CALIFORNIA CANCER REGISTRY
Additions and Changes for 2011 Data Items

This document includes additions (new data items) and changes to existing data items for 2011. The first part of this document (PART I) lists new data items. The second part (PART II) of this document lists revised data items.

Part I – New Data Items

NAACCR Item # (if applicable)	**Data Item**	**Description and Codes**
#135	Census Tract 2010	**Description** This field is provided for coding census tract of patient's residence at time of diagnosis. See Census Tract 1970/80/90 [110]; Census Tract 2000 [130]. Codes are those used by the U.S. Census Bureau for the Year 2010 Census. Census tract codes have a 4-digit basic number and also may have a 2-digit suffix. Census tract numbers range from 0001.01 to 9999.98. **Codes** Census Tract Codes 000100-999998 000000 Area not census tracted 999999 Area census-tracted, but census tract is not available Blank Census Tract 2010 not coded **Clarification of NPCR Required Status** Information on census tract and census tract certainty is required. Census Tract and Census Tract Certainty should be recorded in the year-appropriate data item fields in order to reflect demographic information at the time of diagnosis. Until the 2010 Census is completed and data are available for geocoding, tumors diagnosed in 2010 or later, should be coded to the 2000 census definitions and recorded in Census Tract 2000 [130] and Census Tr Certainty 2000 [365]. When the 2010 Census data are available for geocoding, tumors diagnosed in 2010 or later must be coded to the 2010 census tract definitions and recorded in Census Tract 2010 [135] and Census Tract Certainty 2010 [367]. For tumors diagnosed between January 1, 2008, and December 31, 2009, use of Census Tract 2010 [135] and Census Track Certainty 2010 [367] is recommended. **Field length:** 6 Level: Tumor

NAACCR Item # (if applicable)	Data Item	Description and Codes
#367	Census Tr Certainty 2010	**Description** Code indicating basis of assignment of census tract for an individual record. Helpful in identifying cases tracted from incomplete information or P.O. Box. This item is not coded by the hospital. Central registry staff assign the code. **Codes** 1 Census tract based on complete and valid street address of residence 2 Census tract based on residence ZIP + 4 3 Census tract based on residence ZIP + 2 4 Census tract based on residence ZIP code only 5 Census tract based on ZIP code of P.O. Box 6 Census tract/BNA based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract 9 Not assigned, geocoding attempted Blank Not assigned, geocoding not attempted **Clarification of NPCR Required Status** <u>Census-1990 data items:</u> Census Tract 1970/80/90 [110] Census Tr Cert 1970/80/90 [364] Census Tract Cod Sys--1970/80/90 [120] <u>Census-2000 data items:</u> Census Tract 2000 [130] Census Tr Certainty 2000 [365] <u>Census-2010 data items:</u> Census Tract 2010 [135] Census Tr Certainty 2010 [367] Information on census tract and census tract certainty is required. Census Tract and Census Tract Certainty should be recorded in the year-appropriate data item fields in order to reflect demographic information at the time of diagnosis. Until the 2010 Census is completed and data are available for geocoding, tumors diagnosed in 2010 or later, should be coded to the 2000 census definitions and recorded in Census Tract 2000 [130] and Census Tr Certainty 2000 [365]. When the 2010 Census data are available for geocoding, tumors diagnosed in 2010 or later must be coded to the 2010 census tract definitions and recorded in Census Tract 2010 [135] and Census Tract Certainty 2010 [367]. For tumors diagnosed between January 1, 2008, and December 31, 2009, use of Census Tract 2010 [135] and Census Track Certainty 2010 [367] is recommended. **Field length:** 1 **Level:** Tumor

NAACCR Item # (if applicable)	**Data Item**	**Description and Codes**
#3750-3769 *(applies to all)*	Over-ride CS 1-20	**Description** Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct. **Rationale** Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. **Codes** 1 Reviewed and confirmed as reported Blank Not reviewed or reviewed and corrected **Field length:** 1 **Level:** Admission / Tumor

CCR Data Item #	Data Item	Description and Codes
E1762	Census Source 2010	**Description** Field which tracks how and where year 2010 (Census Tract 2010 and Census Block 2010) was performed. **Codes** Two digit field with codes as follows: First digit (how geocoding performed) 1 Batch computerized geocoding (automatic, non-interactive) 2 Interactive computerized geocoding (done with a software program, but individual makes decision) 3 Manual (using source other than computer software program such as maps, contacting local planning departments, etc.) 9 Year 2010 geocodes not assigned Second digit (where performed) 1 GDT 2 Teale (secondary vendor) 3 CCR 4 Region 5 USC Spatial Sciences (current vendor) 9 Year 2010 geocodes not assigned **Field length:** 2 **Level:** Tumor
E1763	Census Block 2010	**Description** A census block is the smallest geographical unit used by the U.S. Census Bureau. A census block varies greatly in population. The first number of the census block indicates which block group the block is in. **Codes** Always numeric or blank. **Field length:** 4 **Level:** Tumor

CER Data Item #	Data Item	Description and Codes
CER #9751-9756	Chemo 1-6 NSC Numbers (applies to all)	**Description:** Breast, Colorectal, CML. NSC number (*see below for description of NSC numbers) for the first chemotherapy agent administered **as all or part of the first course** of treatment at any facility. Code original agent NSC numbers using the most current SEER*Rx (http://seer.cancer.gov/tools/seerrx/). Include treatment given at all facilities **as all or part of the first course** of therapy. *Please note that the term "NSC" [number] refers to (part of) the acronym of the Cancer Chemotherapy National Service Center (CCNSC)). The NSC number is a National Service Center assigned number from the National Cancer Institute (NCI). This number is assigned to a drug during its investigational phase, prior to the adoption of a United States Adopted Name (USAN). A full list of NSC codes is maintained in SEER*Rx. **Codes:** Enter NSC codes as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry. *If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).* ###### NSC code (enter the actual code) 000000 Chemotherapy was not planned to be administered OR no additional chemotherapy agents were planned 999998 Chemotherapy was planned and/or administered, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes. 999999 Unknown if chemotherapy therapy planned **Field length:** 6 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9761-9766	Chemo 1-6 Num Doses Planned	**Description:** Breast, Colorectal, CML. For the first chemotherapy agent, this item records the total **number** of chemotherapy doses **planned** to be delivered to the patient **as all or part of the first course of treatment** at any facility. **Code:** *If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).* Record the total number of chemotherapy doses planned. 00 Chemotherapy was not planned OR no additional chemotherapy agents were planned 1-96 Actual number of chemotherapy doses planned* 97 97 or more chemotherapy doses planned 98 Chemo was planned and/or administered, but number doses is unknown 99 Unknown if chemotherapy planned *For doses 1-9, use a leading 0. **Field length:** 2 **Level:** Admission / Tumor

<table>
<tr><th>CER Data Item #</th><th>Data Item</th><th>Description and Codes</th></tr>
<tr><td>CER #9771-9776 (applies to all)</td><td>Chemo 1-6 Planned Dose</td><td>
Description: Breast, Colorectal, CML. For the first chemotherapy agent, this item records the planned total dose to be delivered to the patient as all or part of the first course of treatment at any facility (note that this is the total dosage, not the total number of doses).

Total dose for a given agent is the sum of each dose planned for that agent. Add all doses planned into a single total value; do not record per dose rate or individual dose value.

Code: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Record the overall total chemotherapy dose planned, including the units (when dose volume is less than 6 digits, use leading zeros):

Chemo1PlanDose
Enter Dose Volume (as numbers):
Chemotherapy dose planned
000000 Chemotherapy was not planned OR no additional chemotherapy agents were planned
999998 Chemotherapy was planned and/or administered, but the dose planned is unknown
999999 Unknown if chemotherapy planned or not required for this primary site/histology
For more information regarding chemo dose, see Appendix 4: Chemotherapy Example.

Field length: 6
Level: Admission / Tumor
</td></tr>
</table>

<table>
<tr><th>CER Data Item #</th><th>Data Item</th><th>Description and Codes</th></tr>
<tr><td>CER #9781-9786</td><td>Chemo 1-6 Planned Dose Unit</td><td>
Description: Breast, Colorectal, CML. For the first chemotherapy agent, this item records the planned total dose to be delivered to the patient as all or part of the first course of treatment at any facility (note that this is the total dosage, not the total number of doses.)

Total dose for a given agent is the sum of each dose planned for that agent. Add all doses planned into a single total value; do not record per dose rate or individual dose value.

Code: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Record the overall total chemotherapy dose planned, including the units (when dose volume is less than 6 digits, use leading zeros):

<table>
<tr><td colspan="2">Chemo1PlanDoseU
Select Units:</td></tr>
<tr><td>00</td><td>Chemo was not planned OR no additional chemotherapy agents were planned</td></tr>
<tr><td>01</td><td>Mg</td></tr>
<tr><td>02</td><td>Grams</td></tr>
<tr><td>07</td><td>Other (please specify in chemo text field)</td></tr>
<tr><td>98</td><td>Chemo was planned and/or administered, but the dose planned is unknown</td></tr>
<tr><td>99</td><td>Unknown if chemo planned or not required for this primary site/histology</td></tr>
</table>
For more information regarding chemo dose, see Appendix 4: Chemotherapy Example.

Field length: 2
Level: Admission / Tumor
</td></tr>
</table>

CER Data Item #	Data Item	Description and Codes
CER #9791-9796 ***(applies to all)***	Chemo 1-6 Num Doses Receivd	**Description:** Breast, Colorectal, CML. For the first chemotherapy agent, this item records the total **number** of chemotherapy doses delivered to the patient **as all or part of the first course of treatment** at any facility. **Code:** *If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).* Record the total number of chemotherapy doses received. 00 Chemotherapy was not received OR no additional chemotherapy agents were received 1-96 Actual number of chemotherapy doses received* 97 97 or more chemotherapy doses received 98 Chemotherapy was received, but the number of doses is unknown 99 Unknown if chemotherapy received *For doses 1-9, use a leading 0. **Field length:** 2 **Level:** Admission / Tumor

<table>
<tr><th>CER Data Item #</th><th>Data Item</th><th>Description and Codes</th></tr>
<tr><td>CER #9801-9806
(applies to all)</td><td>Chemo 1-6 Received Dose</td><td>Description: Breast, Colorectal, CML. For the first chemotherapy agent, this item records the total dose actually delivered to the patient as all or part of the first course of treatment at any facility. (Note that this is the total dosage received, not the total number of doses).
Total dose for a given agent is the sum of each dose given for that agent. Add all doses received into a single total value; do not record per dose rate or the individual dose value.

Code:
Record the overall total chemotherapy dose received, including the units (when dose volume is less than 6 digits, use leading zeros):

Chemo1RcvDose
Enter Dose Volume (as numbers):
Chemotherapy dose received
000000 Chemotherapy was not received OR no additional chemo agents were received
999998 Chemotherapy was received, but the dose Received is unknown
999999 Unknown if chemotherapy received OR not required for this primary site/histology

Field length: 6
Level: Admission / Tumor</td></tr>
</table>

<table>
<tr><th>CER Data Item #</th><th>Data Item</th><th>Description and Codes</th></tr>
<tr><td>CER #9811-9816
(applies to all)</td><td>Chemo 1-6 Received Dose Unit</td><td>
Description: Breast, Colorectal, CML. For the first chemotherapy agent, this item records the total dose actually delivered to the patient as all or part of the first course of treatment at any facility. (Note that this is the total dosage received, not the total number of doses).

Total dose for a given agent is the sum of each dose given for that agent. Add all doses received into a single total value; do not record per dose rate or the individual dose value.

Code:
If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Record the overall total chemotherapy dose received, including the units (when dose volume is less than 6 digits, use leading zeros):

<table>
<tr><td colspan="2">Chemo1RcvDoseU
Select Units:</td></tr>
<tr><td>00</td><td>Chemo was not received OR no additional chemotherapy agents were received</td></tr>
<tr><td>01</td><td>Mg</td></tr>
<tr><td>02</td><td>Grams</td></tr>
<tr><td>07</td><td>Other (please specify in chemo text field, item # XX)</td></tr>
<tr><td>98</td><td>Chemo was received, but the dose received is unknown</td></tr>
<tr><td>99</td><td>Unknown if chemo received OR not required for this primary site/histology</td></tr>
</table>

For more information regarding chemo dose, see Appendix 4: Chemotherapy Example.

Field length: 2
Level: Admission / Tumor
</td></tr>
</table>

CER Data Item #	Data Item	Description and Codes
CER #9821-9826 ***(applies to all)***	Chemo 1-6 Start Date	**Description:** Breast, Colorectal, CML. For the first chemotherapy agent, this item records the date for the first day of the first cycle that the patient started chemotherapy **as all or part of the first course** of treatment at any facility. **Code:** Record the first date the patient received the first cycle of chemotherapy **as all or part of the first course** of treatment. **Field length:** 8 **Level:** Admission / Tumor
CER #9831-9836 ***(applies to all)***	Chemo 1-6 Start Date Flag	**Description:** Breast, Colorectal, CML. This flag explains why no appropriate value is in the field, Chemo 1 Start Date [9821]. **Codes: (See Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).** 10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered) 11 No proper value is applicable in this context (e.g., no chemotherapy agent administered) 12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown). 15 Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up). Blank A valid date value is provided in item Chemo 1-6 Start Date [9821-9826], or the date was not expected to have been transmitted *Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.* **Field length:** 2 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9841-9846 ***(applies to all)***	Chemo 1-6 End Date	**Description:** Breast, Colorectal, CML. For the first chemotherapy agent, this item records the date for the last day of the last cycle that the patient received chemotherapy **as all or part of the first course** of treatment at any facility. **Code:** Record the last date that the patient received chemotherapy **as all or part of the first course** of treatment **Length:** 8 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9851-9856 ***(applies to all)***	Chemo 1-6 End Date Flag	**Description:** Breast, Colorectal, CML. This flag explains why no appropriate value is in the field, Chemo 1 End Date [9841]. **Codes: (See Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition*, Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).** 10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered) 11 No proper value is applicable in this context (e.g., no chemotherapy agent administered) 12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown). 15 Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up). Blank A valid date value is provided in item Chemo 1-6 End Date [9841-9846], or the date was not expected to have been transmitted *Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.* **Field length:** 2 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9859	Chemo Completion Status	**Description:** Breast, Colorectal, CML. This data item is used to code the completion status of chemotherapy for the first course of treatment. The chemotherapy must be part of the **first course of treatment**. Chemotherapy not complete includes only the situation that chemotherapy was terminated prematurely. **Code:** Code indicating whether or not the patient's chemo therapy was completed as outlined in the initial treatment plan. Codes 0 No chemo treatment 1 Treatment completed as planned 2 Chemo not completed as planned, patient health/complications 3 Chemo not completed as planned, patient expired 4 Chemo not completed as planned, patient/family choice 5 Chemo not completed as planned, cytopenia 6 Chemo not completed as planned, other reason 7 Chemo treatment extends beyond the end of data collection for this project 8 Chemotherapy administered, unknown if completed 9 Unknown if Chemo therapy given or not required for this primary site/histology **Field length:** 1 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9861-9862 ***(applies to all)***	Hormone 1-2 NSC Number	**Description:** Breast, Colorectal, CML. NSC number (*see below for description of NSC numbers) for the first hormonal agent administered **as all or part of the first course** of treatment at any facility. Code original agent NSC numbers using the most current SEER*Rx (http://seer.cancer.gov/tools/seerrx/). Include treatment given at all facilities **as all or part of the first course** of therapy. *Please note that the term "NSC" [number] refers to (part of) the acronym of the Cancer Chemotherapy National Service Center (CCNSC)). The NSC number is a National Service Center assigned number from the National Cancer Institute (NCI). This number is assigned to a drug during its investigational phase, prior to the adoption of a United States Adopted Name (USAN). A full list of NSC codes is maintained in SEER*Rx. **Coding:** NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry. *If there is more than one hormone agent, the order in which they are entered as agent 1 or agent 2 is unimportant.* ###### NSC Number (enter the actual number) 000000 Hormonal therapy was not planned to be administered OR no additional hormonal therapy agents were planned 999998 Hormone therapy was planned, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes. 999999 Unknown if hormonal therapy was planned or not required for this primary site/histology **Field length:** 6 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9871-9872 ***(applies to all)***	BRM 1-2 NSC Number	**Description:** Breast, Colorectal, CML. NSC number (*see below for description of NSC numbers) for the first BRM agent administered **as all or part of the first course** of treatment at any facility. Code original agent NSC numbers using the most current SEER*Rx (http://seer.cancer.gov/tools/seerrx/). Include treatment given at all facilities **as all or part of the first course** of therapy. *Please note that the term "NSC" [number] refers to (part of) the acronym of the Cancer Chemotherapy National Service Center (CCNSC)). The NSC number is a National Service Center assigned number from the National Cancer Institute (NCI). This number is assigned to a drug during its investigational phase, prior to the adoption of a United States Adopted Name (USAN). A full list of NSC codes is maintained in SEER*Rx. **Code:** NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry. *If there is more than one BRM agent planned, the order in which they are entered as agent 1 or agent 2 is unimportant.* ###### NSC Number (enter the actual number) 000000 BRM therapy was not planned to be administered OR no additional BRM therapy agents were planned 777777 Bone marrow transplant, stem cell harvests, or surgical and/or radiation endocrine therapy 999998 BRM therapy was planned, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes. 999999 Unknown if BRM therapy was planned or not required for this primary site/histology **Field length:** 6 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9880	Granulocyte CSF Status	**Description:** Breast, Colorectal, CML. This data item is used to code if the patient was given Granulocyte-Growth Factors/Cytokines (G-CSF) agents during the twelve months after diagnosis. **Code:** Code indicating whether or not the patient received G-CSF agents during the first twelve months of treatment after date of diagnosis. Codes 0 No G-CSF treatment given 1 G-CSF treatment was given 7 G-CSF treatment prescribed – patient, patient's family member, or patient's guardian refused 8 G-CSF treatment prescribed, unknown if administered 9 Unknown if G-CSF therapy given or not required for this primary site/histology **Field length:** 1 **Level:** Admission / Tumor
CER #9881	Erythro Growth Factor Status	**Description:** Breast, Colorectal, CML. This data item is used to code if the patient was given Erythrocyte-Growth Factors/Cytokines agents during the twelve months after diagnosis. **Code:** Code indicating whether or not the patient received Erythrocyte-Growth Factors/Cytokines agents during the first twelve months of treatment after date of diagnosis. Codes 0 No Erythrocyte-Growth Factors/Cytokines treatment given 1 Erythrocyte-Growth Factors/Cytokines therapy was given 7 Erythrocyte-Growth Factors/Cytokines treatment prescribed – patient, patient's family member, or patient's guardian refused 8 Erythrocyte-Growth Factors/Cytokines treatment prescribed, unknown if administered 9 Unknown if Erythrocyte-Growth Factors/Cytokines therapy given or not required for this primary site/histology **Field length:** 1 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9882	Thrombocyte Growth Fact Status	**Description:** Breast, Colorectal, CML. This data item is used to code if the patient was given Thrombocyte-Growth Factors/Cytokines agents during the twelve months after diagnosis. **Code:** Code indicating whether or not the patient received Thrombocyte-Growth Factors/Cytokines agents during the first twelve months of treatment after date of diagnosis. Codes 0 No Thrombocyte-Growth Factors/Cytokines treatment given 1 Thrombocyte-Growth Factors/Cytokines treatment was given 7 Thrombocyte-Growth Factors/Cytokines treatment prescribed – patient, patient's family member, or patient's guardian refused 8 Thrombocyte-Growth Factors/Cytokines treatment prescribed, unknown if administered 9 Unknown if Thrombocyte-Growth Factors/Cytokines therapy given or not required for this primary site/histology **Field length:** 1 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9920	Reason Subsq RX	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. This data item is used to code the reason that the patient received subsequent treatment beyond their first course of therapy. The treatment must NOT be part of the first course of treatment, **rather it should be care that is given subsequent to the first course.** **Code:** Code indicating the reason that the patient received subsequent or palliative treatment beyond their first course of therapy. Codes 0 No subsequent or palliative treatment 1 Subsequent or palliative treatment due to disease progression* 2 Subsequent or palliative treatment due to recurrence of disease* 4 Subsequent or palliative treatment due to development of medical condition (e.g., heart failure or liver disease develops in patient) 5 Subsequent or palliative treatment due to other reason 9 Unknown if subsequent or palliative therapy given or not required for this primary site/histology **Note: Usually, the treating physician will note in the patient's medical record explicitly if subsequent treatment is being given as a result of disease progression or disease recurrence. If it is not noted explicitly, please use the following guideline to determine which code applies:* *If the disease progresses, the interval between initial treatment and a change in treatment will be zero.* *It there is a recurrence, there will be a time interval that passes before new therapy shows up in the record.* **Field length:** 1 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #1660	Subsq RX 2nd Course Date	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. Date of initiation of subsequent treatment. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data. *Note: This data item is no longer supported by COC (as of January 1, 2003), but is being collected for the purposes of the CER special study.* **Field length:** 8 **Level:** Admission / Tumor
CER #9955	Subsq RX 2nd DateFlag CER	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. This flag explains why no appropriate value is in the field, Subsq RX 2nd Course Date [1660]. This data item was first available in Volume II Version 12 (effective January 2010). **Codes: (see Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).** 10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy) 11 No proper value is applicable in this context (e.g., no subsequent therapy) 12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., subsequent therapy given, but date is unknown) 15 Information is not available at this time, but it is expected that it will be available later (e.g., subsequent therapy ordered, but has not been administered at the time of the most recent follow up) Blank A valid date value is provided in item Subsq RX 2nd Course Date [1660], or the date was not expected to have been transmitted *Comment:* This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. **Field length:** 2 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9921	Subsq RX 2nd Course Surg	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. This variable is used to code for the type of surgery given as part of the subsequent course of treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. **Coding:** Subsequent surgery is a treatment consideration for local, regional or distant recurrence or progression of disease. Subsequent surgery is also a treatment consideration when other planned first course of treatment fails. Refer to staging rules to determine if subsequent surgery is local, regional or for distant metastasis. Code "00" for no subsequent surgery. **Codes** 00 None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information 10 Surgery to local site 20 Surgery to regional site/lymph nodes 30 Surgery to distant site/lymph nodes 90 Surgery, NOS; a subsequent surgical procedure was done, but no information on the type of surgical procedure is provided. **Field length:** 2 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9922	Subsq RX 2nd Course Rad	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. This variable is used to code for the type of radiation given as part of the subsequent course of treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. **Codes** 00 None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information 10 Local radiation 20 Regional radiation 30 Distant radiation, NOS 31 Bone 32 Brain 33 Liver 34 Lung 35 Other distant sites/lymph nodes or more than one distant site **Field length:** 2 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9923	Subsq RX 2nd Course Chemo	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. This variable is used to code for the type of chemotherapy given as part of the subsequent course of treatment. . Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. **Codes:** 00 None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information 01 Chemotherapy administered as subsequent therapy, but the type and number of agents is not documented in patient record. 02 Single-agent chemotherapy administered as subsequent therapy. 03 Multiagent chemotherapy administered as subsequent therapy. **Field length:** 2 **Level:** Admission / Tumor
CER #9924	Subsq RX 2nd Course Horm	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. This variable is used to code for the type of hormonal therapy given as part of the subsequent course of treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. **Codes** 00 None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information 01 Hormone therapy administered as subsequent therapy. **Field length:** 2 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9925	Subsq RX 2nd Course BRM	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. This variable is used to code for the type of biological response modifier therapy (immunotherapy) given as part of the subsequent course of treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. **Codes** 00 None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information 01 Immunotherapy administered as subsequent therapy. **Field length:** 2 **Level:** Admission / Tumor
CER #9926	Subsq RX 2nd Course Oth	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. This variable is used to code for the type of other treatment given as part of the subsequent course of treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. **Codes** 0 None -All subsequent cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy) OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information. 1 Other -subsequent treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy). 2 Other–Experimental This code is not defined. It may be used to record participation in institution-based clinical trials. 3 Other–Double Blind A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken. 6 Other–Unproven Cancer treatments administered by nonmedical personnel. **Field length:** 1 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9927	Subsq RX 2ndCrs Trans/End	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. This variable is used to code for the type of transplant/endocrine therapy given as part of the subsequent course of treatment. **Codes** 00 None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information 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 and infusion. Umbilical cord stem cell transplant. 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.) **Field length:** 2 **Level:** Admission / Tumor
CER #9931-9936 ***(applies to all)***	Subsq RX 2nd Chemo 1-6 NSC	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. See description information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items). **Coding:** See coding information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items). **Field length:** 6 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9941-9942 ***(applies to all)***	Subsq RX 2nd Horm 1-2 NSC	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. See description information listed for Hormone 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items). **Coding:** See coding information listed for Hormone 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items). **Field length:** 6 **Level:** Admission / Tumor
CER #9951-9952 ***(applies to all)***	Subsq RX 2nd BRM 1-2 NSC	**Description:** As available, Breast, Colorectal, CML. **NOT** collected for all other sites/histologies. See description information listed for BRM 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items). **Coding:** See coding information listed for BRM 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items). **Field length:** 6 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9960	Height	**Description:** Required for breast, colorectal, and CML when chemotherapy or other drugs given. As available for all other sites/histologies. Height is required for breast, colorectal, and CML when chemotherapy and/or other drugs were given, and should be entered when available for all other sites/histologies. Different tumors for the same patient may have different values. It should be collected from source records once for each cancer. Height should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's hospital medical record or physician office record. The height entered should be that listed at or around the time of diagnosis. If no height was listed on the date of diagnosis, please use the height recorded on the date closest to the date of diagnosis and before treatment was started. **Code:** Entered as 2 digit numbers and measured in inches (note that 1 foot=12 inches). Code "98" for 98 inches or greater. Code "99" for unknown height. *All inches values should be rounded to the nearest whole number; values with decimal place x .5 and greater should be rounded up (e.g., 62.5 inches would be 63 inches).* *Please see Appendix 1 for a height conversion chart. If you prefer, you can also use the following on-line conversion calculator:* http://manuelsweb.com/in_cm.htm If you have trouble opening this link from this file, copy and paste the address into your browser. **Field length:** 2 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9961	Weight	**Description:** Required for breast, colorectal, and CML when chemotherapy or other drugs given. As available for all other sites/histologies. Weight is required for breast, colorectal, and CML when chemotherapy and/or other drugs were given, and should be entered when available for all other sites/histologies. Different tumors for the same patient may have different values. It should be collected from source records once for each cancer. Weight should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's hospital medical record or physician office record. The weight entered should be that listed on the date of diagnosis. If no weight was listed on the date of diagnosis, please use the weight recorded on the date closest to the date of diagnosis and before treatment was started. **Code:** Entered as 3 digit numbers and measured in pounds (note that 1 kg = 2.2 pounds). Code "999" for unknown weight. *All pound values should be rounded to the nearest whole number; values with decimal place x.5 and greater should be rounded up (e.g., 155.5 pounds would be 156 pounds).* *Patients with a weight of under 100 pounds should be recorded with a leading 0* *Please see Appendix 2 for a weight conversion chart. If you prefer, you can also use the following on-line conversion calculator:* http://manuelsweb.com/kg_lbs.htm If you have trouble opening this link from this file, copy and paste the address into your browser. **Field length:** 3 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9900	BCR-ABL Cytogenetic	**Description:** CML. Record the results of the cytogenetic analysis for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. **Code:** 000* Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR OR Test ordered (e.g., results not in source records) 010 Positive *Please note that this variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding "000" for a given case. **Field length:** 3 **Level:** Admission / Tumor
CER #9901	BCR-ABL Cytogenetic Date	**Description:** CML. Record the date of the cytogenetic analysis for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the date of the test results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. Cytogenetic analysis may be used to monitor disease response to therapy and relapse. **Coding:** See *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97* for date format. **Field length:** 8 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9902	BCR-ABL Cytogen Date Flag	**Description:** CML. This flag explains why no appropriate value is in the field, BCR-ABL: Cytogenetic Date [9901]. **Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition*, Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).** 10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: Cytogenetic test done) 11 No proper value is applicable in this context (e.g., no BCR-ABL: Cytogenetic test done or not applicable) 12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: Cytogenetic test done, but date is unknown) 15 Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL: Cytogenetic test ordered, but has not been administered at the time of the most recent follow up) Blank A valid date value is provided in item BCR-ABL: Cytogenetic Date [9901], or the date was not expected to have been transmitted *Comment:* This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. **Field length:** 2 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9903	BCR-ABL FISH	**Description:** CML. Record the results of only the Fluorescence in Situ Hybridization for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. **Coding:** 000* Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR OR Test ordered (e.g., results not in source records) 010 Positive *Please note that this variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding "000" for a given case. **Field length:** 3 **Level:** Admission / Tumor
CER #9904	BCR-ABL FISH Date	**Description:** CML. Record the date of only the Fluorescence in Situ Hybridization for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the date of the test results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. **Coding:** See *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97* for date format. **Field length:** 8 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9905	BCR-ABL FISH Date Flag	**Description:** CML. This flag explains why no appropriate value is in the field, BCR-ABL: FISH Date [9904]. **Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition*, Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).** 10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: FSH test done) 11 No proper value is applicable in this context (e.g., no BCR-ABL: FISH test done or not applicable) 12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: FISH test done, but date is unknown) 15 Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL: FISH test ordered, but has not been administered at the time of the most recent follow up) Blank A valid date value is provided in item BCR-ABL: FISH Date [9904], or the date was not expected to have been transmitted *Comment:* This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. **Field length:** 2 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9906	BCR-ABL RT-PCR Qual	**Description:** CML. Record the results of the *qualitative* Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. **Coding** 000* Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR OR Test ordered (e.g., results not in source records) 010 Positive *Please note that this variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding "000" for a given case. **Field length:** 3 **Level:** Admission / Tumor
CER #9907	BCR-ABL RT-PCR Qual Date	**Description:** CML. Record the date of the *qualitative* Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the date of the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. RT-PCR Qualitative may be used to monitor disease response to therapy and relapse. **Coding:** See *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97* for date format. **Field length:** 8 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9908	BCR-ABL RT-PCR Qual Date Flag	**Description:** CML. This flag explains why no appropriate value is in the field, BCR-ABL: RT-PCR Qual Date [9907]. **Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition*, Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).** 10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: RT-PCR Qual test done) 11 No proper value is applicable in this context (e.g., no BCR-ABL: RT-PCR Qual test done or not applicable) 12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: RT-PCR Qual test done, but date is unknown) 15 Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL: RT-PCR Qual test ordered, but has not been administered at the time of the most recent follow up) Blank A valid date value is provided in item BCR-ABL: RT-PCR Qual Date [9907], or the date was not expected to have been transmitted *Comment:* This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. **Field length:** 2 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9909	BCR-ABL RT-PCR Quant	**Description:** CML. Record results of the quantitative Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL t(9;22) (q34;q11) at time of initial diagnosis. If multiple test results are recorded in the source records, use results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. **Coding:** 000* Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR OR Test ordered (e.g., results not in source records) 001 - 998 Ratio of 0.001 to 0.998 (enter exact ratio) 999 Ratio greater than or equal to 0.999 *Please note that this variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding "000" for a given case. **Field length:** 3 **Level:** Admission / Tumor
CER #9910	BCR-ABL RT-PCR Quant Date	**Description:** CML. Record date of quantitative Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL t(9;22) (q34;q11) at time of initial diagnosis. If multiple test results are recorded in source records, use date related to results that are closest to date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. **Coding:** See *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97* for date format. **Field length:** 8 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9911	BCR-ABL RT-PCR Quan DtFlg	**Description:** CML. This flag explains why no appropriate value is in the field, BCR-ABL: RT-PCR Quan Date [9910]. **Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition*, Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).** 10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: RT-PCR Quant test done) 11 No proper value is applicable in this context (e.g., no BCR-ABL: RT-PCR Quant test done or not applicable) 12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: RT-PCR Quant test done, but date is unknown) 15 Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL: RT-PCR Quant test ordered, but has not been administered at the time of the most recent follow up) Blank A valid date value is provided in item BCR-ABL: RT-PCR Quant Date [9910], or the date was not expected to have been transmitted *Comment:* This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates. **Field length:** 2 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9965-9968 (applies to all)	Tobacco Use: Cigarettes, Other Smoke, Smokeless, NOS	**Description:** All sites/histologies, as available in the source records. Records the patient's past or current use of tobacco. Tobacco use should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats or Nursing Assessment section, or other available source from the patient's hospital medical record or physician office record. The collection of Tobacco Use will be divided into three types of tobacco products and when tobacco use is indicated, but type is not specified: • Cigarette smoking • Smoking tobacco products other than cigarettes (e.g., pipes, cigars, kreteks) • Smokeless tobacco products (e.g, chewing tobacco, snuff, etc.) • Tobacco, NOS **Codes:** 0 Never used 1 Current user 2 Former user, quit within one year of the date of diagnosis 3 Former user, quit more than one year prior to the date of diagnosis 4 Former user, unknown when quit 9 Unknown/not stated/no smoking specifics provided If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than "Never used." If the medical record indicates "None," use 0 ("Never Used"). **Field length:** 1 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9970	Source Comorbidity	**Description:** All. This data item is to record the data source from which comorbidities/complications were collected. This data item refers back to standard NAACCR data item # 3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, and 3164. **Coding:** 0 No comorbid condition or complication identified/Not Applicable 1 Collected from facility face sheet 2 Linkage to facility/hospital discharge data set 3 Linkage to Medicare/Medicaid data set 4 Linkage with another claims data set 5 Combination of two or more sources above 9 Other source **Field length:** 1 **Level:** Admission / Tumor

CER Data Item #	Data Item	Description and Codes
CER #9980	NBCCEDP Linkage Results	**Description:** Breast, Cervix. The purpose of this variable is to enhance the completeness and quality of the central registry database by expanding the linkage with the state Breast and Cervical Cancer Early Detection Program (BCCEDP) data system, and to capture and maintain the resulting information. The information to be captured and maintained includes a BCCEDP link variable and BCCEDP link date. The NBCCEDP MDE Link variable will identify breast or cervical cancer cases in the registry database that matched the same patient and tumor in the NBCCEDP data set (i.e.; patient Jane Doe right breast infiltrating duct carcinoma diagnosed in 2004 in the registry database matched the same Jane Doe right breast infiltrating duct carcinoma diagnosed in 2004 in the NBCCEDP data set). The BCCEDP link date indicates the date this linkage occurred. Results from the linkage between central cancer registries and the breast and cervical cancer screening programs should be used to: • Update MDE data with central cancer registry staging and final diagnosis data • Identify missing cancer cases in either data set • Reconcile differences between the two data sets • Registries are expected to expand these linkages to include post-linkage capture and maintenance of selected data from the BCCEDP data system within the cancer registry; and submit those variables to CDC in the annual NPCR-CSS Call for Data. **Coding** 0 record sent for linkage, no match for this cancer with BCCEP data 1 record sent for linkage, match for this cancer with BCCEP data BLANK record not sent for linkage **Field length:** 1 **Level:** Tumor *(continued on next page)*

CER Data Item #	Data Item	Description and Codes
CER #9980 ***(continued)***		For reportable breast and cervical cancer cases, use the BCCEDP MDE Link variable and BCCEDP MDE Link date to record results from your registry's data linkage with the appropriate BCCEDP program(s) in your state/territory/jurisdiction. For the BCCEDP MDE Link variable, use codes 0 (record sent for linkage, no match for this cancer with BCCEDP data) or 1 (record sent for linkage, match for this cancer with BCCEDP data) to indicate linkage results. If the record was not sent for linkage, this variable is to be left blank. If the registry database record links with a BCCEDP database record, indicated by code 1 in the BCCEDP MDE Link variable, the BCCEDP MDE Link date must be completed to indicate the date the linkage occurred. Otherwise, the BCCEDP MDE Link date must be blank.

CER Data Item #	Data Item	Description and Codes
CER #9981	NBCCEDP Linkage Date	**Description:** Female Breast, Cervix. The purpose of this variable is to enhance the completeness and quality of the central registry database by expanding the linkage with the state Breast and Cervical Cancer Early Detection Program (BCCEDP) data system and to capture and maintain the resulting information. The information to be captured and maintained includes a BCCEDP link variable and BCCEDP link date. The NBCCEDP MDE Link variable will identify breast or cervical cancer cases in the registry database that matched the same patient and tumor in the NBCCEDP data set (i.e.; patient Jane Doe right breast infiltrating duct carcinoma diagnosed in 2004 in the registry database matched the same Jane Doe right breast infiltrating duct carcinoma diagnosed in 2004 in the NBCCEDP data set). The BCCEDP link date indicates the date this linkage occurred. Results from the linkage between central cancer registries and the breast and cervical cancer screening programs should be used to: • Update MDE data with central cancer registry staging and final diagnosis data • Identify missing cancer cases in either data set • Reconcile differences between the two data sets • Registries are expected to expand these linkages to include post-linkage capture and maintenance of selected data from the BCCEDP data system within the cancer registry; and submit those variables to CDC in the annual NPCR-CSS Call for Data. **Coding:** YYYYMMDD = date this cancer linked with BCCEDP data BLANK = record did not link with BCCEDP data For reportable breast and cervical cancer cases, use the BCCEDP MDE Link variable and BCCEDP MDE Link date to record results from your registry's data linkage with the appropriate BCCEDP program(s) in your state/territory/jurisdiction. For the BCCEDP MDE Link variable, use codes 0 (record sent for linkage, no match for this cancer with BCCEDP data) or 1 (record sent for linkage, match for this cancer with BCCEDP data) to indicate linkage results. If the record was not sent for linkage, this variable is to be left blank. If the registry database record links with a BCCEDP database record, indicated by code 1 in the BCCEDP MDE Link variable, the BCCEDP MDE Link date must be completed to indicate the date the linkage occurred. Otherwise, the BCCEDP MDE Link date must be blank. **Field length:** 8 **Level:** Tumor

Part II – Revised Data Items

Data Item Number	Data Item	Description and Code
NAACCR #150	Marital Status at DX	**Added Code:** 6 Domestic Partner (same sex or opposite sex, registered or unregistered)
NAACCR #446	Multiplicity Counter	**Added Codes:** 00 No primary tumor identified 89 Multicentric, multifocal, number unknown
CCR Data Item	Pat No Contact Flag	**Added Code:** 5 VA case
	CoC Surgical Codes - Breast	**Added Code:** 76 Bilateral mastectomy for a single tumor involving both breasts as for bilateral inflammatory carcinoma
	CS Version 02.03.02	For the complete details of CSv 02.03.02, go to the CS web site: http://www.cancerstaging.org/cstage/software/index.html Detailed conversion specifications and release notes will be provided shortly. These list each of the 300 codes that can be automatically converted and the over 300 codes for which manual review by a registrar is either required or recommended.
	CS version 02.03.02 (dated 12/21/2010)	New schema: MyelomaPlasmaCellDisorder

Data Item Number	Data Item	Description and Code
	CS version 02.03.02 (dated 12/21/2010)	New site-specific factors have need added or modified as follows: MyelomaPlasmaCellDisorder, CS SSF 2, Durie-Salmon Staging System MyelomaPlasmaCellDisorder, CS SSF 3, Multiple Myeloma Terminology Testis, CS SSF 12, Postorchiectomy Alpha Fetoprotein (AFP) Lab Value Testis, CS SSF 13, Post-Orchiectomy Alpha Fetoprotein (AFP) Range Testis, CS SSF 14, Post-Orchiectomy Human Chorionic Gonadotropin (hCG) Lab Value Testis, CS SSF 15, Post-Orchiectomy Human Chorionic Gonadotropin (hCG) Range Testis, CS SSF 16, Post-Orchiectomy Lactate Dehydrogenase (LDH) Range KaposiSarcoma, CS SSF 2, Systemic Symptoms at Diagnosis KaposiSarcoma, CS SSF 3, Ulceration and Edema KaposiSarcoma, CS SSF 4, CD4 Cell Count
	CS version 02.03.02 (dated 12/21/2010)	BileDuctsIntraHepat, CS SSF 10, Tumor Growth Pattern, now required for AJCC 7 T value
	CS version 02.03.02 (dated 12/21/2010)	MyelomaPlasmaCellDisorder CS SSF 1, Janus Kinase 2 (JAK2) (also known as JAK2 Exon 12) Testis, CS SSF 11, Persistence of Elevated Serum Tumor Markers

Data Item Number	Data Item	Description and Code
		CSv02.03 SEER Change Requirements: No longer required: • SSF 11 for Testis • SSF 1 for MyelomaPlasmaCellDisorders Additionally required: • Testis: SSF 13, 15 and 16 • Breast SSF 15 • BileDuctIntrahepat: SSF 10 • MyelomaPlasmaCellDisorders: SSF 2 and 3