, Sections 6250-62-65, and Federal Law PL 104-191. CDHS has more than 50 years' experience in handling confidential records. Laws, regulations and programmatic safeguards are in place throughout the system to assure that the identities of patients are not revealed. Some cancer patients may, however, be contacted later by CDHS or the regional cancer registries as part of their ongoing investigations into the causes of cancer.

APPENDIX K

SCREENING LIST OF ICD-9-CM CODES FOR CASEFINDING

Certain ICD-9-CM* codes used by medical records departments for discharge diagnoses identify cases of malignant neoplasms that are reportable to the California Cancer Registry. Case finding procedures should include the review of medical records coded with the following numbers. Newly reportable diseases are followed by the ICD-O-3 morphology and behavior code in parentheses.

ICD-9-CM* CODE

042	AIDS (review cases for AIDS-related malignancies)
140.0-208.9	Malignant neoplasms (primary and secondary)
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
225.0-227.4	Benign central nervous system neoplasms
230.0-234.9	Carcinoma in situ
235.0-238.9	Neoplasms of uncertain behavior
236.2	Ovarian neoplasms of uncertain behavior (8442/1, 8451/1, 8462/1, 8472/1, 8473/1)
237.0-237.9	Central nervous system neoplasms of uncertain behavior
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.7	Chronic myeloproliferative disease (9960/3)
238.7	Myelosclerosis with myeloid metaplasia (9961/3)
238.7	Essential thrombocythemia (9962/3)
238.7	Refractory cytopenia with multilineage dysplasia (9985/3)
238.7	Myelodysplastic syndrome with 5q-syndrome (9986/3)
238.7	Therapy-related myelodysplastic syndrome (9987/3)
239.0-239.9	Neoplasms of unspecified nature
273.2	Gamma heavy chain disease Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
284.9	Refractory anemia (9980/3)
285.0	Refractory anemia with ringed sideroblasts (9982/3)
285.0	Refractory anemia with excess blasts (9983/3)

Screening List Of ICD-9-CM Codes for Casefinding

285.0	Refractory anemia with excess blasts in transformation (9984/3)
288.3	Hypereosinophilic syndrome (9964/3)
289.8	Acute myelofibrosis (9932/3)
V07.3	Other prophylactic chemotherapy
V07.8	Other specified prophylactic measures
V10.0-V10.9	Personal history of malignant neoplasms
V58.0	Radiotherapy session
V58.1	Maintenance chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Follow-up exam following radiotherapy
V67.2	Follow-up exam following chemotherapy
V71.1	Observation for suspected malignant neoplasm
V76.0-V76.9	Special screening for malignant neoplasms

Please Note:

- Code 042 is not a combination code of AIDS with specified malignancies.
- Prostatic Intraepithelial Neoplasia (PIN III), morphology code 8148/2 is not reportable to the CCR.
- Pilocytic/juvenile astrocytoma, morphology code 9421, is reportable as a /3 behavior code and is assigned a regular tumor sequence number per SEER requirements, effective with cases diagnosed 1/1/2001 and forward.
- Ovarian borderline cystadenomas, morphology codes 8442/1, 8451/1, 8462/1, 8472/1 and 8473/1, which changed behavior codes from /3 to /1 will continue to be reportable to the CCR. These tumors are to be sequenced following the American College of Surgeons guideline for benign tumors.

** International Classification of Diseases, 9th Revision, Clinical Modification, 4th ed.*

APPENDIX L.1
CODES FOR CALIFORNIA COUNTIES
(in alphabetical order)

ALAMEDA CO.	001	PLACER CO.	031
ALPINE CO.	002	PLUMAS CO.	032
AMADOR CO.	003	RIVERSIDE CO.	033
BUTTE CO.	004	SACRAMENTO CO.	034
CALAVERAS CO.	005	SAN BENITO CO.	035
CALIFORNIA NOS	000	SAN BERNARDINO	036
COLUSA CO.	006	SAN DIEGO CO.	037
CONTRA COSTA CO.	007	SAN FRANCISCO CO.	038
DEL NORTE CO.	008	SAN JOAQUIN CO.	039
EL DORADO CO.	009	SAN LUIS OBISPO	040
FRESNO CO.	010	SAN MATEO CO.	041
GLENN CO.	011	SANTA BARBARA CO.	042
HUMBOLDT CO.	012	SANTA CLARA CO.	043
IMPERIAL CO.	013	SANTA CRUZ CO.	044
INYO CO.	014	SHASTA CO.	045
KERN CO.	015	SIERRA CO.	046
KINGS CO.	016	SISKIYOU CO.	047
LAKE CO.	017	SOLANO CO.	048
LASSEN CO.	018	SONOMA CO.	049
LOS ANGELES CO.	019	STANISLAUS CO.	050
MADERA CO.	020	SUTTER CO.	051
MARIN CO.	021	TEHAMA CO.	052
MARIPOSA CO.	022	TRINITY CO.	053
MENDOCINO CO.	023	TULARE CO.	054
MERCED CO.	024	TUOLUMNE CO.	055
MODOC CO.	025	US NOT CALIF.	000
MONO CO.	026	VENTURA CO.	056
MONTEREY CO.	027	YOLO CO.	057
NAPA CO.	028	YUBA CO.	058
NEVADA CO.	029		
ORANGE CO.	030		

APPENDIX L.2
CODES FOR CALIFORNIA COUNTIES
(in numerical order)

000	CALIFORNIA NOS	030	ORANGE CO.
000	US NOT CALIF.	031	PLACER CO.
001	ALAMEDA CO.	032	PLUMAS CO.
002	ALPINE CO.	033	RIVERSIDE CO.
003	AMADOR CO.	034	SACRAMENTO CO.
004	BUTTE CO.	035	SAN BENITO CO.
005	CALAVERAS CO.	036	SAN BERNARDINO
006	COLUSA CO.	037	SAN DIEGO CO.
007	CONTRA COSTA CO.	038	SAN FRANCISCO CO.
008	DEL NORTE CO.	039	SAN JOAQUIN CO.
009	EL DORADO CO.	040	SAN LUIS OBISPO
010	FRESNO CO.	041	SAN MATEO CO.
011	GLENN CO.	042	SANTA BARBARA CO.
012	HUMBOLDT CO.	043	SANTA CLARA CO.
013	IMPERIAL CO.	044	SANTA CRUZ CO.
014	INYO CO.	045	SHASTA CO.
015	KERN CO.	046	SIERRA CO.
016	KINGS CO.	047	SISKIYOU CO.
017	LAKE CO.	048	SOLANO CO.
018	LASSEN CO.	049	SONOMA CO.
019	LOS ANGELES CO.	050	STANISLAUS CO.
020	MADERA CO.	051	SUTTER CO.
021	MARIN CO.	052	TEHAMA CO.
022	MARIPOSA CO.	053	TRINITY CO.
023	MENDOCINO CO.	054	TULARE CO.
024	MERCED CO.	055	TUOLUMNE CO.
025	MODOC CO.	056	VENTURA CO.
026	MONO CO.	057	YOLO CO.
027	MONTEREY CO.	058	YUBA CO.
028	NAPA CO.		
029	NEVADA CO.		

APPENDIX M.1

COMMON ACCEPTABLE ABBREVIATIONS

(in order of terms)

Do not use non-standard abbreviations in abstracts. When abbreviating words in an address, refer to the Address Abbreviations section of the *National Zip Code and Post Office Directory*, published by the U.S. Postal Service. For short names of antineoplastic drugs, consult the SEER Program *Self Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs, 3rd Edition*. Other accepted abbreviations are:

Abdomen	ABD	Bartholin's, Urethral, & Skene's	
Abdominal Perineal	AP	Glands	BUS
Above Knee (Amputation)	AK(A)	Below Knee (Amputation)	BK(A)
Acid Phosphatase	ACID PHOS	Benign Prostatic	
Acquired Immunodeficiency		Hypertrophy/Hyperplasia	BPH
Syndrome	AIDS	Bilateral	BIL
Acute Granulocytic Leukemia	AGL	Bilateral Salpingo-oophorectomy	BSO
Acute Lymphocytic Leukemia	ALL	Bile Duct	BD
Acute Myelogenous Leukemia	AML	Biological Response Modifier	BRM
Adenocarcinoma	ADENOCA	Biopsy	BX
Adjacent	ADJ	Blood Urea Nitrogen	BUN
Admission; Admit	ADM	Bone Marrow	BM
Against Medical Advice	AMA	Bone Scan	BSC
Aids Related Complex	ARC	Bowel Movement	BM
Alcohol	ETOH	Bowel Sounds	BS
Alkaline Phosphatase	ALK PHOS	Breath Sounds	BS, BRS
Alpha-fetoprotein	AFP	Bright Red Blood	
Also Known As	AKA	(per Rectum)	BRB(PR)
Ambulatory	AMB	Calcium	CA
Anal Intraepithelial Neoplasia	AIN	Carcinoembryonic Antigen	CEA
Anaplastic	ANAP	Carcinoma	CA
Angiography	ANGIO	Carcinoma In Situ	CIS
Anterior	ANT	CAT Scan	CT, CT SC
Anteroposterior	AP	Centimeter	CM
Appendix	APP	Central Nervous System	CNS
Approximately	APPROX	Cerebrospinal Fluid	CSF
Arteriovenous	AV	Cervical Intraepithelial Neoplasia	CIN
Aspiration	ASP	Cervical Vertebra	C1-C7
Auscultation & Percussion	A&P	Cervix	CX
Autopsy	AUT	Cesium	CS
Axilla(ry)	AX	Chemotherapy	CHEMO
Bacillus Calmette-Guerin	BCG	Chest Xray	CXR
Barium	BA	Chief Complaint	CC
Barium Enema	BE	Chronic Granulocytic Leukemia	CGL
		Chronic Lymphocytic Leukemia	CLL

**Common Acceptable Abbreviations
(in order of terms)**

Chronic Myeloid Leukemia	CML	Examination under Anesthesia	EUA
Cigarettes	CIG	Excision	EXC
Clear	CLR	Exploratory Laparotomy	EXP LAP
Colon		Extend	EXT
Ascending	A-COLON	Extended Care Facility	ECF
Descending	D-COLON	Extension	EXT
Sigmoid	S-COLON	External	EXT
Transverse	T-COLON	Extremity	EXT
Common Bile Duct	CBD	Eyes, Ears, Nose, and Throat	EENT
Complaining of	C/O	Family (Medical) History	F(M)H
Complete Blood Count	CBC	Fever Unknown Origin	FUO
Computerized Axial Tomography		Fingerbreadth	FB
Scan	CT, CAT SCAN	Floor of Mouth	FOM
Consistent with	C/W	Follow-up	FU
Continue	CONT	Fracture	FX
Costal Margin	CM	Frozen Section	FS
Cubic Centimeter	CC	Gallbladder	GB
Cystoscopy	CYSTO	Gastroenterostomy	GE
Cytology	CYTO	Gastroesophageal	GE
Cytomegalovirus	CMV	Gastrointestinal	GI
Date of Birth	DOB	Genitourinary	GU
Dead on Arrival	DOA	Grade	GR
Decreased	DECR (or <)	Gram	GM
Dermatology	DERM	Gynecology	GYN
Diagnosis	DX	Head, Eyes, Ears, Nose, Throat	HEENT
Diameter	DIAM	Hematocrit	HCT
Differentiated	DIFF	Hemoglobin	HGB
Dilatation and Curettage	D&C	Hepatosplenomegaly	HSM
Discharge	DIS, DISCH, DS	History	HX
Discontinued	DC	History and Physical	H&P
Disease	DZ, DIS	History of	HO
Doctor	DR, MD	History of Present Illness	HPI
Ductal Carcinoma In Situ	DCIS	Hormone	HORM
Ductal Intraepithelial Neoplasia	DIN	Hospital	HOSP
Ears, Nose, and Throat	ENT	Hour, Hours	HR, HRS
Electroencephalogram	EEG	Human Chorionic Gonadotropin	HCG
Electromyogram	EMG	Human Immunodeficiency Virus	HIV
Emergency Room	ER	Human Papilloma Virus	HPV
Endoscopic Retrograde Cholangiopancreatography	ERCP	Human T-Lymphotropic Virus Type III	HTLV-III
Enlarged	ENL	Hysterectomy	HYST
Esophagogastroduodenoscopy	EGD	Immunoglobulin	IG
Estrogen Receptor (Assay)	ER(A)	Impression	IMP
Evaluation	EVAL	Includes, Including	INCL
Examination	EXAM	Increase	INCR (or >)

**Common Acceptable Abbreviations
(in order of terms)**

Inferior Vena Cava	IVC	Maxilla(ry)	MAX
Infiltrating	INFILT	Maximum	MAX
Inpatient	IP	Medical Doctor	DR, MD
Intercostal Margin	ICM	Medicine	MED
Internal Mammary Artery	IMA	Metastatic, Metastases	MET, METS
Intrathecal	IT	Microscopic	MICRO
Intravenous	IV	Midclavicular Line	MCL
Intravenous Pyelogram	IVP	Middle Lobe	ML
Iodine	I	Millicurie (hours)	MC(H)
Jugular Venous Distention	JVD	Milligram (hours)	MG(H)
Kidneys, Ureters, Bladder	KUB	Milliliter	ML
Kilogram	KG	Millimeter	MM
Kilovolt	KV	Million Electron Volts	MEV
Laparotomy	LAP	Minimum	MIN
Large	LG	Moderate	MOD
Laryngeal Intraepithelial Neoplasia	LIN	Moderately	
Last Menstrual Period	LMP	Differentiated	MD, MOD DIFF
Lateral	LAT	Modified Radical Mastectomy	MRM
Left	L, LT	Nausea and Vomiting	N&V
Left Costal Margin	LCM	Neck Vein Distention	NVD
Left Lower Extremity	LLE	Negative	NEG (or -)
Left Lower Lobe	LLL	Neurology	NEURO
Left Lower Quadrant	LLQ	No Evidence of Disease	NED
Left Salpingo-oophorectomy	LSO	Normal	NL
Left Upper Extremity	LUE	No Significant Findings	NSF
Left Upper Lobe	LUL	Not Applicable	NA
Left Upper Quadrant	LUQ	Not Otherwise Specified	NOS
Liter	L	Not Recorded	NR
Liver, Kidney, Spleen (Bladder)	LKS(B)	Obstructed (-ing, -ion)	OBST
Lobular Carcinoma In Situ	LCIS	Operating Room	OR
Local M.D.	LMD	Operation	OP
Lower Extremity	LE	Operative Report	OP REPORT
Lower Inner Quadrant	LIQ	Ounce	OZ
Lower Outer Quadrant	LOQ	Outpatient	OP
Lumbar Puncture	LP	Packs per Day	PPD
Lumbar Vertebra	L1-L5	Palpated (-able)	PALP
Lumbosacral	LS	Papanicolaou Smear	PAP
Lymphadenopathy	LAD/LAN	Papillary	PAP
Lymphadenopathy-Associated Virus	LAV	Past Medical History	PMH
Lymph Node(s)	LN, LN'S, LNS	Pathology	PATH
Magnetic Resonance Imaging	MRI	Patient	PT
Malignant	MALIG, MAL	Pelvic Inflammatory Disease	PID
Mandible	MAND	Percussion and Auscultation	P&A
Mastectomy	MAST	Percutaneous	PERC
		Personal (Primary) Medical Doctor	PMD

**Common Acceptable Abbreviations
(in order of terms)**

Physical Examination	PE	Sequential Multiple Analysis	
Platelets	PLT	(Biochem Profile)	SMA
Poorly		Serum Glutamic Oxaloacetic	
Differentiated	PD, POOR DIFF	Transaminase	SGOT
Positive	POS (or +)	Serum Glutamic Pyruvic	
Positron Emission Tomography	PET	Transaminase	SGPT
Possible	POSS	Shortness of Breath	SOB
Posterior	POST	Skilled Nursing Facility	SNF
Posteroanterior	PA	Specimen	SPEC
Postmortem Examination	POST	Split Thickness Skin Graft	STSG
Postoperative (-ly)	PO, POSTOP	Small	SM, SML
Postoperative Day	POD	Small Bowel	SB, SML BWL
Preoperative (-ly)	PREOP	Spine	
Present Illness	PI	Cervical	C-SPINE
Prior to Admission	PTA	Lumbar	L-SPINE
Probable (-ly)	PROB	Sacral	S-SPINE
Progesterone Receptor (Assay)	PR(A)	Thoracic	T-SPINE
Prostatic Intraepithelial Neoplasia	PIN	Squamous	SQ, SQUAM
Pulmonary	PULM	Squamous Cell Carcinoma	SCC
Pulmonary Artery	PA	Squamous Intraepithelial Lesion	SIL
Radiation	RAD	Status Post	S/P
Radiation Absorbed Dose	RAD	Subcutaneous	SUB-Q, SUBQ, SQ
Radiation Therapy	RT/XRT	Superior Vena Cava	SVC
Radical	RAD	Surgery, Surgical	SURG
Radioimmunoassay	RIA	Symptoms	SX
Radium	RA	Thoracic	T
Red Blood Cells	RBC	Thoracic Vertebra	T1-T12
Resection	RESEC	Total Abdominal Hysterectomy-	
Respiratory	RESPIR	Bilateral Salpingo-	
Review of Outside Films	ROF	oophorectomy	TAH-BSO
Review of Outside Slides	ROS	Total Parenteral Nutrition	TPN
Review of Systems	ROS	Total Vaginal Hysterectomy	TVH
Right	R, RT	Transitional Cell Carcinoma	TCC
Right Costal Margin	RCM	Transurethral Resection	TUR
Right Lower Extremity	RLE	Transurethral Resection	
Right Lower Lobe	RLL	Bladder (Tumor)	TURB(T)
Right Lower Quadrant	RLQ	Transurethral Resection	
Right Middle Lobe	RML	Prostate	TURP
Right Salpingo-oophorectomy	RSO	Treatment	RX, TX
Right Upper Extremity	RUE	Tumor Size	TS
Right Upper Lobe	RUL	Undifferentiated	UNDIFF
Right Upper Quadrant	RUQ	Upper Extremity	UE
Rule Out	RO, R/O	Upper Gastrointestinal	UGI
Sacral Vertebra	S1-S5	Upper Inner Quadrant	UIQ
Salpingo-oophorectomy	SO	Upper Outer Quadrant	UOQ
Sentinal Lymph Node	SLN	Vagina, Vaginal	VAG

**Common Acceptable Abbreviations
(in order of terms)**

Vaginal Hysterectomy	VAG HYST	Symbols	
Vaginal Intraepithelial Neoplasia	VAIN	At	@
Vascular	VASC	Comparison	/
Vulvar Intraepithelial Neoplasia	VIN	Decrease, less than	<
Well		Equals	=
Differentiated	WD, WELL DIFF	Increase, more than	>
White Blood Cells	WBC	Negative	-
With	W/ or C	Number*	#
Within Normal Limits	WNL	Positive	+
Without	W/O	Pounds**	#
Work-up	W/U	Times	x
Xray	XR		
Year	YR		

*If it appears before a numeral.

**If it appears after a numeral.

APPENDIX M.2

COMMON ACCEPTABLE ABBREVIATIONS

(in order of abbreviations)

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ABD	Abdomen	BE	Barium Enema
ACID PHOS	Acid Phosphatase	BIL	Bilateral
A-COLON	Ascending Colon	BK(A)	Below Knee (Amputation)
ADENOCA	Adenocarcinoma	BM	Bone Marrow
ADJ	Adjacent	BM	Bowel Movement
ADM	Admission; Admit	BPH	Benign Prostatic Hypertrophy/Hyperplasia
AFP	Alpha-fetoprotein	BRB(PR)	Bright Red Blood (per Rectum)
AGL	Acute Granulocytic Leukemia	BRM	Biological Response Modifier
AIDS	Acquired Immunodeficiency Syndrome	BS, BRS	Breath Sounds
AIN	Anal Intraepithelial Neoplasia	BS	Bowel Sounds
AK(A)	Above Knee (Amputation)	BSC	Bone Scan
AKA	Also Known As	BSO	Bilateral Salpingo-oophorectomy
ALK PHOS	Alkaline Phosphatase	BUN	Blood Urea Nitrogen
ALL	Acute Lymphocytic Leukemia	BUS	Bartholin's, Urethral, & Skene's Glands
AMA	Against Medical Advice	BX	Biopsy
AMB	Ambulatory	C	With
AML	Acute Myelogenous Leukemia	C1-C7	Cervical Vertebra
ANAP	Anaplastic	CA	Calcium
ANGIO	Angiography	CA	Carcinoma
ANT	Anterior	CBC	Complete Blood Count
A&P	Auscultation & Percussion	CBD	Common Bile Duct
AP	Abdominal Perineal	CC	Chief Complaint
AP	Anteroposterior	CC	Cubic Centimeter
APP	Appendix	CEA	Carcinoembryonic Antigen
APPROX	Approximately	CGL	Chronic Granulocytic Leukemia
ARC	Aids Related Complex	CHEMO	Chemotherapy
ASP	Aspiration	CIG	Cigarettes
AUT	Autopsy	CIN	Cervical Intraepithelial Neoplasia
AV	Arteriovenous	CIS	Carcinoma In Situ
AX	Axilla(ry)	CLL	Chronic Lymphocytic Leukemia
BA	Barium	CLR	Clear
BCG	Bacillus Calmette-Guerin		
BD	Bile Duct		

**Common Acceptable Abbreviations
(in order of abbreviations)**

CM	Centimeter		Alcohol
CM	Costal Margin	EUA	Examination under Anesthesia
CML	Chronic Myeloid Leukemia	EVAL	Evaluation
CMV	Cytomegalovirus	EXAM	Examination
CNS	Central Nervous System	EXC	Excision
C/O	Complaining of	EXP LAP	Exploratory Laparotomy
CONT	Continue	EXT	Extend
CS	Cesium	EXT	Extension
CSF	Cerebrospinal Fluid	EXT	External
C-SPINE	Cervical Spine	EXT	Extremity
CT, CT SC	Computerized Axial Tomography Scan, CAT Scan	FB	Fingerbreadth
C/W	Consistent with	F(M)H	Family (Medical) History
CX	Cervix	FOM	Floor of Mouth
CXR	Chest Xray	FS	Frozen Section
CYSTO	Cystoscopy	FU	Follow-up
CYTO	Cytology	FUO	Fever Unknown Origin
D&C	Dilatation and Curettage	FX	Fracture
DC	Discontinued	GB	Gallbladder
DCIS	Ductal Carcinoma In Situ	GE	Gastroenterostomy
D-COLON	Descending Colon	GE	Gastroesophageal
DECR (or <)	Decreased	GI	Gastrointestinal
DERM	Dermatology	GM	Gram
DIAM	Diameter	GR	Grade
DIFF	Differentiated	GU	Genitourinary
DIN	Ductal Intraepithelial Neoplasia	GYN	Gynecology
DIS	Disease	HCG	Human Chorionic Gonadotropin
DIS, DISCH	Discharge	HCT	Hematocrit
DOA	Dead on Arrival	HEENT	Head, Eyes, Ears, Nose, Throat
DOB	Date of Birth	HGB	Hemoglobin
DR	(Medical) Doctor	HIV	Human Immunodeficiency Virus
DS	Discharge	HO	History of
DX	Diagnosis	HORM	Hormone
DZ	Disease	HOSP	Hospital
ECF	Extended Care Facility	H&P	History and Physical
EEG	Electroencephalogram	HPI	History of Present Illness
EENT	Eyes, Ears, Nose, and Throat	HPV	Human Papilloma Virus
EGD	Esophagogastroduodenoscopy	HR, HRS	Hour, Hours
EMG	Electromyogram	HSM	Hepatosplenomegaly
ENL	Enlarged	HTLV-III	Human T-Lymphotropic Virus Type III
ENT	Ears, Nose, and Throat	HX	History
ER	Emergency Room	HYST	Hysterectomy
ER(A)	Estrogen Receptor (Assay)	I	Iodine
ERCP	Endoscopic Retrograde Cholangiopancreatography	ICM	Intercostal Margin
ETOH		IG	Immunoglobulin

**Common Acceptable Abbreviations
(in order of abbreviations)**

IMA	Internal Mammary Artery	MAND	Mandible
IMP	Impression	MAST	Mastectomy
INCL	Includes, Including	MAX	Maxilla(ry)
INCR (or >)	Increase	MAX	Maximum
INFILT	Infiltrating	MC(H)	Millicurie(hours)
IP	Inpatient	MCL	Midclavicular Line
IT	Intrathecal	MD	Medical Doctor
IV	Intravenous	MD	Moderately Differentiated
IVC	Inferior Vena Cava	MED	Medicine
IVP	Intravenous Pyelogram	MET, METS	Metastatic, Metastases
JVD	Jugular Venous Distention	MEV	Million Electron Volts
KG	Kilogram	MG(H)	Milligram (hours)
KUB	Kidneys, Ureters, Bladder	MICRO	Microscopic
KV	Kilovolt	MIN	Minimum
L	Left	ML	Middle Lobe
L	Liter	ML	Milliliter
L1-L5	Lumbar Vertebra	MM	Millimeter
LAD/LAN	Lymphadenopathy	MOD	Moderate
LAP	Laparotomy	MOD DIFF	Moderately Differentiated
LAT	Lateral	MRI	Magnetic Resonance Imaging
LAV	Lymphadenopathy-Associated Virus	MRM	Modified Radical Mastectomy
LCIS	Laryngeal Intraepithelial Neoplasia	NA	Not Applicable
LCM	Left Costal Margin	NED	No Evidence of Disease
LE	Lower Extremity	NEG (or -)	Negative
LG	Large	NEURO	Neurology
LIQ	Lower Inner Quadrant	NL	Normal
LKS(B)	Liver, Kidney, Spleen (Bladder)	NOS	Not Otherwise Specified
LLE	Left Lower Extremity	NR	Not Recorded
LLL	Left Lower Lobe	NSF	No Significant Findings
LLQ	Left Lower Quadrant	N&V	Nausea and Vomiting
LMD	Local M.D.	NVD	Neck Vein Distention
LMP	Last Menstrual Period	OBST	Obstructed (-ing, -ion)
LN, LN'S, LNS	Lymph Node(s)	OP	Operation
LOQ	Lower Outer Quadrant	OP	Outpatient
LP	Lumbar Puncture	OP REPORT	Operative Report
LS	Lumbosacral	OR	Operating Room
LSO	Left Salpingo-oophorectomy	OZ	Ounce
L-SPINE	Lumbar Spine	P&A	Percussion and Auscultation
LT	Left	PA	Posteroanterior
LUE	Left Upper Extremity	PA	Pulmonary Artery
LUL	Left Upper Lobe	PALP	Palpated (-able)
LUQ	Left Upper Quadrant	PAP	Papanicolaou Smear
MAL, MALIG	Malignant	PAP	Papillary
		PATH	Pathology
		PD	Poorly Differentiated
		PE	Physical Examination

**Common Acceptable Abbreviations
(in order of abbreviations)**

PERC	Percutaneous	RUL	Right Upper Lobe
PET	Positron Emission Tomography	RUQ	Right Upper Quadrant
PI	Present Illness	RX	Treatment
PID	Pelvic Inflammatory Disease	S1-S5	Sacral Vertebra
PIN	Prostatic Intraepithelial Neoplasia	SB	Small Bowel
PLT	Platelets	SCC	Squamous Cell Carcinoma
PMD	Personal (Primary) Medical Doctor	S-COLON	Sigmoid Colon
PMH	Past Medical History	SGOT	Serum Glutamic Oxaloacetic Transaminase
PO	Postoperative (-ly)	SGPT	Serum Glutamic Pyruvic Transaminase
POD	Postoperative Day	SIL	Squamous Intraepithelial Lesion
POOR DIFF	Poorly Differentiated	SLN	Sentinal Lymph Node
POS (or +)	Positive	SM	Small
POSS	Possible	SMA	Sequential Multiple Analysis (Biochem Profile)
POST	Posterior	SML	Small
POST	Postmortem Examination	SML BWL	Small Bowel
POSTOP	Postoperative (-ly)	SNF	Skilled Nursing Facility
PPD	Packs per Day	SO	Salpingo-oophorectomy
PR(A)	Progesterone Receptor (Assay)	SOB	Shortness of Breath
PREOP	Preoperative (-ly)	S/P	Status Post
PROB	Probable (-ly)	SPEC	Specimen
PT	Patient	SQ	Subcutaneous
PTA	Prior to Admission	SQ, SQUAM	Squamous
PULM	Pulmonary	S-SPINE	Sacral Spine
R	Right	STSG	Split Thickness Skin Graft
RA	Radium	SUB-Q, SUBQ	Subcutaneous
RAD	Radiation	SURG	Surgery, Surgical
RAD	Radiation Absorbed Dose	SVC	Superior Vena Cava
RAD	Radical	SX	Symptoms
RBC	Red Blood Cells	T	Thoracic
RCM	Right Costal Margin	T1-T12	Thoracic Vertebra
RESEC	Resection	TAH-BSO	Total Abdominal Hysterectomy–Bilateral Salpingo-oophorectomy
RESPIR	Respiratory	TCC	Transitional Cell Carcinoma
RIA	Radioimmunoassay	T-COLON	Transverse Colon
RLE	Right Lower Extremity	TPN	Total Parenteral Nutrition
RLL	Right Lower Lobe	TS	Tumor Size
RLQ	Right Lower Quadrant	T-SPINE	Thoracic Spine
RML	Right Middle Lobe	TUR	Transurethral Resection
RO, R/O	Rule Out	TURB(T)	Transurethral Resection Bladder (Tumor)
ROF	Review of Outside Films	TURP	Transurethral Resection Prostate
ROS	Review of Outside Slides		
ROS	Review of Systems		
RSO	Right Salpingo-oophorectomy		
RT	Radiation Therapy		
RT	Right		
RUE	Right Upper Extremity		

**Common Acceptable Abbreviations
(in order of abbreviations)**

		Symbols	
TVH	Total Vaginal Hysterectomy		
TX	Treatment	@	At
UE	Upper Extremity	/	Comparison
UGI	Upper Gastrointestinal	<	Decrease, less than
UIQ	Upper Inner Quadrant	=	Equals
UNDIFF	Undifferentiated	>	Increase, more than
UOQ	Upper Outer Quadrant	-	Negative
VAG	Vagina, Vaginal	#	Number*
VAG HYST	Vaginal Hysterectomy		Pounds**
VAIN	Vaginal Intraepithelial Neoplasia	+	Positive
VASC	Vascular	x	Times
VIN	Vulvar Intraepithelial Neoplasia		
W/	With		
WBC	White Blood Cells		
WD, WELL DIFF	Well Differentiated		
WNL	Within Normal Limits		
W/O	Without		
W/U	Work-up		
XR	Xray		
XRT	Radiation Therapy		
YR	Year		

* If it appears before a numeral
 ** If it appears after a numeral

APPENDIX N

ICD-0-3 CODES TO BE CONSIDERED ONE PRIMARY SITE WHEN DETERMINING MULTIPLE PRIMARIES

ICD-0-3 Codes	Site Groupings
C01 C02	Base of tongue Other and unspecified parts of tongue
C05 C06	Palate Other and unspecified parts of mouth
C07 C08	Parotid gland Other and unspecified major salivary glands
C09 C10	Tonsil Oropharynx
C12 C13	Pyriform sinus Hypopharynx
C19 C20	Rectosigmoid junction Rectum
C23 C24	Gallbladder Other and unspecified parts of biliary tract
C30 C31	Nasal cavity and middle ear Accessory sinuses
C33 C34	Trachea Bronchus and lung
C37 C38.0-.3 C38.8	Thymus Heart and mediastinum Overlapping lesion of heart, mediastinum, and pleura
C40 C41	Bones, joints and articular cartilage of limbs Bones, joints and articular cartilage of other and unspec. sites
C51 C52 C57.7 C57.8-.9	Vulva Vagina Other specified female genital organs Overlapping lesion and female genital tract, NOS
C60 C63	Penis Other and unspecified male genital organs

**ICD-0-3 CODES TO BE CONSIDERED ONE PRIMARY SITE
WHEN DETERMINING MULTIPLE PRIMARIES**

ICD-0-3 Codes	Site Groupings
C64 C65 C66 C68	Kidney Renal pelvis Ureter Other and unspecified urinary organs
C74 C75	Adrenal gland Other endocrine glands and related structures

APPENDIX O

1980 CENSUS LIST OF SPANISH SURNAMES

INSTRUCTIONS FOR USING 1980 CENSUS LIST OF SPANISH SURNAMES

Attached is the 1980 Census List of Spanish Surnames. This list can be used to code last names in most areas of the United States.

1. All names are listed alphabetically in upper-case letters without any blanks or spaces. For example, names such as "De Leon", "De la Torre", or "La Luz" are shown as "DELEON", "DELATORRE", or "LALUZ".
2. Spanish surnames often have accent marks (´) or a tilde (~) over the n (ñ). Disregard accent marks or tildes as these marks have been omitted from the list. For example, the names "Martínez" and "Núñez" are listed as "MARTINEZ" and "NUNEZ".
3. If a surname consists of two names, separated by a dash or a space, code the person as Spanish if either name appears on the list. For example, for "Collins-Garcia", check "COLLINS" on the list. Since it does not appear, check for "GARCIA". If the name appeared as "Garcia-Collins", then "GARCIA" would be checked first.
4. If the surname is of the form "Lopez R.", ignore the initial and look up the name, "LOPEZ".
5. If the surname consists of two surnames separated by "de" such as "Perez de Seda", first look up the name written first, i.e., "PEREZ"; if it is not on the list, look up the final name including the word "de", i.e., "DESEDA"; if it is still not on the list, look up the final name without the word "de", i.e., "SEDA".
 - a. Surnames written with spaces which begin "de", "de la", or "del", such as "de la Cruz", should be looked up with and without the prefix words, i.e., "CRUZ", "LACRUZ", and "DELACRUZ". If any of the combinations is listed, the surname should be considered Spanish.

A			
ABAD	ABARCA	ABBADIE	ABERASTURI
ABADIA	ABARCO	ABDALA	ABERASTURIA
ABADIANO	ABAROA	ABEA	ABERGEL
ABADIAS	ABARQUEZ	ABEITA	ABESADA
ABADILLA	ABARTA	ABEJA	ABETE
ABADIN	ABARZUA	ABELAIRAS	ABEYTA
ABAIGAR	ABASCAL	ABELAR	ABEYTIA
ABAJO	ABASTA	ABELDANO	ABIEGA
ABALLE	ABASTAS	ABELED0	ABILA
ABALO	ABASTO	ABELLA	ABILES
ABALOS	ABAUNZA	ABELLAN	ABILEZ
ABAONZA	ABAURREA	ABELLEIRA	ABIN
	ABAY	ABELLERA	ABINA
	ABAYA	ABENDANO	ABIO

1980 CENSUS LIST OF SPANISH SURNAMES

ABIOL	ACEITUNO	AGEITOS	AGUINIGA
ABISLAIMAN	ACENCIO	AGIRRE	AGUINO
ABITIA	ACENEDO	AGON	AGUINS
ABITU	ACERA	AGOSTO	AGUIRE
ABITUA	ACEREDO	AGRA	AGUIRRA
ABLANEDO	ACERETO	AGRAIT	AGUIRRE
ABOGADO	ACERO	AGRAMONTE	AGUIRRECHU
ABOITE	ACETY	AGRAS	AGUIRREGAVIRIA
ABOITES	ACEUEDO	AGRAZ	AGUIRRES
ABOLILA	ACEVDO	AGREDA	AGUIRREZABAL
ABONCE	ACEVEDA	AGREDANO	AGULAR
ABORLLEILE	ACEVEDO	AGREGADO	AGULIAR
ABOY	ACEVES	AGRONT	AGULLES
ABOYTES	ACEVEZ	AGUABELLA	AGULLO
ABRAHANTE	ACEVIDO	AGUADO	AGUNDES
ABRAHANTES	ACHA	AGUALLO	AGUNDEZ
ABRAJAN	ACHEZ	AGUANO	AGUNDIS
ABRANTE	ACHON	AGUARISTI	AGUNDIZ
ABREA	ACIDO	AGUAS	AGUON
ABREGO	ACIN	AGUASVIVAS	AGURRIES
ABREO	ACOBÉ	AGUAYA	AGURTO
ABREU	ACOSTA	AGUAYO	AGUSTI
ABREUS	ACOYA	AGUDELO	AGVILAR
ABREUT	ACUESTA	AGUDO	AHEDO
ABREV	ACUNA	AGUEDA	AHIN
ABREW	ACUSTA	AGUELAR	AHUERO
ABREYO	ADAME	AGUERA	AHUMADA
ABRICA	ADAMES	AGUERO	AIBAR
ABRIGO	ADAMEZ	AGUEROS	AINSA
ABRIL	ADAN	AGUERRE	AINZ
ABRIOL	ADANZA	AGUERREBERE	AINZA
ABUIN	ADARGO	AGUERRIA	AIRA
ABUNDES	ADAROS	AGUET	AISA
ABUNDEZ	ADAUTO	AGUIGUI	AISO
ABUNDIS	ADELO	AGUILA	AISPURO
ABUNDIZ	ADONA	AGUILAR	AIZPURU
ABUNDO	ADORNO	AGUILER	AJUNTAS
ABURTO	ADRIASOLA	AGUILERA	AJURIA
ABUTIN	ADROVER	AGUILES	ALABADO
ACABA	ADROVET	AGUILLAR	ALACAN
ACABEO	ADUNA	AGUILLEN	ALACAR
ACARON	ADVINCULA	AGUILLERA	ALADRO
ACASTA	AEDO	AGUILLON	ALAEZ
ACCOSTA	AFAN	AGUILO	ALAFA
ACCUAR	AFANADOR	AGUILON	ALAFFA
ACEBAL	AFRE	AGUILOR	ALAGA
ACEBEDO	AGADO	AGUILOS	ALAGO
ACEBO	AGALA	AGUILU	ALAMAN
ACED	AGANZA	AGUILUZ	ALAMANO
ACEDO	AGAPITO	AGUINAGA	ALAMANZA

1980 CENSUS LIST OF SPANISH SURNAMES

ALAMARES	ALBERIO	ALCOLEA	ALELUNAS
ALAMBAR	ALBERRO	ALCON	ALEMAN
ALAMEDA	ALBERTORIO	ALCONTAR	ALEMANIA
ALAMIA	ALBERU	ALCORTA	ALEMANY
ALAMILLA	ALBEZ	ALCOSER	ALEMAR
ALAMILLO	ALBIAR	ALCOSET	ALEN
ALAMO	ALBIDRES	ALCOVER	ALENCASTRO
ALAMOS	ALBIDREZ	ALCOZAR	ALEQUIN
ALANIS	ALBILLAR	ALCOZER	ALERS
ALANIZ	ALBINES	ALCUDIA	ALERTE
ALANSO	ALBIOL	ALDABA	ALEVEDO
ALANZO	ALBISO	ALDABE	ALEXANDRINO
ALAUINES	ALBITRE	ALDACO	ALFALLA
ALAUINEZ	ALBIZO	ALDAHONDO	ALFARA
ALARCO	ALBIZU	ALDAMA	ALFARD
ALARCON	ALBO	ALDANA	ALFARO
ALARD	ALBONIGA	ALDAPA	ALFASSA
ALARDE	ALBOR	ALDAPE	ALFAU
ALARDIN	ALBORNOZ	ALDARONDO	ALFEREZ
ALARI	ALBORS	ALDAS	ALFONSECA
ALARICO	ALBUERNE	ALDASORO	ALFONSO
ALARID	ALBUJAR	ALDAVA	ALFONZO
ALARY	ALBURQUERQUE	ALDAVE	ALFRIDO
ALAS	ALCADE	ALDAYA	ALGARA
ALATORRE	ALCAIDA	ALDAZ	ALGARIN
ALATRISTE	ALCAIDE	ALDAZABAL	ALGARRA
ALAVA	ALCALA	ALDEBOT	ALGAVA
ALAVARADO	ALCALAN	ALDECOA	ALGEA
ALAVARDO	ALCALDE	ALDECOCEA	ALGECIRAS
ALAYA	ALCANIZ	ALDEIS	ALGORA
ALAYETO	ALCANTA	ALDEREGUIA	ALGORRI
ALAYO	ALCANTAR	ALDERETE	ALGORTA
ALAYON	ALCANTARA	ALDERETTE	ALGUACIL
ALBA	ALCANTARO	ALDERTE	ALGUESEVA
ALBACETE	ALCANTOR	ALDRETE	ALIAGA
ALBALADEJO	ALCARAS	ALDUEN	ALICANTE
ALBALATE	ALCARAZ	ALDUENDA	ALICCA
ALBALOS	ALCAREZ	ALEANTAR	ALICEA
ALBANA	ALCASAS	ALEBIS	ALICIA
ALBANDOZ	ALCAYDE	ALEDO	ALIJA
ALBANEZ	ALCAZAR	ALEGADO	ALINAYA
ALBAREDA	ALCE	ALEGRE	ALIPAZ
ALBARENGA	ALCEDO	ALEGRET	ALIRE
ALBAREZ	ALCERRECA	ALEGRIA	ALIRES
ALBARICO	ALCIBAR	ALEJANDRE	ALIREZ
ALBARRACIN	ALCIVAR	ALEJANDRES	ALLADICE
ALBARRAN	ALCOBER	ALEJANDREZ	ALLADO
ALBEAR	ALCOCER	ALEJANDRO	ALLALA
ALBELO	ALCOCES	ALEJO	ALLANDE
ALBERCA	ALCOLA	ALEJOS	ALLARID

1980 CENSUS LIST OF SPANISH SURNAMES

ALLEGRANZA	ALMIRALL	ALVARAZ	AMARILLA
ALLEGUE	ALMIRUDIS	ALVARDEZ	AMARILLAS
ALLEGUEZ	ALMODOBAR	ALVARDO	AMARO
ALLENDE	ALMODOUAR	ALVAREDO	AMAVISCA
ALLENEGUI	ALMODOVA	ALVARENGA	AMAVIZCA
ALLESANDRO	ALMODOVAR	ALVARES	AMAYA
ALLONGO	ALMOGABAR	ALVAREZ	AMBE
ALLOZA	ALMOGUERA	ALVARIDO	AMBEGUIA
ALMA	ALMOINA	ALVARINO	AMBERT
ALMADA	ALMONACID	ALVARODO	AMBI
ALMADO	ALMONDOVAR	ALVARRAN	AMBRIS
ALMADOVA	ALMONTE	ALVARY	AMBRIZ
ALMAGER	ALMONTES	ALVEAR	AMEJORADO
ALMAGNER	ALMORA	ALVELAIS	AMELY
ALMAGRO	ALMUINA	ALVELO	AMENABAR
ALMAGUER	ALOMA	ALVERADO	AMENEDO
ALMANCE	ALOMAR	ALVERANGA	AMENGUAL
ALMANDOZ	ALONA	ALVERES	AMESCUA
ALMANSA	ALONSO	ALVEREZ	AMESGUITA
ALMANZA	ALONZO	ALVERIO	AMESOLA
ALMANZAN	ALOY	ALVERO	AMESQUA
ALMANZAR	ALOYO	ALVEZ	AMESQUITA
ALMANZO	ALPIZAR	ALVIAR	AMESTI
ALMAQUER	ALPUCHE	ALVIDRES	AMESTOY
ALMARAS	ALPUIN	ALVIDREZ	AMEZAGA
ALMARAZ	ALQUICIRA	ALVILLAR	AMEZCUA
ALMARES	ALSINA	ALVIRA	AMEZOLA
ALMAREZ	ALTAGRACIA	ALVIRDE	AMEZQUITA
ALMARZA	ALTAMIRA	ALVIREZ	AMEZUA
ALMAZAN	ALTAMIRANO	ALVISO	AMIAL
ALMEDA	ALTARRIBA	ALVITRE	AMIEIRO
ALMEDINA	ALTENES	ALVIZAR	AMIEVA
ALMEJO	ALTIMIRANO	ALVIZO	AMIGO
ALMENA	ALTONAGA	ALVIZU	AMILL
ALMENAR	ALTOSINO	ALVO	AMIRA
ALMENARA	ALTRECHE	ALVORADO	AMIRES
ALMENARES	ALTUBE	ALZA	AMOR
ALMENDARES	ALTUNA	ALZAGA	AMORES
ALMENDAREZ	ALTUR	ALZALDE	AMOROS
ALMENDARIZ	ALTURET	ALZATE	AMOROZ
ALMENDRAL	ALTUZARRA	ALZINA	AMOSTEGUI
ALMENDRAS	ALUAREZ	ALZOLA	AMOZURRUTIA
ALMENGER	ALUIZO	ALZUGARAY	AMPARAN
ALMENGOR	ALUSTIZA	ALZURI	AMPARANO
ALMERA	ALUYON	AMABISCA	AMPARO
ALMERAZ	ALVA	AMADOR	AMPUDIA
ALMERIA	ALVANADO	AMAGO	AMPUERO
ALMESTICA	ALVARA	AMALBERT	ANADON
ALMEYDA	ALVARADA	AMALLA	ANALCO
ALMEZQUITA	ALVARADO	AMARGOS	ANALLA

1980 CENSUS LIST OF SPANISH SURNAMES

ANAMOSA	ANGLERO	ANZURES	ARAMBEL
ANASAGASTI	ANGOCO	APABLASA	ARAMBUL
ANAYA	ANGON	APADACA	ARAMBULA
ANAZAGASTY	ANGUEIRA	APAEZ	ARAMBULO
ANCHANDO	ANGUERA	APALATEGUI	ARAMBURO
ANCHIA	ANGUIANO	APALATEQUI	ARAMBURU
ANCHIETA	ANGUINO	APARICIO	ARAMENDIA
ANCHONDO	ANGUITA	APELLANIZ	ARAN
ANCHUNDIA	ANGULO	APEZTEGUIA	ARANA
ANCIRA	ANIAS	APODACA	ARANALDE
ANCISO	ANIBARRO	APODACO	ARANAS
ANDA	ANILLO	APODOCA	ARANAZ
ANDABLO	ANIZ	APOLINAR	ARANCIBIA
ANDALON	ANORGA	APONTE	ARANDA
ANDALUZ	ANQUIANO	APORTELA	ARANDIA
ANDASOLA	ANSALDUA	APRATO	ARANDO
ANDAVAZO	ANSALMO	APRICIO	ARANDULES
ANDAVERDE	ANSISO	APUAN	ARANEGUI
ANDAZOLA	ANSOATEGUI	AQUAYO	ARANETA
ANDEREZ	ANSOLABEHERE	AQUERO	ARANGO
ANDIARENA	ANSURES	AQUEVEQUE	ARANGUA
ANDINA	ANTA	AQUIAR	ARANGUIZ
ANDINO	ANTABLIN	AQUILAR	ARANGURE
ANDOLLO	ANTELO	AQUILERA	ARANGUREN
ANDRACA	ANTEQUERA	AQUILES	ARANIBAR
ANDRADA	ANTIGUA	AQUILLAR	ARANJON
ANDRADE	ANTILLON	AQUIN	ARANO
ANDRADES	ANTIMO	AQUINAGA	ARANZA
ANDRADO	ANTOLIN	AQUINES	ARANZAZU
ANDREOLAS	ANTOLINEZ	AQUIRRE	ARANZUBIA
ANDREU	ANTOMARCHY	ARA	ARAOZ
ANDREZ	ANTONETTY	ARABALO	ARAQUE
ANDRIAL	ANTOPIA	ARABI	ARATER
ANDRINO	ANTRILLO	ARABITG	ARAUGO
ANDUAGA	ANTU	ARACENA	ARAUS
ANDUEZA	ANTUNA	ARACHE	ARAUSA
ANDUIZA	ANTUNANO	ARADILLAS	ARAUX
ANDUJA	ANTUNEZ	ARAGO	ARAUZ
ANDUJAL	ANZALDA	ARAGON	ARAUZA
ANDUJAR	ANZALDO	ARAGONES	ARAVENA
ANDUJO	ANZALDUA	ARAGONEZ	ARAVJO
ANDUYO	ANZAR	ARAGUAS	ARAYA
ANDUZE	ANZARA	ARAGUNDI	ARAYATA
ANEIRO	ANZARDO	ARAGUS	ARBALLO
ANEIROS	ANZELDE	ARAGUZ	ARBELAEZ
ANEL	ANZORENA	ARAICA	ARBELBIDE
ANERO	ANZUA	ARAIN	ARBELLO
ANGELES	ANZUALDA	ARAIZ	ARBELO
ANGLADA	ANZUETO	ARAIZA	ARBESU
ANGLADE	ANZULES	ARAMAYO	ARBIDE

1980 CENSUS LIST OF SPANISH SURNAMES

ARBISO	ARCULETA	AREYAN	ARILES
ARBIZO	ARDAIZ	AREYANO	ARINEZ
ARBIZU	ARDANAZ	ARFE	ARINO
ARBOLAEZ	ARDANS	ARGAEZ	ARISMENDEZ
ARBOLAY	ARDANZ	ARGAIN	ARISMENDI
ARBOLEDA	ARDAVIN	ARGAIS	ARISOLA
ARBOLEYA	ARDIGO	ARGANDA	ARISPE
ARBONA	ARDILA	ARGANDONA	ARISSO
ARBUCIAS	ARDILLA	ARGANZA	ARISTA
ARBURUA	ARDOIS	ARGEANAS	ARISTE
ARCA	ARDON	ARGEL	ARISTIZABAL
ARCACHA	AREA	ARGENAL	ARISTO
ARCADIA	AREAN	ARGENTIN	ARISTONDO
ARCARAZO	AREAS	ARGIBAY	ARISTUD
ARCAS	AREBALO	ARGIL	ARISTY
ARCAUTE	AREBALOS	ARGILAGOS	ARIYASU
ARCAY	ARECES	ARGIZ	ARIZ
ARCAYA	ARECHAGA	ARGOMANIZ	ARIZA
ARCE	ARECHA VALETA	ARGOTE	ARIZABAL
ARCEGA	ARECHE	ARGUDIN	ARIZABALETA
ARCELAY	ARECHIGA	ARGUDO	ARIZAGA
ARCELO	ARECO	ARGUELIES	ARIZALA
ARCELONA	AREDONDO	ARGUELL	ARIZALETA
ARCENTALES	AREGON	ARGUELLES	ARIZMENDEZ
ARCEO	AREGULLIN	ARGUELLEZ	ARIZMENDI
ARCHE	AREIZAGA	ARGUELLO	ARIZMENDIS
ARCHIBEQUE	AREJULA	ARGUERA	ARIZMENDIZ
ARCHILA	ARELANO	ARGUESO	ARIZOLA
ARCHILLA	ARELLANA	ARGUETA	ARIZON
ARCHULETA	ARELLAND	ARGUEZ	ARIZPE
ARCHULETO	ARELLANDO	ARGUIJO	ARIZTIA
ARCHULETTA	ARELLANES	ARGUILEZ	ARIZU
ARCHULTA	ARELLANEZ	ARGUILLES	ARJON
ARCHUNDE	ARELLANO	ARGUILLIN	ARJONA
ARCHUNDIA	ARELLANOS	ARGUINDEGUI	ARMADA
ARCHUTETA	ARELLIN	ARGUINZONI	ARMADILLO
ARCHVLETA	ARENAL	ARGULA	ARMADO
ARCIA	ARENAS	ARGULLIN	ARMAIZ
ARCIAGA	ARENAZ	ARGUMANIZ	ARMANDARIZ
ARCIBA	ARENAZA	ARGUMEDO	ARMARIO
ARCIDES	ARENCIBIA	ARGUMOSA	ARMAS
ARCIGA	ARENDAIN	ARIA	ARMENDA
ARCILA	ARENIBAS	ARIAS	ARMENDARES
ARCINAS	ARENIVAR	ARIAZ	ARMENDAREZ
ARCINIAGA	ARENIVAS	ARIAZA	ARMENDARIS
ARCINIEGA	ARES	ARIBAS	ARMENDARIZ
ARCINO	ARESTEGUI	ARICHETA	ARMENDEZ
ARCIZO	AREU	ARIEY	ARMENDIA
ARCOS	AREVALO	ARIGA	ARMENGOL
ARCOVERDE	AREVALOS	ARIGULLIN	ARMENTA

1980 CENSUS LIST OF SPANISH SURNAMES

ARMENTERO	ARRASTIA	ARRIVILLAGA	ARTOLA
ARMENTEROS	ARRATIA	ARRIZOLA	ARTOLOZAGA
ARMERO	ARRAYA	ARRIZON	ARTURET
ARMESTO	ARRAZCAETA	ARROCENA	ARTUZ
ARMIENTA	ARRAZOLA	ARROJAS	ARUCA
ARMIGO	ARREA	ARROJO	ARUFE
ARMIJO	ARREAGA	ARROLLADO	ARUIZU
ARMIJOS	ARREALA	ARROLLO	ARUJO
ARMINAN	ARREAZOLA	ARRONA	ARUS
ARMINANA	ARREBOLA	ARRONDO	ARUZ
ARMITO	ARRECHE	ARRONGE	ARVALLO
ARMO	ARRECHEA	ARRONIZ	ARVAYO
ARMOLA	ARREDENDO	ARRONTE	ARVELO
ARMORA	ARREDONDA	ARROYA	ARVISU
ARNADO	ARREDONDO	ARROYAS	ARVIZA
ARNAEZ	ARREGUI	ARROYAVE	ARVIZO
ARNAIZ	ARREGUIN	ARROYO	ARVIZU
ARNALDO	ARREGUY	ARROYOS	ARZA
ARNAVAT	ARRELLANO	ARROZ	ARZABAL
ARNEDO	ARRELLIN	ARRUE	ARZABALA
ARNERO	ARRENDO	ARRUFAT	ARZAGA
ARNIELLA	ARRENDONDO	ARSATE	ARZAGOITIA
AROCENA	ARRENQUIN	ARSOLA	ARZAMENDI
AROCHA	ARREOLA	ARSUAGA	ARZAPALO
AROCHE	ARREQUIBE	ARTACHE	ARZATE
AROCHI	ARREQUIN	ARTALEJO	ARZAVE
AROCHO	ARRESTOY	ARTAU	ARZENO
AROIZA	ARRETCHE	ARTAUD	ARZOLA
AROS	ARREY	ARTAVIA	ARZON
AROSEMENA	ARREYGUE	ARTAZA	ARZU
AROSTEGUI	ARREZOLA	ARTEA	ARZUAGA
AROYA	ARRIAGA	ARTEAGA	ASAD
AROYO	ARRIAGO	ARTEAGO	ASCANO
ARoz	ARRIARAN	ARTECHE	ASCAR
ARozENA	ARRIASOLA	ARTECONA	ASCARATE
ARPON	ARRIAZA	ARTEGA	ASCARRUNZ
ARQUELLES	ARRIAZOLA	ARTEGO	ASCENCIO
ARQUELLO	ARRIBA	ARTELLAN	ASCENCION
ARQUER	ARRIBAS	ARTERO	ASCENSIO
ARQUERO	ARRIERA	ARTESONA	ASCUNCE
ARQUES	ARRIERO	ARTETA	ASEBEDO
ARQUETA	ARRIETA	ARTIAGA	ASENCIO
ARQUIMBAU	ARRIETE	ARTIDIELLO	ASENCION
ARQUIZA	ARRIETTA	ARTIEDA	ASENJO
ARRABAL	ARRIGA	ARTIGA	ASENSIO
ARRACHE	ARRILLAGA	ARTIGAS	ASEO
ARRAIGA	ARRIOLA	ARTIGO	ASEVEDO
ARRAIZA	ARRIQUIDEZ	ARTILES	ASEVES
ARRAMBIDE	ARRISOLA	ARTIME	ASIS
ARRANAGA	ARRITOLA	ARTIZ	ASOMOZA

1980 CENSUS LIST OF SPANISH SURNAMES

ASPEITIA	AUMADA	AYUSO	BADELLO
ASPERIN	AURIOLES	AZA	BADIA
ASPEYTIA	AURRECOECHEA	AZARES	BADIAL
ASPIAZU	AUZA	AZCANO	BADIAS
ASPILLAGA	AVALA	AZCARATE	BADILLA
ASPIRAS	AVALO	AZCARRAGA	BADILLO
ASPRA	AVALOS	AZCARRETA	BADIO
ASPURIA	AVALOZ	AZCOITIA	BADIOLA
ASPURO	AVARCA	AZCONA	BAELLA
ASPURU	AVECHUCO	AZCUE	BAELLO
ASSEO	AVECILLAS	AZCUI	BAENA
ASSIS	AVELAR	AZCUY	BAERGA
ASTACIO	AVELLAN	AZIOS	BAESA
ASTENCIO	AVELLANAL	AZNAR	BAEZ
ASTENGO	AVELLANAL	AZNAREZ	BAEZA
ASTIAZARAN	AVELLANETA	AZOCA	BAEZCRUZ
ASTIZ	AVENDANO	AZOCAR	BAGU
ASTOL	AVIGAEL	AZOFRA	BAGUE
ASTORGA	AVILA	AZOR	BAGUER
ASTRAN	AVILAS	AZOY	BAGUERO
ASTUDILLO	AVILES	AZPEITIA	BAGUES
ASTURIAS	AVILEZ	AZPIAZU	BAGUEZ
ASUA	AVILLAN	AZPIRI	BAHADUE
ASUEGA	AVILUCEA	AZPIROZ	BAHAMON
ASUNSOLO	AVINA	AZUA	BAHAMONDE
ASURMENDI	AVITA	AZUARA	BAHAMONDES
ASUSTA	AVITEA	AZUCENA	BAHAMUNDI
ATALA	AVITIA	AZUELA	BAHENA
ATANACIO	AVITUA	AZUETA	BAIDA
ATANCIO	AYABARRENO	AZURDIA	BAIGEN
ATAYDE	AYALA		BAILEZ
ATECA	AYALLA	B	BAILLERES
ATEHORTUA	AYALO	BABARAN	BAILON
ATENCIO	AYAN	BABIDA	BAIRES
ATIENZA	AYARZAGOITIA	BABILONIA	BAISA
ATIENZO	AYBAR	BABIO	BAISDON
ATILANO	AYCART	BACA	BAIZ
ATILES	AYENDE	BACALLAO	BAIZA
ATONDO	AYERBE	BACARDI	BAJADA
ATRA	AYERDI	BACCA	BAJANA
ATRIO	AYERZA	BACELIS	BAJANDAS
ATTENCIO	AYES	BACERRA	BAJE
ATUCHA	AYESTARAN	BACHICHA	BAJO
AUCES	AYLLON	BACILIO	BALADES
AUDELO	AYMAT	BACOS	BALADEZ
AUFFANT	AYMERICH	BACOSA	BALADO
AUGILAR	AYOLA	BADA	BALADRON
AUILA	AYON	BADAJOS	BALAEZ
AUILES	AYORA	BADAJOSA	BALAGIA
AULET	AYOROA	BADELLA	BALAGOT

1980 CENSUS LIST OF SPANISH SURNAMES

BALAGUE	BALDIZAN	BALSERA	BARANDIARAN
BALAGUER	BALDIZON	BALSINDE	BARASORDA
BALAGUERA	BALDOMERO	BALTAR	BARAY
BALAIS	BALDONADO	BALTASAR	BARAZ
BALAJADIA	BALDOQUIN	BALTAZAR	BARBA
BALANDRA	BALDOR	BALTIERRA	BARBACHANO
BALANDRAN	BALDOVINO	BALTIERREZ	BARBARENA
BALANDRANO	BALDOVINOS	BALTODANO	BARBASA
BALANGA	BALDOZ	BALUJA	BARBEITO
BALANON	BALDRICHE	BALVANEDA	BARBERAN
BALANZA	BALEME	BALVERDE	BARBERENA
BALAREZO	BALENCIA	BALZOLA	BARBOA
BALARIN	BALERIO	BAMUELOS	BARBOLA
BALART	BALERO	BANA	BARBONTIN
BALASQUIDE	BALESTERRI	BANAGA	BARBOSA
BALBANEDA	BALGOS	BANAGAS	BARCALA
BALBAS	BALIA	BANALES	BARCELO
BALBASTRO	BALIDO	BANANDO	BARCELON
BALBIN	BALINA	BANARER	BARCENA
BALBINA	BALIZAN	BANARES	BARCENAS
BALBOA	BALLADARES	BANCES	BARCENES
BALBONA	BALLADAREZ	BANCIELLA	BARCENEZ
BALBONTIN	BALLAGAS	BANDA	BARCENILLA
BALBUENA	BALLARDO	BANDERAS	BARCIA
BALCACER	BALLATE	BANDIN	BARCIGALUPIA
BALCARCEL	BALLEJO	BANDURRAGA	BARCIMO
BALCAZAR	BALLEJOS	BANEGAS	BARCINAS
BALCELLS	BALLERAS	BANEZ	BARCON
BALCORTA	BALLESTA	BANIQUED	BARCOS
BALDARAMOS	BALLESTAS	BANOS	BARDALES
BALDARRAMA	BALLESTE	BANREY	BARDINAS
BALDARRAMOS	BALLESTER	BANUELAS	BARDISA
BALDAZO	BALLESTERAS	BANUELOS	BAREA
BALDELOMAR	BALLESTERO	BANUET	BARED
BALDENEGRO	BALLESTEROS	BANVELOS	BARELA
BALDEON	BALLESTROS	BAO	BARELAS
BALDERA	BALLEZ	BAPTISTO	BARENCO
BALDERAMA	BALLEZA	BAQUEDANO	BARENO
BALDERAMOS	BALLI	BAQUERA	BARETTO
BALDERAS	BALLINA	BAQUERIZO	BAREZ
BALDERAZ	BALLINAS	BAQUERO	BARGARA
BALDEROS	BALLOTE	BAQUIRAN	BARGAS
BALDERRAMA	BALMACEDA	BARAGAN	BARGOS
BALDERS	BALMANA	BARAGANA	BARGUIARENA
BALDEVARONA	BALMASEDA	BARAGAS	BARILLAS
BALDEZ	BALMORES	BARAHONA	BARIN
BALDILLEZ	BALOSSO	BARAJAS	BARINAS
BALDIT	BALSA	BARAJOS	BARLOCO
BALDIVIA	BALSECA	BARALT	BARNACHEA
BALDIVIEZ	BALSEIRO	BARANDA	BARO

1980 CENSUS LIST OF SPANISH SURNAMES

BAROCIO	BARRIENTOS	BASORA	BAZA
BAROJAS	BARRIERA	BASQUES	BAZAIN
BAROS	BARRIERO	BASQUEZ	BAZALDUA
BAROSELA	BARRIGA	BASTANCHURY	BAZAMAN
BAROZ	BARRILLAS	BASTARDO	BAZAN
BARQUERA	BARRIO	BASTERRECHEA	BAZAURE
BARQUERO	BARRIONUEVO	BASTIDA	BAZUA
BARQUET	BARRIOS	BASTIDAS	BAZURTO
BARQUEZ	BARRO	BASTIDOS	BEADA
BARQUIN	BARROCAS	BASUA	BEANES
BARRAD	BARRONA	BASUALDO	BEAS
BARRAGAN	BARROSA	BASULTO	BEAZ
BARRAGAR	BARROSO	BASURA	BECARIA
BARRAGON	BARROTERAN	BASURCO	BECCERA
BARRAJAS	BARROZA	BASURTO	BECCERRA
BARRAL	BARROZO	BATALLA	BECEIRO
BARRALES	BARRUECO	BATALLAN	BECENA
BARRAMEDA	BARRUETA	BATAN	BECERA
BARRANDEY	BARSENAS	BATANIDES	BECERRA
BARRANO	BARTOLOME	BATILLA	BECERRIL
BARRANTES	BARTOLOMEY	BATINE	BECERRO
BARRAQUE	BARTUREN	BATIST	BECHARA
BARRARA	BARZA	BATISTA	BECHO
BARRASA	BARZAGA	BATIZ	BECUAR
BARRATACHEA	BARZANA	BATIZA	BEDIA
BARRAZ	BARZILLA	BATLLE	BEDOLLA
BARRAZA	BARZIZA	BATLLIA	BEDOY
BARREDA	BARZOLA	BATRES	BEDOYA
BARREDO	BAS	BATREZ	BEGA
BARREGO	BASABE	BATRIZ	BEGANO
BARREIRO	BASADRE	BATULE	BEGONA
BARRENA	BASAITES	BAUSA	BEGUIRISTAIN
BARRENECHE	BASALDO	BAUSTISTA	BEIRO
BARRENECHEA	BASALDU	BAUTA	BEISTEGUI
BARRENO	BASALDUA	BAUTISTA	BEITIA
BARRERA	BASALDUE	BAUZA	BEITRA
BARRERAGARCIA	BASALLO	BAUZO	BEJAR
BARRERAS	BASALO	BAYANILLA	BEJARAN
BARRERAZ	BASALOVA	BAYARDO	BEJARANO
BARRERO	BASANES	BAYARENA	BEJERANO
BARRETA	BASANEZ	BAYAS	BEJINES
BARRETO	BASANO	BAYCORA	BEJINEZ
BARREZUETA	BASANTES	BAYDES	BELA
BARRIA	BASCON	BAYLINA	BELANCOURT
BARRIAGA	BASCONCILLO	BAYLON	BELANDRES
BARRIAL	BASCOY	BAYO	BELARDE
BARRIAS	BASCUAS	BAYON	BELARDES
BARRIENTES	BASDEO	BAYONA	BELARDO
BARRIENTEZ	BASILLA	BAYRON	BELASQUEZ
BARRIENTO	BASOCO	BAYUGA	BELASQUIDA

1980 CENSUS LIST OF SPANISH SURNAMES

BELAUNDE	BENESTANTE	BERMEA	BESARES
BELAUNZARAN	BENETEZ	BERMEJILLO	BESCOS
BELAUSTEGUI	BENEVIDEZ	BERMEJO	BESERRA
BELAVAL	BENGOA	BERMEO	BESINAIZ
BELCHEZ	BENGOCHEA	BERMUDA	BESTARD
BELDEROL	BENIGUEZ	BERMUDES	BESTEIRO
BELÉN	BENINE	BERMUDEZ	BESU
BELÉNDEZ	BENIQUEZ	BERMUNDEZ	BETANCE
BELETTE	BENITES	BERNABE	BETANCES
BELEZ	BENITEZ	BERNAL	BETANCIS
BELIO	BENITO	BERNALDEZ	BETANCOURT
BELLAFLORES	BENITOA	BERNALL	BETANCOURTH
BELLEZ	BENOVIDEZ	BERNARDEZ	BETANCUR
BELLIARD	BENTA	BERNDES	BETANCURT
BELLIDO	BENTANCOUR	BERNELL	BETETA
BELLMAS	BENTANCOURT	BERNEZ	BETHENCOURT
BELLOSO	BENTANCUD	BERNUDEZ	BETONCOURT
BELMARES	BENTANCUR	BEROIZ	BETRAN
BELMAREZ	BENTURA	BERONDA	BEXAR
BELMONTES	BENUDIZ	BERRAYARZA	BEZA
BELMONTEZ	BENUN	BERRELES	BEZANILLA
BELMUDES	BENZAQUEN	BERRELEZ	BEZARES
BELMUDEZ	BEOVIDES	BERRELLEZ	BEZERRA
BELNAS	BEQUER	BERRELLEZA	BIANE
BELOZ	BERAIN	BERRERA	BIANES
BELTRA	BERASATEGUI	BERREYESA	BIANGEL
BELTRAN	BERAZA	BERRIOS	BIAR
BELTRANENA	BERBAN	BERRIOZABAL	BIASCOECHEA
BELTRE	BERBENA	BERRIZ	BIBIAN
BELVADO	BERBER	BERROA	BIBIANO
BENABE	BERBERENA	BERROCAL	BIBILONI
BENABIDES	BERCEDONIS	BERROCALES	BICHARA
BENADO	BERDEAL	BERRONES	BIDABE
BENALCAZAR	BERDECIA	BERROS	BIDAL
BENALLO	BERDEJA	BERROSPE	BIDART
BENAUIDES	BERDEJO	BERROTERAN	BIDET
BENAVIDEZ	BERDUGO	BERRU	BIDO
BENAVENT	BERDUSCO	BERRUECO	BIDOT
BENAVENTE	BEREA	BERRUECOS	BIEDMA
BENAVIDAS	BEREAL	BERSOSA	BIELMA
BENAVIDES	BERENQUER	BERSOZA	BIENES
BENAVIDEZ	BERENY	BERTAINA	BIERA
BENAVIDOS	BERGADO	BERTOT	BIGON
BENCOMO	BERGARA	BERTRAN	BILANO
BENCOSME	BERGEZ	BERUBEN	BILBAO
BENDALIN	BERGOLLA	BERUMEN	BILBRAUT
BENDAMIO	BERICOCHEA	BERUVIDES	BILLAFRANCO
BENEGAS	BERJAN	BERZOZA	BILLALBA
BENEJAN	BERLANGA	BESA	BILLALOBOS
BENERO	BERLANGO	BESADA	BILLESCAS

1980 CENSUS LIST OF SPANISH SURNAMES

BINAS	BOEZ	BORJON	BRANCACHO
BINELO	BOFILL	BORNIA	BRANCACIO
BINGOCHEA	BOGARIN	BORONDA	BRANDARIZ
BINIMELIS	BOHORQUEZ	BORONDO	BRANUELAS
BIRBA	BOILES	BOROVAY	BRASSELERO
BIRONDO	BOITES	BORQUEZ	BRASUEL
BIRRIEL	BOJORGES	BORRAJO	BRAULIO
BIRRUETA	BOJORGUEZ	BORRAS	BRAVO
BISA	BOJORQUES	BORRAYO	BREA
BISBAL	BOJORQUEZ	BORREGO	BRECEDA
BISCAILUZ	BOLADERES	BORRER	BREIJO
BISCAINO	BOLADO	BORRERO	BREMA
BISCAYART	BOLANO	BORRICO	BRENES
BISTRAIN	BOLANOS	BORRIOS	BRENLLA
BISUANO	BOLEDA	BORROEL	BRETADO
BITELA	BOLET	BORROTO	BRETO
BITHORN	BOLIVAR	BORRUEL	BRETOS
BITOLAS	BOLOIX	BORUNDA	BRIALES
BLADUELL	BOLTARES	BOSMENIER	BRIANO
BLAJOS	BOLUFE	BOSQUE	BRIAS
BLANCARTE	BOMBALIER	BOSQUES	BRIBIESCA
BLANCAS	BONACHEA	BOSQUEZ	BRIBIESCAS
BLANCO	BONAFONT	BOTANA	BRICENO
BLANCOCERDA	BONAL	BOTARD	BRIENO
BLANES	BONALES	BOTAS	BRIEVA
BLANQUET	BONEFONT	BOTELL	BRIGNONI
BLANQUEZ	BONET	BOTELLA	BRIJALBA
BLANQUIZ	BONETA	BOTELLO	BRIJIL
BLASQUEZ	BONICHE	BOTERO	BRILLANTES
BLAYA	BONILLA	BOTILLER	BRINGAS
BLAZQUEZ	BONILLAS	BOTILLO	BRINGUEZ
BLEA	BONILLO	BOUCOURT	BRIO
BLONDET	BONUZ	BOULLON	BRIONES
BOADA	BORAD	BOUZA	BRIONEZ
BOADO	BORBOA	BOUZAS	BRISENO
BOBADILLA	BORBOLLA	BOVADILLA	BRISITA
BOBADILLO	BORBON	BOVEDA	BRISO
BOBE	BORDAGARAY	BOVES	BRISUELA
BOBEA	BORDALLO	BRACAMONTE	BRITO
BOBEDA	BORDANO	BRACAMONTES	BRIZ
BOBELE	BORDAYO	BRACAMONTEZ	BRIZAL
BOBIAN	BORDEGARAY	BRACERO	BRIZENO
BOBILLO	BORDENAVE	BRACEROS	BRIZO
BOCACHICA	BORDOY	BRACHO	BRIZUELA
BOCANEGRA	BOREGO	BRADOR	BROCAS
BOCARDÓ	BORELA	BRAMASCO	BROCHE
BOCHAS	BORERO	BRAMBILA	BRONDO
BODERO	BORGUEZ	BRAMBILL	BROTONS
BODIROGA	BORJA	BRAN	BRUCELAS
BOERAS	BORJAS	BRANA	BRUCIAGA

1980 CENSUS LIST OF SPANISH SURNAMES

BRUGUERA	BURCIAGA	BUTANDA	CABEZA
BRUGUERAS	BURCIAGO	BUTERO	CABEZADEBACA
BRUSUELAS	BURCOS	BUTRON	CABEZAS
BRUZOS	BURDEOS	BUTTANDA	CABEZUDO
BUANTELLO	BURGADO	BUXEDA	CABEZUELA
BUBELA	BURGARA	BUXO	CABIAS
BUCETA	BURGENO	BUYON	CABIDO
BUCIO	BURGOA	BUZANI	CABIEDES
BUELNA	BURGOS	BUZNEGO	CABIGAS
BUENABAD	BURGUAN	BUZO	CABILLO
BUENAFE	BURGUENO		CABLA
BUENAVENTURA	BURGUETE	C	CABRALES
BUENCONSEJO	BURIEL	CAAL	CABRALEZ
BUENDEL	BURILLO	CAAMAL	CABRANES
BUENDIA	BURITICA	CAAMANO	CABRE
BUENFIL	BURNEO	CAAMPUED	CABREJA
BUENO	BURNIAS	CABA	CABREJAS
BUENROSTRO	BURQUEZ	CABADA	CABREJOS
BUENRROSTRO	BURRA	CABAL	CABRER
BUENSUCESO	BURRIEL	CABAL	CABRERA
BUENTELLO	BURRIOLA	CABALEIRO	CABRERAS
BUENTEO	BURROLA	CABALLA	CABRERIZO
BUENTIEMPO	BURRON	CABALLER	CABRERO
BUENTILLO	BURRUEL	CABALLERO	CABRERRA
BUERAS	BURSIAGA	CABALLEROS	CABRET
BUERES	BURUATO	CABALLES	CABREVA
BUERGO	BUSIGO	CABALLO	CABRIALES
BUFANDA	BUSQUET	CABAN	CABRIELES
BUGALLO	BUSQUETS	CABANAS	CABRILES
BUGARIN	BUSTABAD	CABANELAS	CABRILLO
BUIGAS	BUSTABADE	CABANERO	CABRILLOS
BUIGUES	BUSTAMANTE	CABANILLAS	CABRISAS
BUILES	BUSTAMANTES	CABANZON	CABRITO
BUILTRON	BUSTAMANTEZ	CABARCAS	CABRON
BUITRAGO	BUSTAMARTE	CABARCOS	CABUENA
BUITRON	BUSTAMENTE	CABARGA	CABUTO
BUITUREIDA	BUSTAMONTE	CABASA	CACERAS
BUITUREIRA	BUSTANANTE	CABASIER	CACERES
BUJAN	BUSTAS	CABASOS	CACEREZ
BUJANDA	BUSTED	CABASSA	CACHARRON
BUJANOS	BUSTELO	CABASSO	CACHO
BUJOSA	BUSTEMANTE	CABAZA	CACHON
BULERIN	BUSTILLO	CABAZOS	CACHORA
BULLAS	BUSTILLOS	CABEIRO	CACHUA
BULNES	BUSTINZA	CABEJE	CACICEDO
BULOS	BUSTIO	CABELLERO	CADAHIA
BULTRON	BUSTO	CABELLO	CADAVA
BURBANO	BUSTOS	CABERA	CADAVAL
BURBOA	BUSTOZ	CABERERA	CADAVID
BURCET	BUSUTIL	CABERRA	CADAVIECO
		CABESUELA	

1980 CENSUS LIST OF SPANISH SURNAMES

CADEMA	CALCINES	CALVET	CAMPACOS
CADENA	CALDA	CALVILLO	CAMPANERIA
CADENAS	CALDARON	CALVO	CAMPANIONI
CADENAZ	CALDAS	CALZADA	CAMPAS
CADENGO	CALDELAS	CALZADIAS	CAMPAZ
CADIerno	CALDERA	CALZADILLA	CAMPERO
CADILLA	CALDERAS	CALZADILLAS	CAMPILLO
CADILLO	CALDERILLA	CALZADO	CAMPINS
CADIS	CALDERIN	CALZIA	CAMPIRANO
CADIZ	CALDERO	CALZONCIN	CAMPISTA
CADORNIGA	CALDERON	CAMACH	CAMPIZ
CADRIEL	CALDEVILLA	CAMACHE	CAMPOAMOR
CAGIGA	CALEJO	CAMACHO	CAMPODONICA
CAGIGAL	CALENZANI	CAMAMA	CAMPOLLA
CAGIGAS	CALERA	CAMANCHO	CAMPOMANES
CAGUIAS	CALERO	CAMANEZ	CAMPORREDONDO
CAHUE	CALEZ	CAMANO	CAMPOS
CAICEDO	CALIBO	CAMARAZA	CAMPOSAGRADO
CAIGOY	CALIENES	CAMARELLA	CAMPOVERDE
CAILLAU	CALIX	CAMARENA	CAMPOY
CAINAS	CALIXTO	CAMARENO	CAMPOZ
CAINZOS	CALIXTRO	CAMARERO	CAMPOZANO
CAJAR	CALIZ	CAMARGO	CAMPUSANO
CAJAS	CALLADO	CAMARILLO	CAMPUZANO
CAJEN	CALLANTA	CAMARO	CAMUEIRAS
CAJERO	CALLAVA	CAMARON	CAMUNAS
CAJIAO	CALLAZO	CAMARRILLO	CAMUNES
CAJIDE	CALLE	CAMAYA	CAMUNEZ
CAJIGA	CALLEIRO	CAMAYD	CANA
CAJIGAL	CALLEJAS	CAMBA	CANABA
CAJIGAS	CALLEJO	CAMBALIZA	CANABAL
CAJINA	CALLEJON	CAMBERO	CANABATE
CAJO	CALLEJOS	CAMBEROS	CANAHUATI
CAJUSTE	CALLELLA	CAMBIANICA	CANALDA
CALABAZA	CALLEROS	CAMBIS	CANALEJO
CALAFAT	CALLES	CAMBLOR	CANALES
CALAFELL	CALLEYRO	CAMBO	CANALEZ
CALAMA	CALLINICOS	CAMBON	CANALITA
CALAMACO	CALLISTRO	CAMCHO	CANALS
CALAMARS	CALOCA	CAMEJO	CANAMAR
CALAMON	CALOMARDE	CAMERENA	CANAMERO
CALANA	CALONGA	CAMERO	CANAS
CALANCHE	CALONGE	CAMEZ	CANAVA
CALANDRES	CALONJE	CAMILO	CANAVATI
CALAS	CALSADA	CAMINA	CANAVERAL
CALATAYUD	CALSADILLAS	CAMINAS	CANAVES
CALBILLO	CALVEIRO	CAMINERO	CANCEL
CALCADO	CALVERA	CAMOCHO	CANCELA
CALCANEIO	CALVERO	CAMORODA	CANCELO
CALCANO	CALVES	CAMPA	CANCHE

1980 CENSUS LIST OF SPANISH SURNAMES

CANCHOLA	CANTOU	CARACOSA	CARDENAL
CANCINO	CANTOYA	CARACOZA	CARDENALES
CANCINOS	CANTRE	CARAJAL	CARDENAS
CANCIO	CANTRES	CARALT	CARDENAZ
CANDALES	CANTU	CARAMBOT	CARDENES
CANDANEDO	CANTUA	CARAMEROS	CARDENEZ
CANDANO	CANTUTIJERINA	CARAMES	CARDENO
CANDANOSA	CANUELAS	CARAMILLO	CARDENOS
CANDANOZA	CANZONA	CARANTA	CARDENOSA
CANDELARI	CAPABLANCA	CARANZA	CARDENTEY
CANDELARIA	CAPACETE	CARAPIA	CARDET
CANDELARIE	CAPARRA	CARARA	CARDEZA
CANDELARIO	CAPARROS	CARASA	CARDIEL
CANDELAS	CAPAS	CARASCO	CARDINAS
CANDELERIA	CAPATA	CARATACHEA	CARDINEZ
CANDIA	CAPDEVILA	CARATAN	CARDONA
CANDIAS	CAPELES	CARATTINI	CARDONAS
CANEDA	CAPELLAN	CARAVACA	CARDOSA
CANEDO	CAPELO	CARAVAJAL	CARDOVA
CANEGATA	CAPERON	CARAVANTES	CAREAGA
CANEIRO	CAPESTANY	CARAVAYO	CARELA
CANELA	CAPETILLO	CARAVEO	CARETA
CANELLAS	CAPIFALI	CARAVES	CARIAS
CANELLIS	CAPILLA	CARAZA	CARIBE
CANELO	CAPIN	CARAZO	CARIDE
CANERO	CAPIRO	CARBA	CARIDES
CANES	CAPISTRAN	CARBAJAL	CARIELO
CANET	CAPLANO	CARBAJALES	CARIGA
CANETE	CAPMANY	CARBAJO	CARILLO
CANEZ	CAPOTE	CARBALLAR	CARINGAL
CANGA	CAPRILES	CARBALLEA	CARINHAS
CANGAS	CAPRINE	CARBALLEIRA	CARIRE
CANION	CAPUCHIN	CARBALLIDO	CARISALEZ
CANISALES	CAPUCHINA	CARBALLO	CARLA
CANIZAL	CAPUCHINO	CARBALLOSA	CARLETTELLO
CANIZALES	CAQUIAS	CARBELLIDO	CARLOS
CANIZALEZ	CARABA	CARBIA	CARMENATE
CANIZARES	CARABAJAL	CARBONEL	CARMENATES
CANIZAREZ	CARABAL	CARBONELL	CARMENATY
CANJURA	CARABALLO	CARBOT	CARMOEGA
CANLAS	CARABALLOPEREZ	CARCACHE	CARMONA
CANO	CARABANTES	CARCAMO	CARNERA
CANOVAS	CARABAY	CARCANA	CARNERO
CANSECO	CARABAZA	CARCANAQUES	CARNICER
CANSINO	CARABELLA	CARCANO	CARNICERO
CANTARERO	CARABEO	CARCAS	CARO
CANTERO	CARABES	CARCELLERO	CARONADO
CANTILLO	CARABEZ	CARDELLE	CAROPINO
CANTORAN	CARACENA	CARDELLES	CARPENA
CANTOS	CARACHEO	CARDENA	CARPINTERO

1980 CENSUS LIST OF SPANISH SURNAMES

CARPINTEYRO	CARRILLE	CASARIEGO	CASTANED
CARPIO	CARRILLO	CASARRUBIAS	CASTANEDA
CARPIZO	CARRILO	CASAS	CASTANEDO
CARRABALLO	CARRIO	CASASNOVAS	CASTANER
CARRACEDO	CARRION	CASASOLA	CASTANIETO
CARRADA	CARRIQUE	CASASUS	CASTANO
CARRADERO	CARRISAL	CASAUS	CASTANOLA
CARRAL	CARRISALES	CASAVANTES	CASTANON
CARRALEJO	CARRISALEZ	CASCANTE	CASTANOS
CARRALERO	CARRISOSA	CASCON	CASTANUELA
CARRALES	CARRISOZA	CASCOS	CASTANY
CARRALEZ	CARRIZAL	CASCUDO	CASTEJON
CARRAMAN	CARRIZALES	CASELAS	CASTELA
CARRANCA	CARRIZALEZ	CASELLAS	CASTELAN
CARRANCO	CARRIZO	CASERAS	CASTELANO
CARRANTI	CARRIZOSA	CASERES	CASTELAO
CARRANSA	CARRIZOZA	CASERMA	CASTELAR
CARRANZA	CARRODEGUAS	CASERO	CASTELAZO
CARRASCO	CARROLA	CASERZA	CASTELBLANCO
CARRASCOSA	CARROSQUILLO	CASES	CASTELDEORO
CARRASQUILLO	CARRSCO	CASIA	CASTELEIRO
CARRASO	CARRUESCO	CASIAN	CASTELLANAS
CARRASQUILLA	CARTAGEN	CASIANO	CASTELLANES
CARRASQUILLO	CARTAGENA	CASIAS	CASTELLANOS
CARRATALA	CARTAGO	CASICA	CASTELLANOZ
CARRAU	CARTANA	CASIELLES	CASTELLAR
CARRAZANA	CARTAS	CASILLA	CASTELLON
CARRAZCO	CARTAYA	CASILLAN	CASTELLS
CARREAGA	CARUAJAL	CASILLAS	CASTELLVI
CARREDO	CARVAJAL	CASILLOS	CASTELNAU
CARREJO	CARVAJALES	CASINES	CASTELO
CARRENO	CARVAJALINO	CASIQUE	CASTENADA
CARREON	CASABLANCA	CASIQUITO	CASTENEDA
CARRERA	CASABO	CASIS	CASTIBLANCO
CARRERAS	CASADAS	CASMERO	CASTIEL
CARRERO	CASADES	CASORLA	CASTILIO
CARRETE	CASADO	CASPARIS	CASTILL
CARRETERO	CASADOS	CASPILLO	CASTILLA
CARRETO	CASAIS	CASSARES	CASTILLANOS
CARRIAGA	CASAL	CASSAS	CASTILLAS
CARRIAZO	CASALES	CASSIAS	CASTILLEJA
CARRICA	CASALS	CASSILLAS	CASTILLEJO
CARRICABURU	CASAMAYOR	CASSINERIO	CASTILLEJOS
CARRICARTE	CASANAS	CASSO	CASTILLERO
CARRIDO	CASANDRA	CASTAIGNE	CASTILLIO
CARRIEDO	CASANOVA	CASTAN	CASTILLO
CARRIJO	CASANOVAS	CASTANA	CASTILLON
CARRIL	CASANUEVA	CASTANADA	CASTINEIRA
CARRILES	CASARES	CASTANARES	CASTINEIRAS
CARRILLA	CASAREZ	CASTANEADA	CASTINEYRA

1980 CENSUS LIST OF SPANISH SURNAMES

CASTORENA	CAVIEL	CELAYETA	CERTEZA
CASTORENO	CAVLA	CELEDON	CERUANTES
CASTRA	CAVOS	CELEIRO	CERVANES
CASTREJON	CAVOZOS	CELICEO	CERVANTE
CASTRELLON	CAYADO	CELIS	CERVANTES
CASTRESANA	CAYANAN	CELIZ	CERVANTEZ
CASTRILLO	CAYCEDO	CELORIO	CERVENTES
CASTRILLON	CAYERE	CENA	CERVERA
CASTRIZ	CAYEROS	CENDAN	CESANI
CASTRO	CAYIAS	CENDEJAS	CESENA
CASTRODAD	CAYON	CENDOYA	CESIN
CASTROMAN	CAYUELA	CENICEROS	CESPEDES
CASTRON	CAYUSO	CENISEROS	CESPEDEZ
CASTROVERDE	CAZAMIAS	CENISEROZ	CESTERO
CASTRUITA	CAZANAS	CENOZ	CEVALLO
CASUL	CAZARES	CENTELLAS	CEVALLOS
CASUSO	CAZAREZ	CENTENO	CEVILLA
CATA	CAZARIN	CENTERO	CEYANES
CATACALOS	CAZON	CENTURION	CHABARRIA
CATACHE	CDEBACA	CEPEDA	CHABERA
CATALA	CDEVACA	CEPEDES	CHABEZ
CATALAN	CEBADA	CEPERO	CHABOLLA
CATALENA	CEBALLES	CERABELLA	CHABOYA
CATANACH	CEBALLO	CERALDE	CHABRIER
CATANO	CEBALLOS	CERBANTES	CHACA
CATAQUET	CEBEY	CERBANTEZ	CHACANACA
CATASCA	CEBOLLERO	CERCADO	CHACON
CATASUS	CEBRERO	CERDA	CHADES
CATEORA	CEBREROS	CERDEIRA	CHADEZ
CATETE	CEBRIAN	CERDEIRAS	CHAFFINO
CATOLICO	CECENA	CERECEDA	CHAFINO
CATZOELA	CEDANO	CERECEDAS	CHAGAS
CAUAZOS	CEDENO	CERECEDO	CHAGOLLA
CAUCE	CEDILLO	CERECERES	CHAGOLLAN
CAUDALES	CEDILLOS	CERECEREZ	CHAGOY
CAUDILLO	CEDINO	CERECERO	CHAGOYA
CAULA	CEDO	CEREIJO	CHAGOYAN
CAUNDER	CEGARRA	CEREZO	CHAGOYEN
CAUSO	CEGUEDA	CERIN	CHAGRA
CAVANAS	CEIDE	CERMENO	CHAGUACEDA
CAVASAS	CEIJAS	CERNA	CHAIDES
CAVASOS	CEJA	CERNAS	CHAIDEZ
CAVAZ	CEJAS	CERNO	CHAIRA
CAVAZAS	CEJO	CERNUDA	CHAIREZ
CAVAZOS	CEJUDO	CERON	CHALA
CAVAZOZ	CELA	CERPA	CHALAMBAGA
CAVEDA	CELADA	CERRILLO	CHALDU
CAVERO	CELADO	CERRILLOS	CHAMARTIN
CAVEZA	CELARDO	CERRITOS	CHAMIZO
CAVIEDES	CELAYA	CERROS	CHAMORO

1980 CENSUS LIST OF SPANISH SURNAMES

CHAMORRO	CHAVERO	CHIQUETE	CIONCO
CHANDARLIS	CHAVEZ	CHIQUITO	CIPRES
CHANES	CHAVIANO	CHIRIBOGA	CIREROL
CHANEZ	CHAVIRA	CHIRINO	CIRES
CHANGALA	CHAVIRO	CHIRINOS	CIRIA
CHANO	CHAVOLLA	CHOA	CIRIECO
CHANONA	CHAVOYA	CHOLICO	CIRILO
CHANTACA	CHAYRA	CHOMAT	CIRIZA
CHANTALA	CHAYRE	CHOMORI	CIRLOS
CHANTRES	CHAYREZ	CHONO	CIRULI
CHAPA	CHAZARO	CHOPERENA	CISNER
CHAPARRO	CHAZARRETA	CHORNA	CISNERAS
CHAPELA	CHECA	CHOTO	CISNERNOS
CHAPERO	CHECO	CHOUZA	CISNERO
CHAPOY	CHEDA	CHOZA	CISNEROS
CHAPPARO	CHEMALI	CHUCA	CISNEROZ
CHAPRALIS	CHENTE	CHUDALLA	CISTERNA
CHAPRON	CHERENA	CHUMACERO	CIVEROLO
CHARAFA	CHERENE	CHUMISO	CLARA
CHARANZA	CHERINO	CHUPE	CLARIT
CHARBA	CHERTA	CHURBE	CLARO
CHARBULA	CHESSANI	CHURRUCA	CLAROS
CHARCA	CHEVANNES	CIBERAY	CLAROT
CHARCAS	CHEVARRIA	CIBRIAN	CLAUDIO
CHARDON	CHEVAS	CICERON	CLAUSTRO
CHARFAUROS	CHEVERES	CICILIA	CLAVEL
CHARNECO	CHEVEREZ	CID	CLAVELL
CHARO	CHEVEZ	CIDDIO	CLAVELO
CHARRES	CHEVRES	CIEGO	CLAVERAN
CHARRIA	CHIAGO	CIENA	CLAVERIA
CHARRIEZ	CHIAPA	CIENEGA	CLAVERO
CHARRIN	CHICA	CIENEGAS	CLAVIJO
CHARRIS	CHICAS	CIENFUEGOS	CLEMENA
CHARRO	CHICO	CIERRA	CLERO
CHARVEZ	CHICVARA	CIFRE	CLIMENT
CHATON	CHIDE	CIFREDO	COBA
CHAUARRIA	CHIFALO	CIFUENTES	COBALLES
CHAVANA	CHIHUAHUA	CIGAR	COBAR
CHAVANNA	CHILIMIDOS	CIGARROA	COBARRUBIA
CHAVARELA	CHIMAL	CILLERO	COBARRUBIAS
CHAVARIA	CHINANA	CIMADEVILLA	COBARRUBIO
CHAVARILLO	CHINCHILLA	CIMARRON	COBARRUVIAS
CHAVARIN	CHINEA	CIMENTAL	COBAS
CHAVARRA	CHINO	CINDO	COBELO
CHAVARRI	CHIONG	CINEUS	COBEO
CHAVARRIA	CHIONO	CINTA	COBIAN
CHAVARRIAGA	CHIOVARE	CINTAS	COBIELLA
CHAVARRO	CHIPI	CINTORA	COBIO
CHAVECO	CHIPRES	CINTRA	COBO
CHAVERA	CHIQUES	CINTRON	COBOS

1980 CENSUS LIST OF SPANISH SURNAMES

COBREIRO	COLONDRES	CONSONERO	CORDOSO
COCA	COLONNETTA	CONSTANCIO	CORDOVA
COCIO	COLONTORRES	CONSTANTE	CORDOVER
CODINA	COLORADO	CONSUEGRA	CORDOVES
CODON	COLORBIO	CONSUELO	CORDOVEZ
CODORNIZ	COLORE	CONTADOR	CORDOVI
COELLO	COLORES	CONTEMPRATO	CORDOZA
COFINO	COLOROSO	CONTERAS	COREANO
COFRESI	COLSA	CONTEREAS	CORELLA
COIRA	COLUDRO	CONTERO	CORENTE
COLACION	COLUMBIE	CONTIVAL	CORIA
COLACO	COLUNGA	CONTRARAS	CORIANO
COLARTE	COMACHO	CONTREAS	CORIAT
COLAS	COMADURAN	CONTRERA	CORIZ
COLATO	COMAS	CONTRERAS	CORMALIS
COLCA	COMBARRO	CONTRERASS	CORNEJO
COLCHADO	COMELLAS	CONTRERAZ	CORNEJOS
COLDERON	COMESANA	CONTRERES	CORNIDE
COLDIVAR	COMESANAS	CONTREROS	CORNIELL
COLEGIO	COMON	CONTRERRAS	CORNIER
COLET	COMORRE	CONTRESAS	CORODOVA
COLIMA	COMPANIONI	CONTRESTANO	COROMINAS
COLINA	COMPARAN	CONTREVAS	CORONA
COLINDRES	COMPARY	COPADO	CORONADA
COLIO	COMPEAN	COPETILLO	CORONADO
COLLADA	COMPIAN	COPRIVIZA	CORONAS
COLLADO	COMPITO	COQUOZ	CORONEL
COLLANTES	COMPOS	CORA	CORPAS
COLLASO	COMPTIS	CORALES	CORPION
COLLAZO	CONCEPCION	CORANADO	CORPORAN
COLLOZO	CONCEPTION	CORAZON	CORPOS
COLLS	CONCHA	CORBALA	CORPUS
COLMENAR	CONCHADO	CORBEA	CORRADA
COLMENARES	CONCHAS	CORBELLA	CORRAL
COLMENERO	CONCHO	CORBERA	CORRALEJO
COLOCHO	CONCHOLA	CORCES	CORRALES
COLOCIO	CONCHOS	CORCHADO	CORRALEZ
COLODRO	CONDADO	CORCHERO	CORRALIZA
COLOM	CONDARCO	CORCHETE	CORRALLS
COLOMA	CONDE	CORCHO	CORRCA
COLOMAR	CONDENSA	CORCINO	CORREA
COLOMBANA	CONEJERO	CORCOLES	CORREDERA
COLOMBANI	CONEJO	CORCOVELOS	CORREDOR
COLOMBERO	CONESA	CORDENIZ	CORREO
COLOME	CONFORME	CORDERO	CORRES
COLOMER	CONRADO	CORDILLO	CORRETJER
COLOMES	CONRERAS	CORDOBA	CORREU
COLOMINAS	CONRIQUE	CORDOBES	CORRILLO
COLOMO	CONRIQUEZ	CORDOLA	CORRIPIO
COLON	CONS	CORDONA	CORRIZ

1980 CENSUS LIST OF SPANISH SURNAMES

CORROS
CORTADA
CORTAZA
CORTAZAR
CORTES
CORTEZ
CORTIJO
CORTINA
CORTINAS
CORTINAZ
CORTINES
CORTINEZ
CORTIZO
CORUGEDO
CORUJO
CORVAN
CORVERA
CORVISON
CORZA
CORZO
COS
COSCULLUELA
COSILLO
COSILLOS
COSIO
COSME
COSSIO
COSSO
COSTALES
COSTELON
COSTILLA
COSTILLO
COSTOSO
COSTRUBA
COTA
COTARELO
COTAYO
COTELO
COTERA
COTERILLO
COTERO
COTILLA
COTINOLA
COTITTA
COTO
COTRINA
COTTES
COTTO
COTULLA
COUARRUBIAS

COUCE
COUCEYRO
COUMPAROULES
COUSO
COUTIN
COUTINO
COUVERTIER
COVARRUBIA
COVARRUBIAS
COVARRUBIAZ
COVARRUBIO
COVARRUVIAS
COVARRYBIAS
COVARUBIAS
COVAS
COVIAN
COVILLO
COVIO
COVO
COVOS
COYA
COYAZO
CREITOFF
CREMAR
CREMATA
CRESPIN
CRESPO
CRIADO
CRIBEIRO
CRIOLLO
CRIOYOS
CRISANTES
CRISANTO
CRISANTOS
CRISOSTO
CRISOSTOMO
CRISTALES
CRISTAN
CRISTANCHO
CRISTERNA
CRISTIA
CRISTIAN
CRISTIN
CRISTOBAL
CRISTOFOL
CRIXELL
CROSAS
CROZ
CRUANES
CRUANYAS

CRUCES
CRUCETA
CRUZ
CRUZADO
CRUZAT
CRUZATA
CRUZCOSA
CRUZCRUZ
CRUZON
CRUZRODRIGUEZ
CUADRA
CUADRADO
CUADRAS
CUADRAZ
CUADRO
CUADROS
CUAN
CUARA
CUARENTA
CUARON
CUARTAS
CUASCUT
CUATE
CUBANO
CUBAS
CUBENAS
CUBERO
CUBIAS
CUBILLAS
CUBILLO
CUBILLOS
CUBIO
CUBRIEL
CUCALON
CUCUTA
CUEBA
CUEBAS
CUELIAR
CUELLA
CUELLAR
CUELLER
CUELLO
CUEN
CUENCA
CUENCO
CUENTAS
CUENTO
CUERDO
CUERO
CUERVO

CUESTA
CUESTAS
CUETO
CUEVA
CUEVAS
CUEVAZ
CUEVOS
CUILAN
CUIN
CUIZON
CULEBRO
CULTRERI
CUMBA
CUMPIAN
CUMPIANO
CUNANAN
CUNES
CUNEZ
CUNI
CUNILL
CUNYUS
CUPELES
CUPRILL
CURA
CURBELLO
CURBELO
CURET
CURIEL
CURRAIS
CURRAS
CURREA
CURZ
CUSCO
CUSTODIA
CUSTODIO
CUTIE
CUYA
CUYAR
CUZA

D

DABALOS
DABILA
DACUMOS
DAGNESSES
DAGO
DAGUERRE
DAGUILAR
DALAMA
DALBOSCO

1980 CENSUS LIST OF SPANISH SURNAMES

DALIPE	DEARRILLAGA	DECRISTINO	DEHOYAS
DALMAU	DEARROYO	DECRUZ	DEHOYOS
DALMIDA	DEARTEAGA	DECUEVA	DEIBARRA
DANACHE	DEASES	DECUEVAS	DEIDA
DANTUS	DEAVILA	DEDELGADO	DEIMES
DAPENA	DEAYALA	DEDIAZ	DEIRO
DARDANES	DEAZEVEDO	DEDIEGO	DEISLA
DARDIZ	DEBACA	DEDIOS	DEITA
DARDON	DEBARE	DEDOMINGUEZ	DEITURRONDO
DARIAS	DEBARRA	DEDUARTE	DEJARA
DARNAUD	DEBATISTA	DEESPARZA	DEJAUREGUI
DARQUEA	DEBATO	DEESTRADA	DEJESU
DARRIBA	DEBAYONA	DEFALCON	DEJESUS
DARUNA	DEBESA	DEFALLA	DEJESUSGARCIA
DASTAS	DEBONILLA	DEFERIA	DEJESUSORTIZ
DATIL	DEBRAS	DEFERNANDEZ	DEJIMENEZ
DAUBAR	DEBRAVO	DEFEX	DEJORIA
DAUILA	DEBRUYAN	DEFIESTA	DEJUAN
DAUSA	DEBUENO	DEFIGUEROA	DELAARENA
DAUZ	DECABRAL	DEFILLO	DELABARCA
DAVALOS	DECALDERON	DEFLORES	DELABARCENA
DAVILA	DECALLE	DEFRESE	DELABARRERA
DAVILAS	DECAMACHO	DEFRISCO	DELABARZA
DAVILLA	DECANTU	DEFUENTES	DELABRA
DAVILO	DECAPRILES	DEGANI	DELACABADA
DAZA	DECARDENAS	DEGARAY	DELACAL
DCRUZ	DECASAS	DEGARCIA	DELACALLE
DEAGEN	DECASO	DEGARZA	DELACAMARA
DEAGUERO	DECASTANEDA	DEGELIA	DELACAMPA
DEAGUILAR	DECASTILLO	DEGOES	DELACANAL
DEAGUIRRE	DECASTRO	DEGOLLADO	DELACERDA
DEALBA	DECENA	DEGOMEZ	DELACHICA
DEALCALA	DECERDA	DEGONZALES	DELA CONCEPCION
DEALEJANDRO	DECERVANTES	DEGONZALEZ	DELA CONCHA
DEALVA	DECESPEDES	DEGRACIA	DELACORTE
DEALVAREZ	DECHAVEZ	DEGUARA	DELACOTERA
DEAMADOR	DECHOUDENS	DEGUARDIA	DELACRUZ
DEANDA	DECIGA	DEGUERRA	DELACUADRA
DEANDE	DECLLET	DEGUERRERO	DELACUESTA
DEANDRES	DECOLLADO	DEGUEVARA	DELACUEVA
DEAQUERO	DECOLON	DEGUIMERA	DELACURZ
DEARAGON	DECONTRERAS	DEGUTIERREZ	DELAESPRIELLA
DEARCE	DECORDOBA	DEGUZMAN	DELA FE
DEARCO	DECORDOVA	DEHARO	DELA FUENTE
DEARCOS	DECORO	DEHERNANDEZ	DELA FUENTES
DEARELLANO	DECORONA	DEHERRERA	DELA FUNTE
DEARIAS	DECORONADO	DEHESA	DELAGADILLO
DEARMAS	DECORSE	DEHOMBRE	DELAGADO
DEARO	DECORTEZ	DEHORTA	DELAGARRIGUE
DEARRIBA	DECOS	DEHOSTOS	DELAGARZA

1980 CENSUS LIST OF SPANISH SURNAMES

DELAGDO	DELAREZA	DELCUETO	DELOSPRADOS
DELAGRANA	DELARIOS	DELCURTO	DELOSREYES
DELAGUARDIA	DELARIVA	DELDAGO	DELOSRIOS
DELAGUERRA	DELAROCA	DELEGANIS	DELOSSANT
DELAGUILA	DELARROCHA	DELEIJA	DELOSSANTOS
DELAHERA	DELAROSA	DELEON	DELOYA
DELAHERRAN	DELAROZA	DELERIO	DELOYOLA
DELAHOYA	DELARRA	DELERME	DELOZA
DELAHOZ	DELARROYO	DELESCAILLE	DELOZADA
DELAHUERTA	DELARUA	DELEZA	DELPALACIO
DELAISLA	DELASANTOS	DELFANTE	DELPARDO
DELAJARA	DELASCASAS	DELFIERRO	DELPILAR
DELALASTRA	DELASCUEVAS	DELFIN	DELPIN
DELALCAZAR	DELASERNA	DELFRANCIA	DELPINAL
DELALLATA	DELASHERAS	DELGADA	DELPINO
DELALLAVE	DELASIERRA	DELGADILL	DELPORTILLO
DELALLERA	DELATEJA	DELGADILLO	DELPOSO
DELALOZA	DELATEJERA	DELGADO	DELPOZO
DELALTO	DELATOBA	DELGADODEORAMAS	DELPRADO
DELALUZ	DELATORRE	DELGIORGIO	DELPUESTO
DELAMADRID	DELATORRES	DELGODO	DELRAZO
DELAMANCHA	DELATORRIENTE	DELHARO	DELREAL
DELAMATA	DELATRINIDAD	DELHIERRO	DELREY
DELAMAZA	DELAUZ	DELHOYO	DELRICO
DELAMELLA	DELAVARA	DELIGANIS	DELRIEGO
DELAMERCED	DELAVEGA	DELIRA	DELRINCON
DELAMO	DELAVELLANO	DELISEO	DELRIO
DELAMORA	DELAVICTORIA	DELIZ	DELRISCO
DELAMORENA	DELAVINA	DELJUNCO	DELRIVERO
DELAMOTA	DELAYA	DELLANO	DELROSAL
DELANDA	DELAZERDA	DELLLANO	DELROSARIO
DELANGEL	DELBARRIO	DELMARGO	DELSALTO
DELANOVAL	DELBLANCO	DELMENDO	DELSOL
DELANUEZ	DELBOSQUE	DELMERCADO	DELTEJO
DELAO	DELBOSQUEZ	DELMORAL	DELTIEMPO
DELAOSA	DELBOZQUE	DELMUNDO	DELTORO
DELAOSSA	DELBREY	DELMURO	DELUA
DELAPARRA	DELBUSTO	DELNODAL	DELUAO
DELAPASS	DELCADO	DELOA	DELUJAN
DELAPAZ	DELCALVO	DELOEN	DELUNA
DELAPENA	DELCAMPILLO	DELOERA	DELVAL
DELAPEZA	DELCAMPO	DELOLMO	DELVALLE
DELAPIEDRA	DELCASTILLO	DELOPEZ	DELVILLAR
DELAPLATA	DELCASTRO	DELORA	DELVINO
DELAPORTILLA	DELCERRO	DELORO	DEMACIAS
DELAPOZA	DELCID	DELOSADA	DEMALADE
DELAPRIDA	DELCOLLADO	DELOSANGELES	DEMARCHENA
DELAPUENTE	DELCORRAL	DELOSANTOS	DEMARIN
DELARA	DELCORRO	DELOSCOBOS	DEMARQUEZ
DELAREA	DELCRISTO	DELOSMONTEROS	DEMARRERO

1980 CENSUS LIST OF SPANISH SURNAMES

DEMARTINEZ	DEPACO	DESANTOS	DEVILLEGAS
DEMATA	DEPADILLA	DESARACHO	DEVOLIN
DEMATAS	DEPARRA	DESCALZO	DEYA
DEMATEO	DEPAZ	DESEVILLA	DEYCAZA
DEMEDINA	DEPEDRO	DESIERRA	DEYNES
DEMEIRE	DEPENNA	DESIGA	DEZA
DEMENA	DEPEREZ	DESOCARRAS	DEZAMORA
DEMENDEZ	DEPLATA	DESOCARRAZ	DEZARA
DEMENDOZA	DEPONCE	DESOLO	DEZARRAGA
DEMERCADO	DEPORTILLO	DESOSA	DEZAYAS
DEMESA	DEPORTO	DESOTO	DEZUNIGA
DEMIGUEL	DEPORTOLA	DESOTOMAYOR	DIACOS
DEMIRANDA	DEPOZO	DESPANIA	DIAGO
DEMOLINA	DEPRAD	DESPLANTES	DIAMOS
DEMONTEBELLO	DEPRADO	DESPUES	DIASDELEON
DEMONTES	DEQUESADA	DESRVINES	DIAZ
DEMONTEVERDE	DEQUEVEDO	DESSERO	DIAZACEVEDO
DEMONTTOYA	DEQUINTANA	DESTRADA	DIAZCOLON
DEMORALES	DEQUIROZ	DESUACIDO	DIAZCRUZ
DEMORENO	DERAMIREZ	DETAPIA	DIAZDEARCE
DEMOYA	DERAMOS	DETEJADA	DIAZDELCAMPO
DEMUNOZ	DERAS	DETEVIS	DIAZDELCASTILLO
DEMURGA	DERENIA	DETOLEDO	DIAZDELEON
DENA	DEREYES	DETORRES	DIAZDEVILLEGAS
DENAVA	DERIOS	DETRANALTES	DIAZMEDINA
DENAVARRO	DERIVAS	DETRES	DIAZPIEDRA
DENAVAS	DERIVERA	DETRINIDAD	DIAZRIVERA
DENAVEJAR	DERMA	DEULLOA	DIAZRODRIGUEZ
DENECOCHEA	DEROBLES	DEVACA	DIEGO
DENIEVES	DEROCA	DEVALDEZ	DIEGUEZ
DENINA	DERODRIGUEZ	DEVALENCIA	DIEPPA
DENOGEAN	DERODRIQUEZ	DEVALLE	DIEZ
DENORIEGA	DEROJAS	DEVALON	DIMAS
DENUNEZ	DEROMERO	DEVARA	DIODONET
DEOCA	DEROSARIO	DEVARGAS	DIODOSIO
DEOCAMPO	DEROZA	DEVARONA	DIONES
DEOCHOA	DERRERA	DEVASQUEZ	DIOS
DEOLEO	DERUBIO	DEVAZQUEZ	DIOSDADO
DEOLIVIERA	DERUEDA	DEVEGA	DIOSES
DEOLMO	DERUISA	DEVELASCO	DIRECTO
DEORO	DESABOTA	DEVELEZ	DISARUFINO
DEORTA	DESAENZ	DEVENCENTY	DISLA
DEORTEGA	DESALAS	DEVERA	DISTABILE
DEORTIZ	DESALAZAR	DEVIA	DOBAL
DEOSDADE	DESALERNOS	DEVIAN	DOBAO
DEOSORIO	DESALES	DEVICENTE	DOBARGANES
DEOTERIS	DESALINAS	DEVICTORIA	DOBLADO
DEOTERO	DESANCHEZ	DEVILA	DOCAL
DEPABLO	DESANTIAGO	DEVILLA	DOCAMPO
DEPACHECO	DESANTIASGO	DEVILLAR	DOCE

1980 CENSUS LIST OF SPANISH SURNAMES

DOJAQUEZ	DUCOS	ECHEGUREN	ELENA
DOLATRE	DUEN	ECHEMENDIA	ELENES
DOLMO	DUENAS	ECHENIQUE	ELENEZ
DOMENA	DUENES	ECHERIVEL	ELEVARIO
DOMENECH	DUENEZ	ECHERRI	ELEZONDO
DOMENGUEZ	DUENO	ECHEVARIA	ELGARRESTA
DOMENO	DUENOS	ECHEVARRIA	ELGO
DOMENZAIN	DUHAGON	ECHEVARRIETA	ELGUEA
DOMIGUEZ	DUHALDE	ECHEVARRIO	ELGUERA
DOMINCO	DULZAIDES	ECHEVERIA	ELGUESEBA
DOMINGEZ	DUMAGUINDIN	ECHEVERRI	ELGUEZABAL
DOMINGNEZ	DUMBRIGUE	ECHEVERRIA	ELICIER
DOMINGUEZ	DUME	ECHEVERRY	ELISALDA
DOMINGUIZ	DUMENG	ECHEVESTE	ELISALDE
DOMINIGUEZ	DUMENIGO	ECHEZABAL	ELISALDEZ
DOMINQUEZ	DUQUE	ECHEZARRETA	ELISARRARAZ
DOMIO	DURAN	ECHIRIBEL	ELISERIO
DOMONDON	DURANGO	ECHIVERRI	ELISONDO
DONADO	DURANONA	ECHIVESTER	ELIXAVIDE
DONATE	DURANZA	EDERRA	ELIZADE
DONEIS	DURATE	EDESA	ELIZAGA
DONES	DURAZO	EDEZA	ELIZALDA
DONESTEVEZ	DURON	EDILLO	ELIZALDE
DONEZ		EDQUIVEL	ELIZALDI
DONIAS	E	EDREIRA	ELIZANDO
DONJUAN	ECHABARNE	EDROSA	ELIZANDRO
DONLUCAS	ECHANDI	EDROSOLAN	ELIZARDE
DONOSO	ECHANDIA	EDROZO	ELIZARDI
DOPAZO	ECHANIZ	EGANA	ELIZARDO
DOPICO	ECHARREN	EGAS	ELIZARRARAS
DOPORTO	ECHARRI	EGEA	ELIZARRARAZ
DORADO	ECHARTEA	EGIPCIACO	ELIZARRAS
DORAME	ECHAUARRIA	EGLESIAS	ELIZONDA
DORANTES	ECHAURI	EGUED	ELIZONDO
DORREGO	ECHAVARIA	EGUES	ELJAU
DORTA	ECHAVARRI	EGUEZ	ELORDUY
DORTICOS	ECHAVARRIA	EGUIA	ELORREAGA
DOSAL	ECHAVARRIA	EGUIGUREN	ELORRIAGA
DOSAMANTES	ECHAVARRY	EGUILUZ	ELORZA
DOSELA	ECHAVE	EGUINO	ELOSEGUI
DOVAL	ECHAVERIA	EGUIZABAL	ELOSUA
DOVALES	ECHAVES	EGURE	ELUGARDO
DOVALINA	ECHAVESTE	EGURROLA	ELVIRA
DOVO	ECHAVEZ	EGUSQUIZA	ELYCIO
DOZAL	ECHAZABAL	EIRAS	EMMANUELLI
DSPAIN	ECHAZARRETA	EIRIZ	EMMITE
DUARDO	ECHEAGARAY	ELEBARIO	EMPASIS
DUARTE	ECHEANDIA	ELEGINO	EMPERADOR
DUARTES	ECHEBARRIA	ELEJALDE	EMPLEO
DUBON	ECHEGARAY	ELEMEN	ENAMORADO
	ECHEGOYEN		

1980 CENSUS LIST OF SPANISH SURNAMES

ENCALADA	ERRECA	ESCARZEGA	ESPANO
ENCALLADO	ERRISURIZ	ESCASENA	ESPANOL
ENCARNACION	ERRO	ESCATEL	ESPANOLA
ENCERRADO	ERROA	ESCATELL	ESPARAZA
ENCHAUTEGUI	ESCABAR	ESCATIOLA	ESPARRA
ENCHINTON	ESCABEDO	ESCAURIZA	ESPARSA
ENCINA	ESCABI	ESCOBADO	ESPARSEN
ENCINAS	ESCABIA	ESCOBAL	ESPARZ
ENCINIA	ESCAJEDA	ESCOBALES	ESPARZA
ENCINIAS	ESCALA	ESCOBAR	ESPEJEL
ENCINOS	ESCALADA	ESCOBARETE	ESPEJO
ENCINO	ESCALANTE	ESCOBEBO	ESPELETA
ENCINOSA	ESCALENTE	ESCOBEDA	ESPENDEZ
ENCISCO	ESCALERA	ESCOBEDO	ESPENOSA
ENCISO	ESCALET	ESCOBER	ESPEÑOZA
ENCIZO	ESCALLE	ESCOBIDO	ESPERA
ENDARA	ESCALLON	ESCOBIO	ESPERANZA
ENDAYA	ESCALON	ESCOBOSA	ESPERAS
ENDEMANO	ESCALONA	ESCOBOZA	ESPERICUETA
ENDOSO	ESCALONTE	ESCOCHEA	ESPERIQUETA
ENGRACIO	ESCAMILLA	ESCODEDO	ESPERO
ENGUIDANOS	ESCAMILLAS	ESCOJIDO	ESPERON
ENJADY	ESCAMILLO	ESCOLAR	ESPIGUL
ENRIGUEZ	ESCANAME	ESCOMILLA	ESPINA
ENRIQUE	ESCANDELL	ESCONTRIAS	ESPINAL
ENRIQUES	ESCANDON	ESCORCIA	ESPINALES
ENRIQUEZ	ESCANES	ESCORIAZA	ESPINAR
ENRRIQUEZ	ESCANIO	ESCORPISO	ESPINDOLA
ENSENAT	ESCANO	ESCORZA	ESPINDULA
EPIDENDIO	ESCANUELA	ESCOTA	ESPINEIRA
EQUIA	ESCANUELAS	ESCOTO	ESPINEL
EQUIHUA	ESCAPA	ESCOVADO	ESPINELL
ERAS	ESCAPITA	ESCOVAR	ESPINET
ERASO	ESCAPULE	ESCOVEDO	ESPINO
ERAUSQUIN	ESCAR	ESCOVER	ESPINOR
ERAZO	ESCARCEGA	ESCRIBA	ESPINOSA
ERCHED	ESCARCIDA	ESCRIBANO	ESPINOZ
ERCILLA	ESCARCIGA	ESCRICHE	ESPINOZA
ERCILLO	ESCARDA	ESCUADRA	ESPIRICUETA
ERDOZAIN	ESCARENIO	ESCUADER	ESPIRITI
EREBIA	ESCARENO	ESCUDERO	ESPIRITU
EREDIA	ESCARIZ	ESCUETA	ESPITALETA
ERES	ESCARPIO	ESCUJURI	ESPITIA
EREVIA	ESCARRA	ESCUTIA	ESPLANA
ERIBES	ESCARRAMAN	ESGUERRA	ESPONDA
ERIVES	ESCARREGA	ESPADA	ESPRIU
ERIVEZ	ESCARSEGA	ESPADAS	ESPRONCEDA
EROLES	ESCARSIGA	ESPAILLAT	ESPUDO
EROSA	ESCARTIN	ESPALIN	ESPURVOA
ERREA	ESCARZAGA	ESPANA	ESQUEA

1980 CENSUS LIST OF SPANISH SURNAMES

ESQUEDA	ESTEVAN	EVANGELATOS	FANGONILLO
ESQUEDO	ESTEVANE	EVARO	FANJUL
ESQUELL	ESTEVANES	EVIA	FARACH
ESQUENAZI	ESTEVANEZ	EXIGA	FARAGOZA
ESQUER	ESTEYES	EXINIA	FARFAN
ESQUERA	ESTEVEZ	EXPARZA	FARGA
ESQUERDO	ESTEVIS	EXPOSITO	FARGAS
ESQUERO	ESTEVIZ	EYLICIO	FARIAS
ESQUERRA	ESTIEN	EYZAGUIRRE	FARILLAS
ESQUERRE	ESTIMBO	EZCURRA	FARINAS
ESQUEVEL	ESTOLANO	EZETA	FARINOS
ESQUIBAL	ESTOLAS	EZQUEDA	FARIOS
ESQUIBEL	ESTOPELLAN	EZQUER	FARPELLA
ESQUIBIAS	ESTOPINAN	EZQUERRA	FARRALES
ESQUIERDO	ESTOQUE	EZQUERRO	FARRAY
ESQUIJAROSA	ESTORGA	EZRATTY	FARRERA
ESQUIJARROSA	ESTRACA	EZRRE	FARRIAS
ESQUILIANO	ESTRAD		FARROS
ESQUILIN	ESTRADA	F	FARRULLA
ESQUINCA	ESTRADAS	FABAL	FAS
ESQUINEL	ESTRADE	FABELA	FAUDO
ESQUIVAL	ESTRADO	FABELO	FAUELA
ESQUIVEL	ESTRALLA	FABILA	FAUNI
ESQUIVEZ	ESTRANY	FABRA	FAURA
ESQUIVIAS	ESTRELLA	FABREGAS	FAURIA
ESTABA	ESTRELLAS	FABREGAT	FAUSTINOS
ESTABILLO	ESTRELLO	FABROS	FAUSTO
ESTADA	ESTREMERA	FABRYGEL	FAVELA
ESTADES	ESTREMO	FACIO	FAVELLA
ESTALA	ESTRINGEL	FACUNDO	FAVELO
ESTAMPA	ESTRONZA	FADRIQUE	FAVILA
ESTANOL	ESTUDILLO	FAGET	FAYA
ESTAPE	ESTUPINAN	FAGOAGA	FAZ
ESTAVILLA	ETCHEBARREN	FAGUNDO	FEAL
ESTAVILLO	ETCHEBEHERE	FAILA	FEBLES
ESTEBAN	ETCHECHURY	FAILDE	FEBRE
ESTEBANE	ETCHEGARAY	FAJARDO	FEBRES
ESTEBANEZ	ETCHEPARE	FALCHE	FEIGA
ESTEBES	ETCHEVERRIA	FALCON	FEIJOO
ESTEBEZ	ETCHEVERRY	FALERO	FEITO
ESTEFAN	EUDAVE	FALLEJO	FELAN
ESTEFANI	EUFRACIO	FALOMIR	FELANDO
ESTELA	EULATE	FALQUEZ	FELIBERTY
ESTENOZ	EURESTE	FALTO	FELICANO
ESTEPA	EURESTI	FALU	FELICIANO
ESTEPAN	EURIOSTE	FAMANIA	FELICITAS
ESTERAS	EUSEBIO	FAMILIA	FELICO
ESTERO	EUSTAQUIO	FANDINO	FELIPE
ESTEUES	EUZARRAGA	FANEGO	FELISCIAN
ESTEVA	EVANGEL	FANGON	FELIU

1980 CENSUS LIST OF SPANISH SURNAMES

FELIX	FEYJOO	FLECHES	FORTANEL
FELIZ	FIALLO	FLEITAS	FORTEZ
FELPETO	FIALLOS	FLEITES	FORTEZA
FELUMERO	FIDEL	FLEMATE	FORTIZ
FEMAT	FIEROVA	FLETE	FORTUNO
FEMATH	FIERRO	FLETES	FOYO
FEMATT	FIERROS	FLOPES	FRACISCO
FENTANES	FIERROZ	FLORATOS	FRADEJAS
FENTE	FIESTAL	FLORENCIA	FRADERA
FEO	FIGAL	FLORENCIO	FRAGA
FERAMISCO	FIGAREDO	FLORES	FRAGINALS
FERDIN	FIGARELLA	FLORESDELGADO	FRAGO
FEREZ	FIGAROLA	FLOREZ	FRAGOMENO
FERIA	FIGEROA	FLORIDO	FRAGOSA
FERMANDEZ	FIGIROVA	FLORIT	FRAGOSO
FERMIN	FIGOROA	FLORITA	FRAGOZO
FERNADEZ	FIGUEIRAS	FLUXA	FRAGUA
FERNANDE	FIGUERA	FOJO	FRAGUADA
FERNANDEZ	FIGUERAS	FOLGAR	FRAGUAS
FERNANDEZCUETO	FIGUERDA	FOLGUEIRA	FRAGUELA
FERNANDEZDECA	FIGUEREDO	FOLGUEIRAS	FRAGUIO
STRO	FIGUERO	FONALLEDAS	FRAIDE
FERNANDEZDELA	FIGUERIA	FONCERRADA	FRAIJO
RA	FIGUERO	FONNEGRA	FRAIRE
FERNANDO	FIGUEROA	FONSECA	FRAMIL
FERNENDEZ	FIGUEROLA	FONT	FRANCA
FERNIZ	FIGUERON	FONTAN	FRANCISCA
FERNIZA	FIGUERORA	FONTANES	FRANCO
FERRADAS	FIGUEROSA	FONTANET	FRANCOS
FERRADAZ	FIGUERRA	FONTANEY	FRANGUI
FERRAEZ	FIGUROA	FONTANEZ	FRANJUL
FERRAIZ	FIGVEROA	FONTANILLS	FRANQUERO
FERRALES	FILGUEIRAS	FONTANOZA	FRANQUEZ
FERRALEZ	FILIZOLA	FONTEBOA	FRANQUI
FERRANDES	FILLAS	FONTECHA	FRANQUIZ
FERRANDIZ	FILOTEO	FONTELA	FRANSUA
FERRAS	FIMBRES	FONTENO	FRANZOY
FERRE	FIMBREZ	FONTICIELLA	FRAQUA
FERREGUR	FINALES	FONTICOBA	FRASES
FERREIRAS	FIOL	FORCELLEDO	FRASQUILLO
FERREIRO	FIQUEROA	FORCEN	FRATICELLI
FERRER	FIRA	FORDIS	FRAU
FERRERAS	FIRPI	FORERO	FRAUSTO
FERRERIS	FIUZA	FORMANO	FRAUSTRO
FERREYRA	FLACO	FORMENT	FRAXEDAS
FERREYRO	FLAMENCO	FORMEZA	FRAYO
FERREZ	FLANDES	FORNARIS	FRAYRE
FERRUA	FLANDEZ	FORNASERO	FREDELUCES
FERRUSCA	FLAQUER	FORNOS	FREGOSA
FESTEJO	FLECHA	FORNS	FREGOSO

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FREGOZO	FUNES	GALDAMES	GALVAN
FREIJO	FUNEZ	GALDAMEZ	GALVE
FREIRE	FUNO	GALDEANO	GALVES
FREIRIA	FUSANO	GALDOS	GALVEZ
FREIXAS	FUSTE	GALDUROZ	GAMA
FRENES	FUSTER	GALEANA	GAMALLO
FRES		GALEANO	GAMARRA
FRESCAS	G	GALENDEZ	GAMAZA
FRESCAZ	GABALDEN	GALERA	GAMAZO
FRESNEDA	GABALDON	GALERIA	GAMBOA
FRESNEDO	GABANCHO	GALGUERA	GAMERO
FRESNILLO	GABASAN	GALI	GAMEROS
FRESNO	GABELA	GALIANA	GAMEROZ
FRESQUES	GABILONDO	GALICIA	GAMEY
FRESQUEZ	GABINA	GALINANES	GAMEZ
FREYRE	GABINO	GALIND	GAMINO
FREYTA	GABRILES	GALINDA	GAMIO
FREYTES	GABRILLO	GALINDEZ	GAMIZ
FRIAS	GACHARNA	GALINDO	GAMONEDA
FRIAZ	GACHUPIN	GALINDRO	GANADONEGRO
FRIETZE	GADAL	GALINZOGA	GANAN
FRIGOLA	GADEA	GALIZ	GANCEDO
FRISAN	GADIA	GALLAGA	GANCERES
FROMETA	GAETAN	GALLAGOS	GANDAR
FRONDARINA	GAETAN	GALLANES	GANDARA
FRONTADO	GAFARE	GALLARD	GANDARIA
FRONTELLA	GAGO	GALLARDE	GANDARILLA
FRONTERAS	GAHONA	GALLARDO	GANDARILLAS
FROSTO	GAINZA	GALLARETO	GANDIA
FRUGIA	GAITAN	GALLART	GANDON
FRUTOS	GAITERO	GALLARZA	GANDORA
FRUTOZ	GAIVAN	GALLARZO	GANIVET
FUENMAYOR	GAJARDO	GALLASTEGUI	GANUELAS
FUENTAS	GAJATE	GALLEG	GANUZA
FUENTE	GALABEAS	GALLEGAS	GANZALEZ
FUENTECILLA	GALACHE	GALLEGO	GAONA
FUENTEFRIA	GALAGARZA	GALLEGOES	GARABAY
FUENTES	GALAN	GALLEGOS	GARABITO
FUENTEZ	GALARCE	GALLEGOZ	GARACOCHEA
FUENZALIDA	GALARRAGA	GALLEGUS	GARAICOECHEA
FUERO	GALARRETA	GALLENO	GARALDE
FUERTE	GALARSA	GALLERAN	GARAMENDI
FUERTES	GALARTE	GALLERITO	GARAMILLO
FUERTEZ	GALARZA	GALLINAL	GARANA
FUEYO	GALARZE	GALLINAR	GARANSUAY
FULGENCIO	GALAVEZ	GALLOR	GARANZUAY
FULGUEIRA	GALAVIS	GALLOSA	GARAT
FUMERO	GALAVIZ	GALMOS	GARATE
FUNCIA	GALAZ	GALOFRE	GARATEIX
FUNDORA	GALBAN	GALORZA	GARAVITO
	GALCERAN		

1980 CENSUS LIST OF SPANISH SURNAMES

GARAY	GARIBAY	GATELL	GELISTA
GARAYALDE	GARIBY	GATICA	GELY
GARAYGORDOBIL	GARICA	GATO	GENAO
GARAYUA	GARIFE	GATSEOS	GENDES
GARAYZAR	GARISPE	GATTORNO	GENEL
GARAZA	GARITA	GAUBA	GENER
GARBANI	GARITE	GAUCHAS	GENERA
GARBAYO	GARIVAY	GAUCIN	GENESTA
GARBISO	GARMENDIA	GAUD	GENINO
GARBIZO	GARMENDIZ	GAUDIER	GENIZ
GARCA	GARMISA	GAUNA	GENOVES
GARCED	GARNICA	GAUZENS	GERALDES
GARCEL	GARRANDES	GAVALDON	GERALDINO
GARCELL	GARRASTAZU	GAVALES	GERALDO
GARCEO	GARRIDO	GAVAY	GERARDO
GARCERA	GARRIGA	GAVIA	GERENA
GARCERAN	GARRIGAS	GAVICA	GEREZ
GARCES	GARRIGO	GAVIDIA	GERMENIS
GARCEZ	GARRIGOS	GAVILA	GERMES
GARCIA	GARRIO	GAVILAN	GERMONO
GARCIACARDENA	GARROBO	GAVILANES	GEROLAGA
S	GARROCHO	GAVILLA	GERONES
GARCIAGONZALEZ	GARROTE	GAVILLAN	GERRO
GARCIAGUERRER	GARSA	GAVINA	GERUSA
O	GARSES	GAVINO	GHIgliOTTY
GARCIAGUZMAN	GARTICA	GAVIRA	GIJON
GARCIALOPEZ	GARVISO	GAVIRIA	GIL
GARCIAMARTINEZ	GARZA	GAVITO	GILAS
GARCIAPENA	GARZACANTU	GAXIOLA	GILBES
GARCIARIOS	GARZAGARCIA	GAYA	GILBUENA
GARCIAS	GARZAGONGORA	GAYARRE	GILDELAMADRID
GARCIAV	GARZAMARTINEZ	GAYO	GIMENEZ
GARCIDUENAS	GARZAPENA	GAYOL	GIMENO
GARCIGA	GARZARO	GAYOSO	GIMINEZ
GARCILASO	GARZES	GAYOSSO	GINART
GARCILAZO	GARZON	GAYTAN	GINARTE
GARCIO	GARZONA	GAZCA	GINDRO
GARDEA	GARZORIA	GAZIVODA	GINER
GARDIA	GASCA	GAZOLAS	GINET
GARDUNIO	GASCOT	GAZTAMBIDE	GINEZ
GARDUNO	GASERO	GAZTELU	GINORI
GARDUQUE	GASIO	GEA	GINORIO
GAREIA	GASPARDEALBA	GEADA	GINORIS
GARFIAS	GASPORRA	GEAGA	GINORY
GARFIO	GASTELLO	GEBARA	GIRADO
GARGUENA	GASTELLUM	GEIGEL	GIRALD
GARI	GASTELO	GELABERT	GIRALDES
GARIA	GASTELUM	GELACIO	GIRALDEZ
GARIB	GASU	GELERA	GIRALDO
GARIBALDO	GATAN	GELI	GIRALT

1980 CENSUS LIST OF SPANISH SURNAMES

GIRAU	GONZAL	GOVANTES	GRAULAU
GIRAUDO	GONZALAS	GOVEA	GRAUPERA
GIRELA	GONZALE	GOVELLA	GRAVERAN
GIRION	GONZALEA	GOYANES	GRAZA
GIRO	GONZALES	GOYCO	GREIGO
GIRON	GONZALEX	GOYCOCHEA	GRES
GIRONA	GONZALEZ	GOYCOECHEA	GRIEGO
GIRONELLA	GONZALEZDIAZ	GOYCOOLEA	GRIHALVA
GISBERT	GONZALEZHERNA	GOYENECHE	GRIJALBA
GISPERT	NDEZ	GOYOS	GRIJALUA
GIZ	GONZALEZLEON	GOYTIA	GRIJALVA
GLORIA	GONZALEZSOTO	GOYZUETA	GRILLASCA
GOBEA	GONZALO	GOZMAN	GRILLIAS
GOCHEZ	GONZALVEZ	GRACIA	GRIMALDO
GOCHICOA	GONZALVO	GRACIAN	GRISALES
GODINA	GONZALZ	GRACIANI	GROLON
GODINES	GONZAQUE	GRACIANO	GRONA
GODINET	GONZELEZ	GRACIDA	GROSO
GODINEZ	GONZELL	GRADIAS	GROVAS
GODOY	GONZLAES	GRADILLA	GRUESO
GOENA	GONZLAEZ	GRADILLAS	GRULLON
GOENAGA	GONZLES	GRADISAR	GRUSMAN
GOICOCHEA	GONZLEZ	GRADO	GUABA
GOICOURIA	GONZOLES	GRAFALS	GUADA
GOICURIA	GONZOLEZ	GRAGEDA	GUADAGNIN
GOIRICELAYA	GORBEA	GRAIBE	GUADALAJARA
GOITIA	GORDIANY	GRAJALES	GUADALUPE
GOLDEROS	GORDILLO	GRAJEDA	GUADAMUZ
GOMAR	GORDILS	GRAJERA	GUADARAMA
GOME	GORDO	GRAJIOLA	GUADARRAMA
GOMEZ	GORDOA	GRAMAJO	GUADERRAMA
GOMEZDEMOLINA	GORENA	GRANADA	GUADIAN
GOMEZTORRES	GOROSAVE	GRANADAS	GUADIANA
GOMEZTREJO	GOROSTIETA	GRANADINO	GUADIANO
GOMZALEZ	GOROSTIZA	GRANADO	GUADRON
GONALEZ	GOROZA	GRANADOS	GUAIDA
GONAZLEZ	GORRAIZ	GRANADOZ	GUAJACA
GONDAR	GORRICO	GRANAS	GUAJARDO
GONDREZ	GORRINDO	GRANDA	GUAL
GONEZ	GORRITA	GRANDEZ	GUALDARRAMA
GONGALES	GORRITZ	GRANDIO	GUAMAN
GONGALEZ	GORRIZ	GRANDOS	GUANA
GONGORA	GORTAREZ	GRANELA	GUANAJUATO
GONI	GORZELA	GRANERO	GUANCHE
GONSALE	GOSALVEZ	GRANIELA	GUANGORENA
GONSALES	GOTANDA	GRANILLO	GUANILL
GONSALEZ	GOTAY	GRANIS	GUANTE
GONZABA	GOTERA	GRANIZO	GUANTES
GONZAES	GOTIERREZ	GRANJA	GUANTEZ
GONZAGUE	GOTOR	GRATACOS	GUAPO

1980 CENSUS LIST OF SPANISH SURNAMES

GUARA
 GUARACHA
 GUARCH
 GUARDADO
 GUARDAMONDO
 GUARDARRAMA
 GUARDARRAMOS
 GUARDERAS
 GUARDIAN
 GUARDIAS
 GUARDIOLA
 GUARENO
 GUARIS
 GUARJARDO
 GUARNERO
 GUARNEROS
 GUARTUCHE
 GUAS
 GUASCH
 GUASH
 GUASP
 GUAYANTE
 GUAYDACAN
 GUDIEL
 GUDINO
 GUEBARA
 GUECHO
 GUEDE
 GUEDEA
 GUEDES
 GUEDIN
 GUEIMUNDE
 GUEITS
 GUEL
 GUELBENZU
 GUELMES
 GUEMES
 GUEMEZ
 GUERA
 GUERARA
 GUERECA
 GUERENA
 GUERENO
 GUEREQUE
 GUERERO
 GUERERRO
 GUERNICA
 GUERRA
 GUERREO
 GUERRER

GUERRERO
 GUERRIDO
 GUERRIOS
 GUERRO
 GUERRRA
 GUEVARA
 GUEVAREZ
 GUEVARRA
 GUEVERA
 GUEVERRA
 GUEZ
 GUIA
 GUIBOA
 GUICHO
 GUIDERO
 GUIJARRO
 GUIJOSA
 GUILARTE
 GUILBE
 GUILLEZ
 GUILLAMA
 GUILLEMARD
 GUILLEN
 GUILLENA
 GUILLERMETY
 GUILLERMO
 GUINA
 GUIRADO
 GUIRALES
 GUIREMAND
 GUIROLA
 GUISA
 GUISADO
 GUISAO
 GUISAR
 GUITANO
 GUITERREZ
 GUITIAN
 GUITIERREZ
 GUITRON
 GUITTEREZ
 GUITTERREZ
 GUITY
 GUIU
 GUIVAS
 GUIZA
 GUIZADO
 GUIZAR
 GUJARDO
 GULARTE

GULBAS
 GULDRIS
 GULDRIZ
 GULIERREZ
 GUMA
 GUNDIN
 GURARO
 GURELL
 GURIDES
 GUROLA
 GURRERO
 GURRIA
 GURRIES
 GURROLA
 GURRUCHAGA
 GURULE
 GURVLE
 GURZI
 GUSMAN
 GUSME
 GUSTAMANTE
 GUSTAMENTE
 GUSTO
 GUTERREZ
 GUTIERES
 GUTIEREZ
 GUTIERIEZ
 GUTIERR
 GUTIERRE
 GUTIERREA
 GUTIERRER
 GUTIERRES
 GUTIERREZ
 GUTIERREZGARCIA
 GUTIERREZRIOS
 GUTIERRZ
 GUTIRREZ
 GUTTEREZ
 GUTTERREZ
 GUTTIERREZ
 GUZMAN
 GUZMELI
 GUZMON

HARISPURU
 HARO
 HAROS
 HARVIER
 HAYOS
 HECHANOVA
 HECHAVARRIA
 HECHEVARRIA
 HEGUY
 HELGUERA
 HELGUERO
 HELGUEROS
 HENANDEZ
 HENAO
 HENARES
 HENOJOSA
 HENRIGUEZ
 HENRIQUEZ
 HERALDEZ
 HERANDEZ
 HERAS
 HERAZ
 HERBELLO
 HEREBIA
 HEREDERO
 HEREDIA
 HEREIDA
 HERENA
 HERERA
 HERERRA
 HERETER
 HERIA
 HERIDIA
 HERMANDEZ
 HERMIDA
 HERMIDAS
 HERMIS
 HERMOCILLO
 HERMOGENO
 HERMOSA
 HERMOSILLO
 HERMOSO
 HERNADEZ
 HERNAEZ
 HERNAIZ
 HERNAND
 HERNANDE
 HERNANDEL
 HERNANDER
 HERNANDES

H

HACES
 HAEDO
 HANONO
 HARGITA

1980 CENSUS LIST OF SPANISH SURNAMES

HERNANDEZ	HIGUEROS	HOYOS	IBANEZ
HERNANDEZCANT	HIJAR	HOYUELA	IBAR
U	HILARIO	HUACUJA	IBARBO
HERNANDEZORTIZ	HILERIO	HUALDE	IBARGUENGOITIA
HERNANDO	HINAJOSA	HUAMAN	IBARLUCEA
HERNANDORENA	HINESTROSA	HUANTE	IBARRA
HERNANDZ	HINOJAS	HUANES	IBARRIA
HERNANEZ	HINOJO	HUAPE	IBARRONDO
HERNDEZ	HINOJOS	HUARACHA	IBAVE
HERNENDEZ	HINOJOSA	HUARTE	IBAVEN
HERONEMA	HINOJOSE	HUEDA	IBERRA
HERRADA	HINOJOSO	HUERECA	IBERRI
HERRADOR	HINOJOZA	HUERENA	IBINARRIAGA
HERRAN	HINOSTRO	HUEREQUE	IBOS
HERRANZ	HINOSTROSA	HUERGAS	IBUADO
HERRARA	HINOSTROZA	HUERGO	ICAMEN
HERRARTE	HINZO	HUERTA	ICARDO
HERREA	HIPOLITO	HUERTAS	ICASIANO
HERREJON	HIRALDO	HUERTAZ	ICAZA
HERRENA	HIRALES	HUERTERO	ICEDO
HERRER	HIRALEZ	HUERTO	ICHINAGA
HERRERA	HIRIGOYEN	HUERTOS	IDARRAGA
HERRERAS	HIRTADO	HUESCA	IDIAQUEZ
HERRERIA	HISQUIERDO	HUESO	IDIGORAS
HERRERIAS	HITA	HUETE	IDOY
HERRERO	HOGEDA	HUEZO	IDROGO
HERREROS	HOJAS	HUGUEZ	IDROVO
HERRERRA	HOLGIN	HUICI	IGARAVIDEZ
HERROZ	HOLGUIN	HUICOCHEA	IGARTUA
HERVAS	HOLQUIN	HUIDOR	IGLECIAS
HERVELLA	HOMAR	HUIPE	IGLESIA
HERVIS	HOMS	HUISAR	IGLESIAS
HEVIA	HONESTO	HUITRON	IGNACIO
HEYSQUIERDO	HONGOLA	HUIZAR	IGOA
HIBARRA	HONORIO	HUMADA	IGUALADA
HIDALGA	HONRADA	HUMILDAD	IGUINA
HIDALGO	HORABUENA	HURADO	ILARRAZA
HIDALGOGATO	HORACIO	HURBINA	ILDEFONSO
HIDAS	HORCASITAS	HURIEGA	ILHARREGUY
HIDROGO	HORELICA	HURON	ILIZALITURRI
HIERREZUELO	HORMACHEA	HURRIEGA	ILLAN
HIERRO	HORMAZA	HURTADA	ILLANES
HIGADERA	HORMAZABAL	HURTADO	ILLAS
HIGAREDA	HORMILLA	HURTARTE	ILLERA
HIGARES	HORNEDO	HYSQUIERDO	ILLESCAS
HIGNOJOS	HORRUITINER		IMAS
HIGNOJOZ	HORTA		IMAZ
HIGUERA	HOSTAS		INCHAURREGUI
HIGUERAS	HOSTOS		INCHAUSTEGUI
HIGUERO	HOYO		INCHAUSTI
		I	
		IANEZ	
		IANOS	
		IBANES	

1980 CENSUS LIST OF SPANISH SURNAMES

INCLAN	IRIGOYEN	ITURRI	JARMILLO
INDART	IRIMIA	ITURRIA	JAROMILLO
INESTA	IRINEO	ITURRIAGA	JARQUEZ
INESTROZA	IRIONDO	ITURRINO	JARQUIN
INEZ	IRIQUI	ITURRIOZ	JARRIN
INFANTE	IRISARRI	IVANEZ	JARRO
INFANTES	IRIYE	IVARRA	JASO
INFANZON	IRIZAR	IXTA	JASSO
INFIESTA	IRIZARRI	IZA	JATIVA
INGELMO	IRIZARRY	IZABAL	JAUMA
INGRANDE	IRIZARY	IZAGUIRRE	JAUME
INGUANZO	IRIZZARY	IZAQUIRRE	JAUNARENA
INGUITO	IRLAS	IZAR	JAUNES
INIGO	IROZ	IZNAGA	JAURE
INIGUES	IRRIBARREN	IZQUIERDO	JAUREGUI
INIGUEZ	IRRIZARRI	IZURIETA	JAUREGUIBERRY
INIQUEZ	IRRIZARRY		JAUREGUY
INOA	IRRIZARY	J	JAURENA
INOCENCIO	IRROBALI	JACAS	JAUREQUI
INOSTROS	IRUEGAS	JACINTO	JAUREZ
INOSTROSA	IRUNGARAY	JACOBO	JAURGUI
INOSTROZA	IRURETAGOYENA	JACOME	JAURIGI
INSAUSTI	IRVEGAS	JACOMINO	JAURIGUE
INSERNI	ISAGUIRRE	JACOVO	JAURIGUI
INSIGNARES	ISAIS	JACQUEZ	JAURIQUE
INSUA	ISAIZ	JACUINDE	JAURIQUI
INSULAR	ISALES	JAIDAR	JAURQUI
INSUNZA	ISARRARAS	JAILE	JAURRIETA
INSURRIAGA	ISAS	JAIME	JAVIER
INTERIAN	ISASSI	JAIMERENA	JAVIERRE
INTRIAGO	ISERN	JAIMES	JEMENTE
INURRIGARRO	ISIAS	JAIMEZ	JEREZ
INZUNZA	ISIDRON	JAIRALA	JESUS
IPARRAGUIRRE	ISLA	JALAMO	JIMAREZ
IPINA	ISLAS	JALLEO	JIMEMEZ
IQUINA	ISLAVA	JALOMA	JIMENA
IRACHETA	ISONA	JALOMO	JIMENE
IRAGUI	ISORDIA	JALTECO	JIMENES
IRAHETA	ISQUIERDO	JANER	JIMENEZ
IRALA	ISUNZA	JANERO	JIMENIZ
IRAOLA	ITHIER	JAQUEZ	JIMENO
IRASTORZA	ITUARTE	JAQUIAS	JIMENZ
IRAZABAL	ITULE	JARA	JIMINEZ
IRAZOQUI	ITURBE	JARABA	JINETE
IRIART	ITURBI	JARAMILIO	JINEZ
IRIARTE	ITURBIDE	JARAMILLA	JINZO
IRIBARREN	ITURMENDI	JARAMILLO	JIRAU
IRIBE	ITURRALDE	JARDINES	JIRON
IRIGARAY	ITURRASPE	JARDINEZ	JOFRE
IRIGONEGARAY	ITURREGUI	JARERO	JOJOLA

1980 CENSUS LIST OF SPANISH SURNAMES

JOMARRON
 JORAMILLO
 JORDANA
 JORGANES
 JORGE
 JORNACION
 JORQUERA
 JORQUEZ
 JORRIN
 JOVE
 JOVELLANOS
 JOVER
 JOVET
 JOYA
 JUACHON
 JUAN
 JUANCHO
 JUANERO
 JUANES
 JUANEZ
 JUANEZA
 JUANICO
 JUANITAS
 JUANO
 JUARA
 JUARBE
 JUARDO
 JUARE
 JUAREGUI
 JUARES
 JUAREZ
 JUARISTI
 JUARRERO
 JUARROS
 JUBELA
 JUELLE
 JUEZ
 JUFIAR
 JULBE
 JULIA
 JUNCADELLA
 JUNCAL
 JUNCO
 JUNCOSA
 JUNEZ
 JUNGUERA
 JUNQUERA
 JURADO
 JURAEZ
 JURAHUI

JURDI
 JURE
 JURI
 JURREZ
 JUSAINO
 JUSINO
 JUSTINIANI
 JUSTINIANO
 JUSTIZ
 JUVER
 JUVERA

L

LABADOR
 LABADY
 LABANDEIRA
 LABARGA
 LABARTA
 LABASTIDA
 LABASTILLA
 LABIO
 LABIOSA
 LABISTE
 LABOCA
 LABORDA
 LABORI
 LABORICO
 LABORIN
 LABOY
 LABRA
 LABRADA
 LABRADO
 LABRADOR
 LABUZAN
 LACA
 LACALLE
 LACARRA
 LACASA
 LACASELLA
 LACAYO
 LACEBAL
 LACEDONIA
 LACERA
 LACHAPPA
 LACHICA
 LACHICO
 LACOMBA
 LACOME
 LACONCHA
 LACRET

LACRUE
 LACRUZ
 LACSAMANA
 LADAGA
 LAFARGA
 LAFEBRE
 LAFFONT
 LAFORTEZA
 LAFUENTE
 LAFUENTES
 LAGAR
 LAGARDA
 LAGARES
 LAGEYRE
 LAGO
 LAGOA
 LAGOMASINO
 LAGRANA
 LAGUER
 LAGUERUELA
 LAGUILLO
 LAGUNA
 LAGUNAS
 LAGUNES
 LAHOZ
 LAIJA
 LAIJAS
 LAILES
 LAINEZ
 LAISECA
 LAIZ
 LAJARA
 LAJES
 LALLAVE
 LALOMA
 LALUEZA
 LALUZ
 LAMADRID
 LAMADRIZ
 LAMAS
 LAMASA
 LAMATA
 LAMAZARES
 LAMBARDIA
 LAMBAREN
 LAMBARENA
 LAMBARIA
 LAMBARRI
 LAMBOY
 LAMEIRA

LAMELA
 LAMELAS
 LAMIGUEIRO
 LAMORENA
 LAMOSA
 LAMOSO
 LAMOURT
 LAMOUTTE
 LAMPARELLO
 LAMPEDUSA
 LAMPON
 LANAS
 LANCARA
 LANCHA
 LANDA
 LANDAVASO
 LANDAVAZO
 LANDAVERDE
 LANDAZURI
 LANDEIRA
 LANDERO
 LANDEROS
 LANDESTOY
 LANDETA
 LANDEZ
 LANDIN
 LANDIVAR
 LANDOL
 LANDRAU
 LANDRIAN
 LANDRON
 LANET
 LANFRANCO
 LANGARA
 LANGARCIA
 LANGARICA
 LANTIGUA
 LANUEZ
 LANUZA
 LANZISERO
 LANZOT
 LAO
 LAOS
 LAOSA
 LAPADURA
 LAPARRA
 LAPAZ
 LAPENA
 LAPICA
 LAPIZ

1980 CENSUS LIST OF SPANISH SURNAMES

LAPUERTA	LARRUBIA	LAVERNIA	LEGOZA
LAPUZ	LARTUNDO	LAVIADA	LEGRA
LARA	LARZABAL	LAVILLA	LEGUINA
LARACUENTA	LASA	LAVIOS	LEIBA
LARACUENTE	LASAGA	LAVORICO	LEIBAS
LARALDE	LASALDE	LAVORIN	LEIGON
LARAN	LASANTA	LAYANA	LEIJA
LARAS	LASAS	LAYNA	LEIMON
LARDIZABAL	LASAVIO	LAZA	LEIRA
LAREDO	LASCANO	LAZAGA	LEIRO
LARENA	LASCOR	LAZALA	LEISA
LARENAS	LASCURAIN	LAZALDE	LEISECA
LARES	LASERNA	LAZANO	LEITA
LAREZ	LASES	LAZARIN	LEITES
LARIOS	LASHERAS	LAZARINE	LEIVA
LARIVA	LASO	LAZARO	LEIVAS
LARIZ	LASOS	LAZARTE	LEIZAN
LARRA	LASSOS	LAZCANO	LEJARZA
LARRACHE	LASTRA	LAZCOS	LEJARZAR
LARRAGA	LASTRE	LAZES	LELEVIER
LARRAGOITE	LASTRES	LAZO	LEMES
LARRAGOITY	LATASA	LAZODELAVEGA	LEMUS
LARRAINZAR	LATIGO	LAZOS	LEMUZ
LARRALDE	LATONI	LAZRINE	LENERO
LARRAMENDI	LATORRES	LAZU	LENTE
LARRAN	LAUGIER	LAZURTEGUI	LEODORO
LARRANAGA	LAUREAN	LEAL	LEON
LARRANGA	LAUREANO	LEANOS	LEONES
LARRASQUITO	LAUREDO	LEBARIO	LEONGUERRERO
LARRASQUITU	LAUREIRO	LEBRIJA	LEONIS
LARRAURI	LAUREL	LEBRON	LEONOR
LARRAYA	LAURELES	LECARO	LEOS
LARRAZ	LAURIANO	LECAROS	LEOZ
LARRAZABAL	LAURIAS	LECEA	LEPE
LARRAZOLA	LAURIDO	LECHON	LERA
LARRAZOLO	LAUSELL	LECHUGA	LERDO
LARREA	LAUTERIO	LECTORA	LERENA
LARREGUI	LAUZARDO	LECUMBERRI	LERET
LARRETA	LAUZURIQUE	LECUSAY	LERMA
LARREYNAGA	LAVANDEIRA	LEDESMA	LERMO
LARRIBA	LAVANDERA	LEDEZMA	LERNO
LARRIBAS	LAVANDERO	LEDO	LERO
LARRINAGA	LAVARS	LEDON	LESA
LARRINUA	LAVASTIDA	LEGARDA	LESCANO
LARRIVA	LAVAYEN	LEGARRA	LESMES
LARRONDE	LAVEA	LEGARRETA	LESPIER
LARRONDO	LAVEAGA	LEGARRETTA	LESPRON
LARROSA	LAVEGA	LEGASPE	LETAMENDI
LARROY	LAVENDERA	LEGASPI	LETONA
LARRUA	LAVERGATA	LEGORRETA	LETRIZ

1980 CENSUS LIST OF SPANISH SURNAMES

LEURA	LINARES	LLAMAS	LLOREDA
LEVALDO	LINAREZ	LLAMAZARES	LLORENS
LEVARIO	LINEIRO	LLAMBES	LLORENTE
LEYBA	LINERA	LLAMEDO	LLORET
LEYBAS	LINERO	LLAMES	LLOREN
LEYJA	LINEROS	LLAMOSA	LLOSA
LEYRA	LIQUET	LLANA	LLOVERA
LEYRO	LIQUEZ	LLANAS	LLOVERAS
LEYUA	LIRA	LLANERA	LLOVET
LEYVA	LIRAALVARADO	LLANERAS	LLOVIO
LEYVAS	LIRANZO	LLANES	LLUBERES
LEZA	LIRES	LLANEZ	LLUCH
LEZAJA	LIRIANO	LLANIO	LLUIS
LEZAMA	LIRIO	LLANO	LLURIA
LEZANA	LISALDA	LLANOS	LLUVERAS
LEZCANO	LISALDE	LLANTADA	LOA
LIANO	LISAMA	LLANTIN	LOAIZA
LIANOZ	LISARDO	LLANUSA	LOARTE
LIANZA	LISBOA	LLAPUR	LOAYZA
LIBOY	LISCANO	LLARENA	LOBAINA
LIBRAN	LISEA	LLATA	LOBATO
LIBREROS	LISERA	LLAUGER	LOBATOS
LICANO	LISERIO	LLAURADO	LOBATOZ
LICEA	LISOJO	LLAURADOR	LOBERA
LICEAGA	LIZA	LLAUSAS	LODEIRO
LICERIO	LIZALDA	LLAVE	LODEVICO
LICON	LIZALDE	LLAVERIAS	LODOS
LICONA	LIZAMA	LLAVET	LODOZA
LICOR	LIZAN	LLAVONA	LOERA
LICUDINE	LIZANO	LLENIN	LOEZA
LIENDO	LIZAOLA	LLENZA	LOGOLUSO
LIERA	LIZARAGA	LLEO	LOGRONO
LIERAS	LIZARDE	LLEONART	LOINAZ
LIERRA	LIZARDI	LLERA	LOIRA
LIEVANO	LIZARDO	LLERANDI	LOJA
LIEVANOS	LIZARRAGA	LLERAS	LOJERO
LIGUES	LIZARRAGO	LLERENA	LOJO
LIGUEZ	LIZARRALDE	LLERENAS	LOMANA
LIMARDO	LIZARRARAS	LLEVERINO	LOMAYESVA
LIMAS	LIZARZABURU	LLIBRE	LOMBANA
LIMIA	LIZASO	LLINAS	LOMBARDIA
LIMON	LIZASUAIN	LLITERAS	LOMBERA
LIMONES	LIZCANO	LLIZO	LOMBRANA
LIMONEZ	LLABRES	LLOBERA	LOMBRANO
LIMONTA	LLACA	LLOBET	LOMELI
LIMONTORRES	LLACER	LLOMPART	LOMELIN
LIMOSNERO	LLADO	LLONA	LOMELLIN
LIMUEL	LLAGOSTERA	LLOPIS	LOMELY
LINAJE	LLAGUNO	LLOPIZ	LONA
LINAN	LLAMA	LLORCA	LONDONO

1980 CENSUS LIST OF SPANISH SURNAMES

LONGORIA	LOVERA	LUJANO	MACHUCA
LONGORIO	LOVERAS	LUJARDO	MACIA
LONGOVIA	LOVILLE	LUJO	MACIAL
LONGUEVAN	LOVIO	LUJON	MACIAS
LONVELIN	LOYA	LUMBRERA	MACIAZ
LOPATEGUI	LOYNAZ	LUMBRERAS	MACIEL
LOPE	LOYO	LUNA	MACOTELA
LOPENA	LOYOLA	LUNARES	MADA
LOPERA	LOZA	LUPERCIO	MADALA
LOPERENA	LOZADA	LUPEZ	MADARIAGA
LOPETEGUI	LOZADO	LUPIAN	MADERA
LOPEZ	LOZANA	LUPIANEZ	MADERIS
LOPEZCASTRO	LOZANO	LUPIBA	MADERO
LOPEZMENDOZA	LOZEZ	LUPIO	MADIEDO
LOPEZRODRIGUEZ	LOZOLLA	LUQUE	MADOZ
LOPEZSANCHEZ	LOZOYA	LUQUEZ	MADRAZO
LOPEZVEGA	LUA	LUQUIN	MADRIA
LOPOZ	LUACES	LUQUIS	MADRID
LOQUET	LUAN	LURAS	MADRIGAL
LORA	LUAS	LUVIANO	MADRIGALES
LORANCA	LUBE	LUYANDA	MADRIGUAL
LORCA	LUBERTA	LUYANDO	MADRIL
LOREDO	LUBIAN	LUZA	MADRILES
LORENES	LUCARIO	LUZANIA	MADRILL
LORENTE	LUCATERO	LUZANILLA	MADRIZ
LORENZANA	LUCATORTA	LUZANO	MADRONA
LORERA	LUCENA	LUZARDO	MADRUENO
LORETDEMOLA	LUCER	LUZARRAGA	MADRUGA
LOREZ	LUCERO	LUZBET	MADUANO
LORIDO	LUCIO	LUZUNARIS	MADUELL
LORIEGA	LUCO	LUZURIAGA	MADUENA
LORIGA	LUCOS		MADUENO
LORIGO	LUCRET		MADURO
LORONA	LUEBANO	M	MAELIA
LORONO	LUENGAS	MACARAIG	MAES
LORTA	LUENGO	MACARDICAN	MAESE
LORZA	LUERA	MACARENO	MAESO
LOSA	LUERAS	MACARON	MAESTAS
LOSADA	LUEVANO	MACAVINTA	MAESTAZ
LOSADO	LUEVANOS	MACAYA	MAESTES
LOSANA	LUEZA	MACAYAN	MAESTOS
LOSOYA	LUGARDO	MACDONADO	MAESTRE
LOSTAUNAU	LUGARO	MACEDA	MAESTREY
LOUATO	LUGO	MACEIRA	MAESTU
LOUBRIEL	LUGON	MACEN	MAEVA
LOURIDO	LUGONES	MACENA	MAEZ
LOUSTAUNAU	LUINA	MACEO	MAGALDE
LOVATO	LUIS	MACEYRA	MAGALLAN
LOVATON	LUITIN	MACHICHE	MAGALLANES
LOVEIRA	LUJAN	MACHIN	MAGALLANEZ
		MACHORRO	

1980 CENSUS LIST OF SPANISH SURNAMES

MAGALLON	MALAVES	MANDUJANO	MAQUEIRA
MAGALONA	MALAVET	MANGOME	MAQUINALEZ
MAGANA	MALAVEZ	MANGUAL	MAQUIVAR
MAGANTE	MALBAEZ	MANGUIA	MARABOTTO
MAGARINO	MALBAS	MANICOM	MARADIAGA
MAGAZ	MALDANADO	MANIQUIS	MARALES
MAGDAEL	MALDENADO	MANITO	MARANAN
MAGDALANO	MALDOMADO	MANJARES	MARANON
MAGDALENA	MALDONA	MANJAREZ	MARANTE
MAGDALENO	MALDONADA	MANJARRES	MARANTOS
MAGDIRILA	MALDONADO	MANJARREZ	MARASCOLA
MAGENO	MALDONALDO	MANOSA	MARATAS
MAGLICA	MALDONDO	MANQUERO	MARAVEZ
MAGLUTA	MALDONODO	MANQUEROS	MARAVILLA
MAGPAYO	MALENDEZ	MANRESA	MARAVILLAS
MAGPURI	MALFAVON	MANRIGUEZ	MARAVILLO
MAGRINA	MALIAROS	MANRIQUE	MARBAN
MAGSOMBOL	MALIBRAN	MANRIQUES	MARCADIS
MAGUREGUI	MALICAY	MANRIQUEZ	MARCANO
MAIMES	MALLANO	MANRRIQUE	MARCELENO
MAIMO	MALLEA	MANRRIQUEZ	MARCELIN
MAINEGRA	MALLOQUE	MANSANALES	MARCHA
MAINERO	MALLORCA	MANSANALEZ	MARCHAN
MAINEZ	MALONCO	MANSANARES	MARCHANTE
MAIQUEZ	MALONCON	MANSANAREZ	MARCHANY
MAIRENA	MALOVE	MANSILLA	MARCHECO
MAISONAVE	MALPICA	MANSILLAS	MARCHENA
MAISONET	MALTES	MANSITO	MARCHIONDO
MAISTERRA	MALTOS	MANSO	MARCIAL
MAITIA	MALUIA	MANTECA	MARCILLA
MAITO	MALVAEZ	MANTECON	MARCILLO
MAIZ	MALVAREZ	MANTEROLA	MARCOR
MAJALCA	MALVIDO	MANTILLA	MARCOS
MAJANO	MAMARADLO	MANTINEZ	MARDOMINGO
MAJARUCON	MANCEBO	MANUZ	MARDUENO
MAJENO	MANCERA	MANZANA	MAREINA
MAJIA	MANCERO	MANZANAL	MARENCO
MAJUL	MANCHA	MANZANARES	MARENTES
MAJUTA	MANCHACA	MANZANAREZ	MARENTEZ
MALABANAN	MANCHAN	MANZANEDO	MAREQUE
MALABE	MANCHEGO	MANZANERA	MARERO
MALABEHAR	MANCIAS	MANZANERES	MARES
MALACARA	MANCILLA	MANZANERO	MARESMA
MALAGON	MANCILLAS	MANZANET	MAREZ
MALANA	MANCINAS	MANZANILLA	MARFIL
MALANCHE	MANCITO	MANZANO	MARFILENO
MALANDRIS	MANDADO	MANZUR	MARGAILLAN
MALARIN	MANDONADO	MAPALO	MARGARITO
MALAUE	MANDUGARO	MAPULA	MARGUEZ
MALAVE	MANDUJAN	MAQUEDA	MARIANES

1980 CENSUS LIST OF SPANISH SURNAMES

MARIANS	MARTINETS	MASSANA	MAYORDOMO
MARICHAL	MARTINEX	MASSANET	MAYORGA
MARICHALAR	MARTINEZ	MASSAS	MAYORQUIN
MARIDUENA	MARTINEZDECAST	MASSIATTE	MAYSONET
MARIN	RO	MASTACHE	MAYTIN
MARINAS	MARTINEZGARCIA	MASTRAPA	MAYTORENA
MARINELARENA	MARTINEZGONZA	MASVIDAL	MAZA
MARINERO	LEZ	MATA	MAZARA
MARINES	MARTINEZORTIZ	MATAIYA	MAZARIEGO
MARINEZ	MARTINEZRODRIG	MATALLANA	MAZARIEGOS
MARIONA	UEZ	MATALOBOS	MAZON
MARISCAL	MARTINIZ	MATAMOROS	MAZORRA
MARISTANY	MARTIR	MATANZO	MAZPULE
MARISY	MARTIRENA	MATEAS	MAZQUIARAN
MARITNEZ	MARTIZ	MATEO	MAZUCA
MARLANO	MARTLARO	MATEOS	MAZUELOS
MARMOL	MARTNEZ	MATEU	MEASTAS
MARMOLEJO	MARTORELL	MATIAS	MEAVE
MARMOLEJOS	MARTOS	MATIENZO	MECADO
MARONES	MARUFFO	MATILLA	MECARTEA
MARQUEZ	MARUFO	MATOS	MECENAS
MARQUINA	MARULANDA	MATOSO	MECHOSO
MARQUIZ	MARUNO	MATOZA	MEDEL
MARRASQUIN	MARURI	MATTILLO	MEDELES
MARRENO	MARVEZ	MATURANA	MEDELEZ
MARRERO	MARXUACH	MATURINO	MEDELLIN
MARRIAGA	MARZAN	MATUTE	MEDERO
MARRIETTA	MARZOA	MAULEON	MEDEROS
MARRODAN	MARZOL	MAUNA	MEDIANO
MARROGUIN	MARZOVILLA	MAUPOME	MEDIAVILLA
MARROQUIN	MAS	MAURAS	MEDINA
MARRORO	MASCARDO	MAUREL	MEDINAS
MARROZOS	MASCARENA	MAURICIO	MEDINILLA
MARRUFFO	MASCARENAS	MAURIES	MEDIO
MARRUFO	MASCARENAZ	MAURIZ	MEDIZ
MARRUGO	MASCARENO	MAUROSA	MEDOLA
MARRUJO	MASCARINAS	MAUROZA	MEDRAN
MARSACH	MASCARRO	MAYA	MEDRANO
MARSALIA	MASCORRO	MAYAGOITIA	MEGARIZ
MARSELLOS	MASDEO	MAYANS	MEGUI
MARTE	MASDEU	MAYAS	MEIJA
MARTELON	MASEDA	MAYATE	MEIRELES
MARTENEZ	MASERO	MAYDON	MEIZOSO
MARTES	MASFERRER	MAYEN	MEJA
MARTEZ	MASIAS	MAYMI	MEJIA
MARTIARENA	MASIEL	MAYNEZ	MEJIAS
MARTICORENA	MASJUAN	MAYOL	MEJICO
MARTINDELCAMP	MASPERO	MAYORA	MEJIDO
O	MASPONS	MAYORAL	MEJILLA
MARTINES	MASQUIDA	MAYORCA	MEJILLAS

1980 CENSUS LIST OF SPANISH SURNAMES

MEJORADA	MENDIBURU	MERENDON	MIESES
MEJORADO	MENDIETA	MEREZ	MIGNARDOT
MELANDEZ	MENDIETTA	MERGIL	MIGOYA
MELANO	MENDIGUTIA	MERINO	MIGUEL
MELCHOR	MENDINE	MERIZALDE	MIGUELES
MELCON	MENDIOLA	MERJIL	MIGUELEZ
MELECIO	MENDIOLEA	MERLA	MIGUELIZ
MELENA	MENDIONDO	MERLOS	MIGURA
MELENCIANO	MENDITA	MERMEA	MIJANGOS
MELENDE	MENDIVEL	MERMEJO	MIJARES
MELENDES	MENDIVIL	MERMELLA	MIJAREZ
MELLENDEZ	MENDIZ	MERODIO	MIJENES
MELENDRES	MENDIZABAL	MERONO	MILA
MELENDREZ	MENDOSA	MERU	MILANES
MELENEDEZ	MENDOZ	MERUELO	MILANEZ
MELENEZ	MENDOZA	MESA	MILARA
MELENUDO	MENDOZO	MESEGUER	MILERA
MELERO	MENDRE	MESIA	MILIAN
MELGAR	MENDRIN	MESIAS	MILINA
MELGAREJO	MENEDEZ	MESILLAS	MILLAN
MELGARES	MENENDEZ	MESINAS	MILLAND
MELGOSA	MENES	MESONERO	MILLANES
MELGOZA	MENESES	MESORANA	MILLANEZ
MELIAN	MENEZ	MESQUIAS	MILLANPONCE
MELIAS	MENJARES	MESQUIT	MILLARES
MELINDEZ	MENJIVAR	MESQUITA	MILLAYES
MELIOTA	MENJUGA	MESQUITE	MIMIAGA
MELLADO	MENOCAL	MESQUITI	MINABE
MELOCOTON	MENOSCAL	MESSARRA	MINAGA
MEMBRENO	MENOUD	MESSEGUER	MINAGORRI
MEMBRILA	MENOYO	MESTA	MINAMIDE
MENA	MERA	MESTAS	MINATRE
MENACHE	MERANCIO	MESTAZ	MINAYA
MENACHO	MERAS	MESTRE	MINCHACA
MENCHACA	MERAZ	MESTRES	MINDIETA
MENCHAEA	MERCAD	MESTRIL	MINDIOLA
MENCHAVEZ	MERCADA	MEXIA	MINERA
MENCHEGO	MERCADAL	MEXICANO	MINERO
MENCIA	MERCADE	MEZA	MINGUELA
MENCIO	MERCADER	MEZQUITA	MINGURA
MENCOS	MERCADO	MICAN	MINIAREZ
MENDANA	MERCARDO	MICHACA	MINICA
MENDAROS	MERCED	MICHELENA	MINITREZ
MENDEOLA	MERCEDES	MICHELTORENA	MINJARES
MENDEZ	MERCHAIN	MIEDES	MINJAREZ
MENDIA	MERCHAN	MIELES	MINOBE
MENDIAS	MERCODO	MIELGO	MINONDO
MENDIAZ	MERCOLA	MIERA	MINOSO
MENDIBLES	MERCONCHINI	MIERES	MINSAL
MENDIBURO	MERELES	MIEREZ	MIQUEO

1980 CENSUS LIST OF SPANISH SURNAMES

MIR	MOLANO	MONEO	MONTEAGUDO
MIRABAL	MOLDES	MONGE	MONTEALEGRE
MIRABEL	MOLDONADO	MONGES	MONTEAVARO
MIRABENT	MOLEDO	MONGUIA	MONTECELO
MIRADA	MOLENA	MONITA	MONTECINO
MIRAFLORES	MOLENDEZ	MONJARAS	MONTEDEOCA
MIRALES	MOLERA	MONJARAZ	MONTEFALCON
MIRALLA	MOLERES	MONJARDIN	MONTEJANO
MIRALLES	MOLERIO	MONJE	MONTEJO
MIRAMON	MOLGADO	MONJES	MONTELLANO
MIRAMONTES	MOLINA	MONLEON	MONTELONGO
MIRAMONTEZ	MOLINAR	MONLLOR	MONTEMAJOR
MIRANA	MOLINARES	MONNAR	MONTEMAYOR
MIRANDA	MOLINARY	MONOZ	MONTENEGRO
MIRANO	MOLINAS	MONRAZ	MONTEON
MIRASOL	MOLINER	MONREAL	MONTERA
MIRAVAL	MOLINEROS	MONRIAL	MONTERDE
MIRAYA	MOLINET	MONROIG	MONTEREY
MIRAZ	MOLLEDA	MONROY	MONTERO
MIRAZO	MOLLES	MONRREAL	MONTEROLA
MIRDITA	MOLLINDO	MONRRIAL	MONTEROS
MIRELES	MOLLINEDO	MONSALVE	MONTERREY
MIRELEZ	MONAGAS	MONSALVO	MONTERROSA
MIRET	MONARCO	MONSEBAIS	MONTERROSO
MIRILES	MONAREZ	MONSEGUR	MONTERROZA
MIRO	MONARQUE	MONSERRAT	MONTERRUBIO
MIROLLA	MONARQUE	MONSERRATE	MONTES
MISAS	MONARRES	MONSEVAIS	MONTESDEOCA
MISLA	MONARREZ	MONSEVALLES	MONTESINO
MISQUEZ	MONCADA	MONSIBAIS	MONTESINOS
MIYAR	MONCADO	MONSIBAIZ	MONTEVERDE
MIYARES	MONCAYO	MONSISVAIS	MONTEZ
MOCEGA	MONCEVAIS	MONSIVAIS	MONTEZUMA
MOCETE	MONCEVAIZ	MONSIVAIZ	MONTIEL
MOCHO	MONCEVIAS	MONTAIVO	MONTIJO
MOCTEZUMA	MONCIBAIS	MONTALBAN	MONTILLA
MODERO	MONCIBAIZ	MONTALBO	MONTION
MODIA	MONCIVAIS	MONTALUO	MONTMAYOR
MODRONO	MONCIVAIZ	MONTALVAN	MONTOLLA
MOGAS	MONCIVALLES	MONTALVO	MONTONO
MOGOLLON	MONCLOVA	MONTAN	MONTOTO
MOGRO	MONDACA	MONTANE	MONTOVA
MOGUEL	MONDEJAR	MONTANER	MONTOY
MOHEDANO	MONDELO	MONTANES	MONTOYA
MOIZA	MONDONA	MONTANEZ	MONTOYO
MOJADO	MONDOZA	MONTANIO	MONTUFAR
MOJARRO	MONDRAGON	MONTANO	MONTUYA
MOJEDA	MONEDA	MONTANTES	MONZON
MOJENA	MONEDERO	MONTAYA	MOQUETE
MOJICA	MONEGRO	MONTAZ	MOQUINO

1980 CENSUS LIST OF SPANISH SURNAMES

MORA	MORGAS	MOYET	MUNOZCANO
MORADO	MORHAR	MOYRON	MUNQUIA
MORAGA	MORIEL	MOZAS	MUNTANER
MORAGO	MORILLA	MOZQUEDA	MURADAS
MORAGUEZ	MORILLAS	MUCALA	MURADAZ
MORAIDA	MORILLO	MUCINO	MURADO
MORAILA	MORILLON	MUDAFORT	MURAIMA
MORAL	MORILLOS	MUELA	MURAIRA
MORALE	MORIONES	MUELAS	MURALLES
MORALEJO	MORIYON	MUENTES	MURANE
MORALES	MORLA	MUGA	MURATALLA
MORALES	MORLES	MUGARTEGUI	MURAVEZ
MORALES	MORLET	MUGERZA	MURCIA
MORALES	MORLOTE	MUGICA	MURCIANO
MORALES	MOROCHO	MUGUERCIA	MURCIO
MORALES	MORODO	MUGUERZA	MURGA
MORALES	MOROLES	MUGUIRO	MURGADO
MORANDA	MOROLEZ	MUIL	MURGUIA
MORANTES	MORON	MUINA	MURIAS
MORATA	MORONES	MUINAS	MURIEDAS
MORATALLA	MORONEZ	MUINO	MURIEL
MORATAYA	MOROYOQUI	MUINOS	MURIENTE
MORATO	MORQUECHO	MUIRRAGUI	MURIETTA
MORAZA	MORQUEZ	MUIS	MURILLO
MORCATE	MORRAS	MUJICA	MURO
MORCIEGO	MORRAZ	MULERO	MUROLAS
MORCIGLIO	MORRERO	MULET	MUROS
MORCOS	MORRINA	MULGADO	MUROYA
MOREDA	MORTEO	MUNA	MURRIETA
MOREDO	MORTERA	MUNANA	MURRIETTA
MOREIDA	MORUA	MUNARRIZ	MURRILLO
MOREIRAS	MORVA	MUNDO	MURSULI
MOREJON	MOSCOSO	MUNECAS	MURUA
MORELES	MOSINO	MUNERA	MURUAGA
MORELION	MOSQUEA	MUNERO	MURUATO
MORELLON	MOSQUEDA	MUNET	MUSQUEZ
MORELO	MOSQUEDO	MUNETON	MUSQUIZ
MORELOS	MOSQUERA	MUNEZ	MUSTELIER
MORENO	MOTA	MUNGARAY	MUTIO
MORENTIN	MOTAL	MUNGARRO	MUXART
MORERA	MOTILLA	MUNGIA	MUXO
MORERO	MOURE	MUNGUIA	MUZAURIETA
MORETA	MOUREN	MUNILLA	MUZQUIZ
MOREYRA	MOURINO	MUNIVE	
MORFA	MOURIZ	MUNIVEZ	
MORFFI	MOYA	MUNIZ	
MORFI	MOYADO	MUNNE	
MORFIN	MOYANO	MUNOA	
MORGA	MOYEDA	MUNOS	
MORGALO	MOYENO	MUNOZ	

N

NABA
 NABARRETE
 NABARRETTE
 NABAYAN
 NABETA

1980 CENSUS LIST OF SPANISH SURNAMES

NACER	NAVARETTE	NERIA	NOCHERA
NACHON	NAVAREZ	NERIO	NODAL
NACIANCENO	NAVARIA	NERIOS	NODAR
NADAL	NAVARIJO	NERIS	NODARSE
NAFARRATE	NAVARR	NERVAIS	NOGALES
NAFARRETE	NAVARRETE	NEVARES	NOGARE
NAGORE	NAVARRETTE	NEVAREZ	NOGUE
NAJAR	NAVARRRO	NEVARREZ	NOGUEDA
NAJARA	NAVAS	NEYRA	NOGUEIRAS
NAJARES	NAVEDA	NIALS	NOGUELLES
NAJARRO	NAVEDO	NIAVE	NOGUER
NAJERA	NAVEIRA	NIAVES	NOGUERA
NALDA	NAVEIRAS	NIAVEZ	NOGUERAS
NANDIN	NAVEJA	NICACIO	NOGUES
NANDINO	NAVEJAR	NICASIO	NOGUEZ
NANEZ	NAVEJAS	NICOT	NOLASCO
NAPOLES	NAVERAN	NIDEZ	NOLINE
NARANJO	NAVIA	NIDO	NOLLA
NARAVEZ	NAVIDAD	NIEBLA	NOMBRANA
NARBAIZ	NAVO	NIEBLAS	NOMBRANO
NARCHO	NAVODA	NIEGO	NOPERI
NARCIA	NAYA	NIELES	NORALES
NAREDO	NAYARES	NIETO	NORALEZ
NARES	NAZABAL	NIEVA	NORAT
NAREZ	NAZARIO	NIEVE	NORDA
NAREZO	NAZCO	NIEVES	NORDELLA
NARINO	NAZUR	NIEVEZ	NORDELO
NARIO	NEBLINA	NIEZ	NOREIGA
NARONJO	NEBREDA	NIGAGLIONI	NORENA
NARRANJO	NEBRIDA	NIGOS	NORERO
NARRO	NECO	NILA	NORIA
NARVAES	NECOCHEA	NIN	NORIEGA
NARVAEZ	NECOECHEA	NINA	NORIEGO
NARVAIS	NECUZE	NINO	NORIZ
NARVAIZ	NEGRE	NIRA	NORMANDIA
NARVAREZ	NEGREIRA	NISPEROS	NORONA
NARVARTE	NEGRET	NISTAL	NORTE
NATAL	NEGRETE	NIVAL	NORZAGARAY
NATERA	NEGRETTE	NIVAR	NOVALES
NATERAS	NEGRIN	NIVES	NOVAS
NATIVIDAD	NEGRON	NIZ	NOVELA
NAVA	NEGRONCOLON	NOA	NOVELO
NAVAIRA	NEGRONI	NOBARA	NOVEMBRE
NAVAJAR	NEGUERUELA	NOBIDA	NOVIAN
NAVAL	NEIRA	NOBOA	NOVILLO
NAVALES	NEITO	NOBREGAS	NOVO
NAVALLO	NEIVES	NOCAS	NOVOA
NAVANJO	NEJAR	NOCEDA	NOYA
NAVAR	NERADA	NOCEDAL	NOYAS
NAVARETE	NEREY	NOCHE	NOYOLA

1980 CENSUS LIST OF SPANISH SURNAMES

NUANES
 NUANEZ
 NUCHE
 NUEVO
 NUEZ
 NUIN
 NUMEZ
 NUNCIO
 NUNEZ
 NUNGARAY
 NUNO
 NUNTEZ

O

OAXACA
 OBALLE
 OBALLES
 OBANDO
 OBARRIO
 OBAS
 OBAYA
 OBERA
 OBESO
 OBEZO
 OBIEDO
 OBISPO
 OBLEA
 OBLEDO
 OBLIGACION
 OBRADOR
 OBREGON
 OCA
 OCACIO
 OCADIZ
 OCAMPO
 OCAMPOS
 OCANA
 OCANAS
 OCANO
 OCANTO
 OCARANZA
 OCARIZ
 OCARIZA
 OCASIO
 OCEGUEDA
 OCEGUERA
 OCEJO
 OCEQUEDA
 OCHEA
 OCHINERO

OCHIPA
 OCHOA
 OCHOS
 OCHOTERENA
 OCHOTORENA
 OCON
 ODAMA
 ODIO
 ODRIOZOLA
 OFARRILL
 OFERRAL
 OGALDEZ
 OGANDO
 OGARRIO
 OGARRO
 OGAS
 OGAZ
 OGUENDO
 OGUETE
 OHIGGINS
 OJEDA
 OJINAGA
 OJITO
 OLABARRIA
 OLABARRIETA
 OLACHEA
 OLAECHEA
 OLAETA
 OLAEZ
 OLAGE
 OLAGUE
 OLAGUES
 OLAGUEZ
 OLAGUIBEL
 OLAIS
 OLAIZ
 OLALDE
 OLALLA
 OLAQUE
 OLAQUEZ
 OLARTE
 OLASCOAGA
 OLASCUAGA
 OLAVARRI
 OLAVARRIA
 OLAVARRIETA
 OLAVE
 OLAYA
 OLAYO
 OLAZABA

OLAZABAL
 OLAZAGASTI
 OLAZARAN
 OLBA
 OLBERA
 OLBES
 OLDRATE
 OLEA
 OLEAS
 OLETA
 OLGIN
 OLGUIN
 OLIBARES
 OLIBAREZ
 OLIBARRIA
 OLIDE
 OLIU
 OLIVA
 OLIVAN
 OLIVAR
 OLIVARE
 OLIVARES
 OLIVAREZ
 OLIVAROS
 OLIVARRI
 OLIVARRIA
 OLIVAS
 OLIVENCIA
 OLIVERA
 OLIVERAS
 OLIVERAZ
 OLIVERES
 OLIVEREZ
 OLIVERO
 OLIVEROS
 OLIVES
 OLIVIAS
 OLIVIS
 OLIVO
 OLIVOS
 OLLACA
 OLLERBIDEZ
 OLLERVIDES
 OLLERVIDEZ
 OLLIVARES
 OLLOQUE
 OLLOQUI
 OLME
 OLMEDA
 OLMEDO

OLMO
 OLMOS
 OLMOZ
 OLONA
 OLONIA
 OLONO
 OLORTEGUI
 OLQUIN
 OLTIVERO
 OLVEDA
 OLVEDO
 OLVEIRA
 OLVERA
 OLVEZ
 OMAECHEVARRIA
 OMANA
 OMS
 ONATE
 ONDARO
 ONDARZA
 ONDOY
 ONDREAS
 ONDRIAS
 ONGANIA
 ONGAY
 ONOFRE
 ONOZ
 ONSUREZ
 ONTANEDA
 ONTIBEROZ
 ONTIVERAS
 ONTIVERO
 ONTIVEROS
 ONTIVEROZ
 OPIO
 OPORTO
 OQUENDO
 OQUITA
 ORABUENA
 ORACION
 ORAMA
 ORAMAS
 ORANA
 ORANDAY
 ORANTE
 ORANTES
 ORANTEZ
 ORATE
 ORBAY
 ORBEA

1980 CENSUS LIST OF SPANISH SURNAMES

ORBEGOZO	OROL	OSCOS	OVIEDA
ORCA	ORONA	OSCOY	OVIEDO
ORCASITAS	ORONoz	OSEDA	OXIOS
ORDAZ	OROPESA	OSEGUEDA	OYACA
ORDENANA	OROPEZA	OSEGUERA	OYAGUE
ORDENER	OROSA	OSEJO	OYANGUREN
ORDENES	OROSCO	OSELIO	OYARBIDE
ORDENEZ	OROZ	OSEQUERA	OYARZABAL
ORDIALES	OROZCO	OSes	OYARZUN
ORDINARIO	OROZEO	OSETE	OYAS
ORDONES	ORPILLA	OSIO	OYERBIDES
ORDONEZ	ORPINEL	OSLE	OYERVIDES
ORDONO	ORQUIZ	OSNAYA	OYERVIDEZ
ORDOQUI	ORRACA	OSO	OYOLA
ORDORICA	ORRADRE	OSOLLO	OYOQUE
ORDOVER	ORRANTE	OSONA	OYUELA
ORDUNA	ORRANTIA	OSORIA	OZAETA
ORDUNEZ	ORREGO	OSORIO	OZETA
ORDUNO	ORRIOLA	OSORNIA	OZORES
OREGEL	ORRIOLS	OSORNIO	OZORIA
OREJEL	ORSABA	OSORNO	OZORNIA
ORELLANA	ORSUA	OSPINA	OZUNA
ORELLANO	ORTA	OSPINO	OZUNIGA
ORENDAIN	ORTAL	OSPITAL	
ORENGO	ORTAS	OSSA	P
ORENSE	ORTEG	OSSORGIN	PABEY
ORETEGA	ORTEGA	OSSORIO	PABLICO
ORETGA	ORTEGAS	OSTEGUIN	PABLO
ORFILA	ORTEGON	OSTIGUIN	PABLOS
ORGANISTA	ORTES	OSTIQUIN	PABON
ORGE	ORTEZ	OSTOLAZA	PABROS
ORIA	ORTIGAS	OSTOS	PACHARZINA
ORIBA	ORTIGOSA	OSUNA	PACHEC
ORIBE	ORTIGOZA	OTANEZ	PACHECANO
ORIGEL	ORTIVEZ	OTANO	PACHECO
ORIGINALES	ORTIVIZ	OTAZO	PACHELO
ORIHUELA	ORTIZ	OTEGUI	PACHEO
ORIJEL	ORTIZYPINO	OTEIZA	PACHERO
ORIQUE	ORTOLAZA	OTEO	PACHICANO
ORISIO	ORTUNIO	OTERA	PACHO
ORITIZ	ORTUNO	OTERO	PACHON
ORITZ	ORTUZAR	OTHON	PACHUCA
ORIVE	ORUE	OTI	PACIAS
ORIZAGA	ORUNA	OTONDO	PACIFICAR
ORJALES	ORVANANOS	OVADIA	PACILLAS
ORJUELA	ORZA	OVALLE	PACIN
ORNELAS	ORZABAL	OVALLES	PACINA
ORNELAZ	ORZO	OVALLEZ	PACO
ORNELES	OSA	OVANDO	PADDILLA
OROBIO	OSANO	OVARES	PADER

1980 CENSUS LIST OF SPANISH SURNAMES

PADIA	PALIZO	PANDURO	PAREYA
PADIAL	PALLAIS	PANELO	PAREZ
PADIAS	PALLAN	PANENO	PARGA
PADIERNA	PALLANES	PANEQUE	PARGAS
PADILL	PALLANEZ	PANERO	PARIZ
PADILLA	PALLARES	PANETO	PAROCUA
PADILLIA	PALLAREZ	PANIAGUA	PARQUE
PADILLO	PALLEJA	PANIAQUA	PARRA
PADIN	PALLENS	PANIZ	PARRADO
PADOR	PALLOT	PANOPIO	PARRAGA
PADRES	PALMARES	PANTA	PARRAL
PADRINO	PALMAREZ	PANTAJA	PARRALES
PADRO	PALMARIN	PANTALEON	PARRAS
PADRON	PALMAS	PANTIGA	PARRAZ
PADUA	PALMEIRO	PANTIN	PARRENO
PAEZ	PALMERIN	PANTLEO	PARRIERA
PAGAN	PALMEROS	PANTOJA	PARRILLA
PAGANRIVERA	PALOMA	PANTOJAS	PARRONDO
PAGES	PALOMAR	PANTOYAS	PARTAGAS
PAGOLA	PALOMARES	PANTUSA	PARTIDA
PAGON	PALOMAREZ	PANUCO	PARTIDO
PAGUAGA	PALOMEQUE	PANZARDI	PASADA
PAGUIO	PALOMERA	PANZIERA	PASAMONTE
PAHISSA	PALOMIN	PARACHE	PASANTES
PAIACIOS	PALOMINO	PARADA	PASARELL
PAIRADA	PALOMINOS	PARADEDA	PASARET
PAIRIS	PALOMO	PARADELA	PASARIN
PAIZ	PALOP	PARADELO	PASCACIO
PAJARITO	PALOS	PARADES	PASCUAL
PAJARO	PALOU	PARADEZ	PASCUALI
PAJUELO	PAMANES	PARAMO	PASENA
PALACIES	PAMARAN	PARAPAR	PASILLAS
PALACIO	PAMBLANCO	PARAYNO	PASOLS
PALACIOS	PAMIAS	PARAYUELOS	PASOS
PALADINES	PAMINTUAN	PARAZO	PASSAPERA
PALAFOS	PAMPIN	PARCES	PASTORA
PALAFOX	PAMPLONA	PARDAVE	PASTORIZA
PALAGANAS	PANALES	PARDILLO	PASTRAN
PALAMO	PANALEZ	PARDINAS	PASTRANA
PALASOTA	PANAMA	PARDO	PASTRANO
PALATO	PANAMENO	PARDOS	PATINA
PALAU	PANARISO	PARDUCHO	PATINO
PALAZON	PANCEGRAN	PARDES	PATLAN
PALAZUELOS	PANCHANA	PARDEZ	PATRANELLA
PALENCIA	PANCHO	PARREIRA	PATRON
PALENZUELA	PANCORBO	PARREJA	PAUDA
PALEO	PANDAL	PARSELLADA	PAULA
PALGON	PANDAS	PARERA	PAULLADA
PALICIO	PANDES	PARES	PAVEDES
PALITOS	PANDO	PARETS	PAVILA

1980 CENSUS LIST OF SPANISH SURNAMES

PAVON	PELAYO	PERDICES	PERYATEL
PAYAN	PELEGRINA	PERDIDO	PESANTE
PAYANO	PELLECER	PERDIGON	PESANTES
PAYARES	PELLERANO	PERDOMO	PESANTEZ
PAYAS	PELLICIER	PEREA	PESCADO
PAYEN	PELLOT	PEREDA	PESCADOR
PAYERO	PELUFFO	PEREDIA	PESINA
PAZ	PENA	PEREDO	PESQUEDA
PAZMINO	PENABAD	PEREGRINA	PESQUEIRA
PAZOS	PENADO	PEREGRINO	PESQUERA
PECARO	PENAFIEL	PEREIDA	PESQUIERA
PECELUNAS	PENAFLORE	PEREIRO	PEYDRO
PECERO	PENAFLOREDA	PERELES	PEYNADO
PECHERO	PENAGARZA	PERERA	PEYRO
PECINA	PENAHERRERA	PERES	PEZA
PECOS	PENALBA	PEREYDA	PEZEZ
PEDEVILLA	PENALES	PEREYO	PEZINA
PEDRAJA	PENALO	PEREYRA	PIARD
PEDRAS	PENALOSA	PEREZ	PICALLO
PEDRAYES	PENALOZA	PEREZA	PICAR
PEDRAZ	PENALVER	PEREZCANO	PICART
PEDRAZA	PENALVERT	PEREZCHICA	PICASCIA
PEDRE	PENANO	PEREZCOLON	PICASO
PEDREGAL	PENARANDA	PEREZDEALEJO	PICAZO
PEDREGO	PENATE	PEREZDELRIO	PICENO
PEDREGON	PENDAS	PEREZDIAZ	PICHARDO
PEDREGUERA	PENEZ	PEREZGONZALEZ	PICO
PEDREIRA	PENICHE	PEREZJIMENEZ	PICON
PEDREIRO	PENICHET	PEREZLOPEZ	PICOS
PEDRERA	PENILLA	PEREZMENDEZ	PIEDAD
PEDRERO	PENON	PEREZMONTES	PIEDRA
PEDRIANES	PENSADO	PEREZRAMOS	PIEDRAHITA
PEDRINO	PENUELA	PERFECTO	PIEDRAS
PEDROCHE	PENUELAS	PERFINO	PIELAGO
PEDROGO	PENUELAZ	PERICAS	PIERAS
PEDROLA	PENUNURI	PERLAS	PIJUAN
PEDROSA	PEON	PERMUY	PILA
PEDROSO	PEPERAS	PERNAS	PILAR
PEDROZA	PEPITO	PEROLDO	PILARTE
PEGO	PEQUENO	PEROZO	PILLADO
PEGODA	PEQUERO	PERRES	PILOTO
PEGUERO	PERAL	PERRIRAZ	PIMIENTA
PEGUEROS	PERALES	PERTIERRA	PIMIENTO
PEINADO	PERALEZ	PERU	PIMINTEL
PEIRO	PERALTA	PERUMEAN	PINA
PELACHE	PERALTO	PERUSINA	PINADEARCOS
PELAEZ	PERATIS	PERUSQUIA	PINAL
PELAIZ	PERAZA	PERUYERA	PINALES
PELALLO	PERCHES	PERUYERO	PINALEZ
PELATA	PERCHEZ	PERVEZ	PINARES

1980 CENSUS LIST OF SPANISH SURNAMES

PINCAY	PLACENCIO	POMAREZ	POTESTAD
PINEDA	PLACENSIA	POMBROL	POUGES
PINEDO	PLACENTIA	POMELEO	POUSA
PINEIRA	PLACERES	POMPA	POVEDA
PINEIRO	PLAJA	PONCABARE	POVENTUD
PINELA	PLANA	PONCE	POVIONES
PINELO	PLANAS	PONCEDELEON	POYORENA
PINERA	PLANCARTE	PONCHO	POZA
PINERO	PLANCENCIA	PONCIANO	POZAS
PINEROS	PLANELL	PONCIO	POZERO
PINEY	PLANELLAS	PONSDOMENECH	POZO
PINEYRO	PLANES	PONZOA	POZOS
PINGARRON	PLANOS	PORATA	POZUELOS
PINIELLA	PLANTILLAS	PORCAYO	PRADAS
PINILLA	PLANTO	PORCHAS	PRADERE
PINILLO	PLASCENCIA	PORCHO	PRADIA
PINILLOS	PLASENCIA	PORDIA	PRADO
PINO	PLASENCIO	PORFIL	PRAT
PINOL	PLATA	PORLAS	PRATS
PINON	PLATAMONE	PORRAS	PRATTS
PINONES	PLATAS	PORRATA	PRECIADO
PINTADO	PLATERO	PORRAZ	PRELLEZO
PINTOR	PLAZA	PORRERO	PRENDES
PINTOS	PLAZAS	PORRES	PRENDEZ
PINUELA	PLAZOLA	PORROS	PRENDIZ
PINUELAS	PLIEGO	PORTAL	PRESA
PINZON	PLUMA	PORTALATIN	PRESAS
PIOQUINTO	PLUMAS	PORTALES	PRESIADO
PIQUERO	PLUMEDA	PORTALEZ	PRESNO
PIREZ	PLUMEY	PORTELA	PRESTAMO
PIRINEA	POBAR	PORTELLES	PREZAS
PIRIS	POBLANO	PORTES	PRIDA
PIRIZ	POBLETE	PORTIELES	PRIEDE
PIS	POBRE	PORTILLA	PRIEGO
PISANA	PODILLA	PORTILLO	PRIEGUEZ
PISENO	POEY	PORTILLOS	PRIETO
PISONERO	POGAN	PORTOCARRERO	PRIMELLES
PITA	POLA	PORTOLAN	PRIMERA
PITALUGA	POLACO	PORTORREAL	PRIMERO
PITARCH	POLANCO	PORTUGAL	PRIO
PITONES	POLENDO	PORTUGUES	PROA
PITRONES	POLIDURA	PORTUGUEZ	PROANO
PIZANA	POLINA	PORTUONDO	PROCEL
PIZANO	POLITRON	POSADA	PROCELA
PIZARO	POLLERANA	POSADAS	PROCSAL
PIZARRA	POLLORENO	POSAS	PROENZA
PIZARRO	POLVADO	POSOS	PROHIAS
PIZULA	POMALE	POSOS	PROO
PLA	POMALES	POSTIGO	PROVENCIO
PLACENCIA	POMARES	POSTIL	PROVEYER

1980 CENSUS LIST OF SPANISH SURNAMES

PRUDENCIO
 PRUNA
 PRUNEDA
 PRUNES
 PUBILL
 PUBILLONES
 PUCHADES
 PUEBLA
 PUELLA
 PUELLO
 PUENTE
 PUENTES
 PUENTEZ
 PUERTA
 PUERTAS
 PUERTO
 PUERTOS
 PUEYO
 PUGA
 PUGEDA
 PUIG
 PUJADAS
 PUJAL
 PUJALS
 PUJOL
 PUJOLS
 PULGAR
 PULGARIN
 PULIDA
 PULIDO
 PULOMENA
 PUMAR
 PUMARADA
 PUMAREJO
 PUMARES
 PUMARIEGA
 PUMAROL
 PUNALES
 PUNNARA
 PUNO
 PUNTA
 PUNTIEL
 PUPO
 PURA
 PURCELLA
 PURISIMA
 PUYADA
 PUYOL

Q

QUADRENY
 QUALIA
 QUASADA
 QUECLAS
 QUEIPO
 QUEIRO
 QUEIRUGA
 QUELLAR
 QUEMADA
 QUERALT
 QUERDO
 QUERIDO
 QUERO
 QUERT
 QUESADA
 QUESADO
 QUETEL
 QUETGLAS
 QUEVEDO
 QUEZADA
 QUIALA
 QUIAN
 QUIBUYEN
 QUICENO
 QUICHOCHO
 QUIDERA
 QUIHUIS
 QUIHUIZ
 QUIJADA
 QUIJALVO
 QUIJANO
 QUIJAS
 QUILALA
 QUILANTAN
 QUILENDERINO
 QUILES
 QUILEZ
 QUILIMACO
 QUIMBAR
 QUIMIRO
 QUINAL
 QUINCOCES
 QUINDE
 QUINDNEZ
 QUINENES
 QUINES
 QUINI
 QUINIONES
 QUINOA
 QUINONE

QUINONES
 QUINONEZ
 QUINONOS
 QUINORES
 QUINTAMA
 QUINTANA
 QUINTANAL
 QUINTANAR
 QUINTANILLA
 QUINTANS
 QUINTARO
 QUINTAS
 QUINTEIRO
 QUINTELA
 QUINTENILLA
 QUINTERA
 QUINTERO
 QUINTEROS
 QUINTINO
 QUINTONA
 QUINTONES
 QUINTONEZ
 QUINTOS
 QUIONES
 QUIRARTE
 QUIRCH
 QUIRENO
 QUIRINDONGO
 QUIRINO
 QUIRO
 QUIROA
 QUIROBA
 QUIROGA
 QUIROL
 QUIROLA
 QUIROS
 QUIROZ
 QUITA
 QUITANIA
 QUITOS
 QUITUGUA
 QUIZ

R

RABADE
 RABAGO
 RABAJA
 RABANO
 RABASA
 RABASSA

RABAZA
 RABEIRO
 RABELL
 RABELO
 RABIA
 RABIELA
 RABINA
 RABINO
 RABOS
 RADAVERO
 RADILLA
 RADILLO
 RADRIGUEZ
 RAEI
 RAEZ
 RAFAEL
 RAFALIN
 RAFULS
 RAICES
 RAIGOSA
 RAIGOZA
 RAIMUNDEZ
 RAIMUNDI
 RAISOLA
 RAJOY
 RALDIRIS
 RAMALLO
 RAMARIZ
 RAMAS
 RAMBES
 RAMBLAS
 RAMBONGA
 RAMENTOL
 RAMEREZ
 RAMERIZ
 RAMERO
 RAMERY
 RAMIEREZ
 RAMIERZ
 RAMIEZ
 RAMIL
 RAMINEZ
 RAMIR
 RAMIRE
 RAMIRES
 RAMIREZ
 RAMIRIZ
 RAMIRO
 RAMIS
 RAMON

1980 CENSUS LIST OF SPANISH SURNAMES

RAMONEDA	REALYVASQUEZ	REGUEIRO	REQUIRO
RAMONES	REANO	REGUERA	RESCHMAN
RAMOS	REATEGUI	REGUERO	RESENDEZ
RAMOSGONZALEZ	REAZA	REGULES	RESENDIS
RAMOSMEDINA	REAZOLA	REGUSA	RESENDIZ
RAMOSRIVERA	REBELES	REICEN	RESERVA
RAMOSRODRIGUE	REBELEZ	REICES	RESINA
Z	REBELLON	REIGOSA	RESMA
RAMOZ	REBETERANO	REINA	RESON
RAMUDO	REBOLLAR	REINAGA	RESPETO
RAMUZ	REBOLLEDO	REINALDO	RESSY
RANCANO	REBOLLO	REINAT	RESTO
RANDEZ	REBOLLOSO	REINERO	RESTOY
RANERO	REBOREDO	REINOSA	RESTREDO
RANESES	REBOSO	REINOSO	RESTREPO
RANGEL	REBOYRAS	REINUS	RESUREZ
RANGELL	REBOZO	REJAS	RETA
RANGELLOPEZ	REBUSTILLO	REJINO	RETAMAL
RANJEL	RECALDE	REJO	RETAMALES
RANSOLA	RE CAREY	REJON	RETAMAR
RAQUENIO	RECARTE	REL	RETAMOSA
RAQUENO	RECENDES	RELLES	RETAMOZA
RAQUEPO	RECENDEZ	RELLEZ	RETANA
RASALES	RECHANI	RELUCIO	RETANO
RASCOM	RECHANY	REMACHE	RETES
RASCON	RECHY	REMEDIOS	RETEZ
RASPALDO	RECILLAS	REMIGIO	RETIZ
RASURA	RECINOS	REMIJO	RETTA
RATON	RECIO	REMOS	RETURETA
RAUDA	RECLUSADO	RENDEROS	REVADA
RAVAGO	RECOVO	RENDON	REVADO
RAVARD	RECUSET	RENEDO	REVELES
RAVELO	REDE	RENGE	REVELEZ
RAVENTOS	REDERO	RENOBATO	REVELLES
RAXACH	REDONA	RENOVA	REVERON
RAYA	REDONDO	RENOVALES	REVILLA
RAYAS	REDRUELLO	RENOVATO	REVILLAS
RAYGOSA	REFUERZO	RENTA	REVOLLAR
RAYGOZA	REGALADO	RENTAS	REVOLLEDO
RAYMOS	REGALDO	RENTERIA	REVOREDO
RAYMUNDO	REGALES	RENTERIAS	REVUELTA
RAYNA	REGALO	REORDA	REVUELTAS
RAYONEZ	REGALOS	REOYO	REXACH
RAYOR	REGATO	REPOLLET	REY
RAYOS	REGINO	REPREZA	REYEROS
RAZATOS	REGOJO	REQUEJO	REYERS
RAZO	REGOS	REQUENA	REYES
REALES	REGRUTTO	REQUENES	REYESPEREZ
REALIVASQUEZ	REGUA	REQUENEZ	REYESRODRIGUEZ
REALME	REGUEIRA	REQUENO	REYEZ

1980 CENSUS LIST OF SPANISH SURNAMES

REYGADAS	RIBERAS	RIGUAL	RIOZ
REYNA	RIBOT	RIGUERA	RIPALDA
REYNADO	RIBOTA	RIGUERO	RIPES
REYNAGA	RICABAL	RIJO	RIPOL
REYNALDO	RICALDE	RIJOS	RIPOLL
REYNALDOS	RICANO	RIMBLAS	RIPOLLES
REYNERO	RICARDEZ	RINAURO	RIQUELME
REYNEROS	RICARDO	RINCHE	RIQUERO
REYNOS	RICART	RINCON	RISQUET
REYNOSA	RICARTE	RINCONENO	RISUENO
REYNOSO	RICHARTE	RINCONES	RIUS
REYNOZA	RICHIEZ	RINGLERO	RIUSECH
REYNOZO	RICHINA	RIOBO	RIVADA
REYO	RICO	RIOCABO	RIVADENEIRA
REYOS	RICONDO	RIOFRIO	RIVADENEYRA
REZA	RIDRIGUEZ	RIOJA	RIVADULLA
REZENDEZ	RIEDO	RIOJAS	RIVALE
RIALI	RIEGA	RIOJAZ	RIVALI
RIANCHO	RIEGO	RIOJOS	RIVARES
RIANDA	RIEGOS	RIOLLANO	RIVAROLA
RIAVE	RIERA	RIONDA	RIVAS
RIAZA	RIERAS	RIOPEDRE	RIVAZ
RIBADENEIRA	RIESCO	RIOS	RIVEIRA
RIBAL	RIESGO	RIOSECO	RIVEIRO
RIBALTA	RIESTRA	RIOSESPINOZA	RIVERA
RIBAS	RIGAL	RIOSFLORES	RIVERACOLON
RIBERA	RIGALES	RIOSMARTINEZ	
RIBERAL	RIGAU	RIOSPEREZ	
RIVERACRUZ	ROBAU	ROCHA	RODILES
RIVERADIAZ	ROBAYNA	ROCHAS	RODIQUEZ
RIVERALUGO	ROBAYO	ROCHES	RODIRGUEZ
RIVERAPEREZ	ROBEDA	ROCHIN	RODREGUEZ
RIVERARIVERA	ROBELDO	ROCHOA	RODRGUEZ
RIVERAS	ROBELO	ROCIO	RODRIG
RIVERIA	ROBLAS	RODADO	RODRIGEUZ
RIVERO	ROBLEDA	RODALLEGAS	RODRIGEZ
RIVEROL	ROBLEDO	RODARTE	RODRIGIEZ
RIVEROLL	ROBLEJO	RODAS	RODRIGNEZ
RIVERON	ROBLERO	RODEA	RODRIGOEZ
RIVEROS	ROBLES	RODELA	RODRIGS
RIVERRA	ROBLETO	RODELAS	RODRIGU
RIVIERO	ROBLEZ	RODELO	RODRIGUEA
RIZO	ROBREDO	RODENA	RODRIGUERA
ROA	ROCA	RODENAS	RODRIGUEZ
ROACHO	ROCAFORT	RODERO	RODRIGUEZMARTI
ROANO	ROCAFUERTE	RODEZ	NEZ
ROBAINA	ROCAMONTES	RODGRIGUEZ	RODRIGUEZS
ROBALI	ROCAMONTEZ	RODICIO	RODRIGUIEZ
ROBALIN	ROCERO	RODIGUEZ	RODRIGUIZ
ROBALINO	ROCES	RODIL	RODRIGUZ

RODRIQUEZ
RODRQUIZ
RODRIUEZ
RODRIUGEZ
RODRIZUEZ
RODROGUEZ
RODRUGUEZ
RODRUQUEZ
RODUGUEZ
RODULFO
RODZ
ROEL
ROGANS
ROGERIO
ROGES
ROGRIGUEZ
ROGUE
ROHENA
ROIBAL
ROIDE
ROIG
ROIS
ROIZ
ROJA
ROJANO
ROJAS
ROJEL
ROJERO
ROJES
ROJO
ROJOS
ROLDAN
ROLDON
ROLDOS
ROLON
ROMAGOSA
ROMAGUERA
ROMANDIA
ROMANES
ROMANEZ
ROMANILLOS
ROMAY
ROMAYOR
ROMERA
ROMERO
ROMEROS
ROMEU
ROMEZ
ROMIREZ
ROMIRO
ROMO
ROMOS

ROMPAL
RON
RONCES
RONDA
RONDAN
RONDERO
RONDEZ
RONDON
RONGAVILLA
RONJE
RONQUILLO
ROQUE
ROQUENI
ROQUERO
ROQUETA
ROS
ROSA
ROSABAL
ROSADA
ROSADO
ROSAL
ROSALES
ROSALESDELRIO
ROSALEZ
ROSALY
ROSARIA
ROSARIO
ROSARIODIAZ
ROSARO
ROSAS
ROSELI
ROSELLO
ROSELLON
ROSENDO
ROSENEY
ROSERO
ROSES
ROSETE
ROSILES
ROSILEZ
ROSILLO
ROSITAS
ROSQUETE
ROSTRO
ROTEA
ROTELA
ROTGER
ROUCO
ROURA
ROURE
ROVAYO
ROVERA

ROVIRA
ROVIROSA
ROXAS
ROYBAL
ROYBALL
ROYBOL
ROYERO
ROYO
ROYOS
ROYVAL
ROZADA
ROZALES
ROZO
RUACHO
RUALES
RUALO
RUAN
RUANO
RUAS
RUBALACA
RUBALCABA
RUBALCADA
RUBALCADO
RUBALCAUA
RUBALCAVA
RUBERO
RUBERTE
RUBI
RUBIA
RUBIALES
RUBIANES
RUBIANO
RUBIDO
RUBIELLA
RUBIERA
RUBILDO
RUBINOS
RUBIO
RUBIOLA
RUCIO
RUCOBO
RUEDA
RUEDAFLORES
RUEDAS
RUELAS
RUELAZ
RUELOS
RUEMPEL
RUENES
RUESGA
RUEZGA
RUFAT

RUFFENO
RUFIN
RUGAMA
RUGARCIA
RUGERIO
RUIBAL
RUIDAS
RUIDIAZ
RUILOBA
RUISANCHEZ
RUISECO
RUIZ
RUIZCALDERON
RUIZCASTANEDA
RUIZDEESPARZA
RUIZDELVIZO
RUIZE
RUIZESPARZA
RUIZZ
RUL
RULLAN
RUMAYOR
RUMBAUT
RUTIAGA
RUTIZ
RUVALCABA
RUVALCAVA
RUVIRA
RUYBAL
RUYBALID
RUYBOL
RUZ

S

SAA
SAABEDRA
SAAUEDRA
SAAVEDRA
SABALA
SABALLOS
SABALZA
SABANDO
SABATER
SABATES
SABEDRA
SABI
SABICER
SABIDO
SABINES
SABLATURA
SABOGAL
SABORI

SABORIDO	SALAETS	SALIVA	SAMPERIO
SABORIO	SALAIQUES	SALIVAS	SAMTOS
SABORIT	SALAI	SALIZ	SAMUDIA
SABOYA	SALAISES	SALIZAR	SAMUDIO
SABRES	SALAIZ	SALLES	SANABIA
SABROSO	SALAMANCA	SALMERON	SANABRIA
SABUGO	SALANAS	SALMINA	SANAGUSTIN
SACA	SALANO	SALMONES	SANAME
SACARELLO	SALARS	SALORT	SANANDRES
SACASAS	SALAS	SALOS	SANBARTOLOME
SACERIO	SALASAR	SALSA	SANBRANO
SACOS	SALAVARIA	SALSAMEDA	SANCEDO
SACRISTAN	SALAVARRIA	SALSEDO	SANCEN
SADA	SALAVARRIETA	SALSIDO	SANCHA
SADES	SALAVERRIA	SALTARES	SANCHE
SADULE	SALAYA	SALTERO	SANCHEN
SAEDA	SALAYANDIA	SALTOS	SANCHES
SAENS	SALAZ	SALUDES	SANCHEZ
SAENZ	SALAZA	SALUMBIDES	SANCHEZDETAGL
SAETA	SALAZAN	SALVACION	E
SAEZ	SALAZAR	SALVARIA	SANCHEZPEREZ
SAFADY	SALBATO	SALVARREY	SANCHIDRIAN
SAFILLE	SALCEDA	SALVAT	SANCHIZ
SAFONT	SALCEDO	SALVATIERRA	SANCHO
SAGARA	SALCIDA	SALVIDE	SANCHOYERTO
SAGARDIA	SALCIDO	SAMADA	SANCHZ
SAGARDOY	SALCINES	SAMALA	SANCIPRIAN
SAGARIBAY	SALDAMA	SAMALOT	SANDATE
SAGARNAGA	SALDAMANDO	SAMANEGO	SANDAVAL
SAGARO	SALDANA	SAMANIEGO	SANDAVOL
SAGARRA	SALDANO	SAMANO	SANDEZ
SAGAS	SALDARRIAGA	SAMARIO	SANDIA
SAGASTA	SALDATE	SAMARIPA	SANDIEGO
SAGASTEGUI	SALDEZ	SAMARO	SANDIGO
SAGASTUME	SALDIERNA	SAMARRIPA	SANDOBAL
SAGRADO	SALDIVAR	SAMARRIPAS	SANDOMINGO
SAGREDO	SALDONA	SAMARRON	SANDOUAL
SAGRERO	SALDUA	SAMAYOA	SANDOVA
SAGUN	SALEGUI	SAMBADO	SANDOVAL
SAHAGUN	SALGADO	SAMBOLIN	SANDOZ
SAIJO	SALGADOLUNA	SAMBRANO	SANEMETERIO
SAILAS	SALGUEIRO	SAMBUESO	SANETO
SAINA	SALGUERA	SAMBULA	SANEZ
SAINEZ	SALGUERO	SAMILPA	SANFELIPE
SAINZ	SALHUANA	SAMONIEGO	SANFELIX
SAIS	SALIAS	SAMORA	SANFELIZ
SAIZ	SALIDO	SAMORANO	SANFIEL
SAIZA	SALINAS	SAMOT	SANFIORENZO
SALABARRIA	SALINASGARCIA	SAMPAYAN	SANGABRIEL
SALABERRIOS	SALINASRAMIREZ	SAMPAYO	SANGRE
SALACAN	SALINAZ	SAMPEDRO	SANGUESA
SALADO	SALINOS	SAMPERA	SANGUILY

SANGUINO	SANTIBANEZ	SARINANA	SAYGIDIA
SANIN	SANTIESTEBAN	SARINAS	SEANEZ
SANINOCENCIO	SANTIESTEVAN	SARIOL	SEARA
SANJENIS	SANTILLAN	SARMENTERO	SEAVELLO
SANJORGE	SANTILLANA	SARMIENTA	SEBALLOS
SANJORJO	SANTILLANES	SARMIENTO	SEBEO
SANJOSE	SANTILLANEZ	SARMIENTOFLORE	SECA
SANJUAN	SANTILLANO	S	SECADA
SANJURJO	SANTILLIAN	SARMIENTOS	SECADES
SANLUCAS	SANTISTEBAN	SAROZA	SECATERO
SANMARTIN	SANTISTEVAN	SARQUIS	SECO
SANMIGUEL	SANTISTEVEN	SARQUIZ	SEDA
SANMILLAN	SANTIVANEZ	SARRACINO	SEDANO
SANNICOLAS	SANTIZO	SARRAGA	SEDENO
SANOGUET	SANTODOMINGO	SARRARAZ	SEDILLA
SANORA	SANTORINIOS	SARRATEA	SEDILLIO
SANPEDRO	SANTOS	SARREAL	SEDILLO
SANQUICHE	SANTOSCOY	SARRIA	SEDILLOS
SANROMAN	SANTOVENA	SARRIERA	SEGANA
SANSERINO	SANTOVENIA	SARTUCHE	SEGARRA
SANSORES	SANTOY	SARZO	SEGOBIA
SANTAANA	SANTOYA	SARZOZA	SEGONIA
SANTAANNA	SANTOYO	SASPE	SEGORIA
SANTACOLOMA	SANTURIO	SASTRE	SEGOVIA
SANTACRUZ	SANUDO	SASTURAIN	SEGOVIANO
SANTAELLA	SANVICENTE	SATARAIN	SEGRERA
SANTAGO	SANZ	SATARAY	SEGUERA
SANTALIZ	SAPATA	SATURNINO	SEGUI
SANTALLA	SAPEDA	SAUCEDA	SEGUNDO
SANTALO	SAPENA	SAUCEDO	SEGURA
SANTAMARINA	SAPIEN	SAUCIDO	SEGURE
SANTAMATO	SAPIENS	SAUCILLO	SEGUROLA
SANTANA	SAPINOSO	SAUDIA	SEGUY
SANTANDER	SARABIA	SAUEDRA	SEIJAS
SANTANDREU	SARACHAGA	SAULEDA	SEIJO
SANTANO	SARACHO	SAUMA	SEIN
SANTAPAU	SARAGOSA	SAUMELL	SEISDEDOS
SANTAROSA	SARAGOZA	SAURA	SEJA
SANTARRIAGA	SARAGUETA	SAUREZ	SEJAS
SANTEIRO	SARALEGUI	SAURI	SELAYA
SANTELICES	SARANTE	SAUSAMEDA	SELAYANDIA
SANTELISES	SARATE	SAUSEDA	SELEM
SANTELLAN	SARAVIA	SAUSEDO	SELESTINO
SANTELLANA	SARCEDA	SAUZA	SELGADO
SANTELLANES	SARDANETA	SAVALA	SELGAS
SANTELLANO	SARDINAS	SAVALZA	SELLES
SANTESTEBAN	SARDUY	SAVEDRA	SELVERA
SANTEYAN	SARELLANO	SAVELLANO	SEMAYA
SANTIAG	SARENANA	SAVINON	SEMBERA
SANTIAGO	SARIA	SAVORILLO	SEMBRANO
SANTIANA	SARIEGO	SAYAGO	SEMEXANT
SANTIBANES	SARINA	SAYAVEDRA	SEMEY

SEMIDAY	SERRADELL	SIDA	SIRET
SEMIDEI	SERRADO	SIEDO	SIRIAS
SEMIDEY	SERRALLES	SIERRA	SIRIO
SEMINARIO	SERRALTA	SIERRAS	SIROS
SEMPERTEGUI	SERRAND	SIERRO	SISNERO
SEMPRE	SERRANIA	SIERZE	SISNEROS
SENA	SERRANO	SIFONTE	SISNEROZ
SENCION	SERRANTES	SIFONTES	SISNEGAS
SENDEJAR	SERRAT	SIFRE	SISTOS
SENDEJAS	SERRATA	SIFUENTES	SITAL
SENDEJO	SERRATE	SIFUENTEZ	SITJAR
SENDIS	SERRATO	SIFVENTES	SIURANO
SENDON	SERRATOS	SIGALA	SIVA
SENDRAL	SERRAVILLO	SIGALES	SIVERIO
SENERIZ	SERRAVO	SIGARAN	SIXTO
SENJUDO	SERRET	SIGARROA	SIXTOS
SENOSIAIN	SERRITOS	SIGUA	SOBA
SENQUIZ	SERRONO	SIGUEIROS	SOBALVARRO
SENTENA	SERROS	SIGUENZA	SOBERAL
SENTENO	SERTUCHE	SILBAS	SOBERANES
SENTMANAT	SERVANTES	SILERIO	SOBERANEZ
SEOANE	SERVANTEZ	SILGERO	SOBERANIS
SEOANES	SERVERA	SILGUERO	SOBERON
SEPEDA	SERVILLA	SILIEZAR	SOBRADO
SEPIAN	SERVILLO	SILLANO	SOBREMONTE
SEPTIEN	SERVIN	SILLART	SOBRERO
SEPULBEDA	SESANTO	SILLAS	SOBREVILLA
SEPULUEDA	SESATE	SILLEN	SOBRIN
SEPULVEDA	SESE	SILLER	SOBRINO
SEPULVEDO	SESMA	SILLERO	SOCA
SEPULVIDA	SESMAS	SILOS	SOCARRAS
SEQUEIDA	SESTEAGA	SILOT	SOCAS
SEQUEIRO	SESTIAGA	SILQUERO	SOCIAS
SEQUERA	SEVA	SILVARREY	SOCORRO
SEQUERRA	SEVALLOS	SILVAS	SODOY
SEQURA	SEVILLA	SILVERIO	SOEGAARD
SERABALLS	SEVILLANO	SILVESTRE	SOJO
SERABIA	SEVILLO	SILVESTRY	SOL
SERALENA	SEXTO	SILVEYRA	SOLACHE
SERANTES	SEZATE	SIMENTAL	SOLANILLA
SERASIO	SEZUMAGA	SIMENDEL	SOLANO
SERAYDAR	SIACA	SIMIANO	SOLARES
SERBANTES	SIADOR	SINTAS	SOLAREZ
SERBANTEZ	SIANEZ	SIORDIA	SOLARIO
SERDA	SIAZ	SIPRIAN	SOLARZANO
SERDAS	SIBAJA	SIPULA	SOLAUN
SERENIL	SIBERIO	SIQUEIDO	SOLDEVILA
SERMENO	SIBERON	SIQUEIRO	SOLDEVILLA
SERMINO	SIBRIAN	SIQUEIROS	SOLED
SERNA	SICAIROS	SIQUEROS	SOLEDAD
SERNAS	SICARDO	SIQUIEROS	SOLENO
SERRACINO	SICRE	SIRA	SOLER

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SOLORZANO
SOLOZABAL
SOLSONA
SOLTERO
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SOMARRIBA
SOMAVIA
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SOMODEVILLA
SOMOHANO
SOMONTE
SOMOZA
SONABRIA
SONCHAR
SONCHEZ
SONERA
SONICO
SONOQUI
SONORA
SOPENA
SOQUI
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SORATOS
SORBA
SORDIA
SORDO
SORIA
SORIANO
SORIENO
SORIO
SORNOSO
SOROA
SOROLA
SORONDO
SORRANO
SORROCHE
SORTILLON
SORZANO
SOSA
SOSAPAVON

SOSAYA
SOSIAS
SOSTRE
SOTA
SOTELLO
SOTELO
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SOTILLO
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SOTOLONGO
SOTOMAYER
SOTOMAYOR
SOTORRIO
SOTRO
SOTTO
SOTTOSANTO
SOTURA
SOTUYO
SOUCHET
SOUFFRONT
SOURINA
SOVERANEZ
SOZA
SPINDOLA
SUARE
SUARES
SUAREZ
SUASTE
SUASTEGUI
SUAVEZ
SUAZO
SUBEALDEA
SUBEDAR
SUBEGA
SUBELDIA
SUBES
SUBIA
SUBIAS
SUBIDO
SUBIRANA
SUBIRIAS
SUCO
SUDARIA
SUEIRAS
SUEIRO
SUELA
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SUENGAS
SUERA
SUEREZ
SUERO

SUESCUN
SUEYRAS
SUGRANES
SUINA
SULAICA
SULIVERES
SULLANO
SULPACIO
SULSONA
SUMALLA
SUMAYA
SUMBERA
SUMBERAZ
SUNE
SUNER
SUNICA
SUNIGA
SUQUET
SUREDA
SURIA
SURILLO
SURINACH
SURIS
SURITA
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SUSANA
SUSTACHE
SUSTAETA
SUSTAITA
SUSTAYTA
SUSURAS
SWAZO

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TACORONTE
TADEO
TAFFOLLA
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TAFORO
TAFOYA
TAGABAN
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TAGUDAR
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TAMAME
TAMARES
TAMAREZ
TAMARGO
TAMARIT
TAMARIZ
TAMAYA
TAMAYO
TAMBARA
TAMBUNGA
TAMERON
TAMEZ
TAMGUMA
TANCHEZ

TANCO	TEBAR	TERAN	TIRRES
TANDA	TEHAS	TERCERO	TIRREZ
TANFORAN	TEIJEIRO	TERCEROS	TIRSE
TANGUMA	TEIJIZ	TERCILLA	TISCARENO
TANON	TEIJO	TERMINEL	TISINO
TANORI	TEISSONNIERE	TERON	TISNADO
TANTAO	TEIXIDOR	TERRADO	TIXIER
TANUZ	TEJADA	TERRASA	TIZNADO
TAPANES	TEJAS	TERRASAS	TIZOL
TAPETILLO	TEJEDA	TERRASAZ	TOBAL
TAPIA	TEJEDAS	TERRAZA	TOBAR
TAPIAS	TEJEDO	TERRAZAS	TOBARES
TAPICERIA	TEJEDOR	TERRERO	TOBAS
TAPIZ	TEJEIRO	TERREROS	TOBILLA
TAPORCO	TEJERA	TERRIGUEZ	TOBON
TARABINO	TEJERAS	TERRIQUEZ	TOCA
TARACENA	TEJERINA	TERROBA	TOFOYA
TARAF	TEJERON	TERRON	TOGAR
TARAGON	TEJIDOR	TERRONES	TOGORES
TARAILO	TEJO	TERSERO	TOIMIL
TARAJANO	TELAS	TERUEL	TOJEIRA
TARAMASCO	TELAVERA	TERUSA	TOJEIRO
TARANCO	TELLADO	TERVINO	TOLANO
TARANGO	TELLAECHE	TERZADO	TOLEDANO
TARAZON	TELLECHEA	TESILLO	TOLEDO
TARAZONA	TELLERIA	TEVERE	TOLENTINO
TARBES	TELLES	TEXCAHUA	TOLLARDO
TARGA	TELLEZ	TEXIDOR	TOLOSA
TARIN	TELLO	TEYECHEA	TOLOZA
TARNAVA	TELOS	TEZCUCANO	TOLSA
TARRAGO	TELON	TEZINO	TOMADA
TARRANGO	TEMBLADOR	THILLET	TOMAYO
TARRATS	TEMBRAS	TIA	TOMELLOSO
TARRAU	TEMER	TIBALDEO	TOMEU
TARRAZA	TEMORES	TIBLJAS	TOMINES
TARRIDE	TEMPO	TIBON	TOPETE
TARULA	TEMPRANA	TIBURCIO	TOPIA
TASABIA	TENA	TICO	TOQUERO
TATIS	TENARIO	TIENDA	TORAL
TAVALES	TENAS	TIJERINA	TORALBA
TAVAR	TENERIAS	TIJERINO	TORALES
TAVAREZ	TENERIO	TIJERO	TORANO
TAVERA	TENES	TINAJERO	TORANS
TAVERAS	TENEYUCA	TINAZA	TORANZO
TAVIRA	TENEYUQUE	TINEO	TORDESILLAS
TAVISON	TENIENTE	TINERELLA	TORENO
TAVITAS	TENORIA	TINOCO	TORIBIO
TAVIZON	TENORIO	TIO	TORICES
TAVORA	TEPERA	TIRADO	TORIJANO
TAYABAS	TEPEZANO	TIRADOR	TORIZ
TEBA	TEPOSTE	TIRAN	TORMES
TEBAQUI	TEQUIDA	TIRRE	TORMOS

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VALASQUEZ
VALAZQUEZ
VALBUENA
VALCARCE
VALCARCEL
VALCAZAR

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VALDEMAR
VALDENEGRO
VALDEPENA
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VALDERRAMA
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VALDIVIEZO
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VALDOVIN
VALDOVINO
VALDOVINOS
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VALEDON
VALENCIA
VALENCIANA
VALENCIANO
VALENEUELA
VALENQUELA
VALENSUELA
VALENTIN
VALENZUELA
VALENZULA
VALENZVELA
VALERA
VALERIOS
VALERO
VALESQUEZ
VALEZ
VALGAS
VALHUERDI
VALIDO
VALIENTE
VALIGURA

VALINA	VARGAZ	VELAARCE	VERACRUZ
VALINAS	VARGUEZ	VELACUELLAR	VERAMENDI
VALINO	VARIA	VELADO	VERANDAS
VALLADARES	VARONA	VELADOR	VERAS
VALLADAREZ	VARONIN	VELAQUEZ	VERASTEGUI
VALLADO	VAROS	VELAR	VERASTEQUI
VALLADOLID	VAROZ	VELARDE	VERASTIGUI
VALLARTA	VARQUEZ	VELARDES	VERASTIQUE
VALLDEPERAS	VASALDUA	VELARDEZ	VERASTIQUI
VALLE	VASALLO	VELASCO	VERAY
VALLECILLA	VASCONES	VELASGUEZ	VERAZ
VALLECILLO	VASCONEZ	VELASQUES	VERAZA
VALLECILLOS	VASCOS	VELASQUEZ	VERBERA
VALLEDOR	VASGUEZ	VELASTEGUI	VERCELES
VALLEGOS	VASQUE	VELAZCO	VERDAGUER
VALLEJA	VASQUES	VELAZGUEZ	VERDECANNA
VALLEJO	VASQUEZ	VELAZQUES	VERDECIA
VALLEJOS	VASSQUEZ	VELAZQUEZ	VERDEGUEZ
VALLELLANES	VASTI	VELDERRAIN	VERDEJA
VALLENS	VAZGUEZ	VELENZUELA	VERDEJO
VALLERINO	VAZQUE	VELES	VERDERA
VALLES	VAZQUEL	VELESQUEZ	VERDESCA
VALLEZ	VAZQUES	VELEZ	VERDESE
VALLIN	VAZQUETELLES	VELEZPEREZ	VERDESOTO
VALLS	VAZQUEZ	VELEZROMAN	VERDIA
VALMANA	VAZQUEZRIVERA	VELILLA	VERDOZA
VALMORES	VEALSQUEZ	VELIS	VERDUGA
VALQUEZ	VEAS	VELIZ	VERDUGO
VALTERZA	VECIN	VELLAS	VERDUSCO
VALTIER	VECINO	VELLIDO	VERDUZCO
VALTIERRA	VEDARTE	VELLON	VERDUZEO
VALTIERREZ	VEDIA	VELO	VEREA
VALVERDE	VEGA	VELOS	VERELA
VANDO	VEGARA	VELOSO	VEREZ
VANEGAS	VEGATORRES	VELOZ	VERGARA
VANGA	VEGAZO	VELOZQUEZ	VERGARO
VANUELOS	VEGERANO	VELUNZA	VERGEL
VANZURA	VEGES	VELUZ	VERGUIZAS
VAQUE	VEGO	VENCES	VERINO
VAQUER	VEGOS	VENDRELL	VERJIL
VAQUERA	VEGUE	VENECIA	VERNENGO
VAQUERO	VEGUEZ	VENEGAS	VERONIN
VAQUILAR	VEGUILLA	VENERACION	VERQUER
VARA	VEIGUELA	VENEREO	VERTIZ
VARADA	VEINTIDOS	VENEZUELA	VERVER
VARAJAS	VEITIA	VENSOR	VETA
VARAS	VEJAR	VENTA	VEVE
VARCARCEL	VEJARA	VENTOSO	VEYNA
VARCOS	VEJARANO	VENZAL	VEYTIA
VARELA	VEJIL	VENZOR	VIACAVA
VARELAS	VEJO	VENZUELA	VIACOBO
VARGAS	VELA	VERA	VIADA

VIADAS	VIEJO	VILLACRESES	VILLAN
VIADÉ	VIELMA	VILLADA	VILLANEDA
VIADERO	VIELMAN	VILLADO	VILLANES
VIADÉS	VIELMAS	VILLADONIGA	VILLANEUVA
VIADO	VIENTOS	VILLAERREAL	VILLANEVA
VIAGRAN	VIERA	VILLAESCUSA	VILLANEZ
VIALES	VIERAS	VILLAFAN	VILLANNEVA
VIALIZ	VIESCA	VILLAFANA	VILLANUEBA
VIALPANDO	VIESCAS	VILLAFANE	VILLANUERA
VIAMONTE	VIETA	VILLAFLORES	VILLANUEVA
VIANA	VIETTY	VILLAFRANCA	VILLANUEVO
VIANES	VIEYRA	VILLAFRANCO	VILLANVEVA
VIAPANDO	VIEZCAS	VILLAFUERTE	VILLAO
VIARREAL	VIGIL	VILLAGAS	VILLAPADIERNA
VIARRIAL	VIGILIA	VILLAGOMES	VILLAPANDO
VIAYRA	VIGNAU	VILLAGOMEZ	VILLAPLANA
VICARIA	VIGO	VILLAGRAMA	VILLAPOL
VICEDO	VIGOA	VILLAGRAN	VILLAPONDO
VICENCIO	VIGON	VILLAGRANA	VILLAPUDUA
VICENS	VIGUERA	VILLAHERMOSA	VILLAQUIRAN
VICENT	VIGUERAS	VILLALABOS	VILLAR
VICENTE	VIGUERIA	VILLALBA	VILLARAN
VICENTY	VIGUES	VILLALBAZO	VILLARAOS
VICHOT	VIJARRO	VILLALBOS	VILLARAUS
VICIEDO	VIJIL	VILLALOBAS	VILLAREAL
VICINAIZ	VILA	VILLALOBO	VILLAREJO
VICIOSO	VILABOY	VILLALOBOS	VILLARES
VICTORERO	VILADROSA	VILLALOBOZ	VILLARICO
VICTORES	VILANO	VILLALOHOS	VILLARINO
VICUNA	VILANOVA	VILLALON	VILLARINY
VIDACA	VILAR	VILLALONA	VILLARIZA
VIDAL	VILARCHAO	VILLALONGA	VILLAROEL
VIDALES	VILARDELL	VILLALONGIN	VILLARONGA
VIDALEZ	VILARINO	VILLALONGO	VILLAROS
VIDANA	VILARO	VILLALOVAS	VILLARRE
VIDANO	VILAS	VILLALOVOS	VILLARREAL
VIDAURE	VILASQUEZ	VILLALOVOZ	VILLARRIAL
VIDAURI	VILATO	VILLALPANDO	VILLARROEL
VIDAURRAZAGA	VILAUBI	VILLALTA	VILLARRUBIA
VIDAURRE	VILCHES	VILLALUA	VILLARRUEL
VIDAURRETA	VILCHEZ	VILLALUNA	VILLARRUZ
VIDAURRI	VILCHIS	VILLALUZ	VILLARTA
VIDAURRY	VILDOSOLA	VILLALVA	VILLARUBIA
VIDENA	VILLA	VILLALVASO	VILLARUZ
VIDES	VILLABLANCA	VILLALVAZO	VILLAS
VIDOT	VILLACAMPA	VILLAMAN	VILLASAIZ
VIDRIALES	VILLACANA	VILLAMAR	VILLASANA
VIDRIO	VILLACARLOS	VILLAMARIN	VILLASANO
VIDRIOS	VILLACIS	VILLAMAYOR	VILLASANTE
VIDUYA	VILLACORTA	VILLAMIA	VILLASECA
VIEGO	VILLACORTE	VILLAMIL	VILLASENOR
VIEITES	VILLACRES	VILLAMOR	VILLASIS

VILLASTRIGO
VILLASUSO
VILLATE
VILLATORO
VILLAVA
VILLAVERDE
VILLAVICENCIO
VILLAVISENCIO
VILLAZANA
VILLAZON
VILLEDA
VILLEGA
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VILLEJO
VILLELA
VILLENA
VILLERREAL
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VILLESACA
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VILLETE
VILLEZCAS
VILLICANA
VILLICANO
VILLIEGAS
VILLIS
VILLOCH
VILLODAS
VILLOLDO
VILLORIA
VILLORIN
VILLORO
VILLOT
VILLOTA
VILORIO
VILTRE
VINA
VINAGERAS
VINAIXA
VINAJA
VINAJERAS
VINALES
VINALS
VINAS
VINAT
VINCENTY
VINCIONI
VINDIOLA
VINEGRA

VINENT
VINFRIDO
VINGOCHEA
VINIEGRA
VINUELA
VINUELAS
VINZON
VIOLETA
VIORATO
VIOTA
VIQUEZ
VIRADIA
VIRAMONTE
VIRAMONTES
VIRAMONTEZ
VIRATA
VIRAY
VIRCHIS
VIRELLA
VIRGEN
VIRJAN
VIROLA
VIRREY
VIRRUETA
VIRUEGAS
VIRUET
VIRUETE
VIRUZO
VISARRAGA
VISARRIAGAS
VISCAINA
VISCAINO
VISCARRA
VISCASILLAS
VISCAYA
VISERTO
VISOSO
VISPERAS
VISSEPO
VISTRO
VITAL
VITAR
VITELA
VITIER
VIVANCO
VIVANCOS
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VIZCAINO
VIZCARRA
VIZCARRO
VIZCARRONDO
VIZCAYA
VIZCON
VIZOSO
VIZUET
VIZUETA
VOLBEDA
VOSQUEZ
VOZQUEZ
VUELTA

X

XIMENES
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XIQUES
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XUAREZ

Y

YABUT
YANAS
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YARRITU
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YBABEN
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YBARROLA
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YBERA
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YCEDO
YCIANO
YDROGO
YEBARA
YEBRA
YEDO

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YERAS
YERENA
YERO
YESCAS
YESETA
YESTE
YEVERINO
YGLECIAS
YGLIASIAS
YGNACIO
YGUADO
YGUERABIDE
YLARREGUI
YLIZALITURRI
YLLA
YLLADA
YLLANES
YLLESCAS
YNCERA
YNCLAN
YNDA
YNEGAS
YNEGES
YNFANTE
YNIGO
YNIGUEZ
YNIQUEZ
YNOA
YNOCENCIO
YNOSENCIO
YNOSTROSA
YNOSTROZA
YNZUNZA
YOGUEZ
YORBA
YORDAN
YPARRAGUIRRE
YPARREA
YPINA
YRACEBURU
YRACHETA
YRASTORZA
YRIARTE
YRIBARREN

YRIBE	ZABALLA	ZANUDO	ZEBALLOS
YRIGOLLA	ZABALO	ZAPARA	ZEDENO
YRIGOLLEN	ZABALZA	ZAPATA	ZEDILLO
YRIGOYEN	ZACARIAS	ZAPATER	ZEGARRA
YRINEO	ZACUTO	ZAPATERO	ZELADA
YRIQUE	ZADRIMA	ZAPEDA	ZELAYA
YRIQUI	ZAERA	ZAPIAIN	ZELEDON
YRISARRI	ZAFEREO	ZAPIEN	ZEMEN
YRIZARRY	ZAFRA	ZARABOZO	ZENDEJAS
YROZ	ZAGALA	ZARAGOSA	ZENGOTITA
YRUEGAS	ZAGALES	ZARAGOZ	ZENIZO
YRUNGARAY	ZAGONA	ZARAGOZA	ZENOZ
YRURETAGOYENA	ZALACAIN	ZARAGOZI	ZENTELLA
YSAGUIRRE	ZALACE	ZARATE	ZENTENO
YSAIS	ZALAMEA	ZARAZUA	ZEPADA
YSAQUIRRE	ZALAPA	ZARCO	ZEPEDA
YSASAGA	ZALAZAR	ZARCOS	ZEQUEIRA
YSASI	ZALDANA	ZARDENETA	ZERDA
YSASSI	ZALDIVAR	ZARDENETTA	ZERIN
YSER	ZALDUA	ZARDO	ZERMENO
YSERN	ZALDUMBIDE	ZARDON	ZERPA
YSET	ZALDUONDO	ZARDOYA	ZERQUERA
YSLA	ZALVIDEA	ZAROGOZA	ZERTUCHE
YSLAS	ZAMACONA	ZARRAGA	ZERVIGON
YSLAVA	ZAMAGO	ZARRAGOITIA	ZETINA
YSQUIERDO	ZAMANIEGO	ZARRAGOZA	ZETINO
YTUARTE	ZAMANILLO	ZARRIA	ZEVALLOS
YTURBE	ZAMANO	ZARUBICA	ZILBAR
YTURRALDE	ZAMAR	ZARZANA	ZILLAS
YTURRI	ZAMARIPA	ZARZOSA	ZOLETA
YTURRIA	ZAMARIPPA	ZARZOZA	ZOMORA
YTURRIAGA	ZAMARO	ZARZUELA	ZOROLA
YUBETA	ZAMARRI	ZASUETA	ZORRILLA
YUCUPICIO	ZAMARRIPA	ZATARAIN	ZOZAYA
YUDESIS	ZAMARRIPAS	ZATARAY	ZUAZNABAR
YUDICE	ZAMARRON	ZATARIAN	ZUAZO
YUDICO	ZAMAYOA	ZATOREN	ZUAZUA
YULAN	ZAMAZAL	ZAUALA	ZUBELDIA
YULFO	ZAMBADA	ZAUL	ZUBIA
YURIAR	ZAMBRANA	ZAUZA	ZUBIATE
YUSTE	ZAMBRANO	ZAVALA	ZUBIETA
YVANEZ	ZAMILPA	ZAVALETA	ZUBILLAGA
YVARRA	ZAMORA	ZAVALETETA	ZUBIRAN
YZABAL	ZAMORANO	ZAVALLA	ZUBIRI
YZAGUIRRE	ZAMORES	ZAVALZA	ZUBIRIA
YZNAGA	ZAMOREZ	ZAVAT	ZUBIZARRETA
YZQUIERDO	ZAMOT	ZAYAS	ZUGASTI
	ZAMUDIO	ZAYASBAZAN	ZULAICA
Z	ZANABRIA	ZAYAZ	ZULETA
ZABAL	ZANDATE	ZAZUETA	ZULOAGA
ZABALA	ZANDONA	ZAZUETTA	ZULUAGA
ZABALETA	ZANGRONIZ	ZEAS	ZULUETA

ZUMARRAGA
ZUMAYA
ZUNIGA
ZUNIZA
ZUNO
ZUNZUNEGUI
ZURBANO
ZURBARAN
ZURITA
ZURRICA
ZUVIA
ZUVIETA
ZUZUARREGUI

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APPENDIX Q.1

SURGERY CODES (For Cases Diagnosed Prior to January 1, 2003)

ORAL CAVITY

Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C09.9,
Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9,
Other Parts of Mouth C06.0-C06.9

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from this surgical event.

Surgery Codes

ORAL CAVITY

**Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9,
Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9,
Other Parts of Mouth C06.0-C06.9**

Procedures in codes 20-27 include, but are not limited to:

Shave
Wedge resection

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Procedures in code 30 include, but are not limited to:

Hemiglossectomy
Partial glossectomy

- 30 Wide excision, NOS

Procedures in codes 40-43 include, but are not limited to:

Radical glossectomy

- 40 Radical excision of tumor, NOS
- 41 Radical excision of tumor ONLY
- 42 Combination of 41 WITH en bloc mandibulectomy (marginal, segmental, hemi-, or total)
- 43 Combination of 41 WITH en bloc maxillectomy (partial, subtotal, total)

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

ORAL CAVITY

**Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9,
Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9,
Other Parts of Mouth C06.0-C06.9**

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional cervical lymph nodes are:
Caudal jugular (deep cervical)
Cranial jugular (deep cervical)
Dorsal cervical (superficial cervical)
Medial jugular (deep cervical)
Occipital
Paratracheal (anterior cervical)
Prelaryngeal (anterior cervical)
Retroauricular (mastoid, posterior auricular)
Submandibular (submaxillary)
Submental
Supraclavicular

Surgery Codes

ORAL CAVITY

**Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9,
Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9,
Other Parts of Mouth C06.0-C06.9**

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
 - 2 Neck dissection, NOS
 - 3 Selective, limited; nodal sampling; “berry picking”
 - 4 Modified/modified radical
 - 5 Radical
- 9 Unknown; not stated; death certificate ONLY

Terminology of neck dissection (Robbins et al. 1991):

A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more non lymphatic structures are preserved.

A selective neck dissection is a neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

Surgery Codes

ORAL CAVITY

**Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9,
Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9,
Other Parts of Mouth C06.0-C06.9**

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
 - 3 Mandibulectomy (marginal, segmental, hemi-, or total)
 - 4 Maxillectomy (partial, subtotal, or total)

Code a mandibulectomy or a maxillectomy in this field only if the procedure is NOT a part of an en bloc resection of the primary tumor. If the mandibulectomy or maxillectomy ARE a part of an en bloc resection of the primary tumor, code under "Surgery of Primary Site."

- 5 Distant lymph node(s)
- 6 Distant site(s)
- 7 Combination of 6 WITH 2, 3, 4, or 5
- 9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Flaps, grafts, or any type of "plasty," NOS
 - 2 WITHOUT implant/prosthesis
 - 3 WITH implant/prosthesis
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

PAROTID AND OTHER UNSPECIFIED GLANDS
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 4 Open
- 9 Death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from this surgical event.

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
 - 25 Laser excision
 - 26 Polypectomy
 - 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Surgery Codes

PAROTID AND OTHER UNSPECIFIED GLANDS **Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9**

- 30 Less than total parotidectomy, NOS; less than total removal major salivary gland, NOS
 - 31 Facial nerve spared
 - 32 Facial nerve sacrificed
- 33 Superficial lobe ONLY
 - 34 Facial nerve spared
 - 35 Facial nerve sacrificed
- 36 Deep lobe (**WITH or WITHOUT superficial lobe**)
 - 37 Facial nerve spared
 - 38 Facial nerve sacrificed

- 40 Total parotidectomy, NOS; Total removal major salivary gland, NOS
 - 41 Facial nerve spared
 - 42 Facial nerve sacrificed

- 50 Radical parotidectomy, NOS; Radical removal major salivary gland, NOS
 - 51 WITHOUT removal of temporal bone
 - 52 WITH removal of temporal bone

- 80 Parotidectomy, NOS

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative

- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement

- 7 Margins not evaluable

- 8 No surgery of primary site

- 9 Unknown whether margins were involved or negative; death certificate ONLY

Surgery Codes

PAROTID AND OTHER UNSPECIFIED GLANDS Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional cervical lymph nodes are:
Buccal (facial)
Caudal jugular (deep cervical)
Cranial jugular (deep cervical)
Dorsal cervical (superficial cervical)
Medial jugular (deep cervical)
Occipital
Paratracheal (anterior cervical)
Parotid
Prelaryngeal (anterior cervical)
Retroauricular (mastoid, posterior auricular)
Retropharyngeal
Submandibular (submaxillary)
Submental
Supraclavicular

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
 - 2 Neck dissection, NOS
 - 3 Selective, limited; nodal sampling; “berry picking”
 - 4 Modified/modified radical
 - 5 Radical
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

PAROTID AND OTHER UNSPECIFIED GLANDS **Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9**

Terminology of neck dissection (Robbins et al. 1991):

A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection, the same lymph nodes are removed as in a radical neck dissection; however, one or more non-lymphatic structures are preserved.

A selective neck dissection is a neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

Surgery Codes

PAROTID AND OTHER UNSPECIFIED GLANDS
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional sites
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Flaps, grafts, or any type of "plasty," NOS
 - 2 WITHOUT implant/prosthesis
 - 3 WITH implant/prosthesis
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

PHARYNX

**Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9
Pyriiform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0**

SURGICAL APPROACH

Codes

- 0 None; surgery of primary site
- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no of primary site
- 10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Stripping

No specimen sent to pathology from this surgical event.

Surgery Codes

PHARYNX

**Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9
Pyriiform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0**

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

- 30 Pharyngectomy, NOS
 - 31 Limited/partial pharyngectomy; Tonsillectomy, NOS
 - 32 Total pharyngectomy
- 40 Pharyngectomy WITH mandibulectomy (marginal, segmental, hemi-), and/or laryngectomy, NOS
 - 41 WITH laryngectomy (laryngopharyngectomy)
 - 42 WITH mandibulectomy
 - 43 WITH both 41 and 42
- 50 Radical pharyngectomy (includes total mandibular resection), NOS
 - 51 WITHOUT laryngectomy
 - 52 WITH laryngectomy
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

PHARYNX

**Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9
Pyriiform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0**

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

Surgery Codes

PHARYNX

**Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9
Pyriiform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0**

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional cervical lymph nodes are:
Buccal (facial)
Caudal jugular (deep cervical)
Cranial jugular (deep cervical)
Dorsal cervical (superficial cervical)
Medial jugular (deep cervical)
Occipital
Paratracheal (anterior cervical)
Parotid
Prelaryngeal (anterior cervical)
Retroauricular (mastoid, posterior auricular)
Retropharyngeal
Submandibular (submaxillary)
Submental
Supraclavicular

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
 - 2 Neck dissection, NOS
 - 3 Selective, limited; nodal sampling; 'berry picking'
 - 4 Modified/modified radical
 - 5 Radical
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

PHARYNX

**Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9
Pyriiform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Laryngectomy ONLY
 - 3 Mandibulectomy ONLY (marginal, segmental, or hemi-)
 - 4 Combination of 2 and 3
 - 5 Removal of other regional sites
 - 6 Combination of 5 with 2-4
 - 7 Removal of other distant sites(s) or distant lymph node(s)
 - 8 Combination of 7 WITH any of 2-6
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

PHARYNX

**Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9
Pyriiform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Code only the following reconstructive procedures:
Myocutaneous flaps (pectoralis major, trapezius) Reconstruction of mandible Regional flaps

Codes

- 0 No reconstruction/restoration
- 1 Reconstruction/restoration, NOS
 - 2 WITHOUT implant/prosthesis
 - 3 WITH implant/prosthesis
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**ESOPHAGUS
C15.0-C15.9**

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

Endoscopy procedures include:
Esophagoscopy Mediastinoscopy Thoracoscopy

- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided

- 4 Open, NOS
 - 5 Trans-hiatal
 - 6 Thoracotomy (includes split sternum)
 - 7 Laparotomy

- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site

- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from this surgical event.

Surgery Codes

**ESOPHAGUS
C15.0-C15.9**

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

- 30 Partial esophagectomy
- 40 Total esophagectomy
- 50 Partial esophagectomy WITH laryngectomy and/or gastrectomy, NOS
 - 51 WITH laryngectomy
 - 52 WITH gastrectomy, NOS
 - 53 Partial gastrectomy
 - 54 Total gastrectomy
 - 55 Combination of 51 WITH any of 52-54
- 60 Total esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
 - 61 WITH laryngectomy
 - 62 WITH gastrectomy, NOS
 - 63 Partial gastrectomy
 - 64 Total gastrectomy
 - 65 Combination of 61 WITH any of 62-64
- 70 Esophagectomy, NOS WITH pharyngectomy and laryngectomy
- 80 Esophagectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

**ESOPHAGUS
C15.0-C15.9**

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

Surgery Codes

**ESOPHAGUS
C15.0-C15.9**

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional lymph nodes are different for each anatomical subsite. The following list identifies nodes classified as regional for each subsite:	
Cervical esophagus:	Cervical, NOS Internal jugular Periesophageal Scalene Supraclavicular Upper cervical
Intrathoracic esophagus (upper, middle, lower):	Carinal Hilar (pulmonary roots) Internal jugular Mediastinal, NOS Paracardial Periesophageal Perigastric Peritracheal Superior mediastinal Tracheobronchial

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
- 9 Unknown; not stated; death certificate ONLY

Celiac nodes are distant for intrathoracic esophagus. Code removal of celiac nodes in the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

Surgery Codes

**ESOPHAGUS
C15.0-C15.9**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional sites
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**ESOPHAGUS
C15.0-C15.9**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

Code only the following procedures as reconstructive:
Endoluminal stents
Endoprosthesis
Esophageal stents
Esophagogastric fundoplasty
Esophagogastrostomy (cardioplasty)
Esophagojejunostomy
Esophagomyotomy
Esophagoplasty (plastic repair or reconstruction)
Esophagoplasty/WITH/WITHOUT repair of a tracheoesophageal fistula
Esophagostomy
Gastropharyngostomy
Interposition of remaining esophagus with stomach using large or small bowel
Self expanding metal vynal
Stent placement in conjunction with cancer-directed surgery

- 0 No reconstruction/restoration
- 1 Reconstruction/restoration, NOS
 - 2 WITHOUT implant/prosthesis
 - 3 WITH implant/prosthesis
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**STOMACH
C16.0-C16.9**

SURGICAL APPROACH

CODE

0 None; no surgery of primary site

Endoscopy procedures include:
Esophago-/gastro-/duodeno-/jejuno-/scopy Gastroscopy Laparoscopy

- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

CODE

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from this surgical event.

Surgery Codes

STOMACH C16.0-C16.9

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Code 30, partial gastrectomy, includes a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

- 30 Gastrectomy, NOS (partial, subtotal, hemi-)
- 31 Antrectomy, lower (distal)
- 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Resection of less than 40% of stomach

- 40 Near-total or total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

- 50 Gastrectomy, NOS WITH removal of a portion of esophagus
- 51 Partial or subtotal gastrectomy
- 52 Near total or total gastrectomy
- 60 Gastrectomy WITH en bloc resection of other organs, NOS
- 61 Partial or subtotal gastrectomy WITH en bloc resection
- 62 Near total or total gastrectomy WITH en bloc resection
- 63 Radical gastrectomy WITH en bloc resection

EN BLOC RESECTION is the removal of organs in one piece at one time and may include an omentectomy.

- 80 Gastrectomy, NOS

Surgery Codes

**STOMACH
C16.0-C16.9**

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

CODE

0 All margins grossly and microscopically negative

1 Margins involved, NOS

2 Microscopic involvement

5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

Surgery Codes

**STOMACH
C16.0-C16.9**

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:	
Greater Curvature of Stomach	Gastroduodenal Gastroepiploic, left Gastroepiploic, right or NOS Greater omental Greater curvature Pancreaticoduodenal (anteriorly along the first part of duodenum) Pyloric, including subpyloric and infrapyloric
Pancreatic and Splenic Area:	Pancreaticolienal Peripancreatic Splenic hilum
Lesser Curvature of Stomach:	Cardioesophageal Celiac Common hepatic Hepatoduodenal Left gastric Lesser omental Lesser curvature Paracardial; cardial Perigastric, NOS

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**STOMACH
C16.0-C16.9**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of gallbladder, bile ducts, appendix, or vagus nerve. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Removal of other regional sites, ONLY
 - 3 Removal of distant node(s)
 - 4 Removal of distant site(s)
 - 5 Combination of 2 WITH 3 and/or 4
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**STOMACH
C16.0-C16.9**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Gastrostomy
 - 2 WITHOUT reservoir/pouch
 - 3 WITH reservoir/pouch (abdominal)
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**COLON
C18.0 - C18.9**

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

Endoscopy procedures include:
Colonoscopy Laparoscopy Sigmoidoscopy

- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Code removal/surgical ablation of single or multiple liver metastases under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from this surgical event.

Surgery Codes

**COLON
C18.0 - C18.9**

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Procedures coded 30-31 include, but are not limited to:

Appendectomy (for an appendix primary only)
Enterocolectomy
Ileocolectomy
Partial colectomy, NOS
Partial resection of transverse colon and flexures
Segmental resection, e.g., cecectomy
Sigmoidectomy

- 30 Partial colectomy, but less than hemicolectomy
- 31 Partial colectomy **WITH** permanent colostomy (Hartmann's operation)

ALSO CODE colostomy in the data item "Reconstruction/Restoration."

- 40 Hemicolectomy or greater (but less than total); right or left colectomy

A hemicolectomy is the removal of total right or left colon and a portion of transverse colon.
A right hemicolectomy routinely includes removal of a portion of the terminal ileum.

Surgery Codes

COLON C18.0 - C18.9

50 Total colectomy

Removal of colon from cecum to the rectosigmoid or a portion of the rectum

60 Total proctocolectomy

Commonly used for familial polyposis or polyposis coli.

70 Colectomy or coloproctectomy WITH an en bloc resection of other organs; pelvic exenteration

CODE 70 includes any colectomy (partial, hemicolectomy, or total) WITH an en bloc resection of any other organs. The other organs may be partially or totally removed. Procedures that may be a **PART OF AN EN BLOC RESECTION** include, but are not limited to: oophorectomy, partial proctectomy, rectal mucosectomy

EN BLOC resection is the removal of organs in one piece at one time.

THE CREATION OF ILEAL RESERVOIR which is a part of a pelvic exenteration **MUST ALSO BE CODED** in the data item "Reconstruction/Restoration."

80 Colectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS

2 Microscopic involvement

5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

Surgery Codes

**COLON
C18.0 - C18.9**

SCOPE OF REGIONAL LYMPH NODE SURGERY

<p>The pathology report often describes regional lymph nodes by their anatomic location: colic nodes; mesenteric nodes; peri-\epi-\para-\ colic. Regional lymph nodes differ for each anatomical subsite. The following list identifies the regional lymph nodes for each subsite of the colon:</p>	
<p>Cecum and appendix</p>	<p>Anterior cecal Ileocolic Posterior cecal Right colic</p>
<p>Ascending colon</p>	<p>Ileocolic Middle colic Right colic</p>
<p>Hepatic flexure</p>	<p>Middle colic Right colic</p>
<p>Transverse colon</p>	<p>Middle colic</p>
<p>Splenic flexure</p>	<p>Inferior mesenteric Middle colic, left colic</p>
<p>Descending colon</p>	<p>Inferior mesenteric Left colic Sigmoid</p>
<p>Sigmoid colon</p>	<p>Inferior mesenteric Sigmoid mesenteric Sigmoidal Superior rectal(hemorrhoidal)</p>

Surgery Codes

**COLON
C18.0 - C18.9**

Superior mesenteric, external iliac and common iliac nodes are distant lymph nodes. Code the removal of any of these nodes in the data item "Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)."

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
- 9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

Surgery Codes

COLON C18.0 - C18.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of appendix, gallbladder, bile ducts, or spleen. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Removal of other regional site(s), ONLY
 - 3 Removal/surgical ablation of single liver metastasis
 - 4 Removal/surgical ablation of multiple liver metastases
 - 5 Combination of codes 2 and 3 or 4
- 6 Removal of other distant site(s) or distant lymph node(s), ONLY
 - 7 Combination of code 6 WITH 3 or 5
 - 8 Combination of code 6 WITH 4
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**COLON
C18.0 - C18.9**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Do not code anastomosis as reconstruction.

Codes

- 0 No reconstruction/restoration
- 1 Colostomy (permanent)
- 2 Ileostomy, NOS
 - 3 WITHOUT a reservoir or pouch
 - 4 WITH an abdominal reservoir or pouch
 - 5 WITH an anal reservoir or pouch; artificial sphincter
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**RECTOSIGMOID
C19.9**

SURGICAL APPROACH

CODE

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS (includes laparoscopic)
- 4 Open, NOS
 - 5 Transanal
 - 6 Posterior; coccygeal; trans-sacral; abdominosacral
 - 7 Low anterior (LAR)
 - 8 Abdominal perineal (AP)
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

CODE removal/surgical ablation of single or multiple liver metastases under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Node(s)."

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser ablation

No specimen sent to pathology from this surgical event.

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
 - 25 Laser excision
 - 26 Polypectomy
 - 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Surgery Codes

**RECTOSIGMOID
C19.9**

Procedures coded 30 include, but are not limited to:

Anterior resection
Hartmann's operation
Low anterior resection
Partial colectomy, NOS
Rectosigmoidectomy, NOS
Sigmoidectomy

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS

Also code the colostomy in the data item "Reconstruction/Restoration."

Procedures coded 40 include but are not limited to:

Altemeier's operation
Duhamel's operation
Soave's submucosal resection
Swenson's operation
Turnbull's operation

40 Pull through WITH sphincter preservation (coloanal anastomosis)

Procedures coded 50 include but are not limited to:

Abdominoperineal resection (A & P resection)
Anterior/posterior resection (A/P resection)/Miles' operation
Rankin's operation

50 Total proctectomy

51 Total colectomy

Removal of the colon from cecum to the rectosigmoid or a portion of the rectum

60 Combination of 50 and 51

70 Colectomy or proctocolectomy WITH an en bloc resection of other organs; pelvic exenteration

Surgery Codes

**RECTOSIGMOID
C19.9**

EN BLOC RESECTION is the removal of organs in one piece at one time. Procedures that may be a part of an en bloc resection include, but are not limited to: an oophorectomy and a rectal mucosectomy.

Code 70 includes any colectomy (partial, hemicolectomy, or total) WITH an en bloc resection of any other organs. The other organs may be partially or totally removed.

An **ILEAL RESERVOIR**, which is part of a pelvic exenteration, should be coded in the data item "Reconstruction/Restoration".

80 Colectomy, NOS; Proctectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate ONLY

SURGICAL MARGINS

0 All margins grossly and microscopically negative

1 Margins involved, NOS

2 Microscopic involvement

5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

Surgery Codes

**RECTOSIGMOID
C19.9**

SCOPE OF REGIONAL LYMPH NODE SURGERY

The pathology report often identifies regional lymph nodes by their anatomic location: colic; mesenteric; peri-/para-/ colic; perirectal; rectal.

The specific regional lymph nodes are:

Inferior mesenteric
Left colic
Middle rectal (hemorrhoidal)
Perirectal
Sigmoid mesenteric
Sigmoidal
Superior rectal (superior hemorrhoidal)

Superior mesenteric, external iliac and common iliac nodes are distant nodes. Code removal of these nodes under the data item "Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)".

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**RECTOSIGMOID
C19.9**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

Surgery Codes

**RECTOSIGMOID
C19.9**

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of appendix, gallbladder, or bile ducts. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Removal of other regional site(s), ONLY
 - 3 Removal/surgical ablation of single liver metastasis
 - 4 Removal/surgical ablation of multiple liver metastases
 - 5 Combination of codes 2 and 3 or 4
 - 6 Removal of other distant site(s) or distant lymph node(s), ONLY
 - 7 Combination of code 6 WITH 3, 4 or 5
 - 8 Combination of code 6 WITH 3 or 5
- 9 Unknown; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Colostomy (permanent)
- 2 Ileostomy, NOS
 - 3 WITHOUT a reservoir or pouch
 - 4 WITH an abdominal reservoir or pouch
 - 5 WITH an anal reservoir or pouch; artificial sphincter
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

RECTUM C20.9

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS (includes laparoscopy)
- 4 Open, NOS
 - 5 Transanal (Kraske, York-Mason)
 - 6 Posterior; coccygeal; trans-sacral; abdominosacral
 - 7 Low anterior (LAR)
 - 8 Abdominal perineal (AP)
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

CODE removal/surgical ablation of single or multiple liver metastases under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

Codes

- 00 None; surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from this surgical event.

Surgery Codes

**RECTUM
C20.9**

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy
- 28 Curette and fulguration

Specimen sent to pathology from this surgical event.

Procedures coded 30 include, but are not limited to:

Anterior resection
Hartmann's operation
Low anterior resection (LAR)
Trans-sacral rectosigmoidectomy

- 30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 40 include but are not limited to:

Altimeter's operation
Duhamel's operation
Soave's submucosal resection
Swenson's operation
Turnbull's operation

- 40 Pull through WITH sphincter preservation (coloanal anastomosis)

Procedures coded 50 include but are not limited to:

Abdominoperineal resection (A & P resection)
Anterior/Posterior (A/P) resection/Miles' operation
Rankin's operation

- 50 Total proctectomy

Surgery Codes

RECTUM C20.9

- 60 Total proctocolectomy, NOS
- 70 Proctectomy or proctocolectomy WITH an en bloc resection of other organs; pelvic exenteration

EN BLOC RESECTION is the removal of organs in one piece at one time.

The creation of an ileal reservoir, which is a part of a pelvic exenteration, should be coded in the data item "Reconstruction/Restoration".

- 80 Proctectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

Surgery Codes

RECTUM C20.9

SCOPE OF REGIONAL LYMPH NODE SURGERY

The pathology report often identifies regional lymph nodes by their anatomic location: mesenteric nodes; perirectal nodes; rectal nodes.

The specific regional lymph nodes are:

Inferior rectal (hemorrhoidal)
Inferior mesenteric
Internal iliac
Lateral sacral
Middle rectal (hemorrhoidal)
Perirectal
Presacral
Sacral promontory (Gerota's)
Sigmoid mesenteric
Superior rectal (hemorrhoidal)

Superior mesenteric, external iliac and common iliac nodes are classified as distant lymph nodes. Code removal of these nodes under the data item "Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)."

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**RECTUM
C20.9**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

Surgery Codes

RECTUM C20.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of appendix, gallbladder, bile ducts, or spleen. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Removal of other regional site(s), ONLY
 - 3 Removal/surgical ablation of single liver metastasis
 - 4 Removal/surgical ablation of multiple liver metastases
 - 5 Combination of codes 2 with 3 or 4
- 6 Removal of other distant site(s) or distant lymph node(s), ONLY
 - 7 Combination of code 6 WITH 3, 4 or 5
 - 8 Combination of code 6 WITH 3 or 5
- 9 Unknown; death certificate ONLY

Surgery Codes

**RECTUM
C20.9**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Colostomy (permanent)
- 2 Ileostomy, NOS
 - 3 WITHOUT a reservoir or pouch
 - 4 WITH an abdominal reservoir or pouch
 - 5 WITH an anal reservoir or pouch; artificial sphincter
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**ANUS
C21.0-C21.8**

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site

Procedures for codes 10-14 include, but are not limited to:
Cryosurgery Electrocautery Excisional biopsy Laser Thermal ablation

- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from this surgical event.

Surgery Codes

ANUS C21.0-C21.8

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Margins of resection may have microscopic involvement.

- 60 Abdominal perineal resection, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

Surgery Codes

ANUS C21.0-C21.8

SCOPE OF REGIONAL LYMPH NODE SURGERY

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
 - 2 Perirectal, anorectal lymph nodes
 - 3 Internal iliac lymph nodes (hypogastric), unilateral
 - 4 Inguinal lymph nodes, unilateral
 - 5 Combination of 2 and 4
 - 6 Bilateral internal iliac and/or bilateral inguinal lymph nodes
- 9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 90 or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

Surgery Codes

**ANUS
C21.0-C21.8**

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional sites
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Colostomy (permanent)
- 2 Ileostomy, NOS
 - 3 WITHOUT a reservoir or pouch
 - 4 WITH an abdominal reservoir or pouch
 - 5 WITH an anal reservoir or pouch; artificial sphincter
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

LIVER AND INTRAHEPATIC BILE DUCTS C22.0-C22.1

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy ONLY, NOS (laparoscopy)
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Alcohol (PEI)
 - 16 Heat
 - 17 Other (ultrasound, acetic acid)
- 20 Wedge resection, NOS; segmental resection
- 30 Lobectomy, NOS
 - 31 Simple
 - 32 Extended

Extended lobectomy: resection of a single lobe plus a segment of another lobe.
- 40 Excision of a bile duct (for an intrahepatic bile duct primary only)

Surgery Codes

**LIVER AND INTRAHEPATIC BILE DUCTS
C22.0-C22.1**

70 Total hepatectomy with transplant

Liver transplant must also be coded under the data item "Reconstruction/Restoration."

80 Hepatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY
SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS

2 Microscopic involvement

5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional lymph nodes are the hilar nodes:
--

Along the portal vein

Along the inferior vena cava

Along the proper hepatic artery

At the hepatic pedicle

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

Surgery Codes

**LIVER AND INTRAHEPATIC BILE DUCTS
C22.0-C22.1**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional sites(s)
 - 3 Distant lymph node(s) (includes inferior phrenic lymph nodes)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**LIVER AND INTRAHEPATIC BILE DUCTS
C22.0-C22.1**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Rioux-en-Y; hepatojejunostomy including stent
- 2 Liver transplant
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**PANCREAS
C25.0-C25.9**

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS (laparoscopy)
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local excision of tumor, NOS
- 20 Partial pancreatectomy, NOS
- 40 Total pancreatectomy
- 50 Local or partial pancreatectomy and duodenectomy
 - 51 Without subtotal gastrectomy
 - 52 With subtotal gastrectomy (Whipple)
- 60 Total pancreatectomy and subtotal gastrectomy or duodenectomy
- 70 Extended pancreatoduodenectomy
- 80 Pancreatectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

**PANCREAS
C25.0-C25.9**

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Celiac (head only) Hepatic artery Infrapyloric (head only) Lateral aortic Pancreaticolienal (body and tail only) Peripancreatic (superior, inferior, anterior, posterior splenic) Retroperitoneal Splenic (body and tail only) Subpyloric (head only) Superior mesenteric

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
 - 2 Extended lymphadenectomy

An extended pancreaticoduodenectomy incorporates selected aspects of the Whipple procedure and regional pancreatectomy. A wide Kocher maneuver removes all lymphatic tissue over the medical aspect of the right kidney, inferior vena cava, and left renal vein.

Surgery Codes

**PANCREAS
C25.0-C25.9**

9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Removal of other regional sites, ONLY
 - 3 Removal of distant node(s)
 - 4 Removal of distant site(s)
 - 5 Combination of 2 WITH 3 and/or 4
- 9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

- 9 Not applicable (There are no known reconstructive procedures for this site.)

Surgery Codes

LARYNX C32.0-C32.9

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Stripping

No specimen sent to pathology from this surgical event.

Surgery Codes

**LARYNX
C32.0-C32.9**

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
 - 25 Laser excision
 - 26 Polypectomy
 - 27 Excisional biopsy
 - 28 Stripping

Specimen sent to pathology from this surgical event.

- 30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
 - 31 Vertical laryngectomy
 - 32 Anterior commissure laryngectomy
 - 33 Supraglottic laryngectomy
- 40 Total or radical laryngectomy, NOS
 - 41 Total laryngectomy ONLY
 - 42 Radical laryngectomy ONLY
- 50 Pharyngolaryngectomy
- 80 Laryngectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

LARYNX C32.0-C32.9

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional cervical lymph nodes are:

Buccal (facial) Caudal jugular (deep cervical) Cranial jugular (deep cervical) Dorsal cervical (superficial cervical) Medial jugular (deep cervical) Occipital Paratracheal (anterior cervical) Parotid Pre-laryngeal (anterior cervical) Retroauricular (mastoid, posterior auricular) Retropharyngeal Submandibular (submaxillary) Submental Supraclavicular

Surgery Codes

LARYNX C32.0-C32.9

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
- 2 Neck dissection, NOS
 - 3 Selective, limited; nodal sampling; “berry picking”
 - 4 Modified/modified radical
 - 5 Radical
- 9 Unknown; not stated; death certificate ONLY

Terminology of neck dissection (Robbins et al. 1991):

A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more non lymphatic structures are preserved.

A selective neck dissection is a neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.

Surgery Codes

**LARYNX
C32.0-C32.9**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional sites(s)
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**LARYNX
C32.0-C32.9**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Flaps, grafts, or any “plastys,” NOS
 - 2 WITHOUT implant/prosthesis
 - 3 WITH implant/prosthesis
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

LUNG C34.0 - C34.9

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS
 - 2 Bronchoscopy
 - 3 Mediastinoscopy
 - 4 Thoracoscopy
- 5 Open, NOS (thoracotomy, sternotomy)
 - 6 Not assisted by endoscopy
 - 7 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction or excision, NOS
 - 11 Excision
 - 12 Laser ablation or excision
 - 13 Cautery; fulguration
 - 14 Bronchial sleeve resection ONLY
- 20 Resection of less than one lobe
 - 21 Wedge resection
 - 22 Segmental resection, including lingulectomy
- 30 Resection of at least one lobe, but less than the whole lung (partial pneumonectomy, NOS)
 - 31 Lobectomy
 - 32 Bilobectomy

Surgery Codes

**LUNG
C34.0 - C34.9**

Complete pneumonectomy Pneumonectomy, NOS Sleeve pneumonectomy Standard pneumonectomy Total pneumonectomy

40 Resection of whole lung

50 Resection of lung **WITH an en bloc resection of other organs**

51 Wedge resection

52 Lobectomy

53 Bilobectomy

54 Pneumonectomy (less than a radical or extended pneumonectomy)

EN BLOC resection is the removal of organs in one piece at one time.

60 Radical pneumonectomy

Radical pneumonectomy is a complete pneumonectomy WITH removal of mediastinal lymph nodes. Removal of mediastinal nodes is also coded in the data fields "Scope of Regional Lymph Node Surgery" and "Number of Regional Nodes Removed."

70 Extended radical pneumonectomy

An extended radical pneumonectomy is a radical pneumonectomy (including removal of mediastinal nodes) and the removal of other tissues or nodes. Removal of mediastinal nodes is also coded in the data fields "Scope of Regional Lymph Node Surgery" and "Number of Regional Nodes Removed."

80 Resection of lung, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

**LUNG
C34.0 - C34.9**

SURGICAL MARGINS

CODE

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

Mediastinal nodes are:
Aortic (includes subaortic, aorticopulmonary window, periaortic, including ascending aorta or including azygos) Periesophageal Peritracheal (including those that may be designated tracheobronchial, i.e., lower peritracheal, phrenic) Pre- and retrotracheal (includes precarinal) Pulmonary ligament Subcarinal

Surgery Codes

**LUNG
C34.0 - C34.9**

CODE

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
 - 2 Intrapulmonary (includes interlobar, lobar, segmental), ipsilateral hilar and/or ipsilateral peribronchial nodes
 - 3 Ipsilateral mediastinal and/or subcarinal nodes
 - 4 Combination of 2 and 3
 - 5 Contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene and/or supraclavicular nodes
 - 6 Combination of 5 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

Surgery Codes

**LUNG
C34.0 - C34.9**

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of ribs. Ribs are removed to provide access to the lung.

Codes

- 0 None; no surgery to other regional sites, distant sites or distant lymph nodes
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Surgery to a regional site ONLY
 - 3 Removal of a solitary lesion in the same lung (primary site), different (non-primary) lobe

There is one primary. Patient has two tumors with the same histology in different lobes of the same lung.

- 4 Resection of metastasis in a distant site(s) or resection of distant lymph nodes(s), NOS
 - 5 Removal of a solitary lesion in the contralateral lung

Patient has one primary. There is a primary tumor or tumor(s) in one lung and a solitary metastatic lesion in the contralateral lung.

- 6 Removal of a solitary lesion in a distant site or a distant lymph node, NOS

This includes, but is not limited to the removal of a solitary metastatic brain lesion.

- 7 Removal of multiple lesions in distant site(s)

- 9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Chest wall reconstruction/restoration, NOS
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

Bones, Joints, and Articular Cartilage C40.0 - C41.9 **Peripheral Nerves And Autonomic Nervous System C47.0 - C47.9** **Connective, Subcutaneous And Other Soft Tissues C49.0 - C49.9**

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction or excision
- 20 Partial resection/internal hemipelvectomy (pelvis)
- 30 Radical excision or resection of lesion with limb salvage
- 40 Amputation of limb
 - 41 Partial amputation of limb
 - 42 Total amputation of limb
- 50 Major amputation, NOS
 - 51 Forequarter, including scapula
 - 52 Hindquarter, including ilium/hip bone
 - 53 Hemipelvectomy
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

Bones, Joints, and Articular Cartilage C40.0 - C41.9
Peripheral Nerves And Autonomic Nervous System C47.0 - C47.9
Connective, Subcutaneous And Other Soft Tissues C49.0 - C49.9

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

Bones, Joints, and Articular Cartilage C40.0 - C41.9
Peripheral Nerves And Autonomic Nervous System C47.0 - C47.9
Connective, Subcutaneous And Other Soft Tissues C49.0 - C49.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional site(s)
 - 5 Distant lymph node(s)
 - 6 Distant site(s)
 - 7 Combination of 6 WITH 2, 3, 4, or 5
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

Bones, Joints, and Articular Cartilage C40.0 - C41.9
Peripheral Nerves And Autonomic Nervous System C47.0 - C47.9
Connective, Subcutaneous And Other Soft Tissues C49.0 - C49.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Flap, graft, or any "plasty," NOS
 - 2 WITHOUT implant/prosthesis
 - 3 WITH implant/prosthesis
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

SPLEEN AND LYMPH NODES Spleen C42.2, Lymph Nodes C77.0 - C77.9

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local excision, destruction, NOS
For lymphoma, use 10 to code lymph node biopsy that is not an excision of the full chain of lymph nodes.
- 20 Splenectomy, NOS (for spleen primaries only)
 - 21 Partial splenectomy
 - 22 Total splenectomy
- 30 Lymph node dissection, NOS (for lymphomas only)
 - 31 One chain
 - 32 Two or more chains
- 40 Lymph node dissection, NOS plus splenectomy
 - 41 One chain
 - 42 Two or more chains

Surgery Codes

SPLEEN AND LYMPH NODES **Spleen C42.2, Lymph Nodes C77.0 - C77.9**

- 50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
 - 51 One chain
 - 52 Two or more chains
- 60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy (Includes staging laparotomy for lymphoma).
 - 61 One chain
 - 62 Two or more chains
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY (SPLEEN Only)

Note: For primary sites C77.0-C77.9, code this field as '9.'

Codes

- 0 No regional lymph nodes removed (Spleen primary only)
- 1 Regional lymph node(s) removed, NOS (Spleen primary only)
- 9 Unknown; not stated; death certificate ONLY (Use this code for lymphoma)

Surgery Codes

SPLEEN AND LYMPH NODES Spleen C42.2, Lymph Nodes C77.0 - C77.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED (SPLEEN Only)

Note: For primary sites C77.0-C77.9, code this field as "99."

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional site(s)
 - 5 Distant lymph node(s)
 - 6 Distant site(s)
 - 7 Combination of 6 WITH 2, 3, 4, or 5
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

SPLEEN AND LYMPH NODES
Spleen C42.2, Lymph Nodes C77.0 - C77.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

9 At this time, reconstructive procedures are not being collected for these sites

Surgery Codes

**SKIN
C44.0 - C44.9**

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 4 Open approach
- 9 Death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser ablation

No specimen sent to pathology from this surgical event.

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
 - 25 Laser excision
 - 26 Polypectomy
 - 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

- 30 Biopsy of primary tumor followed by a gross excision of the lesion
 - 31 Shave biopsy followed by a gross excision of the lesion; MOHS surgery
 - 32 Punch biopsy followed by a gross excision of the lesion
 - 33 Incisional biopsy followed by a gross excision of the lesion

Less than a wide excision, less than 1 cm margin.

Surgery Codes

SKIN C44.0 - C44.9

40 Wide excision or re excision of lesion or minor (local) amputation, NOS

Margins of excision are 1 cm or more. Margins may be microscopically involved.
Local amputation is the surgical resection of digits, ear, eyelid, lip, or nose.

.50 Radical excision of a lesion, NOS

Margins of excision are greater than 1 cm and grossly tumors free. The margins may be microscopically involved.

60 Major amputation, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS

2 Microscopic involvement

5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

Surgery Codes

**SKIN
C44.0 - C44.9**

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional lymph nodes are different for each anatomical subsite.

Head, neck	Cervical, ipsilateral preauricular, submandibular, and supraclavicular
Thorax	Ipsilateral axillary
Arm	Ipsilateral epitrochlear and axillary
Abdomen, loins, and buttocks	Ipsilateral inguinal
Anal margin and perianal skin	Ipsilateral inguinal
Leg	Ipsilateral inguinal and popliteal

There are boundary zones between the subsites (i.e., between the thorax and arm, the boundary zone is the shoulder and axilla). The boundary zones do not belong to either subsite. If a tumor originates in one of these 4 cm boundary zones, the nodes on either side of the bands are regional.

BETWEEN THE SUBSITES		THE BOUNDARY ZONE IS
Head and neck AND	Thorax	Clavícula-acromion-upper shoulder blade edge
Thorax AND	Arm	Shoulder-axilla-shoulder
Thorax AND	Abdomen, loins, and buttocks	Front: Middle between navel and costal arch Back: Lower border of thoracic vertebrae (midtransverse axis)
Abdomen, loins, and buttock AND	Leg	Groin-trochanter-gluteal sulcus
Right AND	Left	Midline

Surgery Codes

**SKIN
C44.0 - C44.9**

Iliac, other pelvic, abdominal or intrathoracic lymph nodes are distant. Code the removal of these nodes under the data item, "Surgery of Other Regional Site(s), Distant Site(s), or Distant Node(s)."

Codes

0 No regional lymph nodes removed

1 Sentinel node, NOS

A sentinel node is the first node to receive drainage from a primary tumor. It is identified by an injection of a dye or radio label at the site of the primary tumor

2 Regional lymph nodes removed, NOS

9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined

01 One regional lymph node examined

02 Two regional lymph nodes examined

..

90 Ninety or more regional lymph nodes examined

95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate ONLY

Surgery Codes

**SKIN
C44.0 - C44.9**

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional sites(s)
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Pedicle flap, free flap, skin graft, NOS
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**BREAST
C50.0 - C50.9**

SURGICAL APPROACH

CODE

- 0 None; no surgery of primary site
- 4 Open approach, NOS
 - 5 WITHOUT dye or needle localization
 - 6 WITH dye or needle localization
- 9 Death certificate ONLY

SURGERY OF PRIMARY SITE

CODE

- 00 None; no surgery of primary site

Procedures coded as 10-17 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

- 10 Partial mastectomy, NOS; less than total mastectomy, NOS
 - 11 Nipple resection
 - 12 Lumpectomy or excisional biopsy
 - 13 Re excision of the biopsy site for gross or microscopic residual disease.
 - 14 Wedge resection
 - 15 Quadrantectomy
 - 16 Segmental mastectomy
 - 17 Tylectomy

- 30 Subcutaneous mastectomy

A subcutaneous mastectomy is the removal of breast tissue without the nipple and areolar complex or overlying skin. **THIS PROCEDURE IS RARELY PERFORMED TO TREAT MALIGNANCIES.**

Surgery Codes

**BREAST
C50.0 - C50.9**

- 40 Total (simple) mastectomy, NOS
- 41 WITHOUT removal of uninvolved contralateral breast
- 42 WITH removal of uninvolved contralateral breast

A simple mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.

For single primaries only, code removal of involved contralateral breast under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

- 50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
- 52 WITH removal of uninvolved contralateral breast

Removes all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin. The procedure involves an en bloc resection of the axilla. The specimen may or may not include a portion of the pectoralis major muscle. Includes an en bloc axillary dissection.

For single primaries only, code removal of involved contralateral breast under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

- 60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
- 62 WITH removal of uninvolved contralateral breast

Removal of breast tissue, nipple, areolar complex, a variable amount of skin, pectoralis minor, and pectoralis major. Includes an en bloc axillary dissection.

For single primaries only, code removal of involved contralateral breast under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

Surgery Codes

**BREAST
C50.0 - C50.9**

- 70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

Removal of breast tissue, nipple, areolar complex, variable amounts of skin, pectoralis minor, and pectoralis major. Includes removal of internal mammary nodes and an en bloc axillary dissection.

For single primaries only, code removal of involved contralateral breast under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

- 80 Mastectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

BREAST C50.0 - C50.9

SURGICAL MARGINS

Since the codes are hierarchical, if more than one code is applicable, use the numerically higher code. For example, if multiple margins are microscopically and macroscopically involved, code the macroscopic involvement(s).

Multiple margins are two separate margins, both of which are microscopically involved with tumor. **DO NOT CODE** multiple margins (4) if ONE MARGIN has multiple foci of tumor.

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 3 Single margin
 - 4 Multiple margins
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

- 0 No regional lymph nodes removed
- 1 Sentinel lymph node(s) removed

A sentinel node is the first node to receive drainage from a primary tumor. It is identified by an injection of a dye or radio label at the site of the primary tumor

Surgery Codes

**BREAST
C50.0 - C50.9**

- 2 Regional lymph node(s) removed, NOS; axillary, NOS (Levels I, II, or III lymph nodes)
Intramammary, NOS
- 3 Combination of 1 and 2
- 4 Internal mammary
- 5 Combination of 4 WITH any of 1-3
- 9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

Surgery Codes

**BREAST
C50.0 - C50.9**

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE removal of fragments or tags of muscles; removal of the pectoralis minor; the resection of pectoralis muscles, NOS; or the resection of fascia with no mention of muscle.

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional site(s)
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Removal of involved contralateral breast (single primary only)
 - 6 Combination of 4 or 5 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**BREAST
C50.0 - C50.9**

RECONSTRUCTION/RESTORATION - FIRST COURSE

The insertion of a tissue expander is often the beginning of the reconstructive procedure.

Codes

- 0 No reconstruction/restoration
- 1 Reconstruction, NOS (unknown if flap)
 - 2 Implant; reconstruction WITHOUT flap
 - 3 Reconstruction WITH flap, NOS
 - 4 Latissimus dorsi flap
 - 5 Abdominus recti flap
 - 6 Flap, NOS + implant
 - 7 Latissimus dorsi flap + implant
 - 8 Abdominus recti + implant
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**CERVIX UTERI
C53.0 - C53.9**

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Vaginal, NOS
 - 2 Not assisted by endoscopy
 - 3 Assisted by colposcopy
 - 4 Assisted by laparoscopy
- 5 Open, NOS
 - 6 Not assisted by endoscopy
 - 7 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

FOR INVASIVE CANCERS, dilation and curettage is coded as an incisional biopsy (02) under the data item "Non Cancer-Directed Surgery."

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 LEEP

No specimen sent to pathology from this surgical event.

Surgery Codes

**CERVIX UTERI
C53.0 - C53.9**

- 20 Local tumor destruction or excision, NOS (**WITH PATHOLOGY SPECIMEN**)
 - 21 Electrocautery
 - 22 Cryosurgery
 - 23 Laser
 - 24 Cone biopsy WITH gross excision of lesion
 - 25 Dilatation and curettage; endocervical curettage (cancer-directed for in situ only)
 - 26 Excisional biopsy, NOS
 - 27 Cone biopsy
 - 28 LEEP
 - 29 Trachelectomy; removal of cervical stump; cervicectomy

Specimen sent to pathology from this surgical event.

- 30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries

Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

- 40 Total hysterectomy (simple, pan-) WITH removal of tubes or ovary

Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

- 50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy

- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim's procedure
- 54 Extended radical hysterectomy

- 60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries

- 61 WITHOUT removal of tubes and ovaries
- 62 WITH removal of tubes and ovaries

- 70 Pelvic exenteration

- 71 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

Surgery Codes

**CERVIX UTERI
C53.0 - C53.9**

72 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

**CERVIX UTERI
C53.0 - C53.9**

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Common iliac External iliac Hypogastric (obturator) Internal iliac Paracervical Parametrial Presacral Sacral

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**CERVIX UTERI
C53.0 - C53.9**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

Surgery Codes

**CERVIX UTERI
C53.0 - C53.9**

**SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH
NODE(S)**

DO NOT CODE the incidental removal of an appendix. **DO NOT CODE** an omentectomy **IF** it was the only surgery performed in addition to hysterectomy. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional site(s)
 - 3 Distant lymph node(s), NOS
 - 4 Periaortic lymph nodes
 - 5 Distant site(s)
 - 6 Combinations of 5 with 4
 - 7 Combination of 5 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**CERVIX UTERI
C53.0 - C53.9**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Vaginal reconstruction
- 2 Urinary reconstruction
- 3 Bowel reconstruction/restoration
- 4 Combination of 3 with 1 or 2
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**CORPUS UTERI
C54.0 - C55.9**

SURGICAL APPROACH

- 0 None; no surgery of primary site
- 1 Vaginal, NOS
 - 2 Not assisted by endoscopy
 - 3 Assisted by colposcopy
 - 4 Assisted by laparoscopy
- 5 Open, NOS
 - 6 Not assisted by endoscopy
 - 7 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

FOR INVASIVE CANCERS, dilation and curettage is coded as an incisional biopsy (02) under the data item "Non Cancer-Directed Surgery."

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 LEEP

No specimen sent to pathology from this surgical event.

Procedures in code 20 include but are not limited to:
Cryosurgery Electrocautery Excisional biopsy Laser ablation Thermal ablation

Surgery Codes

**CORPUS UTERI
C54.0 - C55.9**

20 Local tumor destruction or excision, NOS; simple excision, NOS **(WITH PATHOLOGY SPECIMEN)**

- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser
- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

Specimen sent to pathology from this surgical event.

Margins of resection may have microscopic involvement.

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies).

- 31 WITHOUT tube(s) and ovary (ies)
- 32 WITH tube(s) and ovary (ies)

Cervix left in place

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary (ies)

Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) or ovary (ies)

Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy

- 61 Modified radical hysterectomy
- 62 Extended hysterectomy
- 63 Radical hysterectomy; Wertheim's procedure
- 64 Extended radical hysterectomy

70 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)

- 71 WITHOUT removal of tube(s) and ovary(ies)
- 72 WITH removal of tube(s) and ovary(ies)

80 Pelvic exenteration

- 81 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

Surgery Codes

**CORPUS UTERI
C54.0 - C55.9**

82 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

83 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

84 Extended exenteration

Includes pelvic blood vessels or bony pelvis

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

0 All margins grossly and microscopically negative

1 Margins involved, NOS

2 Microscopic involvement

5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

Surgery Codes

**CORPUS UTERI
C54.0 - C55.9**

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Common iliac and external iliac
Hypogastric (obturator)
Para aortic
Parametrial
Sacral

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
 - 2 Pariaortic with or without other regional lymph nodes
- 9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

Surgery Codes

**CORPUS UTERI
C54.0 - C55.9**

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of the appendix or an omentectomy **IF** it was the only surgery performed in addition to hysterectomy. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional site(s)
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Vaginal reconstruction
- 2 Urinary reconstruction
- 3 Bowel reconstruction/restoration
- 4 Combination of 3 with 1 or 2
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

OVARY C56.9

SURGICAL APPROACH

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS (laparoscopy)
 - 2 Not image guided
 - 3 Image guided

Open approaches include, but are not limited to:

Low transverse abdominal incision Vertical abdominal incision
--

- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

- 00 None; no surgery of primary site
- 10 Total removal of tumor or (single) ovary, NOS
 - 11 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
 - 12 WITHOUT hysterectomy
 - 13 WITH hysterectomy
 - 14 Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done
 - 15 WITHOUT hysterectomy
 - 16 WITH hysterectomy
- 20 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done
 - 21 WITHOUT hysterectomy
 - 22 WITH hysterectomy
- 30 Unilateral or bilateral (salpingo-) oophorectomy **WITH OMENTECTOMY**, NOS; partial or total; unknown if hysterectomy done
 - 31 WITHOUT hysterectomy
 - 32 WITH hysterectomy

Surgery Codes

**OVARY
C56.9**

- 60 Debulking; cytoreductive surgery, NOS
- 61 WITH colon (including appendix) and/or small intestine resection (not incidental)
- 62 WITH partial resection of urinary tract (not incidental)
- 63 Combination of 61 and 62

Debulking is a partial removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue.

A debulking is usually followed by another treatment modality such as chemotherapy.

- 70 Pelvic exenteration, NOS

- 71 Anterior

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

- 72 Posterior

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

- 73 Total

Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

- 74 Extended

Includes pelvic blood vessels or bony pelvis.

- 80 (Salpingo-) oophorectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

OVARY C56.9

SURGICAL MARGINS

For this site only, this field will describe the residual tumor after cancer-directed surgery.

Codes

- 0 No visible residual tumor
- 1 Visible residual tumor, NOS
 - 2 Visible residual tumor, cumulative maximum of less than 1 cm
 - 3 Visible residual tumor, cumulative maximum of at least 1 cm, not more than 2 cm
 - 4 Visible residual tumor, cumulative maximum of more than 2 cm
- 8 No surgery of primary site
- 9 Unknown whether visible residual tumor was present; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Common iliac
External iliac
Hypogastric (obturator)
Inguinal
Lateral sacral
Paraaortic
Pelvic, NOS
Retroperitoneal, NOS

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**OVARY
C56.9**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE an incidental removal of the appendix. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional site(s)
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**OVARY
C56.9**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Urinary reconstruction
- 2 Bowel reconstruction/restoration
- 3 Combination of 1 and 2
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**PROSTATE
C61.9**

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS (transurethral)
- 2 Laparoscopic, NOS
- 3 Open, NOS
 - 4 Suprapubic
 - 5 Perineal
 - 7 Trans-sacral
 - 8 Retropubic

Code the approach for radical prostatectomy as retropubic unless otherwise specified.

- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the field "Hormone Therapy."

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction or excision, NOS
 - 11 Transurethral resection (TURP), NOS
 - 12 TURP - cancer is incidental finding during surgery for benign disease
 - 13 TURP - patient has suspected/known cancer
 - 14 Cryoprostatectomy
 - 15 Laser
 - 16 Hyperthermia
 - 17 Other method of local resection or destruction

- 30 Subtotal or simple prostatectomy, NOS

A segmental resection or enucleation leaving the capsule intact.

Surgery Codes

**PROSTATE
C61.9**

40 Less than total prostatectomy, NOS

An enucleation using an instrument such as a Vaportrode which may leave all or part of the capsule intact.

50 Radical prostatectomy, NOS; total prostatectomy, NOS

Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy WITH en bloc resection of other organs; pelvic exenteration

Surgeries coded 70 are any prostatectomy WITH an en bloc resection of any other organs. The other organs may be partially or totally removed.

EN BLOC RESECTION is the removal of organs in one piece at one time. Procedures that may involve an en bloc resection include, but are not limited to: cystoprostatectomy, radical cystectomy and prostatectomy.

80 Prostatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

PROSTATE C61.9

SURGICAL MARGINS

The codes are hierarchical, if more than one code is applicable, use the numerically higher code. For example, if multiple margins are microscopically and macroscopically involved, code the macroscopic involvement (5).

Multiple margins are two separate margins, both of which are microscopically involved with tumor. DO NOT CODE multiple margins (4) if one margin has multiple foci of tumor.

Codes

- 0 All margins grossly and microscopically negative
- 1 Margin(s) involved, NOS
 - 2 Microscopic involvement
 - 3 Single margin
 - 4 Multiple margins
 - 5 Macroscopic involvement, NOS
- 7 Margins not evaluable (TURP)
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Hypogastric Iliac, NOS (internal and external) Obturator Pelvic, NOS Periprostatic Sacral, NOS (lateral presacral, promontory [Gerota's] or NOS)

Surgery Codes

**PROSTATE
C61.9**

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
- 9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of nodes unknown /not stated and not documented as sampling or dissection
- 99 Unknown if regional lymph nodes removed; death certificate ONLY

Surgery Codes

**PROSTATE
C61.9**

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S)

DO NOT CODE orchiectomy. For prostate primaries, code orchiectomies under “Hormone Therapy.”

The most commonly removed distant lymph nodes are: aortic (para-aortic, peri-aortic, lumbar), common iliac, inguinal, superficial inguinal (femoral), supraclavicular, cervical, and scalene.

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional site(s)
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Reconstruction/restoration, NOS
 - 2 Collagen injection for incontinence
 - 3 Penile prosthesis
 - 4 Artificial urinary sphincter
 - 5 Combinations of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**TESTIS
C62.0-C62.9**

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 4 Open, NOS
 - 5 Scrotal
 - 6 Inguinal
- 9 Death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local or partial excision of testicle
- 30 Excision of testicle, NOS WITHOUT cord
- 40 Excision of testicle, NOS WITH cord/or cord not mentioned
- 80 Orchiectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

**TESTIS
C62.0-C62.9**

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Interaortocaval Paraaortic (Periaortic) Paracaval Preaortic Precaval Retroaortic Retrocaval

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS; not stated if bilateral or unilateral
 - 2 Unilateral regional lymph nodes
 - 3 Bilateral regional lymph nodes
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**TESTIS
C62.0-C62.9**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional sites
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**TESTIS
C62.0-C62.9**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Testicular implant
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

KIDNEY, RENAL PELVIS, AND URETER **Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9**

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from this surgical event.
- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
 - 25 Laser excision
 - 26 Polypectomy
 - 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Surgery Codes

KIDNEY, RENAL PELVIS, AND URETER
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

Procedures coded 30 include, but are not limited to:

Cryosurgery
Electrocautery
Excisional biopsy
Laser
Segmental resection
Thermal ablation
Wedge resection

- 30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Margins of resection are grossly negative. There may be microscopic involvement

- 40 Complete/total/simple nephrectomy - for kidney parenchyma
Nephroureterectomy

Includes bladder cuff for renal pelvis or ureter

- 50 Radical nephrectomy

May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter

- 70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) **PLUS** an en bloc resection of other organ(s) (colon, bladder)

The other organs, such as colon or bladder, may be partially or totally removed.

- 80 Nephrectomy, NOS
Ureterectomy, NOS

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

KIDNEY, RENAL PELVIS, AND URETER
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are	
Kidney	Aortic (para-aortic, periaortic, lateral aortic) Paracaval Renal hilar Retroperitoneal, NOS
Renal pelvis	Aortic Paracaval Renal hilar Retroperitoneal, NOS
Ureter	Iliac (common, internal [hypogastric], external) Paracaval Pelvic, NOS Periureteral Renal hilar

Surgery Codes

KIDNEY, RENAL PELVIS, AND URETER **Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9**

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS; not stated if bilateral or unilateral
 - 2 Unilateral regional lymph nodes
 - 3 Bilateral regional lymph nodes
- 9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of nodes unknown /not stated and not documented as sampling or dissection
- 99 Unknown if regional lymph nodes removed; death certificate ONLY

Surgery Codes

KIDNEY, RENAL PELVIS, AND URETER
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of ribs during the operative approach.

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional site(s)
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Kidney transplant (primary site)
- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**BLADDER
C67.0-C67.9**

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS
 - 2 Cystoscopy (TURB)
 - 3 Laparoscopy
- 4 Open, NOS
 - 5 Not assisted by endoscopy (laparoscopy)
 - 6 Assisted by endoscopy (laparoscopy)
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS (**WITHOUT PATHOLOGY SPECIMEN**)
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from this surgical event.

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
 - 25 Laser excision
 - 26 Polypectomy
 - 27 Excisional biopsy (TURB)

Specimen sent to pathology from this surgical event.

Surgery Codes

**BLADDER
C67.0-C67.9**

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Radical cystectomy (male only)

This code is used only for men. It involves the removal of bladder and prostate, with or without urethrectomy.

If a radical cystectomy is the procedure name for a woman, use code 71.

70 Pelvic exenteration, NOS

71 Radical cystectomy (female only); anterior exenteration

A radical cystectomy in a female includes removal of bladder, uterus, ovaries, entire vaginal wall and entire urethra.

72 Posterior exenteration

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

BLADDER C67.0-C67.9

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Hypogastric Iliac (internal, external, NOS) Obturator Pelvic, NOS Perivesical Presacral Sacral (lateral, sacral promontory [Gerota's])

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS; not stated if bilateral or unilateral
 - 2 Unilateral regional lymph nodes
 - 3 Bilateral regional lymph nodes
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**BLADDER
C67.0-C67.9**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE the partial or total removal of a ureter during a cystectomy.

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional site(s)
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

**BLADDER
C67.0-C67.9**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 0 No reconstruction/restoration
- 1 Conduit diversion
- 2 Continent reservoir (a bladder substitute)

Types of continent reservoirs include, but are not limited to:
Hemi-Kock Ileal reservoir Ileocecal reservoir Indiana or Mainz pouch Koch Studer pouch W-shaped ileoneobladder by Hautmann

- 8 Reconstruction/restoration recommended, unknown if performed
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM Meninges C70.0 - C70.9, Brain C71.0 - C71.9 Other Parts of Central Nervous System C72.0 - C72.9

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 4 Open
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

DO NOT CODE laminectomies for spinal cord primaries.

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction
- 20 Partial excision of tumor, lesion, or mass (> 5% and < 100%)
 - 21 Subtotal resection, NOS (50% and < 100%)
 - 22 Partial resection (> 50% and <100%)
 - 23 Debulking (> 5% and < 50%)
- 30 Total excision of tumor, lesion, or mass, NOS (100%)
 - 31 Total resection
 - 32 Gross resection
- 40 Partial resection, NOS
 - 41 Partial lobe
 - 42 Partial meninges
 - 43 Partial nerve(s)
- 50 Total resection (lobectomy of brain)
- 60 Radical resection
 - Resection of primary site plus partial or total removal of surrounding organs/tissue

Surgery Codes

BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM

Meninges C70.0 - C70.9, Brain C71.0 - C71.9

Other Parts of Central Nervous System C72.0 - C72.9

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS

2 Microscopic involvement

5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

There are no regional lymph nodes for brain. Code no regional lymph nodes removed (0). Central nervous system sites, however have regional lymph nodes.

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

Surgery Codes

BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM

Meninges C70.0 - C70.9, Brain C71.0 - C71.9

Other Parts of Central Nervous System C72.0 - C72.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

There are no regional lymph nodes for brain. Code no regional lymph nodes removed (00). Central nervous system tumors, however, have regional lymph nodes.

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional site(s)
 - 5 Distant lymph node(s)
 - 6 Distant site(s)
 - 7 Combination of 6 WITH 2, 3, 4, or 5
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM

Meninges C70.0 - C70.9, Brain C71.0 - C71.9

Other Parts of Central Nervous System C72.0 - C72.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

9 Not applicable (There are no known reconstructive procedures for this site.)

Surgery Codes

**THYROID GLAND
C73.9**

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Removal of less than a lobe, NOS
 - 11 Local surgical excision
 - 12 Removal of a partial lobe ONLY
- 20 Lobectomy and/or isthmectomy
 - 21 Lobectomy ONLY
 - 22 Isthmectomy ONLY
 - 23 Lobectomy WITH isthmus
- 30 Removal of a lobe and partial removal of the contralateral lobe
- 40 Subtotal or near total thyroidectomy
- 50 Total thyroidectomy
- 80 Thyroidectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

THYROID GLAND C73.9

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are the cervical and upper mediastinal lymph nodes.

Terminology of neck dissection (Robbins et al. 19):

A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more non lymphatic structures are preserved.

A selective neck dissection is a neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.

Surgery Codes

**THYROID GLAND
C73.9**

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
 - 2 Neck dissection, NOS
 - 3 Selective, limited; nodal sampling; “berry picking”
 - 4 Modified/modified radical
 - 5 Radical
- 9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

Surgery Codes

**THYROID GLAND
C73.9**

**SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH
NODE(S)**

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional site(s)
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

- 9 Not applicable (There are no known reconstructive procedures for this site.)

Surgery Codes

ALL OTHER SITES

C14.1 - C14.8, C17.0 - C17.9, C23.9, C24.0 - C24.9, C26.0 - C26.9, C30.0 - C 30.1, C31.0 - C31.9, C33.9, C37.9, C38.0 - C38.8, C39.0 - C39.9, C42.0 - C42.1, C42.3 - C42.4, C48.0 - C48.8, C51.0 - C51.9, C52.9, C57.0 - C57.9, C58.9, C60.0 - C 60.9, C63.0 - C 63.9, C68.0 - C68.9, C69.0 - C69.9, C74.0 - C76.8, C80.9

SURGICAL APPROACH

Codes

- 0 None; no surgery of primary site
- 1 Endoscopy, NOS
 - 2 Not image guided
 - 3 Image guided
- 4 Open, NOS
 - 5 Not assisted by endoscopy
 - 6 Assisted by endoscopy
- 9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

- 00 None; no surgery of primary site
- 10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery⁷ fulguration
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from this surgical event.

Surgery Codes

ALL OTHER SITES

C14.1 - C14.8, C17.0 - C17.9, C23.9, C24.0 - C24.9, C26.0 - C26.9, C30.0 - C 30.1, C31.0 - C31.9, C33.9, C37.9, C38.0 - C38.8, C39.0 - C39.9, C42.0 - C42.1, C42.3 - C42.4, C48.0 - C48.8, C51.0 - C51.9, C52.9, C57.0 - C57.9, C58.9, C60.0 - C 60.9, C63.0 - C 63.9, C68.0 - C68.9, C69.0 - C69.9, C74.0 - C76.8, C80.9

- 20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

- 30 Simple/partial surgical removal of primary site
- 40 Total surgical removal of primary site; enucleation
- 50 Surgery stated to be “debulking”
- 60 Radical surgery
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Partial or total removal of the primary site WITH an en bloc resection (partial or total removal) of other organs.

Surgery Codes

ALL OTHER SITES

C14.1 - C14.8, C17.0 - C17.9, C23.9, C24.0 - C24.9, C26.0 - C26.9, C30.0 - C 30.1, C31.0 - C31.9, C33.9, C37.9, C38.0 - C38.8, C39.0 - C39.9, C42.0 - C42.1, C42.3 - C42.4, C48.0 - C48.8, C51.0 - C51.9, C52.9, C57.0 - C57.9, C58.9, C60.0 - C 60.9, C63.0 - C 63.9, C68.0 - C68.9, C69.0 - C69.9, C74.0 - C76.8, C80.9

SURGICAL MARGINS

Codes

- 0 All margins grossly and microscopically negative
- 1 Margins involved, NOS
 - 2 Microscopic involvement
 - 5 Macroscopic involvement
- 7 Margins not evaluable
- 8 No surgery of primary site
- 9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

Codes

- 0 No regional lymph nodes removed
- 1 Regional lymph node(s) removed, NOS
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

ALL OTHER SITES

C14.1 - C14.8, C17.0 - C17.9, C23.9, C24.0 - C24.9, C26.0 - C26.9, C30.0 - C 30.1, C31.0 - C31.9, C33.9, C37.9, C38.0 - C38.8, C39.0 - C39.9, C42.0 - C42.1, C42.3 - C42.4, C48.0 - C48.8, C51.0 - C51.9, C52.9, C57.0 - C57.9, C58.9, C60.0 - C 60.9, C63.0 - C 63.9, C68.0 - C68.9, C69.0 - C69.9, C74.0 - C76.8, C80.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

- 00 No regional lymph nodes examined
- 01 One regional lymph node examined
- 02 Two regional lymph nodes examined
- ..
- 90 Ninety or more regional lymph nodes examined
- 95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

- 0 None; no surgery to other regional or distant sites
- 1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
 - 2 Other regional sites
 - 3 Distant lymph node(s)
 - 4 Distant site(s)
 - 5 Combination of 4 WITH 2 or 3
- 9 Unknown; not stated; death certificate ONLY

Surgery Codes

ALL OTHER SITES

**C14.1 - C14.8, C17.0 - C17.9, C23.9, C24.0 - C24.9, C26.0 - C26.9, C30.0 - C 30.1, C31.0 - C31.9,
C33.9, C37.9, C38.0 - C38.8, C39.0 - C39.9, C42.0 - C42.1, C42.3 - C42.4, C48.0 - C48.8,
C51.0 - C51.9, C52.9, C57.0 - C57.9, C58.9, C60.0 - C 60.9, C63.0 - C 63.9, C68.0 - C68.9, C69.0 -
C69.9, C74.0 - C76.8, C80.9**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

9 At this time, reconstructive procedures are not being collected for these sites

Appendix Q-2 Surgery Codes Table of Contents

Oral Cavity.....	1
Parotid & Other Unspecified Glands.....	3
Pharynx.....	5
Esophagus.....	7
Stomach.....	8
Colon.....	10
Rectosigmoid.....	12
Rectum.....	14
Anus.....	16
Liver & Intrahepatic Bile Ducts.....	17
Pancreas.....	18
Larynx.....	19
Lung.....	20
Hematopoietic/ Reticuloendothelial/Immunoproliferative Disease.....	22
Bones, Joints& Articular Cartilage/ Peripheral Nerves/ Connective & Soft Tissue.....	23
Spleen.....	24
Skin.....	25
Breast.....	28
Cervix Uteri.....	29
Corpus Uteri.....	31
Ovary.....	33
Prostrate.....	35
Testis.....	37
Kidney, Renal Pelvis & Ureter.....	38
Bladder.....	40
Brain & Other Parts of Central Nervous System.....	42
Thyroid Gland.....	43
Lymph Nodes.....	44
All Other Sites.....	45
Unknown and Ill Defined Primary Sites.....	46

APPENDIX Q.2
SURGERY CODES
(For Cases Diagnosed on or after January 1, 2003)

ORAL CAVITY
Lip C00.0–C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0–C02.9,
Gum C03.0–C03.9, Floor of Mouth C04.0–C04.9, Palate C05.0–C05.9,
Other Parts of Mouth C06.0–C06.9

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
 - 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from surgical events 10-14.

 - 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation - 25 Laser excision
- Specimen sent to pathology from surgical events 20–27.**
[SEER Guideline: Codes 20-27 include shave and wedge resection]
-
- 30 Wide excision, NOS
 - Code 30 includes:**
 - Hemiglossectomy
 - Partial glossectomy
-
- 40 Radical excision of tumor, NOS
 - 41 Radical excision of tumor ONLY
 - 42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
 - 43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

[SEER Guideline: in continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Surgery Codes

ORAL CAVITY

**Lip C00.0–C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0–C02.9,
Gum C03.0–C03.9, Floor of Mouth C04.0–C04.9, Palate C05.0–C05.9,
Other Parts of Mouth C06.0–C06.9**

(Except for M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes 40–43 include:

Total glossectomy

Radical glossectomy

- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

PAROTID AND OTHER UNSPECIFIED GLANDS Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9 (Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

 - 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from surgical events 10-14.

 - 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation - 25 Laser excision
- Specimen sent to pathology from surgical events 20-27.**
-
- 30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
 - 31 Facial nerve spared
 - 32 Facial nerve sacrificed- 33 Superficial lobe ONLY
 - 34 Facial nerve spared
 - 35 Facial nerve sacrificed- 36 Deep lobe (Total)
[SEER Guideline: with or without superficial lobe]
 - 37 Facial nerve spared
 - 38 Facial nerve sacrificed

- 40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
 - 41 Facial nerve spared
 - 42 Facial nerve sacrificed

- 50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
 - 51 WITHOUT removal of temporal bone
 - 52 WITH removal of temporal bone
 - 53 WITH removal of overlying skin (requires graft or flap coverage)

Surgery Codes

PAROTID AND OTHER UNSPECIFIED GLANDS

Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 80 Parotidectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

PHARYNX

**Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9
Pyiform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0**

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Stripping
- No specimen sent to pathology from surgical events 10-15.**
- 20 Local tumor excision, NOS
- 26 Polypectomy
 - 27 Excisional biopsy
- Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]
- 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
- 25 Laser excision
 - 28 Stripping
- Specimens sent to pathology from surgical events 20-28.**
- 30 Pharyngectomy, NOS
- 31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
 - 32 Total pharyngectomy
- 40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
[SEER Guideline: code 40 includes mandibulectomy (marginal, segmental, hemi-, and/or laryngectomy) NOS]
[SEER Guideline: contiguous bone tissue refers to the mandible]
- 41 WITH Laryngectomy (laryngopharyngectomy)
 - 42 WITH bone
 - 43 WITH both 41 and 42

Surgery Codes

PHARYNX

**Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9
Pyramidal Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0**

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 50 Radical pharyngectomy (includes total mandibular resection), NOS
 - 51 WITHOUT laryngectomy
 - 52 WITH laryngectomy
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

ESOPHAGUS

C15.0-C15.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

 - 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from surgical events 10-14.

 - 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation - 25 Laser excision
- Specimen sent to pathology from surgical events 20-27.**
-
- 30 Partial esophagectomy
-
- 40 Total esophagectomy, NOS
-
- 50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
[SEER Guideline: esophagectomy may be partial, total, or NOS]
 - 51 WITH laryngectomy
 - 52 WITH gastrectomy, NOS
 - 53 Partial gastrectomy
 - 54 Total gastrectomy
 - 55 Combination of 51 WITH any of 52-54
-
- 80 Esophagectomy, NOS
-
- 90 Surgery, NOS
-
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

STOMACH

C16.0-C16.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from surgical events 10-14.

- 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsyAny combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation

Specimen sent to pathology from surgical events 20-27.

- 30 Gastrectomy, NOS (partial, subtotal, hemi-)
 - 31 Antrectomy, lower (distal-less than 40% of stomach)***
 - 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
 - 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:

Partial gastrectomy, including a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

- 40 Near-total or total gastrectomy, NOS
 - 41 Near-total gastrectomy
 - 42 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

Surgery Codes

STOMACH

C16.0-C16.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 50 Gastrectomy, NOS WITH removal of a portion of esophagus
51 Partial or subtotal gastrectomy
52 Near total or total gastrectomy
Codes 50-52 are used for gastrectomy resection when only portions of esophagus are included in procedure.
- 60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***
61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
62 Near total or total gastrectomy, in continuity with the resection of other organs***
63 Radical gastrectomy, in continuity with the resection of other organs***
Codes 60-63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.
[SEER Guideline: codes 60-63 may include omentectomy]
[SEER Guideline: in continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]
- 80 Gastrectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

Surgery Codes

COLON

C18.0-C18.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from surgical events 10-14.

- 20 Local tumor excision, NOS
 - 27 Excisional biopsy
 - 26 Polypectomy, NOS
 - 28 Polypectomy-endoscopic
 - 29 Polypectomy-surgical excision
- Any combination of 20 or 26-29 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy (NOS, endoscopic or surgical excision) or excisional biopsy]
- 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation

- 25 Laser excision

Specimen sent to pathology from surgical events 20-29.

- 30 Partial colectomy, segmental resection
 - 32 Plus resection of contiguous organ; example: small bowel, bladder
- [SEER Guideline: codes 30-31 include but are not limited to: appendectomy (for an appendix primary only), enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures, segmental resection, e.g., cecetomy, sigmoidectomy]
- 40 Subtotal colectomy/hemicolectomy [or greater (but less than total); right or left colectomy] (total right or left colon and a portion of transverse colon)
 - 41 Plus resection of contiguous organ; example: small bowel, bladder
 - 50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
 - 51 Plus resection of contiguous organ; example: small bowel, bladder

Surgery Codes

COLON

C18.0-C18.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
[SEER Guideline: commonly used for familial polyposis or polyposis coli]
61 Plus resection of contiguous organ; example: small bowel, bladder
- 70 Colectomy or coloproctectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)
Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

[SEER Guideline: in continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]
- 80 Colectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes
RECTOSIGMOID
C19.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

- 00 None; no surgery of primary site; autopsy ONLY

- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser ablation

No specimen sent to pathology from surgical events 10-14.

- 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsyCombination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
- 25 Laser excision

Specimen sent to pathology from surgical events 20-27.

- 30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
 - 31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:

- Anterior resection
- Hartmann operation
- Low anterior resection (LAR)
- Partial colectomy, NOS
- Rectosigmoidectomy, NOS
- Sigmoidectomy

Surgery Codes

RECTOSIGMOID

C19.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 40 Pull through WITH sphincter preservation (colo-anal anastomosis)
[SEER Guideline: Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation.]
- 50 Total proctectomy
[SEER Guideline: Procedures coded 50 include but are not limited to: abdominoperineal resection (A & P resection), anterior/posterior resection (A/P resection)/Miles' operation, Rankin's operation]
- 51 Total colectomy [removal of the colon from cecum to rectosigmoid or portion of rectum]
- 55 Total colectomy WITH ileostomy, NOS
 - 56 Ileorectal reconstruction
 - 57 Total colectomy WITH other pouch; example: Koch pouch
- 60 Total proctocolectomy, NOS
 - 65 Total proctocolectomy WITH ileostomy, NOS
 - 66 Total proctocolectomy WITH ileostomy and pouch

Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.
- 70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration
[SEER Guideline: Procedures that may be part of an en bloc resection include, but are not limited to: an oophorectomy and a rectal mucosectomy. Code 70 includes any colectomy (partial, hemicolectomy or total) with an en bloc resection of any other organs. There may be partial or total removal of other organs in continuity with the primary.]
[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]
- 80 Colectomy, NOS; Proctectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

RECTUM

C20.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser

No specimen sent to pathology from surgical events 10-14.

- 20 Local tumor excision, NOS
 - 27 Excisional biopsy
 - 26 PolypectomyAny combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]
 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation- 25 Laser excision
- 28 Curette and fulguration

Specimen sent to pathology from surgical events 20-28.

- 30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 30 include but are not limited to:

- Anterior resection
- Hartmann's operation
- Low anterior resection (LAR)
- Transsacral rectosigmoidectomy

- 40 Pull through WITH sphincter preservation (coloanal anastomosis)
[SEER Guideline: Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soace's submucosal resection, Swenson's operation, Turnbull's operation.]

Surgery Codes

RECTUM

C20.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 50 Total proctectomy
Procedure coded 50 includes, but is not limited to:
Abdominoperineal resection (Miles Procedure)
[SEER Guideline: also called anterior/posterior (A/P) resection/Miles' operation, Rankin's operation]
- 60 Total proctocolectomy, NOS
- 70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration
[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]
- 80 Proctectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

ANUS

C21.0-C21.8

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Thermal Ablation
- No specimen sent to pathology from surgical events 10-15.**
- 20 Local tumor excision, NOS
- 26 Polypectomy
 - 27 Excisional biopsy
- Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]
- 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
- 25 Laser excision
- Specimen sent to pathology from surgical events 20-27.**
[SEER Guideline: margins of resection may have microscopic involvement]
- 60 Abdominal perineal resection, NOS (APR; Miles procedure)
- 61 APR and sentinel node excision
 - 62 APR and unilateral inguinal lymph node dissection
 - 63 APR and bilateral inguinal lymph node dissection
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

LIVER AND INTRAHEPATIC BILE DUCTS

C22.0-C22.1

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Alcohol (Percutaneous Ethanol Injection-PEI)
 - 16 Heat-Radio-frequency ablation (RFA)
 - 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10-17.

- 20 Wedge or segmental resection, NOS
 - 21 Wedge resection
 - 22 Segmental resection, NOS
 - 23 One
 - 24 Two
 - 25 Three
 - 26 Segmental resection AND local tumor destruction

Specimen sent to pathology from surgical events 20-26.

- 30 Lobectomy, [simple or] NOS
 - 36 Right lobectomy
 - 37 Left lobectomy
 - 38 Lobectomy AND local tumor destruction

- 50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
 - 51 Right lobectomy
 - 52 Left lobectomy
 - 59 Extended lobectomy AND local tumor destruction

- 60 Hepatectomy, NOS [formerly SEER code 80]
 - 61 Total hepatectomy and transplant [formerly SEER code 70]

- 65 Excision of a bile duct (for an intra-hepatic bile duct primary only) [formerly SEER code 40]
 - 66 Excision of a bile duct PLUS partial hepatectomy

- 75 Bile duct and hepatectomy WITH transplant

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

PANCREAS

C25.0-C25.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 25 Local excision of tumor, NOS[formerly SEER code 10]
- 30 Partial pancreatectomy, NOS; example: distal [formerly SEER code 20]
- 35 Local or partial pancreatectomy and duodenectomy [formerly SEER code 50]
 - 36 WITHOUT distal/partial gastrectomy[formerly SEER code 51 “without subtotal gastrectomy”]
 - 37 WITH partial gastrectomy (Whipple) [formerly SEER code 52 “with subtotal gastrectomy” (Whipple)”]
- 40 Total pancreatectomy
- 60 Total pancreatectomy and subtotal gastrectomy or duodenectomy
- 70 Extended pancreatoduodenectomy
- 80 Pancreatectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

LARYNX

C32.0-C32.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

 - 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Stripping

No specimen sent to pathology from surgical events 10-15.

 - 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation - 25 Laser excision
 - 28 Stripping
- Specimen sent to pathology from surgical events 20-28.**
-
- 30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
 - 31 Vertical laryngectomy
 - 32 Anterior commissure laryngectomy
 - 33 Supraglottic laryngectomy
-
- 40 Total or radical laryngectomy, NOS
 - 41 Total laryngectomy ONLY
 - 42 Radical laryngectomy ONLY
-
- 50 Pharyngolaryngectomy
-
- 80 Laryngectomy, NOS
-
- 90 Surgery, NOS
-
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

LUNG

C34.0-C34.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction or excision, NOS [formerly SEER code 10]
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
- 15 Local tumor destruction, NOS
12 Laser ablation or cryosurgery [formerly SEER code 12 = laser ablation or excision]
13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction) [formerly SEER code 13 = cautery; fulguration]
No specimen sent to pathology from surgical events 12-13 and 15.
- 20 Excision or resection of less than one lobe, NOS
23 Excision, NOS [formerly SEER code 11 = Excision]
24 Laser excision [formerly SEER code 12 = laser ablation or excision]
25 Bronchial sleeve resection ONLY [formerly SEER code 14]
21 Wedge resection
22 Segmental resection, including lingulectomy
Specimen sent to pathology from surgical events 20-25.
- 30 Resection of [at least one] lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
33 Lobectomy WITH mediastinal lymph node dissection
- 45 Lobe or bilobectomy extended, NOS
46 WITH chest wall
47 WITH pericardium
48 WITH diaphragm
- 55 Pneumonectomy, NOS [formerly SEER codes 40, 50, 51, 52, 53, 54]
56 WITH mediastinal lymph node dissection (radical pneumonectomy)
The mediastinal lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292)

NOTE: Peribronchial or hilar lymph nodes are not included in any of the lung surgery codes. If peribronchial or hilar nodes are dissected as part of a surgical procedure which involves the destruction, excision or resection of the primary tumor then the extent of the nodal dissection is recorded in the item "Scope of Regional Lymph Node Surgery" and the number of nodes dissected is recorded as part of the cumulative "Regional Lymph Nodes Examined."

Surgery Codes

LUNG

C34.0-C34.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 65 Extended pneumonectomy
 - 66 Extended pneumonectomy plus pleura or diaphragm

- 70 Extended radical pneumonectomy
[SEER Guideline: an extended radical pneumonectomy is a radical pneumonectomy (including removal of mediastinal nodes) and the removal of other tissues or nodes]
The mediastinal lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292)

- NOTE: Peribronchial or hilar lymph nodes are not included in any of the lung surgery codes. If peribronchial or hilar nodes are dissected as part of a surgical procedure which involves the destruction, excision or resection of the primary tumor then the extent of the nodal dissection is recorded in the item "Scope of Regional Lymph Node Surgery" and the number of nodes dissected is recorded as part of the cumulative "Regional Lymph Nodes Examined."

- 80 Resection of lung, NOS

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

**HEMATOPOIETIC/RETICULOENDOTHELIAL/
IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE**

C42.0, C42.1, C42.3, C42.4 for all histologies

Or

M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989 for all sites

Code

98 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

Surgical procedures for hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

99 Death certificate only.

NOTE: A hematopoietic case not otherwise specified in the list of 'standard exclusions' (M-9750, 9760-9764, 9800-9720, 9826, 9831-9920, 9931-9964, 9980-9989) in the surgery code appendix should be treated as an "Unknown And Ill-Defined Primary Site." Examples include solitary plasmacytoma and chloroma.

Surgery Codes

BONES, JOINTS, AND ARTICULAR CARTILAGE C40.0-C41.9 PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0-C47.9 CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C49.0-C49.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 998-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction or excision, NOS [formerly SEER code 10 = local tumor destruction or excision]
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
- 15 Local tumor destruction [formerly SEER code 10 = local tumor destruction or excision]
No specimen sent to pathology from surgical event 15.
- 25 Local excision
- 26 Partial resection [formerly SEER code 20 = partial resection/internal hemipelvectomy (pelvis)]
Specimen sent to pathology from surgical events 25-26.
- 30 Radical excision or resection of lesion WITH limb salvage
- 40 Amputation of limb
 - 41 Partial amputation of limb
 - 42 Total amputation of limb
- 50 Major amputation, NOS
 - 51 Forequarter, including scapula
 - 52 Hindquarter, including ilium/hip bone
 - 53 Hemipelvectomy, NOS
 - 54 Internal hemipelvectomy [formerly SEER code 20 = partial resection/internal hemipelvectomy (pelvis)]
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

SPLEEN

Spleen C42.2

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Note: Lymph Nodes surgery codes have been moved to a separate scheme

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction, NOS [formerly SEER code 10 = local excision, destruction, NOS]
No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
- 21 Partial splenectomy
- 22 Total splenectomy
- 80 Splenectomy, NOS [formerly SEER code 20]
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

SKIN

C44.0-C44.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY

 - 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser ablation

No specimen sent to pathology from surgical events 10-14.

 - 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation - 25 Laser excision
- Specimen sent to pathology from surgical events 20-27.**
-
- 30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
 - 31 Shave biopsy followed by a gross excision of the lesion
 - 32 Punch biopsy followed by a gross excision of the lesion
 - 33 Incisional biopsy followed by a gross excision of the lesion
 - 34 Mohs surgery, NOS
 - 35 Mohs with 1-cm margin or less
 - 36 Mohs with more than 1-cm margin
-
- 45 Wide excision or reexcision of lesion or minor (local) amputation with margins more than 1 cm, NOS. Margins MUST be microscopically negative. [formerly SEER code 40 or 50 = wide excision or reexcision of lesion or minor (local) amputation, NOS, margins of excision are 1 cm or more, margins may be microscopically involved]
 - 46 WITH margins more than 1 cm and less than 2 cm
 - 47 WITH margins greater than 2 cm
-
- 60 Major amputation [NOS]
-
- 90 Surgery, NOS
-
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

BREAST

C50.0-C50.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction, NOS
No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
- 20 Partial mastectomy, NOS; less than total mastectomy, NOS [formerly SEER code 10]
21 Partial mastectomy WITH nipple resection [formerly SEER code 11 = nipple resection]
22 Lumpectomy or excisional biopsy [formerly SEER code 12]
23 Reexcision of the biopsy site for gross or microscopic residual disease [formerly SEER code 13]
24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy) [formerly SEER codes 16 = segmental mastectomy, 14 = wedge resection, 15 = quadrantectomy, 17 = tylectomy]
Procedures coded 20-24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.
- 30 Subcutaneous mastectomy
A subcutaneous mastectomy is the removal of breast tissue without the nipple and areolar complex or overlying skin.
[SEER Guideline: this procedure is rarely used to treat, malignancies]
- 40 Total (simple) mastectomy, NOS
41 WITHOUT removal of uninvolved contralateral breast
43 Reconstruction NOS
 44 Tissue
 45 Implant
 46 Combined (Tissue and Implant)
42 WITH removal of uninvolved contralateral breast
47 Reconstruction NOS
 48 Tissue
 49 Implant
 75 Combined (Tissue and Implant)

A simple mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

If contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Surgery Codes

BREAST

C50.0-C50.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 50 Modified radical mastectomy
 - 51 WITHOUT removal of uninvolved contralateral breast
 - 53 Reconstruction, NOS
 - 54 Tissue
 - 55 Implant
 - 56 Combined (Tissue and Implant)
 - 52 WITH removal of uninvolved contralateral breast
 - 57 Reconstruction, NOS
 - 58 Tissue
 - 59 Implant
 - 63 Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.

[SEER Guideline: in continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

[SEER Guideline: “tissue” for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants).]

If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

- 60 Radical mastectomy, NOS
 - 61 WITHOUT removal of uninvolved contralateral breast
 - 64 Reconstruction, NOS
 - 65 Tissue
 - 66 Implant
 - 67 Combined (Tissue and Implant)
 - 62 WITH removal of uninvolved contralateral breast
 - 68 Reconstruction, NOS
 - 69 Tissue
 - 73 Implant
 - 74 Combined (Tissue and Implant)

[SEER Guideline: Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes en bloc axillary dissection. For single primaries only, code removal of involved contralateral breast under the data item “Surgery of other regional sites, distant sites, or distant lymph nodes.”]

Surgery Codes

BREAST

C50.0-C50.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 70 Extended radical mastectomy
 - 71 WITHOUT removal of uninvolved contralateral breast
 - 72 WITH removal of uninvolved contralateral breast

[SEER Guideline: Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes removal of internal mammary nodes and en bloc axillary dissection. For single primaries only, code removal of involved contralateral breast under the data item "Surgery of other regional sites, distant sites, or distant lymph nodes."]

- 80 Mastectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

CERVIX UTERI

C53.0-C53.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Loop Electrocautery Excision Procedure (LEEP)
 - 16 Laser ablation
 - 17 Thermal ablation

No specimen sent to pathology from surgical events 10-17.

- 20 Local tumor excision, NOS
 - 26 Excisional biopsy, NOS
 - 27 Cone biopsy
 - 24 Cone biopsy WITH gross excision of lesion
 - 29 Trachelectomy; removal of cervical stump; cervicectomy
 - Any combination of 20, 24, 26, 27 or 29 WITH
 - 21 Electrocautery
 - 22 Cryosurgery
 - 23 Laser ablation or excision
 - 25 Dilatation and curettage; endocervical curettage (for in situ only)
 - 28 Loop electrocautery excision procedure (LEEP)

Specimen sent to pathology from surgical events 20-29.

- 30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.
- 40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.
- 50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
 - 51 Modified radical hysterectomy
 - 52 Extended hysterectomy
 - 53 Radical hysterectomy; Wertheim procedure
 - 54 Extended radical hysterectomy

Surgery Codes

CERVIX UTERI

C53.0-C53.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
 - 61 WITHOUT removal of tubes and ovaries
 - 62 WITH removal of tubes and ovaries

- 70 Pelvic exenteration
 - 71 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

- 72 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

- 73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

- 74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

CORPUS UTERI

C54.0-C55.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Loop Electocautery Excision Procedure (LEEP)
 - 16 Thermal ablation
- No specimen sent to pathology from surgical events 10-16.**
- 20 Local tumor excision, NOS; simple excision, NOS
- 24 Excisional biopsy
 - 25 Polypectomy
 - 26 Myomectomy
- Any combination of 20 or 24-26 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]
- 21 Electrocautery
 - 22 Cryosurgery
 - 23 Laser ablation or excision
- Specimen sent to pathology from surgical events 20-26.**
[Margins of resection may have microscopic involvement]
[SEER Guideline: Procedures in code 20 include but are not limited to: cryosurgery, electorcautery, excisional biopsy, laser ablation, thermal ablation]
- 30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies).
- 31 WITHOUT tube(s) and ovary(ies)
 - 32 WITH tube(s) and ovary(ies)
- [SEER Guideline: for these procedures, the cervix is left in place]

Surgery Codes
CORPUS UTERI
C54.0-C55.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.
- 50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.
- 60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
 - 61 Modified radical hysterectomy
 - 62 Extended hysterectomy
 - 63 Radical hysterectomy; Wertheim procedure
 - 64 Extended radical hysterectomy
- 65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies) [formerly SEER code 70]
 - 66 WITHOUT removal of tube(s) and ovary(ies) [formerly SEER code 71]
 - 67 WITH removal of tube(s) and ovary(ies) [formerly SEER code 72]
- 75 Pelvic exenteration [formerly SEER code 80]
 - 76 Anterior exenteration [formerly SEER code 81]**Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).**
- 77 Posterior exenteration [formerly SEER code 82]
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 78 Total exenteration [formerly SEER code 83]
Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 79 Extended exenteration [formerly SEER code 84]
Includes pelvic blood vessels or bony pelvis.
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

OVARY

C56.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 17 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 17.
- 25 Total removal of tumor or (single) ovary, NOS
26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
27 WITHOUT hysterectomy
28 WITH hysterectomy
Specimen sent to pathology from surgical events 25-28.
- 35 Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done [formerly SEER code 14]
36 WITHOUT hysterectomy [formerly SEER code 15]
37 WITH hysterectomy [formerly SEER code 16]
- 50 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done [formerly SEER code 20]
51 WITHOUT hysterectomy [formerly SEER code 21]
52 WITH hysterectomy [formerly SEER code 22]
- 55 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done [formerly SEER code 30]
56 WITHOUT hysterectomy [formerly SEER code 31]
57 WITH hysterectomy [formerly SEER code 32]
- 60 Debulking; cytoreductive surgery, NOS
61 WITH colon (including appendix) and/or small intestine resection (not incidental)
62 WITH partial resection of urinary tract (not incidental)
63 Combination of 61 and 62
Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.
- 70 Pelvic exenteration, NOS
71 Anterior
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Surgery Codes

OVARY

C56.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 72 Posterior
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 73 Total
Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 74 Extended
Includes pelvic blood vessels or bony pelvis.
- 80 (Salpingo-)oophorectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

PROSTATE

C61.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item “Hematologic Transplant and Endocrine Procedures” (NAACCR Item#3250).

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 18 Local tumor destruction or excision, NOS [formerly SEER code 10]
- 19 Transurethral resection (TURP), NOS [formerly SEER code 11]
Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003).
- 10 Local tumor destruction, [or excision] NOS
 - 14 Cryoprostatectomy
 - 15 Laser ablation
 - 16 Hyperthermia
 - 17 Other method of local tumor destruction**No specimen sent to pathology from surgical events 10-17.**
- 20 Local tumor excision, NOS [formerly SEER code 10 = local tumor destruction or excision, NOS]
 - 21 Transurethral resection (TURP), NOS [formerly SEER code 11 = transurethral resection (TURP) NOS]
 - 22 TURP---cancer is incidental finding during surgery for benign disease [formerly SEER code 12]
 - 23 TURP---patient has suspected/known cancer [SEER code 13]Any combination of 20-23 WITH
 - 24 Cryosurgery
 - 25 Laser
 - 26 Hyperthermia**Specimen sent to pathology from surgical events 20-26.**
- 30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact [formerly SEER code 30 or 40]
- 50 Radical prostatectomy, NOS; total prostatectomy, NOS
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.
- 70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.
[SEER Guideline: in continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Surgery Codes

PROSTATE

C61.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 80 Prostatectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

TESTIS

C62.0-C62.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 12 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 12.
- 20 Local or partial excision of testicle [formerly SEER code 10]
Specimen sent to pathology from surgical event 20.
- 30 Excision of testicle, NOS WITHOUT cord
- 40 Excision of testicle, NOS WITH cord/or cord not mentioned
- 80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

KIDNEY, RENAL PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Thermal ablation
- No specimen sent to pathology from this surgical event 10-15.**
- 20 Local tumor excision, NOS
- 26 Polypectomy
 - 27 Excisional biopsy
- Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]
- 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
- 25 Laser excision
- Specimen sent to pathology from surgical events 20-27.**
- 30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)
- Procedures coded 30 include, but are not limited to:**
- Segmental resection
 - Wedge resection
- 40 Complete/total/simple nephrectomy---for kidney parenchyma
Nephroureterectomy
- Includes bladder cuff for renal pelvis or ureter.**
- 50 Radical nephrectomy
- May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter.**

Surgery Codes

KIDNEY, RENAL PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)
The other organs, such as colon or bladder, may be partially or totally removed.
[SEER Guideline: in continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]
- 80 Nephrectomy, NOS
Ureterectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

BLADDER

C67.0-C67.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
 - 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Intravesical therapy
 - 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

No specimen sent to pathology from surgical events 10-16.
 - 20 Local tumor excision, NOS
 - 26 Polypectomy
 - 27 Excisional biopsy

Combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

 - 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation - 25 Laser excision
- Specimen sent to pathology from surgical events 20-27.**
- 30 Partial cystectomy
- 50 Simple/total/complete cystectomy
- 60 Radical cystectomy (male only)
[SEER Guideline: This code is used only for men. It involves removal of bladder and prostate, with or with urethrectomy. The procedure is also called cystoprostatectomy. If a radical cystectomy is the procedure for a woman, use code 71.]
 - 61 Radical cystectomy PLUS ileal conduit
 - 62 Radical cystectomy PLUS continent reservoir or pouch, NOS
 - 63 Radical cystectomy PLUS abdominal pouch (cutaneous)
 - 64 Radical cystectomy PLUS in situ pouch (orthotopic)

Surgery Codes

BLADDER

C67.0-C67.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

- 70 Pelvic exenteration, NOS
 - 71 Radical cystectomy (female only); anterior exenteration
A radical cystectomy in a female includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra.
 - 72 Posterior exenteration
 - 73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.
- 74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.
- 80 Cystectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

BRAIN

**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**

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Do not code laminectomies for spinal cord primaries.

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 [Local]Tumor destruction, NOS
No specimen sent to pathology from surgical event 10.
Do not record stereotactic radiosurgery as tumor destruction. It should be recorded in the radiation treatment item *Regional Treatment Modality* (NAACCR Item # 1570).
- 20 Biopsy [excision] of tumor, lesion, or mass
Specimen sent to pathology from surgical event 20.
- 40 Partial resection [NOS]
- 55 Gross total resection [formerly SEER codes 31, 32, 50, 60]
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

THYROID GLAND

C73.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 13 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 13.
- 25 Removal of less than a lobe, NOS [formerly SEER code 10]
 - 26 Local surgical excision [formerly SEER code 11]
 - 27 Removal of a partial lobe ONLY [formerly SEER code 12]**Specimen sent to pathology from surgical events 25-27.**
- 20 Lobectomy and/or isthmectomy
 - 21 Lobectomy ONLY
 - 22 Isthmectomy ONLY
 - 23 Lobectomy WITH isthmus
- 30 Removal of a lobe and partial removal of the contralateral lobe
- 40 Subtotal or near total thyroidectomy
- 50 Total thyroidectomy
- 80 Thyroidectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

LYMPH NODES

Lymph Nodes C77.0-C77.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 19 Local tumor destruction or excision, NOS [formerly SEER code 10 under spleen and lymph nodes]
Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).
- 15 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 15.
- 25 Local tumor excision, NOS
Less than a full chain, includes a lymph node biopsy.
- 30 Lymph node dissection, NOS
 - 31 One chain
 - 32 Two or more chains
- 40 Lymph node dissection, NOS PLUS splenectomy
 - 41 One chain
 - 42 Two or more chains
- 50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
 - 51 One chain
 - 52 Two or more chains
- 60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy
(Includes staging laparotomy for lymphoma.)
 - 61 One chain
 - 62 Two or more chains
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

ALL OTHER SITES

C14.1-C14.8, C17.0-C17.9, C23.9, C24.0-C24.9, C26.0-C26.9, C30.0-C 30.1, C31.0-C31.9, C33.9, C37.9, C38.0-C38.8, C39.0-C39.9, C48.0-C48.8, C51.0-C51.9, C52.9, C57.0-C57.9, C58.9, C60.0-C 60.9, C63.0-C63.9, C68.0-C68.9, C69.0-C69.9, C74.0-C74.9, C75.0-C75.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

11 Photodynamic therapy (PDT)

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26-27 WITH

[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

Specimen sent to pathology from surgical events 20-27.

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation

41 Total enucleation (for eye surgery only)

50 Surgery stated to be “debulking”

60 Radical surgery

Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.

[SEER Guideline: in continuity with or “en bloc” means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

UNKNOWN AND ILL-DEFINED PRIMARY SITES

C76.0-C76.8, C80.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Code

98 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

**Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item
Surgical Procedure/Other Site (NAACCR Item #1294)**

[99 Death certificate only]

APPENDIX T

CNExT OVER-RIDE FLAGS AND EDITS

Edit Name	CNExT Edit #	Flag Name
Date First Admission, Date Diagnosis (Calif)	ED1014	Override, DateDx/DateAdm
Primary Site, Behavior Code (C/NET IF39)	ED2000	Override, Site/Behavior
Morphology--Type & Behavior (C/NET MORPH)	ED2004	Override, Histology
Primary Site, Stage, EOD (Calif)	ED2010	Override, Site/Stage
Age, Primary Site, Morphology (C/NET IF15)	ED2015	Override, Age/Site/Morph
Diagnostic Confirm, Seq Num--Hospital (C/NET IF23)	ED2017	Override, SeqNo/DxConf
Diagnostic Confirmation, Behavior (C/NET IF31)	ED2018	Override, Histology
Diagnostic Confirmation, Histol Type (C/NET IF48)	ED2019	Override, Leuk, Lymphoma
Seq Num--Hosp, Primary Site, Morph (C/NET IF22)	ED2022	Override, Ill-defined Site
Primary Site, Morphology-Type Check (C/NET IF25)	ED2024	Override, Site/Type
Laterality, Primary Site, Morphology (C/NET IF42)	ED2030	Override, Site/Lat/Morph
Primary Site, Laterality, EOD (C/NET IF41)	ED2030	Override, Site/Lat/EOD
Date of Diagnosis, Primary Site, EOD (C/NET IF40)	ED2040	Override, Site/EOD/DX Date
RX Summ--Surgery Type, Diag Conf (C/NET IF46)	ED3011	Override, Surg/DxConf
Race - Spanish Origin - Birthplace (Calif)	ED6013	Override, Race/Spanish/Birthpl
Spanish Origin - Birthplace (Calif)	ED6014	Override, Spanish/Birthplace
Type of Report (DC), Seq Num--Hospital(C/NET IF04)	ED6015	Override, Report Source
First Name, Sex (Calif)	ED7004	Override, FirstName/Sex
Accession Number, Class of Case, Seq Number(C/NET)	ED7007	Override, Accession/Class/Seq
Diagnostic Confirm, Seq Num--Hospital (C/NET IF23)	ED2017	Override, COC Site/Type
		Override, Seq/Dx Confirm
		Override, Seq/Site
		Override, Site/Lat/SeqNum
		Override, Site/TNM Stage
Summary Stage 2000, Site Dist Met 1 (CNET)	ED2029	Override, Stage/Dist Mets
Summary Stage 2000, Regional Nodes Pos (CNET)	ED2028	Override, Stage/Nodes Pos
Summary Stage 2000, TNM M (CNET)	ED2050	Override, Stage/TNM-M
Summary Stage 2000, TNM N (CNET)	ED2051	Override, Stage/TNM-N

APPENDIX U

TABLE OF DATA ITEMS AND THEIR REQUIRED STATUS

Reporting requirements are not uniform for all cancer reporting facilities. Consult the following table to determine which data items must be reported:

Key to Symbols

yes	REQUIRED ON ALL CASES (cannot be blank, but can be coded UNKNOWN)
yes*	REQUIRED ON ALL CASES, BUT IF INFORMATION IS NOT AVAILABLE OR NOT APPLICABLE CAN BE LEFT BLANK
sel	REQUIRED ON SELECTED IDENTIFIABLE CASES, SUCH AS CERTAIN SITES OR YEARS OF DIAGNOSIS (left blank or a specific entry is required on other cases, such as code 0, 9, or UNKNOWN)
no	NOT A PART OF THE DATA SET
may	PART OF THE DATA SET BUT NOT REQUIRED (may be left blank on any and all cases)
gen	GENERATED BY COMPUTER, BY THE REGIONAL REGISTRY, OR BY THE CALIFORNIA CANCER REGISTRY
res	RESERVED FIELD. LEAVE BLANK
SEER	DESIGNATES THE DATA SET OF THE NATIONAL CANCER INSTITUTE'S SEER PROGRAM
ACoS	DESIGNATES THE AMERICAN COLLEGE OF SURGEONS DATA SET
C/N	DESIGNATES THE CNE _x T DATA SET
Region	DESIGNATES THE DATA SET REQUIRED FOR REPORTING BY HOSPITALS TO REGIONAL REGISTRIES IN CALIFORNIA
RX CTR	DESIGNATES THE DATA SET REQUIRED FOR REPORTING BY NON-HOSPITAL TREATMENT CENTERS TO REGIONAL REGISTRIES IN CALIFORNIA
Manual	INDICATES WHERE INSTRUCTIONS FOR THE ITEM ARE FOUND: SECTION NUMBER (indicates section of <i>Abstracting and Coding Procedures for Hospitals</i>); VOL. 2 (California Cancer Reporting System Standards, Volume Two: <i>Standards for Automated Reporting</i>); OR C/N USER (<i>CNE_xT² User Manual</i>)
CCR	DESIGNATES THE DATA SET REQUIRED FOR REPORTING BY REGIONAL REGISTRIES TO THE CALIFORNIA CANCER REGISTRY.

Table of Data Items

Data Items and Their Required Status

<u>Item Name</u>	<u>Manual</u>	<u>C/N</u>	<u>RX Ctr</u>	<u>Transmitted from Hospital to Region</u>	<u>SEER Collect</u>	<u>ACoS</u>
Abstractor	III.1.1	yes	yes	yes	yes	yes
Accession Number (Hosp)	II.2.3	yes	yes	yes	yes	yes
ACoS Approved Flag	III.1.6	yes	yes	yes	no	no
Address at Diagnosis–City	III.2.5	yes	yes	yes	yes	yes
Address at Diagnosis –No. & Street	III.2.5	yes	yes	yes	yes	yes
Address at Diagnosis –No. & Street - Supplemental	III.2.5	yes*	yes*	yes*	yes	yes
Address at Diagnosis–State	III.2.5	yes	yes	yes	yes	yes
Address at Diagnosis–Zip Code	III.2.5	yes	yes	yes	yes	yes
Age at Diagnosis	III.2.11	gen	gen	gen	yes	yes
Alias First Name	III.2.1.6	yes*	yes*	yes*	no	no
Alias Last Name	III.2.1.5	yes*	yes*	yes*	no	no
Birth Date	III.2.10	yes	yes	yes	yes	yes
Birthplace	III.2.12	yes	yes	yes	yes	yes
Casefinding Source	III.3.8	yes	yes	yes	no	no
Cause of Death	VII.2.14	may	no	no	yes	no
Chemotherapy at This Hospital	VI.4	yes	yes	yes	yes	yes
Chemotherapy Summary	VI.4	yes	yes	yes	yes	yes
Class of Case	III.3.5	yes	yes	yes	no	no
Coding Procedure	III.1.5	gen	gen	yes	no	no
Contact City	VII.3	yes*	yes*	yes*	yes	no
Contact Country	VII.3	may	may	may	no	no
Contact Name	VII.3	yes*	yes*	yes*	yes	no
Contact State	VII.3	yes*	yes*	yes*	yes	no
Contact Street	VII.3	yes*	yes*	yes*	yes	no
Contact Street - Supplemental	VII.3	yes*	yes*	yes*	no	yes
Contact Zip	VII.3	yes*	yes*	yes*	yes	no
County of Residence at Diagnosis	III.2.5	yes	yes	yes	yes	no
Date of Chemotherapy	VI.1.3.2	sel	sel	yes*	no	no
Date of Diagnosis	III.3.3	yes	yes	yes	yes	yes
Date of First Admission	III.3.1	yes	yes	yes	no	yes
Date of Inpatient Admission	III.3.2	yes*	no	yes*	no	no
Date of Inpatient Discharge	III.3.2	yes*	no	yes*	no	no
Date of Hormone Therapy	VI.1.3.2	sel	sel	yes*	no	no
Date of Immunotherapy	VI.1.3.2	sel	sel	yes*	no	no
Date of Last Patient Contact or Death	VII.2.1	yes	yes	yes	yes	yes
Date of Last Tumor Status	VII.2.3	yes	yes	yes	no	no

Table of Data Items

Date of Most Definitive Surgery of the Primary Site	VI.2.5	gen	gen	yes*	no	yes
Date of Other Therapy	VI.1.3.2	sel	sel	yes*	no	yes
Date of Radiation	VI.1.3.2	sel	sel	yes*	no	yes
Date of Systemic Therapy	VI.1.3.2	gen	gen	yes*	no	yes
Date of Surgery	VI.1.3.2	gen	gen	yes*	no	yes
Date of Surgery– Diagnostic or Staging Procedures	VI.2.12	sel	sel	yes*	no	yes
Date of Surgery– Procedures 1-3	VI.2.5	sel	sel	yes	no	no
Date of Therapy	Vol III	no	no	no	yes	yes
Date of Transplant/Endocrine Procedures	VI.7.2	sel	sel	yes*	no	no
Death File Number	VII.2.14	may	no	no	no	no
Diagnostic Confirmation	IV.2	yes	yes	yes	yes	yes
EOD – Extension	V.4	yes	yes	yes	yes	no
EOD – Extension (Path)	V.4	yes	yes	yes	yes	no
EOD – Lymph Node Involvement	V.4	yes	yes	yes	yes	no
First Name	III.2.1.2	yes	yes	yes	yes	yes
Follow up Contact Address–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact Address–Other - Supplemental	VII.3	yes*	yes*	yes*	no	no
Follow up Contact City–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact Name–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact State–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact Zip–Other	VII.3	yes*	yes*	yes	yes	no
Follow up–Last Type (Patient)	VII.2.6.2	yes	yes	yes	no	no
Follow up–Last Type (Tumor)	VII.2.6.1	yes	yes	yes	no	no
Follow up–Next Type	VII.2.8	yes*	yes*	yes*	no	no
Follow up Hospital (Next)	VII.2.9	yes*	no	no	no	yes
Follow up Hospital (Last)	VII.2.7	yes	yes	yes	no	no
Histology Text	IV.1.7	yes	yes	yes	yes	no
Histology–Behavior (ICD-O-2)	V.3.4	yes	yes	yes	yes	no
Histology–Behavior (ICD-O-3)	V.3.4	yes	yes	yes	yes	yes
Histology–Grade/ Differentiation	V.3.5	yes	yes	yes	yes	yes
Histology–Type (ICD-O-2)	V.3	yes	yes	yes	yes	no
Histology–Type (ICD-O-3)	V.3	yes	yes	yes	yes	yes
Hormone Therapy at This Hospital	VI.5	yes	yes	yes	yes	yes
Hormone Therapy Summary	VI.5	yes	yes	yes	yes	yes
Hospital Number (Reporting)	III.1.4	yes	yes	yes	yes	yes
Hospital Patient Number	Vol. 2	gen	gen	yes	no	no
Hospital Referred From	III.3.10	yes	yes	yes	no	yes
Hospital Referred To	III.3.11	yes	yes	yes	no	no
ICD-O-3 Conversion Flag	Vol. 2	gen	gen	yes	yes	yes

Table of Data Items

Immunotherapy at This Hospital	VI.6	yes	yes	yes	yes	yes
Immunotherapy Summary	VI.6	yes	yes	yes	yes	yes
Industry-Text	III.2.13.2	yes	no	yes	no	no
Last Name	III.2.1.1	yes	yes	yes	yes	yes
Laterality	V.2	yes	yes	yes	yes	yes
Maiden Name	III.2.1.4	yes*	yes*	yes*	yes	no
Marital Status	III.2.6	yes	yes	yes	yes	no
Medical Record Number	III.2.2	yes*	yes*	yes*	yes	yes
Middle Name	III.2.1.3	yes*	yes*	yes*	yes	yes
Mother's First Name	III.2.1.9	yes*	yes*	yes*	no	no
Name Suffix	III.2.1.8	yes*	yes*	yes*	yes	no
Number of Regional Lymph Nodes Examined-Surgery Summary	VI.2.2	gen	gen	yes	no	no
Number of Regional Lymph Nodes Examined-Procedures 1-3	VI.2.3	yes	yes	no	no	no
Occupation-Text	III.2.13.1	yes	no	yes	no	no
Other Therapy at This Hospital	VI.7	yes	yes	yes	yes	yes
Other Therapy Summary	VI.7	yes	yes	yes	yes	yes
Over-ride Flags	Appendix T	yes	yes	yes	yes	yes
Pathology Report Number- Biopsy/FNA	IV.1.7.1	yes*	yes*	yes*	no	no
Pathology Report Number- Surgery	IV.1.7.2	yes*	yes*	yes*	no	no
Patient No Research Contact Flag	III.2.14	yes	yes	yes	no	no
Payment Source (Primary)	III.3.9	yes	yes	yes	no	yes
Payment Source (Secondary)	III.3.9	yes*	yes*	yes*	no	no
Payment Source Text	III.3.9	yes	yes	yes	no	no
Pediatric Stage	V.7.8	sel	sel	sel	no	no
Pediatric Stage Coder	V.7.10	sel	sel	sel	no	no
Pediatric Stage System	V.7.9	sel	sel	sel	no	no
Phone Number (Patient)	III.2.4	yes*	yes*	yes*	yes	yes
Physician (Attending)	III.3.12	yes	yes	yes	no	no
Physician (Following)	VII.2.10	yes*	yes*	yes*	yes	yes
Physician (Medical Oncologist)	III.3.12	yes*	yes*	yes*	no	yes
Physician (Other)	III.3.12	yes*	yes*	yes*	no	no
Physician (Other)	III.3.12	yes*	yes*	yes*	no	no
Physician (Radiation Oncologist)	III.3.12	yes*	yes*	yes*	no	yes
Physician (Referring)	III.3.12	yes*	yes*	yes*	no	no
Physician (Surgeon)	III.3.12	yes*	yes*	yes*	no	yes
Place of Death	VII.2.14	sel	yes*	yes*	no	no
Place of Diagnosis	III.3.4	may	may	yes*	no	no
Protocol Participation	VI.9	sel	sel	sel	no	no
Quality of Survival	VII.2.5	may	no	no	no	no
Race 1	III.2.9	yes	yes	yes	yes	yes

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Race 2	III.2.9	yes	yes	yes	yes	yes
Race 3	III.2.9	yes	yes	yes	yes	yes
Race 4	III.2.9	yes	yes	yes	yes	yes
Race 5	III.2.9	yes	yes	yes	yes	yes
Radiation at This Hospital	VI.3	yes	no	no	yes	no
Radiation - Boost RX Modality	VI.3.4	yes	yes	yes	no	yes
Radiation - Regional RX Modality	VI.3.3	yes	yes	yes	no	yes
Radiation Summary	VI.3	yes	yes	yes	yes	no
Radiation/Surgery Sequence	VI.3.4	yes	yes	yes	yes	yes
Reason for No Radiation	VI.3.3	yes	yes	yes	no	yes
Reason for No Surgery	VI.2.10	yes	yes	yes	yes	yes
Recurrence Date	VII.2.13.1	may	may	may	no	yes
Recurrence Sites	VII.2.13.3	may	may	may	no	no
Recurrence Type	VII.2.12.2	may	may	may	no	yes
Regional Data	-	may	may	yes*	no	no
EOD- Regional Nodes Examined	V.4	yes	yes	yes	yes	yes
EOD- Regional Nodes Positive	V.4	yes	yes	yes	yes	yes
Religion	III.2.8	yes	yes	yes	no	no
Scope of Regional Lymph Node Surgery 98-02 Summary	VI.2.2	gen	gen	yes	no	no
Scope of Regional Lymph Node Surgery-Summary	VI.2.2	gen	gen	yes	yes	yes
Scope of Regional Lymph Node Surgery-Procedures 1-3	V.7.12	yes	yes	yes	no	no
Sequence Number	II.2.4	yes	yes	yes	yes	yes
Sex	III.2.7	yes	yes	yes	yes	yes
Site Text	IV.1	yes	yes	yes	yes	no
Site-Primary	V.1.1	yes	yes	yes	yes	R
Social Security Number	III.2.3	yes*	yes*	yes*	yes	yes
Social Security Number Suffix	III.2.3	yes*	yes*	yes*	no	no
Spanish/Hispanic Origin	III.2.9.2	yes	yes	yes	yes	yes
Stage-Alternate	V.5.6	may	may	may	no	no
Summary Stage 1977	V.5	sel	sel	sel	no	no
Summary Stage 2000	V.5	sel	sel	sel	no	yes
Surgery at This Hospital- Diagnostic or Staging Procedure	VI.2.11	yes	yes	yes	no	yes
Surgery at This Hospital-Reconstructive	VI.2.8	yes	no	no	no	no
Surgery at This Hospital	VI.2.1	gen	gen	no	no	yes
Surgery of Primary Site 98-02 Summary	VI.2.1	gen	gen	yes	no	no
Surgery of Primary Site-Summary	VI.2.1	gen	gen	yes	yes	yes
Surgery of Primary Site-Procedures 1-3	VI.2.1	yes	yes	yes	no	no

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Surgery of Other Site – Summary – 98-02	VI.2.4	gen	gen	yes	no	no
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)–Summary	VI.2.4	gen	gen	yes	yes	yes
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)–Procedures 1-3	VI.2.4	yes	yes	yes	no	no
Surgery Summary– Diagnostic or Staging Procedure	VI.2.11	yes	yes	yes	no	yes
Surgery Summary– Reconstructive	VI.2.8	yes	yes	yes	no	no
Surgical Margins– Procedures 1-3	VI.2.7	yes	yes	no	no	no
Surgical Margins– Summary	VI.2.7	gen	gen	no	no	yes
Text RX–Chemotherapy	VI.4	sel	sel	sel	no	no
Text RX –Hormone Therapy	VI.5	sel	sel	sel	no	no
Text RX–Immunotherapy	VI.6	sel	sel	sel	no	no
Text RX–Other Therapy	VI.7	sel	sel	sel	no	no
Text RX–Radiation (Beam)	VI.3	sel	sel	sel	no	no
Text RX –Radiation (Other)	VI.3	sel	sel	sel	no	no
Text RX- Radiation Boost RX Modality	VI.3	sel	sel	sel	no	no
Text RX- Radiation Regional RX Modality	VI.3	sel	sel	sel	no	no
Text RX–Surgery	VI.2	sel	sel	sel	no	no
Text–DxProc–Lab Tests	IV.1.5	yes*	yes*	yes*	no	no
Text–DxProc–Operative	IV.1.6	yes*	yes*	yes*	no	no
Text–DxProc– Pathological	IV.1.7	yes*	yes*	yes*	no	no
Text–DxProc–PE	IV.1.2	yes*	yes*	yes*	no	no
Text–DxProc–Scopes	IV.1.4	yes*	yes*	yes*	no	no
Text–DxProc–X–ray	IV.1.3	yes*	yes*	yes*	no	no
Text–Remarks	VIII.1	yes*	yes*	yes*	no	no
TNM Coder (Clinical)	V.7.6	yes*	yes*	yes*	no	yes
TNM Coder (Path)	V.7.6	yes*	yes*	yes*	no	yes
TNM Edition	V.7.7	yes*	yes*	yes*	no	yes
TNM Stage (Clinical)	V.7.5	yes*	yes*	yes*	no	yes
TNM Stage (Path)	V.7.5	yes*	yes*	yes*	no	yes
TNM–M Code (Clinical)	V.7.4	yes*	yes*	yes*	no	yes
TNM–M Code (Path)	V.7.4	yes*	yes*	yes*	no	yes
TNM–N Code (Clinical)	V.7.4	yes*	yes*	yes*	no	yes
TNM–N Code (Path)	V.7.4	yes*	yes*	yes*	no	yes
TNM–T Code (Clinical)	V.7.4	yes*	yes*	yes*	no	yes
TNM–T Code (Path)	V.7.4	yes*	yes*	yes*	no	yes
Transplant/Endocrine Procedures At This Hospital	VI.7.1	yes	yes	yes	no	no
Transplant/Endocrine Procedures Summary	VI.7.1	yes	yes	yes	yes	yes

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Treatment Hospital Number-Procedure 1-3	VI.2.6	yes	yes	yes	no	no	
Tumor Markers 1-3	V.6	sel	sel	sel	yes	no	
Tumor Marker-CA-1	V.6.4	sel	sel	sel	no	no	
Tumor Size	V.4	yes	yes	yes	yes	yes	
Tumor Status	VII.2.4	yes	yes	yes	no	yes	
Type of Admission	III.3.7	yes	yes	yes	no	no	
Type of Reporting Source	III.3.6	yes	yes	yes	yes	no	
Vendor Version	-	gen	yes	gen	no	no	
Vital Status	VII.2.2	yes	yes	yes	yes	yes	
Year First Seen	II.2.1	yes	no	yes	no	no	