WCRS Coding Manual

Wisconsin Cancer Reporting System (WCRS)
Office of Health Informatics
Division of Public Health
Department of Health Services

Updated for 2016 - 2017 Diagnoses

Seventh Edition

Wisconsin
Department of Health Services

P-00832 (03/2017)

Wisconsin Cancer Reporting System
Division of Public Health
Wisconsin Department of Health Services
WCRS Coding Manual, 7th Edition
February 2017

This project was supported in part by a cooperative agreement between the Centers for Disease Control and Prevention (CDC) and the Wisconsin Department of Health Services #U58/DP12-1205

Wisconsin Cancer Reporting System on the Web:
https://www.dhs.wisconsin.gov/wcrs/index.htm
Wisconsin Cancer Reporting System Cancer Reporter's Web Page:
https://www.dhs.wisconsin.gov/wcrs/reporterinfo/index.htm

Table of Contents

ABOUT THIS MANUAL

The primary purpose of this WCRS Coding Manual is to assist Wisconsin cancer reporters in reporting cancer cases to the Wisconsin Cancer Reporting System (WCRS). If questions arise that can't be answered from the materials provided in this coding manual or other resources cited within, call or email the WCRS staff for further assistance. Please see Appendix I for WCRS staff contact information.

Since the passage of Public Law 102-515, the Cancer Registries Amendment Act, by the 102nd Congress in October 1992, there has been a tremendous effort by all national agencies collecting cancer data to unify and standardize data sets. With the establishment of the National Program of Cancer Registries (NPCR) in 1994, all central registries funded by the Centers for Disease Control and Prevention (CDC) through NPCR are required to follow stringent data management procedures; provide training for state personnel and hospital/clinic reporting staff; publish an annual report; and conduct casefinding and re-abstracting audits at randomly selected facilities.

Although WCRS began receiving CDC/NPCR funding in 1995, the registry was established in 1976 by the Wisconsin Legislature; therefore our index (reference) year is 1976. WCRS collects data that: 1) are compliant with required NPCR data elements; 2) meet standard requirements designated by the North American Association of Central Cancer Registries (NAACCR) for incidence reporting and endorsed by CDC; and 3) assist WCRS staff when assessing data quality. WCRS also uses the data to provide useful feedback to submitting facilities for quality assurance activities and administrative purposes.

The following Overview section of this manual addresses frequently asked questions about the "what, why, who, when and how" of cancer reporting.

OVERVIEW

WHAT IS THE WISCONSIN CANCER REPORTING SYSTEM (WCRS)?

The Wisconsin Cancer Reporting System (WCRS) collects and processes information on cancer cases in Wisconsin. In addition, WCRS provides data and produces reports on cancer incidence and mortality statewide and other geographic areas in Wisconsin, by gender and anatomic site (i.e., breast, lung, colon, prostate, etc.), and by stage of disease. Because of its comprehensive database of information on cancer cases in Wisconsin, WCRS serves as an important resource for citizens, health care professionals and researchers.

One of the oldest cancer registries in the country, WCRS has been collecting information on Wisconsin residents with cancer for over 40 years. The first state mandate requiring hospitals and physicians to report cancer cases diagnosed in Wisconsin was passed in 1976 by the Wisconsin State Legislature. WCRS began collecting data from Southeast Wisconsin that year. In 1978, WCRS began collecting data statewide.

In 1995, WCRS began receiving additional funding from the Centers for Disease Control and Prevention (CDC) through a cooperative agreement under the federal Cancer Registries Amendment Act. These funds have permitted WCRS to make many improvements in the collection and processing of data over the last 20 years. We have increased the number and quality of data elements collected on each cancer patient, consistent with the standards of the National Program of Cancer Registries (NPCR). Through this agreement, WCRS also began applying national standard edits to all cases diagnosed 1995 and later. WCRS data from that year forward are considered high quality and are available on public use query sites, provided to researchers, and submitted annually to CDC and other standard setters.

WHY REPORT TO WCRS?

WCRS is a population-based cancer incidence registry responsible for the collection of demographic, diagnostic and treatment information on all patients with active cancer disease, diagnosed with, or treated for cancer at hospitals, laboratories and physicians throughout Wisconsin. Submission of data is mandated under Wisconsin Statute, Chapter 255.04.

In determining case reportability, WCRS follows the rules of the Surveillance, Epidemiology and End Results (SEER) Program of the National Cancer Institute (NCI). Data items are based on fields required and/or recommended by the National Program of Cancer Registries (NPCR) for central registries collecting incidence data. Additional fields are required for quality assurance.

WCRS collects a wide variety of information that can be used for research and public health planning and evaluation. Because the Registry data are population-based for Wisconsin, they can be used to monitor cancer incidence patterns in the state.

Data collected by WCRS are used:

- ✓ to determine cancer rates and trends;
- ✓ to prepare health policy and planning;

- ✓ for research in epidemiological studies (including case-control studies);
- ✓ for evaluation of cancer control interventions;
- ✓ to identify and target high-risk populations; and
- ✓ to respond to public concerns regarding perceived excesses of cancer.

WCRS also plays an important role in research to identify the causes of cancer. Researchers have used the data to identify cancer patients who could be interviewed about possible exposures they had before they were diagnosed with cancer. These responses can be compared to interview responses of people without cancer in order to determine whether there were different exposures. One study of this kind found a possible association between alcohol intake and breast cancer. Researchers can also use WCRS data to determine whether groups of people with specific exposures, for example, those who work in a particular occupation, are more likely to develop cancer than people who do not have these exposures.

WHO REPORTS TO WCRS?

As mandated by statute, hospitals, laboratories and physicians must report information concerning any person diagnosed as having cancer or a precancerous condition to WCRS.

This includes all:

- ✓ Wisconsin hospitals
- ✓ Physicians licensed in Wisconsin working in any of the following settings:
  - Diagnostic and Treatment Centers
  - Radiation Treatment Centers
  - Ambulatory Surgery Centers
  - Nursing Homes
  - Hospice Centers
  - Clinics
  - Private physician offices
- ✓ Laboratories

Wisconsin facilities/physicians are required by law to report active primary cancers to WCRS (specific reporting requirements are described in Chapter 1). A facility may be small or large, and the extent of information submitted varies, depending on facility size, services available to the patient and the reporting methods for each facility. Some facilities have had their own cancer registries for years in accordance with the American College of Surgeons Commission on Cancer (ACoS - CoC) requirements, while others have limited registries or no registry and only provide the minimum data required by Wisconsin law.

Wisconsin cancer reporting requirements are governed by chapter 255.04, Wisconsin Statutes; Wisconsin Administrative Rule DHS 124.05(3)(h); NPCR requirements as defined under Public Law 102-515; NPCR program standards and NAACCR reporting standards. Copies of the statute, administrative rule and Public Law 102-515 are included in Appendix II.

DATA EXCHANGE AGREEMENTS

To ensure that cancer reporting in Wisconsin is as complete as possible, WCRS has established formal agreements with 46 states, including all neighboring states except Minnesota, to exchange information regarding cancer patients. The lack of reporting from the Minnesota state cancer registry is a major source of concern for WCRS since many Wisconsin residents are diagnosed and treated in that state. To reduce the effect of underreporting for Wisconsin citizens living in Western Wisconsin, WCRS also has individual data agreements with many Minnesota hospitals to collect data on Wisconsin residents seen over the border for their cancer diagnosis and/or care. There are still major gaps in reporting (for example, the Mayo Clinic facility in Rochester, MN diagnoses or treats ~1,000 Wisconsinites annually but does not share their data on those residents with WCRS). However, the data would be much less complete without the voluntary reports we do get from a large number of Minnesota hospitals. Their willingness to contribute to Wisconsin cancer control and prevention is highly appreciated.

WHAT INFORMATION IS COLLECTED ABOUT PATIENTS WITH CANCER?

When WCRS first started collecting data in 1976, only a minimal amount of information about the patient and tumor was collected. Over the years, as the population ages and knowledge about the disease increases along with continued research, the volume of cancer cases has increased and the amount of data collected for each case has also expanded. The data can be divided into two major types: information pertaining to the disease process and information about the patient. Disease-process data includes:

- ✓ anatomic site of the tumor (breast, lung, lymph nodes, etc.)
- ✓ stage of disease at the time of diagnosis
- ✓ cancer cell type (leukemia, melanoma, osteosarcoma, etc.) and
- ✓ the type of first course treatment rendered to destroy the tumor (surgery, chemotherapy, immunotherapy, etc.)

If a person is diagnosed with more than one type of cancer in his/her lifetime, this same information is collected for each new unique tumor.

WCRS also collects specific socio-demographic information on each person diagnosed with cancer consisting of, but not limited to:

- ✓ age at the time of diagnosis
- ✓ sex
- ✓ ethnicity (Hispanic or non-Hispanic)
- ✓ race
- ✓ residence at the time of diagnosis
- ✓ longest held occupation and
- ✓ place of birth

WCRS also links to the Wisconsin Annual Resident Death File and the National Death Index to add the date and cause of death for persons diagnosed with cancer that have died. In total, more than 100 different data items are collected and stored for each person in the WCRS database.

The WCRS database contains data on all malignant cancers, except basal and squamous cell skin cancers and non-invasive (in situ) cervical cancers. Malignant cancers include those with both invasive and in situ behavior. In situ cancers are very early cancers that have not extended into the organ to which they are attached or have not spread to other parts of the body, while invasive cancers have invaded into the organ or origin or spread beyond that organ. In 2004, WCRS also began collecting data on brain and nervous system tumors classified as benign or which have an uncertain behavior. While these benign tumors don't have the potential to metastasize beyond the tissue where they originated, they are treated as aggressively as if they were malignant, which is one of the main reasons the national standard setters determined that state cancer registries should start requiring those cases to be reported.

HOW ARE CANCER REPORTS SUBMITTED TO WCRS AND PROCESSED?

Electronic cancer reporting is required in Wisconsin and WCRS uses a secure Internet application, called Web Plus (a CDC application customized for Wisconsin reporting) for all data submissions. WCRS also offers, to interested facilities, a no-cost data entry software application called Abstract Plus for abstracting the required cancer cases and creating the files that are submitted using Web Plus. Abstract Plus contains all required data items and edits for state-mandated reporting and has built in on-line help features (reference manuals needed to report) and pre-populated pull down menus for many of the data items.

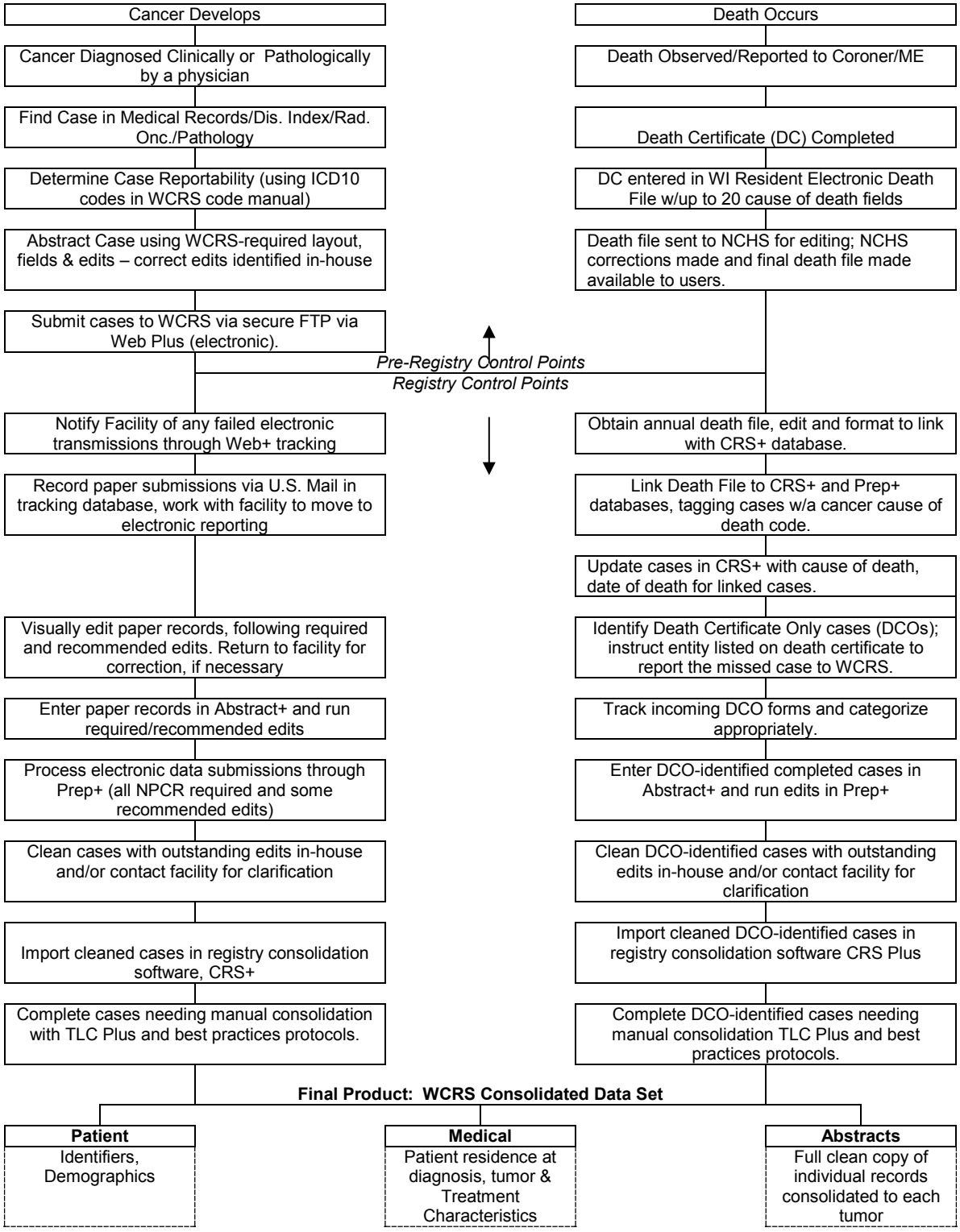
Facilities should electronically submit cancer case files to WCRS via Web Plus at least once a month for annual caseloads over 500, or quarterly for smaller annual caseloads.

Once WCRS receives the uploaded files, the data are processed through a series of computerized and manual operations before they can be used for analysis. WCRS uses CDC batch edit software and also visually edits a percentage of random sample cases.

One of the primary strengths of the WCRS data is its multiple-source reporting for diagnosed cases to ensure complete statewide coverage and completeness (patients are often seen at more than one facility for diagnosis and treatment or follow up). On average, 1.4 reports are received for each primary tumor diagnosed. All incoming reports are first electronically matched against all patients already in the WCRS database. If the incoming record does not match, it is added as a new patient/tumor in the database. For patients that do match, a second match is run to determine if the tumor reported on the incoming record is already in the database, or is a new tumor. This second tumor match is manually conducted by Certified Tumor Registrars on staff at WCRS. About 8.6 percent of all patients in the WCRS database have multiple primaries (more than one cancer in their lifetime). For some types of cancer, such as melanoma, or oral cavity and pharyngeal cancers, the number of multiple primaries for a person may be quite high.

The following chart illustrates the 'life' of a cancer report, from diagnosis to final processing.

Cancer Incidence and Mortality Data Flow 2017



WCRS staff monitor the number of cases submitted by each facility and the total number of cancer cases for a given diagnosis year. Although facilities are required to submit cases within six months (12 months for breast cancer cases) some are not received until after a year or more has passed. This can greatly affect the completeness and quality of the data WCRS includes in its publications and on-line query systems. In recent years, WCRS has been actively working to improve the timeliness and completeness of facility reporting, through reinstatement of the biannual Feedback Summary Reports and working with the American Cancer Society to acknowledge timely and complete reporting with the annual Data Merit Awards.

Once most of the data for the most recent publishable diagnosis year are received and processed, WCRS begins the annual 'death certificate only' process.

WHAT IS THE DEATH CERTIFICATE ONLY PROCESS?

When the Wisconsin Vital Records Section receives death certificates, an underlying cause of death (UCOD) is assigned based on all of the causes of death listed (up to 20 conditions can be factored in the determination of the UCOD). Any history of cancer can also be listed on the death certificate regardless of whether the person died as a direct result of the cancer. For example, the decedent died from pneumonia but was diagnosed with prostate cancer 2 years prior; the cancer is often listed on the death certificate as a 'significant' condition.

Each year, WCRS links this death file to the WCRS database to identify persons in the database who died and adds the date and cause of death to the cancer record on file. In instances when no person match is found, or when the type of cancer on the death certificate is different from that recorded in the WCRS database, then the result is a 'Death Certificate Only' (DCO) cancer, meaning the cancer was listed on the death certificate but WCRS doesn't have a record of that cancer from a reporting facility through the routine mandated data collection process. WCRS is required to follow-back with the hospital, physician or coroner listed on the death certificate to request information on that cancer diagnosis. Once a full abstract is provided, or the DCO is proven not to be reportable to WCRS (the patient was actually a resident of another state when diagnosed, for example), then the case is not called a DCO anymore and it becomes a permanent entry in the database.

This DCO process is important to improve the completeness of the data and it also identifies missing data submissions or facilities that need to improve their casefinding routines; if your facility receives a large number of DCOs from WCRS it probably means that there was 1) a failed file submission or 2) your casefinding routine is not catching all of the reportable cancers and needs to be updated. WCRS cannot use solely the information on the death certificate because the true year of diagnosis, stage of disease, histology, treatment provided and many other important pieces of information are not available on the death certificate.

Approximately 600-800 cases each year end up being DCO cases. These are the cases WCRS was not able to follow up on to complete or delete. These 'lost to follow up' DCOs are often hospice or nursing home deaths, or the physician listed on the death certificate is not associated with a Wisconsin hospital and the address on file is no longer valid.

FILE RETENTION

There is no statute governing how long cancer case abstracts or files must be kept by reporting facilities. However, WCRS recommends retaining them for at least seven years. WCRS's Abstract Plus data entry software has a backup function; the database should be backed up on a network drive routinely. Abstract Plus users can call WCRS with questions about file backup. If your facility uses a commercial cancer software product, you should contact your software representative or your information technology service department for back up instructions.

ARE THERE MEASURES OF QUALITY APPLIED TO THE CANCER REGISTRY?

The following three national indicators commonly measure the quality of cancer reporting:

- ✓ the percentage of cases reported by death certificates only;
- ✓ the percentage of cases confirmed microscopically; and
- ✓ the percentage of cases with nonspecific diagnoses.

The number of "death certificate only" cases gives an indication of the completeness of casefinding within a facility. The number of microscopically confirmed cases and the number with nonspecific diagnoses (unknown primary site, subsite or cell type) measure the accuracy of the diagnostic information provided. A high percent of cases without microscopic confirmation or with nonspecific diagnoses can point to inadequate medical record abstracting and reporting or the diagnostic work-ups may not have been as complete as they could have been.

WCRS uses the indicators below, along with the national indicators, to also measure data quality and identify areas for improved reporting from individual facilities:

- ✓ the percent of cases reported with only a PO Box for the street address;
- ✓ unknown stage at diagnosis;
- ✓ unknown maiden name;
- ✓ unknown race.

WCRS measures the timeliness of the cases submitted:

- ✓ Percent of cases received within six months
- ✓ Percent of cases received within nine months
- ✓ Percent of cases received within 12 months
- ✓ Percent of cases received after 12 months.

Lastly, WCRS measures the completeness of the number of cases submitted by diagnosis year against the estimated annual caseload for each facility:

- ✓ 100% of annual estimated caseload submitted
- ✓ 95% of annual estimated caseload submitted
- ✓ 90% of annual estimated caseload submitted
- ✓ <90% of annual estimated caseload submitted

WCRS provides biannual Feedback Summary Reports to all reporting facilities that focus on timeliness, completeness and a select number of data quality indicators, as mentioned above.

IS IT NECESSARY TO SUBMIT CORRECTIONS OR CHANGES TO RECORDS?

The change/correction procedure ensures that the most accurate information is available to users by enabling reporting facilities to provide updated or corrected information to WCRS after the original case has been transmitted.

Example #1: At the time a case was reported to WCRS, the primary site was unknown. On a subsequent admission several months later, the primary site was documented as upper lobe of the left lung. An update should be submitted to revise the primary site, laterality and any other information that may have become available.

Example #2: A case was submitted stating the patient's primary site was a cervical lymph node and the morphology was an adenocarcinoma. Because a lymph node is a secondary site (a metastatic site) of an adenocarcinoma, the facility would be contacted to request further review of the patient's medical record in order to determine the actual primary site of this malignancy.

Example #3: A case was reported before the radiation treatment was started or completed. Update the abstract and resubmit to WCRS with updated radiation treatment information.

A representative from WCRS might contact a reporting facility when questionable or inconsistent information is received or when required data fields are missing. In addition to correcting the information in the software being used at the facility, corrected information must be provided to WCRS as soon as possible. Registrars are encouraged to obtain the most accurate and complete information for each case.

More details on how to submit a change are in Chapter 3, page C3-24.

WHAT IS THE DIFFERENCE BETWEEN WCRS AND HOSPITAL DISCHARGE FILES?

Hospitals report many of the same data items on the same patients to different agencies and this can be burdensome. It is important to understand the different uses and needs of the data collected through the cancer reporting statute, 255.04 and Chapter 153, which contains the mandate for hospital discharge data collection.

The Wisconsin Hospital Association (WHA) maintains a database of all hospital discharges in Wisconsin. This is a valuable source of information on treatment, cost and patterns of care related to cancer. Cancer patients may be admitted to the hospital many times over the course of their treatment and recovery. Often, a patient is seen at several different hospitals over the course of several years.

WCRS counts the number of primary tumors diagnosed in a person's lifetime, not the number of hospital admissions that person had for any particular cancer. Counting tumors is not possible with the WHA data, because the discharge files do not contain important clinical information needed to determine whether a cancer is a new tumor or a recurrence. In addition, many data

elements important for studying cancer—such as stage at diagnosis, histology, behavior and laterality—are not available in the discharge files.

WHAT DOES WCRS DO TO PROTECT PRIVACY?

Per Wisconsin Statute 255.04(3), "Any information reported to the department under sub. (1) or (5) which could identify any individual who is the subject of the report or the person submitting the report shall be confidential and may not be disclosed by the department." See Appendix II for more information on state statute and federal law protecting confidentiality.

WCRS policy identifies the following required data items as confidential:

1. Patient name
2. Street address
3. Date of birth
4. Social security number
5. Patient medical record number
6. Cancer registry patient accession number (assigned by facility)
7. Name of physician
8. Date of death
9. Death certificate number

In addition, WCRS policy identifies the following combinations of data items as potentially identifying, based on the number of items combined and the size of the geographic area being analyzed.

1. Race
2. Age
3. Sex
4. Year of diagnosis
5. Cancer site
6. Cancer cell type
7. Geographic area

Policies and procedures are in place to protect every patient's privacy. Access to WCRS work areas is restricted and all WCRS employees sign confidentiality agreements and conduct annual training on handling confidential information. Statute and policies govern the release of data to outside investigators. All research studies involving data with patient identifiers must comply with Wisconsin Statute, Chapter 255.04(3)(c),(8),(9) and (10) and be approved by the Division of Public Health's Data Governance Board. Individual-level data without identifiers for small geographic areas are also protected by data release policies. Statistics for areas smaller than the county level are only released when there are enough cases in the area to guard against revealing confidential information about an individual. When there are fewer than six cases of a particular type of cancer in small area, for example, four cases of bladder cancer, then the exact number of cases is not revealed.

The Health Insurance Portability and Accountability Act known as HIPAA allows for the reporting of identifiable cancer data to public health entities. Because the Wisconsin Cancer Reporting System falls under the definition of a public health authority, HIPAA allows your facility to continue reporting cancer incidence data in compliance with Wisconsin Statute 255.04 and Administrative Rule DHS 124.05(3) (h). Written informed consent from each cancer patient reported to public health entities is not required under HIPAA, nor is a Business Associate Agreement required; rather, facilities must document that reporting has occurred.

WHAT KIND OF DATA DOES WCRS RELEASE?

Deidentified data are submitted annually to NAACCR for Registry Certification and publication in *Cancer in North America* (CINA). Registries whose data meet established criteria for timeliness, accuracy and completeness are recognized annually as NAACCR Certified registries. WCRS is recognized as a NAACCR Gold-Certified registry. WCRS also submits data annually to CDC for inclusion in the *United States Cancer Surveillance* annual publication and is recognized as a "Registry of Excellence." CDC provides deidentified Wisconsin data to other national and international organizations for use in their public use data query systems and publications.

WCRS data are also available online on the Division of Public Health's Wisconsin Interactive Statistics on Health (WISH) website at https://www.dhs.wisconsin.gov/wish/cancer/index.htm and the Cancer-Rates.info site, http://www.cancer-rates.info/wi/index.php. Data are available by cancer incidence, mortality, stage of disease at the time of diagnosis and geographic locations within Wisconsin.

Periodically, WCRS produces exclusive special reports and collaborative reports that include more detailed data than are available online. These can be found on the WCRS web site: https://www.dhs.wisconsin.gov/wcrs/publications.htm . Examples of exclusive reports include "Wisconsin Cancer Survival" and "Breast Cancer Disparities between African American and White Women in Wisconsin." The Wisconsin Facts and Figures (WCRS and the American Cancer Society Midwest Division) is our most frequently used collaborative report.

WCRS also releases confidential data to qualified researchers when all statutory requirements have been met and the request has been approved by the Data Governance Board. More details on how to apply are available at: https://www.dhs.wisconsin.gov/wcrs/researcherinfo.htm

Chapter 1

DETERMINING REPORTABILITY

Before reporting a newly diagnosed cancer, one must be able to determine if the case is reportable to the State. This chapter will provide you with the information needed to make that determination.

Casefinding Techniques

Reportable cases may come from a variety of sources. The hospital pathology laboratory can provide cases diagnosed by histology, cytology, hematology, bone marrow or autopsy. Other resources include daily discharges, ICD-10-CM coding logs, disease indices, inpatient and outpatient surgery logs, radiotherapy consults, treatment reports and logs, oncology clinic treatment reports and Current Procedural Terminology (CPT) codes and logs. Never rely solely on the pathology department to provide reportable cases. Doing so could exclude cases for which the facility has no diagnostic tissue reports. Cases diagnosed elsewhere but treated at your facility and those diagnosed radiographically or clinically only, without tissue confirmation, would be missed during casefinding unless additional resources are employed. It is essential to include review of the disease index (usually provided by Health Information Management (HIM)/Medical Records). Other tracking tools such as medical and radiation oncology clinic logs can help to ensure that all reportable cases are identified. It would be advisable to form an alliance with staff from the aforementioned HIM, radiation oncology and pathology departments. This will help to establish and develop a systematic method to routinely receive necessary information from them.

Cases That Must Be Reported

Refer to the Disease Index Codes list beginning on page C1-7 when casefinding. (Not all ICD-10-CM codes listed will need to be used by all facilities, depending on the type of facility.)

1. Cases diagnosed on or after January 1, 1976, for hospitals, or on or after January 1, 1992, for all nonhospital reporting entities (clinics/physician offices, etc.).

2. Patients whose residence at diagnosis is in Wisconsin **or** anywhere else. WCRS has data exchange agreements with 46 states and two U.S. territories. These other states provide WCRS with reports on Wisconsin residents and we provide them with reports on their residents. Interstate data exchange is a NPCR requirement.

3. Cases with diagnosis codes specified on the ICD-10-CM reportable list that meet the reportable criteria established by WCRS.

4. Invasive or *in situ* (noninvasive) malignancies (behavior code of /2 or /3 in the ICD-O-3 coding manual).

5. Beginning with cases diagnosed on or after January 1, 2002, the following types of squamous neoplasia are reportable to WCRS (per NPCR requirement):

Squamous Intraepithelial Neoplasia, Grade III (ICD-O3 histology 8077/2)	**ICD-O-3 Site Code**	**ICD-10-CM Code**
Anal Intraepithelial Neoplasia - AIN III	C21.1	D01.3
Vulvar Intraepithelial Neoplasia - VIN III	C51.x	D07.1
Vaginal Intraepithelial Neoplasia - VAIN III	C52.x	D07.2

6. Beginning with cases diagnosed on or after January 1, 2004, non-malignant primary intracranial and central nervous system (CNS) tumors are required to be reported:

Topography Codes for Benign Brain Tumors		
Description	**ICD-O3 Site Code**	**ICD-10-CM Code**
Meninges	C70.0 – C70.9	D32.0, D32.1, D32.9
Brain	C71.0 – C71.9	D33.0 – D33.2
Spinal Cord, Cranial Nerves, Other parts of CNS	C72.0 – C72.5, C72.8, C72.9	D33.3, D33.4, D33.7, D33.9
Other Endocrine Glands and Related Structures	C75.1 – C75.3	D35.2 - D35.4

7. Beginning with cases diagnosed on or after January 1, 2010, the following hematopoietic diseases are reportable to WCRS:

Terms and Codes Changing from Nonreportable to Reportable	**ICD-10-CM Code || ICD-O-3 Histology Code**
Chronic Lymphoproliferative disorder of NK-cells or T-cell large granular lymphocytic leukemia	C91Z0 – C91Z2 || 9831/3
Langerhans cell histiocytosis, NOS, unifocal or multifocal	D76.1-D76.3 || 9751/3
Myelodysplastic/Myeloproliferative neoplasm, unclassifiable or Myeloproliferative disease, NOS or Myeloproliferative neoplasm unclassifiable	D46 || 9975/3

8. Beginning with cases diagnosed on or after January 1, 2015, the following diseases are reportable to WCRS:

New Reportable Terms	ICD-10-CM Code || ICD-O-3 Histology Code
Non-invasive mucinous cystic neoplasm of the pancreas with high-grade dysplasia replaces mucinous cystadenocarcinoma, non-invasive	D01.7 || 8470/2
Solid pseudopapillary neoplasm of pancreas is synonymous with solid pseudopapillary carcinoma	C25.0-C25.9 || 8452/3
Based on expert pathologist consultation, metastases have been reported in some cystic pancreatic endocrine neoplasm (CPEN) cases. With all other pancreatic endocrine tumors now considered malignant, CPEN will also be considered malignant, until proven otherwise. Most CPEN cases are non-functioning and are REPORTABLE using histology code 8150/3, unless the tumor is specified as a neuroendocrine tumor, grade 1 (assign code 8240/3) or neuroendocrine tumor, grade 2 (assign code 8249/3)	C25.0-C25.9 || 8150/3 8240/3 8249/3
Laryngeal intraepithelial neoplasia, grade III (LINIII)	D02.0 || 8077/2
Squamous intraepithelial neoplasia, grade III (SINIII), except Cervix and Skin	C15.9 || 8077/2
Mature teratoma of the testes in **adults** is reported as malignant • Adult is defined as post-puberty. • Pubescence can take place over a number of years. • Do not rely solely on age to indicate pre- or post-puberty status. Review all information (physical history, etc.) for documentation of pubertal status. When testicular teratomas occur in adult males, pubescent status is likely to be stated in the medical record because it is an important diagnostic factor. • Do not report if unknown whether patient is pre- or post-pubescence. When testicular teratoma occurs in a male and there is no mention of pubescence, it is likely that the patient is a child, or pre-pubescent, and the tumor is benign.	C62.x || 9080/3
Gastrointestinal stromal tumors (GIST), while frequently nonmalignant, must be reported and assigned behavior code /3 if they have multiple foci, metastasis or positive lymph nodes.	ICD-O3 histology code 8936/3

10. New/Updated ICD-10-CM Casefinding Codes for 2016 and 2017 (effective October 2016 and forward):

C49.A0	Gastrointestinal stromal tumor, unspecified site.
C49.A1	Gastrointestinal stromal tumor of esophagus.
C49.A2	Gastrointestinal stromal tumor of stomach.
C49.A3	Gastrointestinal stromal tumor of small intestine.
C49.A4	Gastrointestinal stromal tumor of large intestine.
C49.A5	Gastrointestinal stromal tumor of rectum.
C49.A9	Gastrointestinal stromal tumor of other sites.
Z19.1	Hormone sensitive malignancy status.
Z19.2	Hormone resistant malignancy status. Castrate resistant prostate malignancy status.
R97.20	Elevated prostate specific antigen [PSA].
R97.21	Rising PSA following treatment for malignant neoplasm of prostate.
C81.10	Nodular sclerosis Hodgkin lymphoma unspecified site.
C81.11	Nodular sclerosis Hodgkin lymphoma, lymph nodes of head, face, and neck.
C81.12	Nodular sclerosis Hodgkin lymphoma, intrathoracic lymph nodes.
C81.13	Nodular sclerosis Hodgkin lymphoma, intraabdominal lymph nodes.
C81.14	Nodular sclerosis Hodgkin lymphoma, lymph nodes of axilla and upper limb.
C81.15	Nodular sclerosis Hodgkin lymphoma, lymph nodes inguinal region, lower limb.
C81.1	Nodular sclerosis Hodgkin lymphoma, intrapelvic lymph nodes.
C81.17	Nodular sclerosis Hodgkin lymphoma, spleen.
C81.18	Nodular sclerosis Hodgkin lymphoma, lymph nodes of multiple sites.
C81.19	Nodular sclerosis Hodgkin lymphoma, extranodal and solid organ sites.
D47.Z2	Castleman disease. Code also if applicable human herpesvirus 8 infection (B10.89). Excludes Kaposi's sarcoma (C46-).

11. Continued use of the ICD-O-3 histology code crosswalk to identify the correct ICD-O-3 term to use for selected histologies is required. The crosswalk (taken from the NAACCR Guidelines for ICD-O-3 Update Implementation) is included as Appendix VIII.

12. **Hospital requirement**: Patients with a reportable cancer that was diagnosed and received first-course therapy at another facility that are now seen at your facility for diagnosis and/or treatment of recurrent or metastatic disease. Record all available information regarding the **original** diagnosis, the stage **at diagnosis** and the **original** first-course treatment, if information is available. Do **not** provide information on the recurrence or metastatic treatment.

    Example 1: Patient was originally diagnosed with prostate cancer in 2006 at another facility and is admitted to your facility in 2015 with a questionable chest x-ray. A biopsy shows metastatic adenocarcinoma consistent with a prostate

primary. **THIS CASE IS REPORTABLE**. Report all information you have on the **ORIGINAL** prostate cancer diagnosis, staging and treatment.

Example 2: Patient with a history of breast cancer diagnosed and treated elsewhere five years ago is admitted to your facility's ER for a broken hip. The patient was not diagnosed with a recurrence or treated for her breast cancer during this admission. **THIS CASE IS NOT REPORTABLE**.

13. **Hospital requirement**: All active primary cancers.

14. **Hospital requirement**: Patients who die at your facility with **active** cancer, who were neither diagnosed nor treated at your facility, are also reportable.

15. **Nonhospital requirement**: Patients treated at your facility – this type of case is always reportable by the nonhospital facility.

16. **Nonhospital requirement**: Patients clinically diagnosed at your facility but NOT treated at your facility - this case is only reportable when the patient is NOT referred to a WISCONSIN hospital. (If your facility did not treat the patient and referred the case to a Wisconsin hospital, you do not need to report it to WCRS.)

17. Basal cell carcinomas (histology codes 8090 – 8110) and squamous cell cancers (8050 – 8084) that originate in mucoepidermoid sites:

SITE	ICD-O-3 SITE CODE	ICD-10 CODE
Lip	C00.0-C00.9	C00.0 – C00.9
Anus	C21.0	C21.0
Vulva	C51.0-C51.9	C51.0 - C51.9
Vagina	C52.9	C52
Penis	C60.0- C60.9	C60.0 – C60.9
Scrotum	C63.2	C63.2

Note: Basal and squamous cell carcinomas of **skin** are NOT reportable to WCRS.

18. Malignant tumors of the **skin** such as adnexal carcinoma/ adenocarcinoma (8390/3-8420/3), adenocarcinoma, lymphoma, melanoma, sarcoma, and Merkel cell tumor **ARE** reportable. Any carcinoma arising in a hemorrhoid is reportable, since hemorrhoids arise in mucosa, not in the skin.

19. Pilocytic/juvenile astrocytoma is reported as a malignant cancer even though the behavior code changed to borderline malignant in the ICD-O-3 coding manual. NPCR requires state registries to collect these cases as malignant with behavior code /3.

20. WCRS only requires casefinding for the "Reportable Neoplasms" as listed on the SEER web site https://seer.cancer.gov/tools/casefinding/; WCRS recommends, but does not require, that facilities also review cases from the SEER supplemental list. Casefinding lists for cancers diagnosed before 2016 can also be found on the SEER web site.

Please note: For reportable cases which your facility did not diagnose and/or treat – WCRS is aware that a facility might not have enough information to enter specific codes for treatment or staging besides 'unknown' or 'not available in chart' but could document additional information, as stated by physicians or otherwise noted in the chart, in the appropriate text fields. These types of nonanalytic cases are required by central cancer registries to ensure complete incidence reporting for the state's population. It is a 'catchment' requirement to cover instances when the facility diagnosing or treating the patient does not report the case as required to the central cancer registry.

Refer to Appendix III for more details on differences for hospitals and nonhospital reporting.

Disease Index Codes for Casefinding 2016 and 2017 (effective 10/1/2016)

The following codes and/or code ranges are required cases for state reporting. The list is in ICD-10-CM order. Please note that the ICD-10-CM codes are not as detailed as the ICD-O3 site/histology code combinations. Upon review, a reporter may determine that a potentially reportable case with a code in this table may not be truly reportable. The casefinding list is a starting place for determining reportable status, but full review of the medical chart is needed to make the final determination.

REPORTABLE CASES

ICD-10-CM	Diagnosis [with preferred ICD-O-3 terminology]
C00.0 – C43.9	Malignant neoplasms stated or presumed to be primary (of the specified site) and certain specified histologies
C4A.0 – C4A.9	Merkel cell carcinoma
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip (excludes basal and squamous cell)
C44.10x, C44.19x	Unspecified/other malignant neoplasm of eyelid, including canthus (excludes basal and squamous cell)
C44.20x, C44.29x	Unspecified/other malignant neoplasm of ear and external auricular canal (excludes basal and squamous cell)
C44.30x, C44.39x	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face (excludes basal and squamous cell)
C44.40, C44.49	Unspecified/other malignant neoplasm of scalp and skin of neck (excludes basal and squamous cell)
C44.50x, C44.59x	Unspecified/other malignant neoplasm of skin of trunk, except scrotum (excludes basal and squamous cell)
C44.60x, C44.69x	Unspecified/other malignant neoplasm of skin of upper limb, including shoulder (excludes basal and squamous cell)
C44.70x, C44.79x	Unspecified/other malignant neoplasm of skin of lower limb, including hip (excludes basal and squamous cell)
C44.80, C44.89	Unspecified/other malignant neoplasm of other specified sites of skin (excludes basal and squamous cell)
C44.90, C44.99	Unspecified/other malignant neoplasm of skin, site unspecified (excludes basal and squamous cell)
C45.0 - C96.9	Malignant neoplasms stated or presumed to be primary (of the specified site) and certain specified histologies
D00.0 – D09.9	Carcinoma *in situ*
D18.02	Hemangioma of intracranial structures and any site
D18.1	Lymphangioma of brain, other parts of nervous system or endocrine glands
D32.x	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.x	Benign neoplasm brain and other parts of central nervous system
D35.2 – D35.4	Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, rathke's pouch, sella turcica, pineal gland, pineal body

ICD-10-CM	Diagnosis [with preferred ICD-O-3 terminology]
D42.0 – D43.9	Neoplasm of uncertain behavior of the brain & spinal cord, meninges, endocrine glands & other & unspecified parts of nervous system
D44.3 – D44.5	Neoplasm of uncertain behavior of the pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera [ICD-O3 9950/3] *ICD-10-CM Coding instruction note: Excludes familial polycythemia (ICD-10-CM C75.0), secondary polycythemia (ICD-10-CM D75.1)*
D46.0	Refractory neutropenia [ICD-O3 9991/3] or Refractory thrombocytopenia [ICD-O3 9992/3] or listed as refractory anemia without ring sideroblasts
D46.1 – D46.2	Refractory anemia with ringed sideroblasts [ICD-O3 9982/3] or refractory anemia with excess of blasts [ICD-O3 9983/3]
D46.4	Refractory anemia [ICD-O3 9980/3]
D46.9	Myelodysplastic syndrome, unclassifiable/unspecified [ICD-O3 9989/3]
D46A, D46B	Refractory cytopenia with multilineage dysplasia [ICD-O3 9985/3]
D46C	Myelodysplastic syndrome with 5q- syndrome [ICD-O3 9986/3]
D46.Z	Other myelodysplastic syndromes
D47.1	Chronic myeloproliferative disease [ICD-O3 9963/3] *ICD-10-CM Coding instruction note: Excludes the following: Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_), Chronic myeloid leukemia BCR/ABL-positive (C92.1_), Myelofibrosis & Secondary myelofibrosis (D75.81), Myelophthisic anemia & Myelophthisis (D61.82)*
D47.3	Essential thrombocythemia [ICD-O3 9962/3] *Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia*
D47.4	Osteomyelofibrosis [ICD-O3 9961/3] *Includes: Chronic idiopathic myelofibrosis, Myelofibrosis (idiopathic) (with myeloid metaplasia), Myelosclerosis (megakaryocytic) with myeloid metaplasia), Secondary myelofibrosis in myeloproliferative disease*
D47.Zx	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified [ICD-O3 9960/3, 9970/1, 9971/3, or 9931/3]
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified [ICD-O3 9970/1 or 9931/3]
D49.6, D49.7	Neoplasms of unspecified behavior of brain, endocrine glands and other CNS
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

ADDITIONAL DETAIL FOR SELECT HEMATOPOIETIC CASES

(These codes are included in the above reportable table code ranges)

C84.4, C84.A	Primary cutaneous gamma-delta T-cell lymphoma [ICD-O3 9726/3]
C82.6	Primary cutaneous follicle centre lymphoma [ICD-O3 9597/3]
C83.3	T-cell/histiocyte rich large B-cell lymphoma [ICD-O3 9688/3] or Intravascular large B-cell lymphoma [ICD-O3 9712/3] or Plasmablastic lymphoma [ICD-O3 9735/3]
C84.6	ALK positive large B-cell lymphoma [ICD-O3 9737/3]
C84.Z	Hydroa vacciniforme-like lymphoma [ICD-O3 9725/3]
C85.8	Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease [ICD-O3 9738/3]
C88.0	Macroglobulinemia (Waldenstrom's macroglobulinemia) [ICD-O3 9761/3]
C88.2, C88.3	Gamma heavy chain disease; Franklin's disease [ICD-O3 9762/3]
C90.2, C90.3	Extramedullary plasmacytoma [ICD-O3 9734/3], Solitary plasmacytoma [ICD-O3 9731/3]
C91Z	B lymphoblastic leukemia/lymphoma NOS [ICD-O3 9811/3] or B lymphoblastic leukemia/lymphoma with: t(9;22)(q34;11.2); BCR-ABL1 [ICD-O3 9812/3] or B lymphoblastic leukemia/lymphoma with t(v;11q23); MLL rearranged [ICD-O3 9813/3] or B lymphoblastic leukemia/lymphoma with t(12;21)(p13;q22); TEL-AML1 (ETV6-RUNX1) [ICD-O3 9814/3] or B lymphoblastic leukemia/lymphoma with hyperdiploidy [ICD-O3 9815/3] or B lymphoblastic leukemia/lymphoma with hypodiploidy (hypodiploid ALL) [ICD-O3 9816/3] or B lymphoblastic leukemia/lymphoma with t(5;14)(q31;q32);IL3-IGH [ICD-O3 9817/3] or B lymphoblastic leukemia/lymphoma with t(1;19)(q23;p13.3);E2A PBX1 (TCF3 PBX1) [ICD-O3 9818/3] or T lymphoblastic leukemia/lymphoma [ICD-O3 9837/3] or Chronic lymphoproliferative disorder of NK-cells [ICD-O3 9831/3] or T-cell large granular lymphocytic leukemia [ICD-O3 9831/3]
C92.0	Acute myeloid leukemia with t(6;9)(p23;q34) DEK-NUP214 [ICD-O3 9865/3] or

	Acute myeloid leukemia with inv(3)(q21,q26.2) [ICD-O3 9869/3] or Acute myeloid leukemia with t(3;3)(q21;q26.2); RPN1EVI1 [ICD-O3 9869/3] or Acute myeloid leukemia with (megakaryoblastic) with t(1;22)(p13;q13); RBM15-MKL1 [ICD-O3 9911/3] or Therapy-related myelodysplastic syndrome [ICD-O3 9920/3]
C92.Z	Myeloid leukemia associated with Down's Syndrome [ICD-O3 9898/3] or Myeloid and lymphoid neoplasms with FGFR1 abnormalities [ICD-O3 9967/3] or Myeloid and lymphoid neoplasms with PDGFRB rearrangement [ICD-O3 9965/3] or Myeloid and lymphoid neoplasms with PDGFRB arrangement [ICD-O3 9966/3]
C94.4	Acute panmyelosis with myelofibrosis [ICD-O3 9931/3]
C94.8	Hypereosinophilic syndrome (9964/3), also called chronic eosinophilic leukemia
C95.0	Mixed phenotype acute leukemia with t(9;22)(q34;11.2); BCR-ABL1 [ICD-O3 9806/3] or Mixed phenotype acute leukemia with t(v;11q23); MLL rearranged [ICD-O3 9807/3] or Mixed phenotype acute leukemia, B/myeloid NOS [ICD-O3 9808/3] or Mixed phenotype acute leukemia, T/myeloid NOS [ICD-O3 9809/3]
C96.2	Systemic mastocytosis [ICD-O3 9741/3]
C96.4	Fibroblastic reticular cell tumor [ICD-O3 9759/3]
C96.5, C96.6	Langerhans cell histiocytosis, NOS or Langerhans cell histiocytosis, unifocal or Langerhans cell histiocytosis, multifocal [ICD-O3 9751/3]

Nonreportable Cases

1. Any skin cancer of the following types: malignant neoplasms, NOS; epithelial carcinomas, papillary and squamous cell carcinomas or basal cell carcinomas; ICD-O3 histology codes 8000-8110. (Skin cancers with ICD-O3 histologies higher than 8110 *are* reportable.)

2. Patients who have a **history** of cancer but no diagnosis or treatment at your facility.

3. Records, slides or patients seen only in consultation to confirm a diagnosis; no chart is created in your facility for this case. (If a chart is created, it is a reportable case.)

4. Pathology cases that are consultative readings of slides submitted from outside facilities.

   Exception*: If the outside facility is an out-of-state facility or pathology laboratory, then that case is reportable.*

5. Patients with carcinoma *in situ* (non-invasive) of the cervix, cervical intraepithelial neoplasia (CIN) diagnosed on or after January 1, 2001 or prostatic intraepithelial neoplasia (PIN) diagnosed on or after January 1, 2003.

6. Patients with a pre-cancerous condition or benign tumor NOT described in #6 on page C1-2.

7. Patients diagnosed before 1976 (hospital) or before 1992 (nonhospital facility).

8. Metastatic sites or recurrences of a primary cancer that was already reported by your facility.

Ambiguous Diagnostic Terms

A patient has a reportable malignancy when stated by a recognized medical practitioner. The medical record usually presents the diagnosis clearly; however, physicians sometimes use vague or ambiguous terms to describe a tumor when its behavior is uncertain. This may occur in the absence of a cytologic/histologic diagnosis, as well as when there is a cytologic/histologic diagnosis.

Reporting requirements depend on the term used. Some malignancies may be first diagnosed clinically with ambiguous terms. Reportable terms must always include a reference to malignancy, cancer, etc. (Exception: non-malignant primary intracranial and central nervous system tumors.)

Reportable Ambiguous Terms

1. Apparent(ly)
2. Appears
3. Comparable with
4. Compatible with
5. Consistent with
6. Favors
7. Malignant appearing
8. Most likely
9. Presumed
10. Probably
11. Suspect(ed)
12. Suspicious (for)
13. Typical of
14. Tumor or Neoplasm*

*beginning with 2004 diagnoses and only for the reportable benign tumors (page C1-2)

Example 1: Discharge summary/diagnoses and X-ray results report "CT of the chest ***compatible with*** carcinoma of left lung." Although there may be no further work-up or treatment, the case is clinically diagnosed and is reportable.

Example 2: Barium enema (BE) reveals a suspicious sigmoid mass. Colonoscopy reveals a sigmoid mass, "***questionable*** malignant neoplasm." The patient is referred for biopsy and colon resection at another facility revealing carcinoma. The case is NOT reportable for your facility because mass and neoplasm are not associated with a reportable malignant term, whereas if it had been stated "*suspicious* sigmoid mass, *probable* malignant neoplasm," for example, it would be reportable.

Exception: Do not report cytology suspicious for malignancy, unless confirmed by biopsy or the physician states that the case supports a malignant diagnosis.

Nonreportable Ambiguous Terms**

1. Approaching
2. Cannot be ruled out
3. Equivocal
4. Possible
5. Potentially malignant
6. Questionable
7. Rule out
8. Suggests
9. Very close to
10. Worrisome

**Unless additional information is available

Please note: Physicians are not aware or trained on these lists of reportable and nonreportable ambiguous terminology. It is important to introduce these terms to your physicians to clarify how they are used to determine the reportable status of your facility's cancer cases.

Chapter 2

DETERMINING THE NUMBER OF PRIMARY TUMORS

(Adapted from the National Cancer Institute's Multiple Primary and Histology Rules)

Now that you've learned how to determine if a case is reportable, you must next determine if the case is a single or a multiple primary. Use the following rules when abstracting cases diagnosed January 1, 2007, and later.

The 2007 Multiple Primary and Histology (MP/H) Coding Rules, sponsored by the National Cancer Institute (NCI) Surveillance Epidemiology and End Results (SEER) Program, present site-specific multiple primary and histology rules that promote consistent and standardized coding by cancer registrars.

The rules include site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, benign central nervous system (CNS) tumors and malignant CNS tumors. A separate set of rules addresses the specific and general rules for malignant solid tumors originating in all other sites. The multiple primary rules standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions. For example, there are instructions and guidance for identifying histologic lineages, differentiating between general (NOS) terms and specific histologic types, and correctly assigning mixed and combination codes.

The rules are available in three formats: flowchart, matrix and text. The different formats were developed to meet the needs of registrars who have different learning styles. The manual can be downloaded at http://seer.cancer.gov/tools/mphrules/download.html Please make sure the version downloaded was revised 8/24/2012 (latest revision).

> **Note:** The MP/H rules do not apply to hematopoietic/lymphoid primaries (lymphoma, leukemia and other blood disorders). Use the hematopoietic database web site at http://seer.cancer.gov/seertools/hemelymph/ to determine single/multiple primaries for these primary cancers. This website also allows you to check the reportable status of all hematopoietic/lymphoid diseases.

Definitions

Note: *Use the terms and definitions in the following table for all reportable cases except hematopoietic primaries (ICD-O-3 histology codes 9590-9989).*

Bilateral	Relating to the right **and** left sides of the body or of a body structure; bilaterality is **not** an automatic indication of single or multiple primaries; consult the site-specific instructions.
Clinical Diagnosis	A diagnosis that is not microscopically confirmed. It may be based on information from diagnostic imaging or the clinician's expertise.
Contiguous tumor	A single tumor that involves, invades, or bridges adjacent or connecting sites or subsites.
Focal	An adjective meaning limited to one specific area. A focal cancer is limited to one specific area or organ. The area may be microscopic **or** macroscopic.
Foci	Plural of focus.
Focus	A term used by pathologists to describe a group of cells that can be **seen only by a microscope**. The cells are noticeably different from the surrounding tissue by their appearance, chemical stain, or other testing.
Laterality	Indication of which side of a **paired organ/site** a tumor is located. (See **Paired organ/site** below.)
Most representative specimen	The pathologic specimen from the surgical procedure that removed the most **tumor** tissue.
Multiple primaries	More than one reportable case for the same patient.
Overlapping tumor	The involved sites are adjacent (next to each other) and the tumor is contiguous.
Paired organ/site	There are two sides, one on the left side of the body and one on the right side of the body. (See **Laterality** above.)
Recurrence *This term has two meanings*:	1. The reappearance of disease that was thought to be cured or inactive (in remission). Recurrent cancer starts from cancer cells that were not removed or destroyed by the original therapy. 2. A new occurrence of cancer arising from cells that have nothing to do with the earlier (first) cancer. A new or another occurrence, incidence, episode, or report of the same disease (cancer) in a general sense – a new occurrence of cancer.
Single primary	One reportable case for a patient.
Unilateral	Relating to one side of the body or one side of a body structure.

Determining Multiple Primaries for Solid Malignant Tumors–General Instructions

1. Use these rules to determine the number of reportable primary sites. Do **not** use these rules to determine case reportability, stage, or grade.

2. The 2007 multiple primary and histology coding rules **replace all previous** multiple primary and histology coding rules.

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

4. Read the **General Instructions** and the **site-specific Equivalent Terms and Definitions** in the MPH manual before using the multiple primary rules.

5. The multiple primary and histology coding rules are available in **three formats**: flowchart, text, and matrix. The **rules are identical;** only the formats differ. Examples are given in three different formats later in this chapter so you can use the rules in the format that is easiest for you to follow.

6. **Notes** and **examples** are included with some of the rules to **highlight key points** or to add **clarity** to the rules.

7. **Do not use** a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary. Use the multiple primary rules as written **unless** a **pathologist compares** the present tumor to the "original" tumor and states that this tumor is a recurrence of cancer from the previous primary.

8. Determining Multiple Primaries: hematopoietic (Lymphoma and Leukemia), use the hematopoietic website at http://seer.cancer.gov/seertools/hemelymph/.

How to Use the Multiple Primary Rules

1. **Use** the **Multiple Primary** rules to **make a decision on the number of primary malignancies** to be abstracted for reportable solid malignant tumors.

2. Use the **site-specific rules** for the following primary sites:

- Brain, malignant (intracranial & CNS)
- Brain and other CNS, benign
- Breast
- Colon
- Head and neck
- Kidney
- Lung
- Melanoma of the skin, malignant
- Renal pelvis, ureter, bladder, and other urinary

3. Use the **Other Sites rules** for solid malignant tumors that occur in primary sites not covered by the site-specific rules.

4. Each module is an independent, complete set of coding rules.
   I. Unknown if Single or Multiple Tumors
   II. Single Tumor
   III. Multiple Tumors

   a. When there is no tumor in the primary site, only metastatic lesions are present:
      I. Use the primary site documented by a physician and use the multiple primary and histology coding rules for that primary site.
      II. If no primary site is documented, code the primary site as unknown and use the general multiple primary and histology coding rules. Use the "Unknown if Single or Multiple Tumors" module to determine multiple primaries and the "Single Tumor" module for coding histology.
   b. To choose the appropriate module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors),
      I. Use the multiple primary and histology coding rules for the primary site.
      II. Determine the number of tumors:
         i. Do not count metastatic lesions.
         ii. When the tumor is only described as multicentric or multifocal and the number of tumors is not mentioned, use the "Unknown if Single or Multiple Tumors" module.
         iii. When there is a tumor or tumors with separate microscopic foci, ignore the separate microscopic foci and use the "Single Tumor" or "Multiple Tumors" modules as appropriate.
         iv. When the patient has a single tumor, use the "Single Tumor" module.
         v. If there are multiple tumors, use the "Multiple Tumors" module.
      III. See the Equivalent Terms and Definitions for Head and Neck for guidance in coding the primary site.
      IV. Use the primary site documented by the physician on the medical record.

5. If a **single primary**, prepare **one abstract**.

6. If there are **multiple primaries**, prepare **two or more abstracts**.

7. Rules are in **hierarchical** order within each module (Unknown if Single or Multiple Tumors, Single Tumor, and Multiple Tumors).

Use the first rule that applies and

STOP.

Determining Histology for Solid Malignant Tumors–General Instructions

Note: Do not use these rules to determine case reportability.

1. The 2007 histology coding rules **replace all previous** histology coding **rules**.

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

3. The histology coding rules are available in **three formats**: flowchart, text, and matrix. The **rules are identical;** only the formats differ. The histology coding rules follow the multiple primary (site) coding rules in each site section. Use the rules in the format that is easiest for you to follow.

4. **Notes** and **examples** are included with some of the rules to **highlight key points** or to add **clarity** to the rules.

5. Rules are in **hierarchical** order within each section (Single Tumor and Multiple Tumors Abstracted as a Single Primary).

How to Use the Histology Coding Rules

1. Read the **General Instructions**.

2. Read the **site-specific Equivalent Terms and Definitions**.

3. Use these rules to make a decision on coding the histology for all reportable solid malignant tumors.

4. Use the multiple primary rules to determine whether the patient has a single or multiple primaries before coding the histology.

5. Code the histology for **each** primary in a **separate abstract**.

6. Use the **site-specific rules** for the following primary sites:

   • Brain, malignant (intracranial and CNS)
   • Benign brain and other CNS
   • Breast
   • Colon
   • Head and neck
   • Kidney
   • Lung
   • Malignant melanoma of the skin
   • Renal pelvis, ureter, bladder, and other urinary

7. Use the **Other Sites rules** for all solid malignant tumors that occur in primary sites **not included** in the site-specific rules.

8. Determine whether the patient has a single tumor or multiple tumors that will be abstracted as a single primary site:

    a. Do not count metastatic tumors.
    b. When the tumor is described as multifocal or multi-centric, use the Multiple Tumors module.
    c. When there is a tumor or tumors with separate foci of tumor do not count the foci.
    d. Only count the tumors that will be used to prepare that abstract. For example, when there are two tumors that will be abstracted as multiple primaries, you would use the Single Tumor modules to determine the histology code for each of the abstracts.

9. **Each section** (Single Tumor and Multiple Tumors Abstracted as a Single Primary) contains an independent, **complete set of coding rules**. For example, if the patient has multiple tumors that will be abstracted as a single primary site, start with the first rule under the heading Multiple Tumors Abstracted as a Single Primary. Do not use any of the rules under the header Single Tumor.

Use the first rule that applies and

STOP.

Priority Order for Using Documents to Code Histology

Medical records frequently include multiple pathology reports and references to histologic diagnosis. Use the following instructions to identify which reports best represent the histology to be coded.

1. Pathology report:
    a. From the **most representative** tumor specimen examined.
    b. From the **final diagnosis.**

    Note 1: Use information from **addenda** and **comments** associated with the final diagnosis to code the histology.
    Note 2: A **revised/amended diagnosis** replaces the original final diagnosis. Code the histology from the revised/amended diagnosis.
    Note 3: The new rules **limit** the information **to the final diagnosis**. The old rules allowed coding from information in the microscopic description. You will only use information from the microscopic portion of the pathology report when instructed to do so in one of the site-specific rules.

2. Cytology report.
3. When you do not have either a pathology report or cytology report, use information from:
    a. Documentation in the medical record that references pathology or cytology findings.
    b. Mention of type of cancer (histology) in the medical record.

Ambiguous Terms Used to Code Histology

The following terms, while almost exactly the same as the ambiguous terms for case reportability, should NOT be used to determine case reportability when they are strictly used to describe the histology of a solid tumor.

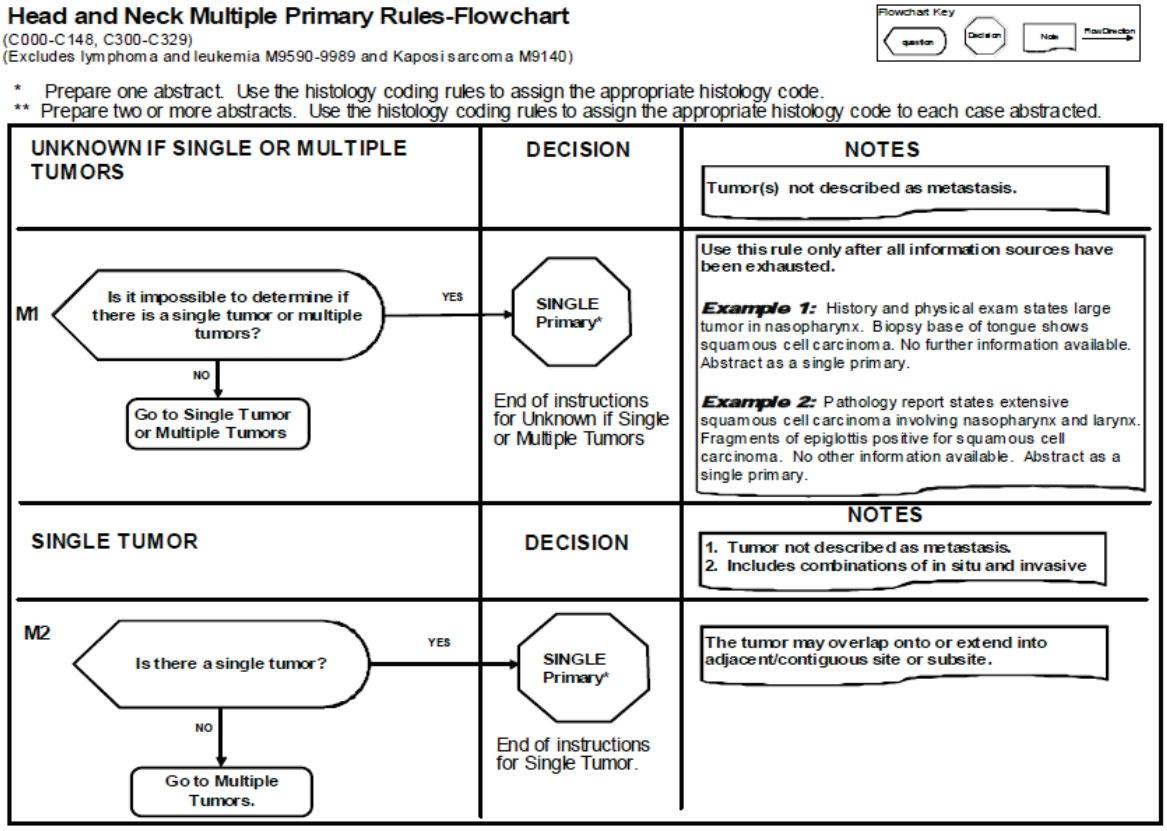
1. Apparent(ly)
2. Appears
3. Comparable with
4. Compatible with
5. Consistent with
6. Favor(s)
7. Most likely
8. Presumed
9. Probable
10. Suspect(ed)
11. Suspicious (for)
12. Typical (of)

When any of the above terms are used to describe a more specific histology, code to the more specific histology.

Example: Non-small cell carcinoma, most likely adenocarcinoma.
Code the adenocarcinoma.

Note: For lymphomas, leukemia and other hematopoietic malignancies, primary site and timing are not applicable for determining single or multiple primaries – histology becomes the determining factor. Use the hematopoietic database website at http://seer.cancer.gov/seertools/hemelymph/.

Example of Flowchart Format



Choose the format that's easiest for you to follow.

The information in all three formats is exactly the same.

Example of Matrix Format

Head and Neck Multiple Primary Rules – Matrix
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

Rule	Site	Histology	Timing	Behavior	Notes/Examples	Primary
UNKNOWN IF SINGLE OR MULTIPLE TUMORS					Tumor(s) not described as metastasis	
M1					Use this rule only after all information sources have been exhausted. ***Example 1:*** History and physical exam states large tumor in nasopharynx. Biopsy base of tongue shows squamous cell carcinoma. No further information available. Abstract as a single primary. ***Example 2:*** Pathology report states extensive squamous cell carcinoma involving nasopharynx and larynx. Fragments of epiglottis positive for squamous cell carcinoma. No other information available. Abstract as a single primary.	Single*
SINGLE TUMOR					***1.*** Tumor not described as metastasis ***2:*** Includes combinations of in situ and invasive	
M2	Single				The tumor may overlap onto or extend into adjacent/contiguous site or subsite.	Single*
MULTIPLE TUMORS **Multiple tumors may be a single primary or multiple primaries**					***1.*** Tumors not described as metastases ***2:*** Includes combinations of in situ and invasive	
M3	Right side and left side of a paired site				See Table 1 for list of paired sites	Multiple**
M4	**Upper** lip (C000 or C003) **and lower** lip (C001 or C004)					Multiple**
M5	**Upper** gum (C030) **and lower** gum (C031)					Multiple**

Choose the format that's easiest for you to follow.

The information in all three formats is exactly the same.

Example of Text Format

Head and Neck Multiple Primary Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS
Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary.*
Note: Use this rule only after all information sources have been exhausted.
Example 1: History and physical exam states large tumor in nasopharynx. Biopsy base of tongue shows squamous cell carcinoma. No further information available. Abstract as a single primary.
Example 2: Pathology report states extensive squamous cell carcinoma involving nasopharynx and larynx. Fragments of epiglottis positive for squamous cell carcinoma. No other information available. Abstract as a single primary.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR
Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

This is the end of instructions for Single Tumor.
*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**

MULTIPLE TUMORS
Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 Tumors on the **right** side **and** the **left** side of a **paired site** are multiple primaries. **
Note: See Table 1 for list of paired sites.

Rule M4 Tumors on the **upper lip** (C000 or C003) **and** the **lower lip** (C001 or C004) are multiple primaries. **
Rule M5 Tumors on the **upper gum** (C030) **and** the **lower gum** (C031) are multiple primaries. **

Choose the format that's easiest for you to follow.

The information in all three formats is exactly the same.

Chapter 3

GENERAL INSTRUCTIONS

Now that you have determined the reportability of each case and the number of primaries to be reported, you are ready to complete the abstract for submission to the State. This chapter includes general instructions on completing the required data items for each case. Chapter 5, the data dictionary, provides specific information on each required and some recommended fields.

Important Items to Remember

- The SEER Summary Staging Manual 2000 must be used to assign the summary stage for all cases diagnosed from January 1, 2001, forward. The manual is available on line at https://seer.cancer.gov/tools/ssm/SSSM2000-122012.pdf. Please make sure you are using this on line version, do not use the printed red cover book; it does not have any of the recent updates or errata.

- The AJCC Cancer Staging Manual, 7th edition, must be used to assign TNM stage for all eligible cases diagnosed in 2016 and 2017.

- Completed cases should be submitted to WCRS within six months of date of diagnosis, or date of initial contact if diagnosed elsewhere. Breast cancer cases should be submitted to WCRS within 12 months of date of diagnosis or date of initial contact if diagnosed elsewhere (breast cancer treatment and sometimes staging information - are often not complete within the six month time frame).

Timely Reporting Calendar	
Month Case Dx/Seen	Month Case Due
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

Timely Reporting Calendar for **Breast** Cases	
Month Case Dx/Seen	Month Case Due
January	December
February	January
March	February
April	March
May	April
June	May
July	June
August	July
September	August
October	September
November	October
December	November

- Electronic reporting is required for all hospitals. WCRS will provide free data entry software (Abstract Plus) and data submission software upon request. Please note: Abstract Plus MUST be downloaded from the WCRS web site, do NOT download the generic version from CDC. The WCRS web site contains the customized version for Wisconsin reporters which include physician and facility tables for Wisconsin along with Wisconsin-specific edits.

- While Collaborative Stage is NOT required for cases diagnosed in 2016 or later, the Collaborative Staging Manual Version 2.05 must still be used to derive stage for cases diagnosed on or after January 1, 2004, through December 31, 2015.

- **Hospitals**: All **active** cancer cases diagnosed after December 31, 1975 must be abstracted and reported to WCRS (this includes cases that may not have been diagnosed or treated for cancer in your facility).

- **Clinics**: All cancer patients receiving cancer-directed treatment in your facility after December 31, 1991 must be abstracted and reported to WCRS. In addition, all cancer patients diagnosed in your facility that you do NOT treat and do NOT refer to a Wisconsin hospital must also be reported.

- **Early Case Capture (ECC) of Pediatric and Young Adult Cancers**: All reportable ECC data items for cancers diagnosed among children and young adults ages 0-19 are required to be submitted to WCRS within 30 days from the date of diagnosis. Appendix VII contains the data items WCRS requires for ECC reporting. Details are available on the WCRS ECC web page:
  https://www.dhs.wisconsin.gov/wcrs/reporterinfo/earlycasecapture.htm

  If your facility is not currently reporting these cases under this requirement, please contact the WCRS Program Director (contact information in Appendix I) to establish the reporting process.

The following coding manuals are needed to complete case reporting for WCRS. (If the link does not open directly from this manual, copy and paste the URL to your Internet browser.)

1. SEER Summary Stage 2000 Manual
   http://seer.cancer.gov/tools/ssm/SSSM2000-122012.pdf
   Use this manual to determine the summary stage for each reportable case. If you still have a red-cover SEER hard copy, it is outdated. Please download the updated reference from this website.

2. AJCC Cancer Staging Manual, 7th Edition
   http://www.springer.com/us/book/9780387884400
   This manual is required to complete TNM staging for 2016 and 2017 diagnoses.

3. SEER Multiple Primary and Histology Coding Rules
   http://www.seer.cancer.gov/tools/mphrules/download.html
   Scroll to 'Complete Manual' – Download the complete manual with the latest updates. Use this manual to determine the number of reports needed to complete each case.

4. Hematopoietic Multiple Primary and Histology Coding Rules Website
   http://seer.cancer.gov/seertools/hemelymph/
   Use this site to determine the multiple primary status and correct histology and grade for all hematopoietic reportable diseases.

5. Data Collection of Primary Central Nervous System Tumors
   http://www.cdc.gov/cancer/npcr/pdf/btr/braintumorguide.pdf
   Use this manual to learn more about benign brain and CNS tumors (reportable to WCRS beginning January 1, 2004).

6. Site-Specific Surgery Codes
   https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/fords%202016.ashx
   From this site, scroll down the left column and select Appendix B – site-specific surgery codes.

7. International Classification of Diseases for Oncology, 3rd Edition (ICD-O3)
   http://codes.iarc.fr/
   This is the definitive classification of neoplasms and is used to describe the topography, morphology, malignant behavior and grade of all neoplasms.

8. Collaborative Stage Manual Version 2.05 (For 2004 - 2015 diagnoses)
   https://cancerstaging.org/cstage/coding/Pages/Version-02.05.aspx
   Use the general instructions (Part I) and site-specific coding (Part II).

Please note: All of the above tools (except the AJCC Cancer Staging Manual and ICD-O3 Manual) are available in the Registry Plus Online Help tool (included in the Abstract Plus software) which can also be downloaded as a stand-alone reference at no cost from: http://www.cdc.gov/cancer/npcr/tools/registryplus/rpoh_tech_info.htm

General Coding Instructions for Place of Residence at Diagnosis

The Wisconsin Cancer Reporting System collects information on place of residence at diagnosis. Rules for determining residency at diagnosis are either identical or comparable to rules used by the U.S. Census Bureau, to ensure comparability of definitions of cases (numerator) and the population at risk (denominator).

Coding Priorities/Sources

1. Code the **street address** of usual residence as stated by the patient. Definition: *U.S. Census Bureau Instructions:* "The place where he or she lives and sleeps most of the time or the place the person says is his or her usual home."

2. **Post Office Box** is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographic information for analyzing cancer incidence. Use the post office box address **only if** no street address information is available after follow-back.

3. Use residency information from a death certificate **only when** residency from other sources is coded as unknown. Review each case carefully and apply the U.S. Census Bureau rules for determining residence. The death certificate may give the person's previous home address rather than the nursing home address as the place of residence; use the nursing home address as the place of residence.

4. Do NOT use **legal status** or **citizenship** to code residence.

Persons with More than One Residence

Example: Persons who live in the south for the winter months but in the north during the summer months (or vice versa) or people with vacation residences that they occupy for a portion of the year.

a. Code the residence where the patient spends the majority of time (usual residence).

b. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

Persons with No Usual Residence

Homeless people and transients are examples of persons with no usual residence. Code the patient's residence at diagnosis such as the shelter or hospital where diagnosis was confirmed.

Temporary Residents of the Wisconsin Area

1. Code the place of **usual** residence rather than the temporary address for:

a. Migrant workers
b. Educators temporarily assigned to a university in the Wisconsin area
c. Persons temporarily residing with family during cancer treatment
d. Military personnel on temporary duty assignments (TDY)
e. Boarding school students below college level (code the parent's residence)

2. Code the residence where the student is living while he/she is attending college**.**

3. Code the address of the institution for Persons in Institutions**.** *U.S. Census Bureau definition:* "Persons under formally authorized, supervised care or custody are residents of the institution."

a. Persons who are incarcerated
b. Persons who are physically handicapped or have an intellectual disability, who are residents of homes, schools, hospitals or wards
c. Residents of nursing, convalescent, and rest homes
d. Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships (Merchant Marine)

1. **Armed Forces**: For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.

2. **Personnel Assigned to Navy, Coast Guard, and Maritime Ships**: The U.S. Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and homeport. Refer to U.S. Census Bureau Publications for detailed rules: http://www.census.gov

General Coding Instructions for Reporting Race

1. Code the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. The five race fields allow for the coding of multiple races consistent with the U.S. 2000 Census. In Wisconsin, only about 1% of the population is multiracial. Most of the time you will only code one race field for the patient (in the Race 1 field). When there is only one race to be coded, then the Race 2-5 fields will be coded to '88' (meaning no other races listed). For cases diagnosed/reported after January 1, 2000, **all race fields must be coded (using '88's in the 'extra' race fields).**

2. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white in the next race field.

3. If the person's race is a combination of more than one non-white race, code Race 1 to the first stated non-white race (02-98), Race 2 to the second, etc.

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

4. Asian race codes are specific to unique groups and every attempt should be made to report the patient's most detailed race. Do not code '96' Asian if a more specific race has been indicated.

   Example: A patient is described as Asian in a consultation note, but as second-generation Hmong in the history and physical. Code Race 1 as '12' Hmong.

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

   a. Code the patient's stated race, if possible. Refer to Appendix V, "Race and Nationality Descriptions from the 2000 Census and National Center for Health Statistics," for guidance if you are not sure about a particular nationality.

      Example 1: Patient is stated to be Hmong. Code Race 1 as '12' Hmong and Race 2-5 as '88.'

      Example 2: Patient is stated to be German-Irish. Code Race 1 as '01' White and Race 2-5 as '88.'

      Example 3: Patient is described as Arab. Code Race 1 as '01' White and Race 2-5 as '88.'

      Example 4: When the race is recorded as Oriental, Mongolian, or Asian (coded to 96 Other Asian) and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on **birthplace** information. (The person's race is recorded as Asian and the place of birth is recorded as Japan. Code Race 1 as '05' Japanese because it is more specific than '96' Asian, NOS (Not Otherwise Specified), and Race 2-5 as '88.')

      This is the national standard that's applied in race algorithms (using place of birth to provide a more specific race category), central cancer registries adapt it as the best practice for race reporting of more specific Asian countries.

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

   Example: The patient is described as Asian-American with Korean parents. Code Race 1 as '08' Korean because it is more specific than '96' Asian, NOS, and Race 2-5 as '88.'

7. If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of a race category.

   Example 1: Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code Race 1 as '02' Black and Race 2-5 as '88.'

   Example 2: Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as '25' Polynesian, Race 2 as '26' Tahitian, and Race 3-5 as '88.'

8. If race is unknown or not stated in the medical record and birthplace is recorded, in some cases race may be inferred from the nationality. Refer to Appendix V to identify nationalities from which race codes may be inferred.

   Example 1: Record states: "this native of Portugal..." Code Race 1 as '01,' White per Appendix V.

   Example 2: Record states: "this patient was Nigerian..." Code Race 1 as '02,' Black per Appendix V.

9. Use of patient name in determining race:

   a. Do not code race from name alone, especially for females with no maiden name given.
   b. In general, a name may be an indicator of a racial group, but should not be taken as the only indicator of race.
   c. A patient name may be used to identify a more specific race code.

      Example 1: Race reported as Asian, name is Hatsu Mashimoto. Code Race 1 as '05' Japanese.

      Example 2: Birthplace is reported as Guatemala and name is 'Jose Chuicol' [name is identified as Mayan]. Code Race 1 as '03' Native American.

   d. A patient name may be used to infer Spanish ethnicity (not the same thing as the patient's race!) or place of birth, but a Spanish name alone (without a statement about race or place of birth) cannot be used to determine the race code. Refer to ethnicity guidelines for further information.

      Example: Alice Gomez is a native of Indiana (implied birthplace: United States). Code Race 1-5 as '99,' Unknown, because nothing is known about her race.

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

    Example: Sabrina Fitzsimmons is a native of Brazil. Code Race 1 as '01,' White per Appendix V, and Race 2-5 as '88.'

11. When the race is recorded as Negro or African-American, code Race 1 as '02,' Black, and Race 2-5 as '88.'

12. Code '03' should be used for any person stated to be Native American or [Western Hemisphere] Indian, whether from North, Central, South, or Latin America.

13. Death certificate information may be used to supplement ante-mortem race information only when race is coded 'unknown' in the patient record, or when the death certificate information is more specific.

    Example 1: In the cancer record, Race 1-5 are coded as '99,' Unknown. The death certificate states race as 'Black.' Change the cancer record for Race 1 to '02,' Black and Race 2-5 to '88.'

    Example 2: Race 1 is coded in the cancer record as '96,' Asian. The death certificate gives birthplace as China. Change Race 1 in the cancer record to '04,' Chinese and code Race 2-5 as '88.'

General Coding Instructions for Reporting Ethnicity

1. Coding Spanish Surname or Origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.

2. Portuguese, Brazilians and Filipinos are not Spanish; code non-Spanish (code '0').

3. All information should be used to determine the Spanish/Hispanic Origin, including the stated ethnicity in the medical record, stated Hispanic origin on the death certificate, birthplace, information about life history and/or language spoken found in the abstracting process, and a last name and maiden name found on a list of Hispanic/Spanish names. Assign code '7' when the only evidence of the patient's Hispanic origin is a surname or maiden name and there is no evidence that the patient is not Hispanic. If the origin is not stated in the medical record and the hospital registry does not have a list of Hispanic surnames, assign code '9,' "Unknown whether Spanish/Hispanic or not."

4. Do **NOT** code the Race field to '98,' Other Race, when a patient is determined to be Hispanic.

General Coding Rules for Reporting Behavior

1. The behavior of a neoplasm describes the level of malignancy of the tumor.

2. Behavior codes 0 (benign) and 1 (borderline) are reportable for intracranial and CNS sites only, beginning with January 1, 2004, diagnoses.

3. *In situ* noninvasive tumors (code 2)**:** Clinical evidence alone cannot identify the behavior as *in situ* (/2); the code must be based on pathologic examination and documentation.

4. *In situ* and Invasive (code 3) components in the same tumor**:** Code the behavior as invasive malignant (/3) if any portion of the primary tumor is invasive no matter how limited; i.e., microinvasion.

   Example: Pathology from mastectomy: Large mass composed of intraductal [*in situ*] carcinoma with a single focus of invasion. Code the behavior as malignant /3.

5. ICD-O-3 Manual Histology/Behavior Code Listing: The ICD-O-3 manual may have only one behavior code, either *in situ* /2 or malignant /3, listed for a specific histology.

   If the pathology report describes the histology as *in situ* /2 and the ICD-O-3 histology code is only listed with a malignant /3 behavior code, assign that histology code and change the behavior code to *in situ* /2, to match the pathologist's findings.

   Likewise, if the pathology report describes histology as malignant /3 and the ICD-O-3 histology code is only listed with an *in situ* /2 behavior code, assign that histology code and change the behavior code to malignant /3, again, to match the pathologists' findings.

   Refer to the Morphology and Behavior Code Matrix discussion on page 29 in the ICD-O-3 manual for more information.

Example: The pathology report states large cell carcinoma *in situ*. The ICD-O-3 lists large cell carcinoma as 8013/3; only as malignant. Change the behavior code of /3 to /2 and code the histology and behavior code to 8013/2 as specified by the pathologist. Make sure to note in the appropriate text field that the behavior code was confirmed by pathology. In addition, your software edits may require using an override code for this rare situation.

6. Synonyms for in situ: The following list contains common synonyms for *in situ*, noninvasive tumors.

    a. AIN III (anal canal)
    b. Behavior code '2'
    c. Bowen disease (not reportable for skin primary cancers)
    d. Clarks level I for melanoma (limited to epithelium)
    e. Confined to epithelium
    f. Hutchinson melanotic freckle, NOS
    g. Intracystic, non-infiltrating
    h. Intraductal
    i. Intraepidermal, NOS
    j. Intraepithelial, NOS
    k. Involvement up to, but not including, the basement membrane
    l. Lentigo maligna
    m. Lobular, noninfiltrating
    n. Noninfiltrating
    o. Noninvasive
    p. No stromal invasion/involvement
    q. Papillary, noninfiltrating or intraductal
    r. Precancerous melanosis
    s. Queyrat erythroplasia
    t. Stage 0
    u. VAIN III (Vagina, NOS)
    v. VIN III (Labium majus and minus, clitoris, vulva, NOS)

General Coding Instructions for Reporting Grade

Use these instructions to code grade for cases diagnosed 2014 and later.

Hematopoietic and Lymphoid Neoplasms - Cell Indicator (Codes 5, 6, 7, 8, 9)

Cell Indicator (Codes 5, 6, 7, 8) describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used only for hematopoietic and lymphoid neoplasms. Code 9 indicates cell type not determined, not stated, or not applicable.

Coding Grade for Hematopoietic and Lymphoid Neoplasms

1. Determine the histology based on the current Hematopoietic and Lymphoid Neoplasm Manual: http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.
2. Determine the Cell Indicator by applying the "Grade of Tumor Rules" section in the manual, to code the grade:

Terminology	Grade Code
T-cell; T-precursor	5
B-Cell; Pre-B; B-precursor	6
Null cell; Non T-non B	7
NK cell (natural killer cell)	8
Grade unknown, not stated, or not applicable	9

Important note: 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 do NOT refer to the histologic grade collected by WCRS. Refer to the SEER Hematopoietic manual for the correct grade assignment.

In addition, do not use the 1, 2 or 3 grade that is often described for follicular lymphoma or Hodgkin's lymphoma. This code refers to the *type of cell*, not the grade or differentiation. Again, refer to the SEER Hematopoietic manual for the correct grade assignment

Solid tumors - Grade, Differentiation (Codes 1, 2, 3, 4, 9)

Pathologic examination determines the grade, or degree of differentiation, of the tumor. For these cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin).

Well-differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little (poorly differentiated) or no (undifferentiated) resemblance to the tissue from the organ of origin.

These similarities or differences may be based on pattern (architecture), cytology, nuclear (or nucleolar) features, or a combination of these elements, depending upon the grading system that is used. Some grading systems use only pattern; for example, Gleason grading in prostate. Others use only a nuclear grade (usually size, amount of chromatin, degree of irregularity, and mitotic activity). Fuhrman's grade for kidney is based only on nuclear features. Most systems use a combination of pattern and cytologic and nuclear features; for example, Nottingham's for breast combines numbers for pattern, nuclear size and shape, and mitotic activity. The information from this data item is useful for determining prognosis and treatment.

Pathologists describe the tumor grade using three systems or formats:

a. Two levels of similarity; also called a two-grade system.

b. Three levels of similarity; also called a three-grade system.

- Grade I, well
- Grade II, moderately
- Grade III, poorly

c. Four levels of similarity; also called a four-grade system. The four-grade system describes the tumor as

- Grade I; also called well-differentiated
- Grade II; also called moderately differentiated
- Grade III; also called poorly differentiated
- Grade IV; also called undifferentiated or anaplastic

Breast and prostate grades may convert differently from other sites. These exceptions are noted in "Coding for Solid Tumors," rules 7 and 8 below.

General Rules for Solid Tumors

1. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code grade based on information prior to neoadjuvant therapy even if grade is unknown.

2. Code the grade from the primary tumor only.
   a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.
   b. If primary site is unknown, code grade to 9.

3. Code the grade shown below (6th digit) for specific histologic terms that imply a grade.
   Carcinoma, undifferentiated (8020/3<u>4</u>)
   Carcinoma, anaplastic (8021/3<u>4</u>)
   Follicular adenocarcinoma, well differentiated (8331/3<u>1</u>)
   Thymic carcinoma, well differentiated (8585/3<u>1</u>)

Sertoli-Leydig cell tumor, poorly differentiated (8631/33)
Sertoli-Leydig cell tumor, poorly differentiated with heterologous elements (8634/33)
Undifferentiated sarcoma (8805/34)
Liposarcoma, well differentiated (8851/31)
Seminoma, anaplastic (9062/34)
Malignant teratoma, undifferentiated (9082/34)
Malignant teratoma, intermediate type (9083/32)
Intraosseous osteosarcoma, well differentiated (9187/31)
Astrocytoma, anaplastic (9401/34)
Oligodendroglioma, anaplastic (9451/34)
Retinoblastoma, differentiated (9511/31)
Retinoblastoma, undifferentiated (9512/34)

4. *In situ* and/or combined *in situ*/invasive components:
   a. If a grade is given for an *in situ* tumor, code it. Do NOT code grade for dysplasia such as high-grade dysplasia.
   b. If there are both *in situ* and invasive components, code only the grade for the invasive portion, no matter how small the invasive component is, even if its grade is unknown.

5. If there is more than one grade, code the highest grade within the applicable system. Code the highest grade even if it is only a focus. Code grade in the following priority order using the first applicable system:
   a. Special grade systems for the sites listed in rule number 6.
   b. Differentiation: use rule number 7 (the 2-, 3-, or 4- grade system).
   c. Nuclear grade: use rule number 7 (the 2-, 3-, or 4- grade system).
   d. If it isn't clear whether the grade was based on cell differentiation or nuclear grade AND a 2-, 3-, or 4- grade system was used, code the grade as listed.
   e. Terminology: use rule number 8.

6. Use the information from the special grade systems first. If no special grade can be coded, continue with rules 7-9.

   The names of the special grade systems for breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma are listed in the next table, and specific information on how to code grade for these sites is detailed in the Special Grade System Rules section (following the general rules).

CS Schema	Special grade system
Breast	Nottingham or Bloom-Richardson (BR) Score/Grade (SSF7)
Prostate	Gleason's Score on Needle Core Biopsy/Transurethral Resection of Prostate (TURP) (SSF 8)
Prostate	Gleason's Score on Prostatectomy/Autopsy (SSF 10)
Heart, Mediastinum	Grade for Sarcomas (SSF 1)
Peritoneum	Grade for Sarcomas (SSF 1)
Retroperitoneum	Grade for Sarcomas (SSF 1)
Soft Tissue	Grade for Sarcomas (SSF 1)
Kidney Parenchyma	Fuhrman Nuclear Grade (SSF 6)

Important note: Do not use the special grade system rules to code grade for other grade systems not listed in the above table. This includes the World Health Organization (WHO) grade for CNS tumors, the WHO/ISUP grade for bladder or renal pelvis, or the Federation Internationale de Gynecologie et d'Obstetrique (FIGO) grade system for female gynecologic sites.

7. Use the Two-, Three- or Four-grade system information:

a. Two-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/2, I/II	Low grade	2	1
2/2, II/II	High grade	4	3

In transitional cell carcinoma for bladder, the terminology high grade TCC and low-grade TCC are coded in the two-grade system.

b. Three-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/3	Low grade	2	1
2/3	Intermediate grade	3	2
3/3	High grade	4	3

c. Four-grade system

Term	Description	Grade Code
1/4	Grade I; Well differentiated	1
2/4	Grade II; Moderately differentiated	2
3/4	Grade III; Poorly differentiated	3
4/4	Grade IV; Undifferentiated	4

Any four-grade system, including Edmondson and Steiner grade for liver.

8. Terminology: use the 'Description' column or the 'Grade' column to code grade. Breast & Prostate use the same grade code with a few noted exceptions:

Description	Grade	Assign Grade Code	Exception for Breast and Prostate Grade Code
Differentiated, NOS	I	1	
Well differentiated	I	1	
Only stated as 'Grade I'	I	1	
Fairly well differentiated	II	2	
Intermediate differentiation	II	2	
Low grade	I-II	2	1
Mid differentiated	II	2	
Moderately differentiated	II	2	
Moderately well differentiated	II	2	
Partially differentiated	II	2	
Partially well differentiated	I-II	2	1
Relatively or generally well differentiated	II	2	
Only stated as 'Grade II'	II	2	
Medium grade, intermediate grade	II-III	3	2
Moderately poorly differentiated	III	3	
Moderately undifferentiated	III	3	
Poorly differentiated	III	3	
Relatively poorly differentiated	III	3	
Relatively undifferentiated	III	3	
Slightly differentiated	III	3	
Dedifferentiated	III	3	
Only stated as 'Grade III'	III	3	
High grade	III-IV	4	3
Undifferentiated, anaplastic, not differentiated	IV	4	
Only stated as 'Grade IV'	IV	4	
Non-high grade		9	

9. If no description fits or grade is unknown prior to neoadjuvant therapy, code as 9 (unknown).

Special Grade Rules for Breast – Bloom Richardson, Nottingham Score

Use Bloom Richardson (BR) or Nottingham score/grade to code grade based on CSv2 site-specific factor 7 (SSF) as stated below. If your registry does not collect this SSF, use the description in the table below to determine grade.

BR could also be referred to as: Bloom-Richardson, modified Bloom-Richardson, BR, BR grading, Scarff-Bloom-Richardson, SBR grading, Elston-Ellis modification of Bloom-Richardson score, Nottingham modification of Bloom-Richardson score, Nottingham modification of Scarff-Bloom-Richardson, Nottingham-Tenovus grade, or Nottingham grade.

Code the tumor grade using the following priority order

a. BR scores 3-9
b. BR grade (low, intermediate, high)

BR score may be expressed as a range, 3-9. The score is based on three morphologic features: degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism/nuclear grade of tumor cells. If a report uses words such as low, intermediate, or high rather than numbers, use the table below to code grade.

If only a grade of 1 through 4 is given, with no information on the score, and it is unclear if it is a Nottingham or BR Grade, do not use the table below. Continue with the next priority according to "Coding for Solid Tumors" #7 above.

Code the highest score if multiple scores are reported (exclude scores from tests after neoadjuvant therapy began). Examples: different scores may be reported on multiple pathology reports for the same primary cancer; different scores may be reported for multiple tumors assigned to the same primary cancer.

CS Site-Specific Factor 7 Nottingham or Bloom-Richardson (BR) Score/Grade

Description	CS Code	Grade Code
Score of 3	030	1
Score of 4	040	1
Score of 5	050	1
Score of 6	060	2
Score of 7	070	2
Score of 8	080	3
Score of 9	090	3
Low Grade, Bloom-Richardson (BR) grade 1, score not given	110	1
Medium (Intermediate) Grade, BR grade 2, score not given	120	2
High Grade, BR grade 3, score not given	130	3

Breast Grade Conversion Guide Table (use in priority order from left to right*)

Nottingham/Bloom Richardson (BR) Scores	BR Grade	Differentiation/ Nuclear Grade-- 2-, 3- or 4-Grade System Info	Grade Terminology/Descriptions	GRADE CODES:
3-5	Low (BR Grade 1)	1/2, 1 of 2; 1/3, 1 of 3; 1/4, 1 of 4	***Only stated as* Grade I;** Low Grade**; Grade I-II** **Well differentiated,** Differentiated NOS; Partially well differentiated	**1**
6,7	Medium/Intermediate (BR Grade 2)	2/3, 2 of 3; 2/4, 2 of 4	***Only stated as* Grade II;** Medium grade, Intermediate Grade, **GR II-III;** **Moderately differentiated,** Fairly well differentiated, Intermediate differentiation, Mid differentiated, Moderately well differentiated, Partially differentiated, Relatively or generally well differentiated	**2**
8,9	High (BR Grade 3)	2/2, 2 of 2; 3/3, 3 of 3; 3/4, 3 of 4	***Only stated as* Grade III;** High Grade**, Grade III-IV;** **Poorly differentiated,** Moderately poorly differentiated, Moderately undifferentiated, Relatively poorly differentiated, Relatively undifferentiated, Slightly differentiated, Dedifferentiated	**3**
---	---	4/4, 4 of 4	***Only stated as* Grade IV** **Undifferentiated,** anaplastic, not differentiated;	**4**
---	---	---	Non-high grade	**9**

*Per Grade Rule 5, if there is more than one grade, code the highest grade (even if only a focus), in priority order, from the first applicable grading system. Each column represents an applicable grading system as expressed in Rule 5. (This table is for guidance only and it does not replace the official Grade document rules.)

Special Grade Rules for Kidney Parenchyma – Fuhrman Nuclear Grade

The Fuhrman Nuclear Grade should be used to code grade for kidney parenchyma based on Collaborative Stage Site Specific Factor 6 or the Grade Description, if your facility does not collect CS Site Specific Factor 6. Do not use for kidney renal pelvis.

The Fuhrman nuclear grade is a four-grade system based on three parameters:

1. Nuclear diameter and shape
2. The prominence of nucleoli
3. Presence of chromatin clumping in the highest grade

Use the table below to determine grade based on your SSF 6 code or the grade description in the medical chart.

Description	CS Code	Grade Code
Grade 1	010	1
Grade 2	020	2
Grade 3	030	3
Grade 4	040	4

Special Grade Rules for Soft Tissue Sarcoma

This rule applies to sarcomas in the following sites: soft tissue, heart, mediastinum, peritoneum and retroperitoneum.

The Grade for Sarcomas should be used to code grade based on CSv2 SSF 1 as stated below. If your registry does not collect this SSF, use the description in the table to determine grade.

The grading system of the French Federation of Cancer Centers Sarcoma Group (FNCLCC) is the preferred system.

Record the grade from any three-grade sarcoma grading system the pathologist uses. For terms such as "well differentiated" or "poorly differentiated," go to Coding for Solid Tumors rule number 8.

In some cases, especially for needle biopsies, grade may be specified only as "low grade" or "high grade." The numeric grade takes precedence over “low grade” or “high grade.”

Description	CS Code	Grade Code
Specified as Grade 1 [of 3]	010	2
Specified as Grade 2 [of 3]	020	3
Specified as Grade 3 [of 3]	030	4
Grade stated as low grade, NOS	100	2
Grade stated as high grade, NOS	200	4

Special Grade Rules for Prostate

1. Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy.
2. Use a known value over an unknown value.
3. Exclude results from tests performed after neoadjuvant therapy began.

This information is collected in CSv2 SSF 8 (Gleason score from biopsy/transurethral resection of the prostate (TURP)) and SSF 10 (Gleason score from prostatectomy/autopsy) as stated below. Use the table below to determine grade even if your registry does not collect these SSFs.

Usually prostate cancers are graded using Gleason score or pattern. Gleason grading is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason grade; the secondary pattern is usually indicated by the second number. These two numbers are added to create a pattern score, ranging from 2 to 10.

If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score. If only one number is given on a particular test and it is less than or equal to 5 and not specified as a score, do not use the information because it could refer to either a score or a grade. If only one number is given and it is greater than 5, assume that it is a score and use it. If the pathology report specifies a specific number out of a total of 10, the first number given is the score. Example: The pathology report says Gleason 3/10. The Gleason score would be 3.

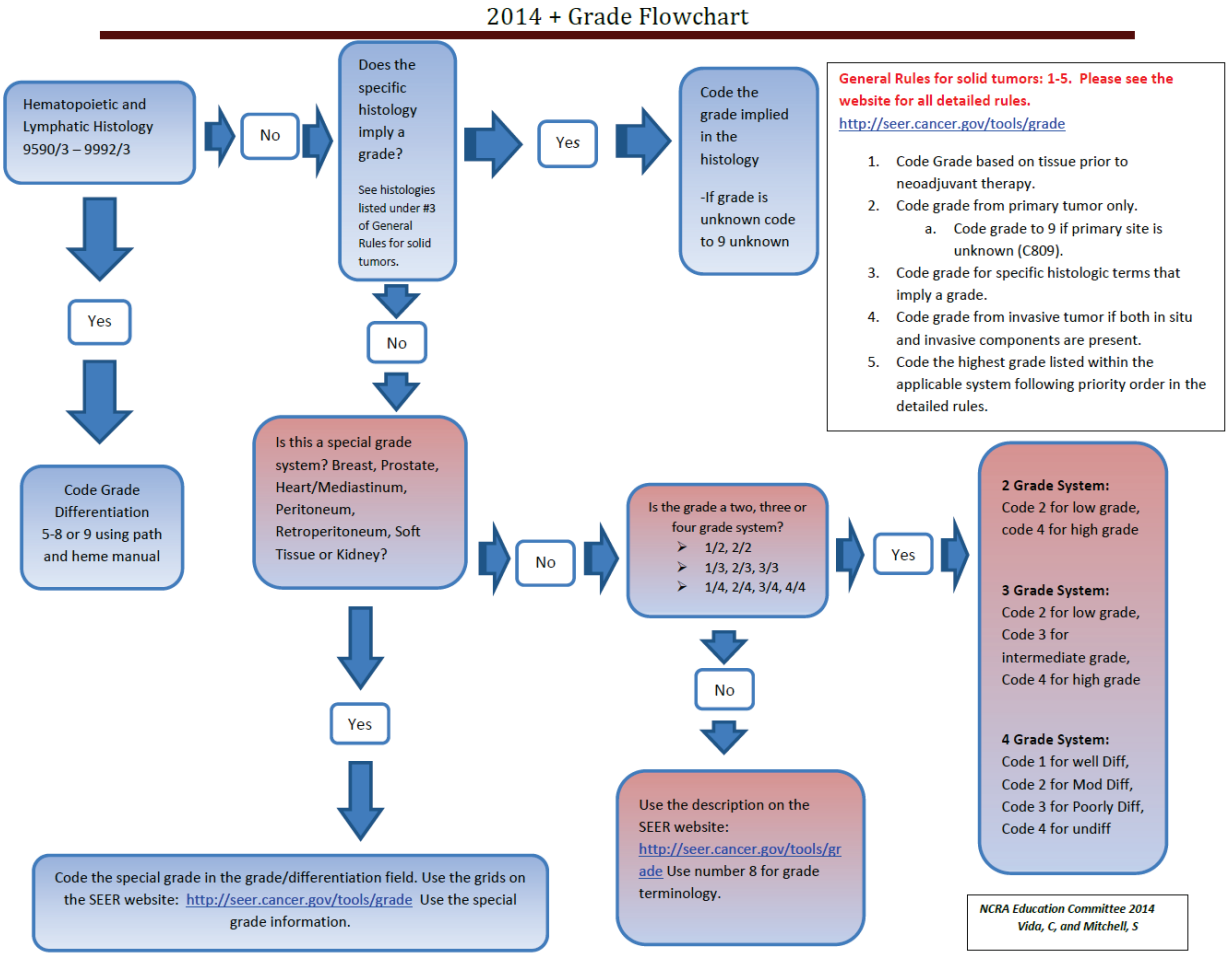
Prostate Grade Conversion Table (use in priority order from left to right*)

Gleason Score	Differentiation/Nuclear Grade-- 2-, 3- or 4-Grade System Info	Grade Terminology/Descriptions	GRADE CODES:
2,3,4	1/2, 1 of 2; 1/3, 1 of 3; 1/4, 1 of 4	***Only stated as* Grade I;** Low Grade, **Grade I-II;** **Well differentiated,** Differentiated NOS, Partially well differentiated	1
5,6			1
7	2/3, 2 of 3; 2/4, 2 of 4	***Only stated as* Grade II;** Medium grade, Intermediate Grade, **GR II-III;** **Moderately differentiated,** Fairly well differentiated, Intermediate differentiation, Mid differentiated, Moderately well differentiated, Partially differentiated, Relatively or generally well differentiated	2
8,9,10	2/2, 2 of 2; 3/3, 3 of 3; 3/4, 3 of 4	***Only stated as* Grade III;** High Grade, **Grade III-IV;** **Poorly differentiated,** Moderately poorly differentiated, Moderately undifferentiated, Relatively poorly differentiated, Relatively undifferentiated, Slightly differentiated, Dedifferentiated	3
---	4/4, 4 of 4	***Only stated as* Grade IV;** **Undifferentiated,** anaplastic, not differentiated	4
---	---	Non-high grade	9

*Per Grade Rule 5, if there is more than one grade, code the highest grade (even if only a focus), in priority order, from the first applicable grading system. Each column represents an applicable grading system as expressed in Rule 5. (This table is for guidance only and it does not replace the official Grade document rules.)

Grade Flowchart

This flowchart can also be downloaded from the following website:
http://www.cancerregistryeducation.org/Files/Org/f3f3d382a7a242549a9999654105a63b/site/2014_Grade_Flow_Chart.pdf



Changing Information Already Reported to WCRS

It is possible that after a cancer case has been abstracted and submitted to WCRS, additional information was clarified or added to the patient's chart, which may lead to changes in specific data items submitted on the initial abstract.

1. Do not submit changes as a regular new report.

2. Changes to specific reporting fields below should be submitted to WCRS.

    a. Last name
    b. First name
    c. Middle name
    d. Maiden name
    e. Address at diagnosis; includes city, county, state and zip code
    f. Race
    g. Spanish/Hispanic origin
    h. Sex
    i. Birthdate
    j. Social Security number
    k. Date of diagnosis
    l. Primary site
    m. Morphology type, behavior and grade
    n. Laterality
    o. Diagnostic confirmation
    p. Stage (TNM, Summary Stage and Collaborative Stage)
    q. Type and date of first course definitive treatment

3. Submissions will be accepted in two formats: faxing the change to 608-266-2431 or using the 'M' NAACCR record layout. (Contact your vendor for specific instructions on submitting these changes if using the M layout.)

Paper Abstracts

Paper reports should only be completed when electronic reporting options are not working properly at the reporting facility. Contact WCRS directly if you are having problems reporting electronically. Hospitals using Abstract Plus may submit cases diagnosed prior to 2003 on paper (due to the difficulty of clearing staging edits).

The official reporting form is available from the WCRS website. If it's necessary to use paper, the abstracts should be faxed to WCRS or submitted in a well-sealed envelope, marked "CONFIDENTIAL" and mailed to:

Wisconsin Cancer Reporting System
P.O. Box 2659
Madison WI 53701-2659

Electronic Data Transmissions

Electronic data must be sent using the NAACCR Version 16 layout (see web site for a complete list of required data items). Data must be sent using Web Plus software. Contact WCRS to obtain a Web Plus account (userID and password) for secure data submission.

Important note: Web Plus passwords expire every six months. If you do not submit your cases regularly, you will need to contact WCRS to have your password reset.

WCRS requests the following submission schedule to maintain timely reporting and reduce issues with Web Plus password expirations:

Annual caseload > 500	Monthly
Annual caseload < 500	Monthly or quarterly

Chapter 4

FIRST COURSE OF THERAPY

Treatment or therapy for cancer should modify, control, remove, or destroy cancer tissue (cancer-directed treatment). Therapy can be used to treat cancer tissue in a primary or metastatic site(s), regardless of the patient's response to that treatment. The first course of therapy should include all cancer-directed treatments indicated in the initial treatment plan and delivered to the patient after the initial diagnosis of cancer. Multiple modalities of treatment may be included, and therapy may include regimens of a year or more. **WCRS requires facilities to report the first course therapy/ treatment provided at that facility or any other facility if the information is available in the medical chart.**

The treatment plan specifies the types of cancer-directed therapies proposed to eliminate or control the patient's disease. Treatment intentions may be found in discharge summaries, consultations, and outpatient records. All cancer-directed therapies (surgery, radiation, chemotherapy, hormone therapy, immunotherapy, transplant/endocrine or other therapy) documented in the physician treatment plan and administered are considered first-course therapy.

Make sure you enter first-course treatment only in the standard software treatment fields. Do not report subsequent treatment (for a class 32, as an example) in those fields. Subsequent treatment can be 1) recorded in the treatment text fields or 2) entered in specific second course treatment fields that your software vendor may make available to you. (WCRS Abstract Plus software does not have any subsequent or second-course treatment fields.)

The SEER web site has a current list of drugs with the associated classification: http://seer.cancer.gov/seertools/seerrx/ Site-specifc surgery codes are available in the FORDS manual, Appendix B: https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/fords%202016.ashx (Use the bookmark feature to quickly move to the appendix.)

Reportable hematopoietic diseases: Some treatments for reportable hematopoietic diseases, such as transfusions, phlebotomy, and aspirin administration, do not meet the usual standard criteria for and definition of definitive treatment. Please refer to the SEER Hematopoietic and Lymphoid Neoplasm Database to look up the appropriate reportable treatments for these diseases. The website lists the standard treatments on each disease page. http://seer.cancer.gov/seertools/hemelymph/

No treatment: No treatment is considered a treatment option and may represent the first course of therapy. Reason for no treatment should be entered in the appropriate treatment field.

If there is no treatment plan and no other treatment guidelines are established, evaluate the therapy and the time it began in relation to the diagnosis date. If the therapy is a part of an established protocol or within accepted guidelines for the disease, consider it part of the first course of therapy.

If there is no treatment plan, no established protocol or management guidelines, and no physician counsel is available, use the following principle: *initial treatment must begin within four months of the date of initial diagnosis.*

Leukemia: For patients with a diagnosis of leukemia, the first course of therapy includes all cancer-directed treatments and planned therapies during or after the initial diagnosis of leukemia. All remission-inducing or maintenance cancer-directed therapy is recorded as the first course, including radiation to the central nervous system. The multiple modalities of therapy for the treatment of leukemia may involve a year or more.

Examples:

Example 1: If the patient has an adverse reaction, the regimen may be changed and a new drug introduced. If the new chemotherapy drug(s) is in the same group as the initial therapy (anti-metabolite, alkylating agent, etc.) it is considered continuation of the first course of treatment. If the drug(s) is not in the same group, it is no longer the first course of therapy. Additionally, if the patient fails to respond to treatment and the regimen is changed, it is no longer first course of treatment.

Example 2: Physician plans a combination regimen of chemotherapy. Velban is one of the drugs but, due to adverse reactions, it is replaced with Oncovin after several cycles. The treatment continues as first course of therapy because Oncovin and Velban are both alkaloids. Conversely, if Velban had been replaced with Fludara, it is no longer first-course therapy because Fludara is an anti-metabolite.

Example 3: Physician plans a regimen of Adriamycin/Cytoxan. The patient does not respond and disease progresses so the treatment plan is changed to Methotrexate/5FU. The treatment becomes subsequent (and no longer reportable to WCRS) because the planned first course of treatment failed.

Note: Surgical diagnostic and staging procedures such as biopsies, thoracentesis, and bypasses do not modify or destroy cancer cells. Surgical procedures that aspirate, biopsy or remove regional lymph nodes to diagnose and/or stage disease are to be entered in Scope of Regional Lymph Node Surgery, not in the Primary Site Surgery field.

Note: Procedures performed to palliate or alleviate symptoms may include surgery, radiation, systemic therapy and/or other pain management therapy; types of therapy that can also be considered first–course, cancer-directed treatment in other situations. If the therapy is used for palliative purposes only, the palliative treatment itself is NOT reportable to WCRS (but the case still is reportable - refer to Chapter 1 for rules on reportable case determination, if necessary).

Chapter 5

DATA DICTIONARY

This data dictionary contains all required and recommended fields for 2016 diagnoses.

The required/recommended data items on the following pages are listed in alphabetical order. Each data item description contains:

Field name
Field name as listed in the **Abstract Plus Version 3.6** software display screen
Item length (for electronic submission)
NAACCR Item Number Version 16 Layout
Description
Codes (if applicable)
Allowable Values
Rationale (if applicable)
Definition (if necessary)

ABSTRACTED BY

Abstract Plus Field Name: Abstracted By

Required
Item Length: 3
NAACCR Item #: 570

Description
A code assigned by the reporting facility that identifies the individual abstracting the case.

Allowable Values
First, middle and last name initials of the abstractor. If the abstractor does not have a middle name, just enter the two initials. If there is more than one abstractor with the same three initials in the facility, use the first and last name initials followed by a numeric sequence (JD1, JD2, etc.).

ACCESSION NUMBER

Abstract Plus Field Name: Accession Number

Required
Item Length: 9
NAACCR Item #: 550

Description
Provides a unique identifier for the patient consisting of the year in which the patient was first seen at the reporting facility and the consecutive order in which the patient was abstracted. The first four numbers specify the year, and the last five numbers are the numeric order in which the patient was entered into the registry database. Within a registry, all primary cancers for an individual must have the same accession number. The first four digits must equal the year when the case was first abstracted.

Example: The 31st patient abstracted at facility X in calendar year 2011 will have a hospital accession number of 201100031. If this same patient is seen in 2013 with a new primary cancer as the 4th patient seen in 2013, the accession number will still stay the same as the original, first time seen in that facility (201100031). The sequence number field will change to indicate the new primary cancer.

Rationale
This data item protects the identity of the patient and allows cases to be identified on a local, state, and national level. If the central registry preserves this number, they can refer to it when communicating with the reporting facility. It also provides a way to link computerized follow-up reports from hospitals into the central database.

Allowable values
Numeric only.

ADDRESS AT DIAGNOSIS -- CITY

Abstract Field Name: City at DX

Required
Item Length: 50
NAACCR Item #: 70

Description
Name of the city (no abbreviations) in which the patient resides at the time the reportable tumor was diagnosed. If the patient resides in a rural area, record the name of the city used in the mailing address. If the patient has multiple primaries, the city of residence may be different for each primary.

Allowable Values
Alpha characters and spaces only.

Codes
(in addition to valid city)
UNKNOWN. Patient's city is unknown.

ADDRESS at DIAGNOSIS – Number & Street

Abstract Plus Field Name: Street Address at DX

Required
Item Length: 60
NAACCR Item #: 2330

Description
The number and street address or the rural mailing address of the patient's residence at the time THE REPORTABLE TUMOR WAS DIAGNOSED. If the patient has multiple tumors, address at diagnosis may be different for each tumor.

Supplemental address information such as facility, nursing home, or name of apartment complex should be entered in the supplemental address field. Do not update this data item if patient moves after diagnosis. U.S. addresses should conform to the U.S. Postal Service (USPS) *Postal Addressing Standards*. These standards are referenced in USPS Publication 28, November 2000, *Postal Addressing Standards*. The current USPS Pub. 28 can be downloaded from the following website: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.

Rationale
Addresses formatted to conform to USPS *Postal Addressing Standards* can be more properly geocoded by GIS software and vendors to the correct census tract, which is required by NPCR and SEER registries. The USPS Standards also address a number of issues that are problematic in producing precise addresses, including the use of punctuation, abbreviations, and proper placement of address elements, such as street direction, apartment and suite numbers, and unusual addressing situations. Spanish-language addresses also are covered by the USPS Standard.

Allowable Values
The address should be fully spelled out with standardized use of abbreviations and punctuation per USPS postal addressing standards. Upper case is required. Abbreviations should be limited to those recognized by USPS standard abbreviations; these include but are not limited to:

APT	apartment	UNIT	unit
N	North	SE	southeast
BLDG	building	RM	room
NE	northeast	SW	southwest
FL	floor	DEPT	department
NW	northwest	E	east
STE	suite	W	west
S	south		

Punctuation marks should be avoided, except when necessary to convey the meaning. Punctuation is limited to periods when it carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 1/2 MAIN ST –this is common in Northwestern Wisconsin), and hyphens when it carries meaning (e.g., 289-01 MONTGOMERY AVE). The pound sign (#) should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101.

Codes (in addition to valid street address)
UNKNOWN Patient's number and street address is unknown

Special note on the use of PO Boxes: The use of PO Boxes should be avoided; they should only be provided if it is the ONLY address available for the patient. If both the street address ***and*** PO Box are available, do **NOT** put the PO Box in this field or the supplemental address field, only use the street address. Geocoding software will only code the PO Box and ignore the more accurate street address information. With the increase in demand for local data in recent years, having accurate street addresses is more important than ever.

ADDRESS AT DIAGNOSIS – POSTAL CODE

Abstract Plus Field Name: Zip Code at DX

Required
Item Length: 9
NAACCR Item #: 100

Description
Postal code for the address of the patient's residence at the time the reportable tumor is diagnosed. If the patient has multiple tumors, the postal code may be different for each tumor.

For U.S. residents, use either the 5-digit or the extended 9-digit ZIP code. Blanks follow the 5-digit code. If the 4-digit extension is not collected, then the corresponding characters of an unknown value may be blank.

For Canadian residents, use the 6-character alphanumeric postal code. Blanks follow the 6-character code.

When available, enter the postal code for other countries.

Codes (in addition to US and Canadian postal codes)	
888888888	Resident of country **other than** the United States, U.S. possessions or territories, or Canada, and the postal code is unknown.
999999999	Resident of the United States (including its possessions, etc.) or Canada and the postal code is unknown.

ADDRESS AT DIAGNOSIS - STATE

Abstract Plus Field Name: State at DX

Required
Item Length: 2
NAACCR Item #: 80

Description
USPS abbreviation for the state, territory, commonwealth, U.S. possession, or Canada Post abbreviation for the Canadian province/ territory in which the patient resides at the time the reportable tumor is diagnosed. If the patient has multiple primaries, the state of residence may be different for each tumor.

Codes (in addition to USPS abbreviations)	
CD	Resident of Canada, NOS (province/territory unknown)
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ	Residence unknown

ADDRESS AT DIAGNOSIS – SUPPLEMENTAL

Abstract Plus Field Name: Supplemental Address

Required
Item Length: 60
NAACCR Item #: 2335

Description
This data item provides the ability to store additional address information such as the name of a place, institution, facility, nursing home, or apartment complex. If the patient has multiple tumors, supplemental address at diagnosis may be different for each tumor.

Rationale
Sometimes the registry receives the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding or mapping. By having a supplemental street address field to hold address information, the registry can look up and store the street address and not lose the facility name due to a shortage of space in the data entry field. The presence of a supplemental street address field to hold additional address information also aids in follow-up.

Allowable values
Numbers, alpha characters and spaces are allowed. Enter the full name of the facility (Sunnyside Nursing Home, for example) in this field.

Special note on the use of PO Boxes: The use of PO Boxes should be avoided; they should only be provided if it is the ONLY address available for the patient. If both the street address ***and*** PO Box are available, do **NOT** put the PO Box in this field, leave the supplemental field blank. Geocoding software will only code the PO Box and ignore the more accurate street address information. With the increase in demand for local data in recent years, having accurate street addresses is more important than ever.

AGE AT DIAGNOSIS

Abstract Plus Field Name: Age at Diagnosis

Required
Item Length: 3
NAACCR Item #: 230

Description
Age of the patient at the time of diagnosis, in complete years.

Codes	Description
000	Less than 1 year old
001	1 year old, but less than 2 years
002	2 years old
…	(show actual age in completed years)
101	101 years old
…	
120	120 years old
999	Unknown age

***Notes*:**

a. *Different tumors for the same patient may have different age values.*
b. *Many software programs, including Abstract Plus, calculate this field automatically upon entry of the date of birth and date of diagnosis.*
c. *Unknown age should only be used when the date of birth or complete date of diagnosis is unknown.*

Please remember to include the patient's age in the PE Text field.

BEHAVIOR CODE -- ICD-O3

Abstract Plus Field Name: Behavior

Required
Item Length: 1
NAACCR Item #: 523

WCRS requires facilities to report malignancies with *in situ* /2 and malignant /3 behavior codes as described in ICD-O-3. WCRS also requires facilities to report benign /0 and borderline /1 intracranial and CNS tumors for cases diagnosed on or after January 1, 2004. Behavior is the fifth digit of the morphology code after the slash (/).

For a complete list of benign, borderline and malignant cases required to be reported, please see Chapter 1 of this manual.

Codes	Description
0	Benign (Reportable for intracranial and CNS sites only)
1	Uncertain whether benign or malignant, borderline malignancy, low malignant potential, and uncertain malignant potential (Reportable for intracranial and CNS sites only)
2	Carcinoma *in situ*; intraepithelial; noninfiltrating; noninvasive
3	Malignant, primary site (invasive)
6	Malignant, metastatic site
9	Unknown behavior

BIRTHPLACE-STATE

Abstract Plus Field Name: Birthplace-State

Required
Item Length: 2
NAACCR Item #: 252

Description
State of birth of the patient.

Description
USPS abbreviation for the state, territory, commonwealth, U.S. possession, or Canada Post abbreviation for the Canadian province/ territory in which the patient was born. If the patient has multiple primaries, all records should contain the same code.

Rationale
Birthplace-State is helpful for patient matching and can be used when reviewing race and ethnicity. In addition, adding birthplace-state data to race and ethnicity data allows for a more specific definition of the population being reported. Careful descriptions of ancestry, birthplace, and immigration history of populations studied are needed to make the basis for classification into ethnic groups clear. Birthplace has been associated with variation in genetic, socioeconomic, cultural, and nutritional characteristics that affect patterns of disease. A better understanding of the differences within racial and ethnic categories also can help states develop effective, culturally sensitive public health prevention programs to decrease the prevalence of high-risk behaviors and increase the use of preventive services.

Allowable Values
Alpha-only

Codes
See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes at http://seer.cancer.gov/manuals/2015/SPCSM_2015_AppendixB.pdf

Codes (in addition to USPS abbreviations)	
CD	Resident of Canada, NOS (province/territory unknown)
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ	Residence unknown

BIRTHPLACE-COUNTRY

Abstract Plus Field Name: Birthplace-Country

Required
Item Length: 3
NAACCR Item #: 254

Description
Patient's country of birth.

Description
International Standards Organization 3-character country code for the country in which the patient was born. If the patient has multiple primaries, all records should contain the same code.

Rationale
Birthplace-Country is helpful for patient matching and can be used when reviewing race and ethnicity. In addition, adding birthplace-country data to race and ethnicity data allows for a more specific definition of the population being reported. Careful descriptions of ancestry, birthplace, and immigration history of populations studied are needed to make the basis for classification into ethnic groups clear. Birthplace has been associated with variation in genetic, socioeconomic, cultural, and nutritional characteristics that affect patterns of disease. A better understanding of the differences within racial and ethnic categories also can help states develop effective, culturally sensitive public health prevention programs to decrease the prevalence of high-risk behaviors and increase the use of preventive services.

Allowable Values
Alpha-only

Codes
See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes at http://seer.cancer.gov/manuals/2015/SPCSM_2015_AppendixB.pdf
.

Codes (in addition to ISO abbreviations)	
ZZN	North America, NOS
ZZC	Central America, NOS
ZZS	South America, NOS
ZZP	Pacific, NOS
ZZE	Europe, NOS
ZZF	Africa, NOS
ZZA	Asia, NOS
ZZX	Non-United States, NOS
ZZU	Unknown

CASEFINDING SOURCE

Abstract Plus Field Name: Casefinding Source

Required
Item Length: 2
NAACCR Item #: 501

Description
This variable codes the earliest source of identifying information. For cases identified by a source other than reporting facilities (such as through death clearance or as a result of an audit), this variable codes the type of source through which the tumor was first identified. This data item cannot be used by itself as a data quality indicator. The timing of the casefinding processes (e.g., death linkage) varies from registry to registry, and this variable is a function of that timing.

Rationale
This data item will help reporting facilities as well as regional and central registries in prioritizing their casefinding activities. It will identify reportable tumors that were first found through death clearance or sources other than traditional reporting facilities. It provides more detail than "Type of Reporting Source."

Coding Instructions
This variable is intended to code the source that first identified the tumor. Determine where the case was first identified and enter the appropriate code.

Codes	Description
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, codes 23; includes nuclear medicine)
27	Tumor Board
28	Hospital Rehabilitation Service or Clinic
29	Other Hospital Source (including clinic, NOS or outpatient department, NOS)
30	Physician-Initiated Case
40	Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
50	Independent (non-hospital) Pathology-Laboratory Report
60	Nursing Home-Initiated Case
70	Coroner's Office Records Review
75	Managed Care Organization (MCO) or Insurance Records
80	Death Certificate (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 such as casefinding audit of a regional or central registry)
99	Unknown

CAUSE OF DEATH

Abstract Plus Field Name: Cause of Death

Required
Item Length: 4
NAACCR Item #: 1910

Description
Official cause of death as coded from the death certificate in a valid ICD-10 code.

Rationale
Cause of death is used for calculation of adjusted survival rates by the life table method. The adjustment corrects for deaths other than from the diagnosed cancer.

Coding Instructions
Use the appropriate ICD-10 underlying cause of death code. If exact ICD-10 code is unknown, use one of the special codes below.

Codes	Description
0000	Patient alive at last contact
7777	Patient deceased but cause of death ICD-10 code is unknown

CLASS OF CASE

Abstract Plus Field Name: Class of Case

Required
Item Length: 2
NAACCR Item #: 610

Description
Class of Case describes the conditions under which a case was diagnosed and treated.

Rationale
This field helps determine the timeliness of reporting by using it in conjunction with the date of first contact, date of diagnosis and date case completed. It also provides insight into the staging and treatment information for the case. For example, if the report states Class 10-14, then first course treatment should also be included in that report.

Codes	Description
	Analytic cases (diagnosed and or received first course treatment at your facility) Initial Diagnosis at the Reporting Facility
00	Diagnosis at the reporting facility and all of the *first course* of treatment was performed elsewhere or the decision not to treat was made at another facility.
10	Diagnosis at the reporting facility or staff physician office, and ALL OR PART of the *first course* of treatment (or decision not to treat) was performed at the reporting facility.
13	Initial diagnosis at the reporting facility AND PART of first course treatment was at same facility.
14	Initial diagnosis at the reporting facility AND ALL first course treatment or a decision not to treat was done at the reporting facility.
	Analytic cases - Initial Diagnosis at a Staff Physician Office
11	Initial diagnosis in staff physician office AND PART of first course treatment was done at the reporting facility.
12	Initial diagnosis in staff physician office AND ALL first course treatment or a decision not to treat was done at the reporting facility.
	Analytic cases - Initial Diagnosis Elsewhere
20	Diagnosis elsewhere, and ALL OR PART of the *first course* of treatment (or decision not to treat) was done at the reporting facility.
21	Initial diagnosis elsewhere AND PART of treatment was done at the reporting facility.
22	Initial diagnosis elsewhere AND ALL first course treatment was done at the reporting facility.

	Nonanalytic cases (Diagnosis and first course treatment done elsewhere) Patient appears in person at reporting facility
30	Diagnosis and all *first course* of treatment performed elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment consult only, staging workup post diagnosis, etc.).
31	Diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care.
32	Diagnosis and all first course treatment provided elsewhere AND patient presents at reporting facility with disease RECURRENCE OR PERSISTENCE (active disease).
33	Diagnosis and all first course treatment provided elsewhere AND patient presents at reporting facility with HISTORY ONLY (not reportable to WCRS).
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment performed by reporting facility.
35	Diagnosis is prior to the reference date of the registry and all or part of *first course* of treatment was performed at the reporting facility.
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND part or all of first course treatment by reporting facility.
37	Case diagnosed prior to the registry's reference date AND initial diagnosis was elsewhere and ALL OR PART of first course therapy performed at the reporting facility
38	Diagnosed at autopsy; cancer not suspected prior to death.
	Nonanalytic cases – Patient does NOT appear in person at reporting facility
40	Diagnosis and all *first course* of treatment completed by one staff physician in an office setting.
41	Diagnosis and all first course treatment given in two or more different staff physician offices.
42	Non-staff physician office or other clinic or facility that is not part of the reporting facility AND the reporting facility accessions the case (for example, a hospital that reports for an independent radiation facility by agreement, or abstracts for an independent surgery center).
43	Pathology or other lab specimen report only. Patient does not enter the reporting facility at any time for diagnosis or treatment. This category excludes tumors diagnosed at autopsy.
49	Diagnosis was established by death certificate only.
99	Unknown. Sufficient detail for determining Class of Case is not stated in patient record.

COUNTY AT DIAGNOSIS

Abstract Plus Field Name: County at DX

Required
Item Length: 3
NAACCR Item #: 90

Description:
This field contains the county of the patient's residence at the time the tumor was diagnosed. For U.S. residents, standard codes are those of the FIPS (Federal Information Processing Standards) publication "Counties and Equivalent Entities of the United States, its Possessions, and associated areas." If the patient has multiple tumors, the county code may be different for each tumor. Detailed standards have not been set for Canadian provinces/territories. Use code 998 for Canadian residents. See below for complete list of Wisconsin county names, abbreviations and FIPS codes. If entering data electronically, use the FIPS code for that county.

Codes (in addition to FIPS and Geocodes)	
998	Known town, city, state, or country of residence but county not known AND a non-Wisconsin resident. (Must meet all criteria to use this code.)
999	County unknown

Wisconsin County Names, Abbreviations and FIPS Numeric Codes

COUNTY	ABBR	FIPS	COUNTY	ABBR	FIPS	COUNTY	ABBR	FIPS
Adams	ADAM	001	Iowa	IOWA	049	Polk	POLK	095
Ashland	ASHL	003	Iron	IRON	051	Portage	PORT	097
Barron	BARR	005	Jackson	JACK	053	Price	PRICE	099
Bayfield	BAYF	007	Jefferson	JEFF	055	Racine	RACI	101
Brown	BROW	009	Juneau	JUNE	057	Richland	RICH	103
Buffalo	BUFF	011	Kenosha	KENO	059	Rock	ROCK	105
Burnett	BURN	013	Kewaunee	KEWA	061	Rusk	RUSK	107
Calumet	CALU	015	La Crosse	LACR	063	St. Croix	STCR	109
Chippewa	CHIP	017	Lafayette	LAFA	065	Sauk	SAUK	111
Clark	CLAR	019	Langlade	LANG	067	Sawyer	SAWY	113
Columbia	COLU	021	Lincoln	LINC	069	Shawano	SHAW	115
Crawford	CRAW	023	Manitowoc	MANI	071	Sheboygan	SHEB	117
Dane	DANE	025	Marathon	MARA	073	Taylor	TAYL	119
Dodge	DODG	027	Marinette	MARI	075	Trempealeau	TREM	121
Door	DOOR	029	Marquette	MARQ	077	Vernon	VERN	123
Douglas	DOUG	031	Menominee	MENO	078	Vilas	VILA	125
Dunn	DUNN	033	Milwaukee	MILW	079	Walworth	WALW	127
Eau Claire	EACL	035	Monroe	MONR	081	Washburn	WASB	129
Florence	FLOR	037	Oconto	OCON	083	Washington	WASH	131
Fond du Lac	FODU	039	Oneida	ONEI	085	Waukesha	WAUK	133
Forest	FORE	041	Outagamie	OUTA	087	Waupaca	WAUP	135
Grant	GRAN	043	Ozaukee	OZAU	089	Waushara	WAUS	137
Green	GREE	045	Pepin	PEPI	091	Winnebago	WINN	139
Green Lake	GRLA	047	Pierce	PIER	093	Wood	WOOD	141

CS EXTENSION

Abstract Plus Field Name: CS Extension

Required for 2004-2015 Diagnosed Cases
Item Length: 3
NAACCR Item #: 2810

Description
Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in this field.

Rationale
This field is required to calculate the Derived Summary Stage and is needed so the CS derivation algorithm works properly.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Reminder: Include text justification for the code entered in this field in one of the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS LYMPH NODES

Abstract Plus Field Name: CS Lymph Nodes

Required for 2004-2015 Diagnosed Cases
Item Length: 3
NAACCR Item #: 2830

Description
Identifies the regional lymph nodes involved with cancer at the time of diagnosis.

Rationale
This field is required to calculate the Derived Summary Stage and is needed so the CS derivation algorithm works properly.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Reminder: Include text justification for the code entered in this field in one of the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS LYMPH NODES EVALUATION

Abstract Plus Field Name: CS Lymph Nodes Eval

Required for 2004-2015 Diagnosed Cases
Item Length: 1
NAACCR Item #: 2840

Description
Records how the code for CS Lymph Nodes was determined, based on the diagnostic methods employed.

Rationale
This field is required to calculate the Derived Summary Stage and is needed so the CS derivation algorithm works properly.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Reminder: Include text justification for the code entered in this field in one of the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS METASTASES AT DIAGNOSIS

Abstract Plus Field Name: CS Mets at DX

Required for 2004-2015 Diagnosed Cases
Item Length: 2
NAACCR Item #: 2850

Description
Identifies the distant site(s) of metastatic involvement at time of diagnosis.

Rationale
This field is required to calculate the Derived Summary Stage and is needed so the CS derivation algorithm works properly.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS METS AT DIAGNOSIS - BONE

Abstract Plus Field Name: CS Mets at DX—Bone

Required for 2004-2015 Diagnosed Cases
Item Length: 1
NAACCR Item #: 2851

Description
Identifies the presence of distant metastatic involvement of the bone at time of diagnosis.

Rationale
The presence of metastatic bone disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive SEER Summary Stage codes for some sites.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Note: This includes only the bone, not the bone marrow.

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS METS AT DIAGNOSIS - BRAIN

Abstract Plus Field Name: CS Mets at DX—Brain

Required for 2004-2015 Diagnosed Cases
Item Length: 1
NAACCR Item #: 2852

Description
Identifies the presence of distant metastatic involvement of the brain at time of diagnosis.

Rationale
The presence of metastatic brain disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive SEER Summary Stage codes for some sites.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Note: This includes only the brain, not spinal cord or other parts of the central nervous system.

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS METS AT DIAGNOSIS - LIVER

Abstract Plus Field Name: CS Mets at DX—Liver

Required for 2004-2015 Diagnosed Cases
Item Length: 1
NAACCR Item #: 2853

Description
Identifies the presence of distant metastatic involvement of the liver at time of diagnosis.

Rationale
The presence of metastatic liver disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive SEER Summary Stage codes for some sites.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS METS AT DIAGNOSIS - LUNG

Abstract Plus Field Name: CS Mets at DX—Lung

Required for 2004-2015 Diagnosed Cases
Item Length: 1
NAACCR Item #: 2854

Description
Identifies the presence of distant metastatic involvement of the lung at time of diagnosis.

Rationale
The presence of metastatic lung disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive SEER Summary Stage codes for some sites.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Note: This includes only the lung, not pleura or pleural fluid.

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS METASTASES EVALUATION

Abstract Plus Field Name: CS Mets Eval

Required for 2004-2015 Diagnosed Cases
Item Length: 1
NAACCR Item #: 2860

Description
Records how the code for CS Mets at DX was determined based on the diagnostic methods employed.

Rationale
This field is required to calculate the Derived Summary Stage and is needed so the CS derivation algorithm works properly.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS SITE-SPECIFIC FACTORS 1 - 17

Abstract Plus Field Name: SSF 1 - 17

Required for 2004-2017 Diagnosed Cases
Item Length: 3
NAACCR Items #: 2861 – 2871, 2880, 2890, 2900, 2910, 2920, 2930

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
These fields are required to complete CS staging for selected primary sites and some site/histology combinations. Some SSFs are still required for 2016 and later reporting. Refer to Appendix VI for the SSF 1 through SSF 17 site/histologies that are required for state reporting by diagnosis year.

Site-specific factors not listed in Appendix VI are "recommended-only" for WCRS reporting.

Codes
See version 2.05 of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules. The same codes are used for SSFs still required for 2016 reporting.

Reminder: Include text justification for the code(s) entered in these fields in at least one of the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS SITE-SPECIFIC FACTORS 18 - 24

Abstract Plus Field Name: SSF 18 - 24

Recommended
Item Length: 3
NAACCR Item #: 2872 - 2878

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
These fields are recommended for WCRS reporting, but not required.

Codes
See version 2.05 of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Reminder: Include text justification for the code(s) entered in these fields in at least one of the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS SITE-SPECIFIC FACTOR 25

Abstract Plus Field Name: SSF 25

Required for 2004-2017 Diagnosed Cases
Item Length: 3
NAACCR Item #: 2879

Description
Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale
This field is required to complete CS staging for selected primary sites and some site/histology combinations and is still required for 2016 and later reporting. Refer to Appendix VI for the SSF 25 site/histologies that are required to be manually coded for state reporting.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Note: Vendor software systems will auto code this field for 99% of reported tumors.

CS TUMOR SIZE

Abstract Plus Field Name: CS Tumor Size

Required for 2004-2015 Diagnosed Cases
Item Length: 3
NAACCR Item #: 2800

Description
CS Tumor Size is used to record the largest dimension, or the diameter of the primary tumor in millimeters (for example: 1 mm = 001, 1 cm = 010).

Rationale
This field is required to complete the CS staging for Summary Stage and is needed so the CS algorithm can work properly.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS TUMOR SIZE/EXTENSION EVALUATION

Abstract Plus Field Name: CS Tumor Size/Ext Eval

Required for 2004-2015 Diagnosed Cases
Item Length: 1
NAACCR Item #: 2820

Description
Records how the codes for the two items CS Tumor Size and CS Extension were determined based on the diagnostic methods employed.

Rationale
This field is required to complete CS staging and is needed so the CS algorithm can work properly.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions* for site-specific codes and coding rules.

Reminder: Include text justification for the code entered in this field in at least one of the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

CS VERSION DERIVED

Abstract Plus Field Name: CS Version Derived

Required for 2004-2015 Diagnosed Cases
Item Length: 6
NAACCR Item #: 2936

Description
This data item is recorded the first time the CS output fields are derived and should be updated each time the CS Derived items are recomputed. The CS version number is returned as part of the output of the CS algorithm.

The correct version for 2015 cases is 020550.

Note: This field should be auto coded in your vendor software.

CS VERSION INPUT CURRENT

Abstract Plus Field Name: CS Version Input Current

Required for 2004-2015 Diagnosed Cases
Item Length: 6
NAACCR Item #: 2937

Description
This data item identifies the version after CS input fields have been updated or recoded.

Note: This field should be auto coded in your vendor software.

CS VERSION INPUT ORIGINAL

Abstract Plus Field Name: CS Version Input Original

Required for 2004-2015 Diagnosed Cases
Item Length: 6
NAACCR Item #: 2935

Description
This field describes the collaborative stage version that was used to run the algorithm that derives the stage when the case was first abstracted. This field is only required for electronic reporting and should be automatically filled in by your vendor software. This field is not updated if changes are made to CS data items.

DATE CASE COMPLETED

Abstract Plus Field Name: Date Case Completed

Required
Item Length: 8
NAACCR Item #: 2090

Description
The date that the abstractor decided that the tumor report was complete and the case passed all edits that were applied.

Allowable Values
YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when complete date is unknown

DATE INITIAL RX SEER

Abstract Plus Field Name: Initial RX Date

Required
Item Length: 8
NAACCR Item #: 1260

Description
Date of initiation of the first course therapy for the tumor being reported, using the SEER definition of first course.

Allowable Values
YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when complete date is unknown

DATE INITIAL RX SEER FLAG

Abstract Plus Field Name: Initial RX Date Flag

Required
Item Length: 2
NAACCR Item #: 1261

Description
This flag explains why no appropriate value is in the field Date Initial RX SEER.

Allowable Values
10 Unknown if therapy was administered
11 Therapy was not administered
12 Therapy was administered and complete date is unknown
Blank Therapy was administered and a valid date value (complete date, month and year only, or year only) is provided in item Date Initial RX SEER

DATE OF 1st CONTACT

Abstract Plus Field Name: 1st Contact Date

Required
Item Length: 8
NAACCR Item #: 580

Description
Date of first patient contact, as inpatient or outpatient, with the reporting facility for the diagnosis and/or treatment of the tumor. The date may represent the date of an outpatient visit for a biopsy, x-ray, scan, or laboratory test.

Rationale
Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations. Date of First Contact is one of several data items that can be used to measure timeliness of reporting by individual facilities to central cancer registries.

Allowable Values
YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when complete date is unknown

DATE OF 1st CONTACT FLAG

Abstract Plus Field Name: 1st Contact Date Flag

Required
Item Length: 2
NAACCR Item #: 581

Description
This flag explains why no appropriate value is in the field Date of 1st Contact.

Allowable Values
12 Date of 1st Contact is unknown
Blank A valid date value (complete date, month/year or only year) is provided, or the date was not expected to have been transmitted

DATE OF BIRTH

Abstract Plus Field Name: Date of Birth

Required
Item Length: 8
NAACCR Item #: 240

Description
Patient's date of birth. If age at diagnosis and year of diagnosis are known, but year of birth is unknown, then year of birth should be calculated and so coded. Estimate date of birth when information is not available. It is better to estimate than to code as unknown.

Allowable Values
YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown

This field cannot be blank.

Special Coding Instructions
If the Date of **Birth** is **unknown**, but the **Age** at Diagnosis and Date of **Diagnosis** are **known:**

a. Leave month and day blank.
b. Calculate the year of birth by subtracting the patient's age at diagnosis from the year of diagnosis.

Note: *A zero must precede a single-digit month and a single-digit day.*

DATE OF BIRTH FLAG

Abstract Plus Field Name: Date of Birth Flag

Required
Item Length: 2
NAACCR Item #: 241

Description
This flag explains why no appropriate value is in the field Date of Birth.

Allowable Values
12 Date of Birth is unknown
Blank A valid date value is provided (complete date of birth, month/year or only year)

DATE OF DIAGNOSIS

Abstract Plus Field Name: Diagnosis Date

Required
Item Length: 8
NAACCR Item #: 390

Description
Date of *initial* diagnosis (clinically or pathologically) by a recognized medical practitioner.

Allowable Values
YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when complete date is unknown

DATE OF DIAGNOSIS FLAG

Abstract Plus Field Name: Diagnosis Date Flag

Required
Item Length: 2
NAACCR Item #: 391

Description
This flag explains why no appropriate value is in the field Date of Diagnosis.

Allowable Values
12 Date of Diagnosis is unknown
Blank A valid date value (complete date of diagnosis, month/year or year only) is provided

DATE OF LAST CONTACT (DATE OF DEATH)

Abstract Plus Field Name: Last Contact Date

Required
Item Length: 8
NAACCR Item #: 1750

Description
Date of last contact with the patient, or date of death. If the patient has multiple tumors, Date of Last Contact should be the same for all tumors.

Rationale
Used for follow-up and /or to record the date of death.

Allowable Values
YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when complete date is unknown

DATE OF LAST CONTACT FLAG

Abstract Plus Field Name: Last Contact Date Flag

Required
Item Length: 2
NAACCR Item #: 1751

Description
This flag explains why no appropriate value is in the field Date of Last Contact.

Allowable Values
12 Date of Last Contact is unknown
Blank A valid date value (complete date of last contact, month/year or year only) is provided

DERIVED SUMMARY STAGE 2000

Abstract Plus Field Name: Derived SS2000

Required for 2004-2015 Diagnosed Cases/Electronic
Item Length: 1
NAACCR Item #: 3020

Description
This item is the derived "SEER Summary Stage 2000" from the Collaborative Staging algorithm. It is a required field for reporters using an electronic data entry system, such as Abstract Plus. *It is calculated automatically* by the algorithm embedded in the data entry software for cases diagnosed 2004 or later.

Codes

Storage Code	Display String	Comments
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)
0	IS	In situ
1	L	Localized
2	RE	Regional, direct extension
3	RN	Regional, lymph nodes only
4	RE+RN	Regional, extension and nodes
5	RNOS	Regional, NOS
7	D	Distant
8	NA	Not applicable
9	U	Unknown/Unstaged

The computer software usually displays the display string code (column 2) when running the algorithm, but will populate the data item field with the storage code (column 1).

DERIVED SUMMARY STAGE 2000 – FLAG

Abstract Plus Field Name: Derived SS2000—Flag

Required for 2004-2015 Diagnosed Cases/Electronic
Item Length: 1
NAACCR Item #: 3050

Description
Flag to indicate whether the derived SEER Summary Stage 2000 was derived from the Collaborative Stage algorithm or from Extent of Disease codes. *It is calculated automatically* by the algorithm embedded in the data entry software for cases diagnosed 2004 or later.

Codes

1	SS2000 derived from Collaborative Staging Manual and Coding Instructions
2	SS2000 derived from EOD (prior to 2004)
Blank	Not derived

DIAGNOSTIC CONFIRMATION

Abstract Plus Field Name: Diagnostic Confirmation **Required**
Item Length: 1
NAACCR Item #: 490

Description
Records the best method used to confirm the presence of the cancer being reported. The data item is not limited to the confirmation at the time of diagnosis; it is the best method of confirmation used during the entire course of the disease.

Rationale
Diagnostic confirmation is useful to calculate rates based on microscopically confirmed cancers. Full incidence calculations must also include tumors that are only confirmed clinically. The percentage of tumors that are clinically diagnosed only is an indication of whether casefinding is including sources outside of pathology reports.

Codes for Solid Tumors

Codes	Label	Description
1	Positive histology	Histologic confirmation (tissue microscopically examined.)
2	Positive cytology	Cytologic confirmation (no tissues microscopically examined; fluid cells microscopically examined)
4	Positive microscopic confirmation, method not specified.	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver primaries. Elevated PSA is not diagnostic of cancer. However, if the physician used the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiology and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only (other than 5, 6, or 7)	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed; death certificate only	A malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).

Coding Instructions for Solid Tumors

1. The codes are in **priority order**; code 1 has the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods.
2. Change to a lower code if at ANY TIME during the course of disease the patient has a diagnostic confirmation which has a higher priority (lower code number).
3. Assign **code 1** when the microscopic diagnosis is based on:
    a. Tissue specimens from biopsy, frozen section, surgery, autopsy or D&C.
    b. Bone marrow specimens (aspiration and biopsy).
4. Assign **code 2** when the microscopic diagnosis is based on cytologic examination of cells from sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.
5. Assign **code 5** when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer.
    Example 1: The presence of alpha-fetoprotein for liver cancer.
    Example 2: An abnormal electrophoretic spike for multiple myeloma or Waldenstrom macroglobulinemia.
    Example 3: If the workup for a prostate cancer patient is limited to a highly elevated PSA and the physician diagnosis and/or treatment of the patient is based only on that PSA, code the diagnostic confirmation to 5.

6. Assign **code 6** when the diagnosis is based only on:
    a. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined.
    b. Gross autopsy findings (no tissue or cytologic confirmation).
7. Assign **code 8** when the case was diagnosed by any clinical method not mentioned in preceding codes. The diagnostic confirmation is coded 8 when the only confirmation of disease is a physician's clinical diagnosis.

Codes for Nonsolid Tumors – Hematopoietic and Lymphoid Neoplasms

Codes	Label	Description
1	Positive histology	Histologic confirmation (tissue microscopically examined.)
2	Positive cytology	Cytologic confirmation (no tissues microscopically examined; fluid cells microscopically examined)
3	Positive histology PLUS - positive immunophenotyping AND/OR positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia. Genetic testing shows AML with inv(16)(p13.1q22)
4	Positive microscopic confirmation, method not specified.	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiology and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only (other than 5, 6, or 7)	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed; death certificate only	A malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).

Coding Instructions for Hematopoietic or Lymphoid Tumors

1. There is no priority hierarchy for coding Diagnostic Confirmation for nonsolid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing.
2. Assign **code 1** when the microscopic diagnosis is based on:
    a. Tissue specimens from biopsy, frozen section, surgery, autopsy or D&C.
    b. Bone marrow specimens (aspiration and biopsy).
    c. For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow or blood.
3. Assign **code 2** when the microscopic diagnosis is based on cytologic examination of cells (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.
4. Assign code 3 when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.
5. Assign **code 5** when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but there is no positive histologic confirmation.
6. Assign **code 6** when the diagnosis is based only on:
    a. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined.
    b. Gross autopsy findings (no tissue or cytologic confirmation).
7. Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

FOLLOW UP SOURCE

Abstract Plus Field Name: Not Included in Abstract Plus

Required When Available
Item Length: 1
NAACCR Item #: 1790

Description
Records the source from which the latest follow-up information was obtained.

Rationale
For registries performing follow-up, this field helps evaluate the success rates of various methods of follow-up. It also can be used to report to institutions the source of follow-up information that is sent to them. When there is a conflict in follow-up information, knowing the source can help resolve the inconsistency.

Codes

Codes	Description
0	Reported Hospitalization
1	Readmission
2	Physician
3	Patient
4	Department of Motor Vehicles
5	Medicare/Medicaid File
7	Death Certificate
8	Other
9	Unknown, not stated in patient record

GRADE OR DIFFERENTIATION

Abstract Plus Field Name: Grade

Required
Item Length: 1
NAACCR Item #: 440

Description
Describes the tumor's resemblance to normal tissue. Well differentiated (Grade 1) is the most like normal tissue, and undifferentiated (Grade 4) is the least like normal tissue. Grades 5–8 define particular cell lines for lymphomas and leukemia.

Rationale
This data item is useful for prognosis.

Instructions for Coding
1. See Chapter 3 – General Rules for Coding Grade, for specific details to properly code this field.

2. Code the grade or differentiation as stated in the final pathologic diagnosis. If the grade is not stated in the final pathologic diagnosis, use the information from the microscopic description or comments.
3. When the pathology report(s) lists more than one grade of tumor, code to the highest grade, even if the highest grade is only a focus (Rule G, ICD-O-3, p. 21).
4. Code the grade or differentiation from the pathologic examination of the primary tumor, not from metastatic sites.
5. Code the grade or differentiation from the pathology report prior to any neoadjuvant treatment. If there is no pathology report prior to neoadjuvant treatment, assign code 9.
6. When there is no tissue diagnosis, it may be possible to establish grade through magnetic resonance imaging (MRI) or positron emission tomography (PET). When available, code grade based on the recorded findings from these imaging reports.
7. If the primary site is unknown, code Grade/Differentiation as 9 (Unknown).
8. Code the grade for in situ lesions if the information is available. If the lesion is both invasive and in situ, code only the invasive portion. If the invasive component grade is unknown, then code 9,
9. Do not use "high grade," "low grade" or "intermediate grade" descriptions for lymphomas as a basis for differentiation. These terms are categories in the Working Formulation of Lymphoma Diagnoses and do not relate to Grade/Differentiation.
10. Codes 5-8 define T-cell or B-cell origin for leukemia and lymphomas. Do not use codes 1-4 for these cases.
11. Do not code “high grade dysplasia” as Grade/Differentiation; the term “grade” has a different meaning in that context.

Codes	Description
1	well-differentiated; differentiated, NOS
2	moderately differentiated; moderately well-differentiated; intermediate differentiation
3	poorly differentiated; dedifferentiated
4	undifferentiated; anaplastic
5	T-cell; T-precursor
6	B-Cell; Pre-B; B-precursor
7	Null cell; Non T-non B
8	NK cell (natural killer cell) (effective with diagnosis January 1, 1995 and after)
9	Grade/differentiations unknown, not stated, or not applicable

HISTOLOGIC TYPE – MORPHOLOGY

Abstract Plus Field Name: Histology

Required
Item Length: 4
NAACCR Item #: 522

Description
Histologic type refers to the classification of malignancy described in the pathology or cytology report. The International Classification of Diseases for Oncology, Third Edition (ICD-O-3), is used for coding the morphology (histology) of all cancers.

The histology, also called morphology, of a tumor can be coded only after the determination of multiple primaries has been completed. (Refer to the Rules for Determining Multiple Primaries to determine the number of primaries.)

Usually the FINAL pathological diagnosis is used to make the code determination. However, if the microscopic description indicates a more specific histological diagnosis, use the most definitive code available.

Example: The final pathologic diagnosis is carcinoma (8010) of the prostate. Microscopic diagnosis states adenocarcinoma (8140) of the prostate. Adenocarcinoma (8140) should be coded because it provides a more specific description of the type of cancer.

ICD REVISION NUMBER

Abstract Plus Field Name: ICD Revision Number

Required
Item Length: 1
NAACCR Item #: 1920

Description
Indicator for the coding scheme used to code the cause of death field.

Codes	Description
0	Patient alive
1	Patient Deceased (ICD-10)

INSTITUTION REFERRED FROM

Abstract Plus Field Name: Referred From

Required
Item Length: 10
NAACCR Item #: 2410

Description
Identifies the facility that referred the patient to the reporting facility.

Rationale
This number is used to document and monitor referral patterns. It is also used by the central registry to identify potential areas of underreporting or noncompliance.

Instructions for Coding
For hospitals, use the WCRS facility number or the CoC assigned FIN number. For clinics, use the WCRS facility number only. Please visit the WCRS website for a complete list of current reporting facilities and WCRS codes. https://www.dhs.wisconsin.gov/wcrs/reporterinfo/index.htm

Allowable Values
Numeric and alpha are both acceptable. (Alpha is reserved for clinics and pathology labs only.) Right justified with leading zeros.

Codes (in addition to WCRS or CoC assigned codes)	Description
0000000000	Case not referred from a facility
9999999999	Case referred from a facility, but facility number is unknown

INSTITUTION REFERRED TO

Abstract Plus Field Name: Referred To

Required
Item Length: 10
NAACCR Item #: 2420

Description
Identifies the facility that the patient was referred to for further care after discharge from the reporting facility.

Rationale
This number is used to document and monitor referral patterns. It is also used by the central registry to identify potential areas of underreporting or noncompliance.

Instructions for Coding
For hospitals, use the WCRS facility number or the CoC assigned FIN number. For clinics, use the WCRS facility number only. Please visit the WCRS website for a complete list of current reporting facilities and WCRS codes. https://www.dhs.wisconsin.gov/wcrs/reporterinfo/index.htm

Allowable Values
Numeric and alpha are both acceptable. (Alpha is reserved for clinics and pathology labs only.) Right justified with leading zeros.

Codes (in addition to WCRS or CoC assigned codes)	Description
0000000000	Case not referred from a facility
9999999999	Case referred from a facility, but facility number is unknown

LATERALITY

Abstract Plus Field Name: Laterality

Required
Item Length: 1
NAACCR Item #: 410

Description
Laterality identifies the side of a paired organ or side of the body on which the reportable tumor originated. For each primary, determine whether laterality should be coded.

Codes	Description
0	Not a paired site
1	Right: origin of primary
2	Left: origin of primary
3	Only one side involved, right or left origin unspecified
4	Bilateral involvement, lateral origin unknown; stated to be single primary
5	Paired site; midline tumor
9	Paired site, but no information concerning laterality

Coding Instructions

1. Use code **0** if the site is **not** listed in the following table.
2. Code laterality using codes **1-5, 9** for all of the sites listed in the table below.
3. Code the side where the primary tumor originated.
   Assign **code 3** if the laterality is not known but the tumor is confined to a single side of the paired organ.
4. Code **4** is seldom used EXCEPT for the following diseases:

   i. Both ovaries involved simultaneously, single histology
   ii. Bilateral retinoblastomas
   iii. Bilateral Wilm's tumors

5. Assign code **5** when there is a midline tumor.

   Example: Patient has an excision of a melanoma located just above the umbilicus.

6. Assign code **9** when the disease originated in a paired site, but the laterality is unknown.

   Example: Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer.

Sites for Which Laterality Codes Must Be Recorded

ICD-O-3 Code	Site or Subsite
C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
C090	Tonsillar fossa
C091	Tonsillar pillar
C098	Overlapping lesion of tonsil
C099	Tonsil, NOS
C300	Nasal cavity (excluding nasal cartilage, nasal septum)
C301	Middle ear
C310	Maxillary sinus
C312	Frontal sinus
C340	Main bronchus (excluding carina)
C341-C349	Lung
C384	Pleura
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C413	Rib, clavicle (excluding sternum)
C414	Pelvic bones (excluding sacrum, coccyx, symphysis pubis)
C441	Skin of the eyelid
C442	Skin of the external ear
C443	Skin of other and unspecific parts of the face (if midline, assign code 9)
C445	Skin of the trunk (if midline, assign code 9)
C446	Skin of upper limb and shoulder
C447	Skin of the lower limb and hip
C471	Peripheral nerves & autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of the lower limb and hip
C491	Connective, subcutaneous, & other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of the lower limb and hip
C500-C509	Breast
C569	Ovary
C570	Fallopian tube
C620-C629	Testis
C630	Epididymis
C631	Spermatic cord
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter
C690-C699	Eye and adnexa
C700	Cerebral meninges, NOS (Effective with cases diagnosed on/after 1/1/2004)
C710	Cerebrum (Effective with cases diagnosed on/after 1/1/2004)
C711	Frontal lobe (Effective with cases diagnosed on/after 1/1/2004)
C712	Temporal lobe (Effective with cases diagnosed on/after 1/1/2004)
C713	Parietal lobe (Effective with cases diagnosed on/after 1/1/2004)
C714	Occipital lobe (Effective with cases diagnosed on/after 1/1/2004)
C722	Olfactory nerve (Effective with cases diagnosed on/after 1/1/2004)
C723	Optic nerve (Effective with cases diagnosed on/after 1/1/2004)
C724	Acoustic nerve (Effective with cases diagnosed on/after 1/1/2004)
C725	Cranial nerve, NOS (Effective with cases diagnosed on/after 1/1/2004)
C740-C749	Adrenal gland
C754	Carotid body

LYMPH-VASCULAR INVASION

Abstract Plus Field Name: LVI

Required for 2004-2015 Diagnosed Cases – Site-specific
Item Length: 1
NAACCR Item #: 1182

Description
Indicates whether lymphatic duct or blood vessel (LVI) is identified in the pathology report.

Rationale
This data item will record the information as stated in the record. Presence or absence of cancer cells in the lymphatic ducts or blood vessels is useful for prognosis.

T**his data item is required by WCRS for cancer of the penis and testes** and is recommended for all other sites.

Codes

Codes	Description
0	Lymph-vascular Invasion stated as Not Present
1	Lymph-vascular Invasion Present/Identified
8	Not Applicable
9	Unknown

MARITAL STATUS AT DIAGNOSIS

Abstract Plus Field Name: Marital Status at DX

Required
Item Length: 1
NAACCR Item #: 150

Description
The patient's marital status at the time of diagnosis.

Rationale
While many national standard setters no longer require this data item, WCRS does require it for State reporting. Marital status helps in record linkages, identifying errors with date of birth, age at diagnosis and date of diagnosis, and it is essential for assessing the quality of the assigned algorithmic Hispanic ethnicity using the national NAACCR formula.

Codes	Description
1	Single (never married)
2	Married (including common law)
3	Separated
4	Divorced
5	Widowed
6	Unmarried or Domestic Partner (same sex or opposite sex, registered or unregistered)
9	Unknown

Note: *If the patient has multiple tumors, marital status may be different for each tumor.*

MEDICAL RECORD NUMBER

Abstract Plus Field Name: Med. Rec. Number

Required
Item Length: 11
NAACCR Item #: 2300

Description
Medical record number used by the facility to identify the patient. The COC *FORDS Manual* instructs registrars to record numbers assigned by the facility's Health Information Management (HIM) Department only, not department-specific numbers. This number identifies the patient in a facility. It can be used by a central registry to point back to the patient record, and it helps identify multiple reports on the same patient.

Codes (in addition to the medical record number)	Description
UNK	Medical record number unknown
RT	Radiation therapy department patient without HIM number
SU	1-day surgery clinic patient without HIM number

Note: *Other standard abbreviations may be used to indicate departments within the facility for patients without assigned HIM numbers.*

Allowable Values
Alpha-numeric, right justified.

METS AT DIAGNOSIS - BONE

Abstract Plus Field Name: Mets at DX—Bone

Required for 2016-2017 Diagnosed Cases
Item Length: 1
NAACCR Item #: 1112

Description
Identifies the presence of distant metastatic involvement of the bone at time of diagnosis.

Rationale
The presence of metastatic bone disease at diagnosis is an independent prognostic indicator and has implications to survival among patients with initial late stage disease.

Instructions for Coding
See the FORDS manual, pages 145-146, for site-specific codes and coding rules. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

Note: This includes only the bone, not the bone marrow.

Codes

Code	Description
0	None: no bone metastases
1	Yes, distant bone metastases
8	Not applicable
9	Unknown whether bone is an involved metastatic site, or Not documented in patient record

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

METS AT DIAGNOSIS - BRAIN

Abstract Plus Field Name: Mets at DX—Brain

Required for 2016-2017 Diagnosed Cases
Item Length: 1
NAACCR Item #: 1113

Description
Identifies the presence of distant metastatic involvement of the brain at time of diagnosis.

Rationale
The presence of metastatic brain disease at diagnosis is an independent prognostic indicator and has implications to survival among patients with initial late stage disease.

Instructions for Coding
See the FORDS manual, pages 147-148, for site-specific codes and coding rules. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

Note: This includes only the brain only, not the spinal cord or other parts of the central nervous system.

Codes

Code	Description
0	None: no brain metastases
1	Yes, distant brain metastases
8	Not applicable
9	Unknown whether brain is an involved metastatic site, or Not documented in patient record

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

METS AT DIAGNOSIS – DISTANT LYMPH NODES

Abstract Plus Field Name: Mets at DX—DistLN

Required for 2016-2017 Diagnosed Cases
Item Length: 1
NAACCR Item #: 1114

Description
Identifies the presence of distant metastatic involvement of distant lymph nodes at time of diagnosis.

Rationale
The presence of distant lymph nodes at diagnosis is an independent prognostic indicator and has implications to survival among patients with initial late stage disease.

Instructions for Coding
See the FORDS manual, pages 149-150, for site-specific codes and coding rules. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

Note: This includes only distant lymph nodes, not regional lymph nodes (with the exception of lymph nodes for placenta, which are considered M1, distant).

Codes

Code	Description
0	None: no distant lymph node metastases
1	Yes, distant lymph node metastases
8	Not applicable
9	Unknown whether distant lymph node(s) are an involved metastatic site, or Not documented in patient record

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

METS AT DIAGNOSIS - LIVER

Abstract Plus Field Name: Mets at DX—Liver

Required for 2016-2017 Diagnosed Cases
Item Length: 1
NAACCR Item #: 1115

Description
Identifies the presence of distant metastatic involvement of the liver at time of diagnosis.

Rationale
The presence of metastatic liver disease at diagnosis is an independent prognostic indicator and has implications to survival among patients with initial late stage disease.

Instructions for Coding
See the FORDS manual, pages 151-152, for site-specific codes and coding rules. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

Codes

Code	Description
0	None: no liver metastases
1	Yes, distant liver metastases
8	Not applicable
9	Unknown whether liver is an involved metastatic site, or Not documented in patient record

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

METS AT DIAGNOSIS - LUNG

Abstract Plus Field Name: Mets at DX—Lung

Required for 2016-2017 Diagnosed Cases
Item Length: 1
NAACCR Item #: 1116

Description
Identifies the presence of distant metastatic involvement of the lung at time of diagnosis.

Rationale
The presence of metastatic lung disease at diagnosis is an independent prognostic indicator and has implications to survival among patients with initial late stage disease.

Instructions for Coding
See the FORDS manual, pages 153-154, for site-specific codes and coding rules. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

Note: This includes only the lung, not pleura or pleural fluid.

Codes

Code	Description
0	None: no lung metastases
1	Yes, distant lung metastases
8	Not applicable
9	Unknown whether lung is an involved metastatic site, or Not documented in patient record

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

METS AT DIAGNOSIS - OTHER

Abstract Plus Field Name: Mets at DX—Other

Required for 2016-2017 Diagnosed Cases
Item Length: 1
NAACCR Item #: 1117

Description
Identifies the presence of distant metastatic involvement of parts of the body other than bone, brain, distant lymph nodes, liver or lung at time of diagnosis. Some examples include: adrenal gland, bone marrow, pleura, peritoneum, skin, etc.

Rationale
The presence of metastatic disease at diagnosis is an independent prognostic indicator and has implications to survival among patients with initial late stage disease.

Instructions for Coding
See the FORDS manual, pages 155-156, for site-specific codes and coding rules. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

Note: This data item should NOT be coded for bone, brain, liver, lung or distant lymph node metastases.

Codes

Code	Description
0	None: no other metastases
1	Yes, distant metastases in known site(s) other than bone, brain, liver, lung or distant lymph nodes
8	Not applicable
9	Unknown whether any other metastatic site, or Not documented in patient record

Reminder: Include text justification for the code entered in this field in the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

NAACCR RECORD VERSION

Abstract Plus Field Name: Hidden from view, Automatically Coded

Required
Item Length: 3
NAACCR Item #: 50

Description
This item applies only to record types I, C, A and M. Code the NAACCR record version used to create the record.

Allowable Code
160 Version 16

NAME -- ALIAS

Abstract Plus Field Name: Name—Alias

Required
Item Length: 40
NAACCR Item #: 2280

Description
Records an alternate name or "AKA" (also known as) used by the patient, if known. Note that maiden name is entered in maiden name field; do not use this field for patient's maiden name.

Allowable Values:
Characters, hyphens and spaces only. Leave field blank if unknown.

NAME – FIRST

Abstract Plus Field Name: Name—First

Required
Item Length: 40
NAACCR Item #: 2240

Description:
First name of the patient.

Allowable Values:
Characters, hyphens and spaces only. Cannot be blank.

NAME -- LAST

Abstract Plus Fieldname: Name—Last

Required
Item Length: 40
NAACCR Item #: 2230

Description:
Last name of the patient.

Allowable Values:
Characters, hyphens and spaces only. Cannot be blank. The field may be updated if the last name changes.

NAME – MAIDEN

Abstract Plus Field Name: Name—Maiden

Required
Item Length: 40
NAACCR Item #: 2390

Description
Maiden name of female patients who are or have ever been married.

Allowable Values:
Characters, hyphens and spaces only. Leave field blank if unknown.

Rationale
This field is used to link reports on a woman who changed her name between reports. It also is critical when using Spanish surname algorithms to categorize ethnicity. Since a value in this field may be used by linkage software or other computer algorithms, do not use "UNKNOWN" or "NOT APPLICABLE" or any such variation.

NAME – MIDDLE

Abstract Plus Field Name: Name—Middle

Required
Item Length: 40
NAACCR Item #: 2250

Description:
Middle name or, if middle name is unavailable, middle initial of the patient.

Allowable Values:
Characters, hyphens and spaces only. Can be left blank if information not available.

NAME -- SUFFIX

Abstract Plus Field Name: Name—Suffix

Required
Item Length: 3
NAACCR Item #: 2270

Description
Title that follows a patient's last name, such as generation order or credential status (e.g., MD, JR).

Allowable Values:
Characters only. Do not use punctuation marks.

NPI –INSTITUTION REFERRED FROM

Abstract Plus Field Name: Not Available in Abstract Plus

Recommended
Item Length: 10
NAACCR Item #: 2415

Description
The NPI (National Provider Identifier) code that identifies the facility that referred the patient to the reporting facility.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

This field should be used in place of Institution Referred From when the institution is a clinic AND the facility software does not allow alpha character entry in that field.

Rationale
The NPI equivalent of Institution Referred From [NAACCR Item 2410].

Codes
Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://npiregistry.cms.hhs.gov/

NPI –INSTITUTION REFERRED TO

Abstract Plus Field Name: Not Available in Abstract Plus

Recommended
Item Length: 10
NAACCR Item #: 2425

Description
The NPI (National Provider Identifier) code that identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

This field should be used in place of Institution Referred To when the institution is a clinic AND the facility software does not allow alpha character entry in that field.

Rationale
The NPI equivalent of Institution Referred From [NAACCR Item 2420].

Codes
Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://npiregistry.cms.hhs.gov/

NPI –PHYSICIAN—FOLLOW UP

Abstract Plus Field Name: Follow-Up Phys. NPI

Required
Item Length: 10
NAACCR Item #: 2475

Description
The NPI (National Provider Identifier) code for the physician currently responsible for the patient's medical care.

NPI, a unique identification number for U.S. health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Codes
Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://npiregistry.cms.hhs.gov/

NPI –PHYSICIAN—MANAGING

Abstract Plus Field Name: Not Available in Abstract Plus

Recommended
Item Length: 10
NAACCR Item #: 2465

Description
The NPI (National Provider Identifier) code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer..

NPI, a unique identification number for U.S. health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Codes
Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://npiregistry.cms.hhs.gov/

NPI—REPORTING FACILITY

Abstract Plus Field Name: NPI—Reporting Facility

Required
Item Length: 10
NAACCR Item #: 545

Description
The NPI (National Provider Identifier) code for the facility submitting the data in the record.

NPI, a unique identification number for U.S. health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Reporting Facility [540].

Codes
Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://npiregistry.cms.hhs.gov/

OVER-RIDE AGE/SITE/MORPH

Abstract Plus Field Name: Over-Ride Age/Site/Morph

Required When Necessary
Item Length: 1
NAACCR Item #: 1990

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.

This over-ride is used with the following edits in the WCRS Abstract Plus and Web Plus Metafile:

Age, Primary Site, Morph ICDO3--Adult (SEER)
Age, Primary Site, Morph ICDO3--Pediatric (NPCR)

Over-ride Flag as Used in the EDITS Software Package
Some cancers occur almost exclusively in certain age groups. Edits of the type Age, Primary Site, Morphology require review if a site/morphology combination occurs in an age group for which it is extremely rare. The edit Age, Primary Site, Morph ICDO3--Adult (SEER) edits cases with an Age at Diagnosis of 15 and older. The edit Age, Primary Site, Morph ICDO3--Pediatric (NPCR) edits cases with an Age at Diagnosis of less than 15.

Instructions for Coding
1. Leave blank if the program does not generate an error message (and if the case was not diagnosed *in utero*) for the edits of the type Age, Primary Site, Morphology.
2. Correct any errors for the case if an item is discovered to be incorrect.
3. Code 1, 2 or 3 as indicated if review of items in the error or warning message confirms that all are correct.

Codes:

Code	Description
1	Reviewed and confirmed that age/site/histology combination is correct as reported
2	Reviewed and confirmed that case was diagnosed *in utero*
3	Reviewed and confirmed that conditions 1 and 2 both apply
Blank	Not reviewed, or reviewed and corrected

OVER-RIDE HISTOLOGY

Abstract Plus Field Name: Over-Ride Histology

Required When Necessary
Item Length: 1
NAACCR Item #: 2040

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.

This over-ride is used with the following edit in the WCRS Abstract Plus and Web Plus Metafile:

Diagnostic Confirmation, Behavior ICDO3 (SEER IF31)
Morphology--Type/Behavior ICDO3 (SEER MORPH)

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Diagnostic Confirmation, Behavior check that, for *in situ* cases (Behavior = 2), Diagnostic Confirmation specifies microscopic confirmation (1, 2, or 4). The distinction between *in situ* and invasive is very important to a registry, since prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissues, i.e., *in situ*, is made microscopically, cases coded *in situ* in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or *in situ* without microscopic evidence. If an edit of the type, Diagnostic Confirmation, Behavior, gives an error message or warning, check that Behavior and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

Instructions for Coding
1. Leave blank if the program does not generate an error message for the edit Diagnostic Confirmation, Behavior ICDO3.
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.
3. Code 1, 2, or 3 as indicated if review of all items in the error or warning message confirms that all are correct.

Codes:

Code	Description
1	Reviewed and confirmed that the pathologist states the primary to be "*in situ*" or "malignant" although the behavior code of the histology is designated as "benign" or "uncertain" in ICD-O-3
2	Reviewed and confirmed that the behavior code is "*in situ*," but the case is not microscopically confirmed
3	Reviewed and confirmed that conditions 1 and 2 both apply
Blank	Not reviewed, or reviewed and corrected

OVER-RIDE HOSPSEQ/DXCONF

Abstract Plus Field Name: Over-Ride HospSeq/DxConf

Required When Necessary
Item Length: 1
NAACCR Item #: 1986

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.

This over-ride is used with the following edit in the WCRS Abstract Plus and Web Plus Metafile:

Diagnostic Confirm, Seq Num--Hosp (CoC)

Over-ride Flag as Used in the EDITS Software Package
The edit, Diagnostic Confirm, Seq Num--Hosp (CoC), does the following:
1. If any case is one of multiple primaries and is not microscopically confirmed or lacks a positive lab test/marker study, i.e., Diagnostic Confirmation > 5 and Sequence Number--Hospital > 00 (more than one primary), review is required.
2. If Primary Site specifies an ill-defined or unknown primary (C760-C768, C809), no further checking is done.
3. If Sequence Number--Hospital is in the range of 60-88, this edit is skipped.

It is important to verify that the non-microscopically confirmed case is indeed a separate primary from any others that may have been reported. This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study.

1. If the suspect case is confirmed accurate as coded and if the number of primaries is correct, set the Over-ride HospSeq/DxConf to '1.' Do not set the over-ride flag on the patient's other primary cancers.
2. If it turns out that the non-microscopically confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary. Also check for other data items on the remaining cases that may need to be changed as a result of the corrections, such as stage and treatment.

Instructions for Coding
1. Leave blank if the program does not generate an error message for the edit Diagnostic Confirm, Seq Num--Hosp (CoC).
2. Correct any errors for the case if an item is discovered to be incorrect.
3. Code 1 as indicated if review of items in the error or warning message confirms that all are correct.

Codes:

Code	Description
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

OVER-RIDE HOSPSEQ/SITE

Abstract Plus Field Name: Over-Ride HospSeq/Site

Required When Necessary
Item Length: 1
NAACCR Item #: 1988

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.

This over-ride is used with the following edit in the WCRS Abstract Plus and Web Plus Metafile:

Seq Num--Hosp, Primary Site, Morph ICDO3 (CoC)

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Seq Num--Hosp, Primary Site, Morph force review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site.

1. If Sequence Number--Hospital indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:
   - C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-3 histology < 9590. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.
   - C770-C779 (lymph nodes) and ICD-O-3 histology not in the range 9590-9729; or C420-C424 and or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.
   - Any site and ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.
2. If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Instructions for Coding
- Leave blank if the program does not generate an error message for an edit of the type Seq Num--Hosp, Primary Site, Morph.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that hospital sequence number and site are both correct.

Codes:

Code	Description
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

OVER-RIDE LEUK, LYMPHOMA

Abstract Plus Field Name: Over-Ride Leuk, Lymphoma

Required When Necessary
Item Length: 1
NAACCR Item #: 2070

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.

This over-ride is used with the following edit in the WCRS Abstract Plus and Web Plus Metafile:

Diagnostic Confirmation, Histology ICDO3 (SEER IF48)

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Diagnostic Confirmation, Histology check the following:

1. Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation of direct visualization or clinical, and any leukemia with a diagnostic confirmation of direct visualization.
2. If histology = 9590-9729 for ICD-O-3 (lymphoma) then Diagnostic Confirmation cannot be 6 (direct visualization) or 8 (clinical).
3. If histology = 9731-9948 for ICD-O-3 (leukemia and other) then Diagnostic Confirmation cannot be 6 (direct visualization).

Instructions for Coding

- Leave blank if the program does not generate an error message for the edits of the type Diagnostic Confirmation, Histology.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- If the edit produces an error or warning message, verify that the ICD-O-3 histology and diagnostic confirmation are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in Diagnostic Confirmation) for leukemia. Code 1 indicates that a review has taken place and histologic type and diagnostic confirmation are correctly coded.

Codes:

Code	Description
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

OVER-RIDE SITE/BEHAVIOR

Abstract Plus Field Name: Over-Ride Site/Behavior

Required When Necessary
Item Length: 1
NAACCR Item #: 2071

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.

This over-ride is used with the following edit in the WCRS Abstract Plus and Web Plus Metafile:

Primary Site, Behavior Code ICDO3 (SEER IF39)

Over-ride Flag as Used in the EDITS Software Package
Edits of the type, Primary Site, Behavior Code, require review of the following primary sites with a behavior of *in situ* (ICD-O-3 behavior = 2):

- C269 Gastrointestinal tract, NOS
- C399 Ill-defined sites within respiratory system
- C559 Uterus, NOS
- C579 Female genital tract, NOS
- C639 Male genital organs, NOS
- C689 Urinary system, NOS
- C729 Nervous system, NOS
- C759 Endocrine gland, NOS
- C760-C768 Ill-defined sites
- C809 Unknown primary site

Since the designation of *in situ* is very specific and almost always requires microscopic confirmation, ordinarily specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being *in situ* is reliable. If an *in situ* diagnosis is stated, try to obtain a more specific primary site. A primary site within an organ system can sometimes be identified based on the diagnostic procedure or treatment given or on the histologic type. If no more specific site can be determined, it is usually preferable to code a behavior code of 3. In the exceedingly rare situation in which it is certain that the behavior is *in situ* and no more specific site code is applicable, set Over-ride Site/Behavior to 1.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Primary Site, Behavior Code ICDO2 (SEER IF39) and/or the edit Primary Site, Behavior Code ICDO3 (SEER IF39).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of site and behavior verifies that the patient has an *in situ* cancer of a nonspecific site and no further information about the primary site is available.

Codes:

Code	Description
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

OVER-RIDE SITE/LAT/EOD

Abstract Plus Field Name: Over-Ride Site/Lat/EOD

Required When Necessary
Item Length: 1
NAACCR Item #: 2073

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.

This over-ride is used with the following edit in the WCRS Abstract Plus and Web Plus Metafile:

Primary Site, Laterality, CS Extension (SEER IF177)

Over-ride Flag as Used in the EDITS Software Package
Edits of this type Primary Site, Laterality, EOD apply to paired organs and do not allow the extent of disease to be specified as *in situ*, localized, or regional by direct extension if laterality is coded as "bilateral, site unknown," or "laterality unknown."

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Primary Site, Laterality, CS Extension (SEER IF177).
- Code 1 if the case has been reviewed and it has been verified that the patient had laterality coded nonspecifically and extent of disease coded specifically.

Codes:

Code	Description
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

OVER-RIDE SITE/LAT/MORPH

Abstract Plus Field Name: Over-Ride Site/Lat/Morph

Required When Necessary
Item Length: 1
NAACCR Item #: 2074

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.

This over-ride is used with the following edit in the WCRS Abstract Plus and Web Plus Metafile:

Laterality, Primary Site, Morph ICDO3 (SEER IF42)

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Laterality, Primary Site, Morph do the following:

1. If the Primary Site is a paired organ and ICD-O-3 behavior is *in situ* (2), then laterality must be 1, 2, or 3.
2. If diagnosis year less than 1988 and ICD-O-3 histology ≥ 9590, no further editing is performed.
3. If diagnosis year greater than 1987 and ICD-O-3 histology = 9140, 9700, 9701, 9590- 9980, no further editing is performed.

The intent of this edit is to force review of *in situ* cases for which laterality is coded 4 (bilateral) or 9 (unknown laterality) as to origin. In rare instances when the tumor is truly midline (5) or the rare combination is otherwise confirmed correct, enter a code 1 for Override Site/Lat/Morph.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Laterality, Primary site, Morph ICDO3 (SEER IF42).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of site, laterality and morphology verifies that the case had behavior code of "*in situ*" and laterality is not stated as "right: origin of primary;" "left: origin of primary;" or "only one side involved, right or left origin not specified".

Codes:

Code	Description
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

OVER-RIDE SITE/TNM-STGGRP

Abstract Plus Field Name: Over-Ride Site/TNM-STGGRP

Required When Necessary
Item Length: 1
NAACCR Item #: 1989

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.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Primary Site, AJCC Stage Group - Ed 7, ICDO3 (NPCR)

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 override flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Primary Site, AJCC Stage Group - Ed 6 and Primary Site, AJCC Stage Group - Ed 7 check that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the AJCC Cancer Staging Manual Sixth Edition and AJCC Cancer Staging Manual Seventh Edition, using the codes described for the items TNM Clin Stage Group [970] and TNM Path Stage Group [910]. Combinations of site and histology not represented in any AJCC schema must be coded 88. Unknown stage groups must be coded 99. Blanks are not permitted.

Since pediatric cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, Override Site/TNM-Stage Group is used to indicate pediatric cases not coded according to the AJCC manual. Pediatric Stage groups should not be recorded in the TNM Clin Stage Group or TNM Path Stage Group items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any components of either is used to stage a pediatric case, follow the instructions for coding AJCC items and leave Override Site/TNM-Stage Group blank.

Instructions for Coding

1. Leave blank if the program does not generate an error message for the edits of the type Primary Site, AJCC Stage Group - Ed 6 and Primary Site, AJCC Stage Group - Ed 7.
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.
3. Code 1 if the case is confirmed to be a pediatric case that was coded using a pediatric coding system.

Codes:

Code	Description
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

OVER-RIDE SITE/TYPE

Abstract Plus Field Name: Over-Ride Site/Type

Required When Necessary
Item Length: 1
NAACCR Item #: 2030

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.

This over-ride is used with the following edits in the WCRS Abstract Plus and Web Plus Metafile:

Primary Site, Morphology-Type ICDO3 (SEER IF25)
Primary Site, Morphology-Type, Behavior ICDO3 (SEER IF25)

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. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Instructions for Coding

- Leave blank if the program does not generate an error message for the edits of the type Primary Site, Morphology-Type.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and both the site and histology are correct.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SUMMARY STAGE/NODES POSITIVE

Abstract Plus Field Name: Over-Ride SS/Nodes Pos

Required When Necessary
Item Length: 1
NAACCR Item #: 1981

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.

This over-ride is used with the following edit in the WCRS Abstract Plus and Web Plus Metafile:

Summary Stage 2000, Regional Nodes Pos (NAACCR)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error or warning 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. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit Summary Stage 2000, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 2000 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, Regional Nodes Pos (NAACCR) or the edit Summary Stage 2000, Regional Nodes Pos (NAACCR).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and it has been verified that the case has both SEER Summary Stage 1977 and Nodes Positive coded correctly or SEER Summary Stage 2000 and Nodes Positive coded correctly.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SURG/DXCONF

Abstract Plus Field Name: Over-Ride Surg/DxConf

Required When Necessary
Item Length: 1
NAACCR Item #: 2020

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.

This over-ride is used with the following edit in the WCRS Abstract Plus and Web Plus Metafile:

RX Summ--Surg Prim Site, Diag Conf (SEER IF76)

Over-ride Flag as Used in the EDITS Software Package
Edits of the type RX Summ--Surg Prim Site, Diag Conf check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed. If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer. Verify the surgery and diagnostic confirmation codes, and correct any errors. Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery; for example, the tissue removed may be inadequate for evaluation.

Instructions for Coding
- Leave blank if the program does not generate an error message for edits of the type, RX Summ—Surg Prim Site, Diag Conf.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review confirms that they are correct. The patient had surgery, but the tissue removed was not sufficient for microscopic confirmation.

Codes:

Code	Description
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

PHYSICIAN—FOLLOW UP

Abstract Plus Field Name: Follow Up Physician

Required
Item Length: 8
NAACCR Item #: 2470

Description
Code for the physician currently responsible for the patient's medical care.

Allowable Values
Wisconsin Department of Safety and Professional Services physician license number. Right justified with leading zeros. A list of registered physicians is available on the WCRS web site: https://www.dhs.wisconsin.gov/wcrs/reporterinfo/codingresources.htm The list is available alphabetically or sorted by physician license number.

Codes in addition to medical license numbers:

Code	Description
00000000	No follow-up physician
99999999	Follow-up physician unknown or ID number not assigned

PLACE OF DEATH - COUNTRY

Abstract Plus Field Name: Death Place-Country

Required
Item Length: 3
NAACCR Item #: 1944

Description
Country where patient died.

Description
International Standards Organization 3-character country code for the country in which the patient died. If the patient has multiple primaries, all records should contain the same code.

Rationale
Place of death is helpful for carrying out death clearance.

Allowable Values
Alpha-only

Codes
See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes at http://seer.cancer.gov/manuals/2015/SPCSM_2015_AppendixB.pdf
.

Codes (in addition to ISO abbreviations)	
ZZN	North America, NOS
ZZC	Central America, NOS
ZZS	South America, NOS
ZZP	Pacific, NOS
ZZE	Europe, NOS
ZZF	Africa, NOS
ZZA	Asia, NOS
ZZX	Non-United States, NOS
ZZU	Unknown

PLACE OF DEATH - STATE

Abstract Plus Field Name: Death Place-State

Required
Item Length: 2
NAACCR Item #: 1942

Description
State where patient died.

Description
USPS abbreviation for the state, territory, commonwealth, U.S. possession, or Canada Post abbreviation for the Canadian province/ territory in which the patient was born. If the patient has multiple primaries, all records should contain the same code.

Rationale
This field also helps the central registry conduct the annual death clearance.

Allowable Values
Alpha-only

Codes
See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes at: http://seer.cancer.gov/manuals/2015/SPCSM_2015_AppendixB.pdf

Codes (in addition to USPS abbreviations)	
CD	Resident of Canada, NOS (province/territory unknown)
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
XX	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ	Residence unknown

PRIMARY PAYER AT DIAGNOSIS

Abstract Plus Field Name: Primary Payer at DX

Required
Item Length: 2
NAACCR Item #: 630

Description
Primary payer/insurance carrier at the time of initial diagnosis and/or treatment at the reporting facility.

Rationale
This item is used in financial analysis and as an indicator for quality and outcome analyses.

Codes	Description
01	Not insured
02	Not insured, self-pay
10	Insurance, NOS
20	Private Insurance: Managed care, HMO, or PPO
21	Private Insurance: Fee-for-Service
31	Medicaid
35	Medicaid -Administered through a Managed Care plan
60	Medicare/Medicare, NOS
61	Medicare with supplement, NOS
62	Medicare - Administered through a Managed Care plan
63	Medicare with private supplement
64	Medicare with Medicaid eligibility
65	TRICARE
66	Military
67	Veterans Affairs
68	Indian/Public Health Service
99	Insurance status unknown

PRIMARY SITE

Abstract Plus Field Name: Primary Site

Required
Item Length: 4
NAACCR Item #: 400

Description
The primary site is defined as the organ or site in which the cancer originated or began. A metastatic site indicates that the primary (originating) tumor has spread from the original site to other areas in the body. Cancer registries code **only** the primary site in this field, using the ICD-0-3 manual to determine the correct site code. Indications of metastatic sites are used in the registry for identifying the extent of the patient's disease and for staging purposes.

Identify the exact location of the primary (originating) tumor. The most specific location of a tumor should be coded. If the specific subsite of an organ cannot be determined, use the NOS (not otherwise specified) category for that organ or region. The registrar should use all documents available in the medical record to determine the most specific site code, including pathology reports, scans, x-rays, MRIs, etc.

For cases diagnosed January 1, 2001 and later, code the primary site using the topography section of the I*nternational Classification of Diseases for Oncology*, Third Edition (ICD-O-3).

The ICD-O-3 has topography codes listed in two sections; the first is a numeric listing by code number, the second is an alphabetic listing by anatomic site. The topography code consists of a lead character (the letter 'C') followed by two numeric digits, a decimal point, and one additional numeric digit. The decimal point is not entered as part of the code.

Example 1: The pathology report says the primary site is the cardia of the stomach. The code (C16.0) is found in the Alphabetic Index under either "stomach" or "cardia." Enter the code as C160; do not record the decimal point.

Example 2: The pathology report states that the primary site is breast. The mammogram states that the tumor was found in the upper outer quadrant. This further defines the area in the breast where the tumor was found. Upon looking this up in the Alphabetic Index of the ICD-0-3, the code C50.4 was found. Enter the code as C504; do not record the decimal point.

RACE 1 – RACE 5

Abstract Plus Field Names: Race 1, Race 2, Race 3, Race 4, Race 5

Required
Item Length: 2
NAACCR Item #: 160, 161, 162, 163, 164

Description
Race identifies the primary race of the patient. Race (and ethnicity) is defined by specific physical, hereditary and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship. 'Origin' is defined by the U.S. Census Bureau as the heritage, nationality group, lineage, or in some cases, the country of birth of the person or the person's parents or ancestors before their arrival in the United States.

All resources in the facility, including the medical record, face sheet, physician and nursing notes, photographs, and any other sources, must be used to determine race. If a facility does not print race in the medical record but does maintain it in the electronic form, the electronic data must also be reviewed. Recommendation: document how the race code was determined in a text field.

Code the patient's race. **Race is coded separately from Spanish/Hispanic Origin** [190]. If you know the patient to be Hispanic, you must still report the race in these fields. All tumors for the same patient should have the same race code. If the patient is multiracial (not Hispanic), use codes RACE 2 through RACE 5 [161-164]. If the patient is not multiracial, code RACE 1 as the patient's race and code RACE 2 through RACE 5 as 88 (no further race documented).

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. **The full coding system should be used to allow accurate national comparison and collaboration**, even if the state population does not include many of the race categories.

Codes			
01	White	20	Micronesian, NOS
02	Black	21	Chamorran
03	American Indian, Aleutian, Alaskan Native or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	88	No further race documented
13	Kampuchean	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

Reminder: Make sure to justify the code you enter in the race field by including race information in the PE text field

RADIATION—REGIONAL RX MODALITY

Abstract Plus Field Name: Radiation Modality

Required
Item Length: 2
NAACCR Item #: 1570

Description
Records the dominant modality of radiation therapy used to deliver the clinically most significant regional dose to the primary volume of interest during the first course of treatment.

Rationale
Radiation treatment frequently is delivered in two or more phases that can be summarized as regional and boost treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Codes	Description
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
43	Gamma Knife
50	Brachytherapy, NOS
51	Brachytherapy, Intracavitary, Low Dose Rate (LDR)
52	Brachytherapy, Intracavitary, High Dose Rate (HDR)
53	Brachytherapy, Interstitial, Low Dose Rate (LDR)
54	Brachytherapy, Interstitial, High Dose Rate (HDR)
55	Radium
60	Radio-isotopes, NOS
61	Strontium - 89
62	Strontium - 90
80	Combination modality, specified
85	Combination modality, NOS
98	Other, NOS
99	Unknown

Reminder: Make sure to justify the code you enter in this field by completing the associated text field(s): RX TEXT RAD (BEAM) or RX TEXT RAD (OTHER)

REASON FOR NO RADIATON

Abstract Plus Field Name: Reason No Radiation

Required
Item Length: 1
NAACCR Item #: 1430

Description
Records the reason that no radiation was administered to the primary site.

Rationale
This data item provides information related to the quality of care and describes why radiation to the primary site was not performed as part of first course therapy.

Codes	Description
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first-course treatment.
2	Radiation therapy was not administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.).
5	Radiation therapy was not administered because the patient died prior to planned or recommended surgery.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not performed as part of the first-course therapy. No reason was noted in the patient's record.
7	Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Radiation therapy was recommended, but it is unknown if it was performed.
9	It is unknown if radiation therapy was recommended or administered. Death-certificate-only cases and autopsy-only cases.

Reminder: Make sure to justify the code you enter in this field by completing the associated text field(s): RX TEXT RAD (BEAM) or RX TEXT RAD (OTHER)

REASON FOR NO SURGERY

Abstract Plus Field Name: Reason No Surgery

Required
Item Length: 1
NAACCR Item #: 1340

Description
Records the reason that no surgery was performed on the primary site.

Rationale
This data item provides information related to the quality of care and describes why primary site surgery was not performed.

Codes	Description
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first-course treatment.
2	Surgery of the primary site was not recommended/performed because it was contraindicated 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 not performed; it was recommended by the patient's physician, but was not performed as part of the first-course therapy. No reason was noted in the patient's record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown if surgery of the primary site was recommended or performed. Death-certificate-only cases and autopsy-only cases.

Reminder: Make sure to justify the code you enter in this field by completing the associated text field(s): RX TEXT SURGERY

RECORD TYPE

Abstract Plus Field Name: Hidden Field, Automatically Coded

Required
Item Length: 1
NAACCR Item #: 10

Description
Generated field that identifies which of the seven NAACCR data exchange record types is being used in a file of data exchange records. A file should only contain records of one type.

Codes

I Incidence-only record type (nonconfidential coded data)
Length = 3339

C Confidential record type (incidence record plus confidential data)
Length = 5564

A Full case Abstract record type (incidence and confidential data plus text summaries; used for reporting to central registries)
Length = 22,824

U Correction/Update record type (short format record used to submit corrections to data already submitted)
Length = 1543

M Record Modified since previous submission to central registry (identical in format to the "A" record type)
Length = 22,824

L Pathology Laboratory

Note: WCRS accepts record types A and M. M type records must be submitted separately from A records and the file must be identified as a M type file in the Web Plus comments field.

REGIONAL NODES EXAMINED

Abstract Plus Field Name: Reg. Nodes Examined

Required
Item Length: 2
NAACCR Item #: 830

Description
The total number of regional lymph nodes that were removed* and examined by the pathologist.

Rationale
This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Codes	Description
00	No nodes were examined.
01-89	1-89 nodes were examined (code the exact number of regional lymph nodes examined).
90	90 or more nodes were examined.
95	No regional nodes were removed, but aspiration of regional nodes was performed.
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated.
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated.
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown.
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record.

*Exception is code 95 – no nodes removed, only aspiration.

Reminder: Include text justification for the code entered in this field in at least one of the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

REGIONAL NODES POSITIVE

Abstract Plus Field Name: Reg. Nodes Positive

Required
Item Length: 2
NAACCR Item #: 820

Description
Records the exact number of regional nodes examined by the pathologist and found to contain metastases.

Rationale
This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports as well as the extent of the surgical evaluation and treatment of the patient.

Codes	Description
00	All nodes examined are negative.
01-89	1-89 nodes are positive (code exact number of nodes positive).
90	90 or more nodes are positive.
95	Positive aspiration of lymph node(s) was performed.
97	Positive nodes are documented, but the number is unspecified.
98	No nodes were examined.
99	It is unknown whether nodes are positive; not applicable; not stated in patient record.

Reminder: Include text justification for the code entered in this field in at least one of the appropriate text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC -- PATHOLOGY

REPORTING FACILITY

Abstract Plus Field Name: Reporting Facility

Required
Item Length: 10
NAACCR Item #: 540

Description
WCRS facility code or CoC facility code for the facility that is reporting the data described in the submitted cases. This is usually the facility that saw, diagnosed or treated the patient, but sometimes it refers to the facility that is reporting for another facility under a reporting agreement between those facilities (hospital cancer registry reporting for affiliated system clinics or physician offices, or even another hospital).

Please visit the WCRS website for a complete list of current reporting facilities and WCRS codes.
https://www.dhs.wisconsin.gov/wcrs/reporterinfo/index.htm

Rationale
The Reporting Facility identification number or FIN is used to identify a reporting facility in the central registry database and is useful for monitoring data submission, ensuring the accuracy of data and identifying areas for special studies.

Allowable values
Numeric and alpha characters. Must be right justified with leading zeroes.

RX CODING SYSTEM - CURRENT

Abstract Plus Field Name: Hidden from View, Automatically Coded

Required
Item Length: 2
NAACCR Item #: 1460

Description
Code describing how treatment for this tumor now is coded. This field is often auto-coded by the vendor software.

Codes

Codes	Description
00	Treatment data not coded/transmitted (i.e., all treatment fields blank)
01	Treatment data coded using 1-digit surgery codes (obsolete)
02	Treatment data coded according to 1983-1992 SEER manuals and 1983-1995 CoC manuals
03	Treatment data coded according to 1996 *ROADS Manual*
04	Treatment data coded according to 1998 *ROADS* Supplement
05	Treatment data coded according to 1998 *SEER Manual*
06	Treatment data coded according to *FORDS* manual
07	Treatment data coded according to 2010 SEER Coding Manual
99	Other coding, including partial or nonstandard coding

RX DATE -- BIOLOGICAL RESPONSE MODIFIER (BRM)

Abstract Plus Field Name: Immuno Start Date

Required
Item Length: 8
NAACCR Item #: 1240

Description
Date the BRM was first administered as part of first course of treatment.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

Allowable Values
YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when complete date is unknown or treatment not provided

Please remember to include the date of BRM treatment in the RX TEXT— BRM text field

RX DATE BRM FLAG

Abstract Plus Field Name: Immuno Date Flag

Required
Item Length: 2
NAACCR Item #: 1241

Description
This flag explains why no appropriate value is in the field RX Date-BRM.

Allowable Values
10 Unknown if BRM therapy was administered
11 No BRM was administered or an autopsy-only case
12 BRM was administered, but all of the date is unknown
15 BRM is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
Blank A valid date (complete date, month/year or year only) is provided

RX DATE -- CHEMOTHERAPY

Abstract Plus Field Name: Chemo Start Date

Required
Item Length: 8
NAACCR Item #: 1220

Description
Date the chemotherapy was first administered as part of first course of treatment.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

Allowable Values
YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when complete date is unknown or treatment not provided

Please remember to include the date of chemotherapy treatment in the RX TEXT— CHEMO text field

RX DATE CHEMOTHERAPY FLAG

Abstract Plus Field Name: Chemo Date Flag

Required
Item Length: 2
NAACCR Item #: 1221

Description
This flag explains why no appropriate value is in the field RX Date-Chemotherapy.

Allowable Values
10 Unknown if chemotherapy was administered
11 No chemotherapy was administered or an autopsy-only case
12 Chemotherapy was administered, but all of the date is unknown
15 Chemotherapy is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
Blank A valid date (complete date, month/year or year only) is provided

RX DATE -- HORMONE

Abstract Plus Field Name: Hormone Start Date

Required
Item Length: 8
NAACCR Item #: 1230

Description
Date the hormone therapy was first administered as part of first course of treatment.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

Allowable Values
YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when complete date is unknown or treatment not provided

Please remember to include the date of hormone treatment in the RX TEXT— HORMONE text field

RX DATE HORMONE FLAG

Abstract Plus Field Name: Hormone Date Flag

Required
Item Length: 2
NAACCR Item #: 1231

Description
This flag explains why no appropriate value is in the field RX Date-Hormone.

Allowable Values
10 Unknown if hormone therapy was administered
11 No hormone therapy was administered or an autopsy-only case
12 Hormone therapy was administered, but all of the date is unknown
15 Hormone therapy is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
Blank A valid date (complete date, month/year or year only) is provided

RX DATE -- OTHER

Abstract Plus Field Name: Other RX Date

Required
Item Length: 8
NAACCR Item #: 1250

Description
Date other cancer-directed therapy was first administered as part of first course of treatment.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

Allowable Values
YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when complete date is unknown or treatment not provided

Please remember to include the date of Other treatment in the RX TEXT— OTHER text field

RX DATE OTHER FLAG

Abstract Plus Field Name: Other RX Date Flag

Required
Item Length: 2
NAACCR Item #: 1251

Description
This flag explains why no appropriate value is in the field RX Date-Other.

Allowable Values
10 Unknown if other therapy was administered
11 No other therapy was administered or an autopsy-only case
12 Other therapy was administered, but all of the date is unknown
15 Other therapy is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
Blank A valid date (complete date, month/year or year only) is provided

RX DATE -- RADIATION

Abstract Plus Field Name: Radiation Start Date

Required
Item Length: 8
NAACCR Item #: 1210

Description
Date the radiation treatment was first administered as part of first course of therapy.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

Allowable Values
YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when complete date is unknown or treatment not provided

Please remember to include the date of Radiation treatment in the appropriate RX TEXT— RADIATION text field

RX DATE RADIATION FLAG

Abstract Plus Field Name: Radiation Date Flag

Required
Item Length: 2
NAACCR Item #: 1211

Description
This flag explains why no appropriate value is in the field RX Date-Radiation.

Allowable Values
10 Unknown if radiation was administered
11 No radiation was administered or an autopsy-only case
12 Radiation was administered, but all of the date is unknown
15 Radiation is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
Blank A valid date (complete date, month/year or year only) is provided

RX DATE -- SURGERY

Abstract Plus Field Name: Surgery Date

Required
Item Length: 8
NAACCR Item #: 1200

Description
Date the first surgery of the type described under Surgery of Primary Site, Scope of Regional Lymph Node Surgery or Surgery of Other Regional Site(s)/Distant site(s) was performed.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

Allowable Values

YYYYMMDD	when complete date is known and valid
YYYYMM	when year and month are known and valid, and day is unknown
YYYY	when year is known and valid, and month and day are unknown
Blank	when complete date is unknown or treatment not provided

Please remember to include the date of first surgical treatment in the OP procedures and Surgery text fields

RX DATE SURGERY FLAG

Abstract Plus Field Name: Surgery Date Flag

Required
Item Length: 2
NAACCR Item #: 1201

Description
This flag explains why no appropriate value is in the field RX Date-Surgery.

Allowable Values
10 Unknown if surgery was administered
11 No surgery was administered or an autopsy-only case
12 Surgery was administered, but all of the date is unknown
15 Surgery is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
Blank A valid date (complete date, month/year or year only) is provided

RX DATE – MOST DEFINED SURGERY (MST DEFN SRG)

Abstract Plus Field Name: Definitive Surg. Date

Required 2015 and later Diagnoses
Item Length: 8
NAACCR Item #: 3170

Description
Date of most definitive surgical resection of the primary site performed as part of the first course of treatment.

Rationale
The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

Allowable Values

YYYYMMDD	when complete date is known and valid
YYYYMM	when year and month are known and valid, and day is unknown
YYYY	when year is known and valid, and month and day are unknown
Blank	when complete date is unknown or treatment not provided

Please remember to include the date of the most definitive surgical treatment (if more than one surgical procedure done) in the OP procedures and Surgery text fields

RX DATE MST DEFN SRG FLAG

Abstract Plus Field Name: Defin. Surg. Date Flag

Required 2015 and later diagnoses
Item Length: 2
NAACCR Item #: 3171

Description
This flag explains why no appropriate value is in the field RX Date-Mst Defn Srg.

Allowable Values
10 Unknown if surgery was administered
11 No surgery was administered or an autopsy-only case
12 Surgery was administered, but all of the date is unknown
15 Surgery is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
Blank A valid date (complete date, month/year or year only) is provided

RX DATE -- SYSTEMIC THERAPY

Abstract Plus Field Name: Systemic Date

Required
Item Length: 8
NAACCR Item #: 3230

Description
Date of initiation of systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormone agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy.

Rationale
Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Allowable Values

YYYYMMDD	when complete date is known and valid
YYYYMM	when year and month are known and valid, and day is unknown
YYYY	when year is known and valid, and month and day are unknown
Blank	when complete date is unknown or treatment not provided

RX DATE SYSTEMIC FLAG

Abstract Plus Field Name: Systemic Date Flag

Required
Item Length: 2
NAACCR Item #: 3231

Description
This flag explains why no appropriate value is in the field RX Date-Systemic.

Allowable Values
10 Unknown if systemic therapy was administered
11 No systemic therapy was administered or an autopsy-only case
12 Systemic therapy was administered, but all of the date is unknown
15 Systemic therapy is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
Blank A valid date (complete date, month/year or year only) is provided

RX SUMM -- BIOLOGICAL RESPONSE MODIFIER – BRM (IMMUNOTHERAPY)

Abstract Plus Field Name: Immuno Summary

Required
Item Length: 2
NAACCR Item #: 1410

Description
Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at all facilities or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale
Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy.

Codes	Description
00	None, immunotherapy was not part of the planned first course of therapy.
01	Immunotherapy administered as first-course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., 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 first-course therapy. No reason was stated in the patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the 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.

Note: For tumors diagnosed on or after 1/1/2003, information on bone marrow transplants and stem cell transplants should be coded in the field, RX SUMM – Transplant/Endocrine.

Reminder: Make sure to justify the code you enter in this field by completing the associated text field: RX TEXT -- BRM

RX SUMM -- CHEMOTHERAPY

Abstract Plus Field Name: Chemo Summary

Required
Item Length: 2
NAACCR Item #: 1390

Description
Describes the chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Includes treatment given at all facilities as part of the first course.

Codes	Description
00	None, chemotherapy was not part of the planned first course of therapy.
01	Chemotherapy, NOS
02	Chemotherapy, single agent.
03	Chemotherapy, multiple agents.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Chemotherapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the 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.

Reminder: Make sure to justify the code you enter in this field by completing the associated text field: RX TEXT -- CHEMO

RX SUMM -- HORMONE THERAPY

Abstract Plus Field Name: Hormone Summary

Required
Item Length: 2
NAACCR Item #: 1400

Description
Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale
Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy.

Codes	Description
00	None; hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy administered as first-course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., 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 first-course therapy. No reason was stated in the patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the 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 the patient record.

Note: For tumors diagnosed on or after 1/1/2003, information on endocrine surgery and/or endocrine radiation should be coded in the field, RX Summ – Transplant/Endocrine.

Reminder: Make sure to justify the code you enter in this field by completing the associated text field: RX TEXT -- HORMONE

RX SUMM -- OTHER CANCER-DIRECTED THERAPY

Abstract Plus Field Name: Other RX Summary

Required
Item Length: 1
NAACCR Item #: 1420

Description
Identifies other treatment given at all facilities that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment modifies, controls, removes, or destroys proliferating cancer tissue. Such treatments include phlebotomy, transfusions, and aspirin.

Rationale
Information on other therapy is used to describe and evaluate the quality-of-care and treatment practices.

Codes	Description
0	None
1	Other
2	Other Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended
9	Unknown; unknown if administered

Reminder: Make sure to justify the code you enter in this field by completing the associated text field: RX TEXT -- OTHER

RX SUMM -- SCOPE OF REGIONAL LYMPH NODE SURGERY

Abstract Plus Field Name: Scope Reg. Nodes **Required**
Item Length: 1
NAACCR Item #: 1292

Description
This field describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

Codes	Description
0	None
1	Biopsy or aspiration of regional lymph node, NOS
2	Sentinel lymph node biopsy
3	Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
4	1 to 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 not noted.
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

Instructions for Coding

1. This field is collected for each surgical event, even if the surgery of the primary site was not performed.
2. Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item.
3. Codes 0-7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
4. If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the **cumulative** effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7. Do not rely on registry software to determine the cumulative code.
5. Use Code 9 for intracranial and central nervous system primaries, lymphomas with a lymph node primary site, unknown or ill-defined primary site or for hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease,
6. Do **not** code **distant** lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in a different data field.
7. Refer to the AJCC Cancer Staging Manual for site-specific identification of regional lymph nodes.

Codes	Description
0	No effort was made to locate sentinel lymph nodes and no nodes were found in pathologic analysis.
1	(C14.0 – Pharynx) Aspiration of regional lymph node to confirm histology of widely metastatic disease.
2	(C50.1 – Breast) There was an attempt at sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.
2	(C44.5 – Skin of Back) patient has melanoma of the back. A sentinel lymph node dissection was done with the removal of one lymph node. Node was negative for disease.
3	(C61.9 – Prostate) Bilateral pelvic lymph node dissection for prostate cancer.
6	(C50.3 – Breast) Sentinel lymph node biopsy of right axilla (SLNBx), followed by right axillary lymph node dissection (ALND) during same surgical event.
7	(C50.4 – Breast) SLNBx of left axilla, followed in a second procedure 5 days later by a left ALND.
9	(C34.9 – Lung) Patient admitted for radiation therapy following surgery for lung cancer. No documentation on the extent of lymph node surgery in patient record.

RX SUMM – SURGERY OTHER REGIONAL/DISTANT SITES

Abstract Plus Field Name: Surgery-Other Sites

Required
Item Length: 1
NAACCR Item #: 1294

Description
This field records the removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

Rationale
The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Codes	Description
0	None; or diagnosed at autopsy
1	Non-primary surgical procedure performed, NOS
2	Non-primary surgical procedure to other regional sites
3	Non-primary surgical procedure to distant lymph node(s)
4	Non-primary surgical procedure to distant site
5	Any combination of codes 2, 3, or 4
9	Unknown or not applicable

Reminder: Make sure to justify the code you enter in this field by completing the associated text fields: RX TEXT – SURGERY, TEXT – DX PROC – OPERATIVE PROCEDURE

RX SUMM -- SURGERY PRIMARY SITE

Abstract Plus Field Name: Surgery-Primary Site

Required
Item Length: 2
NAACCR Item #: 1290

Description
The type of surgery ***to the primary site*** performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment.

Codes	Description
00	Surgery not performed
10-19	Site-specific surgery performed; tumor destruction*
20-80	Site-specific surgery performed; resection*
90	Surgery, NOS
98	Site-specific codes; special
99	Unknown

*Specific surgery codes for individual primary sites are located in the FORDS Manual Appendix B, Site-specific Surgery Codes: https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/fords%202016.ashx Specific surgery codes are also included in the NPCR Registry Plus Online Help tool: http://www.cdc.gov/cancer/npcr/tools/registryplus/rpoh_tech_info.htm

Reminder: Make sure to justify the code you enter in this field by including justification in at least one of the associated text fields: RX TEXT – SURGERY, TEXT – DX PROC – OPERATIVE PROCEDURE

RX SUMM -- SURGERY/RADIATION SEQUENCE

Abstract Plus Field Name: Surgery/Radiation Seq.

Required
Item Length: 1
NAACCR Item #: 1380

Description
Codes for the sequencing of radiation and surgery (primary site or regional/distant site) given as part of the first course of treatment.

Codes	Description
0	No radiation and/or no surgery OR unknown if surgery and/or radiation was given
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 and/or after surgery
7	Surgery both before and after radiation
9	Sequence unknown, but both surgery and radiation were given

RX SUMM -- SYSTEMIC/SURGERY SEQUENCE

Abstract Plus Field Name: Surgery/Systemic Seq.

Required
Item Length: 1
NAACCR Item #: 1639

Description
Records the sequencing of systemic therapy (chemotherapy, hormone therapy, immunotherapy, transplant or endocrine surgery) and surgical procedures given as part of the first course of treatment.

Rationale
The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the time of delivery of treatment to the patient.

Codes	Description
0	No systemic therapy and/or surgical procedures OR unknown if surgery and/or systemic therapy was given
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before and/or after surgery
7	Surgery both before and after systemic therapy
9	Sequence unknown, but both surgery and systemic therapy were given

RX SUMM -- TRANSPLANT/ENDOCRINE THERAPY

Abstract Plus Field Name: Transplant/Endocrine

Required
Item Length: 2
NAACCR Item #: 3250

Description
Identifies systemic therapeutic procedures administered as part of the first course of treatment at this and all other facilities. If none of these procedures were administered, this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Rationale
This data item allows the evaluation of patterns of treatment that involve the alteration of the immune system or change the patient's response to tumor cells but do not involve the administration of antineoplastic agents.

Codes	Description
00	No transplant procedure or endocrine therapy was administered as part of first course therapy; or diagnosed at autopsy.
10	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.
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 was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age).
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian; refusal 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.

Reminder: Make sure to justify the code you enter in this field by completing the associated text field: TEXT – REMARKS

RX SUMM – TREATMENT STATUS

Abstract Plus Field Name: RX Status Summary

Required
Item Length: 1
NAACCR Item #: 1285

Description
This data item is a summary of the status for all treatment modalities. It also indicates active surveillance (watchful waiting).

Rationale
This field will document active surveillance (watchful waiting) and eliminate searching each treatment modality to determine whether treatment was given.

Codes	Description
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment given

RX TEXT— BRM

Abstract Plus Field Name: BRM

Required
Item Length: 1000
NAACCR Item #: 2660

Description
Field used to manually document information regarding the biological response modifiers or immunotherapy treatment provided or reason why BRM was not provided.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
- Date BRM began or reason why BRM was not given (patient refused, patient died, contraindicated, etc.)
- Where BRM was given; e.g., at this facility; at another facility.
- Type of BRM agent; e.g., Interferon, BCG.
- BRM procedures; e.g., bone marrow transplant, stem cell transplant.

Text Recommendation:
- Other treatment information; e.g., treatment cycle incomplete; unknown if BRM was given.

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Name	Item Number
RX Summ- BRM	1410
RX Date – BRM	1240
RX Summ – Systemic/Surgery Sequence	1639
RX Date Systemic	3230

RX TEXT— CHEMOTHERAPY

Abstract Plus Field Name: Chemo

Required
Item Length: 1000
NAACCR Item #: 2640

Description
Field used to manually document information regarding the chemotherapy treatment provided or reason why no chemotherapy was provided.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
- Date chemotherapy began or reason why it was not given (patient refused, patient died, contraindicated, etc.).
- Where chemotherapy was given; e.g., at this facility; at another facility.
- Type of chemotherapy, e.g. name of agent(s) or protocol.

Text Recommendation:
- Other treatment information; e.g., treatment cycle incomplete; unknown if chemotherapy was given.

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Name	Item Number
RX Summ- Chemotherapy	1390
RX Date – Chemotherapy	1220
RX Summ – Systemic/Surgery Sequence	1639
RX Date Systemic	3230

RX TEXT — HORMONE

Abstract Plus Field Name: RX Text—Hormone

Required
Item Length: 1000
NAACCR Item #: 2650

Description
Field used to manually document information regarding the hormone treatment provided or reason why no hormone was provided.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
- Date hormone therapy began or reason why it was not given (patient refused, patient died, contraindicated, etc.).
- Where hormone therapy was given; e.g., at this facility; at another facility.
- Type of hormone or antihormone, e.g., Tamoxifen.

Text Recommendations:
- Type of endocrine surgery or radiation, e.g., orchiectomy.
- Other treatment information; e.g., treatment cycle incomplete; unknown if hormones were given.

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Name	Item Number
RX Summ- Hormone	1400
RX Date – Hormone	1230
RX Summ – Systemic/Surgery Sequence	1639
RX Date Systemic	3230

RX TEXT— OTHER

Abstract Plus Field Name: Other RX

Required
Item Length: 1000
NAACCR Item #: 2670

Description
Field used to manually document information regarding the other cancer-directed treatment provided.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
- Date other treatment began or reason why it was not given (patient refused, patient died, contraindicated, etc.).
- Where other treatment was given; e.g., at this facility; at another facility.
- Type of other treatment, e.g., blinded clinical trial, hyperthermia.

Text Recommendations:
- Other treatment information; e.g., treatment cycle incomplete; unknown if other treatment was given.

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Name	Item Number
RX Summ- Other	1420
RX Date – Other	1250

RX TEXT— RADIATION (BEAM)

Abstract Plus Field Name: Rad. Beam

Required
Item Length: 1000
NAACCR Item #: 2620

Description
Field used to manually document information regarding the beam radiation treatment provided or reason why no beam radiation was provided.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• Use NAACCR-approved abbreviations.
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
• Date beam radiation began or reason why it was not given (patient refused, patient died, contraindicated, etc.).
• Where beam radiation was given; e.g., at this facility; at another facility.
• Type of beam radiation **as defined in the FORDS Manual** (Photons [MV range], Orthovoltage, Cobalt-60, IMRT, etc.).
Text Recommendation:
• Other treatment information; e.g., patient discontinued after 5 treatments; unknown if radiation treatment was given.

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Name	Item Number
Rad Regional RX Modality	1570
RX Date – Radiation	1210
RX Summ – Surgery/Radiation Sequence	1380

RX TEXT— RADIATION (OTHER)

Abstract Plus Field Name: Rad. Other

Required
Item Length: 1000
NAACCR Item #: 2630

Description
Field used to manually document information regarding the other radiation treatment provided or reason why no other radiation treatment was provided.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• Use NAACCR-approved abbreviations.
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
• Date non-beam radiation began or reason why it was not given (patient refused, patient died, contraindicated, etc.).
• Where non-beam radiation was given; e.g., at this facility; at another facility.
• Type of non-beam radiation; e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131).
Text Recommendation:
• Other treatment information; e.g., unknown if radiation was given.

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected c odes in the following fields:

Item Name	Item Number
Rad Regional RX Modality	1570
RX Date – Radiation	1210
RX Summ – Surgery/Radiation Sequence	1380

RX TEXT— SURGERY

Abstract Plus Field Name: Primary Site Surgery

Required
Item Length: 1000
NAACCR Item #: 2610

Description
Field used to manually document information regarding all surgical procedures performed (or reason why not performed) as first-course treatment.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
- Date and type of each surgical procedure (incl. excisional biopsies and surgery to other/distant sites).
- Document if lymph nodes, regional tissues or metastatic sites were removed; if so, document LN number or site.
- Facility where each procedure was performed.
- Positive and negative findings. Record positive findings first.
- Other treatment information, e.g., planned procedure aborted; unknown if surgery performed.

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Name	Item Number	Item Name	Item Number
RX Summ – Surgery Primary Site	1290	Reason for No Surgery	1340
RX Date – Surgery	1200	RX Summ – Surgery/Radiation Sequence	1380
RX Summ – Scope Reg. LN Surgery	1292	RX Summ – Systemic/Surgery Sequence	1639
RX Summ – Surgery Oth/Distant Site	1294		

SEER SUMMARY STAGE 2000

Abstract Plus Field Name: Summary Stage

Required for cases diagnosed 2001 and later
Item Length: 1
NAACCR Item #: 759

Description
This code is for summary stage at the initial diagnosis or treatment of the reportable tumor. For hospital registries, CoC requires its use in the absence of a defined AJCC classification. For site-specific definitions of categories, see SEER *Summary Staging Manual 2000*. Summary stage should include all information available through completion of surgery(ies) as part of the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer. The manual can be downloaded from the SEER website: https://seer.cancer.gov/tools/ssm/SSSM2000-122012.pdf

Rationale
Stage information is important when evaluating the effects of cancer control programs. It is crucial in understanding whether changes over time in cancer incidence rates or outcomes are due to earlier detection (detecting cancer at an earlier stage of the disease). In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

Codes	Description
0	*In situ*
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable ***Note:*** *Code **8** should only be used for reportable benign tumors (e.g., benign brain or other CNS).*
9	Unstaged

Clarification of WCRS Required Status
This field is required for ALL cases diagnosed 2001 and later, no exceptions.

SEQUENCE NUMBER

Abstract Plus Field Name: Sequence Number

Required
Item Length: 2
NAACCR Item #: 560

Description
This field indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has only one malignant neoplasm in his/her lifetime (regardless of registry reference date). Sequence Number 01 indicates the first of two or more malignant neoplasms, while 02 indicates the second of two or more malignant neoplasms, and so on. Because the time period of Sequence Number spans a person's lifetime (how many cancers the patient had in his/her life), reportable neoplasms not included in the hospital registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the hospital registry's reference date. Similarly, Sequence Number 60 indicates the patient has only one non-malignant neoplasm, and Sequence Number 61 represents the first of multiple non-malignant neoplasms.

Timing Rule
If two or more malignant tumors are diagnosed at the same time, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. Likewise, if two or more non-malignant tumors are diagnosed at the same time, the lowest sequence number is assigned to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Codes	Description
***In situ* or Malignant Tumors:**	
00	One malignant primary only in the patient's lifetime
01	First of two or more malignant primaries
02	Second of two or more malignant primaries
…	(Actual number of this malignant primary)
99	Unspecified sequence number of a primary malignant tumor or unknown (When a patient has multiple tumors with unspecified/unknown sequence numbers code 99 should only be used once.)
Nonmalignant Tumors	**Description**
60	Only one non-malignant tumor in the patient's lifetime
61	First of two or more non-malignant tumors
62	Second of two or more non-malignant tumors
…	
88	Unspecified number of non-malignant tumors (When a patient has multiple unspecified neoplasms in this category code, 88 should only be used once.)

The table below shows which sequence number series to use by type of neoplasm:

Neoplasm	SeqNum-Hospital
***In situ* and Malignant**	**(code range)**
One *in situ* (behavior code = 2) or malignant (behavior code=3) primary tumor only in the patient's lifetime	00
First of multiple *in situ* or malignant primary tumors in the patient's lifetime	01
Actual sequence of two or more *in situ* or malignant primary tumors	02-35
Unspecified in situ or malignant sequence number OR unknown	99
Non-Malignant	
One benign (behavior code = 0) or borderline (behavior code = 1) primary tumor only in the patient's lifetime	60
First of two or more benign or borderline primary tumors in the patient's lifetime	61
Actual sequence of two or more non-malignant primary tumors	62-87
Unspecified non-malignant sequence number OR unknown	88

SEX

Abstract Plus Field Name: Sex

Required
Item Length: 1
NAACCR Item #: 220

Description
Sex of the patient at the time of diagnosis.

Codes	
1	Male
2	Female
3	Other (hermaphrodite)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not stated/Unknown

Definition:
Transsexual: Surgically altered gender.

Please remember to include the patient's sex in the PE text field.

SOCIAL SECURITY NUMBER

Abstract Plus Field Name: SSN

Required
Item Length: 9
NAACCR Item #: 2320

Description
The patient's Social Security number. Note: This is not always identical to the Medicare claim number.

Allowable Values
Numbers only, no spaces, no dashes or any letter suffix. Cannot be blank.

Codes (in addition to Social Security number)

999999999	Unknown

Alert:

This is a required field; it is extremely important for accurate merging of cases submitted on different tumors or from different facilities for the same person. Many new Electronic Health Record systems are not making the SSN available to personnel in the facility system outside the billing staff. If you are unable to access the SSN in your medical chart or through your EHR for WCRS required reporting, you must contact your HIM and IT management immediately to make them aware of the reporting requirement so the software can be updated to allow access for reporting.

SPANISH/HISPANIC ORIGIN

Abstract Plus Field Name: Hispanic Ethnicity

Required
Item Length: 1
NAACCR item #: 190

Description
This data item is used to identify patients with Spanish/Hispanic/Latino surname or of Spanish origin. Persons of Spanish or Hispanic/Latino surname/origin MAY BE OF ANY RACE.

If a patient has a Hispanic name, but there is reason to believe he or she is not Hispanic (e.g., the patient is Filipino, or the patient is a woman known to be non-Hispanic who has a Hispanic married name), the code in this field would be 0 (non-Hispanic).

If the patient has multiple tumors, all records should have the same code.

Rationale
See the rationales for Races 1-5. Ethnic origin has a significant association with cancer rates and outcomes. Hispanic populations have patterns of cancer occurrence different from other populations that may be included in the "white" category of Race.

Codes	Description
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS, or Hispanic, NOS, or Latino, NOS There is evidence, other than surname or maiden name, that the person is Hispanic, but he/she cannot be assigned to any of the categories 1-5.
7	Spanish surname only. The only evidence of the person's Hispanic origin is the surname or maiden name and there is no contrary evidence that the patient is not Hispanic.
8	Dominican Republic
9	Unknown whether Spanish/Hispanic/Latino or not

Reminder: Make sure to justify the code you enter in the this field by including Hispanic information in the PE text field

Caution! Do not use race code '98-other' when the patient is Hispanic. Choose the correct Hispanic code and separately code the appropriate race field (most often '01-white,' but Hispanic persons can be of any race).

TELEPHONE

Abstract Plus Field Name: Telephone

Recommended
Item Length: 10
NAACCR item #: 2360

Description
Current telephone number with area code for the patient. Number is entered without dashes.

Rationale
WCRS uses this field to help determine person matches with record linkages. As SSN and maiden name (which are still required) are not being provided, the patient phone number ,readily available in most cases, is used give a potential match more weight, when the incoming number is the same as the number already in the database.

Codes (in addition to valid telephone number)

0000000000 Patient does not have a telephone
9999999999 Telephone number unavailable or unknown

TEXT—DX PROC--LAB TESTS

Abstract Plus Field Name: Labs

Required
Item Length: 1000
NAACCR Item #: 2550

Description
Text area for manual documentation of information from laboratory examinations other than cytology or histopathology.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• Use NAACCR-approved abbreviations.
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.
Note: For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• Type of lab test/tissue specimen(s)
• Record both positive and negative findings. Record positive test results first.
• Date(s) of lab test(s)
Text Notes:
• Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
• Tumor markers include, but are not limited to:
- Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu.
- Prostate Cancer – Prostatic Specific Antigen (PSA)
- Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

Data Item(s) to be verified/validated using the text entered in this field:

Item Name	Item Number
Diagnostic Confirmation	490
Required Lab-based SSFs (ER, PR, HER2, for example)	

TEXT—DX PROC -- OPERATIVE REPORT

Abstract Plus Field Name: Op

Required
Item Length: 1000
NAACCR Item #: 2560

Description
Text area for manual documentation of all surgical procedures (not just first-course therapy) that provide information for staging.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived
- Number of lymph nodes removed
- Size of tumor removed
- Documentation of residual tumor
- Evidence of invasion of surrounding areas
- If surgery planned but not performed; reason primary site surgery could not be completed

Data Item(s) to be verified/validated using the text entered in this field:

Item Name	Item Number
Reason for No Surgery	1340
CS Extension	2810
CS Extension Evaluation Code	2820, 2840, 2860
CS Lymph Nodes	2830
Mets at DX	2850, (2851-2854 if applicable)
RX Summ – Surgery Primary Site	1290
SEER Summary Stage 2000	759
T, N and M fields	

TEXT—DX PROC--PATHOLOGY

Abstract Plus Field Name: Pathology

Required
Item Length: 1000
NAACCR Item #: 2570

Description
Text area for manual documentation of information from cytology and histopathology reports.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• Use NAACCR-approved abbreviations.
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.
Note: For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
• Date(s) of procedure(s) and type of tissue specimen(s)
• Tumor type and grade (include all modifying adjectives, such as predominantly, with features of, with foci of)
• Tumor **size** and **extent** of tumor **spread**
• Involvement of resection margins
• Number of lymph nodes involved and examined
• Positive and negative findings. Record positive test results first.
Text Recommendations:
• Note if pathology report is a slide review or a second opinion from an outside source (AFIP, Mayo, etc.).
• Record any additional comments from the pathologist, including differential diagnoses considered, ruled out or favored.

Data Item(s) to be verified/validated using the text entered in this field:

Item Name	Item Number	Item Name	Item Number
Date of Diagnosis	390	SEER Summary Stage 2000	759
Primary Site	400	CS Tumor Size	2800
Laterality	410	CS Extension, Lymph Nodes, Mets	2810, 2830, 2850
Histologic Type	522	CS Extension Evaluation Codes	2820, 2840, 2860
Grade	440	SSFs required, if applicable by site	2880, 2890, 2900
Diagnostic Confirmation	490		2862-2868
Regional Nodes Positive & Examined	820, 830	T, N and M data items	

TEXT—DX PROC--PE

Abstract Plus Field Name: PE

Required
Item Length: 1000
NAACCR Item #: 2520

Description
Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• Use NAACCR-approved abbreviations.
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.
Note: For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
• Age, sex, marital status, race and ethnicity
• Prior cancer history (previous cancers diagnosed and when)
• Date of physical exam
• Impression (when stated and pertains to cancer diagnosis)
Text Recommendations:
• Behavioral risk factors (smoking history, etc.)
• Family history of cancer

Data Item(s) to be verified/validated using the text entered in this field:

Item Name	Item Number
Sex	220
Sequence Number	560
Age at Diagnosis	230
Race 1-5	160-164
Spanish/Hispanic Origin	190
Marital Status	150

TEXT—DX PROC--SCOPES

Abstract Plus Field Name: Scopes

Required
Item Length: 1000
NAACCR Item #: 2540

Description
Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• Use NAACCR-approved abbreviations.
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.
Note: For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
• Date(s) of endoscopic exam(s)
• Record site and type of endoscopic biopsy
• Tumor location
• Tumor size
• Primary site
• Histology (if given)
• Record positive and negative clinical findings. Record positive results first.

Data Item(s) to be verified/validated using the text entered in this field:

Item Name	Item Number
Diagnostic Confirmation	490
Primary Site	400
Laterality	410
Applicable Staging Fields	

TEXT—DX PROC – X-RAY/SCAN

Abstract Plus Field Name: Imaging

Required
Item Length: 1000
NAACCR Item #: 2530

Description
Text area for manual documentation from all X-rays, scan, and/or other imaging examinations that provide information about staging.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• Use NAACCR-approved abbreviations.
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.
Note: For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
• Date(s) of X-ray/Scan(s)
• Tumor location and size
• Lymph nodes
• Distant disease or metastasis
• Primary site and Histology (if given)
• Positive and negative clinical findings. Record positive results first.

Data Item(s) to be verified/validated using the text entered in this field:

Item Name	Item Number	Item Name	Item Number
Primary Site	400	CS Extension	2810
Laterality	410	CS Lymph Nodes	2830
Histology ICD-O3	522	CS Mets	2850, 2851-54
SEER Summary Stage 2000	759	CS Extension/Tumor Size Evaluation	2820
CS Tumor Size	2800	T, N and M Fields	

TEXT--HISTOLOGY TITLE

Abstract Plus Field Name: Histology Title

Required
Item Length: 100
NAACCR Item #: 2590

Description
Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• Use NAACCR-approved abbreviations.
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.
Note: For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
• Histologic type (adenocarcinoma, sarcoma, CLL, squamous cell, etc.) and behavior (benign, in situ, malignant)
• Grade, differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc.

Data Item(s) to be verified/validated using the text entered in this field:

Item Name	Item Number
Histologic Type ICD-O3	522
Behavior Code	523
Grade	440

TEXT—PLACE OF DIAGNOSIS

Abstract Plus Field Name: Place of Diagnosis

Recommended
Item Length: 60
NAACCR Item #: 2690

Description
Text area for manual documentation of the facility and/or physician office where the diagnosis was made.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
- Prioritize entered information in the order of the fields listed below.
- NAACCR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

TEXT--PRIMARY SITE TITLE

Abstract Plus Field Name: Primary Site Title

Required
Item Length: 100
NAACCR Item #: 2580

Description
Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• Use NAACCR-approved abbreviations.
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.
Note: For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
• Location of the primary site of the tumor, including subsite.
• Tumor laterality

Data Item(s) to be verified/validated using the text entered in this field:

Item Name	Item Number
Primary Site	400
Laterality	410

TEXT—REMARKS

Abstract Plus Field Name: Remarks

Required
Item Length: 1000
NAACCR Item #: 2680

Description
Text area for information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data can also be placed here. Problematic coding issues can also be discussed in this section.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
• Use NAACCR-approved abbreviations.
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
• Justification of over-ride flags (if an over-ride flag is set)
• Justification of transplant/endocrine surgery field
• Information clarifying anything unusual, such as reason for reporting a case seemingly not reportable for that facility, or reason for coding numerous fields as unknown.

Text recommendations:
• Smoking history
• Family and personal history of cancer
• Comorbidities
• Information on previous cancers if a person was diagnosed with another cancer out-of-state or before the registry's reference date
• Place of birth if available

TEXT--STAGING

Abstract Plus Field Name: Stage

Required
Item Length: 1000
NAACCR Item #: 2600

Description
Additional text area for staging information not already entered in the Text--DX Proc areas.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

Instructions
• Include enough information to be able to code from the text all applicable staging fields: SEER Summary Stage, Collaborative stage (esp. tumor size, extension, lymph nodes and metastases) and AJCC TNM staging components (clinical and pathologic)
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• Use NAACCR-approved abbreviations.
• Do not repeat information from other text fields.
• Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
• If information is missing from the record, state that it is missing.
• Do not include irrelevant information.
• Do not include information that the registry is not authorized to collect.
Note: For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Text Requirements:
• Tumor Size
• Date(s) of biopsy and/or other procedure(s) (including clinical) that provided information for assigning stage
• Extent of tumor (depth of spread in primary and other organs involved by direct extension)
• Status of margins
• Number and sites of positive lymph nodes (and condition of nodes if applicable – matted vs. moveable)
• Site(s) of distant metastasis

Data Item(s) to be verified/validated using the text entered in this field that is not entered in DX PROC text fields:

Item Name	Item Number
Collaborative Stage Fields	2800-2930
AJCC T, N, M, Stage Group Fields	880-1060
SEER Summary Stage 2000	759
Regional Nodes Positive	820
Regional Nodes Examined	830

TEXT—USUAL INDUSTRY

Abstract Plus Field Name: Industry

Required
Item Length: 100
NAACCR Item #: 320

Description
Text description of the patient's usual industry or type of occupational setting. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

If the patient is a child, please put CHILD in this text field.

Rationale
Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

Allowable Values
Record the primary type of business activity performed by the company/employer or setting where the patient was employed for the most number of years before diagnosis of the tumor. Distinguish whether the industry or setting is involved in manufacturing, wholesale, retail, service, farming, mining, teaching, etc. If the primary activity is unknown, it may be appropriate to record the name of the company/employer or setting and the city or town. The central registry office may use the name of the company/employer or setting and the city or town to determine the type of business activity performed. If the patient is retired and no other information is available, do **not** list retired. Leave field blank if information is unavailable. Example: If the patient was a teacher (occupation) the industry would be the type of school (elementary, high school, technical college, etc.) at which he/she taught.

TEXT—USUAL OCCUPATION

Abstract Plus Field Name: Occupation

Required
Item Length: 100
NAACCR Item #: 310

Description
Text description of the patient's usual occupation. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

If the patient is a child, please put CHILD in this text field.

Rationale
Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

Allowable Values
Record the primary type of employee activity performed by the patient where the patient was employed for the most number of years before diagnosis of the tumor. If the patient was a housewife/househusband and also worked outside the home, record the occupation outside the home. If the patient was a housewife/househusband and never worked outside the home, record "homemaker," "housewife," or "househusband." If the patient was NOT a student or homemaker, and never worked, record "never worked," or "never employed." If the patient is retired and no other information is available, do **not** list retired. Leave field blank if information is unavailable.

TNM CLINICAL DESCRIPTOR

Abstract Plus Field Name: TNM Clin Descriptor

Required for 2016-2017 Diagnoses
Item Length: 1
NAACCR Item #: 980

Description
Identifies the American Joint Commission on Cancer (AJCC) clinical stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

Codes

Codes	Description
0	None
1	E (extranodal, lymphomas only)
2	S (spleen, lymphomas only)
3	M (multiple primaries in a single tumor)
5	E & S (extranodal and spleen, lymphomas only)
9	Unknown, not stated in patient record

TNM CLINICAL M

Abstract Plus Field Name: TNM Clin M

Required for 2016-2017 Diagnoses
Item Length: 4
NAACCR Item #: 960

Description
Detailed site-specific codes for the clinical metastases (M) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

Codes
The following codes are valid for AJCC 7th TNM edition:

```
c0
c0I+
c1
c1A
c1B
c1C
c1D
c1E
p1
p1A
p1B
p1C
p1D
p1E
88
blank
```

Reminder: Include text justification for the code entered in this field in at least one of the following text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC – PATHOLOGY.

TNM CLINICAL N

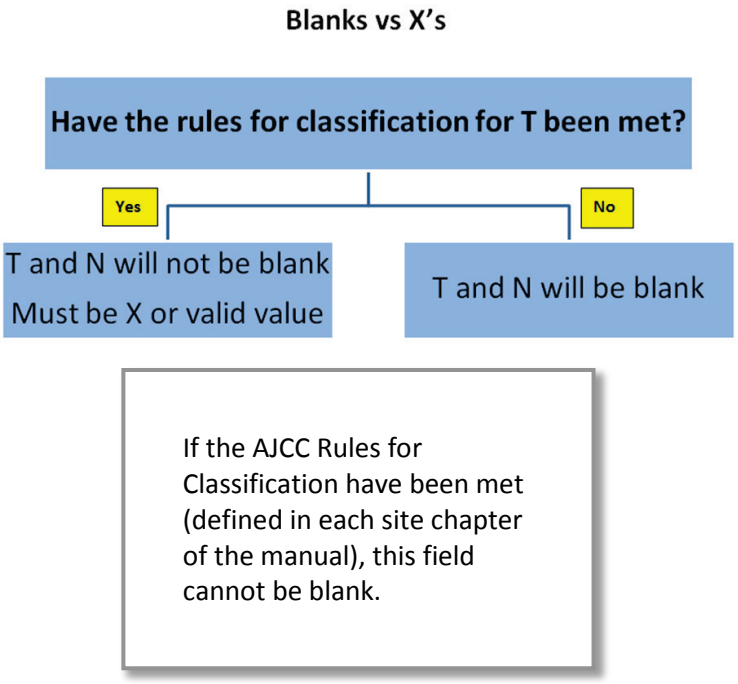
Abstract Plus Field Name: TNM Clin N

Required for 2016-2017 Diagnoses
Item Length: 4
NAACCR Item #: 950

Description
Detailed site-specific codes for the clinical nodes (N) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

Codes
The following codes are valid for AJCC 7th edition:

```
cX
c0
c0A
c0B
c1
c1A
c1B
c1C
c2
c2A
c2B
c2C
c3
c3A
c3B
c3C
c4
88
Blank
```



Reminder: Include text justification for the code entered in this field in at least one of the following text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC – PATHOLOGY.

TNM CLINICAL STAGE GROUP

Abstract Plus Field Name: TNM Clin Stage Grp

Required for 2016-2017 diagnoses
Item Length: 4
NAACCR Item #: 970

Description
Detailed site-specific codes for the clinical stage group as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

Rationale
AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes
The following codes are valid for AJCC 7th edition:

0
0A
0S
0IS
1
1A
1A1
1A2
1B
1B1
1B2
1C
1S
2
2A
2A1
2A2
2B
2C
3
3A
3B
3C
3C1
3C2
4
4A
4A1
4A2
4B
4C
88
99
OC

Reminder: Include text justification for the code entered in this field in at least one of the following text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC – PATHOLOGY.

TNM CLINICAL T

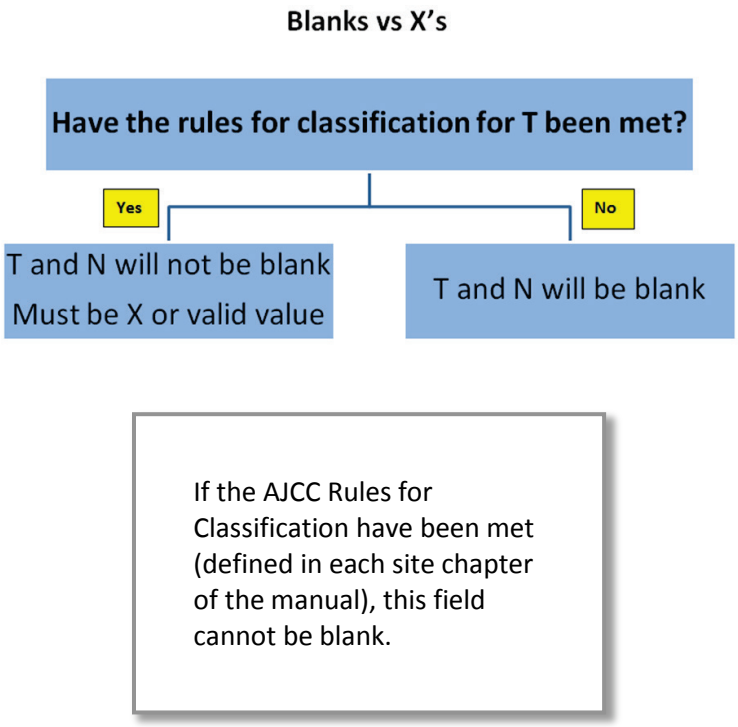
Abstract Plus Field Name: TNM Clin T

Required for 2016-2017 diagnoses
Item Length: 4
NAACCR Item #: 940

Description
Detailed site-specific codes for the clinical tumor (T) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

Codes
The following codes are valid for AJCC 7th edition:

cX
c0
c1
c1A
c1A1
c1A2
c1B
c1B1
c1B2
c1C
c1D
c1MI
c2
c2A
c2A1
c2A2
c2B
c2C
c2D
c3
c3A
c3B
c3C
c3D
c4
c4A
c4B
c4C
c4D
c4E
pA
pIS
pISU
pISD
88
Blank



Reminder: Include text justification for the code entered in this field in at least one of the following text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC – PATHOLOGY.

TNM EDITION NUMBER

Abstract Plus Field Name: TNM Edition Number

Required for 2016-2017 diagnoses
Item Length: 2
NAACCR Item #: 1060

Description
A code that indicates the edition of the American Joint Commission on Cancer (AJCC) manual used to stage the case.

Rationale
TNM codes have changed over time and conversion is not always simple. Therefore, a case-specific indicator is needed to allow grouping of cases for comparison.

Codes

Codes	Description
00	Not staged (cases that have AJCC staging scheme and staging was not done)
01	First edition
02	Second edition (published 1983)
03	Third edition (published 1988)
04	Fourth edition (published 1992), recommended for use for cases diagnosed 1993-1997
05	Fifth Edition (published 1997), recommended for use for cases diagnosed 1998-2002
06	Sixth Edition (published 2002), recommended for use for cases diagnosed 2003-2009
07	Seventh Edition (published 2009), recommended for use with cases diagnosed 2010+
88	Not applicable (cases that do not have an AJCC staging scheme)
99	Edition Unknown

TNM PATHOLOGIC DESCRIPTOR

Abstract Plus Field Name: TNM Path Descriptor

Required for 2016-2017 diagnoses
Item Length: 1
NAACCR Item #: 920

Description
Identifies the American Joint Commission on Cancer (AJCC) pathologic stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

Codes

Codes	Description
0	None
1	E (extranodal, lymphomas only)
2	S (spleen, lymphomas only)
3	M (multiple primaries in a single tumor)
4	Y (Classification during or after initial multimodality therapy)—pathologic staging only
5	E & S (extranodal and spleen, lymphomas only)
6	M & Y (Multiple primary tumors and initial multimodality therapy)
9	Unknown, not stated in patient record

TNM PATHOLOGIC M

Abstract Plus Field Name: TNM Path M

Required for 2016-2017 diagnoses
Item Length: 4
NAACCR Item #: 900

Description
Detailed site-specific codes for the pathologic metastases (M) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

Codes
The following codes are valid for AJCC 7th edition:

```
c0
c0I+
c1
c1A
c1B
c1C
c1D
c1E
p1
p1A
p1B
p1C
p1D
p1E
88
Blank
```

Reminder: Include text justification for the code entered in this field in at least one of the following text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC – PATHOLOGY.

TNM PATHOLOGIC N

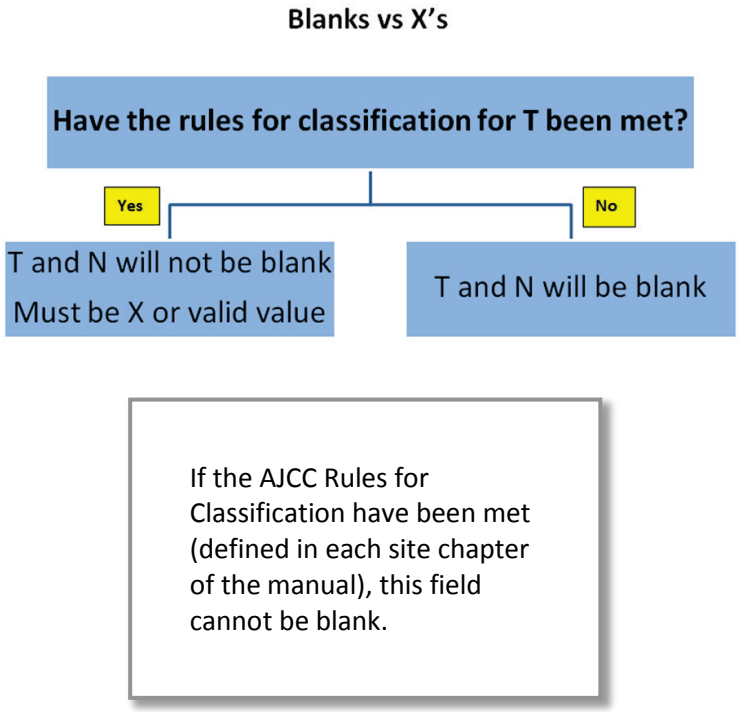
Abstract Plus Field Name: TNM Path N

Required for 2016-2017 diagnoses
Item Length: 4
NAACCR Item #: 890

Description
Detailed site-specific codes for the pathologic nodes (N) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

Codes
The following codes are valid for AJCC 7th edition:

```
pX
p0
p0I-
p0I+
p0M-
p0M+
p1
p1A
p1B
p1C
p1M
p1MI
p2
p2A
p2B
p2C
p3
p3A
p3B
p3C
p4
c0
88
p0A
p0B
Blank
```



Reminder: Include text justification for the code entered in this field in at least one of the following text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC – PATHOLOGY.

TNM PATHOLOGIC STAGE GROUP

Abstract Plus Field Name: TNM Path Stage Group

Required for 2016-2017 diagnoses
Item Length: 4
NAACCR Item #: 910

Description
Detailed site-specific codes for the pathologic stage group as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

Codes
The following codes are valid for AJCC 7th edition:

```
0
0A
0S
0IS
1
1A
1A1
1A2
1B
1B1
1B2
1C
1S
2
2A
2A1
2A2
2B
2C
3
3A
3B
3C
3C1
3C2
4
4A
4A1
4A2
4B
4C
88
99
OC
Blank
```

Reminder: Include text justification for the code entered in this field in at least one of the following text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC – PATHOLOGY.

TNM PATHOLOGIC T

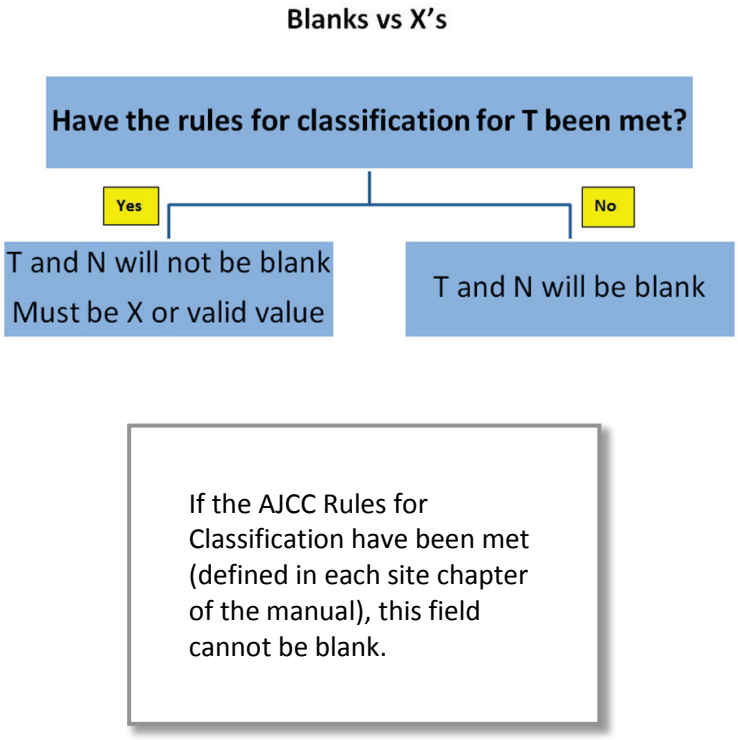
Abstract Plus Field Name: TNM Path T

Required for 2016-2017 diagnoses
Item Length: 4
NAACCR Item #: 880

Description
Detailed site-specific codes for the pathologic tumor (T) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

Codes
The following codes are valid for AJCC 7th edition:

```
pX
p0
pIS
pISU
pISD
pA
p1
p1A
p1A1
p1A2
p1B
p1B1
p1B2
p1C
p1D
p1MI
p2
p2A
p2A1
p2A2
p2B
p2C
p2D
p3
p3A
p3B
p3C
p3D
p4
p4A
p4B
p4C
p4D
p4E
88
Blank
```



Reminder: Include text justification for the code entered in this field in at least one of the following text fields: TEXT – STAGING, TEXT – DX PROC – X-RAY/SCAN and/or TEXT – DX PROC – PATHOLOGY.

TYPE OF REPORTING SOURCE

Abstract Plus Field Name: Reporting Source

Required
Item Length: 1
NAACCR Item #: 500

Description
This variable codes the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original case finding (for example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician's office, code this item 4).

Rationale
The code in this field can be used to explain why tumor information may be incomplete. For example, death-certificate-only cases have unknown values for many data items, so they may be excluded from some analyses. This field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death-certificate-only cases where no hospital admission was involved. However, too high a percentage can imply shortcomings in case-finding and also that follow-back was incomplete in uncovering missed hospital reports.

Coding Instructions
Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This change prioritizes laboratory reports over nursing home reports.

This data item is intended to indicate the completeness of information available to the abstractor. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients. Therefore, these sources are grouped with inpatients and given the code with the highest priority.

Sources coded with '2' usually have complete information on the cancer diagnosis, staging, and treatment.

Sources coded with '8' would include, but would not be limited to, outpatient surgery and nuclear medicine services. A physician's office that calls itself a surgery center should be coded as a physician's office. Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. If a physician's office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Codes	Description
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3	Laboratory only (hospital-affiliated or independent)
4	Physician's office/private medical practitioner (LMD)
5	Nursing/convalescent home/hospice
6	Autopsy only
7	Death certificate only
8	Other hospital outpatient units/surgery centers

TUMOR SIZE SUMMARY

Abstract Plus Field Name: Tumor Size Summary

Required for 2016 and 2017 diagnoses
Item Length: 3
NAACCR Item #: 756

Description
This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen. This data item should only be used for cases diagnoses 2016 or later.

Rationale
Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Instructions for Coding: (See the *FORDS* manual for specifics and examples.)

1. All measurements should be in millimeters (mm).
2. Record size is specified order:
    a. Size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.
    b. If neoadjuvant therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment, if unknown code size as 999.
    c. If no surgical resection, then largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment.
    d. If a, b, and c do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.
3. Tumor size is the diameter of the tumor, not the depth or thickness of the tumor.
4. Recording less than/greater than: If tumor size is reported as less than X mm or X cm, the reported tumor size should be 1mm less. If tumor size is reported as more than X mm or X cm, code size as 1mm more.
5. Rounding: Round the tumor size only if it is described in fractions of millimeters.
6. Priority of imaging techniques: Information on size from imaging techniques can be used to code size when there is no more specific size information from a pathology or operative report. It should be taken over a physical exam.
7. If there is a difference in reported tumor size among imaging/radiographic techniques, record the largest unless the physician specifies which imaging is most accurate.
8. Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis.
9. Record the size of the invasive component, if given.
10. Record the largest dimension or diameter of tumor.
11. Record the size as stated for purely in situ lesions.
12. Disregard microscopic residual or positive surgical margins when coding tumor size.
13. Do not add the size of pieces or chips together to create a whole, unless the pathologist states an aggregate or composite size.
14. If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor (or in situ, if all tumors are in situ).
15. Use tumor size code 999 when the size is unknown or not applicable.

TUMOR SIZE SUMMARY CODES

000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2mm-988mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	SITE-SPECIFIC CODES

Alternate descriptions of tumor size for specific sites:

Familial/multiple polyposis:
Rectosigmoid and rectum (C19.9, C20.9)
Colon (C18.0, C18.2-C18.9)

If no size is documented:
Circumferential:
Esophagus (C15.0 C15.5, C15.8 C15.9)

Diffuse; widespread: 3/4s or more; linitis plastica:
Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9)

Diffuse, entire lung or NOS:
Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9)

Diffuse:
Breast (C50.0 C50.6, C50.8 C50.9)

999	Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable

VENDOR NAME

Abstract Plus Field Name: Hidden, Automatically Coded

Required
Item Length: 10
NAACCR Item #: 2170

Description
This is a system-generated field: the abstractor should not need to fill this in manually. It contains the name of the computer services vendor who programmed the system submitting the data. Code is self-assigned by vendor.

Rationale
This is used to track which vendor and which software version submitted the case. It helps define the source and extent of a problem discovered in data submitted by a software provider.

VITAL STATUS

Abstract Plus Field Name: Vital Status

Required
Item Length: 1
NAACCR Item #: 1760

Description
Vital status of the patient as of the date entered in Date of Last Contact. If the patient has multiple tumors, vital status should be the same for all tumors.

Codes	Description
0	Dead
1	Alive

APPENDIX I – WCRS Contact Information *(updated February 2017)*

Nancy Sonnleitner, CTR
Education Trainer/Coordinator
Phone/Madison: 608-261-8388
Phone/Green Bay: 920-448-5226
Email: Nancy.Sonnleitner@dhs.wisconsin.gov

Laura Stephenson, CTR
Quality Assurance & Software
Phone: 608-266-8926 Email: laura.stephenson@dhs.wisconsin.gov

Kim Ortman
Data Submission Coordinator/DCO Follow-Up/Web Plus Accounts
Phone: 608-267-0239 Email: kim.ortman@dhs.wisconsin.gov

Robert Borchers
Data Manager, GIS Specialist
Phone: 608-266-0633 Email: robert.borchers@dhs.wisconsin.gov

Mary Foote
Epidemiologist/Data Requests
Phone: 608-261-8874 Email: mary.foote@dhs.wisconsin.gov

Robin Malicki
Program Director
Phone: 608-266-6781 Email: robin.malicki@dhs.wisconsin.gov

Mailing Address	**Express Courier Address**
Wisconsin Cancer Reporting System P.O. Box 2659 Madison WI 53701-2659	Wisconsin Cancer Reporting System 1 W. Wilson Street, Room 118 Madison WI 53703
Web Plus Login URL (for data submissions)	https://webplus.wisconsin.gov/logonen.aspx
WCRS Email Address:	DHSWCRSdata@dhs.wisconsin.gov
WCRS Fax Number:	608-266-2431
WCRS Website: Reporter Page	www.dhs.wisconsin.gov/wcrs/index.htm https://www.dhs.wisconsin.gov/wcrs/reporterinfo/index.htm

APPENDIX II – Laws Governing Wisconsin Cancer Reporting

WISCONSIN STATUTES

255.04 Cancer reporting.

(1) Any hospital, as defined under s. 50.33 (2), any physician and any laboratory certified under 42 USC 263a shall report information concerning any person diagnosed as having cancer or a precancerous condition to the department as prescribed by the department under sub. (2).

(2) The department shall prescribe:

(a) The form on which the report under sub. (1) shall be submitted.

(b) The time schedule under which the report under sub. (1) shall be submitted.

(c) The types of cancer and precancerous conditions to be reported under sub. (1).

(3) Any information reported to the department under sub. (1) or (5) which could identify any individual who is the subject of the report or a physician submitting the report shall be confidential and may not be disclosed by the department except to the following:

(a) A central tumor registry in another state if the individual who is the subject of the information resides in the other state.

(b) A national tumor registry recognized by the department.

(c) A researcher who proposes to conduct research, if all of the following conditions are met:

1. The researcher applies in writing to the department for approval of access to individually identifiable information under sub. (1) or (5) that is necessary for performance of the proposed research, and the department approves the application. An application under this subdivision shall include all of the following:

a. A written protocol to perform research.

b. The researcher's professional qualifications to perform the proposed research.

c. Documentation of approval of the research protocol by an institutional review board of a domestic institution that has a federalwide assurance approved by the office for human research protections of the federal department of health and human services.

d. Any other information requested by the department.

2. The proposed research is for the purpose of studying cancer, cancer prevention, or cancer control.

(4) The report of information under sub. (1) or (5) may not be construed as a violation of any person's responsibility for maintaining the confidentiality of patient health care records, as defined under s. 146.81 (4).

(5) The department may, to the extent feasible, collect information related to the occupation of cancer patients in order to fulfill the purpose of s. 250.04 (3) (b) 4.

(6) The department may charge a reasonable fee for disclosing information to a researcher under sub. (3) (c).

(7) Information obtained by the department under sub. (1) or (5) or obtained by a person under sub. (3) (c) is not subject to inspection, copying, or receipt under s. 19.35 (1).

(8) No person to whom information is disclosed under sub. (3) (c) may do any of the following:

(a) Use the information for a purpose other than for the performance of research as specified in the application under sub. (3) (c)1., as approved by the department.

(b) Disclose the information to a person who is not connected with performance of the research.

(c) Reveal in the final research product information that may identify an individual whose information is disclosed under sub.(3) (c).

(9) Whoever violates sub. (8) (a), (b), or (c) is liable to the subject of the information for actual damages and costs, plus exemplary damages of up to $1,000 for a negligent violation and up to $5,000 for an intentional violation.

(10) (a) Whoever intentionally violates sub. (8) (a), (b), or (c) may be fined not more than $15,000 or imprisoned for not more than one year in the county jail or both.

(b) Any person who violates sub. (8) (a), (b), or (c) may be required to forfeit not more than $100 for each violation. Each day of continued violation constitutes a separate offense, except that no day in the period between the date on which a request for a hearing is filed under s. 227.44 and the date of the conclusion of all administrative and judicial proceedings arising out of a decision under this paragraph constitutes a violation.

(c) The department may directly assess forfeitures under par. (b). If the department determines that a forfeiture should be assessed for a particular violation or for failure to correct the violation, the department shall send a notice of assessment to the alleged violator. The notice shall specify the alleged violation of the statute and the amount of the forfeiture assessed and shall inform the alleged violator of the right to contest the assessment under s. 227.44.

History: 1985 a. 29; 1989 a. 173 ss. 2, 13; 1993 a. 16; 1993 a. 27 s. 48; Stats. 1993 s. 255.04; 1993 a. 183; 1997 a. 114; 2009 a. 28.

250.04(3)(b)3 Health; Administration and Supervision. Powers and duties of the department.

The department may conduct investigations, studies, experiments and research pertaining to any public health problems which are a cause or potential cause of morbidity or mortality and methods for the prevention or amelioration of those public health problems. For the conduct of the investigations, studies, experiments and research, the department may on behalf of the state accept funds from any public or private agency, organization or person. It may conduct investigations, studies, experiments and research independently or by contract or in cooperation with any public or private agency, organization or person including any political subdivision of the state. Individual questionnaires or surveys shall be treated as confidential patient health care records under ss. 146.81 to 146.835, but the information in those questionnaires and surveys may be released in statistical summaries.

146.82(2)(a)5 and 146.82(2)(a)8 Access without informed consent.

146.82(2)(a)5: In response to a written request by any federal or state governmental agency to perform a legally authorized function, including but not limited to management audits, financial audits, program monitoring and evaluation, facility licensure or certification or individual licensure or certification. The private pay patient, except if a resident of a nursing home, may deny access granted under this subdivision by annually submitting to a health care provider, other than a nursing home, a signed, written request on a form provided by the department. The provider, if a hospital, shall submit a copy of the signed form to the patient's physician.

146.82(2)(a)8: To the department under s. 255.04. The release of a patient health care record under this subdivision shall be limited to the information prescribed by the department under s. 255.04 (2).

WISCONSIN ADMINISTRATIVE CODE

DHS 124.05(3)(h) Cancer reporting. Every hospital shall report to the department all malignant neoplasms that are diagnosed by the hospital and all malignant neoplasms diagnosed elsewhere if the individual is subsequently admitted to the hospital. The report of each malignant neoplasm shall be made on a form prescribed or approved by the department and shall be submitted to the department within 6 months after the diagnosis is made or within 6 months after the individual's first admission to the hospital if the neoplasm is diagnosed elsewhere, as appropriate. In this paragraph, "malignant neoplasm" means an in situ or invasive tumor of the human body, but does not include a squamous cell carcinoma or basal cell carcinoma arising in the skin.

DHS 120.31(3)(b) Release of data. The department shall provide to other entities the data necessary to fulfill their statutory mandates for epidemiological purposes or to minimize the duplicate collection of similar data elements.

FEDERAL LAW

106 STAT. 3372 PUBLIC LAW 102–515—OCT. 24, 1992
An Act
Entitled the "Cancer Registries Amendment Act".
Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,
SECTION 1. SHORT TITLE.
This Act may be cited as the "Cancer Registries Amendment Act".
SEC. 2. FINDINGS AND PURPOSE.
(a) FINDINGS.—Congress finds that—
(1) cancer control efforts, including prevention and early detection, are best addressed locally by State health departments that can identify unique needs;
(2) cancer control programs and existing statewide population-based cancer registries have identified cancer incidence and cancer mortality rates that indicate the burden of cancer for Americans is substantial and varies widely by geographic location and by ethnicity;
(3) statewide cancer incidence and cancer mortality data, can be used to identify cancer trends, patterns, and variation for directing cancer control intervention;
(4) the American Association of Central Cancer Registries (AACCR) cites that of the 50 States, approximately 38 have established cancer registries, many are not statewide and 10 have no cancer registry; and
(5) AACCR also cites that of the 50 States, 39 collect data on less than 100 percent of their population, and less than half have adequate resources for insuring minimum standards for quality and for completeness of case information.
(b) PURPOSE.—It is the purpose of this Act to establish a national program of cancer registries.
SEC. 3. NATIONAL PROGRAM OF CANCER REGISTRIES.
Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following new part:

PART M—NATIONAL PROGRAM OF CANCER REGISTRIES

SEC. 399H. NATIONAL PROGRAM OF CANCER REGISTRIES.

(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control, may make grants to States, or may make grants or enter into contracts with academic or nonprofit organizations designated by the State to operate the State's cancer registry in lieu of making a grant directly to the State, to support

the operation of population-based, statewide cancer registries in order to collect, for each form of in-situ and invasive cancer (with the exception of basal cell and squamous cell carcinoma of the skin), data concerning—

(1) demographic information about each case of cancer;

(2) information on the industrial or occupational history of the individuals with the cancers, to the extent such information is available from the same record;

(3) administrative information, including date of diagnosis and source of information;

(4) pathological data characterizing the cancer, including the cancer site, stage of disease (pursuant to Staging Guide), incidence, and type of treatment; and

(5) other elements determined appropriate by the Secretary.

(b) MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may make a grant under subsection (a) only if the State, or the academic or nonprofit private organization designated by the State to operate the cancer registry of the State, involved agrees, with respect to the costs of the program, to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 25 percent of such costs or $1 for every $3 of Federal funds provided in the grant.

(2) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION; MAINTENANCE OF EFFORT.—

(A) Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(B) With respect to a State in which the purpose described in subsection (a) is to be carried out, the Secretary,

in making a determination of the amount of non-Federal contributions provided under paragraph (1), may include only such contributions as are in excess of the amount of such contributions made by the State toward the collection of data on cancer for the fiscal year preceding the first year for which a grant under subsection (a) is made with respect to the State. The Secretary may decrease the amount of non-Federal contributions that otherwise would have been required by this subsection in those cases in which the State can demonstrate that decreasing such amount is appropriate because of financial hardship.

(C) ELIGIBILITY FOR GRANTS.—

(1) IN GENERAL.—No grant shall be made by the Secretary under subsection (a) unless an application has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such a manner, and be accompanied by such information, as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the purposes specified in the approved application and in accordance with the requirements of this section, that the application will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under subsection (a)

of this section, and that the applicant will comply with the peer review requirements under sections 491 and 492.

(2) ASSURANCES.—Each applicant, prior to receiving Federal funds under subsection (a), shall provide assurances satisfactory to the Secretary that the applicant will—

(A) provide for the establishment of a registry in accordance with subsection (a);

(B) comply with appropriate standards of completeness, timeliness, and quality of population-based cancer registry data;

(C) provide for the annual publication of reports of cancer data under subsection (a); and

(D) provide for the authorization under State law of the statewide cancer registry, including promulgation of regulations providing—

(i) a means to assure complete reporting of cancer cases (as described in subsection (a)) to the statewide cancer registry by hospitals or other facilities providing screening, diagnostic or therapeutic services to patients with respect to cancer;

(ii) a means to assure the complete reporting of cancer cases (as defined in subsection (a)) to the statewide cancer registry by physicians, surgeons, and all other health care practitioners diagnosing or providing treatment for cancer patients, except for cases directly referred to or previously admitted to a hospital or other facility providing screening, diagnostic or therapeutic services to patients in that State and reported by those facilities;

(iii) a means for the statewide cancer registry to access all records of physicians and surgeons, hospitals, outpatient clinics, nursing homes, and all other facilities, individuals, or agencies providing such services to patients, identifying cases of cancer or would establish characteristics of the cancer, treatment of the cancer, or medical status of any identified patient;

(iv) for the reporting of cancer case data to the statewide cancer registry in such a format, with such data elements, and in accordance with such standards of quality timeliness and completeness, as may be established by the Secretary;

(v) for the protection of the confidentiality of all cancer case data reported to the statewide cancer registry, including a prohibition on disclosure to any person of information reported to the statewide cancer registry that identifies, or could lead to the identification of, an individual cancer patient, except for disclosure to other State cancer registries and local and State health officers; (vi) for a means by which confidential case data may in accordance with State law be disclosed to cancer researchers for the purposes of cancer prevention, control and research;

(vii) for the authorization or the conduct, by the statewide cancer registry or other persons and organizations, of studies utilizing statewide cancer registry data, including studies of the sources and causes of cancer, evaluations of the cost, quality, efficacy, and appropriateness of diagnostic, therapeutic, rehabilitative, and preventative services and programs relating to cancer, and any other clinical, epidemiological, or other cancer research; and

(viii) for protection for individuals complying with the law, including provisions specifying that no person shall be held liable in any civil action with respect to a cancer case report provided to the statewide cancer registry, or with respect to access to cancer case information provided to the statewide cancer registry.

(D) RELATIONSHIP TO CERTAIN PROGRAMS.—

(1) IN GENERAL.—This section may not be construed to act as a replacement for or diminishment of the program carried out by the Director of the National Cancer Institute and designated by such Director as the Surveillance, Epidemiology, and End Results Program (SEER).

(2) SUPPLANTING OF ACTIVITIES.—In areas where both such programs exist, the Secretary shall ensure that SEER support is not supplanted and that any additional activities are consistent with the guidelines provided for in subsection (c)(2) (C) and (D) and are appropriately coordinated with the existing SEER program.

(3) TRANSFER OF RESPONSIBILITY.—The Secretary may not transfer administration responsibility for such SEER program from such Director.

"(4) COORDINATION.—To encourage the greatest possible efficiency and effectiveness of Federally supported efforts with respect to the activities described in this subsection, the Secretary shall take steps to assure the appropriate coordination of programs supported under this part with existing Federally supported cancer registry programs.

(e) REQUIREMENT REGARDING CERTAIN STUDY ON BREAST CANCER.—In the case of a grant under subsection (a) to any State specified in section 399K(b), the Secretary may establish such conditions regarding the receipt of the grant as the Secretary determines are necessary to facilitate the collection of data for the study carried out under section 399C.

SEC. 399I. PLANNING GRANTS REGARDING REGISTRIES.

(a) IN GENERAL.—

(1) STATES.—The Secretary, acting through the Director of the Centers for Disease Control, may make grants to States for the purpose of developing plans that meet the assurances required by the Secretary under section 399B(c)(2).

(2) OTHER ENTITIES.—For the purpose described in paragraph (1), the Secretary may make grants to public entities other than States and to nonprofit private entities. Such a grant may be made to an entity only if the State in which the purpose is to be carried out has certified that the State approves the entity as qualified to carry out the purpose.

(b) APPLICATION.—The Secretary may make a grant under subsection (a) only if an application for the grant is submitted to the Secretary, the application contains the certification required in subsection (a)(2) (if the application is for a grant under such subsection), and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

SEC. 399J. TECHNICAL ASSISTANCE IN OPERATIONS OF STATEWIDE CANCER REGISTRIES.

The Secretary, acting through the Director of the Centers for Disease Control, may, directly or through grants and contracts, or both, provide technical assistance to the States in the establishment and operation of statewide registries, including assistance in the development of model legislation for statewide cancer registries and assistance in establishing a computerized reporting and data processing system.

SEC. 399K. STUDY IN CERTAIN STATES TO DETERMINE THE FACTORS CONTRIBUTING TO THE ELEVATED BREAST CANCER MORTALITY RATES.

(a) IN GENERAL.—Subject to subsections (c) and (d), the Secretary, acting through the Director of the National Cancer Institute, shall conduct a study for the purpose of determining the factors contributing to the fact that breast cancer mortality rates in the States specified in subsection (b) are elevated compared to rates in other States.

(b) RELEVANT STATES.—The States referred to in subsection (a) are Connecticut, Delaware, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont, and the District of Columbia.
(c) COOPERATION OF STATE.—The Secretary may conduct the study required in subsection (a) in a State only if the State agrees to cooperate with the Secretary in the conduct of the study, including providing information from any registry operated by the State pursuant to section 399H(a).
(d) PLANNING, COMMENCEMENT, AND DURATION.—The Secretary shall, during each of the fiscal years 1993 and 1994, develop a plan for conducting the study required in subsection (a). The study shall be initiated by the Secretary not later than fiscal year 1994, and the collection of data under the study may continue through fiscal year 1998.
(e) REPORT.—Not later than September 30, 1999, the Secretary shall complete the study required in subsection (a) and submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report describing the findings and recommendations made as a result of the study.

SEC. 399L. AUTHORIZATION OF APPROPRIATIONS.

(a) REGISTRIES.—For the purpose of carrying out this part, the Secretary may use $30,000,000 for each of the fiscal years 1993 through 1997. Out of any amounts used for any such fiscal year, the Secretary may obligate not more than 25 percent for carrying out section 399I, and not more than 10 percent may be expended for assessing the accuracy, completeness and quality of data collected, and not more than 10 percent of which is to be expended under subsection 399J.
(b) BREAST CANCER STUDY.—Of the amounts appropriated for the National Cancer Institute under subpart 1 of part C of title IV for any fiscal year in which the study required in section 399K is being carried out, the Secretary shall expend not less than $1,000,000 for the study.

Approved October 24, 1992.

HIPAA (Health Insurance Portability and Accountability Act)

Information on HIPAA for Cancer Registrars
NAACCR (North American Association of Central Cancer Registries)
http://www.naaccr.org/Research/HIPAA.aspx

APPENDIX III – Comparison of Hospital and Nonhospital Cancer Reporting Procedures

	HOSPITAL	CLINIC/PHYSICIAN OFFICE
Manual	WCRS Coding Manual	Same as Hospital requirement
Paper Form	F-45709: Wisconsin Cancer Reporting System Cancer Report	Same as Hospital requirement
Electronic File	NAACCR Layout Version16 Type A record	Same as Hospital requirement
Reportable Cases	All malignant *in situ* and invasive cancer except basal cell and squamous cell carcinomas of the skin and *in situ* cervical cancers; and all benign central nervous system cancers diagnosed after 2004.	Same as Hospital requirement
Diagnosis Date	Diagnosed 1976 and forward	Required: 1992 and forward Accepted: 1976-1991
Coverage[1]	All patients for which a medical record is created regardless of residence (WCRS requires out of state cases to be reported)	Patients of clinics or physicians' offices whose records are not maintained with a hospital's inpatient records
Reportable Cases By Nature of Care	Diagnosed and/or treated by the hospital **-- or –** Admitted for ***any reason*** with ***active*** cancer (including diagnosis, treatment, palliative care, terminal care, care for noncancerous condition)	Clinic provided definitive, first-course cancer treatment **-- or –** Diagnosed at clinic but treatment NOT provided at clinic AND patient NOT referred to a **Wisconsin hospital** within 2 months following diagnosis
Timing[2]	Within six months of diagnosis by facility or within six months of first contact if diagnosed elsewhere	Same as Hospital requirement

[1]Coverage maintains the emphasis on hospital reporting, and supplements hospital reports with clinic reports for the types of cancers only seen in an outpatient setting or the clinic first-course treatment not provided and/or reported by a hospital.

[2]If all of the planned first-course treatment has not started within the six-month time period, hold reporting the case until all treatment is started as long as the case is still reported within 12 months. It is important to note that, in general, this scenario will only apply to breast cancer cases.

When a Patient Is Seen by a Clinic and a Hospital

Ordinarily when a patient is seen by one or more freestanding clinics or physician offices and by one or more hospitals, each facility will independently report the case. In each case, the date of initial diagnosis will be the same for each reporting facility. Here are some examples of which facility reports and when.

- If a patient is diagnosed by a freestanding clinic and sent to a hospital for treatment, the hospital will report the case. The clinic only needs to report the case if it also provided some definitive, first-course treatment.

- If a patient is diagnosed by a freestanding clinic and the patient is NOT referred to a Wisconsin hospital, the clinic must report the case even if the clinic does not treat the patient.

- If a clinic diagnoses a case, sends the patient to the hospital for surgery, then the clinic provides chemotherapy, radiotherapy or any non-surgical cancer-directed therapy following the surgery, both the clinic and the hospital will report the case. The criterion requiring clinic reporting is that it provided some of the first-course treatment.

- If a hospital (1) diagnosed a case OR (2) provided first-course treatment OR (3) saw the patient for a non-cancer issue BUT the medical record indicated the patient has active cancer, it must report the case. Any follow-up clinic visits are not reportable by the clinic unless it provides first-course treatment.

- If a hospital or clinic sees a patient with active disease that is metastases or a recurrence, the original primary IS reportable under the conditions above if the original primary had not been reported by the facility when it was first diagnosed.

In many Wisconsin communities, larger health systems and hospitals routinely abstract cancer cases diagnosed or treated at their affiliated local freestanding clinics and physician offices (or those in geographic proximity) through a formal or informal arrangement with those facilities. This often occurs between facilities that share the same electronic health record system. WCRS will work with facilities to accept cases abstracted in these situations; it is cost-effective and time-saving for both the facilities and WCRS. The following situations apply:

- The facility having its cases reported routinely by another facility IS responsible for reporting any required cases not completed by the reporting facility.

- The reporting facility must report the first-course treatment provided by all facilities, not just the treatment provided at the reporting facility's location.

- The facilities must maintain accurate, current updates on these reporting agreements and send a copy via email or fax to WCRS when first initiated or changes are made.

Appendix IV – WCRS Reference Materials Websites

SEER Summary Staging 2000 Manual
http://www.seer.cancer.gov/tools/ssm/

AJCC Cancer Staging Manual, 7th Edition
http://www.springer.com/us/book/9780387884400
This manual is required to complete TNM staging for 2016 and 2017 diagnoses

Multiple Primary and Histology Coding Rules
http://www.seer.cancer.gov/tools/mphrules/download.html

Scroll to 'Complete Manual' – Download the complete manual with the latest updates. Use this coding manual to determine the number of reports needed to complete for each case. This manual contains the rules for all malignant tumors and benign brain and central nervous system tumors.

Hematopoietic Multiple Primary and Histology Coding Rules
http://seer.cancer.gov/seertools/hemelymph/

Use this website to determine the multiple primary status and correct histology and grade for all hematopoietic reportable diseases.

Data Collection of Primary Central Nervous System Tumors
http://www.cdc.gov/cancer/npcr/pdf/btr/braintumorguide.pdf

Use this manual to determine reportability and correct coding for benign brain and CNS tumors (reportable to WCRS beginning January 1, 2004).

FORDS Manual
https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/fords%202016.ashx This site contains the complete manual along with a separate reference to Appendix B (site-specific surgery codes) along the left-side thumbnail column on the screen.

NAACCR Data Standards and Data Dictionary
http://www.naaccr.org/StandardsandRegistryOperations/VolumeIIArchive.aspx

Click on Version 15 Data Standards and Data Dictionary document.

SEER*Rx - Interactive Antineoplastic Drugs Database
http://www.seer.cancer.gov/seertools/seerrx/

International Classification of Diseases for Oncology, 3rd Edition (ICD-O3)
http://codes.iarc.fr/

This is the definitive classification of neoplasms and is used to describe the topography, morphology, malignant behavior and grade of all neoplasms.

Recommended Abbreviations for Abstractors to Use in Text Fields
http://www.naaccr.org/Applications/ContentReader/Default.aspx?c=17

Collaborative Stage Manual Version 2 (CSv02.05) For 2004 – 2015 diagnoses only.
https://cancerstaging.org/cstage/coding/Pages/Version-02.05.aspx

Please note: All of the above tools (except the AJCC Cancer Staging Manual and ICD-O3 Manual) are available in the Registry Plus Online Help tool (included in the WCRS Abstract Plus software). It can also be downloaded at no cost from:

http://www.cdc.gov/cancer/npcr/tools/registryplus/rpoh_tech_info.htm

APPENDIX V – Race and Nationality Descriptions from the Census, National Center for Statistics and NAACCR Ethnicity Descriptions

Note: Use these lists only when race is not stated but other information is provided in the medical record.

References:

1. Race and Ethnicity Code Set, Version 1.0, Centers for Disease Control and Prevention, March 2000.
2. Instruction manual, part 4: Classification and Coding Instructions for Death Records, 1999-2001, Division of Vital Statistics, National Center for Health Statistics, undated.

Key for Code 01

***** Terms listed in reference 2, above.

! Description of religious affiliation rather than stated nationality or ethnicity; should be used with caution when determining appropriate race code.

(Use Code 01 unless patient is American Indian/Native Alaskan or other race)

CODE THE FOLLOWING DESCRIPTIONS TO WHITE, 01, IF ONE OF THESE DESCRIPTIONS IS IN THE CHART BUT NO OTHER RACE INFORMATION IS AVAILABLE		
Afghan, Afghanistani	Afrikaner	Albanian
Algerian*	Amish*	Anglo-Saxon*
Arab, Arabian	Argentinian*	Armenian
Assyrian	Australian*	Austrian*
Azores*	Basque*	Bavarian*
Bolivian*	Bozniak/Bosnian	Brava/Bravo*
Brazilian	Bulgarian	Cajun
Californio	Canadian*	Caucasian*
Central American	Chechnyan	Chicano*
Chilean	Colombian*	Costa Rican*
Croat/Croatian	Crucian*	Cuban (*unless specified as Black*)*
Cypriot	Czechoslovakian*	Eastern European
Ebian*	Ecuadorian*	Egyptian
English	English-French*	English-Irish*
European*	Finnish*	French
French Canadian*	Georgian*	German
Greek*	Guatemalan	Gypsy*
Hebrew*!	Herzegovenian	Hispanic*
Honduran	Hungarian*	Iranian, Iran
Iraqi	Irish	Islamic*!
Israeli	Italian	Jordanian*
Kurd/Kurdish	Kuwaitian*	Ladina/Ladino*

Latin American*	Latino	Latvian*
Lebanese	Libyan*	Lithuanian*
Maltese*	Marshenese*	Mauritian*
Moroccan*	Mediterranean*	Mexican
Middle Eastern	Moroccan*	Moslem*!
Muslim*	Near Easterner	Nicaraguan
Nordic*	North African	Norwegian*
Other Arab	Palestinian	Panamanian
Paraguayan	Parsi*	Persian*
Peruvian*	Polish	Portuguese*
Puerto Rican (*unless specified as Black*)	Romanian*	Rumanian
Russian*	Salvadoran	Saudi Arabian*
Scandinavian*	Scottish, Scotch	Semitic*!
Serbian*	Servian*	Shiite!
Sicilian*	Slavic, Slovakian*	South American
Spanish*, Spaniard	Sunni*!	Swedish*
Syrian	Tunisian*	Turkish, Turk*
Ukranian*	United Arab Emirati	Uruguayan
Venezuelan*	Welsh*	White
Yemenite*	Yugoslavian*	Zoroastrian*

CODE THE FOLLOWING DESCRIPTIONS TO BLACK – AFRICAN AMERICAN, 02, IF ONE OF THESE DESCRIPTIONS IS IN THE CHART BUT NO OTHER RACE INFORMATION IS AVAILABLE

African	African American	Afro-American
Bahamian	Barbadian	Bilalian*
Black	Botswana	Cape Verdean*
Dominica Islander (*unless specified as White*)	Dominican/Dominican Republic (*unless specified as White*)	Eritrean*
Ethiopian	Ghanian*	Haitian
Hamitic*	Jamaican	Kenyan*
Liberian	Malawian*	Mugandan*
Namibian	Nassau*	Negro
Nigerian	Nigritian	Nubian*
Other African	Santo Domingo*	Seychelloise*
Sudanese*	Tanzanian*	Tobagoan
Togolese*	Trinidadian	West Indian
Zairean		

CODE THE FOLLOWING DESCRIPTIONS TO AMERICAN INDIAN/ALASKA NATIVE, 03, IF ONE OF THESE DESCRIPTIONS IS IN THE CHART BUT NO OTHER RACE INFORMATION IS AVAILABLE		
Alaska Native	Aleut	American Indian
Central American Indian	Eskimo	Meso American Indian
Mexican American Indian	Native American	South American Indian
Spanish American Indian		

SPECIFIC ASIAN CODES

Definition	Race Code
Amerasian	96
Asian Indian NOS	15
Asian	96
Asiatic	96
Bangladeshi	96
Bhutanese	96
Bornean	96
Bruneian	96
Burmese	96
Cambodian	13
Celebesian	96
Ceram	96
Ceylonese	96
Chinese	04
Eurasian	96
Filipino	06
Hmong	12
Indian (from India)	16
Indo-Chinese	96
Indonesian	96
Iwo Jiman	05
Japanese	05
Javanese	96
Kampuchean	13
Korean	08
Laotian	11
Maldivian	96
Madagascar	96
Malaysian	96
Mongolian	96
Montagnard	96
Nepalese	96
Okinawan	05

Definition	Race Code
Oriental	96
Other Asian	96
Pakistani	17
Sikkimese	96
Singaporean	96
Sri Lankan	96
Sumatran	96
Taiwanese	04
Thai	14
Tibetan	96
Vietnamese	10
Whello	96
Yello	96

SPECIFIC NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER CODES

Definition	Race Code
Bikinian	20
Carolinian	20
Chamorro	21
Chuukese	20
Cook Islander	25
Eniwetok, Enewetak	20
Fijian	31
Guamanian	22
Hawaiian	07
Kirabati	20
Kosraean	20
Kwajalein	20
Maori	97
Mariana Islander	20
Marshallese	20
Melanesian	30
Micronesian, NOS	20
Native Hawaiian	07
Nauruan	97
New Caledonian	30
New Hebrides	30
Other Pacific Islander	97
Pacific Islander	97
Palauan	20
Papua New Guinean	32
Part Hawaiian	07
Pohnpeian	20
Polynesian	25

Definition	Race Code
Ponapean	20
Saipanese	20
Samoan	27
Solomon Islander	30
Tahitian	26
Tarawan	20
Tinian	20
Tokelauan	25
Tongan	28
Trukese	20
Tuvaluan	25
Vanuatuan	30
Yapese	20

98 = OTHER RACE, NOT ELSEWHERE CLASSIFIED
Do not use this code for Hispanic, Latino or Spanish, NOS.

OTHER RACE DESCRIPTIONS

Note 1: The following descriptions of ethnic origin cannot be coded to a specific race code. Look for other descriptions of race in the medical record. If no further information is available, code race as 99, Unknown.

Aruba Islander
Azerbaijani
Belizean
Bermudan
Cayenne
Cayman Islander
Creole
Guyanese
Indian (*not specified as Native American, Eastern Indian, Northern, Central, or South American Indian*)
Mestizo
Morena
South African
Surinam
Tejano

Note 2: The following terms self-reported in the 2000 Census cannot be coded to a specific race code. Look for other descriptions of race in the medical record. If no further information is available, code race as 99 Unknown.

Biracial	Interracial	Mixed
Multiethnic	Multinational	Multiracial

Indian Tribes of the United States, Canada and Mexico (Race Code 03)
Source: National Center for Health Statistics: Appendix C, *Instruction Manual, part 4: Classification and Coding Instructions For Death Records, 1999-2001*.

Abnaki	Absentee-Shawnee	Acoma
Ak Chin	Alabama-Coushatt Tribes - TX	Alsea
Apache	Arapaho	Arikara
Assiniboin	Atacapa	Athapaskan
Atsina	Aztec	Bear River
Beaver	Bella Coola	Beothuk
Blackfoot	Boold Piegan	Blue Lake
Brotherton	Caddo	Cakchiquel-lenca
Calapooya	Carrier	Catawba
Cattaraugus	Cayuga	Cayuse
Chasta Costa	Chehalis	Chemehuevi
Cherokee	Chetco	Cheyenne
Cheyenne River Sioux	Chickahominy	Chickasaw
Chinook	Chipewyan	Chippewa
Chippewa-Ojibwa	Chiricahua Apache	Chitimacha
Choctaw	Chol	Chontal
Chorti	Chuckchansi	Chumash
Clallam	Clatsop	Clackamus
Clear Lake	Coast Salish	Cochimi
Cochiti	Cocopa	Coeur D'Alene Tribe of Idaho
Cocopah	Columbia	Colville
Comox	Comanche	Concow
Conquille	Coushatta	Covelo
Cow Creek	Cowichan	Cowlitz
Coyotero Apache	Cree	Creek
Crow	Crow Creek Sioux	Dakota
Delaware	Diegueno	Digger
Dog Rib	Duckwater	Eskimo
Euchi	Eyak	Flathead
Fort Hall Res. Tribe of Idaho	French Indian	Gabrieleno
Galice Creek	Gay Head	Gosiute
Gros Ventre	Haida	Han

Hare	Hat Creek	Hawasupai
Hidatsa	Hoh	Hoopa
Hopi	Houma	Hualapai
Huastec	Humboldt Bay	Hupa
Huron	Illinois	Ingalik
Iowa	Iroquois	Isleta
Jemez	Joshua	Juaneno
Jicarilla Apache	Kaibah	Kalispel
Kanosh Band of Paiutes	Kansa	Karankawa
Karok	Kaska	Kaw
Kawai	Keresan Pueblos	Kern River
Kichai	Kickapoo	Kiowa
Kiowa Apache	Kitamat	Klamath
Klikitat	Koasati	Kootenai Tribe of Idaho
Kusa	Kutchin	Kutenai
Kwakiutl	Lac Courte Oreilles	Laguna
Lakmuit	Lipan Apache	Lower Brule Sioux
Luiseno	Lummi	Maidu
Makah	Malecite	Mandan
Maricopa	Mary's River	Mashpee
Mattaponi	Maya	Mayo
Mdewakanton Sioux	Menominee	Menomini
Mequendodon	Mescalero Apache	Miami
Micmac	Mission Indians	Missouri
Miwok	Mixe	Mixtec
Modoc	Mohave	Mohawk
Mohegan	Molala	Monachi
Mono	Montagnais	Montauk
Muckleshoot	Munsee	Nambe
Namsemond	Nanticoke	Narragansett
Naskapi	Natchez	Navaho
Navajo	Nez Perce	Niantic
Nipmuck	Nisenan-Patwin	Nisqually
Nomelaki	Nooksak	Nootka
Northern Paiute	Oglala Sioux	Okanogan
Omaha	Oneida	Onondaga
Opata	Opato	Osage
Oto	Otoe	Otomi
Ottawa	Ozette	Paiute
Pamunkey	Panamint	Papago
Passamaquoddy	Patwin	Pawnee
Pen d'Oreille	Penobscot	Peoria
Pequot	Picuris	Pima
Pit River	Pojoaque	Pomo
Ponca	Poosepatuck	Potawatomi

Potomac	Powhatan	Pueblos
Puyallup	Quapaw	Quechan
Quileute	Quinaielt	Quinault
Rappahannock	Rogue River	Rosebud Sioux
Sac and Fox	Saginaw	Salish
Sandia	San Felipe	San Ildefonso
San Juan	San Lorenzo	San Luis Obispo
San Luiseno	Sanpoil	Sanpoil Nespelem
Sant'ana	Santa Barbara	Santa Clara
Santa Ynez	Santee	Santee Sioux
Santiam	Sauk and Fox	Scaticook
Sekane	Seminole	Seneca
Seri	Shasta	Shawnee
Shinnecock	Shivwits Band of Paiutes	Shoshone
Shoshone-Bannock	Shuswap	Siouans
Sioux	Sisseton	Sisseton-Wahpeton Sioux
Siuslaw	Skagit Suiattle	Skokomish
Slave	Smith River	Snake
Snohomish	Snoqualmi	Songish Southern Paiute
Squaxin	Stockbridge	Sumo-Mosquito
Suquamish	Swinomish	Taimskin
Tanana	Tanoan Pueblos	Taos
Tarahumare	Tarascan	Tawakoni
Tejon	Tenino or Warm Springs	Tesuque
Teton	Teton Sioux	Tillamook
Timucua	Thlinget	Tolowa
Tonawanda	Tonkawa	Tonto Apache
Topinish	Totonac	Tsimshian
Tulalip	Tule River Indians	Tunica
Tuscarora	Tututni	Umatilla
Umpqua	Upper Chinook	Ute
Waca	Waicuri-Pericue	Wailaki
Walapai	Walla Walla	Wampanoag
Wapato	Warm Springs	Wasco
Washo	Washoe	Western Apache
Western Shoshone	Whilkut	Wichita
Wikchamni	Wind River Shoshone	Ho Chunk (Winnebago)
Wintu	Wintun	Wishram
Wyandotte	Xicaque	Yahooskin
Yakima	Yamel	Yana
Yankton	Yanktonnais Sioux	Yaqui
Yaquina	Yavapai	Yawilmani
Yellow Knife	Yerington Paiute	Yokuts
Yokuts-Mono	Yomba Shoshone	Yuchi
Yuki	Yuma	Yurok

Zacatec	Zapotec	Zia
Zoque	Zuni	

NAACCR Ethnicity Description and Codes

Codes	Description
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS, Hispanic, NOS, Latino, NOS
7	Spanish surname only. The only evidence of the person's Hispanic origin is the surname or maiden name and there is no contrary evidence that the patient is not Hispanic.
8	Dominican Republic
9	Unknown whether Spanish or not

Appendix VI – Site-Specific Factors Required for 2016 and 2017
(and 2015 for comparison)

2016 SITE-SPECIFIC FACTOR (SSF) – SCHEMA – Description by Site		
SSF 1	**Brain, CNS Other, Intracranial Gland**	– WHO Grade Classification
	Breast	– ERA
	Melanoma-Skin – Measured Thickness (Depth) or Breslow's Measurement	
	Mycosis Fungoides	- Peripheral Blood Involvement
	Placenta	- Prognostic Scoring Index
	Prostate	– PSA Lab Value
	Retinoblastoma	- Extension Evaluated at Enucleation
SSF 2	**Breast**	– PRA
SSF 5	**GIST** (Peritoneum)	– Mitotic Count
SSF 6	**GIST** (Esophagus, Small Intestine, Stomach)	– Mitotic Count
SSF 8	**Breast**	- HER-2 IHC Lab Value
	Prostate	- Gleason Score on Needle Core Bx/TURP
SSF 9	**Breast**	- HER-2 IHC Interpretation
SSF 10	**GIST** (Peritoneum)	- Location of Primary Tumor
	Prostate	- Gleason Score on Prostatectomy/Autopsy
SSF 11	**Carcinoma** (Appendix)	- Histopathologic Grading
	Breast	- HER-2 FISH Lab Interpretation
	GIST (Appendix, Colon, Rectum)	– Mitotic Count
SSF 13	**Breast**	- HER-2 CISH Lab Interpretation
	Testis	- Post Orchiectomy AFP Range
SSF 14	**Breast**	- Result of Other/ Unknown HER-2 Test

2016 SITE-SPECIFIC FACTOR (SSF) – SCHEMA – Description by Site	
SSF 15	**Breast** - HER-2 Summary Result of Testing **Testis** - Post Orchiectomy hCG
SSF 16	**Breast** - Combinations of ER/PR/HER-2 Results **Testis** - Post Orchiectomy LDH
SSF 17	Not Required for Any Site Schema
SSF 18	Not Required for Any Site Schema
SSF 19	Not Required for Any Site Schema
SSF 20	Not Required for Any Site Schema
SSF 21	Not Required for Any Site Schema
SSF 22	Not Required for Any Site Schema
SSF 23	Not Required for Any Site Schema
SSF 24	Not Required for Any Site Schema
SSF 25	**Bile Ducts** (Distal, Perihilar), **Cystic Duct**, **Esophagus-GE Junction**, **Melanoma** (Ciliary Body, Iris), **Nasopharynx**, **Pharyngeal Tonsil**, **Stomach** - Schema Discriminator

2015 SITE-SPECIFIC FACTOR (SSF) – SCHEMA – Description by Site	
SSF 1	**Brain, CNS Other, Intracranial Gland** – WHO Grade Classification
	Breast – ERA
	Buccal Mucosa, **Epiglottis** (Anterior), **Gum** (Lower, Upper and Other), **Hypopharynx**, **Larynx** (Glottic, Subglottic, Supraglottic, Other), **Lip** (Lower, Upper, Other), **Mouth** (Other), **Nasal Cavity**, **Nasopharynx**, **Oropharynx**, **Palate** (Hard or Soft), **Parotid Gland**, **Pharyngeal Tonsil**, **Salivary Gland** (Other), **Sinus** (Ethmoid or Maxillary), **Submandibular Gland**, **Tongue** (Anterior, Base) – Size of Lymph Nodes
	Conjunctiva – Tumor Size
	Esophagus, **Esophagus-GEJunction**, **NETStomach**, **Rectum**, **Stomach** – Clinical Assessment of Regional LNs
	Heart-Mediastinum, Peritoneum, **Retroperitoneum**, **Soft Tissue** – Grade for Sarcomas
	Lung – Separate Tumor Nodules – Ipsilateral Lung
	Melanoma-Conjunctiva – Measured Thickness (Depth)
	Melanoma-Skin – Measured Thickness (Depth) or Breslow's Measurement
	Mycosis Fungoides - Peripheral Blood Involvement
	Placenta - Prognostic Scoring Index
	Pleura – Pleural Effusion
	Prostate – PSA Lab Value
	Retinoblastoma - Extension Evaluated at Enucleation
SSF 2	**Appendix-Corpus-Carcinoma**, **Carcinoid-Appendix**, **Colon, NETColon**, **NETRectum**, **Small Intestine** – Clinical Assessment of Regional LNs
	Bladder - Size of Mets in Lymph Nodes
	Breast – PRA
	Corpus (Adenocarcinoma, Carcinoma, Sarcoma) – Peritoneal Cytology
	Lymphoma, **Lymphoma-Ocular-Adnexa** – Systemic Symptoms at Diagnosis
	Melanoma (Choroid, Ciliary Body) - Measured Basal Diameter
	Melanoma-Iris – Size of Largest Metastasis
	Melanoma-Skin - Ulceration

2015 SITE-SPECIFIC FACTOR (SSF) – SCHEMA – Description by Site	
SSF 3	**Breast** - Positive Ipsilateral Level I-II Lymph Nodes
	Melanoma (Choroid, Ciliary Body) – Measured Thickness (Depth)
	Melanoma-Skin, Merkel Cell (Penis, Scrotum, Iris, Vulva) - Clinical Status of Lymph Node Metastasis
	Prostate - CS Extension – Pathological Extension
SSF 4	**Breast** - IHC of Lymph Nodes
	Melanoma (Choroid, Ciliary Body) - Size of Largest Metastasis
	Melanoma-Skin – LDH
	Testis - Radical Orchiectomy Performed
SSF 5	Breast - MOL of Lymph Nodes
	GIST (Peritoneum) – Mitotic Count
	Testis - Size of Metastasis in Lymph Node
SSF 6	**GIST** (Esophagus, Small Intestine, Stomach) – Mitotic Count
	Skin-Eyelid – Perineural Invasion
SSF 7	**Melanoma-Skin** - Primary Tumor Mitotic Count/Rate
SSF 8	**Breast** - HER-2 IHC Lab Value
	Prostate - Gleason Score on Needle Core Bx/TURP
SSF 9	**Breast** - HER-2 IHC Interpretation
SSF 10	**GIST** (Peritoneum) - Location of Primary Tumor
	Intrahepatic Bile Ducts - Tumor Growth Patterns
	Prostate - Gleason Score on Prostatectomy/Autopsy
SSF 11	**Carcinoma** (Appendix, Corpus) - Histopathologic Grading
	Breast - HER-2 FISH Lab Interpretation
	GIST (Appendix, Colon, Rectum) – Mitotic Count
	Vulva - Regional Lymph Nodes – Laterality
SSF 12	**Scrotum**, **Skin** – High Risk Features
SSF 13	**Breast** - HER-2 CISH Lab Value
	Testis - Post Orchiectomy AFP Range

2015 SITE-SPECIFIC FACTOR (SSF) – SCHEMA – Description by Site		
SSF 14	**Breast**	- Result of Other/ Unknown HER-2 Test
SSF 15	**Breast**	- HER-2 Summary Result of Testing
	Testis	- Post Orchiectomy hCG
SSF 16	**Breast**	- Combinations of ER/PR/HER-2 Results
	Scrotum, **Skin**	– Size of Lymph Nodes
	Testis	- Post Orchiectomy LDH
SSF 17	**Penis**	- Extranodal Extension of Regional Lymph Nodes
SSF 18	Not Required for Any Site Schema	
SSF 19	Not Required for Any Site Schema	
SSF 20	Not Required for Any Site Schema	
SSF 21	Not Required for Any Site Schema	
SSF 22	Not Required for Any Site Schema	
SSF 23	Not Required for Any Site Schema	
SSF 24	Not Required for Any Site Schema	
SSF 25	**Bile Ducts** (Distal, Perihilar), **Cystic Duct**, **Esophagus-GE Junction**, **Melanoma** (Ciliary Body, Iris), **Nasopharynx**, **Peritoneum**, **Pharyngeal Tonsil**, **Stomach**	- Schema Discriminator

Appendix VII – Pediatric and Young Adult Early Case Capture Required Data Items

KEY CRITERIA	SPECIFICATIONS/GUIDANCE
Diagnosis Date	January 1, 2015 forward
Age at Diagnosis	Age 0 - 19
Reportable Diagnoses	All ICD-O-3 diseases with a behavior code of "/2" (in situ disease) or "/3" (malignant disease), except: • Basal and squamous cell carcinomas of the skin; • Carcinoma in situ of the cervix uteri and cervical intraepithelial neoplasia; and • Prostatic intraepithelial neoplasia All solid tumors of brain and central nervous system, including the meninges and intracranial endocrine structures, listed in the ICD-O-3 with behavior codes of "/0" (benign disease) and "/1" (disease of uncertain malignant potential).
Diagnostic Confirmation	All reportable cases should be submitted to the central registry, regardless of the type of diagnostic confirmation. Due to the requirement for rapid reporting, cases should be reported whether there is a clinical or pathologic diagnosis. If a facility submits a non-microscopically confirmed case that subsequently is determined not to be cancer or otherwise reportable, they must notify the central cancer registry so the case may be removed from the database.
Timeframe for Facility Reporting to Central Cancer Registry (CCR)	Initial Early Case Capture report with minimal data items submitted to central cancer registry within 30 days of diagnosis. Subsequent complete report submitted within normal CCR reporting timeframe.

ITEM NAME	NAACCR ITEM NUMBER(S)	COLLECT FROM FACILITIES	COMMENT
Record Type	10	Required	Is usually auto-generated by software.
Hospital Accession Number	550	Required	
Last Name	2230	Required*	
First Name	2240	Required*	
Middle Name	2250	Recommended	
Birth Date	240	Required*	
Date of Birth Flag	241	Required	If DOB is unknown, this field should be '12.'
Age at Diagnosis	230	Required*	
Social Security Number	2320	Required*	
Addr at DX--City	70	Required	Current city address can be used as a default for this field.
Addr at DX—No & Street	2330	Required	Current street address can be used as a default for this field.
Addr at DX—Postal Code	100	Required	Current zip code can be used as a default for this field.
Addr at DX—State	80	Required	Current state can be used as a default for this field.

ITEM NAME	NAACCR ITEM NUMBER(S)	COLLECT FROM FACILITIES	COMMENT
Addr at DX—Supplementl	2335	Required	Current supplemental address can be used as a default for this field.
County at DX	90	Required	Current county can be used as a default for this field.
Addr Current--City	1810	Required*	
Addr Current—No & Street	2350	Required*	
Addr Current—Postal Code	1830	Required*	
Addr Current—State	1820	Required*	
Addr Current—Supplementl	2355	Required*	
County--Current	1840	Required*	
Patient Phone Number	2360	Required*	
Physician Contact Information	Determined by WCRS	Recommended	WCRS would like to receive the managing or follow up physician information if available within 30 days, in either text form or in the appropriate data fields.
Sex	220	Required*	
Race 1	160	Required*	
Race 2	161	Required	
Race 3	162	Required	
Race 4	163	Required	
Race 5	164	Required	
Spanish/Hispanic Origin	190	Required*	
Primary Site (ICD-O-3)	400	Required*#	This field can be generated from the ICD-10-CM code
Histology (ICD-O-3)	522	Required#	For some cancers, this field can be generated from the ICD-10-CM code.
Behavior (ICD-O-3)	523	Required#	For some cancers, this field can be generated from the ICD-10-CM code.
Laterality	410	Required#	For some cancers, this field can be generated from the ICD-10-CM code.
Date of Diagnosis	390	Required#	Date of Diagnosis may be approximate and can be either clinically or pathologically determined. For flat file EHR-direct submissions, the date of first contact can be used as a default diagnosis date.
Date of Diagnosis Flag	391	Required	
Date of 1st Contact	580	Required*	The first encounter or problem date can be used as a default for this date.
Date of 1st Contact Flag	581	Required	

ITEM NAME	NAACCR ITEM NUMBER(S)	COLLECT FROM FACILITIES	COMMENT
Diagnostic Confirmation	490	Required	
Sequence Number – Hospital	560	Required#	
Type of Reporting Source	500	Required*	
Reporting Facility	540	Required*	
NPI-Reporting Facility	545	Required, as available	
Follow-up Contact--City	1842	Required, as available	Follow-up contact information is intended to capture parental contact information for active follow-up or consent for study participation.
Follow-up Contact—State	1844	Required, as available	
Follow-up Contact – Postal	1846	Required, as available	
Follow-up Contact—No&St	2392	Required, as available	
Follow-up Contact—Suppl	2393	Required, as available	
Follow-up Contact--Name	2394	Required, as available	
Follow-up Contact—Phone Number	NA	Required, as available	

* Bare bones data requirement for EHR-direct flat file submissions (must work with WCRS to set up submission process from EHR).
# These fields can sometimes be generated from the ICD-10-CM code.

Appendix VIII – Continued Use of ICD-O-3 Histology Code Crosswalk

ICD-O-3 Change	ICD-O-3 Histology Code (do NOT use these codes)	Description	Comment	Histology Code Effective January 1, 2015 and forward
New term and code	8158/1	Endocrine tumor, functioning, NOS	Not reportable	
New related term	8158/1	ACTH-producing tumor	Not reportable	
New term and code	8163/3	Pancreatobiliary-type carcinoma (C24.1)	DO NOT use new code	8255/3
New synonym	8163/3	Adenocarcinoma, pancreatobiliary-type (C24.1)	DO NOT use new code	8255/3
New term	8213/3	Serrated adenocarcinoma		8213/3*
New code and term	8265/3	Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	DO NOT use new code	8507/3*
New code and term	8480/1	Low grade appendiceal mucinous neoplasm (C18.1)	Not reportable	
New term and code	8552/3	Mixed acinar ductal carcinoma	DO NOT use new code	8523/3
New term and code	8975/1	Calcifying nested epithelial stromal tumor (C22.0)	Not reportable	
New term and code	9395/3	Papillary tumor of the pineal region	DO NOT use new code	9361/3*

ICD-O-3 Change	ICD-O-3 Histology Code (do NOT use these codes)	Description	Comment	Histology Code Effective January 1, 2015 and forward
New term and code	9425/3	Pilomyxoid astrocytoma	DO NOT use new code	9421/3
New term and code	9431/1	Angiocentric glioma	DO NOT use new code	9380/1*
New term and code	9432/1	Pituicytoma	DO NOT use new code	9380/1*
New term and code	9509/1	Papillary glioneuronal tumor	DO NOT use new code	9505/1
New related term	9509/1	Rosette-forming glioneuronal tumor	DO NOT use new code	9505/1
New term and code	9741/1	Indolent systemic mastocytosis	Not reportable	

* ICD-O-3 rule F applies (code the behavior stated by the pathologist). If necessary, over-ride any advisory messages.