WCRS
Coding and Data Requirements Manual

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

Updated for 2018 - 2020 Diagnoses

Revised Eighth Edition

Wisconsin
Department of Health Services

P-00832-19 (04/2019)

Wisconsin Cancer Reporting System
Division of Public Health
Wisconsin Department of Health Services
WCRS Coding Manual, Revised 8th Edition
Revised January 2020

This project is supported in part by a cooperative agreement between the Centers for Disease Control and Prevention (CDC) and the Wisconsin Department of Health Services #U58/DP17-1701

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/announcements.htm

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 cannot be answered from the materials provided or resources cited within, contact WCRS staff for further assistance. See Appendix I for contact information.

Since the passage of Public Law 102-515 *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 Wisconsin Legislature had already established the registry in 1976; therefore, our *index* (reference) year is 1976. WCRS collects data that are compliant with required NPCR data elements; meet standard requirements designated by the North American Association of Central Cancer Registries (NAACCR) for incidence reporting and endorsed by CDC; and 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 *Overview* section of this manual addresses frequently asked questions about the *Who, What, When, Why* and *How* of cancer reporting.

Table of Contents

Appendices

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, anatomic site (e.g. *breast, lung, colon,* and *prostate*) and stage of disease.

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 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 funding from the Centers for Disease Control and Prevention (CDC) through a cooperative agreement under the *Cancer Registries Amendment Act*. These funds have permitted WCRS to make improvements in the collection and processing of data, such as increasing the number and quality of data elements collected on each cancer patient, consistent with standards of the National Program of Cancer Registries (NPCR). Also through this agreement, WCRS began applying national standard edits to cancer cases. Since 1995, WCRS data have been available on public use query sites, provided to researchers, and submitted annually to CDC and standard setters.

Why Report to WCRS?

WCRS is a population-based cancer registry responsible for collection of demographic, diagnostic, and treatment information on patients with active cancer disease that was diagnosed or treated at hospitals, laboratories and physicians throughout Wisconsin.

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

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

Data items collected by WCRS are used to:

- ✓ Determine cancer rates and trends
- ✓ Prepare health policy and planning
- ✓ Conduct research in epidemiological studies (including case-control studies)
- ✓ Evaluate cancer control interventions
- ✓ Identify and target high-risk populations
- ✓ Respond to public concerns regarding perceived excesses of cancer

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

IMPORTANT: Submission of data is mandated under Wisconsin Statute, Chapter 255.04.

Who Reports to WCRS?

All Wisconsin hospitals, laboratories and physicians in certain settings must report information concerning any person diagnosed as having cancer or a precancerous condition to WCRS.

Physicians licensed in Wisconsin working in any of the following settings:

- ✓ Radiation Treatment Centers
- ✓ Ambulatory Surgery Centers
- ✓ Nursing Homes
- ✓ Hospice Centers
- ✓ Clinics
- ✓ Private physician offices
- ✓ Diagnostic and Treatment Centers

By law, Wisconsin facilities and physicians are required 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 reporting methods for each facility. Some facilities have their own cancer registries, 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 chapter 255.04, Wisconsin Statutes, governs requirements; 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 cancer reporting is as complete as possible, WCRS established formal agreements with 45 states and 2 U.S. territories, including all neighboring states except Minnesota, to exchange information regarding cancer patients. The lack of reporting from the Minnesota state cancer registry is concerning for WCRS since many Wisconsin residents are diagnosed and treated in that state. To reduce the effect of underreporting for citizens living in Western Wisconsin, WCRS 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, *Mayo Clinic* in Rochester, Minnesota diagnoses or treats approximately 1,200 Wisconsinites annually but does not share their data with WCRS. However, the data would be much less complete without the voluntary reports we get from some Minnesota hospitals. Their willingness to contribute to Wisconsin cancer control and prevention is highly appreciated.

What Information Is Collected About Patients with Cancer?

In 1976, when WCRS started collecting data, 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 expanded. 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, such as *breast*, *lung*, or *lymph nodes*.
- ✓ Stage of disease at the time of diagnosis
- ✓ Cancer cell type, such as *leukemia*, *melanoma*, and *osteosarcoma*.
- ✓ Type of first course treatment rendered to destroy the tumor

  Example: surgery chemotherapy, or immunotherapy.

If a person is diagnosed with more than one type of cancer in his/her lifetime, the 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:

- ✓ Sex
- ✓ Age at time of diagnosis
- ✓ Race
- ✓ Residence at time of diagnosis
- ✓ Longest held occupation
- ✓ Place of birth
- ✓ Ethnicity (Hispanic or non-Hispanic)

IMPORTANT: In 2004, WCRS began collecting data on brain and nervous system tumors classified as benign or which have an uncertain behavior. While these benign tumors won't metastasize beyond the tissue they originated, they are treated aggressively as if they were malignant, which is one of the main reasons those cases are reported.

In total, more than 160 different data items are collected for each person in the WCRS database. The 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 invasive and *in situ* behavior. *In situ* cancers are early cancers that have not extended into the organ to which they are attached or have not spread to other parts of the body. Invasive cancers have invaded into the organ of origin or spread beyond that organ.

How Are Cancer Reports Submitted to WCRS and Processed?

Electronic cancer reporting is required in Wisconsin. WCRS uses a secure internet application called *Web Plus* developed by the CDC for most data submissions. A separate Department of Public Health (DPH) Hypertext Transfer Protocol Secure (HTTPS) and CDC-developed public health information network messaging system are used for *Early Case Capture* pediatric reporting and submissions from out of state pathology laboratories. WCRS supports a data entry software application called *Abstract Plus,* which is used for abstracting and creating files that are submitted using *Web Plus*. *Abstract Plus* contains all required data items, edits for state-mandated reporting, and has built-in online help features, reference manuals, and pre-populated pull-down menus for many data items.

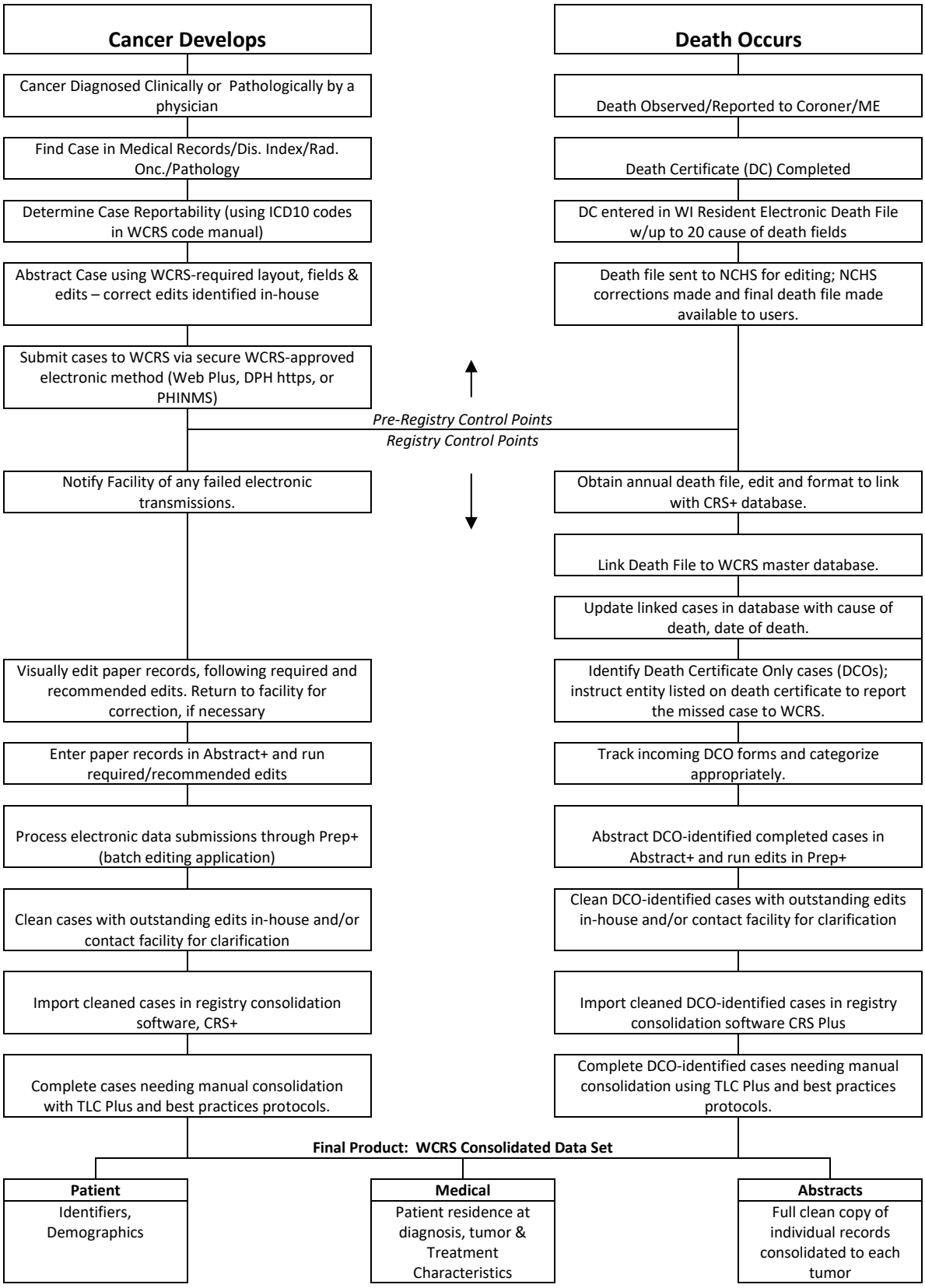
> **Note:** Facilities should electronically submit cancer case files via *Web Plus* at least once a month for annual caseloads over 500, or quarterly for smaller annual caseloads.

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

One of the primary strengths of WCRS data is *multiple-source* reporting to ensure statewide coverage and completeness because patients are often seen at more than one facility for diagnosis, treatment, or follow up. On average, 1.6 reports are received for each primary tumor diagnosed. Incoming reports are electronically matched with patients already in the WCRS database. If the incoming record does not match, it is added as a new patient and tumor in the database. For patients that do match, a second match is run to determine if the tumor on the incoming record is already in the database, or is a new tumor. Certified Tumor Registrars CTRs) at WCRS manual conduct this match. About 13.8 percent of patients in the database have multiple primaries, meaning they have more than one cancer in their lifetime. For some types of cancer, such as *melanoma* and *pharyngeal* cancers, the number of multiple primaries for a person may be high.

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

Cancer Incidence and Mortality Data Flow 2018



What Is the *Death Certificate Only* Process?

WCRS begins the *Death Certificate Only* process once most of the data for the most recent diagnosis year are received and processed.

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

Each year WCRS links the death file to the WCRS database to identify persons in the database who have died and adds the date and UCOD to the record. 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, the result is a *Death Certificate Only* (*DCO*), meaning the cancer was listed on the death certificate but WCRS does not have a record of that cancer. WCRS is required to follow-back with the hospital, physician, or coroner listed on the death certificate to request information on the cancer diagnosis. If a DCO is proven not to be reportable to WCRS (the patient was actually a resident of another state when diagnosed, for example) the DCO is deleted. When a full abstract is provided for a missed case the case is no longer considered a DCO and the abstract is added to the database as a complete case.

DCO process improves the completeness of data and identifies missing data submissions or facilities that need to improve their casefinding routines. If a facility receives many DCOs it probably means that there was a failed file submission or 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 it does not provide the true year of diagnosis, stage of disease, histology, treatment provided, and other information.

There are approximately 600-800 DCO cases each year that 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 reporting facilities must keep cancer case abstracts or files. However, WCRS recommends retaining them for at least seven years. WCRS's *Abstract Plus* data entry software has a backup function that should be routinely used to backup the database on a network drive. You can call WCRS with questions about file backup. If your facility uses a commercial cancer software product, you should contact your software representative or information technology department for instructions.

Are There Measures of Quality Applied to the Cancer Registry?

Three national indicators measure the quality of cancer reporting:

1. Percentage of cases reported by death certificates only (DCO)
2. Percentage of cases confirmed microscopically
3. Percentage of cases with nonspecific diagnoses

The number of DCO cases indicates 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 information provided. A high percent of cases without microscopic confirmation or with nonspecific diagnoses can indicate inadequate medical record abstracting and reporting, or that the diagnostic work-ups were not 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 facilities:

- ✓ Percent of cases reported with only a PO Box for the street address
- ✓ Cases with an unknown stage at diagnosis
- ✓ Cases with an unknown maiden name
- ✓ Cases with an unknown race

WCRS uses the following measures to calculate timeliness of 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

WCRS measures the completeness 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
- ✓ Less than 90% of annual estimated caseload submitted

WCRS provides biannual *Feedback Summary Reports* to reporting facilities that focuses on timeliness, completeness and select 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.

A representative from WCRS may need to contact a facility if questionable or inconsistent information was 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.

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. **Submit an update** to revise the primary site, laterality and any information that may have become available.

Example 2: A case was reported before the radiation treatment was started or completed. **Submit an update** with radiation treatment information.

Example 3: A case was submitted stating the primary site was *cervical lymph node* and the morphology was *adenocarcinoma*. Because a lymph node is a secondary (metastatic) site of an adenocarcinoma, **the facility would be contacted to request further review** of the medical record to determine the actual primary site.

Note: More details on how to submit a change are in *Chapter 3.*

What Are the Differences 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 uses and needs of data collected through 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, including information on treatment, cost, and patterns of care related to cancer. Cancer patients may be admitted to the hospital many times during their treatment and recovery. Often, a patient is seen at several different hospitals over the course of several years.

> **Note:** WCRS counts the number of primary tumors diagnosed in a person's lifetime, not the number of hospital admissions that person had for cancer. Counting tumors is not possible with WHA data because discharge files do not contain clinical information needed to determine whether a cancer is a new tumor or a recurrence. In addition, data elements important for studying cancer—such as *stage at diagnosis*, *histology*, *behavior* and *laterality*—are not available in discharge files.

How Does WCRS 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:

- ✓ Patient name
- ✓ Street address
- ✓ Date of birth
- ✓ Social security number
- ✓ Patient medical record number
- ✓ Cancer registry patient accession number (assigned by facility)
- ✓ Name of physician
- ✓ Date of death
- ✓ Death certificate number

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

- ✓ Age
- ✓ Race
- ✓ Sex
- ✓ Year of diagnosis
- ✓ Cancer site
- ✓ Cancer cell type
- ✓ Geographic area

Policies and procedures are in place to protect patient's privacy. Access to WCRS work areas is restricted and 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 the exact number of cases is not revealed.

The *Health Insurance Portability and Accountability Act* (HIPAA) allows reporting of identifiable cancer data to public health entities. Because WCRS is a public health authority, HIPAA allows your facility to report 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?

De-identified data are submitted annually to NAACCR for registry certification and publication in *Cancer in North America.* Registries whose data meet established criteria for timeliness, accuracy and completeness are recognized as NAACCR-Certified registries. WCRS is recognized as a NAACCR *Gold-Certified Registry*. WCRS submits data to CDC for inclusion in the *United States Cancer Surveillance* annual publication and is recognized as a *Registry of Excellence*. CDC provides de-identified Wisconsin data to national and international organizations for use in public use data query systems and publications.

WCRS data are available 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 can be filtered by cancer incidence, mortality, stage of disease at the time of diagnosis**,** and geographic location.

Periodically, WCRS produces *exclusive reports* and *collaborative reports* that include more detailed data than are available online. These are on the WCRS website at https://www.dhs.wisconsin.gov/wcrs/data-pubs.htm. Examples of exclusive reports include "Changing Incidence in Lung Cancer Among Women in Wisconsin: Emerging Trends from the WCRS" and "The Increasing Burden of Liver Cancer in Wisconsin." The "Wisconsin Facts and Figures*"* (WCRS and the *American Cancer Society Midwest Division* collaborative report) is our most frequently visited report.

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

Wisconsin Is in the SEER Program! What Does That Mean?

On May 1, 2018, Wisconsin was one of 19 jurisdictions (states, metropolitan regions and tribal nations) awarded a National Cancer Institute *Surveillance and Epidemiology End Results* (SEER) contract, with a 10-year period of performance, May 1, 2018 through April 30, 2028.

Wisconsin is currently awarded for just one of the three main components covered in the contract.

Which Component Did SEER Award WCRS?

1. ***Core Infrastructure Support Activities***
   This component includes all activities surrounding core registry operations and functions of a SEER central cancer registry: collection and submission of population-based cancer data including incidence, treatment, and survival following SEER reporting requirements. ***WCRS was not awarded funds for this major component.***

2. ***Virtual Pooled Registry***
   This component includes registry participation to support a *one-stop shopping* process through which interested researchers can submit one research application and one research file which will undergo standardized linkage simultaneously at multiple registries. ***WCRS was not awarded funds for this component.***

3. ***Programmatic Meeting***
   This component required participation in the initial *programmatic kick-off meeting* for all newly contracted SEER jurisdictions. It satisfies the requirement of being awarded this contract, and allows WCRS to apply for funds to support the core infrastructure and the virtual pooled registry components over the next 10-year contract period. ***WCRS was awarded funds to participate in the meeting.***

What Does This Mean for Cancer Reporters?

- There are no changes to Wisconsin's current reporting requirements as posted on the WCRS web site.

- WCRS is not submitting data to SEER for its Calls for Data or other research projects or patterns of care studies.

- WCRS is not receiving funds from SEER for any core registry activities, staff, or software maintenance.

WCRS is working with SEER and other partners to attain *core registry* status. That will require many transitions including adding data items to the required reporting list, participating in SEER *Calls for Data* and other studies, and converting the current CDC *Registry Plus* software to the *SEER Data Management System.*

Until then, WCRS will continue to use CDC *Registry Plus* software and maintain current reporting requirements as assigned through CDC's NPCR, along with current state-specific reporting requirements.

What Does This Mean for Researchers?

- There is no change to research application requirements as specified in the WCRS *Research Application Manual* posted on the WCRS web site.
- The long-term SEER award does not change data availability listed in the manual's *data inventory* and *data dictionary.*
- Future opportunities in research are expected to be available after WCRS advances in the SEER *core registry* program.

Chapter 1:
Determining Reportability for State Reporting

Cases That Must Be Reported to WCRS

- Cases diagnosed on or after January 1, 1976, for hospitals, or on or after January 1, 1992, for all nonhospital reporting entities such as clinics and physician offices.

- Patients whose residence at diagnosis is in Wisconsin or **anywhere else**. WCRS has data exchange agreements with 45 states and two U.S. territories. These states provide WCRS with reports on Wisconsin residents and we provide them reports on their residents. Interstate data exchange is an NPCR requirement.

- Cases with diagnosis codes specified on the ICD-10-CM *casefinding list* that meet WCRS reportable criteria.

  Note: 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.

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

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

- *Basal cell carcinomas* (histology codes 8090 – 8110) and *squamous cell cancers* (8050 – 8084) that originate in the following *mucoepidermoid* sites:

Cases That Must Be Reported to WCRS		
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.

- *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 must collect these cases as malignant with behavior code /3.

Hematopoietic and Lymphoid Neoplasms

The Hematopoietic and Lymphoid Database is a tool to assist in screening for reportable cases and determining reportability requirements. The tool must be used to determine case reportability. The database is on the SEER website: https://seer.cancer.gov/tools/heme/.

Clinically Diagnosed Cases

Clinically Diagnosed Cases are reportable. In absence of histologic or cytologic confirmation of a reportable neoplasm, **accession a case based on *clinical diagnosis***. A *clinical diagnosis* is when a recognized medical practitioner says the patient has a cancer, carcinoma, malignant neoplasm, or reportable neoplasm. It may be recorded in the final diagnosis on the face sheet or other parts of the medical record.

Note: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a negative biopsy, the case would not be reported.

Exception: If a patient receives treatment for cancer, accession the case.

Note: Standard treatments for cancer may be given for non-malignant conditions. Follow back with the physician to clarify if needed.

Exception: If it has been six months or longer since the negative biopsy, and the physician continues to call this a reportable disease, accession the case.

Brain or CNS Neoplasms

A brain or a CNS neoplasm identified only by diagnostic imaging is reportable

- ***Neoplasm*** and ***tumor*** are **reportable** terms for brain and CNS because they are listed in ICD-O-3 with behavior codes of /0 and /1.

- ***Mass*** and ***lesion*** are **not reportable** terms for brain and CNS because they are not listed in ICD-O-3 with behavior codes of /0 or /1.

Cytology

- ***Cytology*** refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears; usually a function of the pathology department.

- **Report** with cytology diagnoses that are **positive for malignant cells.**

> **IMPORTANT: Do not report** a case based only on **suspicious cytology.**

What to Report: Additional Hospital-Only Requirements

- All active primary cancers.

- Patients who die at your facility with active cancer, even if they were not diagnosed nor treated at your facility.

- Patients that received initial diagnosis and first-course therapy at another facility, but are now seen at your facility for diagnosis and/or treatment of recurrent or metastatic disease.

  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.**

  Note: Report all available information regarding the original diagnosis, stage at diagnosis and the original first-course treatment, if available. Do not provide information on the recurrence or metastatic treatment.

What to Report: Additional Nonhospital-Only Requirements

- Patients treated at your facility.
- Patients clinically diagnosed at your facility but not treated at your facility are only reportable when the patient is **not** referred to a Wisconsin hospital.

  Note: 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.

IMPORTANT: 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 appropriate text fields. These types of nonanalytic cases are required by central cancer registries. It is a 'catchment' requirement to cover instances when the facility diagnosing or treating the patient does not report the case as required.

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

Nonreportable Cases

- Patients who have a history **of cancer** but **no diagnosis or treatment** at your facility.
- Records, slides or patients seen only in **consultation to confirm a diagnosis where no chart is created in your facility. If a chart is created, it is reportable.**
- 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, the case is reportable.

- **Metastatic sites or recurrences** of a primary cancer that was **already reported by your facility.**
- **Nonhospital Facilities:** Patients diagnosed before 1992.
- **Hospital Facilities:** Patients diagnosed before 1976.
- 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.
- **Any skin cancer of the following types:**

Malignant neoplasms, NOS	*Squamous cell carcinomas*
Epithelial carcinomas	*Basal cell carcinomas*
Papillary carcinomas	*ICD-O3 histology codes 8000-8110*

Note: Skin cancers with ICD-O3 histologies higher than 8110 are reportable.

Casefinding Techniques

Casefinding (*case ascertainment*) is the process of identifying all reportable cases through review of source documents and case listings. Casefinding covers a range of cases that need to be assessed to determine whether or not they are reportable.

IMPORTANT: A casefinding list is not the same as a reportable list. Casefinding lists are intended for searching a variety of cases so you don't miss any reportable cases. WCRS only requires casefinding for the Reportable Neoplasms listed on the SEER website https://seer.cancer.gov/tools/casefinding/. WCRS recommends that facilities review cases from the SEER supplemental list.

Use the casefinding lists to screen prospective cases and identify cases for inclusion in the registry. Include all casefinding sources when searching for reportable cases.

Sources

- Inpatient/Outpatient Admission/Discharge Documents
- Pathology/Cytology Pathology Reports
- Surgery Logs/Schedules
- Radiology
- Nuclear Medicine
- Radiation Therapy Logs
- Chemotherapy Outpatient Logs
- Emergency Room Records
- Autopsy Reports
- Pain Clinic Logs

It is essential to include review of the disease index, which is usually provided by Health Information Management (HIM) or Medical Records Departments. Other tracking tools such as medical and radiation oncology clinic logs help ensure that all reportable cases are identified.

> **Note**: It is advisable to form an alliance with staff from HIM, radiation oncology and pathology departments. This will help develop a systematic method to receive necessary information from them.

IMPORTANT: Never rely solely on the pathology department to provide reportable cases. Doing so excludes cases that the facility has no diagnostic tissue reports. Cases diagnosed elsewhere but treated at your facility and those diagnosed radiographically or clinically, without tissue confirmation would be missed during casefinding.

Disease Index Codes for Casefinding 2018

Effective: 10/01/2017-09/30/18

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

Casefinding list can be found at:
https://seer.cancer.gov/tools/casefinding/fy2018-casefindinglist-icd10cm.pdf.

Disease Index Codes for Casefinding 2018	
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 (excluding category C49.A) stated or presumed to be primary (of the specified site) and certain specified histologies ***NEW for FY2018:*** *C96.20 Malignant mast cell neoplasm, unspecified* *C96.21 Aggressive systemic mastocytosis* *C96.22 Mast cell sarcoma* *C96.29 Other malignant cell neoplasm*
C49.Ax	Gastrointestinal Stromal Tumors *Note: GIST is only reportable when it is malignant (/3). GIST, NOS (not stated whether malignant or benign) is a /1 and is not reportable.*

Disease Index Codes for Casefinding 2018	
ICD-10-CM	**Diagnosis [with preferred ICD-O-3 terminology]**
D00.0 – D09.9	Carcinoma *in situ* *Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*
D18.02	Hemangioma of intracranial structures and any site
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
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.x	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
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

Disease Index Codes for Casefinding 2019

Effective: 10/01/2018-09/30/19

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

Casefinding list can be found at:
https://seer.cancer.gov/tools/casefinding/fy2019-casefindinglist-icd10cm.pdf

Disease Index Codes for Casefinding 2019	
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)
C44.13	Sebaceous cell carcinoma of skin of eyelid, including canthus Note: Effective 10/01/18
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 (excluding category C49.A) stated or presumed to be primary (of the specified site) and certain specified histologies
C44.Ax	Gastrointestinal Stromal Tumors *Note: GIST is only reportable when it is malignant (/3). GIST, NOS (not stated whether malignant or benign) is a /1 and is not reportable.*

Disease Index Codes for Casefinding 2019	
ICD-10-CM	**Diagnosis [with preferred ICD-O-3 terminology]**
D00.0 – D09.9	Carcinoma *in situ* *Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*
D18.02	Hemangioma of intracranial structures and any site
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
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.x	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
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 Reportable Solid Tumor Cases

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
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 (history, physical, 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 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	

Additional Detail for Select Reportable Hematopoietic Cases

ICD-10-CM	Diagnosis [with preferred ICD-O-3 terminology]
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]
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)
C44.13	Sebaceous cell carcinoma of skin of eyelid, including canthus Note: Effective 10/01/18
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)

ICD-10-CM	Diagnosis [with preferred ICD-O-3 terminology]
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]
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 (excluding category C49.A) stated or presumed to be primary (of the specified site) and certain specified histologies
C44.Ax	Gastrointestinal Stromal Tumors *Note: GIST is only reportable when it is malignant (/3). GIST, NOS (not stated whether malignant or benign) is a /1 and is not reportable.*
D00.0 – D09.9	Carcinoma *in situ* *Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*
D18.02	Hemangioma of intracranial structures and any site
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
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)*

ICD-10-CM	Diagnosis [with preferred ICD-O-3 terminology]
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]
D46.x	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
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

Ambiguous Terminology

Reportable malignancies are 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 absence of a cytologic/histologic diagnosis, or when there is a cytologic/histologic diagnosis***.

Ambiguous terminology may originate in any source document, such as a pathology report, radiology report, or clinical report. The terms listed below are reportable when they are used with a term such as *cancer*, *carcinoma*, and *sarcoma*. Ambiguous terms not listed below are not reportable.

Reportable Ambiguous Terms

Apparent(ly)	*Favor(s)*	*Suspect(ed)*
Appears	*Malignant appearing*	*Suspicious (for)*
Comparable with	*Most likely*	*Typical(of)*
Compatible with	*Presumed*	
Consistent with	*Probable*	

- There may be ambiguous terms preceded by a modifier**, such as "*mildly*" suspicious. In general,** ignore modifiers **or other adjectives and accept the reportable ambiguous term.**

- **Do not substitute synonyms** such as *supposed* for *presumed* or**,** *equal* for *comparable*. Do not substitute *likely* for *most likely.*

- ***Suspicious cytology*** is any cytology report diagnosis that uses an ambiguous term, including those listed as reportable in this manual. Follow back on cytology diagnoses using ambiguous terminology is recommended.

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

Example 2: Barium enema (BE) reveals a *suspicious* sigmoid mass. Colonoscopy reveals a sigmoid mass stated as a ***questionable*** malignant neoplasm*.* The patient is referred for biopsy and colon resection at another facility revealing carcinoma. **Do not report** because in this example *mass* and *neoplasm* are not associated with a reportable malignant term. If it stated ***suspicious*** sigmoid mass*,* ***probable*** malignant neoplasm it would be reportable.

Nonreportable Ambiguous Terms

Note: Only nonreportable if no additional information is available.

Rule out	*Potentially malignant*	*Suggests*
Equivocal	*Questionable*	*Cannot be ruled out*
Possible	*Worrisome*	

Example 1: Inpatient discharge summary documents a chest x-ray as c*onsistent with neoplasm* of the right upper lobe. The patient refused further work-up or treatment. *Consistent with neoplasm* is not indicative of cancer. **Do not report.** While *consistent with* can indicate involvement, *neoplasm* without specification of malignancy is not diagnostic except for non-malignant primary intracranial and central nervous system tumors.

Example 2: Final diagnosis is reported as *possible carcinoma* of the breast. **Do not report.** *Possible* is not a diagnostic term for cancer.

Note: Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute a diagnosis.

IMPORTANT: Physicians are not aware of reportable and nonreportable ambiguous terminology. Introduce these terms to your physicians to clarify how they are used to determine reportability.

Additional Ambiguous Terminology Guidelines for Solid Tumors

- **If any of the reportable ambiguous terms** precede **a word that is** synonymous with an *in situ* or invasive tumor **(e.g. *cancer*, *carcinoma*, *malignant neoplasm*), accession the case.**

  Example 1: Pathology report states: "Prostate biopsy with markedly abnormal cells *typical of adenocarcinoma*." Accession the case. *Typical of* is a reportable ambiguous term preceding *adenocarcinoma*

  Example 2: Final diagnosis on the outpatient report reads: "*Rule out* pancreatic cancer," **Do not accession the case.** *Rule out* is a nonreportable ambiguous term preceding *pancreatic cancer.*

  Example 3: Mass on CT scan is *consistent with* pituitary *tumor.* **Accession the case**. Reportable term (*consistent with)* precedes *tumor.*

- Discrepancies Between Reportable and Nonreportable Terms

  - Accession the case based on the reportable ambiguous term when there are **reportable and non-reportable ambiguous terms in the medical record**.

    Exception: **Do not accession** a case when original source document used a **non-reportable** ambiguous term and subsequent documents refer to history of cancer.

    Example: Report from the dermatologist states *possible* melanoma. Patient admitted later for unrelated procedure and physician listed *history of* melanoma. **Do not accession the case.** Give priority to the information from the dermatologist. *Possible* is not a reportable ambiguous term. The later information is less reliable in this case.

- Accept the reportable term and accession the case when there is a **single report** in which both reportable and non-reportable terms are used.

  Example: Abdominal CT reveals a 1 cm liver lesion. "The lesion is *consistent with* hepatocellular carcinoma" appears in the discussion section of the report. The final diagnosis is "1 cm liver lesion, *possibly* hepatocellular carcinoma." **Accession the case.** *Consistent with* is a reportable ambiguous term. Accept *consistent with* over the non-reportable term *possibly***.**

- Use the reportable ambiguous terms when screening diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing (with the exception of tumor markers).

  Note: ***Do not accession*** a case when **resection, excision, biopsy, cytology, or physician's statement** proves the ambiguous diagnosis is not reportable.

  Example 1: Mammogram report states "calcifications *suspicious* for intraductal carcinoma." The **biopsy** of the area surrounding the calcifications is negative for malignancy. **Do not accession the case.** The biopsy proved that the *suspicious* diagnosis was proven false.

  Example 2: CT report states "mass in the right kidney highly suspicious for renal cell carcinoma. Malignant neoplasm cannot be excluded." Discharged back to the nursing home and no other information is available. The suspicious CT finding was **biopsied** and not proven to be malignant. **Do not accession the case.**

  Example 3: Stereotactic biopsy of the left breast is "focally suspicious for DCIS" and is followed by a negative needle localization excisional biopsy. The needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic **biopsy** finding. **Do not accession the case.** The biopsy proved that the *suspicious* diagnosis was proven false.

  Example 4: Esophageal **biopsy** with diagnosis of "focal areas *suspicious* for adenocarcinoma in situ." Diagnosis on partial esophagectomy specimen "with foci of high grade dysplasia; no invasive carcinoma identified." **Do not accession the case.** The esophagectomy proved that the *suspicious* biopsy result was false.

Additional Ambiguous Terminology Guidelines for Hematopoietic and Lymphoid Neoplasms

- ***Do not report*** the case when biopsy or physician's statement **confirms a non-reportable** condition or **proves the ambiguous diagnosis is wrong.**

  Example: CT scan shows enlarged lymph nodes *suspicious for* lymphoma. Subsequent biopsies of the lymph nodes thought to be involved with a neoplasm are negative for malignancy. **Do not report the case.** The pathology is more reliable than the scan; the negative biopsy proves that the ambiguous diagnosis was wrong.

- ***Do not report cases*** diagnosed only by ***ambiguous cytology*** (cytology diagnosis preceded by ambiguous term).

  Example: Parotid ultrasound guided FNA states "*consistent with* non-Hodgkin's lymphoma." Case diagnosed based on cytology/fine needle aspiration (FNA) preceded by ambiguous terminology (*consistent with*). **Do not report this case** based on ambiguous cytology.

- ***Report the case*** when the patient is treated for a reportable neoplasm.

  Note 1: ***Report the case*** even if the diagnostic tests are inconclusive, equivocal, or negative.

  Note 2: For treatment information see the *National Cancer Institute's Physicians' Data Query* (PDQ) website at: http://www.cancer.gov/cancertopics/pdq or the *SEER*Rx Antineoplastic Drugs Database.*

- ***Report the case*** when a reportable diagnosis appears in any text or report described as a ***Definitive Diagnostic Method*** in the *Hematopoietic database.* Search the *Hematopoietic Database* to determine case reportability.

  Note: Definitive diagnostic methods differ depending upon the histology. See the *Hematopoietic Database* for details: https://seer.cancer.gov/seertools/hemelymph

Chapter 2:
Determining the Number of Primary Tumors

Now that you have 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, 2018, and later.

The 2007 Multiple Primary and Histology (MPH) Coding Rules have been revised and are now referred to as *2018 Solid Tumor Rules.* The 2007 Multiple Primary and Histology Coding Rules were developed to promote consistent and standardized coding by cancer registrars and the 2018 Solid Tumor Rules continue to provide coding instructions to ensure accurate data collection. It is important to note that eight site specific coding modules have been updated for 2018.

The primary reference for both the 2007 MPH rules and 2018 Solid Tumor Rules are the WHO Classification of Tumors books (blue books). Since 2007, WHO has continued publishing updates to the WHO Classification of Tumors series. As part of each new edition, subject matter experts review current literature and make recommendations regarding current practices in histology terminology and diagnosis. The College of American Pathologists (CAP) has adopted the new histologic terminology and diagnosis criteria into the site-specific 2018 CAP Protocols. The 2018 Solid Tumors Rules have been revised to reflect current CAP and WHO practices.

IMPORTANT:
For the complete *SEER Solid Tumor Rules* see: https://seer.cancer.gov/tools/solidtumor/

To determine multiple primaries for hematopoietic cancers such as lymphoma and leukemia, use the hematopoietic website at: https://seer.cancer.gov/seertools/hemelymph/

Definitions

Note: Use the terms and definitions in the following table for all reportable cases except lymphoma and leukemia primaries (ICD-O-3 histology codes 9590-9992).

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.
De novo	In cancer, the first occurrence of cancer in the body.
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.)
Multiple primaries	More than one reportable case for the same patient.
NED	Acronym for "no evidence of disease"; disease free.
Non-contiguous	Not touching along the boundary; not being in actual contact.
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.

2018 Solid Tumor Rules - What You Need to Know

(Excludes lymphoma and leukemia M9590 – M9992)

IMPORTANT: There are specific instructions preceding each set of histology rules that define terms which may be used to code histology as well as terms which may not be used to code histology. These changes are in accordance with current WHO and CAP guidelines.

Eight site groups have been revised for 2018. The 2018 General Instructions apply only to the revised sites listed below:

1. Head & Neck
2. Colon (includes rectosigmoid and rectum for cases diagnosed 1/1/2018 forward)
3. Lung
4. Breast
5. Kidney
6. Urinary sites
7. Non-malignant CNS
8. Malignant CNS and Peripheral Nerves

The 2007 Multiple Primary & Histology rules and the 2007 General Instructions are to be used for cases diagnosed 1/1/2007 to 12/31/2019 for the following site groups:

- ***Cutaneous melanoma.*** Site rules will be revised for 2020 implementation to incorporate information from the new WHO 4th Edition Tumors of Skin.
- ***Other Site***
    - Primary sites excluded are:

        Rectosigmoid and ***rectum*** which are included in 2018 Colon rules.

        Peripheral nerves which are included in 2018 Malignant Brain rules.

    - Other Sites rules will be revised for 2020 implementation. The Solid Tumor Task Force has identified the need to expand the rules to include GYN, soft tissue, thyroid as well as other site-specific solid tumors.

General Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with

  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**.

- Adenocarcinoma; glandular carcinoma; carcinoma
- De novo; new tumor; frank (obsolete term)
- Majority; major; predominantly; greater than 50%
- Multicentric; multifocal
- Simultaneous; synchronous; at the same time; prior to first course treatment
- Topography; site code
- Tumor; mass; tumor mass; lesion; neoplasm; nodule
  - The terms tumor, mass, tumor mass, lesion, neoplasm and nodule are **not** used in a **standard manner** in clinical diagnoses, scans, or consults. **Disregard** the terms unless there is a **physician's statement** that the term is **malignant/cancer**
  - These terms are used **ONLY** to determine multiple primaries
  - **Do not** use these terms for casefinding or determining reportability
- Type; subtype; variant

How to Use Equivalent Terms and Definitions

The Equivalent Terms and Definitions contain the following:

- Changes from the 2007 Multiple Primary and Histology Rules
- Equivalent and equal terms
- Terms that are not equivalent or equal
- Tables for coding (Primary Site Codes, Combination Histologies, Reportable Histologies and Subtypes/Variants, Not Reportable Histologies, Paired Sites)
- Illustrations

General Instructions - Multiple Primaries for Solid Tumors

1. Use the Solid Tumor Rules at: https://seer.cancer.gov/tools/solidtumor/ to determine the number of reportable **primaries** and to code **histology**. Do **not** use these rules to determine case reportability, stage, or tumor grade.

2. The rules are effective for cases diagnosed **January 1, 2018**, and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2018.

   Note: For tumors diagnosed 01/01/2007 through 12/31/2017, use the 2007 Multiple Primary and Histology (MP/H) Rules: https://seer.cancer.gov/tools/mphrules.

3. Read the **General Instructions** and the **site-specific Equivalent Terms and Definitions** in the Solid Tumor Rule manual before using the rules.

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 module. User the first rule that applies and **STOP.**

6. **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 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.

7. These rules do not apply to tumors described as metastases.

IMPORTANT: Do **not** use Solid Tumor Rules to determine case reportability, casefinding, stage, or tumor grade.

General Instructions - Multiple Primaries Rules for Solid Tumors

1. To choose the appropriate module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors), determine the **number of tumors**.

    a. Do not count **metastatic** lesions when determining which module to use.

    b. When the number of tumors is **unknown/not documented**, use the "Unknown if Single or Multiple Tumors" module.

        Note: When there is a tumor or tumors with separate microscopic foci, ignore the microscopic foci.

    c. When the patient has a **single tumor**, use the "Single Tumor" module.

    d. When the patient has **multiple tumors**, use the "Multiple Tumors" module.

2. When the rules return a single primary, prepare one abstract.

3. When the rules return multiple primaries, prepare two or more abstracts.

4. For those sites/histologies which have recognized **biomarkers**, the biomarkers frequently identify the histologic type. Currently, there are clinical trials being conducted to determine whether these biomarkers can be used to identify multiple primaries. Follow the Multiple Primary Rules; do not code multiple primaries based on biomarkers.

Timing Rules for Solid Tumors

Each Solid Tumor site group includes timing rules in the Multiple Primary Rules. It is important to remember that timing rules differ by site.

Examples of timing rules:

- Abstract **multiple primaries** when the patient has a subsequent tumor for the same site after being **clinically disease-free** for **greater than** the time frame interval as listed in the Solid Tumor Rule site-specific chapters (for example, the colon cancer interval is three years, where the invasive breast cancer interval is five years).

  Note: If there is a recurrence less than or equal to the time frame interval as listed in the Solid Tumor Rule site-specific chapter, the **"clock"** starts over. The time interval is now calculated from this **date of last recurrence**, instead of the original date of diagnosis**.**

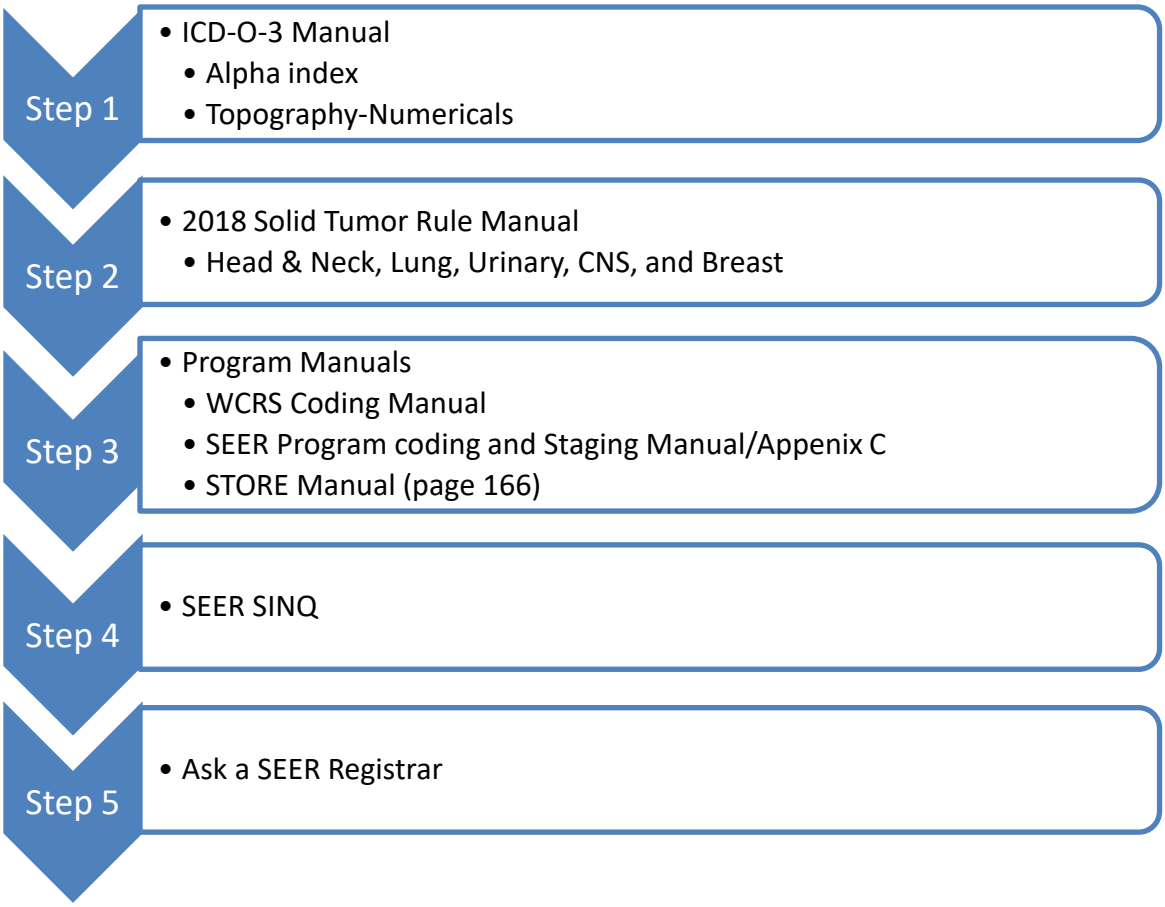
- Abstract a **single primary** (the invasive) when an **invasive** tumor is diagnosed **less than or equal to 60** days **after** an **in-situ** tumor

- **Clinically disease-free** means that there was **no evidence** of recurrence on follow-up.

- When it is **unknown/not documented** whether the patient had a recurrence, default to **date of diagnosis** to compute the time interval.

- Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary or a recurrence. The **ONLY exception** is when a **pathologist compares slides** from the subsequent tumor to the "original" tumor and documents the subsequent tumor is a recurrence of the previous primary. Never code multiple primaries based only on a physician's statement of "recurrence" or "recurrent".

Steps for Coding Primary Site for Solid Tumors



Step 1

http://codes.iarc.fr/

Step 2

https://seer.cancer.gov/tools/solidtumor/STM_2018.pdf

Step 3

https://www.dhs.wisconsin.gov/wcrs/reporterinfo/manual.htm

https://seer.cancer.gov/tools/codingmanuals/index.html

https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx

Step 4

https://seer.cancer.gov/seerinquiry/index.php

Step 5

https://seer.cancer.gov/registrars/contact.html

General Information - Coding Histologic Type for Solid Tumors

The North American Association of Central Registries (NAACCR) has released Guidelines for ICD-O-3 Histology Code and Behavior Update effective for cases diagnosed January 1, 2018 forward.

The update includes:

- New ICD-O codes
- Changes in behaviors for existing ICD-O codes
- New preferred terminology

Since a release date for either ICD-O-3.2 or ICD-O-5 is unknown, the Solid Tumor editors recommend coding histology using:

- Updated ICD-O histology codes and terms: https://seer.cancer.gov/icd-o-3/
- The 2018 *Solid Tumor Rules*
- The ICD-O

When a histology code cannot be identified using the above recommendations, review *SEER SINQ* to see if this scenario has been previously submitted and answered by SEER. If not, submit a question to "*Ask a SEER Registrar*."

General Instructions - Histology Coding Rules for Solid Tumors

Note 1: **Do not use these rules to determine case reportability.**

Note 2: Refer to *Solid Tumor Rules* for instructions on the order in which to use the rules.

1. Rules are divided into two sections: Single Tumor and Multiple Tumors Abstracted as a Single Primary.

   Note 1: Each section is a complete set of rules.

   Note 2: Within each section, the rules are hierarchical. Use the first rule that applies and **STOP**. Do not continue through the rules.

2. Code the histology diagnosis prior to **neoadjuvant therapy**. Neoadjuvant therapy can change the histological profile of the tumor.

3. Code the histology assigned by the physician. **Do not change histology** in order to make the case applicable to **staging**.

4. A list of terms which can be used and terms which cannot be used to code histology precede each set of histology rules.

5. Code a histology when described by ambiguous terminology **only** when:

   a. Histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)

   b. Patient is treated for the histology described by an ambiguous term.

   c. Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available or documented.

      Note: If the histology described by ambiguous terminology does not meet any of the criteria in the above bullets, **DO NOT CODE** the histology.

Ambiguous Terminology for Solid Tumor Histology

Apparently	*Appears*
Comparable with	*Compatible with*
Consistent with	*Favor(s)*
Malignant appearing	*Most likely*
Presumed	*Probable*
Suspect(ed)	*Suspicious (for)*
Typical (of)	

IMPORTANT: Ambiguous terminology to determine histology for Solid Tumor Rules is NOT the same as ambiguous terminology used to determine reportability.

Priority Order for Using Documents to Code Histology

For each site, priorities include biomarkers, tissue/histology, cytology, radiography/scans, and physician diagnoses. **You must use the priority order that precedes the histology rules for each site.**

- Priority order will differ by site. Biomarkers and/or tissue pathology always takes precedence.
- The specific types of radiography/scans also differ by site.

General Information – Coding Hematopoietic and Lymphoid Neoplasm Multiple Primary Tumors and Histology

The Hematopoietic & Lymphoid Neoplasm Database (Heme DB) contains abstracting and coding information for all hematopoietic and lymphoid neoplasms (9590/3-9992/3). The Coding Manual contains reportability instructions and rules for determining the number of primaries, the primary site and histology.

IMPORTANT: 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.
Refer to the Heme DB and Coding Manual for complete instructions on the SEER website at:
http://seer.cancer.gov/seertools/hemelymph/

Steps in Priority Order for Using the Hematopoietic and Lymphoid Neoplasm Database and Coding Manual

1. Identify the working (preliminary) **histology code(s)** by searching the Heme DB.

Examples of Searches		
Search	**Example**	**Notes**
Unique word in diagnosis	"precursor"	If diagnosis is precursor acute lymphoblastic leukemia
Complete name (diagnosis)	"acute myelomonocytic leukemia"	The number of matched terms will be much smaller than just searching on "leukemia". Results displayed will have all three words in the histology name. The words may appear in any part of the entry (alternative names, abstractor notes, transformations, etc.
Abbreviations	AMML	Acute myelomonocytic leukemia
Histology code	9867/3	Code search display's: Acute myelomonocytic leukemia

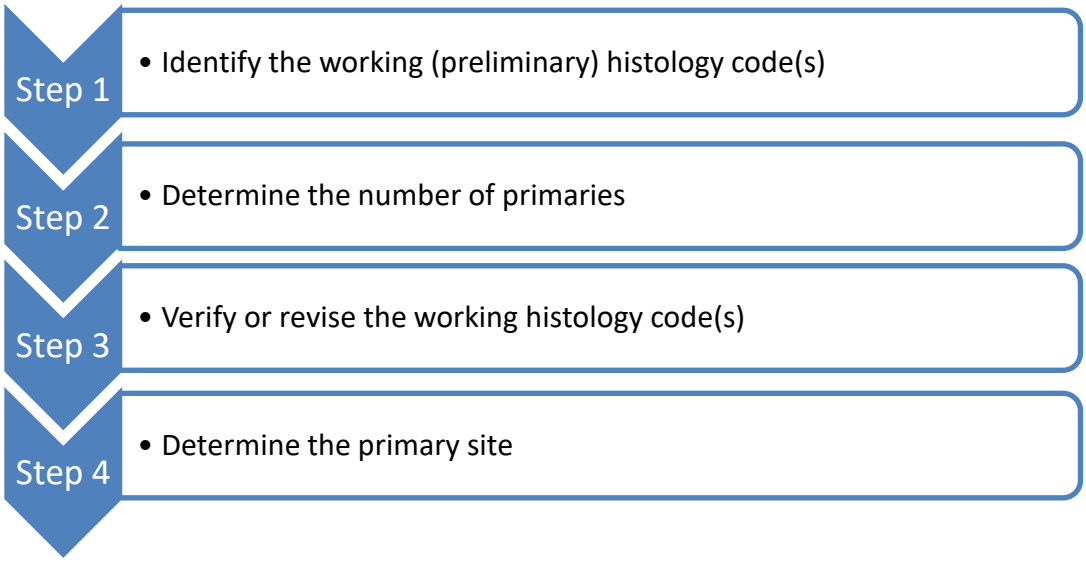
Note: When multiple results are displayed, click on the desired term to display the record.

2. Use the Multiple Primary Rules to determine the **number of primaries** using the working histology code(s).
    a. Start with rule M1, move through the rules in consecutive order and stop at the first rule that applies. The M rule references in the Heme DB are to be used as a guide only.
    b. Use the Hematopoietic Multiple Primaries Calculator in the Heme DB only when instructed by the rules in the Hematopoietic Manual.
3. Verify or revise the working histology code(s) using the Primary Site and Histology Rules.
    a. When the PH rules lead you to a different histology code, enter that code in the Heme DB search box and display the record for that histology.
    b. The PH rules referenced in the Heme DB are the most common rule(s) used to code Primary Site and Histology for the selected histology. More than one Module/PH Rule may be needed to code Primary Site and Histology.
4. Determine primary site using the *Primary Site and Histology Rules*
    a. See Primary Site Coding Instructions.
    b. For certain histologies, only one primary site code is displayed.
    c. When there is no primary site code listed under **Primary Site(s)**
        - Review the **Primary Site Text** field for common primary sites or other primary site instructions and rules.
        - Search the Hematopoietic Manual and/or database to find applicable modules.
        - Read the **Abstractor Notes** to find other information regarding sites of involvement for stages II, III, and IV lymphomas. Use the **Abstractor Notes** to confirm that the **site/histology combination indicated by the involvement documented in the medical record is probable**.
        - You may also seek a physician's help in determining the primary site.

IMPORTANT: Grade is no longer applicable for Hematopoietic and Lymphoid Neoplasms for cases diagnosed 2018 and forward.

- **For cases with histologies 9590/3-9992/3, the clinical grade must be coded to '8'.**
- **Grade fields are coded to '8', not applicable**
    - ***Exception***: Follicular lymphomas occurring in the Lymphoma Ocular Adnexa schema.

Steps for Using the Hematopoietic and Lymphoid Neoplasm Database



Example: A patient is diagnosed at your facility in 2018 with acute myeloid leukemia. The patient is in your registry database with refractory anemia with ring sideroblasts diagnosed and treated in 2010.

Step 1: Identify the working histology code (s).

- Refractory anemia with ring sideroblasts – 9982/3
- Acute myeloid leukemia – 9861/3

Step 2: Determine the number of primaries.

- Rule M10: Abstract as multiple primaries when a neoplasm is originally diagnosed as a chronic neoplasm AND there is a second diagnosis of an acute neoplasm more than 21 days after the chronic diagnosis.

Note: Check the Hematopoietic Database to determine if histology is transformation to/from.

Step 3: Verify or revise the working histology code (s).

- 2010 – 9982/3
- 2018 – 9861/3

Step 4: Determine the primary site.

- 2010 - C421
- 2018 – C421

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 2018 must be used to assign the summary stage for all cases diagnosed from January 1, 2018, forward. The manual is available on line at https://seer.cancer.gov/tools/ssm/2018-Summary-Stage-Manual.pdf.

- 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		Timely Reporting Calendar for Breast Cases	
Month Case Dx/Seen	**Month Case Due**	**Month Case Dx/Seen**	**Month Case Due**
January	July	January	December
February	August	February	January
March	September	March	February
April	October	April	March
May	November	May	April
June	December	June	May
July	January	July	June
August	February	August	July
September	March	September	August
October	April	October	September
November	May	November	October
December	June	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**: This project was conducted from 2014-2019. During that time, all reportable ECC data items for cancers diagnosed among children and young adults ages 0-19 were required to be submitted to WCRS within 30 days from the date of diagnosis. Appendix VI contains the data items that WCRS required for ECC reporting. Details are available on the WCRS ECC web page.

Note: Refer to *Appendix IV* for a list of coding manuals and other resources needed to complete case reporting for WCRS.

General Instructions - 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.

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

2. 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 disabled 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 Information - Reporting Race

Race refers to a person's physical characteristics, such as bone structure and skin, hair, or eye color.

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. 2010 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).

Note: When there is only one race to be coded, then the Race 2-5 fields will be coded to '88' meaning no other races are listed). 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. 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.

IMPORTANT: For cases diagnosed/reported after January 1, 2000, **all race fields must be coded (using '88's in the 'extra' race fields)**. 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.

Priorities for Coding Multiple Races

1. Code **12** takes priority over all other codes.

   Example: Patient is described as Hmong and Laotian. Code Race 1 as 12 (Hmong), Race 2 as 11 (Laotian).

2. Codes **02-32, 96-98** take priority over code **01.**

3. Code only the specific race when both a specific race and a non-specific race code apply.

   a. Codes 04-17 take priority over code 96.
   b. Codes 16-17 take priority over code 15.
   c. Codes 20-32 take priority over code 97.
   d. Codes 02-32 and 96-97 take priority over code 98.
   e. Code 98 takes priority over code 99.

General Instructions - Coding Race

IMPORTANT: See Coding Instruction 15, Exception, for the only situation in which name is taken into account when coding race.

1. Do **not** use patient name as the basis for coding race, especially for females with no maiden name given.

    a. A name may be an indicator of a racial group, but should not be taken as the only indicator of race.

    b. 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.

    c. A patient name may be used to infer Spanish ethnicity or place of birth, but a Spanish name alone without a statement about race or place of birth cannot be used to determine the race code.

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

        Note: Patient's ethnicity is not the same as patient's race. Refer to ethnicity guidelines for further information.

2. Code race using the highest priority source available according to the list below (when race is reported differently by two or more sources).

    Sources in Priority Order

    a. The patient's self-declared identification
    b. Documentation in the medical record
    c. Death certificate

    Note: 'a' is the highest and 'c' is the lowest.

3. Assign the same race code(s) for all tumors for one patient.

4. Code the race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5.

   Note: Code **88** for the remaining race fields (Race 2 – Race 5) when at least one race, but fewer than five races, are reported.

5. Use the associated text field to document.

   a. Why a particular race code was chosen when there are discrepancies in race information.

      Example: The patient is identified as Black in nursing notes and White in a dictated physical exam. Use a text field to document why one race was coded rather than the other.

   b. That no race information is available.

6. Code as **01** (White) when:

   a. The race is described as White or Caucasian regardless of place of birth.

   b. There is a statement that the patient is Hispanic or Latino(a) and no further information is available.

   Note 1: 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.

   Note 2: Do **not** code a patient stated to be Hispanic or Latino as '98,' Other Race, in Race 1 and '88' in Race 2-5. in this situation.

   Example 1*:* Patient is a Latina. Code race as 01 (White).

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

7. Code race as **02** (Black) when the stated race is African-American, Black, or Negro.

8. Assign code **03** for any person stated to be

   a. Native American (western hemisphere) OR
   b. Indian, whether from North, Central, South, or Latin America

9. Assign a specific code when a specific Asian race is stated.

   Example: Patient is described as Asian in a consult note and as second generation Korean-American in the history. Code Race 1 as 08 (Korean) and Race 2 through Race 5 as 88.

   Note 1: Asian race codes are specific to unique groups and every attempt should be made to report the patient's most detailed race.

   Note 2: Do not use code 96 when a specific race is known

   Note 3: Do not code 96 (Other Asian including Asian, NOS and Oriental, NOS) in a subsequent race field when a specific Asian race has been coded.

10. Code the race based on birthplace information when the race is recorded as Oriental, Mongolian, or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation.

    Example 1: Race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 (Japanese) because it is more specific than 96.

    Example 2: The person describes himself as an Asian-American born in Laos. Code race as 11 (Laotian) because it is more specific than 96.

IMPORTANT: 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.

11. 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.'

12. 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.'

    Note: Do not use code 96, 97, or 98 for "multi-racial."

    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.'

13. All race fields must be coded 99 (Unknown) when Race 1 is coded 99 (Unknown).

    Note: Assign code 99 in Race 2-5 only when Race 1 is coded 99.

14. 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.'

    Note: Assign code 99 for death certificate only (DCO) cases when race is unknown.

15. If race is unknown or not stated in the medical record and birth place is recorded. Refer to Appendix V "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics".

    Note: In some cases, race may be inferred from the nationality. Use Appendix V to identify nationalities from which race codes may be inferred.

    Example 1: Record states: "this native of Portugal..." Code race as 01 (White) per Appendix V.

Example 2*:* Record states: “this patient was Nigerian...” Code race as 02 (Black) per the Appendix V.

Exception: Code Race 1 through Race 5 as 99 (Unknown) when patient’s name is incongruous with the race inferred on the basis of nationality. Do not code the inferred race when the patient’s name is incongruent with the race inferred on the basis of nationality.

Example 1: Patient’s name is Siddhartha Rao and birthplace is listed as England. Code Race 1 through Race 5 as 99 (Unknown).
Example 2: Patient’s name is Ping Chen and birthplace is Ethiopia. Code Race 1 through Race 5 as 99 (Unknown).

16. When the patient face-sheet indicates “Race Other,” look for other descriptions of the patient’s race. When **no further race information is available**, code race as 99 (Unknown) and document that patient face-sheet indicates “Race Other,” and no further race information is available.

17. Patient photographs may be used with caution to determine race in the absence of any other information.

    Note: Use caution when interpreting a patient photograph to assist in determining race. Review the patient record for a statement to verify race. The use of photographs alone to determine race may lead to misclassification of race.

18. Code race in the order stated when no other priority applies.

Additional Coding Examples for Race

Example 1: Patient stated to be Japanese. Code Race 1 as ‘05’ (Japanese) and Race 2-5 as ‘88’.

Example 2: Patient stated to be German-Irish. Code Race 1 as ‘ 01’ (White) and Race 2-5 as ‘88’.

Example 3: Patient described as Arabian. Code Race 1 as ’01’, (White) and Race 2-5 as ‘88’.

Example 4: Patient described as a black female. Code as ‘02’, (Black) and Race 2-5 as ‘88’ .

Example 5: The patient is described as Asian-American with Korean parents. Code Race 1 as ‘08’ (Korean) because it is more specific than ‘96’ (Asian) [-American].

Example 6: Patient stated to be Chinese and black. Code Race 1 as 04 (Chinese), code Race 2 as 02 (Black). Code in the order stated when no other priority applies.

Example 7: Patient described as Middle Eastern. Code as 01 (White).

Example 8: Patient described as Greek. Code as 01 (White).

Example 9: 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’.

Example 10: Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Hawaiian), Race 2 as 05 (Japanese).

General Instructions - Reporting Ethnicity (Spanish Surname or Origin)

Note: Ethnicity refers to cultural factors, including nationality, regional culture, ancestry, and language.

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. Use all information to determine the Spanish/Hispanic Origin including:

    a. Ethnicity stated in the medical record

        Note: Self-reported information takes priority over other sources.

    b. Hispanic origin stated on the death certificate
    c. Birthplace
    d. Life history and/or language spoken found in the abstracting process
    e. Last name or maiden name found on a list of Hispanic/Spanish names

3. Assign code **6** when there is more than one ethnicity/origin (multiple codes), such as Mexican (code 1) and Dominican Republic (code 8). There is no hierarchy among the codes 1-5 or 8.

4. 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.

    Note: Code 7 is ordinarily for central registry use only.

5. Portuguese, Brazilians, and Filipinos are not presumed to be Spanish or non-Spanish

    a. Assign code **7** when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list.

    b. Assign code **0** when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list.

6. Assign code 9 for death certificate only (DCO) cases when Spanish/Hispanic origin is unknown.

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

Coding Examples - Reporting Ethnicity (Spanish Surname or Origin)

Example 1: Married female, no maiden name, Race 99, born in Mexico, married name is not on Spanish surname list. Code as 1 (Mexican) using coding instruction 2.c.

Example 2: Married female, no maiden name, Race 01, born in Philippines, married last name not on Spanish surname list and medical record states “Hispanic.” Code as 6 (Hispanic, NOS) using coding instruction 2.a.

Example 3: Married female, no maiden name, Race 99, born in Peru, married last name is on Spanish surname list, no statement regarding ethnicity available. Code as 4 (South or Central America) using coding instruction 2.c.

Example 4: Patient has two last names, one of the last names is on the Spanish surname list. Code as 7 (Spanish surname only) using coding instruction 4.

General Instructions - Reporting Behavior

1. The behavior of a neoplasm describes the malignant potential 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.

   Code the behavior from CT scan, Magnetic Resonance Imaging (MRI), or Positron Emission Tomography (PET) report when there is no tissue diagnosis (pathology or cytology report). Code the behavior listed on the scan. Do not use the WHO grade to code behavior.

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.

   Re-code the behavior as malignant (/3) when metastases are attributed to a tumor originally thought to be in situ.

   Example*:* Right colon biopsy reveals tubulovillous adenoma with microfocal carcinoma in situ; right hemicolectomy is negative for residual disease. Later core liver biopsy consistent with metastatic adenocarcinoma of gastrointestinal origin. Oncologist states most likely colon primary. Change the behavior code for the colon primary from /2 to /3. There were no other colon primaries in this case.

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 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.

Note: Make sure the behavior code in the appropriate text field was confirmed by pathology. In addition, your software edits may require using an override code for this rare situation.

Common Synonyms for In Situ, Noninvasive Tumors

- AIN III (anal canal)
- Behavior code '2'
- Bowen disease (not reportable for skin primary cancers)
- Clarks level I for melanoma (limited to epithelium)
- Confined to epithelium
- Hutchinson melanotic freckle, NOS
- Intracystic, non-infiltrating
- Intraductal
- Intraepidermal, NOS
- Intraepithelial, NOS
- Involvement up to, but not including, the basement membrane
- Lentigo maligna
- Lobular, noninfiltrating
- Noninfiltrating
- Noninvasive
- No stromal invasion/involvement
- Papillary, noninfiltrating or intraductal
- Precancerous melanosis
- Queyrat erythroplasia
- Stage 0
- VAIN III (Vagina, NOS)
- VIN III (Labium majus and minus, clitoris, vulva, NOS)

General Instructions - Reporting Grade

Hematopoietic and Lymphoid Neoplasms

Historically the cell lineage indicator (B-cell, T-cell, Null cell, NK-cell) was collected in the Grade data item. Cell lineage indicator/grade for hematopoietic and lymphoid neoplasms will no longer be collected for cases diagnosed 1/1/2018 and forward.

IMPORTANT: Grade is no longer applicable for Hematopoietic and Lymphoid Neoplasms for cases diagnosed 2018 and forward.

- **For cases with histologies 9590/3-9992/3, the clinical grade must be coded to '8'.**
- **Grade fields are coded to '8', not applicable**
    - ***Exception***: Follicular lymphomas occurring in the Lymphoma Ocular Adnexa schema.

Solid tumors - Grade, Differentiation

For solid tumors diagnosed 2018 and forward, grade will be collected in three different data items, Grade Clinical, Grade Pathological, and Grade Post Therapy, and the codes and coding instructions will depend on the type of cancer. The tables for grade were restructured for 2018. There may be a combination of numeric and alphabetic codes within the same table, according to this template.

Template for a Cancer-Specific Grade Table	
Codes	**Grade Description**
1-5	Site-specific grade system category
8	Not applicable (Hematopoietic neoplasms only)
9	Grade cannot be assessed; Unknown
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated and anaplastic
E	Site-Specific grade system category
H	High grade
L	Low grade
M	Site-specific grade system category
S	Site-specific grade system category
Blank	(Post therapy only)

Grade Coding Instructions - Solid Tumors

1. 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**.

2. If there is more than one grade for the same primary site; code the highest grade within the applicable grade table.

3. In situ and/or combined in situ/invasive component:

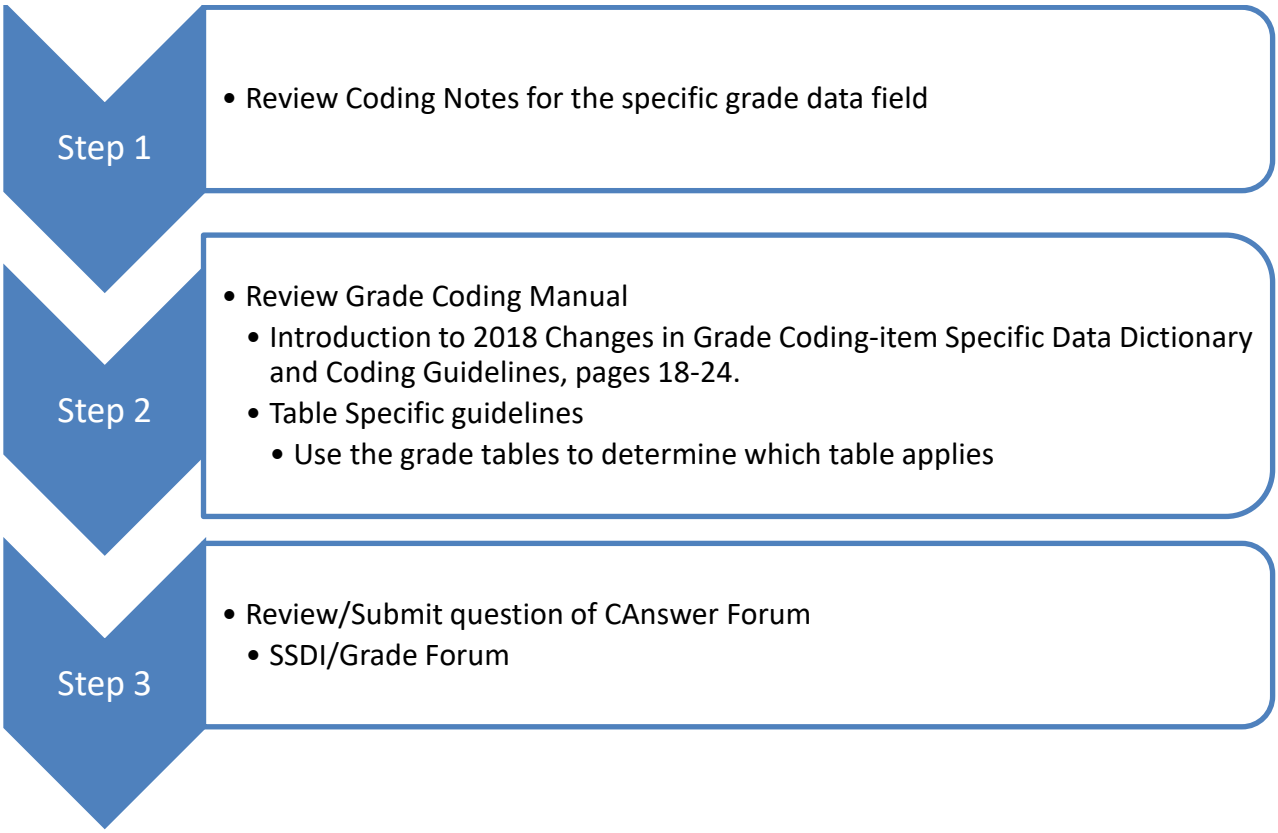
    a. If a grade is given for an in situ tumor, code it. Do NOT code grade for dysplasia such as high-grade dysplasia.

    b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.

4. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code clinical grade based on information prior to neoadjuvant therapy even if grade is unknown during the clinical timeframe. Grade can now be collected in grade post therapy cases when grade is available from post neoadjuvant surgery

See the individual site-specific Grade Clinical tables for additional notes:
https://www.naaccr.org/SSDI/Grade-Manual.pdf?v=1527608547

Steps for Coding Grade



Step 1

Grade Clinical
This input is used for staging.
Coding Guidelines
Note 1: Clinical grade must not be blank.
Note 2: Assign the highest grade from the primary tumor.
Note 3: Priority order for codes.

Step 2
https://www.naaccr.org/SSDI/Grade-Manual.pdf?v=1527608547

Step 3
http://cancerbulletin.facs.org/forums/

General Instructions - Time Frames for Grade

The three new grade data items reflect the points in time in the patient's care when grade may be assessed.

Required by WCRS for All Cases

Grade Clinical

For the Grade Clinical data item, record the grade of a solid primary tumor before any treatment. Treatment may include surgical resection, systemic therapy, radiation therapy, or neoadjuvant therapy. All surgical procedures are not treatment, e.g. TURB and endoscopic biopsies.

Grade Pathological

For the Grade Pathological data item, record the grade of a solid primary tumor that has been surgically resected and for which no neoadjuvant therapy was administered. If AJCC pathological staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup, as all information from diagnosis (clinical staging) through the surgical resection is used for pathological staging.

Grade Post Therapy

For the Grade Post Therapy data item, record the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC post therapy staging is being assigned, the tumor must have met the surgical resection requirements for yp in the AJCC manual. Neoadjuvant therapy must meet guidelines or standards, and not have been given for variable or unconventional reasons as noted in the AJCC manual. This data item corresponds to the yp staging period only.

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.

    - Last name
    - First name
    - Middle name
    - Maiden name
    - Address at diagnosis; includes city, county, state and zip code
    - Race
    - Spanish/Hispanic origin
    - Sex
    - Birthdate
    - Social Security number
    - Date of diagnosis
    - Primary site
    - Morphology type, behavior and grade
    - Laterality
    - Diagnostic confirmation
    - Summary Stage
    - Type and date of first course definitive treatment

3. Submissions will be accepted in two formats:

    a. Fax the change to 608-266-2431, or

    b. Use the 'M' NAACCR electronic record layout. (Contact your vendor for specific instructions on submitting these changes if using the M layout.)

Paper Reporting Forms

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 forms are available from the WCRS website at: https://www.dhs.wisconsin.gov/wcrs/reporterinfo/manual.htm. If it is necessary to use paper, the forms 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 18 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 (user ID and password) for secure data submission.

IMPORTANT: 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:

Submission Schedules	
Annual Caseload	**Schedule**
More than 500	Monthly
Less than 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.

> **Note 1:** 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.)
>
> **Note 2:** 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.

Site-specific surgery codes are available in the *Standards for Oncology Registry Entry* (STORE) manual, Appendix B:
https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018
(Use the bookmark feature to quickly move to the appendix.)

The SEER RX web site contains drug classifications by specific treatment category (hormone, chemotherapy, etc.): http://seer.cancer.gov/seertools/seerrx/.

Definitions

First course of therapy: All treatments administered to the patient after the original diagnosis of cancer in an attempt to **destroy or modify the cancer tissue**.

Active surveillance: A treatment plan that involves closely watching a patient's condition but not giving any treatment unless there are changes in test results that show the condition is getting worse. Active surveillance may be used to avoid or delay the need for treatments such as radiation therapy or surgery, which can cause side effects or other problems.

Concurrent therapy: A treatment that is given at the same time as another.

Example: Chemotherapy and radiation therapy

***Hospice*:** A program that provides special care for people who are near the end of life and for their families, either at home, in freestanding facilities, or within hospitals. Hospice care **may** include treatment that destroys or modifies cancer tissue. If performed as part of the first course, treatment that destroys or modifies cancer tissue is collected when given in a hospice setting. "Hospice, NOS" is not specific enough to be included as first course treatment.

Neoadjuvant therapy: Systemic therapy or radiation therapy given prior to surgery to shrink the tumor.

Palliative treatment: The World Health Organization describes palliative care as treatment that improves the quality of life by preventing or relieving suffering.

Note 1: Palliative therapy **is part of the first course of therapy only** when it **destroys or modifies cancer tissue**.

Example*:* The patient was diagnosed with stage IV cancer of the prostate with painful bone metastases. The patient starts radiation treatment intended to shrink the tumor in the bone and relieve the intense pain. The radiation treatments are palliative because they relieve the bone pain; the radiation is also first course of therapy because it destroys proliferating cancer tissue.

Note 2: 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).

Watchful waiting: Closely watching a patient's condition but not giving treatment unless symptoms appear or change. Watchful waiting is sometimes used in conditions that progress slowly. It is also used when the risks of treatment are greater than the possible benefits. During watchful waiting, patients may be given certain tests and exams. Watchful waiting is sometimes used in prostate cancer. It is a type of expectant management.

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:

a. 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.

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

New WCRS Required Data Field for 2018: Phase 1 Radiation Treatment Modality

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during the first phase of radiation.

The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.

Coding Instructions

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- For purposes of this data item, photons, x-rays and gamma-rays are equivalent.
- Use code 13 - Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90.

Codes for Phase 1 Radiation Treatment Modality

Code	Label
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-223
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Radiation treatment modality unknown; Unknown if radiation treatment administered

Treatment Timing

Use the following instructions **in hierarchical order.**

1. Use the **documented** first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is **completed** no matter how long it takes to complete the plan.

   Example: Hormonal therapy (e.g., Tamoxifen) after surgery, radiation, and chemotherapy. First course ends when hormonal therapy is completed, even if this takes years, unless there is documentation of disease progression, recurrence, or treatment failure (see #2 below).

2. First course of therapy ends when there is documentation of **disease progression, recurrence, or treatment failure.**

   Example 1: The documented treatment plan for sarcoma is pre-operative (neoadjuvant) chemotherapy, followed by surgery, then radiation or chemotherapy depending upon the pathology from surgery. Scans show the tumor is not regressing after pre-operative chemotherapy. Plans for surgery are cancelled, radiation was not administered, and a different type of chemotherapy is started. Code only the first chemotherapy as first course. Do **not** code the second chemotherapy as first course because it is administered after documented treatment failure.

   Example 2: The documented treatment plan for a patient with locally advanced breast cancer includes mastectomy, chemotherapy, radiation to the chest wall and axilla, and hormone therapy. The patient has the mastectomy and completes chemotherapy. During the course of radiation therapy, the liver enzymes are rising. Workup proves liver metastases. The physician stops the radiation and does not continue with hormone therapy (the treatment plan is altered). The patient is placed on a clinical trial to receive Herceptin for metastatic breast cancer. Code the mastectomy, chemotherapy, and radiation as first course of treatment. Do not code the Herceptin as first course of therapy because it is administered after documented disease progression.

When there is **no documentation** of a treatment plan or progression, recurrence or a treatment failure, first course of therapy ends one year after the date of diagnosis. **Any treatment given after one year is second course of therapy in the absence of a documented treatment plan or a standard of treatment**.

General Instructions - Treatment Coding for Solid Tumors

1. Code all treatment fields to 0 or 00 (Not done) when the physician opts for **active surveillance.** When the disease progresses or the patient becomes symptomatic, any prescribed treatment is second course.

   Note: Code Treatment Status (RX Summ--Treatment Status) to 2.

2. Code the treatment as first course of therapy if the patient refuses treatment but changes his/her mind and **the prescribed treatment is implemented less than one year** from the date of diagnosis, AND there is no evidence of disease progression.

3. The first course of therapy is **no treatmen**t when the patient **refuses** all treatment. Code all treatment fields to Refused.

   Note: Keep the refused codes even if the patient later changes his/her mind and decides to have the prescribed treatment.

   a. More than one year after diagnosis, **or**

   b. When there is evidence of disease progression before treatment is implemented

4. Code all treatment that was started and administered, whether completed or not. Document treatment discontinuation in text fields.

   Example: The patient completed only the first dose of a planned 30-day chemotherapy regimen. Code chemotherapy as administered.

5. Code the treatment on each abstract when a patient has multiple primaries and the treatment given for one primary also affects/treats another primary

   Example 1: The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate cancer was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional lymph nodes for the bladder. Code the radiation as treatment for both the bladder and prostate cases.

Example 2: The patient had a hysterectomy for ovarian cancer. The pathology report reveals a previously unsuspected microinvasive cancer of the cervix. Code the hysterectomy as surgical treatment for both the ovarian and cervix primaries.

6. Code the treatments only for the site that is affected when a patient has multiple primaries and the treatment affects only one of the primaries

   Example: The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and regional nodes. Do not code the radiation for the colon. Do not code the hemicolectomy for the tonsil.

7. Code the treatment given as first course even if the correct primary is identified later when a patient is diagnosed with an unknown primary.

   Example 1: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Code the chemotherapy as first course of treatment.

   Note: Do not code treatment added to the plan when the primary site is discovered as first course. This is a change in the treatment plan.

   Example 2: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code the chemotherapy as first course of treatment. The hormone therapy is second course because it was not part of the initial treatment plan.

General Instructions - Treatment Coding for Hematopoietic Neoplasms

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/.

First Course of Treatment for Hematopoietic Neoplasms

Treatment varies by the type of hematopoietic neoplasm. Lymphomas can be treated with surgery (extranodal or nodal), chemotherapy, and radiation, while leukemias are often treated with chemotherapy and bone marrow transplants. In addition, immunotherapy (biologic response modifiers) and hormones are frequently used to treat hematopoietic neoplasms. Also, for many of these diseases, the principal treatment is either supportive care, observation, or another type of treatment that does not meet the usual definition of treatment that "modifies, controls, removes or destroys proliferating cancer tissue."

IMPORTANT: For further information regarding first course of therapy for hematopoietic and lymphoid neoplasms, refer to the NCI, SEER *Hematopoietic and Lymphoid Neoplasm Coding Manual* at: http://seer.cancer.gov/tools/heme/index.html.

Coding Instructions for Hematopoietic Neoplasms

1. When there is only one neoplasm (one primary), use the documented first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is completed, no matter how long it takes to complete the plan.

2. Chronic neoplasm followed by an acute neoplasm.

    a. The presence/absence of treatment **DOES NOT** affect the number of primaries when a chronic neoplasm transforms to an acute neoplasm.

        Example: Patient diagnosed in 2000 with follicular lymphoma. Patient refused treatment. Patient returns in 2014 with DLBCL. Abstract the DLBCL as a second primary even though there was no treatment for the follicular lymphoma.

b. First course of treatment for the chronic neoplasm may or may not be completed when the chronic neoplasm transforms to the acute neoplasm.

3. Acute neoplasm followed by a chronic neoplasm.

   a. The presence/absence of treatment **DOES** impact the determination of the number of primaries when the acute neoplasm reverts to a chronic neoplasm (see Rules M12 and M13).

   b. The planned first course of therapy may not have been completed when a biopsy/pathologic specimen shows only chronic neoplasm after an initial diagnosis of an acute neoplasm.

   c. The patient may have completed the first course of treatment and have been cancer free (clinically, no evidence of the acute neoplasm) for an interim when diagnosed with the chronic neoplasm.

   d. The patient may not have been cancer free, but completed the first course of treatment and biopsy/pathology shows only chronic neoplasm.

Code the treatment on both abstracts when a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary.

> **Example**: Patient is diagnosed in May 2014 with both multiple myeloma (9732/3) and mantle cell lymphoma (9673/3), which are separate primaries per rule M15. The oncologist states she began Velcade chemotherapy for the lymphoma. Velcade would affect both primaries, so it should be coded on both abstracts.

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.

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.

Reporting Phlebotomy, Blood-Thinners/Anti-Clotting Medications, and Transfusions as Other Therapy

- Do **not** collect **blood transfusions** (whole blood, platelets, etc.) as treatment. Blood transfusions are widely used to treat anemia and it is not possible to collect this procedure in a meaningful way.
- Collect **phlebotomy** for polycythemia vera (9950/3) ONLY.
- Collect **blood-thinners** and/or **anti-clotting agents** for essential thrombocythemia (9962/3) **ONLY.**

Donor Leukocyte Infusions

The use of donor leukocyte infusions for treatment of hematopoietic neoplasms, specifically leukemia's, is increasing. Abstract as immunotherapy when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion, even if it is not listed in the treatment section of the Hematopoietic database for the specific neoplasm.

Chapter 5: Data Dictionary

This data dictionary lists all required and recommended fields for 2018 and 2019 diagnoses in alphabetical order.

Each data item description contains:

- ✓ **Field name**
- ✓ **Field name** as listed in the **Abstract Plus Version 3.7** software display screen
- ✓ **Item length** (for electronic submission)
- ✓ **NAACCR Item Number Version 18 Layout**
- ✓ **Description**
- ✓ **Codes** (if applicable)
- ✓ **Allowable Values**
- ✓ **Rationale** (if applicable)
- ✓ **Definition** (if necessary)
- ✓ **Standard Source** (field-specific)

The standard source (NAACCR, SEER, or CoC) identifies the correct reference which may contain more detailed coding instructions than what WCRS references in this manual for selected required or recommended data items.

Websites

SEER	
Main coding website	http://seer.cancer.gov/registrars/
Summary Stage 2018	https://seer.cancer.gov/tools/ssm/
Solid Tumor Rules	https://seer.cancer.gov/tools/solidtumor/
Hematopoietic Database	https://seer.cancer.gov/tools/heme/
CoC	
STORE Manual	https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx
Site-specific Surgery Codes Appendix B *(starts on page 439)*	https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx
NAACCR	
Site-specific Data Items	https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1552396699
Grade	https://www.naaccr.org/SSDI/Grade-Manual.pdf?v=1552396699

WCRS 2018 Required Data Items

Refer to the following pages for specific required data item explanation.

New WCRS required data fields are shaded in light red.		
NAACCR Item	**Data Item**	**Notes**
570	Abstracted By	
550	Accession Number--Hosp	Document if available
70	Addr at DX--City	
2330	Addr at DX--No & Street	
100	Addr at DX--Postal Code	
80	Addr at DX--State	
2335	Addr at DX--Supplementl	
230	Age at Diagnosis	
523	Behavior Code ICD-O-3	
254	Birthplace--Country	Document if available
252	Birthplace--State	Document if available
501	Casefinding Source	
1910	Cause of Death	
610	Class of Case	
2152	**CoC Accredited Flag**	*Will be defaulted for Abstract Plus users*
90	County at DX Reported	
2090	Date Case Completed	*Should be defaulted by software*
1260	Date Initial RX SEER	
1261	Date Initial RX SEER Flag	
580	Date of 1st Contact	
581	Date of 1st Contact Flag	
240	Date of Birth	
241	Date of Birth Flag	
390	Date of Diagnosis	
391	Date of Diagnosis Flag	
1750	Date of Last Contact	
1751	Date of Last Contact Flag	
490	Diagnostic Confirmation	
1790	Follow-Up Source	Document if available
522	Histologic Type ICD-O-3	
1920	ICD Revision Number	
2410	Institution Referred From	
2420	Institution Referred To	
410	Laterality	
1182	Lymph-vascular Invasion	Document if available
150	Marital Status at DX	
2300	Medical Record Number	
1112	Mets at DX-Bone	

New WCRS required data fields are shaded in light red.		
NAACCR Item	**Data Item**	**Notes**
1113	Mets at DX-Brain	
1114	Mets at Dx-Distant LN	
1115	Mets at DX-Liver	
1116	Mets at DX-Lung	
1117	Mets at DX-Other	
470	Morph Coding Sys--Current	*Should be defaulted by software*
480	Morph Coding Sys--Original	*Should be defaulted by software*
50	NAACCR Record Version	*Should be defaulted by software*
2280	Name--Alias	
2240	Name--First	
2230	Name--Last	
2390	Name--Maiden	
2250	Name--Middle	
2270	Name--Suffix	
2475	NPI--Physician--Follow-Up	Document if available
2465	NPI--Physician--Managing	Document if available
545	NPI--Reporting Facility	
1990	Over-ride Age/Site/Morph	
3769	**Over-ride CS 20**	
2040	Over-ride Histology	
1986	Over-ride HospSeq/DxConf	
1988	Over-ride HospSeq/Site	
2116	Over-ride ICD-O-3 Conversion Flag	*Should be defaulted by software*
2070	Over-ride Leuk, Lymphoma	
2078	**Over-ride Name/Sex**	
2071	Over-ride Site/Behavior	
2073	Over-ride Site/Lat/EOD	*Used in a couple of CS extension edits*
2074	Over-ride Site/Lat/Morph	
2030	Over-ride Site/Type	
1981	Over-ride SS/NodesPos	
2020	Over-ride Surg/DxConf	
1506	**Phase I Radiation Treatment Modality**	
2470	Physician--Follow-Up	
2460	Physician--Managing	
1944	Place of Death--Country	
1942	Place of Death--State	
630	Primary Payer at DX	
400	Primary Site	
160	Race 1	
161	Race 2	
162	Race 3	
163	Race 4	

New WCRS required data fields are shaded in light red.		
NAACCR Item	**Data Item**	**Notes**
164	Race 5	
170	Race Coding System--Current	*Should be defaulted by software*
180	Race Coding System--Original	*Should be defaulted by software*
1430	Reason for No Radiation	
1340	Reason for No Surgery	
10	Record Type	*Should be defaulted by software*
830	Regional Nodes Examined	
820	Regional Nodes Positive	
540	Reporting Facility	
1460	RX Coding System--Current	*Should be defaulted by software*
1240	RX Date BRM	
1241	RX Date BRM Flag	
1220	RX Date Chemo	
1221	RX Date Chemo Flag	
1230	RX Date Hormone	
1231	RX Date Hormone Flag	
3170	RX Date Most Definitive Surgery	
3171	RX Date Most Definitive Surgery Flag	
1251	RX Date Other Flag	
1210	RX Date Radiation	
1211	RX Date Radiation Flag	
1200	RX Date Surgery	
1201	RX Date Surgery Flag	
3230	RX Date Systemic	
3231	RX Date Systemic Flag	
1410	RX Summ--BRM	
1390	RX Summ--Chemo	
1400	RX Summ--Hormone	
1420	RX Summ--Other	
1292	RX Summ--Scope Reg LN Sur	
1294	RX Summ--Surg Oth Reg/Dis	
1290	RX Summ--Surg Prim Site	
1380	RX Summ--Surg/Rad Seq	
1639	RX Summ--Systemic/Sur Seq	
3250	RX Summ--Transplnt/Endocrine	
1285	RX Summ--Treatment Status	
2660	RX Text--BRM	
2640	RX Text--Chemo	
2650	RX Text--Hormone	
2670	RX Text--Other	
2620	RX Text--Radiation (Beam)	
2610	RX Text--Surgery	

New WCRS required data fields are shaded in light red.		
NAACCR Item	**Data Item**	**Notes**
560	Sequence Number--Hospital	
220	Sex	
450	Site Coding Sys--Current	*Should be defaulted by software*
460	Site Coding Sys--Original	*Should be defaulted by software*
2320	Social Security Number	Full number - NOT just the last 4 digits
190	Spanish/Hispanic Origin	
3816	**SSDI--Brain Molecular Markers**	**New for 2018 - Brain**
3817	SSDI--Breslow Tumor Thickness	Previous SSF 1 - Melanoma, Skin
3827	SSDI--Estrogen Receptor Summary	Previous SSF 1 - Breast
3835	**SSDI--Fibrosis Score**	**New for 2018 - Liver**
3843	**SSDI--Grade Clinical**	**New for 2018 - All Sites**
3844	**SSDI--Grade Pathological**	**New for 2018 - All Sites**
3845	**SSDI--Grade Post Terapy**	**New for 2018 - All Sites**
3855	SSDI--HER2 Overall Summary	Previous SSF 15 - Breast
3932	**SSDI--LDH Pretreatment Lab Value**	**New for 2018 - Melanoma Skin**
3890	SSDI--Microsatellite Instability (MSI)	Previous SSF 7 - Appendix, Carcinoid Appendix, Colon, Rectum Document if available
3915	SSDI--Progesterone Receptor Summary	Previous SSF 2 - Breast
3920	SSDI--PSA (Prostatic Specific Antigen) Lab Value	Previous SSF 1 - Prostate
3926	**SSDI--Schema Discriminator 1**	
3927	**SSDI--Schema Discriminator 2**	
3800	**SSDI--Schema ID**	
764	**Summary Stage 2018**	Previous Summary Stage 2000
2360	**Telephone**	
2550	Text--DX Proc--Lab Tests	
2560	Text--DX Proc--Op	
2570	Text--DX Proc--Path	
2520	Text--DX Proc--PE	
2540	Text--DX Proc--Scopes	
2530	Text--DX Proc--X-ray/Scan	
2590	Text--Histology Title	
2690	Text--Place of Diagnosis	
2580	Text--Primary Site Title	
2680	Text--Remarks	
2600	Text--Staging	
320	Text--Usual Industry	
310	Text--Usual Occupation	
756	Tumor Size Summary	
500	Type of Reporting Source	
2170	Vendor Name	*Should be defaulted by software*
1760	Vital Status	

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 2018 will have a hospital accession number of 201800031. If this same patient is seen in later in 2018 with a new primary cancer, the accession number will still stay the same as the original, first time seen in that facility (201800031). 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:

Code	Description	Code	Description
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		

Avoid punctuation marks 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

IMPORTANT: 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.

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.

Code*	Description
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.

***in addition to US and Canadian postal codes**

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.

Code*	Description
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

***in addition to USPS abbreviations**

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.

IMPORTANT: 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.

Code	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

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

IMPORTANT: Remember to include the patient's age in the PE Text field.

BEHAVIOR CODE -- ICD-O-3

Abstract Plus Field Name: Behavior

Required
Item Length: 1
NAACCR Item #: 523

Description
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.

Code	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-COUNTRY

Abstract Plus Field Name: Birthplace-Country

Required
Item Length: 3
NAACCR Item #: 254

Description
This is the 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

Coding Instructions
See Appendix B of the SEER Program Code Manual for numeric and alphabetic lists of places and codes at https://seer.cancer.gov/manuals/2018/SPCSM_2018_AppendixB.pdf

Code*	Description
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

***in addition to ISO abbreviations**

BIRTHPLACE-STATE

Abstract Plus Field Name: Birthplace-State

Required
Item Length: 2
NAACCR Item #: 252

Description
This is the 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

Coding Instructions
See Appendix B of the SEER Program Code Manual for numeric and alphabetic lists of places and codes at https://seer.cancer.gov/manuals/2018/SPCSM_2018_AppendixB.pdf

Code*	Description
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

***in addition to USPS abbreviations**

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.

Code	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.

Code	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
Standard Source: CoC

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	
Analytic cases *Diagnosed and or received first course treatment at your facility. Initial Diagnosis at Reporting Facility.*	
00	Diagnosis at the reporting facility and all *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.

CoC Accredited Flag

Abstract Plus Field Name: N/A (Field is hidden)

Required
Item Length: 1
NAACCR Item #: 2152

Description
CoC Accredited Flag is assigned at the point and time of data abstraction to label an abstract being prepared for an analytic cancer case at a facility accredited by the Commission on Cancer (CoC). The flag may be assigned manually or can be defaulted by the registry's software.

Rationale
CoC-accredited facilities are required to collect certain data items including TNM staging. It is burdensome for central registries to maintain a list of accredited facilities, and the list changes frequently. The flag is a means of incorporating the accredited status into abstracts at the time of abstraction by someone who has knowledge of the status. The flag thus simplifies validating that required items have been abstracted by CoC-accredited facilities. NPCR will use this flag to for validating and consolidating TNM.

Code	Description
0	Abstract prepared at a facility WITHOUT CoC accreditation of its cancer program (Default for Abstract Plus Users)
1	ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 10-22)
2	NON-ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 30-43 and 99, plus code 00 which CoC considers analytic but does not require to be staged)
Blank	Not Applicable; DCO

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.

Code*	Description
998	Known town, city, state, or country of residence, but county is not known AND address is for a non-Wisconsin resident. (Must meet all criteria to use this code.)
999	County unknown

***in addition to WCRS or CoC assigned code**

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

DATE CASE COMPLETED

Abstract Plus Field Name: Date Case Completed

Required
Item Length: 8
NAACCR Item #: 2090

Description
The date that: (1) the abstractor decided that the tumor report was complete and (2) the case passed all edits that were applied. Definitions may vary among registries and software providers.

This field is locally used by central registries.

This field is protected in Abstract Plus and can't be updated manually
(May be defaulted in other software programs)

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 (all treatments administered to the patient after the original diagnosis of cancer in an attempt to **destroy or modify the cancer tissue)** for the tumor being abstracted, WCRS uses the SEER definition of first course, as defined in the SEER Program Coding and Staging Manual 2018.

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 accompanies the Date Initial RX SEER data item and is used to define the reason treatment was not administered.

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.

When pathology-specimen-only tumors are collected (Class of Case 43, Type of Reporting Source 3), the date of specimen collection from the pathology report should be used as the Date of 1st Contact.

When death certificate only (Class of Case 49, Type of Reporting Source 7) tumors are collected, the date of death should be used as the Date of 1st Contact. When Autopsy Only (Class of Case 38, Type of Reporting Source 6) tumors are collected, the date of death should be used as the Date of 1st Contact.

Rationale
Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations. Date of 1st 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 accompanies the Date of 1st Contact field and is used when date of 1st contact is unknown.

Allowable Values	
12	Date of 1st Contact is unknown
Blank	A valid date value (complete date, month/year or only year) is provided.

DATE OF BIRTH

Abstract Plus Field Name: Date of Birth

Required
Item Length: 8
NAACCR Item #: 240

Description
The 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. This field cannot be blank.

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

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

1. Leave month and day blank.

2. Calculate the year of birth by subtracting the patient's age at diagnosis from the year of diagnosis.

DATE OF BIRTH FLAG

Abstract Plus Field Name: Date of Birth Flag

Required
Item Length: 2
NAACCR Item #: 241

Description
This flag accompanies the Date of Birth field and is used when date of birth is unknown.

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
Standard Source: SEER

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

For more discussion on determining date of diagnosis, consult the *SEER Program Coding and Staging Manual* or CoC *STORE* manual.

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

Coding Instructions

1. Code the month, day and year the tumor was first diagnosed, clinically or microscopically, by a recognized medical practitioner.

   Note: When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis.

   Example*:* Area of microcalcifications in breast suspicious for malignancy on 02/13/2018. Biopsy positive for ductal carcinoma on 02/28/2018. The date of diagnosis 02/13/2018.

2. When the **only** information available is a positive pathology or cytology report, code the date the biopsy was **done**, not the date the report was dictated or transcribed.

3. The first diagnosis of cancer may be **clinical** (i.e., based on clinical findings or physician's documentation)

   Note*:* Do **not** change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology.

   Example*:* On May 15, 2018, physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung in June 3, 2018. The date of diagnosis remains May 15, 2018.

4. Positive **tumor markers** alone are **not** diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

   Example 1: The patient has an elevated PSA and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the prostate. The biopsy is positive for adenocarcinoma. The date of diagnosis is the date of the biopsy (do not code the date of the PSA or the date the procedure was dictated or transcribed).

   Example 2: The patient has an elevated PSA and the physical examination is negative. The physician documents that he/she suspects that the patient has prostatic cancer and is referring the patient for a needle biopsy. The needle biopsy is positive, confirming the physician's suspicion of cancer. The date of diagnosis is the date the physician documented that he/she **suspects** that the patient has prostatic cancer.

   Note: Positive tumor markers alone are never used for case ascertainment.

5. Do **not** use cytology as a basis for diagnosis when **ambiguous terms** are used. **Ambiguous cytology** is **not** diagnostic of cancer. Use the date of clinical, histologic, or **positive** cytologic confirmation as the date of diagnosis.

   Note 1: "Ambiguous" cytology means that the diagnosis is preceded by an ambiguous term such as apparently, appears, compatible with, etc.

   Note 2: Do **not** use ambiguous cytology alone for case ascertainment.

6. Code the **earlier date** as the date of diagnosis when:
   a. A recognized medical practitioner says that, in **retrospect**, the patient had cancer at an earlier date.
   b. The original slides are reviewed and the pathologist documents that cancer was present. Code the date of the original procedure as the diagnosis date.

      Example*:* The patient had an excision of a benign fibrous histiocytoma in January 2018. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The physician documents in the chart that the previous tumor must have been malignant. Code the diagnosis date as January 2018.

7. Code the **date of death** as the date of diagnosis for autopsy-only cases

8. Death certificate only (DCO) Cases
   - Use information on the death certificate to estimate the date of diagnosis
   - Record the date of death as the date of diagnosis when there is not enough information available to estimate the date of diagnosis; for example, the time from onset to the date of death is described as 'years'
   - If no information is available, record the date of death as the date of diagnosis

9. **Estimate the date of diagnosis** if an exact date is not available. Use all information available to calculate the month and year of diagnosis.
   a. Estimating the **month**
      - Code "spring" to April
      - Code "summer" or "middle of the year" to July
      - Code "fall" or "autumn" as October
      - For "winter" try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month of diagnosis.
      - Code "early in year" to January
      - Code "late in year" to December
      - Use whatever information is available to calculate the month of diagnosis

        Example 1: Admitted October 2018. History states that the patient was diagnosed 7 months ago. Subtract 7 from the month of admission and code date of diagnosis to March 2018.

        Example 2: Outpatient bone scan done January 2018 that states history of prostate cancer. The physician says the patient was diagnosed in 2018. Assume bone scan was part of initial work-up and code date of diagnosis to January 2018.

      - Code the month of admission when there is no basis for estimation
      - Leave month blank (or convert 99 to blank) if there is no basis for approximation

b. Estimating the **year**

- Code “a couple of years” to two years earlier
- Code “a few years” to three years earlier
- Use whatever information is available to calculate the year of diagnosis
- Code the year of admission when there is no basis for estimation
- If **no information** about the date of diagnosis is available, code day, month and year as unknown

Coding Instructions: Nursing Home and Hospice Residents (Not hospitalized for their cancer; no information other than nursing home or hospice records and/or death certificate)

1. Use the **best approximation** for the date of diagnosis when the only information available is that the patient **had cancer while in the nursing home** and it is unknown whether the patient had cancer when admitted.

2. Code the **date of admission** to the nursing home as the date of diagnosis when:

   a. The **only information available** is that the patient had cancer when admitted to the nursing home
   b. The **only information available** is that the patient had cancer while in the nursing home, it is unknown whether the patient had cancer when admitted, and there is **no basis for approximation**

Coding Instructions: Cases Diagnosed Before Birth

Record the actual date of diagnosis for diagnoses made in utero even though this date will precede the date of birth.

Example: Fetal intrahepatic mass consistent with hepatoblastoma diagnosed via ultrasound at 39 weeks gestation (01/30/2018). Live birth by C-section 02/04/2018. Code the date of diagnosis as 01/30/2018.

Note: Prenatal diagnoses are reportable when there is a live birth.

DATE OF DIAGNOSIS FLAG

Abstract Plus Field Name: Diagnosis Date Flag

Required
Item Length: 2
NAACCR Item #: 391

Description
This flag accompanies the Diagnosis Date field and is used when the diagnosis date is unknown.

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
This is the date of last contact with the patient, or the date of death. If the patient has multiple tumors, this field must 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 accompanies the Last Contact Date field and is used when the date of last contact is unknown.

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

DIAGNOSTIC CONFIRMATION

Abstract Plus Field Name: Diagnostic Confirmation

Required
Item Length: 1
NAACCR Item #: 490
Standard Source: SEER

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

Code	Label	Description
1	Positive histology	Microscopic histologic confirmation
2	Positive cytology	Microscopic cytologic confirmation
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 Diagnostic Confirmation of 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 fine needle aspirate, biopsy, 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 4** when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.

6. 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.

    Note*:* For tests and tumor markers that may be used to help diagnose cancer, see:
    http://www.cancer.gov/cancertopics/factsheet/detection
    http://www.cancer.gov/cancertopics/factsheet/detection/tumor-markers

7. 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).

8. Assign **code 7** when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/sonography.

9. 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.

    Example: CT diagnosis is possible lung cancer. Patient returns to the nursing home with a DNR order. Physician enters a diagnosis of lung cancer in the medical record. Code the diagnostic confirmation to 8: there is a physician's clinical diagnosis – clinical diagnosis made by the physician using the information available for the case.

10. Assign code 9 when it is unknown if the diagnosis was confirmed microscopically or for a death certificate only case.

Codes for Nonsolid Tumors – Hematopoietic and Lymphoid Neoplasms (9590/3 – 9992/3)		
Code	**Label**	**Description**
1	Positive histology	Microscopic histologic confirmation
2	Positive cytology	Microscopic cytologic confirmation
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) *Effective for cases diagnosed 01/01/2010 and later.*
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 Diagnostic Confirmation of Hematopoietic or Lymphoid Tumors
Follow the coding instructions in the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database: https://seer.cancer.gov/tools/heme/index.html

FOLLOW UP SOURCE

Abstract Plus Field Name: Follow-Up Source

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.

Code	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

HISTOLOGIC TYPE ICD-O-3 – MORPHOLOGY

Abstract Plus Field Name: Histology

Required
Item Length: 4
NAACCR Item #: 522
Standard Source: SEER

Description
Histologic Type ICD-O-3 describes the microscopic composition of cells and/or tissue for a specific primary. The 2018 Solid Tumor Rules, the *Hematopoietic and Lymphoid Neoplasm Coding Manual*, the *Hematopoietic and Lymphoid Neoplasm Database*, and the *International Classification of Diseases for Oncology*, Third Edition (ICD-O-3) are the standard references for histology codes.

2018 ICD-O-3 Update
There are new codes, changes in behavior codes, and new terms associated with current codes for all cases diagnosed January 1, 2018 and later. These changes reflect updates to the WHO Classifications for Tumors (Blue Books). The new codes, new terms, and codes with changes to behavior are available at: https://www.naaccr.org/2018-implementation.

ICD-O-3.1
The International Classification of Diseases for Oncology, Third Edition, First Revision has not been approved for use in the United States. It includes codes and terms which are **not** approved for use at this time. 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.

Histology Coding for Solid Tumors

1. Apply the general instructions and instructions for coding histologic type in the 2018 Solid Tumor Rules.

2. Apply the site-specific histology coding rules in the 2018 Solid Tumor Rules.

Site-specific histology coding rules cover the following:	
Primary Site	**Topography**
Head and Neck	C00-C148, C300-C329, C410, C411, C442
Colon, Rectosigmoid, Rectum	C180-189, C199, C209
Lung	C340-C349
Cutaneous Melanoma	C440-C449 with Histology 8720-8780
Breast	C500-506, C508-C509
Kidney	C649
Urinary Sites	C659, C669, C670-679, C680-681, C688-689
Non-malignant CNS	C700, C701, C709, C710-719, C720-725, C728, C729, C751-753
Malignant CNS and Peripheral Nerves	C470-479, C700, C701, C709, C70-719, C720-725, C728, C729, C751-C753
Other Sites	Excludes Head and Neck, Colon, Rectosigmoid, Rectum, Lung, Cutaneous Melanoma, Breast, Kidney, Urinary Sites, Peripheral Nerves, CNS

Histology Coding for Hematopoietic and Lymphatic Primaries: Apply the Histology Coding Rules in the *Hematopoietic and Lymphoid Neoplasm Coding Manual and Database*.

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.

Code	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
This field 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/coding-resources.htm

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

Code*	Description
0000000000	Case not referred from a facility
9999999999	Case referred from a facility, but facility number is unknown

***in addition to WCRS or CoC assigned code**

INSTITUTION REFERRED TO

Abstract Plus Field Name: Referred To

Required
Item Length: 10
NAACCR Item #: 2420

Description
This field 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/coding-resources.htm

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

Code*	Description
0000000000	Case not referred from a facility
9999999999	Case referred from a facility, but facility number is unknown

***in addition to WCRS or CoC assigned code**

LATERALITY

Abstract Plus Field Name: Laterality

Required
Item Length: 1
NAACCR Item #: 410
Standard Source: SEER

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.

Code	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 at the time of diagnosis, OR lateral origin unknown for a single primary, OR both ovaries involved simultaneously with a single histology, OR bilateral retinoblastomas, OR bilateral Wilms tumors
5	Paired site; midline tumor
9	Paired site, but no information concerning laterality

Coding Instructions

1. Assign code 0 when the primary site is unknown, or not listed in the following table: *Sites for Which Laterality Codes Must be Recorded*.

2. Code laterality using codes 1-5, 9 for all of the sites listed in the table.

3. Code the side where the primary tumor originated.

   Note: Assign code 3 if the laterality is not known but the tumor is confined to a single side of the paired organ.

   Example: Pathology Report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.

4. Code 4 is seldom used except for:

   a. Both ovaries involved simultaneously with a single histology, or epithelial histologies (8000-8799).
   b. Diffuse bilateral lung nodules.
   c. Bilateral retinoblastomas.
   d. Bilateral Wilms tumors.

5. Assign code 5 when the tumor originates in the midline of the following sites:

   C700, C710-C714, C722-C725, C443, C445

   Note: Do not assign code 5 to sites not listed above.

   Example: Patient has an excision of a melanoma located just above the umbilicus (C445, laterality 5).

6. Assign code 9 when:

   a. The disease originated in a paired site, and the laterality is unknown, and there is no statement that only one side of the paired organ is involved.

      Example 1: 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.

      Example 2: Widely metastatic ovarian carcinoma surgically debunked. Ovaries could not be identified in the specimen.

   b. Laterality is unknown for a death certificate only (DCO) case with primary site: C079-C081, C090-C091, C098-C099, C301, C310, C312, C341-C349, C384, C400-C403, C441-C443, C445-C447, C471-C472, C491-C492, C500-C509, C569, C570, C620-C629 C630-C631, C649, C659, C669, C690-C699, C700, C710-C714, C722-C725, C740- C749, or C754

7. Document the laterality in a text field.

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: Lymph-Vass. Invasion

Document as Available for 2018 Diagnoses
Item Length: 1
NAACCR Item #: 1182

Description
Indicates whether tumor cells are present or absent in the lymphatic channels (not lymph nodes) or blood vessels (LVI) within the primary tumor as identified in the pathology report. LVI includes lymphatic invasion, vascular invasion, and lymph vascular invasion.

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.

Code	Description
0	Lymph-vascular Invasion stated as Not Present
1	Lymph-vascular Invasion Present/Identified
2	Lymphatic and small vessel invasion only (L)
3	Venous (large vessel) invasion only (V)
4	BOTH lymphatic and small vessel AND venous (large vessel) invasion
8	Not Applicable
9	Unknown/Indeterminate/not mentioned in path report

MARITAL STATUS AT DIAGNOSIS

Abstract Plus Field Name: Marital Status at DX

Required for State Reporting
Item Length: 1
NAACCR Item #: 150

Description
Record 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.

Code	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

IMPORTANT: 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
Record the medical record number used by the facility to identify the patient. The COC *STORE 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.

Allowable Values
Alpha-numeric, right justified

Code	Description
UNK	Medical record number unknown
RT	Radiation therapy department patient without HIM number
SU	1-day surgery clinic patient without HIM number

***in addition to the medical record number**

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

METS AT DIAGNOSIS - BONE

Abstract Plus Field Name: Mets at DX—Bone

Required
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 CoC STORE manual, pages 178-188, 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.

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

IMPORTANT: 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
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 CoC STORE manual, pages 178-188, 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.

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

IMPORTANT: 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—Distant LN

Required
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, CoC STORE manual, pages 178-188, 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).

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

IMPORTANT: 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
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, CoC STORE manual, pages 178-188, 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.

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

IMPORTANT: 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
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, CoC STORE manual, pages 178-188, 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.

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

IMPORTANT: 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
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 CoC STORE manual, pages 178-188, 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.

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

IMPORTANT: 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

MORPHOLOGY CODING SYSTEM - CURRENT

Abstract Plus Field Name: Hidden from view, Automatically Coded *(Should be defaulted by software)*

Required
Item Length: 1
NAACCR Item #: 470

Description
This item describes how morphology is currently coded.

MORPHOLOGY CODING SYSTEM – ORIGINAL

Abstract Plus Field Name: Hidden from view, Automatically Coded *(Should be defaulted by software)*

Required
Item Length: 1
NAACCR Item #: 480

Description
This item describes how morphology was originally coded.

NAACCR RECORD VERSION

Abstract Plus Field Name: Hidden from view, Automatically Coded *(Should be defaulted by software)*

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	
180	Version 18

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 –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 NPI Registry Public Search is a free directory of all active **National Provider Identifier** (NPI) records.
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 NPI Registry Public Search is a free directory of all active **National Provider Identifier** (NPI) records.
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 NPI Registry Public Search is a free directory of all active **National Provider Identifier** (NPI) records.
https://npiregistry.cms.hhs.gov/

OVER-RIDE AGE/SITE/MORPH

Abstract Plus Field Name: OR - 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 Vendor Software Metafiles:
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.

Coding Instructions

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.

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 CS 20

Abstract Plus Field Name: Not applicable – hidden field

Required When Necessary
Item Length: 1
NAACCR Item #: 3769

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.

Over-ride CS 20 has been designated as a flag for directly coded SEER Summary Stage 2000 [759] to support CDC's National Program of Cancer Registries (NPCR) requirements.

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. For diagnosis years 2012 and later, NPCR permits the use of SEER Summary Stage 2000 [759] in those cases where collection of Collaborative Stage version 2 data items is not feasible due to a lack of data or staffing and time constraints at the local or central cancer registry. Over-ride CS 20 has been designated as a special-purpose flag to identify cases where SEER Summary Stage 2000 [759] is directly coded and reported in lieu of Derived SS2000 [3020], in accordance with NPCR reporting requirements.

Code	Description
1	Directly coded SEER Summary Stage 2000 [759] used to report Summary Stage; Derived Summary Stage 2000 [3020] must be blank.
Blank	Derived Summary Stage 2000 [3020] reported using Collaborative Stage Data Collection System or case diagnosed prior to 2012.

OVER-RIDE HISTOLOGY

Abstract Plus Field Name: OR - 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 Vendor Software Metafiles:
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.

Coding Instructions

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.

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: OR – 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 Vendor Software Metafiles:
Diagnostic Confirmation
Seq Numb--Hosp (CoC)

Over-ride Flag as Used in the EDITS Software Package
The edit, Diagnostic Confirm, Seq Numb--Hosp (CoC), does the following: 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 does not equal 00 (more than one primary), review is required. If Primary Site specifies an ill-defined or unknown primary (C760-C768, C809), no further checking is done. If Sequence Number--Hospital is in the range of 60-88, this edit is skipped.

Coding Instructions

1. Leave blank if the program does not generate an error message for the edit Diagnostic Confirm, Seq Num--Hosp (CoC).

2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.

3. Code 1 if review of all items in the error or warning message confirms that all are correct.

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

OVER-RIDE HOSPSEQ/SITE

Abstract Plus Field Name: OR – 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 Vendor Software Metafiles:
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 differ in use of ICD-O-3 morphology. They 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:
    a. C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-3 histology less than 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.
    b. C770-C779 (lymph nodes) and ICD-O-3 histology not in the range 9590-9729; or C420-C424 and 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.
    c. 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.

Coding Instructions

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

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

OVER-RIDE ICD-O-3 CONVERSION FLAG

Abstract Plus Field Name: Not applicable – hidden field *(Should be defaulted by software)*

Required When Necessary
Item Length: 1
NAACCR Item #: 2116

Description
Code specifying how the conversion of site and morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Code	Description
0	Morphology (Morph--Type&Behav ICD-O-3 [521]) originally coded in ICD-O-3
1	Morphology (Morph--Type&Behav ICD-O-3 [521]) converted from (Morph--Type&Behav ICD-O-2 [419]) without review
3	Morphology (Morph--Type&Behav ICD-O-3 [521]) converted from (Morph--Type&Behav ICD-O-2 [419]) with review
Blank	Not converted (clarification for cases diagnosed as of January 1, 2007: cases coded in prior ICD-O version and not converted to ICD-O-3)

OVER-RIDE LEUK, LYMPHOMA

Abstract Plus Field Name: OR – Leuk/Lymph

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 Vendor Software Metafiles:
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

1. Leave blank if the program does not generate an error message for the edits of the type Diagnostic Confirmation, Histology.

2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.

3. 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.

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

OVER-RIDE NAME/SEX

Abstract Plus Field Name: OR - Name/Sex

Required When Necessary
Item Length: 1
NAACCR Item #: 2078

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 Vendor Software Metafiles:
Sex, Name-First, Date of Birth (NAACCR)

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Sex, Name does not allow extremely rare or nonexistent combinations of first name and sex, such as John/female.

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

OVER-RIDE SITE/BEHAVIOR

Abstract Plus Field Name: OR - 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 Vendor Software Metafiles:
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.

Coding Instructions

1. 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).

2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.

3. 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.

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

OVER-RIDE SITE/LAT/EOD

Abstract Plus Field Name: OR - 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 Vendor Software Metafiles:
Primary Site, Laterality, CS Extension (SEER IF177)

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Primary Site, Laterality, CS Extension apply to paired organs and do not allow the CS Extension field to be specified as *in situ*, localized, or regional by direct extension if laterality is coded as:

- Bilateral
- Site Unknown
- Laterality Unknown

Coding Instructions

1. Leave blank if the program does not generate an error message.

2. Code 1 if the case has been reviewed and it has been verified that the patient had laterality coded nonspecifically and EOD/CS Extension coded specifically.

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

OVER-RIDE SITE/LAT/MORPH

Abstract Plus Field Name: OR - 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 Vendor Software Metafiles:
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.

Coding Instructions

1. Leave blank if the program does not generate an error message for the edit Laterality, Primary site, Morph ICDO3 (SEER IF42).

2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.

3. 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".

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

OVER-RIDE SITE/TYPE

Abstract Plus Field Name: OR - 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 Vendor Software Metafiles:
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.

Coding Instructions

1. Leave blank if the program does not generate an error message for the edits of the type Primary Site, Morphology-Type.

2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.

3. Code 1 if the case has been reviewed and both the site and histology are correct.

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

OVER-RIDE SUMMARY STAGE/NODES POSITIVE

Abstract Plus Field Name: OR - 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 Vendor Software Metafiles:
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.

Coding Instructions

1. 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).

2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.

3. 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.

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

OVER-RIDE SURG/DXCONF

Abstract Plus Field Name: OR - Surgery/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 Vendor Software Metafiles:
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.

Coding Instructions

1. Leave blank if the program does not generate an error message for edits of the type, RX Summ—Surg Prim Site, Diag Conf.

2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.

3. Code 1 if review confirms that they are correct. The patient had surgery, but the tissue removed was not sufficient for microscopic confirmation.

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

PHASE 1 RADIATION TREATMENT MODALITY

Abstract Plus Field Name: Ph. 1 Rad.RX Modality

Required
Item Length: 2
NAACCR Item #: 1506

Description
This field is new for 2018. It identifies the radiation modality administered during the first phase of radiation treatment delivered during the first course of treatment.

Rationale
Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during the first phase of radiation.

Historically, the previously-named Regional Treatment Modality data item [1570] used codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of radiation modality and radiation treatment planning techniques is to clarify this information and implement mutually exclusive categories. A separate data item for delivery technique has **NOT** been implemented because this information is not consistently reported in end treatment summaries.

Code	Description
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Treatment radiation modality unknown; Unknown if radiation treatment administered

Coding Instructions
Assign code 13, Radioisotopes, NOS, for Radioembolization procedures, e.g., intravascular Yttrium-90.

IMPORTANT: Make sure to justify the code you enter in this field by completing the associated radiation text field.

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 (DSPS) physician license number. Right justified with leading zeros. This list contains physicians who are registered to practice medicine in Wisconsin, they may reside out of state, but if practicing in Wisconsin, must have a valid DSPS physician license number.

A list of registered physicians is available on the WCRS web site: https://www.dhs.wisconsin.gov/wcrs/reporterinfo/coding-resources.htm. The list is available alphabetically or sorted by physician license number.

The WCRS list is updated on-line annually, so there may be instances when a newly licensed physician is not on the WCRS list. You can find individual physician license numbers on the DSPS search web site: https://app.wi.gov/licensesearch

Code*	Description
00000000	No follow-up physician
99999999	Follow-up physician unknown, or ID number not assigned, or Out of State physician who does NOT have a valid DSPS license number.

***in addition to valid DSPS license numbers**

PHYSICIAN—MANAGING

Abstract Plus Field Name: Managing Physician

Required
Item Length: 8
NAACCR Item #: 2460

Description
Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for their cancer.

Allowable Values
Wisconsin Department of Safety and Professional Services (DSPS) physician license number. Right justified with leading zeros. This list contains physicians who are registered to practice medicine in Wisconsin, they may reside out of state, but if practicing in Wisconsin, must have a valid DSPS physician license number.

A list of registered physicians is available on the WCRS web site: https://www.dhs.wisconsin.gov/wcrs/reporterinfo/coding-resources.htm. The list is available alphabetically or sorted by physician license number.

The WCRS list is updated on-line annually, so there may be instances when a newly licensed physician is not on the WCRS list. You can find individual physician license numbers on the DSPS search web site: https://app.wi.gov/licensesearch

Code*	Description
00000000	No managing physician
99999999	Managing physician unknown, or ID number not assigned, or Out of State physician who does NOT have a valid DSPS license number.

***in addition to valid DSPS license numbers**

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 https://seer.cancer.gov/manuals/2018/SPCSM_2018_AppendixB.pdf

Code*	Description
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

***in addition to ISO abbreviations**

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 https://seer.cancer.gov/manuals/2018/SPCSM_2018_AppendixB.pdf

Code*	Description
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

***in addition to USPS abbreviations**

PRIMARY PAYER AT DIAGNOSIS

Abstract Plus Field Name: Primary Payer at DX

Required
Item Length: 2
NAACCR Item #: 630
Standard Source: SEER

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

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

Code	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

Coding Instructions

1. Code the type of insurance reported on the patient's admission record.

2. Code the **first** insurance mentioned when multiple insurance carriers are listed on one admission record.

3. Code the type of insurance reported **closest to the date of diagnosis** when there are multiple insurance carriers reported for multiple admissions and/or multiple physician encounters.

4. Code the patient's insurance at the time of **initial diagnosis and/or treatment**. Do not change the insurance information based on subsequent information.

5. Use code **02** when the only information available is "self-pay."

6. Use code **10** for prisoners when no further information is available.

7. Assign code **99** for death certificate only (DCO) cases when the primary payer at diagnosis is unknown.

PRIMARY SITE

Abstract Plus Field Name: Primary Site

Required
Item Length: 4
NAACCR Item #: 400
Standard Source: SEER

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.

Coding Instructions for Primary Site of Solid Tumors
See the Coding Guidelines for Topography and Morphology in the introduction of the ICD-O-3 for additional details. Refer also to the 2018 Solid Tumor Rules for selected primary site coding instructions.

1. Unless otherwise instructed, use all available information in the medical record to code the site

2. Code the site in which the primary tumor originated, even if it extends onto/into an adjacent subsite

> **Example 1:** Final diagnosis is adenocarcinoma of the upper lobe of the right lung. Code the topography to lung, upper lobe (C341).
>
> **Example 2:** The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. Code the primary site to upper inner quadrant of breast (C502).
>
> **Example 3:** Patient has a right branchial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the branchial cleft cyst. Thyroidectomy pathology is negative. Code the primary site to branchial cleft (C104).

Example 4: The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for non-cancer reasons. She now has widespread cystadenocarcinoma in the peritoneum. Code the primary site to peritoneum, NOS (C482). (The chart may or may not state that the patient has extra-ovarian carcinoma.)

Example 5: Pathology report shows adenocarcinoma arising in a patch of endometriosis on the sigmoid colon. Code the primary site to sigmoid colon (C187), the site in which the cancer originated.

3. Code the last digit of the primary site code to '8' when a **single tumor overlaps** an adjacent **subsite**(s) of an organ and the point of origin cannot be determined

   Example: The patient has a primary tumor of the cervicothoracic esophagus and the point of origin is unknown. Code the primary site to C158.

   Note: Skin cancers overlapping sites in the head and neck ONLY.

   Assign the primary site code for the site where the bulk of the tumor is or where the epicenter is; do **not** use code C448**.**

4. Code the site of the invasive tumor when there is an invasive tumor and in situ tumor in different subsites of the same anatomic site

   Example 1: Patient has an invasive breast tumor in the upper-outer quadrant of the left breast and in situ tumor in multiple quadrants of the left breast. Code the primary site to C504 (upper outer quadrant of breast).

   Example 2: Patient has in situ Paget disease of the right nipple and invasive duct carcinoma of the lower inner quadrant of the right breast. Code the primary site to C503 (lower inner quadrant).

5. Code the last digit of the primary site code to '9' for **single primaries**, when **multiple tumors arise** in **different subsites** of the same anatomic site and the point of origin cannot be determined

   Example 1: During a transurethral resection of the bladder (TURB), the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).

   Example 2: Patient has an infiltrating duct tumor in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. Code the primary site as breast, NOS (C509).

6. Some histology/behavior terms in ICD-O-3 have a **related site code** in parentheses; for example, hepatoma (C220).

   - Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a primary site is specified in the medical record

     Example: The path report says "infiltrating duct carcinoma of the head of pancreas." The listing in ICD-O-3 is infiltrating duct carcinoma 8500/3 (C50_). Code the primary site to head of pancreas (C250), NOT to breast (C50_) as suggested by the ICD-O-3.

   - Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or the primary site is unknown

     Example 1: The biopsy is positive for hepatoma, and no information is available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.

Example 2: Excision of the right axillary nodes reveals metastatic infiltrating duct carcinoma. The right breast is negative. ICD-O-3 shows infiltrating duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).

- Use the site code suggested by ICD-O-3 when there is no information available indicating a different primary site.

  Example: Biopsy of lymph node diagnosed as metastatic non-small cell carcinoma. Patient expired and there is no information available about the primary site. Assign C349 based on the site code suggested in ICD-O-3.

7. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).

8. See the site-specific coding guidelines in Appendix C of the SEER Program Coding and Staging Manual 2018 for primary site coding guidelines for the following sites: Bladder, Breast, Colon, Esophagus, Kaposi Sarcoma of All Sites, Lung and Rectosigmoid Junction.

9. Angiosarcoma

   - Code C422 (spleen) as the primary site for angiosarcoma of spleen.
   - Code C50_ (breast) for angiosarcoma of breast. Although angiosarcoma actually originates in the lining of the blood vessels, an angiosarcoma originating in the breast has a poorer prognosis than many other breast tumors.

10. Gastrointestinal Stromal Tumors (GIST): Code the primary site to the location where the malignant GIST originated.

11. Transplants

    - Code the primary site to the location of the transplanted organ when a malignancy arises in a transplanted organ, i.e., code the primary site to where the malignancy resides or lies

      Example: There is a diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus. Document the situation in a text field.

    - For information about organ or tissue transplants, see the Determining Multiple Primaries Section in the SEER Program Coding and Staging Manual 2018.

    - For additional information about hematopoietic-related transplants, refer to the *Hematopoietic and Lymphoid Neoplasm Coding Manual* and *Database*

12. In the ***absence of any additional information*** about the primary site, assign the codes listed for these primary sites/histologies:

Primary Site/Histology	Code	Primary Site/Histology	Code
Anal Margin	C445	Glossotonsillar sulcus	C109
Anal verge	C211	Incisura, incisura angularis	C163
Angle of the stomach	C162	Infrahilar area of lung	C349
Angular incisura of stomach	C163	Leptomeninges	C709
Book-leaf lesion (mouth)	C068	Masticatory space	C069
Colored/lipstick portion of upper lip	C000	Melanoma, NOS	C449
Cutaneous leiomyosarcoma	C44_	Nail bed, thumb	C446
Distal conus	C720	Pancreatobiliary	C269
Edge of tongue	C021	Parapharyngeal space	C490
Frontoparietal (brain)	C718	Perihilar bile duct	C240
Gastric angular notch (incisura)	C163	Testis, descended post orchiopexy	C621

13. When the medical record does **not** contain **enough information** to assign a primary

    - Consult a physician advisor to assign the site code

    - Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site

      Note: Assign C760 for Occult Head and Neck primaries with positive cervical lymph nodes. Schema Discriminator 1: Occult Head and Neck Lymph Nodes is used to discriminate between these cases and other uses of C760.

      For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.

    - Assign the NOS code for the body system when there are two or more possible primary sites documented and all are within the same system

      Example: Two possible sites are documented in the GI system such as colon and small intestine; code to the GI tract, NOS (C269). Document the possible primary sites in a text field.

    - Code unknown primary site when there is a physician statement of unknown primary site **ONLY** when **none of the above instructions can be applied**

    - Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category

Sarcoma

The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system, which includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones, and cartilage. The default code for sarcomas of unknown primary site is **C499** rather than C809.

Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. **Code the primary site to the organ of origin.**

> **Example 1:** The pathology identifies a carcinosarcoma of the uterine corpus. Code the primary site to corpus uteri (C549).
>
> **Example 2:** Rhabdomyosarcoma of ethmoid sinus. Code primary site to C311.

Code the organ of origin as the primary site when leiomyosarcoma arises in an organ. Do not code soft tissue as the primary site in this situation.

> **Example 1:** Leiomyosarcoma arises in kidney. Code the primary site to kidney (C649).
>
> **Example 2:** Leiomyosarcoma arises in prostate. Code primary site to prostate (C619).

Coding Instructions for Primary Site of Hematopoietic and Lymphoid Neoplasms (9590/3-9992/3)

See the *Hematopoietic and Lymphoid Neoplasm Coding Manual* and *Database* for instructions on coding the primary site for hematopoietic and lymphoid neoplasms.

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
Standard Source: SEER

Description
This field identifies the primary race of the patient. Please refer to Chapter 3 – General Instructions, pages XX, for the definition and examples for coding the race fields. Appendix III contains race and nationality listings as defined by the Census Bureau.

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.

Code only the patient's race in this field. **Race is coded separately from the Spanish/Hispanic Origin** required data item. 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 AND not Hispanic, use codes RACE 2 through RACE 5, as needed. 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.

Code	Description	Code	Description
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		

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

RACE CODING SYSTEM - CURRENT

Abstract Plus Field Name: Hidden from view, Automatically Coded *(Should be defaulted by software)*

Required
Item Length: 1
NAACCR Item #: 170

Description
This field describes how the race field is currently coded. If the data have been converted, this field shows the system to which it has been converted.

RACE CODING SYSTEM - ORIGINAL

Abstract Plus Field Name: Hidden from view, Automatically Coded *(Should be defaulted by software)*

Required
Item Length: 1
NAACCR Item #: 180

Description
This field describes how the race field was originally coded. If data have been converted, this field identifies the coding system originally used to code the case.

REASON FOR NO RADIATON

Abstract Plus Field Name: Reason No Radiation

Required
Item Length: 1
NAACCR Item #: 1430

Description
This field records the reason 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.

Code	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.

IMPORTANT: Make sure to justify the code you enter in this field by completing the associated RADIATION text field

REASON FOR NO SURGERY

Abstract Plus Field Name: Reason No Surgery

Required
Item Length: 1
NAACCR Item #: 1340

Description
This field records the reason 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.

Code	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.

IMPORTANT: Justify the code you enter in this field by completing the associated text field: RX TEXT SURGERY

RECORD TYPE

Abstract Plus Field Name: Hidden Field, Automatically Coded *(Should be defaulted by software)*

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	**I**ncidence-only record type (non-confidential coded data) Length = 4,048
C	**C**onfidential record type (incidence record plus confidential data) Length = 6,154
A	Full case **A**bstract record type (incidence/confidential data and text summaries; used for reporting to central registries) Length = 24,194
U	Correction/**U**pdate record type (short format record used to submit corrections to data already submitted) Length = 1543
M	Record **M**odified since previous submission to central registry (identical in format to the "A" record type) Length =24,194
L	Pathology **L**aboratory

IMPORTANT: 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.

Code	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.

Coding Instructions

1. **Regional lymph nodes only.** Record information only about regional lymph nodes in this field.
2. **This field is based on pathologic information only.** This field is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.
3. **Use Code 00** when
    a. The assessment of lymph nodes is clinical
    b. No lymph nodes are removed and examined
    c. “dissection” of a lymph node drainage area is found to contain no lymph nodes at time of pathologic examination.

    Note: When Regional Nodes Examined is coded 00, Regional Nodes Positive is coded 98.
4. Nodes removed and examined is cumulative. Record the total number of regional lymph nodes removed and examined by the pathologist.
5. **Priority of lymph node counts.** Use information in the following priority when there is a discrepancy regarding the number of lymph nodes examined
    a. Final diagnosis
    b. Synoptic report (also known as CAP protocol or pathology report checklist)
    c. Microscopic description
    d. Gross description

6. **Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

   Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. **Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.**

7. **Lymph node excision biopsy.** If a lymph node excision biopsy was performed, code the number of nodes removed, if known.

8. Definition of **"sampling"** (**code 96**). A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy and, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.

9. Definition of **"dissection"** (**code 97**). A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, and lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.

10. **Multiple lymph node procedures**. Use code 97 when both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown.

11. Use **code 98** when neither the type of lymph node removal procedure nor the number of lymph nodes examined is known

12. **Code 99** when:

    a. Unknown whether nodes were removed or examined.
    b. The primary site is C420, C421, C423-C424, C700-C709, C710-C729, C751-C753, C761-C768, or C809.

IMPORTANT: 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
Standard Source: SEER

Description
Records the exact number of regional nodes examined by the pathologist and found to contain metastases.

Code	Description
00	All nodes examined are negative.
01-89	1-89 nodes are positive (code exact number of nodes positive).
90	90 or more nodes are positive.
95	Positive aspiration of lymph node(s) was performed.
97	Positive nodes are documented, but the number is unspecified.
98	No nodes were examined.
99	It is unknown whether nodes are positive; not applicable; not stated in patient record.

Coding Instructions

1. **Regional lymph nodes only.** Record information only about regional lymph nodes in this field.

2. **This field is based on pathologic information only.** This field is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.

3. True *in situ* cases cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined.).

4. Nodes positive is cumulative. Record the total number of regional lymph nodes removed and examined by the pathologist.

5. **Priority of lymph node counts.** Use information in the following priority when there is a discrepancy regarding the number of lymph nodes examined

    a. Final diagnosis
    b. Synoptic report (also known as CAP protocol or pathology report checklist)
    c. Microscopic description
    d. Gross description

6. **Positive nodes in multiple primaries in same organ**

    a. Determine the histology of the metastases in the nodes and code the nodes as positive for the primary with that histology when there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive

    b. Code the nodes as positive for all primaries when no further information is available

    Example*:* A breast case is two separate primaries as determined by the SEER multiple primary rules. The pathology report states "3 of 11 lymph nodes positive for metastasis" with no further information available. **Code Regional Nodes Positive as 03 and Regional Nodes Examined as 11 for both primaries.**

7. **Isolated Tumor Cells (ITCs)** in lymph nodes
    a. For all primary sites **except** cutaneous melanoma and Merkel cell carcinoma of skin
        i. Count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size)
        ii. Assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive when the path report indicates that nodes are positive but the size of metastasis is not stated
        iii. Do **not** include in the count of lymph nodes positive any nodes that are identified as containing ITCs
    b. For cutaneous melanoma and Merkel cell carcinoma

        Note: Count nodes with ITCs as positive lymph nodes
8. **Code 95** when
    a. The only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue)
    b. A positive lymph node is aspirated and there are no surgically resected lymph nodes

        Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. **Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.**
    c. A positive lymph node is aspirated and surgically resected lymph nodes are negative

        Example: Lung cancer patient has aspiration of suspicious hilar mass that shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes neoadjuvant (preoperative) radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes. **Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected.**
9. **Code 97** should be used for any combination of positive aspirated, biopsied, sampled, or dissected lymph nodes when the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.

    Example: Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant (preoperative) chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection, "several" of 10 nodes are positive; the remainder of the nodes show chemotherapy effect. **Code Regional Nodes Positive as 97 because the total number of positive nodes biopsied and removed is unknown, and code Regional Nodes Examined as 10.**

    Note: If the aspirated node is the only one that is microscopically positive, use code 95.
10. **Use Code 98** when:
    a. The assessment of lymph nodes is clinical only
    b. No lymph nodes are removed and examined
    c. A "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination
    d. Regional Nodes Positive is coded 98, Regional Nodes Examined is usually coded 00
11. **Use Code 99** when:
    a. Unknown whether regional lymph nodes are positive.
    b. If the primary site is C420, C421, C423-C424, C700-C709, C710-C729, C751-C753, C761-C768, or C809.

IMPORTANT: 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/coding-resources.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 *(Should be defaulted by software)*

Required
Item Length: 2
NAACCR Item #: 1460

Description
Code describing the resource/reference used to code the treatment. This field is often auto-coded by the vendor software. V18 software will be autocoded to '08.'

Code	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
08	Treatment data coded according to *STORE Manual* and *2018 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 that immunotherapy, also called BRM, began 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

Coding Instructions

1. Record the date of the first/earliest immunotherapy if immunotherapy was given and recorded as part of the first course of therapy

   Note: Code the date that the prescription was written if date administered unknown

2. RX DATE - BRM should be the same as the DATE INITIAL RX SEER when BRM\immunotherapy is the only treatment administered

IMPORTANT: 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 accompanies the RX DATE – BRM data item and is used to define the reason treatment was not given or unknown if given.

Allowable Values	
10	Unknown if BRM therapy was administered (also use this code for Death Certificate Only cases)
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 began 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

Coding Instructions

1. Record the date of the first/earliest chemotherapy if chemotherapy was given and recorded as part of the first course of therapy

   Note: Code the date that the prescription was written if date administered unknown

2. RX DATE - Chemotherapy should be the same as the DATE INITIAL RX SEER when chemotherapy is the only treatment administered

IMPORTANT: 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 accompanies the RX DATE – CHEMOTHERAPY data item and is used to define the reason treatment was not given or unknown if given.

Allowable Values	
10	Unknown if chemotherapy was administered (also use this code for Death Certificate Only cases)
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 began 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

Coding Instructions

1. Record the date of the first/earliest hormone therapy if hormone therapy was given and recorded as part of the first course of therapy.

   Note: Code the date that the prescription was written if date administered unknown

2. RX DATE - Hormone should be the same as the DATE INITIAL RX SEER when hormone therapy is the only treatment administered

IMPORTANT: 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 accompanies the RX DATE – HORMONE data item and is used to define the reason treatment was not given or unknown if given.

Allowable Values	
10	Unknown if hormone therapy was administered (also use this code for Death Certificate Only cases)
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 -- MOST DEFINITIVE SURGERY (MST DEFN SRG)

Abstract Plus Field Name: Definitive Surg. Date

Required for 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

Coding Instructions
Record the date of the most invasive, extensive, or definitive surgery when RX SUMM – SURGERY PRIMARY SITE was recorded as part of the first course of therapy

Note: This is the date of the procedure coded in RX SUMM – SURGERY PRIMARY SITE

IMPORTANT: 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 -- MOST DEFINITIVE SURGERY FLAG

Abstract Plus Field Name: Defin. Surg. Date Flag

Required for 2015 and later diagnoses
Item Length: 2
NAACCR Item #: 3171

Description
This flag accompanies the RX DATE – MOST DEFINITIVE SURGERY data item and is used to define the reason treatment was not given or unknown if given.

Allowable Values	
10	Unknown if surgery was administered (also use this code for Death Certificate Only cases)
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 -- OTHER

Abstract Plus Field Name: Other RX Date

Required
Item Length: 8
NAACCR Item #: 1250

Description
RX DATE - OTHER is the date when an alternative treatment other than surgery, radiation, chemotherapy, immunotherapy, and hematologic transplant and endocrine procedure is initiated/started as part of the first course of therapy. Examples include phlebotomy or aspirin when administered as forms 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

Coding Instructions

1. Record the date of the first/earliest other treatment if an alternative treatment was given and recorded as part of the first course of therapy

2. RX DATE - OTHER should be the same as the RX DATE INITIAL SEER when an alternative treatment is the only treatment administered

IMPORTANT: 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 accompanies the RX DATE – OTHER data item and is used to define the reason treatment was not given or unknown if given.

Allowable Values	
10	Unknown if other therapy was administered (also use this code for Death Certificate Only cases)
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 began as part of first course of therapy.

RX DATE - RADIATION will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the date radiation started may require assistance from the radiation oncologist for consistent coding.

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

Coding Instructions

1. Record the date of the first/earliest radiation treatment if radiation was given and recorded as part of the first course of therapy

2. RX DATE – RADIATION should be the same as the RX DATE – INITIAL SEER when radiation is the only treatment administered.

3. There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.

IMPORTANT: 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 accompanies the RX DATE – RADIATION data item and is used to define the reason treatment was not given or unknown if given.

Allowable Values	
10	Unknown if radiation was administered (also use this code for Death Certificate Only Cases)
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
RX DATE - SURGERY is the date the first surgery was performed as part of first course of therapy. This is either the date of the surgery of the primary site, scope of regional lymph node surgery, or a surgical procedure of another site, whichever is earliest.

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

Coding Instructions

1. Record the date of the first/earliest surgery.

2. RX DATE - SURGERY should be the same as RX DATE INITIAL SEER when surgery is the only treatment administered

3. Record the polypectomy date as the date of first surgical procedure when a surgical procedure to remove polyps is performed without removing the entire tumor, and a subsequent surgery is performed.

   Note: When reportable tumor is found in the specimen, polypectomies are surgery for the purposes of cancer registry data collection regardless of whether or not there is residual tumor after the polypectomy

IMPORTANT: 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 accompanies the RX DATE – SURGERY data item and is used to define the reason treatment was not given or unknown if given.

Allowable Values	
10	Unknown if surgery was administered (also use this code for Death Certificate Only Cases)
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
The earliest date of administration of chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvests, or surgical and/or radiation endocrine therapy is recorded in this field.

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

Coding Instructions
Record the date of the first/earliest systemic therapy if chemotherapy, hormone therapy, immunotherapy, or hematologic transplant or endocrine procedure was recorded as part of the first course of therapy

RX DATE -- SYSTEMIC FLAG

Abstract Plus Field Name: Systemic Date Flag

Required
Item Length: 2
NAACCR Item #: 3231

Description
This flag accompanies the RX DATE – SYSTEMIC THERAPY data item and is used to define the reason treatment was not given or unknown if given.

Allowable Values	
10	Unknown if systemic therapy was administered (also use this code for Death Certificate Only cases)
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
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
Standard Source: CoC

Description
This data item records immunotherapeutic (biological therapy, biotherapy or biological response modifier) agents administered as first course of therapy. See the SEER*RX Interactive Drug Database (http://seer.cancer.gov/tools/seerrx/) for immunotherapy drug codes.

Immunotherapy **uses** the body's **immune system**, either directly or indirectly, to fight cancer or to reduce the side effects that may be caused by some cancer treatments. Record only those treatments that are administered to affect the cancer cells.

Code	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.

Prior to 2013, targeted therapies that invoke an immune response, such as Herceptin, had been coded as chemotherapy. Effective with cases diagnosed January 1, 2013, and forward, the therapies listed below are classified as biological response modifiers.

Drug Name/Brand Name	Previous Category	New Category	Effective Date (See Note)
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno	01/01/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno	01/01/2013
Rituximab/Rituxan	Chemotherapy	BRM/Immuno	01/01/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno	01/01/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno	01/01/2013
Certuximab/Erbitux	Chemotherapy	BRM/Immuno	01/01/2013

Use the **date of diagnosis**, not the date of treatment, to determine whether to code these drugs as chemotherapy or BRM/Immunotherapy.

Types of Immunotherapy

Cancer Treatment Vaccine

Also called therapeutic vaccines, are a type of immunotherapy. The vaccines work to boost the body's natural defenses to fight a cancer. Doctors give treatment vaccines to people already diagnosed with cancer. The vaccines may:

1. Prevent cancer from returning
2. Destroy any cancer cells still in the body after other treatment
3. Stop a tumor from growing or spreading

Please refer to SEER*Rx to determine how to code non-FDA approved vaccines.

Interferons

Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

Interleukins

Interleukins (IL-2) are often used to treat kidney cancer and melanoma.

Monoclonal Antibodies

Monoclonal antibodies (Mab) are produced in a laboratory. The artificial antibodies are used in a variety of ways in systemic therapy and can be chemotherapy, immunotherapy, or ancillary drugs. Some are injected into the patient to seek out and disrupt cancer cell activities. When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy. Other Mabs are linked to radioisotopes (conjugated monoclonal antibodies). The Mab finds and attaches to the target tumor cells and brings with it the radioisotope that actually kills the tumor cell. The monoclonal antibody itself does nothing to enhance the immune system. Conjugated monoclonal antibodies such as tositumomab (Bexxar) or ibritumomab (Zevalin) are coded to the part of the drug that actually kills the cells, usually radioisotopes. A third function of Mab is to enhance the immune response against the cancer, either by identifying tumor cells that are mimicking normal cells, or by boosting the body's natural defenses that destroy foreign cells. Consult SEER*Rx for the treatment category in which each monoclonal antibody should be coded.

Coding Instructions

1. Assign code **00** when**:**
    a. The medical record states that immunotherapy was not given, not recommended, or not indicated
    b. There is no information in the patient's medical record about immunotherapy **AND**
        i. It is known that immunotherapy is **not** usually given for this type and/or stage of cancer
        ii. There is **no reason to suspect** that the patient would have had immunotherapy
    c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include immunotherapy
    d. Patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation. Patient's decision not to pursue immunotherapy is not a refusal of immunotherapy in this situation.
    e. Active surveillance, watchful waiting is the first course of treatment (e.g., prostate)
    f. Patient diagnosed at autopsy
    g. Anti-thymocyte globulin treatment is given. Anti-thymocyte globulin is used to treat transplant rejection. Do not code as immunotherapy.

2. Assign code **87** when:

    a. The patient refused recommended immunotherapy

    b. The patient made a blanket refusal of all recommended treatment and immunotherapy is a customary option for the primary site/histology

    c. The patient refused all treatment before any was recommended and immunotherapy is a customary option for the primary site/histology

3. Assign code **88** when the only information available is that the patient was referred to an oncologist

    Note: Review cases coded 88 periodically for later confirmation of immunotherapy.

4. Assign code **99:**

    a. When there is no documentation that immunotherapy was recommended or performed **AND**
    b. Immunotherapy is usually given for this type and/or stage of cancer
    c. Or for death certificate only (DCO) cases

IMPORTANT: 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
Standard Source: CoC

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.

Code	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.

Prior to 2013, targeted therapies that invoke an immune response, such as Herceptin, had been coded as chemotherapy. For cases diagnosed *before* January 1, 2013, the therapies listed below are classified as chemotherapy**.**

Drug Name/Brand Name	Previous Category	New Category	Effective Date (See Note)
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno	01/01/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno	01/01/2013
Rituximab/Rituxan	Chemotherapy	BRM/Immuno	01/01/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno	01/01/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno	01/01/2013
Certuximab/Erbitux	Chemotherapy	BRM/Immuno	01/01/2013

Use the **date of diagnosis**, not the date of treatment, to determine whether to code these drugs as chemotherapy or BRM/Immunotherapy.

Definitions

***Chemotherapy recommended*:** a consult recommended chemotherapy, or the attending physician documented that chemotherapy was recommended. A referral to a clinical oncologist is equivalent to a recommendation.

Multiple agent chemotherapy: planned first course of therapy included two or more chemotherapeutic agents and those agents were administered. The planned first course of therapy may or may not have included other agents such as hormone therapy, immunotherapy, or other treatment in addition to the chemotherapeutic agents.

Single agent chemotherapy: only one chemotherapeutic agent was administered to destroy cancer tissue during the first course of therapy. The chemotherapeutic agent may or may not have been administered with other drugs classified as immunotherapy, hormone therapy, ancillary, or other treatment.

Coding Instructions

1. Code the chemotherapeutic agents whose actions are chemotherapeutic only; **do not code** the method of **administration**

2. When chemotherapeutic agents are used as radiosensitizers or radioprotectants, they are given at a much lower dosage and do not affect the cancer. Radiosensitizers and radioprotectants are classified as ancillary drugs. See SEER*Rx. **Do not code as chemotherapy**. Review the radiation-oncology progress notes for information about radiosensitizing chemotherapy.

   Note: Do not assume that a chemo agent given with radiation therapy is a radiosensitizer. Seek additional information. Compare the dose given to the dose normally given for treatment.

   For additional information, see *The National Cancer Institute Physician Data Query (PDQ), Health Professional Version* **AND/OR** *The National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology*

3. The physician may change a drug during the first course of therapy because the patient cannot tolerate the original agent

   - This is a continuation of the first course of therapy when the chemotherapeutic agent that is substituted belongs to the same group (alkylating, antimetabolites, natural products, targeted therapy, or other miscellaneous)

   - Do **not** code the new agent as first course therapy when the original chemotherapeutic agent is changed to one that is NOT in the same group. Code only the original agent as first course. When the new agent is in a different group, it is second course therapy.

   - Use SEER*Rx and compare the subcategory of each chemotherapy agent to determine whether or not they belong to the same group (subcategory). See "Chemotherapeutic Agents" below for the groups and their definitions.

4. Code as treatment for both primaries when the patient receives chemotherapy for invasive carcinoma in one breast and also has in situ carcinoma in the other breast. Chemotherapy would likely affect both primaries.

5. Assign code **00** when:
   a. The medical record documents chemotherapy was not given, was not recommended, or was not indicated
   b. There is no information in the patient's medical record about chemotherapy, **AND**
      i. It is known that chemotherapy is not usually performed for this type and/or stage of cancer **OR**
      ii. There is no reason to suspect that the patient would have had chemotherapy
   c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include chemotherapy
   d. Patient elects to pursue no treatment following the discussion of chemotherapy. Discussion does not equal a recommendation. Patient's decision not to pursue chemotherapy is not a refusal of chemotherapy in this situation.
   e. Active surveillance/watchful waiting is the first course of treatment (e.g., CLL)
   f. Patient diagnosed at autopsy

      Example: Patient is diagnosed with plasma cell myeloma. There is no mention of treatment or treatment plans in the medical record. Follow-back finds that the patient died three months after diagnosis. There are no additional medical records or other pertinent information available. Assign code 00 since there is no reason to suspect that the patient had been treated.

6. Do not code combination of ancillary drugs administered with single agent chemotherapeutic agents as multiple chemotherapy. For example, the administration of 5-FU (antimetabolite) and Leucovorin (ancillary drug) is coded to single agent (Code 02).

7. Assign code **82** when chemotherapy is a customary option for the primary site/histology but it was not administered due to patient risk factors, such as:

    a. Advanced **age**
    b. **Comorbid** condition(s) (heart disease, kidney failure, other cancer, etc.)

8. Assign code **87** when:

    a. The patient refused recommended chemotherapy
    b. The patient made a blanket refusal of all recommended treatment and chemotherapy is a customary option for the primary site/histology
    c. The patient refused all treatment before any was recommended and chemotherapy is a customary option for the primary site/histology

9. Assign code **88** when the only information available is:

    a. The patient was **referred** to an oncologist
    b. Insertion of **port-a-cath**

    Note: Review cases coded 88 periodically for later confirmation of chemotherapy.

10. Assign code **99** when there is no documentation that chemotherapy was recommended or administered for **death certificate only (DCO) cases**

Chemotherapeutic Agents
Chemotherapeutic agents are chemicals that affect cancer tissue by means other than hormonal manipulation. Chemotherapeutic agents can be divided into five groups.

1. *Alkylating agents*
2. *Antimetabolites*
3. *Natural products*
4. *Targeted therapy*
5. *Miscellaneous*

Alkylating Agents
Alkylating agents are **not cell-cycle-specific**. Although they are toxic to all cells, they are most active in the resting phase of the cell. Alkylating agents directly damage DNA to prevent the cancer cell from reproducing. Alkylating agents are used to treat many different cancers including acute and chronic leukemia, lymphoma, Hodgkin disease, multiple myeloma, sarcoma, and cancers of the lung, breast, and ovary. Because the drugs damage DNA they can cause long-term damage to the bone marrow and can, in rare cases, lead to acute leukemia. The risk of leukemia from alkylating agents is "dose-dependent."

Examples of alkylating agents include:

- *Mustard gas derivatives/nitrogen mustards:* mechlorethamine, cyclophosphamide, chlorambucil, melphalan, and ifosfamide
- *Ethylenimines*: thiotepa and hexamethylmelamine
- *Alkylsulfonates*: busulfan
- *Hydrazines* and *Trizines*: altretamine, procarbazine, dacarbazine, and temozolomide
- *Nitrosureas*: carmustine, lomustine, streptozocin, and nitrosourea are unique because they can cross the blood-brain barrier and can be used in treating brain tumors
- *Metal salts*: carboplatin, cisplatin, and oxaliplatin

Antimetabolites

Antimetabolites are **cell-cycle specific**. Antimetabolites are very similar to normal substances within the cell. When the cells incorporate these substances into the cellular metabolism, they are unable to divide. Antimetabolites are classified according to the substances with which they interfere.

- *Folic acid antagonist*: methotrexate
- *Pyrimidine antagonist*: 5-fluorouracil, floxuridine, cytarabine, capecitabine, and gemcitabine
- *Purine antagonist*: 6-mercaptopurine and 6-thioguanine
- *Adenosine deaminase inhibitor*: ladribine, fludarabine, nelarabine, and pentostatin

Natural Products

1. Plant Alkaloids **are cell-cycle specific** which means they attack the cells during various phases of division. They block cell division by preventing microtubule function. Microtubules are vital for cell division. Without them, division cannot occur. Plant alkaloids, as the name implies, are derived from certain types of plants.

    - *Vinca alkaloids*: vincristine, vinblastine, and vinorelbine
    - *Taxanes*: paclitaxel and docetaxel
    - *Podophyllotoxins*: etoposide and teniposide
    - *Camptothecan analogs*: irinotecan and topotecan

2. Antitumor antibiotics are also **cell-cycle specific** and act during multiple phases of the cell cycle. They are made from natural products and were first produced by the soil fungus Streptomyces. Antitumor antibiotics form free radicals that break DNA strands, stopping the multiplication of cancer cells.

    - *Anthracyclines*: doxorubicin, daunorubicin, epirubicin, mitotane, and idarubicin
    - *Chromomycins*: dactinomycin and plicamycin
    - *Miscellaneous*: mitomycin and bleomycin

3. Topoisomerase inhibitors interfere with the action of topoisomerase enzymes (topoisomerase I and II). They control the manipulation of the structure of DNA necessary for replication.

    - *Topoisomerase I inhibitors*: irinotecan, topotecan
    - *Topoisomerase II inhibitors*: amsacrine, etoposide, etoposide phosphate, teniposide

Targeted Therapy

Targeted cancer therapies are drugs or other substances that block the growth and spread of cancer by interfering with specific molecules ("molecular targets") that are involved in the growth, progression, and spread of cancer. Targeted cancer therapies are sometimes called "molecularly targeted drugs," "molecularly targeted therapies," "precision medicines," or similar names. Examples of molecularly targeted therapy are imatinib (Gleevec), lapatinib (Tykerb), erlotinib (Tarceva), sunitinib (Sutent).

Miscellaneous

Miscellaneous antineoplastics that are unique:

- *Ribonucleotide reductase inhibitor*: hydroxyurea
- *Adrenocortical steroid inhibitor*: mitotane
- *Enzymes*: asparaginase and pegaspargase
- *Antimicrotubule agent*: estramustine
- *Retinoids*: bexarotene, isotretinoin, tretinoin (ATRA)

Coding for Tumor Embolization

The American College of Surgeons Commission on Cancer (CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the SEER Program have collaborated to clarify and refine coding directives for tumor embolization and are jointly issuing the following instructions.

Definitions

Chemoembolization: A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

Radioembolization: Tumor embolization combined with the injection of small radioactive beads or coils into an organ or tumor.

Tumor embolization**:** The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Coding Instructions

Code as Chemotherapy when the embolizing agent(s) is a chemotherapeutic drug(s). Use SEER*Rx to determine whether the drugs used are classified as chemotherapeutic agents. Use codes 01, 02, 03 as specific information regarding the agent(s) is documented.

Example: The patient has hepatocellular carcinoma (primary liver cancer). From a procedure report: Under x-ray guidance, a small catheter is inserted into an artery in the groin. The catheter's tip is threaded into the artery in the liver that supplies blood flow to the tumor. Chemotherapy is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the tumor.

Do not code pre-surgical (pre-operative) embolization of hypervascular tumors with agents such as particles, coils, or alcohol as a treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

IMPORTANT: 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
Standard Source: CoC

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.

Code	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.

Coding Instructions

1. Code the hormonal agent given as part of combination chemotherapy (e.g., R-CHOP), whether it affects the cancer cells or not

   Note: Check SEER*Rx to determine if a hormone agent is part of a combination chemotherapy regimen

2. Assign code **00** when:

   a. The medical record states that hormone therapy was not given, was not recommended, or was not indicated.

   b. There is no information in the patient's medical record about hormone therapy **AND**

      i. It is known that hormone therapy is not usually performed for this type and/or stage of cancer **OR**
      ii. There is no reason to suspect that the patient would have had hormone therapy

   c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include hormone therapy

   d. Patient elected to pursue no treatment following the discussion of hormone therapy treatment. Discussion does not equal a recommendation. Patient's decision not to pursue hormone therapy is not a refusal of hormone therapy in this situation.

   e. Active surveillance/watchful waiting (e.g., prostate)

   f. Patient diagnosed at autopsy

   g. Hormone treatment was given for a non-reportable condition or as chemoprevention prior to diagnosis of a reportable condition

Example 1: Tamoxifen given for hyperplasia of breast four years prior to breast cancer diagnosis. Code 00 in Hormone Therapy. Do not code tamoxifen given for hyperplasia as treatment for breast cancer.

Example 2: Patient with a genetic predisposition to breast cancer is on preventative hormone therapy. Do not code hormone therapy given before cancer is diagnosed.

3. Assign code **87** when:

    a. The patient refused recommended hormone therapy

    b. The patient made a blanket refusal of all recommended treatment and hormone therapy is a customary option for the primary site/histology

    c. The patient refused all treatment before any was recommended and hormone therapy is a customary option for the primary site/histology

4. Assign code **88** when the only information available is that the patient was **referred** to an oncologist

    Note: Review cases coded 88 periodically for later confirmation of hormone therapy.

5. Assign code **99** when there is no documentation that hormone therapy was recommended or performed for death certificate only (DCO) cases

Coding Examples

Example 1: Endometrial cancer may be treated with progesterone. Code all administration of progesterone to patients with endometrial cancer in this field. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer.

Example 2: Follicular and papillary cancers of the thyroid are often treated with thyroid hormone to suppress serum thyroid-stimulating hormone (TSH). If a patient with papillary and/or follicular cancer of the thyroid is given a thyroid hormone, code the treatment in this field.

Example 3: Bromocriptine suppresses the production of prolactin, which causes growth in pituitary adenoma. Code bromocriptine as hormone treatment for pituitary adenoma.

Example 4: Lupron is a hormonal treatment for prostate cancer. Code as hormonal treatment when Lupron is given for prostate cancer.

Example 5: Lupron is hormone therapy that has been approved as an ovarian suppressor for pre-menopausal breast cancer.

IMPORTANT: 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
Standard Source: CoC

Description
Other cancer-directed therapy identifies treatment given that cannot be classified as surgery, radiation, systemic therapy, or ancillary treatment. This data item includes all complementary and alternative medicine (CAM) used by the patient in conjunction with conventional therapy or in place of conventional therapy.

Code	Description
0	None
1	Other
2	Other Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended
9	Unknown; unknown if administered

Coding Instructions

1. Assign code **0** when:

    a. There is no information in the patient's medical record about other therapy **AND**

        i. It is known that other therapy is not usually performed for this type and/or stage of cancer **OR**
        ii. There is no reason to suspect that the patient would have had other therapy

    b. First course of treatment was active surveillance/watchful waiting

    c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy

    d. Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation. Patient's decision not to pursue other therapy is not a refusal of other therapy in this situation.

    e. Patient diagnosed at autopsy

2. Assign code **1** for hematopoietic treatments such as: phlebotomy or aspirin (See SEER*Rx and *Hematopoietic and Lymphoid Neoplasm Coding Manual* and *Database* for specific guidance on coding)

    Note*:* Do **not** code blood transfusion as treatment.

    Rationale: Blood transfusions may be used for any medical condition that causes anemia. It would be virtually impossible for the registrar to differentiate between blood transfusions used for a co-morbidity (i.e., anemia) from those given as prophylactic treatment of a hematopoietic neoplasm.

3. PUVA (Psoralen (P) and long-wave ultraviolet radiation (UVA)) in the **RARE** event that it is used as treatment for extremely thin melanomas or cutaneous T-cell lymphomas (e.g., mycosis fungoides)

   Note: Code UVB phototherapy for mycosis fungoides as photodynamic therapy under Surgery of Primary Site for skin. Assign code 11 [Photodynamic therapy (PDT)] if there is no pathology specimen. Assign code 21 [Photodynamic therapy (PDT)] if there is a pathology specimen.

4. Photophoresis. This treatment is used ONLY for thin melanoma or cutaneous T-cell lymphoma (mycosis fungoides).

5. Cancer treatment that could not be assigned to the previous treatment fields (surgery, radiation, chemotherapy, immunotherapy, or systemic therapy)

6. Assign code **2** for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy.

   Note: Hyperbaric oxygen has been used to treat cancer in clinical trials, but it is also used to promote tissue healing following head and neck surgeries. Do not code the administration of hyperbaric oxygen to promote healing as an experimental treatment.

7. Assign code **3** when the patient is enrolled in a double blind clinical trial. When the trial is complete and the code is broken, review and recode the therapy.

8. Assign code **6** for cancer treatment administered by nonmedical personnel

   Example: Cannabis oil or medical marijuana that is used for treatment.

9. **Unconventional** methods whether they are the only therapy or are given **in combination** with conventional therapy

   Example*:* DC vax given for brain cancer. Assign code 6. DC vax is not an approved treatment for brain cancer and should not be coded in the immunotherapy or any of the other treatment fields.

10. **Complementary and Alternative Medicine (CAM**) as any medical system, practice, or product that is not thought of as "western medicine" or standard medical care. CAM treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation.

    a. *Alternative medicine* is treatment that is used instead of standard medical treatments. Alternative therapy is when the patient receives **no** other type of standard treatment.

    b. *Complementary medicine*: treatments that are used along with standard medical treatments but are not standard treatments; also called conventional medicine. One example is using acupuncture to help lessen some side effects of cancer treatment in conjunction with standard treatment.

    Note: See complete information on types of complementary and alternative medicine specific to cancer at NCI Office of Cancer Complementary and Alternative Medicine. For additional information on cancer and other diseases, please visit NIH National Center for Complementary and Integrative Health.

11. **Integrative medicine.** A total approach to medical care that combines standard medicine with the CAM practices that have shown to be safe and effective. They treat the patient's mind, body, and spirit.

12. Assign code **8** when **other therapy** was recommended by the physician **but there is no information** that the treatment was given

13. Assign code **9** when there is no documentation that other therapy was recommended or performed for death certificate only (DCO) cases.

Coding for Tumor Embolization

The American College of Surgeons Commission on Cancer (CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the SEER Program have collaborated to clarify and refine coding directives for tumor embolization and are jointly issuing the following instructions.

Definitions

***Chemoembolization*:** A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

***Radioembolization*:** Tumor embolization combined with injecting small radioactive beads or coils into an organ or tumor.

Tumor embolization: The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Coding Instructions

Code as "Other Therapy" when tumor embolization is performed using **alcohol** as the embolizing agent. Use code 1.

> **Example**: For head and neck primaries: Ideally, an embolic agent is chosen that will block the very small vessels within the tumor but spare the adjacent normal tissue. Liquid embolic agents, such as ethanol or acrylic, and powdered particulate materials can penetrate into the smallest blood vessels of the tumor.

Use code 1 for embolization of a tumor in a site other than the liver when the embolizing agent is unknown.

Do not code pre-surgical (pre-operative) embolization of hypervascular tumors with agents such as particles, coils, or alcohol as a treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

IMPORTANT: 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
Standard Source: CoC

Description
This field describes the removal, biopsy or aspiration of regional lymph node(s) performed during the initial work-up or first course of therapy.

Code	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

Coding Instructions

1. Use the **operative report** as the primary source document to determine whether the operative procedure was a SLNBx, or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the **operative report takes precedence** when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.

2. Code r**egiona**l lymph node procedures in this data item. Record distant lymph node removal in Surgical Procedure of Other Site.

   Note: Include lymph nodes that are regional in the current AJCC Staging Manual or EOD 2018

3. Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site. The regional lymph node surgical procedure(s) may be done to **diagnose** cancer, **stage** the disease, or as a part of the initial **treatment**.

   Example: Patient has a sentinel node biopsy of a single lymph node. Assign code 2 (Sentinel lymph node biopsy [only]).

4. Include lymph nodes obtained or biopsied during any procedure within the first course of treatment. A separate lymph node surgery is not required.

   Note: Code the removal of intra-organ lymph nodes in Scope of Regional Lymph Node Surgery

   Example*:* Local excision of breast cancer. Specimen includes an intra-mammary lymph node. Assign code 4 (1 to 3 regional lymph nodes removed).

5. Add the number of all of the lymph nodes removed during each surgical procedure performed as part of the first course of treatment. The Scope of Regional Lymph Node field is **cumulative**.

   Example*:* Patient has excision of a positive cervical node. The pathology report from a subsequent node dissection identifies three cervical nodes. Assign code 5 (4 or more regional lymph nodes removed).

   Note: Lymph node aspirations

   - Do not double-count when a regional lymph node is aspirated and that node is in the resection field. Do not add the aspirated node to the total number.
   - Count as an additional node when a regional lymph node is aspirated and that node is NOT in the resection field. Add it to the total number.

6. Code the removal of regional nodes for both primaries when the patient has **two primaries with common regional lymph nodes**

   Example*:* Patient has a cystoprostatectomy and pelvic lymph node dissection for bladder cancer. Pathology identifies prostate cancer as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. Code Scope of Regional Lymph Node Surgery to 5 (4 or more regional lymph nodes removed) for both primaries.

7. Assign code **0** when:

   a. Regional lymph node removal procedure was **not** performed

      Note*:* Excludes all sites and histologies that would be coded 9. (See Coding Instruction #12 below.)

   b. First course of treatment was active surveillance/watchful waiting,
   c. The operative ***report lists a lymph node dissection, but no nodes were found by the*** pathologist

8. Assign code **2** when:

   a. The operative report states that a **SLNBx was performed**,
   b. The operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination

   Note: When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code **2**). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as **6**.

9. Codes **3, 4, and 5**: The operative report states that a regional lymph node dissection was performed (a SLNBx was **not** done during this procedure or in a prior procedure)

   - Code **3**: Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7)
   - Code **4** should be used infrequently. Review the operative report to ensure the procedure was **not** a SLNBx only.
   - Code **5:** If a relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was **not** a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was **not** a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7).

Note: Infrequently, a SLNBx is attempted and the patient **fails to map** (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. **Code these cases as 2** if no further dissection of regional lymph nodes was undertaken, **or 6** when regional lymph nodes were dissected during the same operative event.

10. Code **6**: SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known

    - Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes.
    - If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only
    - Infrequently, a SLNBx is attempted and the patient **fails to map** (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. **Code these cases as 6**.

11. Code **7**: SLNBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events

    - Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes.
    - If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only

12. Code **9:** The status of regional lymph node evaluation should be known for surgically treated cases (i.e., cases coded 19-90 in the data item Surgery of Primary Site [NAACCR Item #1290]). Review surgically treated cases coded as 9 in Scope of Regional Lymph Node Surgery to confirm the code.

    Assign code 9 for:

    - Schema ID with primary site:
      C420, C421, C423, C424, C700-C709, C710-C729, C751-C753, C761-C768, C809)
    - Brain 00721
    - CNS Other 00722
    - Intracranial Gland 00723
    - Lymphoma (excluding CLL/SLL) (Primary sites C770-C779 only) 00790
    - Lymphoma (CLL/SLL) (Primary sites C770-C779 only) 00795
    - Plasma Cell Myeloma 00821
    - Plasma Cell Disorders (excluding histology 9734/3) 00822
    - HemeRetic 00830
    - Ill-Defined Other (includes Unknown Primary Site) 99999

Examples of Scope of Regional Node Surgery	
Code	**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.

See the SEER Program Coding and Staging Manual 2018 for specific coding instructions for SLNBx breast primaries.

RX SUMM – SURGERY OTHER REGIONAL/DISTANT SITES

Abstract Plus Field Name: Surgery-Other Sites

Required
Item Length: 1
NAACCR Item #: 1294
Standard Source: CoC

Description
This field records the removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

Code	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

Coding Instructions

1. Assign code **0** when:
    a. No surgical procedures were performed that removed distant lymph node(s) or other tissue(s) or organ(s) beyond the primary site **OR**
    b. First course of treatment was active surveillance/watchful waiting
2. The codes are **hierarchical.** Codes **1-5** have **priority** over codes 0 and 9
3. Assign code **1** when:
    a. The **involved** contralateral breast is removed for a **single** primary breast cancer

        Note: See also notes and codes in Appendix C, Breast surgery codes.

    b. Surgery is performed to remove tumors and the primary site is unknown or ill-defined (C760-768, C809)
    c. Surgery is performed for: Plasma Cell Myeloma 00821, Plasma Cell Disorder 00822, or HemeRetic 00830

    For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
4. Do **not** code tissue or organs such as an appendix that were removed **incidentally**, and the organ was not involved with cancer

    Note*:* Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer. Examples of incidental removal of organ(s) would be removal of appendix, gallbladder, etc., during abdominal surgery.
5. Do not code removal of uninvolved contralateral breast in this data item. See Surgery Codes for Breast in Appendix C.
6. Assign code **2** for sites that are regional
7. Assign code **4** for sites that are distant
8. Assign code **9** for death certificate only (DCO) cases

IMPORTANT: 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
Standard Source: CoC

Description
This field describes a surgical procedure that removes and/or destroys tissue ***of the primary site*** that is performed as part of the initial diagnostic and staging work-up or first course of therapy.

General Coding Structure

Code	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

Site-Specific surgery codes for individual primary sites are located in the STORE Manual Appendix B, Site-specific Surgery Codes: https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx.

Site-Specific surgery codes are also included in Appendix C of the SEER Program Coding and Staging Manual 2018, https://seer.cancer.gov/manuals/2018/appendixc.html.

Coding Instructions

1. Code **00** when:

    a. No surgery was performed on the primary site
    b. First course of treatment was active surveillance/watchful waiting
    c. Case was diagnosed at autopsy

    Note: Excludes all sites and histologies that would be coded as 98. (See Coding Instruction 10 below.)

2. Use the site-specific coding scheme corresponding to the primary site or histology

3. Code the most **invasive, extensive, or definitive** surgery if the patient has multiple surgical procedures of the primary site even if there is no residual tumor found in the pathologic specimen from the more extensive surgery

    Example*:* Patient has a needle biopsy of prostate that is positive for adenocarcinoma. The patient chooses to have a radical prostatectomy. The pathologic examination of the prostatectomy specimen shows no residual tumor. Code the radical prostatectomy.

4. Code an **excisional biopsy**, even when documented as **incisional**, when:

    a. All disease is removed (**margins free**)
    b. All gross disease is removed and there is only microscopic residual at the margin

    Note 1*:* Do **not** code an excisional biopsy when there is macroscopic residual disease.

    Note 2: Shave or punch biopsies are most often diagnostic. Code as a surgical procedure **only** when the entire tumor is removed and margins are clear.

5. Code total **removal of the primary site** when a previous procedure resected a portion of the site and the current surgery removed the rest of the organ. The previous procedure may have been cancer directed or non-cancer directed surgery.

6. Code the removal of regional or distant **tissue/organs** when they are resected in continuity with the primary site (**en bloc**) and that regional organ/tissue is listed in the Surgery of Primary Site codes. Specimens from an en bloc resection may be submitted to pathology separately.

   Example*:* Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

7. Code surgery for extra-lymphatic lymphoma using the **site-specific** surgery coding scheme for the primary site. Do **not** use the lymph node scheme.

8. Assign the surgery code(s) that best represents the extent of the surgical procedure that was actually carried out when surgery is aborted. If the procedure was aborted before anything took place, assign code 00. See 1.a. above.

9. Code **80** or **90** only when there is no specific information

10. Code **98** for the following sites/schema unless the case is death certificate only:

    a. Any case coded to primary site C420, C421, C423, or C424
    b. Cervical Lymph Nodes and Unknown Primary 00060
    c. Plasma Cell Myeloma 00821
    d. Plasma Cell Disorders 00822
    e. HemeRetic 00830
    f. Ill-defined Other (includes Unknown Primary Site) 99999

    Note: Excluding Spleen (C422) and C770-C779 (lymph nodes)

    For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.

11. Code **99** for death certificate only (DCO) cases

IMPORTANT: 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

This field records the order in which surgery and radiation therapies were administered for those patients who had **both surgery and radiation**. For the purpose of coding this data item, 'Surgery' is defined as a RX SUMM – SURGERY PRIMARY SITE (codes 10-90) or RX SUMM - Scope of Regional Lymph Node Surgery (codes 1-7) or RX SUMM – Surgery other regional/distant sites (codes 1-5).

Code	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

Coding Instructions

1. Assign code 0 when:

    a. The patient did not have either surgery or radiation
    b. The patient had surgery but not radiation
    c. The patient had radiation but not surgery
    d. It is unknown whether or not the patient had surgery and/or radiation
    e. It is a death certificate only case

2. Assign codes 2-9 when first course of therapy includes both cancer-directed surgery and radiation therapy

    a. Assign code 4 when there are at least two courses, episodes, or fractions of radiation therapy given before and at least two more after surgery to the primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s)

        Example*:* Preoperative radiation therapy was administered to shrink a large, bulky lesion, AND a resection was performed, AND postoperative radiation therapy was administered after resection.

    b. Assign code 7 when there are at least two surgeries; radiation was administered between one surgical procedure and a subsequent surgical procedure.

        Example 1: Sentinel lymph node biopsy, AND radiation therapy, AND Surgery of primary site. Code Radiation Sequence with Surgery as 7 (surgery both before and after radiation).

        Example 2: Lymph node aspiration, AND radiation, AND surgery of primary site. Code Radiation Sequence with Surgery as 7 (surgery both before and after radiation) because lymph node aspiration is coded in Scope of Regional Lymph Node Surgery.

RX SUMM -- SYSTEMIC/SURGERY SEQUENCE

Abstract Plus Field Name: Surgery/Systemic Seq.

Required
Item Length: 1
NAACCR Item #: 1639

Description
This field records the sequence of any systemic therapy and surgery given as first course of therapy for those patients who had both systemic therapy and surgery. For the purpose of coding systemic treatment sequence with surgery, 'Surgery' is defined as a surgical procedure to the primary site (codes 10-90) or scope of regional lymph node surgery (codes 1-7) or surgical procedure of another site (codes 1-5).

Systemic therapy is defined as chemotherapy, hormone therapy, biological response therapy/immunotherapy, bone marrow transplant, stem cell harvests, and surgical and/or radiation endocrine therapy.

Code	Label	Definition	Example/Note
0	No systemic therapy and/or surgical treatment; Unknown if surgery and/or systemic therapy given	The patient did not have both systemic therapy and surgery. It is unknown whether or not the patient had surgery and/or systemic therapy	Example: Death certificate only case
2	Systemic therapy before surgery	The patient had systemic therapy prior to surgery	
3	System therapy after surgery	The patient had systemic therapy after surgery	
4	System therapy both before and after surgery	Systemic therapy was administered prior to surgery and also after surgery	Note: Code 4 is intended for situations with at least two episodes or courses of systemic therapy
5	Intraoperative systemic therapy	The patient had intraoperative systemic therapy	
6	Intraoperative systemic therapy with other systemic therapy administered before and/or after surgery	The patient had intraoperative systemic therapy and also had systemic therapy before and/or after surgery	Note: The systemic therapy administered before and/or after surgery does not have to be the same type as the intraoperative systemic therapy.
7	Surgery both before and after systemic therapy (effective for cases diagnoses 01/01/2012 and later)	Systemic therapy was administered between two separate surgical procedures	Example: Patient has LN dissection, followed by chemo, followed by primary site surgery.
9	Sequence unknown	The patient had systemic therapy and also had surgery. It is unknown whether the systemic therapy was administered prior to surgery, after surgery, or intraoperatively	

RX SUMM -- TRANSPLANT/ENDOCRINE THERAPY

Abstract Plus Field Name: Transplant/Endocrine

Required
Item Length: 2
NAACCR Item #: 3250

Description
This data item records systemic therapeutic procedures administered as part of the first course of treatment. These procedures include bone marrow transplants (BMT) and stem cell harvests with rescue (stem cell transplant), endocrine surgery and/or radiation performed for hormonal effect (when cancer originates at another site), and a combination of transplants and endocrine therapy.

Code	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.

Definitions

Bone marrow transplant (BMT): Procedure where bone marrow is used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.

BMT Allogeneic: Receives bone marrow from a donor. This includes haploidentical (or half-matched) transplants.

***BMT Autologous*:** Uses the patient's own bone marrow. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.

***BMT Syngeneic*:** Bone marrow received from an identical twin.

***Conditioning*:** High-dose chemotherapy with or without radiation administered prior to transplant such as BMT and stem cells to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field and the radiation is coded in the Radiation field.

***Hematopoietic growth factors*:** A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.

***Non-myeloablative therapy*:** Uses immunosuppressive drugs pre- and post-transplant to ablate (destroy) the bone marrow. These are not recorded as therapeutic agents.

Peripheral Blood Stem Cell Transplantation (PBSCT): Rescue that uses peripheral blood stem cells to replace stem cells after conditioning.

***Rescue*:** Rescue is the actual BMT or PBSCT done after conditioning.

Stem cells: Immature cells found in bone marrow, blood stream, placenta, and umbilical cords. The stem cells mature into blood cells.

Stem cell transplant: Procedure to replenish supply of healthy blood-forming cells. Also known as bone marrow transplant, PBSCT, or umbilical cord blood transplant, depending on the source of the stem cells. When stem cells are collected from bone marrow and transplanted into a patient, the procedure is known as a bone marrow transplant. If the transplanted stem cells came from the bloodstream, the procedure is called a peripheral blood stem cell transplant—sometimes shortened to stem cell transplant.

Umbilical cord stem cell transplant: Treatment with stem cells harvested from umbilical cord blood.

Coding Instructions

1. Assign code **00** when:
    a. The medical record states that there was no hematologic transplant or endocrine therapy, or these were not recommended, or not indicated
    b. There is no information in the patient's record about transplant procedure or endocrine therapy **AND**
        i. It is known that transplant procedure or endocrine therapy is not usually performed for this type and/or stage of cancer **OR**
        ii. There is no reason to suspect that the patient would have had transplant procedure or endocrine therapy
    c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include transplant procedure or endocrine therapy
    d. Patient elects to pursue no treatment following the discussion of transplant procedure or endocrine therapy. Discussion does not equal a recommendation. Patient's decision not to pursue transplant procedure or endocrine therapy is not a refusal of transplant procedure or endocrine therapy in this situation.
    e. Active surveillance/watchful waiting is the first course of treatment (e.g., CLL)
    f. Patient diagnosed at autopsy
2. Assign code **10** if the patient has a bone marrow transplant and it is unknown if autologous or allogeneic (BMT, NOS) or "mixed chimera transplant (mini-transplant or non- myeloablative transplant). These transplants are a mixture of the patient's cells and donor cells.
3. Codes **11 and 12** have priority over code 10 (BMT, NOS)
4. Assign code **12** (allogeneic) for a syngeneic bone marrow transplant (from an identical twin) or for a transplant from any person other than the patient

5. Assign code **20** for:

    a. Allogeneic stem cell transplant
    b. Peripheral blood stem cell transplant
    c. Umbilical cord stem cell transplant (single or double)

    Note: If the patient does not have a rescue, code the stem cell harvest as **88**, (recommended, unknown if administered) or if harvested but unknown if infused.

6. Assign code **30** for endocrine radiation and/or surgery. Endocrine organs are testes and ovaries. Endocrine radiation and/or surgical procedures must be bilateral, or must remove the remaining paired organ for hormonal effect.

7. Assign code **87** if:

    a. The patient **refused** recommended transplant or endocrine procedure

    b. The patient made a **blanket refusal** of all recommended treatment and the treatment coded in this data item is a customary option for the primary site/histology

    c. The patient **refused all treatment** before any was recommended

8. Assign code **88** when:

    a. The only information available is that the patient was referred to an oncologist for consideration of hematologic transplant or endocrine procedure

    b. A bone marrow or stem cell harvest was undertaken, but it was not followed by a rescue or reinfusion as part of first course treatment

    Note: Review cases coded 88 periodically for later confirmation of transplant procedure or endocrine therapy.

9. Assign code **99** when:

    a. There is no documentation that transplant procedure or endocrine therapy was recommended or performed

    b. It is a death certificate only (DCO) case

IMPORTANT: Justify 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 documents active surveillance (watchful waiting).

Rationale
This field eliminates searching each treatment modality to determine whether treatment was given.

Code	Description
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment given

Coding Instructions

1. Assign code **1** when the patient receives treatment collected in any of the following fields:
    - Surgery of Primary Site
    - Scope of Regional Lymph Node Surgery
    - Surgical Procedure of Other Site
    - Radiation
    - Chemotherapy
    - Hormone Therapy
    - Immunotherapy
    - Hematologic Transplant and Endocrine Procedures
    - Other Therapy
2. Assign code **9** for death certificate only (DCO) cases

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/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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name
1410	RX Summ- BRM
1240	RX Date – BRM
1639	RX Summ – Systemic/Surgery Sequence
3230	RX Date Systemic

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 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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name
1390	RX Summ- Chemotherapy
1220	RX Date – Chemotherapy
1639	RX Summ – Systemic/Surgery Sequence
3230	RX Date Systemic

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 beyond the field item length listed above, WCRS requests the software indicate 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 (e.g. patient refused, patient died, contraindicated)
- Where hormone therapy was given; e.g., at this facility; at another facility.
- Type of hormone or anti-hormone, 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 Number	Item Name
1400	RX Summ- Hormone
1230	RX Date – Hormone
1639	RX Summ – Systemic/Surgery Sequence
3230	RX Date Systemic

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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name
1420	RX Summ- Other
1250	RX Date – Other

RX TEXT— RADIATION

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 beyond the field item length listed above, WCRS requests the software indicate 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 STORE Manual** (External Beam, Brachytherapy, Radioisotopes).

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 Number	Item Name
1506	Phase I Radiation Treatment Modality
1210	RX Date – Radiation
1380	RX Summ – Surgery/Radiation Sequence

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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name	Item Number	Item Name
1290	RX Summ – Surgery Primary Site	1340	Reason for No Surgery
1200	RX Date – Surgery	1380	RX Summ – Surgery/Radiation Sequence
1292	RX Summ – Scope Reg. LN Surgery	1639	RX Summ – Systemic/Surgery Sequence
1294	RX Summ – Surgery Oth/Distant Site		

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.

***In situ* or Malignant Tumors**	
SeqNum	**Description**
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	
SeqNum	**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.)

Sequence Number Series by Type of Neoplasm	
SeqNum-Hospital	***In situ* and Malignant**
00	One *in situ* (behavior code 2) or malignant (code 3) primary tumor only in the patient's lifetime
01	First of multiple *in situ* **or** malignant primary tumors in the patient's lifetime
02-59	Actual sequence of two or more *in situ* **or** malignant primary tumors
99	Unspecified in situ or malignant sequence number **or** unknown
SeqNum-Hospital	**Non-Malignant**
60	One benign (behavior code 0) or borderline (code 1) primary tumor only in the patient's lifetime
61	First of two or more benign or borderline primary tumors in the patient's lifetime
62-87	Actual sequence of two or more non-malignant primary tumors
88	Unspecified non-malignant sequence number OR unknown

In situ/Malignant Coding Instructions

1. Count all previous and current in situ/malignant reportable primaries which occur(red) over the lifetime of the patient, regardless of where he/she lived at diagnosis

   Note: A 'reportable' primary refers to the site/histology/behavior of the tumor and the years when reporting was required. Review of the reportability requirements in effect during the diagnosis year will be needed.

2. Code **00** when there is only **one** primary in the patient's lifetime

3. Sequence in situ/malignant primaries chronologically as 01 (first of one or more), 02 (second primary), 03 (third primary), and assign the appropriate sequence number to all primaries in the database when there are multiple primaries

   Example 1: The patient has a history of breast cancer in 1999. She has colon cancer in 2010. Assign sequence number 02 to the colon cancer and change the sequence number on the breast cancer from 00 to 01.

   Example 2: In 1987, patient was diagnosed and treated for childhood leukemia in another state. After becoming a resident of a SEER region, the patient develops bladder cancer. The SEER registry assigns a sequence number of 02 to the bladder cancer. Document the first diagnosis in a text field.

   Note: Change the sequence number of the first primary from 00 to 01 when one patient has a primary with sequence 00 and then develops another reportable /2 or /3 primary

   Exception: There are certain cancers that were only reportable for some years. The following are some examples (not a complete list):

   - Borderline tumors of the ovary were reported for 1992-2000, Sequence 00-59
   - Refractory anemia is reported only for 2001+
   - Myelodysplastic syndromes are reported only for 2001+
   - Newly reportable hematopoietic neoplasms as of 01/01/2010

4. Assign the lower sequence number to the primary with the worse prognosis when **two primaries are diagnosed simultaneously**

   - Base the prognosis decision on the primary site, histology, and extent of disease for each of the primaries

   - If there is no difference in prognosis, the sequence numbers may be assigned in any order

Non-Malignant Coding Instructions

1. Include all non-malignant primary tumors of the brain/CNS diagnosed in 2004 and forward regardless of where the patient lived at diagnosis

2. Assign sequence number **60** when there are no prior or subsequent non-malignant brain/CNS tumors

   Note: The sequence number is 60 when a patient has **no** prior reportable non-malignant tumors. If a tumor has a sequence 60 and there is another reportable non-malignant tumor, change the sequence number of the first primary from 60 to 61.

3. Assign sequence numbers in chronological order according to the order in which they occur(red). Reportable benign and borderline brain tumors are restricted to primary site codes C700-C729, C751-C753 with behavior codes of /0 or /1.

4. Sequence multiple non-malignant tumors chronologically as 61 (first of two or more), 62 (second), etc.

5. Sequence a non-malignant brain/CNS tumor and a malignant brain/CNS tumor (/2 or /3) independently when one patient has both. The non-malignant tumor has a sequence number of 60 and the malignant (/2 or /3) tumor has a sequence number of 00.

6. Sequence tumors other than those required by SEER in the 60-87 range when a registry chooses to collect non-reportable tumors. These non-reportable tumors are often referred to as "Reportable by agreement."

   Example*:* Cervix in situ was diagnosed in 2003 and lung cancer was diagnosed in 2018. The cervix in situ, if collected by the registry, would be a sequence number 60 and the lung would be assigned a sequence number of 00.

   Note: Sequence all cervix in situ cases in the 60-88 range regardless of diagnosis year. Submission of cervical carcinoma in situ is no longer required as of 2018 NCI SEER data submission.

7. Juvenile astrocytomas should be reported as a malignant cancer: 9421/3.

RX CODING SYSTEM - CURRENT

Abstract Plus Field Name: Hidden from View, Automatically Coded
(Should be defaulted by software)

Required
Item Length: 1
NAACCR Item #: 450

Description
Code that best describes how the primary site currently is coded. If converted, this field shows the system to which it is converted.

Codes	
1	ICD-8 and MOTNAC
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

RX CODING SYSTEM - ORIGINAL

Abstract Plus Field Name: Hidden from View, Automatically Coded *(Should be defaulted by software)*

Required
Item Length: 1
NAACCR Item #: 460

Description
Code that best describes how primary site was originally coded. If converted, this field shows the original coding system used.

Codes	
1	ICD-8 and MOTNAC
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

SEX

Abstract Plus Field Name: Sex

Required
Item Length: 1
NAACCR Item #: 220

Description
Sex of the patient at the time of diagnosis.

Code	Description
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not stated/Unknown

Definitions

Intersex: A person born with ambiguous reproductive or sexual anatomy; chromosomal genotype and sexual phenotype other than XY-male and XX-female. An example is 45,X/46,XY mosaicism, also known as X0/XY mosaicism.

***Transsexual*:** A person who was assigned one gender at birth based on physical characteristics but who self-identifies psychologically and emotionally as the other gender.

Coding Instructions

1. Assign code **3** for

    a. Intersexed (persons with sex chromosome abnormalities)
    b. Hermaphrodite

    Note: Hermaphrodite is an outdated term.

2. Codes 5 and 6 may be used for cases diagnosed prior to 2015
3. Codes 5 and 6 have priority over codes 1 and 2
4. Assign code **5** for transsexuals who are natally male or transsexuals with primary site of C600-C639
5. Assign code **6** for transsexuals who are natally female or transsexuals with primary site of C510-C589
6. Assign code **4** for transsexuals with unknown natal sex and primary site is not C510-C589 or C600-C639
7. When gender is not known

    a. Assign code **1** when the primary site is C600-C639
    b. Assign code **2** when the primary site is C510-C589
    c. Assign code **9** for primary sites not included above

IMPORTANT: 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.

Code*	
999999999	Unknown

***in addition to Social Security number**

IMPORTANT: 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. **This is NOT a race field; persons of Spanish or Hispanic/Latino surname/origin also have a separate race identification.**

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.

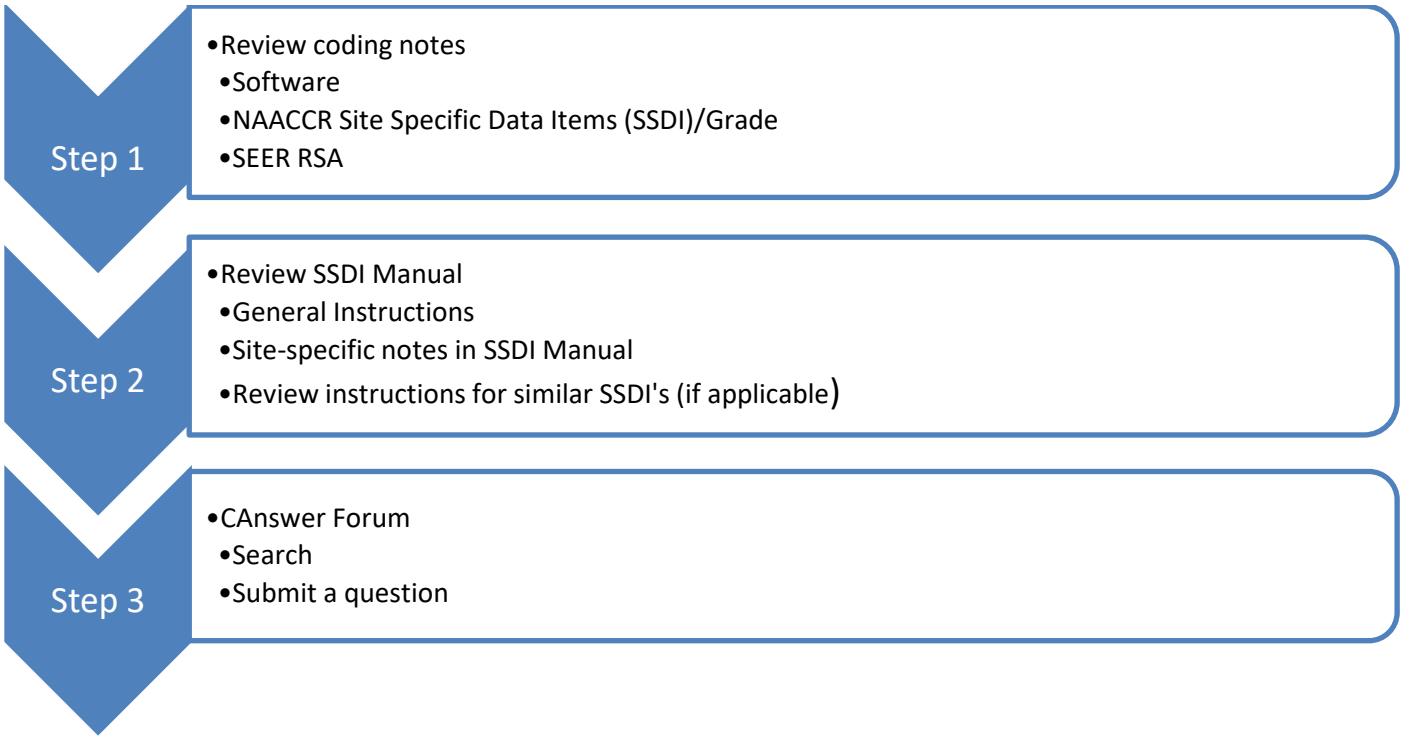
Rationale
Ethnic origin has a significant association with cancer rates and outcomes. Hispanic populations have patterns of cancer occurrence different from other populations that may be included in the "white" Race category.

Code	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

IMPORTANT: Justify the code you enter in the this field by including Hispanic information in the PE text field.

IMPORTANT: 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).

SSDI - STEPS TO CODING SITE-SPECIFIC DATA ITEMS (SSDI)
WCRS-required SSDIs on following pages



Step 1*
https://apps.naaccr.org/ssdi/list/
https://seer.cancer.gov/tools/staging/

Step 2
https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547

Step 3
http://cancerbulletin.facs.org/forums/

*Coding notes may be included in the vendor software. If not, go the NAACCR Site or SEER RSA.

SSDI – BRAIN MOLLECULAR MARKERS
NEW FOR 2018 - BRAIN

Abstract Plus Field Name: BrainMolec.Markers

Required
Item Length: 2
NAACCR item #: 3816
Standard Source: NAACCR

Description
Multiple brain molecular markers have become standard pathology components necessary for diagnosis. This data item captures clinically important brain cancer subtypes identified by molecular markers that are not distinguishable by ICD-O-3 codes.

Rationale
Collection of these clinically important brain cancer subtypes has been recommended by CBTRUS.

Codes	
01	Diffuse astrocytoma, IDH-mutant (9400/3)
02	Diffuse astrocytoma, IDH-wildtype (9400/3)
03	Anaplastic astrocytoma, IDH-mutant (9401/3)
04	Anaplastic astrocytoma, IDH-wildtype (9401/3)
05	Glioblastoma, IDH-wildtype (9440/3)
06	Oligodendroglioma, IDH-mutant and 1 p/19q co-deleted (9450/3)
07	Anaplastic oligodendroglioma, IDH-mutant and 1 p/19q co-deleted (9451/3)
08	Medulloblastoma, SHH-activated and TP53-wildtype (9471/3)
09	Embryonal tumor with multilayered rosettes, C19MC-altered (9478/3)
85	Not applicable: Histology not 9400/3, 9401/3, 9440/3, 9450/3, 9451/3, 9471/3, 9478/3
86	Benign or borderline tumor
87	Test ordered, results not in chart
88	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 88 will result in an edit error.)
99	Not documented in patient record No microscopic confirmation Brain molecular markers not assessed or unknown if assessed

Coding Instructions

1. This data item applies only to ICD-O-3 histology codes:

   - 9400/3
   - 9401/3
   - 9440/3
   - 9450/3
   - 9451/3
   - 9471/3
   - 9478/3

   Note: If a histology is not included in this list, assign, code 85.

2. Physician statement of histologic subtype can be used to code this data item.

3. Only one code is applicable for each tumor.

    - IDH mutation status distinguishes between clinically important subtypes within ICD-O-3 9400/3, Diffuse astrocytoma and 9401/3, Anaplastic astrocytoma.

    - IDH mutant and 1p/19q co-deletion distinguishes between clinically important subtypes within ICD-O-3 code 9450/3, Oligodendroglioma and 9451/3, Anaplastic Oligodendroglioma.

    - IDH-wildtype distinguishes clinically important subtypes within ICD-O-3 9400/3, Diffuse astrocytoma, 9401/3, Anaplastic astrocytoma and 9440/3, Glioblastoma, Epithelioid glioblastoma and Glioblastoma, NOS (note that the new ICD-O-3 code 9445/3 applies to Glioblastoma, IDH-mutant; information regarding this subtype is not collected using this data item).

    - SHH-activation and TP53-wildtype distinguishes between clinically important subtypes within ICD-O-3 histology code 9471/3, Medulloblastoma.

    - C19MC alteration status distinguishes a clinically important highly aggressive subtype within ICD-O-3 9478/3, Embryonal tumor with multilayered rosettes.

Example 1: Biopsy of brain tumor, microscopic confirmation diagnosis: Diffuse Astrocytoma (9400/3). Additional testing done, and IDH-mutant is identified. Code 01. Biopsy of brain tumor, microscopic confirmation diagnosis: Anaplastic astrocytoma (9401/3). No further testing or results unknown. Code 99.

Example 2: MRI of brain tumor, clinical diagnosis: glioblastoma. No further workup. Code 99.

Example 3: Biopsy of brain tumor, microscopic confirmation diagnosis: Mixed glioma (9382/3). Code 85.

SSDI – BRESLOW TUMOR THICKNESS
PREVIOUS SSF 1 – MELANOMA, SKIN

Abstract Plus Field Name: Breslow Thickness

Required
Item Length: 4
NAACCR item #: 3817
Standard Source: NAACCR

Description
Breslow Tumor Thickness, the measurement of the thickness of a melanoma as defined by Dr. Alexander Breslow, is a prognostic factor for Melanoma of the Skin.

Codes	
0.0	No mass/tumor found
0.1	Greater than 0.0 and less than or equal to 0.1
0.2-99.9	0.2 - 99.9 millimeters
XX.1	100 millimeters or larger
A0.1-A9.9	Stated as "at least" some measured value of 0.1 to 9.9
AX.0	Stated as greater than 9.9 mm
XX.8	Not applicable: Information not collected for this schema (If this item is required by your standard setter, use of code XX.8 will result in an edit error)
XX.9	Not documented in medical record Microinvasion; microscopic focus or foci only and no depth given Cannot be determined by pathologist In situ melanoma Breslow Tumor Thickness not assessed or unknown if assessed

Definition
A measure of how deeply a melanoma tumor has grown into the skin. The tumor thickness (depth) is usually measured from the top of the tumor to the deepest tumor cells. If the tumor is ulcerated (the skin is broken), it is measured from the base of the ulcer to the deepest tumor cells. Breslow thickness is used to help determine the stage of cancer. Thicker tumors are linked with lower survival rates.

Coding guidelines

1. Code a measurement specifically labeled as “thickness” or “depth” or “Breslow depth of invasion” from the pathology report. In the absence of this label, a measurement described as taken from the cut surface of the specimen may be coded. And in the absence of either of these labels, the third dimension in a statement of tumor size can be used to code this field.

2. Code the greatest measured thickness from any procedure performed on the lesion, whether it is described as a biopsy or an excision. Do not add measurements together from different procedures.

   Example*:* A punch biopsy with a thickness of 0.5 mm is followed by a re-excision with a thickness of residual tumor of 0.2 mm. *Code 0.5 mm.*

3. If the tumor is excised post-neoadjuvant treatment, tumor measurements cannot be compared before and after treatment to determine which would indicate the greater involvement. The same code (XX.9) is used for cases with no surgical procedure of the primary site and cases with surgical procedure of the primary site after neoadjuvant treatment.

4. Because the thickness table is similar to many other tables that collect a measurement, it is important to identify the correct unit of measurement.

5. In the range 0.1-99.9, code the actual tumor thickness, tumor depth, or Breslow measurement in **tenths** of millimeters as stated in the pathology report. If the measurement is given in hundredths of millimeters, use the general rules for rounding to determine the value in tenths of millimeters. This is a four-digit field with a decimal point in the third digit.

   Example 1: Tumor described as 0.5 mm in depth – *code as 0.5*
   Example 2: Lesion 1 mm thick – *code as 1.0*.
   Example 3: Breslow 2.5 mm – *code as 2.5*
   Example 4: Thickness of 10 mm (1 cm) – *code as 10.0*

Additional Information

***Source documents*:** pathology report

For further information, refer to the **Melanoma** cancer protocol published by the College of American Pathologists for AJCC 8th edition

***Other names*:** maximum tumor thickness, Breslow depth of invasion, Breslow thickness, Breslow measurement, Breslow's microstaging

Coding Instructions
Physician statement of Breslow Tumor Thickness can be used to code this data item when no other information is available, or the available information is ambiguous.

1. Code Breslow tumor thickness, not size. Record actual measurement in tenths of millimeters from the pathology report. Measurement given in hundredths of millimeters should be rounded to the nearest tenth.

   Examples:
   0.4 mm – 0.4
   1.0 mm- 1.0
   2.5 mm – 2.5
   2.56 mm- 2.6
   11 mm – 11.0
   12.35 mm – 12.4 mm

2. Code the greatest measured thickness from any procedure performed on the lesion, whether it is described as a biopsy or an excision.

   Example: If a punch biopsy with a thickness of 1.5 mm is followed by a re-excision with a thickness of residual tumor of 0.2 mm, code 1.5.

3. Do not add measurements together from different procedures (even in the rare circumstance that the pathologist adds the measurements from two specimens).

4. If the pathologist describes the thickness as "at least," use the appropriate A code. An exact measurement takes precedence over A codes.

   If the pathologist states "greater than" instead of "at least", code to XX.9, unless it is greater than 9.9 mm (Code AX.0)

   Example 1: Pathologist states the thickness is "at least 2.0 mm." Code A2.0
   Example 2: Pathologist states the thickness is "greater than 4 mm." Code XX.9

SSDI – ESTROGEN RECEPTOR SUMMARY

PREVIOUS SSF 1 - BREAST

Abstract Plus Field Name: ER Summary

Required
Item Length: 1
NAACCR item #: 3827
Standard Source: NAACCR

Description

ER (Estrogen Receptor) Summary is a summary of results of the estrogen receptor (ER) assay.

Codes	
0	ER negative
1	ER positive
7	Test ordered, results not in chart
9	Not documented in medical record Cannot be determined (indeterminate) ER (Estrogen Receptor) Summary status not assessed or unknown if assessed

Coding guidelines

Record the pathologist's interpretation of the assay value from the tumor specimen. Results from the ER assay done prior to neoadjuvant therapy take priority. If there are no results prior to neoadjuvant treatment, code the results from a post-treatment specimen. Do not report results of an ER done as part of a multigene test such as OncotypeDX or MammaPrint.

- Code 0 when the ER is reported as negative or normal
- Code 1 when the ER is reported as positive or elevated
- Code 7 when the ER test was ordered but the results are not available
- Code 9 when
    a. It is unknown whether the ER test was performed
    b. The patient has only a clinical diagnosis of breast cancer (no tissue diagnosis)
    c. The ER is reported as borderline; undetermined whether positive or negative
    d. The ER cannot be determined by the pathologist (e.g. inadequate specimen)

Coding Instructions

1. Physician statement of ER (Estrogen Receptor) Summary status can be used to code this data item when no other information is available.
2. The result of the ER test performed on the primary breast tissue is to be recorded in this data item.
3. Results from nodal or metastatic tissue may be used ONLY when there is no evidence of primary tumor.
4. In cases where ER is reported on more than one breast tumor specimen, record the highest value. If any sample is positive, record as positive.

    Exception: If ER is positive on an in situ specimen and ER is negative on all tested invasive specimens, code ER as negative (code 0).

5. If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy. If neoadjuvant therapy is given and there are no ER results from pre-treatment specimens, report the findings from post-treatment specimens.
6. If the patient is ER positive and node negative, a multigene test such as Oncotype Dx may be performed, in which case another ER test will be performed. The multigene test may include an ER assessment, but do not record the results of ER from the multigene test in this field.

    Note: Record only the results of the test which made the patient eligible to be given the multigene test.

SSDI – FIBROSIS SCORE
NEW FOR 2018 - LIVER

Abstract Plus Field Name: Fibrosis Score

Required
Item Length: 1
NAACCR item #: 3835
Standard Source: NAACCR

Description
Fibrosis Score (Ishak Score), the degree of fibrosis of the liver based on pathological examination, is a prognostic factor for liver cancer.

Codes	
0	Ishak fibrosis score 0-4 No to moderate fibrosis METAVIR score F0-F3 Batt-Ludwig score 0-3
1	Ishak fibrosis score 5-6 Advanced/severe fibrosis METAVIR score F4 Batt-Ludwig score 4 Developing cirrhosis Incomplete cirrhosis Transition to cirrhosis Cirrhosis, probable or definite Cirrhosis, NOS
7	Clinical statement of advanced/severe fibrosis or cirrhosis, AND Not histologically confirmed or unknown if histologically confirmed
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Stated in medical record that patient does not have advanced cirrhosis/advanced fibrosis, not histologically confirmed or unknown if histologically confirmed Fibrosis score stated but cannot be assigned to codes 0 or 1 Fibrosis score stated but scoring system not recorded Fibrosis Score not assessed or unknown if assessed

Definitions

Fibrosis Score is based on degree of parenchymal fibrosis or cirrhosis of the nontumorous liver as defined in the surgical pathology report. Multiple fibrosis scoring systems have been described for use in pathological evaluation of liver disease.

Ishak system: uses a scale of 0-6 with 6 indicating cirrhosis. Recommended by AJCC and CAP.

Batts-Ludwig system*:* uses a score of 0-4, with a score of 3 defined as fibrous septa with architectural distortion but no obvious cirrhosis, and a score of 4 defined as cirrhosis o Used most commonly by US pathologists

METAVIR*:* uses scores of F0-F4 o Used mostly in Europe

Additional Information

Source documents: pathology report (biopsy or FNA path report)

Other names: Nontumoral hepatic parenchymal fibrosis/cirrhosis (Intrahepatic Bile Duct Tumors)

Coding Instructions

1. Physician statement of fibrosis score can be used to code this data item when no other information is available. However, code 7 when the physician statement of fibrosis score is not based on histologic examination of the liver.

2. FIB-4 is NOT a pathological fibrosis score of 4. It is a scoring method using the patient's age and relevant lab values to calculate a score. The medical record may show something like "FIB-4 = 3.52." Do not code FIB-4 values in this data item.

3. AJCC classifies Ishak fibrosis scores 0-4 (none to moderate fibrosis) as F0, and Ishak fibrosis scores 5-6 (cirrhosis/severe fibrosis) as F1. This is not the same as METAVIR score F0 or F1.

4. Record the results based on information collected during the initial work-up. If multiple biopsies are taken and have conflicting scores, use the results from the biopsy closest to the start of treatment. Information collected after the start of treatment may not be used to code this data item.

5. Code the absence (code 0) or presence (code 1) of fibrosis as documented in the pathology report.

6. If no score is mentioned, descriptive terms may be used to assign codes 0 and 1 – see specific terms in the table below.

7. If a fibrosis score is stated but the scoring system is not recorded, consult with the physician. If no further information is available, code 9.

SSDI – GRADE CLNICAL
NEW FOR 2018 – ALL SITES

Abstract Plus Field Name: Grade Clinical

Required
Item Length: 1
NAACCR item #: 3843
Standard Source: NAACCR

Description
Grade Clinical is new for 2018. This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). For cases diagnosed 2018 and later, this data item replaces NAACCR Data Item Grade [440] as well as the collaborative stage site-specific factors for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Codes
Refer to the Grade Coding Instructions and Tables, https://www.naaccr.org/SSDI/Grade-Manual.pdf, in the SSDI Manual for site-specific instructions.

Organization of the Grade Coding Instructions and Tables and Suggestions for How to Use Them
The Grade Coding Instructions and Tables (Grade Manual) is the primary resource for documentation and coding instructions for Grade for cases diagnosed on or after January 1, 2018. Before using the Grade Manual as a coding reference, it is important to review the introductory materials and general instructions of the manual carefully. These reflect several important changes in the collection of Grade data items.

To understand how the Grade Tables are organized in the Grade Manual, you must be familiar with the concept of Schema ID's which is described in the SSDI Manual. A particular Grade Table defines the set of applicable codes for a set of schemas. For example, "Grade ID 01 – Clinical Grade Instructions" defines a single set of codes that apply to clinical grade for 23 Schemas. Similar to the SSDI's, registry software will populate the grade field pick lists for each case with the appropriate grade codes based on the Schema ID, so the registrar will not have to use the manual to determine which grade codes apply for a particular case.

For registrars who are coding 2018 diagnosed cases before software is available, the Grade Manual provides Grade Table Indexes to assist the registrar in identifying the correct code Tables. These indexes are located at the beginning of the Grade Manual, immediately after the Table of Contents. The first Index provides information sorted in Schema ID # order, which contains Schema number and name, and the Summary Stage Chapter name along with a hyperlink to the appropriate Grade Table. A hyperlink is also provided to return to the Grade Table (Schema ID order) at the end of the coding instructions for each schema. A second index with similar information and functionality, sorted in alphabetical order by schema name, is also provided.

In addition to understanding the concept and structure of the Grade Tables, it is critically important to review all of the general information included in the Manual. Thorough understanding of this material will be necessary in order to code the new Grade Data Items accurately.

SSDI – GRADE PATHOLOGICAL
NEW FOR 2018 – ALL SITES

Abstract Plus Field Name: Grade Clinical

Required
Item Length: 1
NAACCR item #: 3844
Standard Source: NAACCR

Description
This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup.

Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical workup or the surgical resection.

For cases diagnosed January 1, 2018, and later, this data item, along with Grade Clinical and Grade Post-Neoadjuvant, replaces NAACCR Data Item Grade [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Rationale
Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the pathological stage group.

For those cases that are eligible AJCC staging, the recommended grading system is specified in the AJCC Chapter. The AJCC Chapter-specific grading systems (codes 1-5) take priority over the generic grade definitions (codes A-E, L, H, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Codes (Refer to the most recent version of the SSDI Manual for additional site-specific instructions)
Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank. Leave blank for cases diagnosed prior to 2018.

SSDI – GRADE POST THERAPY
NEW FOR 2018 – ALL SITES

Abstract Plus Field Name: Grade Clinical

Required
Item Length: 1
NAACCR item #: 3845
Standard Source: NAACCR

Description
This data item records the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual.

Record the highest grade documented from the surgical treatment resection specimen of the primary site following neoadjuvant therapy.

For cases diagnosed January 1, 2018, and later, this data item, along with Grade Clinical and Grade Pathological, replaces NAACCR Data Item Grade [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Codes
Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the post-neoadjuvant stage group.

For those cases that are eligible AJCC staging, the recommended grading system is specified in the AJCC Chapter. The AJCC Chapter-specific grading systems (codes 1-5) take priority over the generic grade definitions (codes A-E, L, H, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Codes (Refer to the most recent version of the SSDI Manual for additional site-specific instructions)
Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank. Leave blank for cases diagnosed prior to 2018.

SSDI – HER2 OVERALL SUMMARY
PREVIOUS SSF 15 – BREAST

Abstract Plus Field Name: Her2 Summary

Required
Item Length: 1
NAACCR item #: 3855
Standard Source: NAACCR

Description
HER2 Overall Summary is a summary of results from HER2 testing.

Codes	
0	HER2 negative; equivocal
1	HER2 positive
7	Test ordered, results not in chart
9	Not documented in medical record Cannot be determined (indeterminate) HER2 Overall Summary status not assessed or unknown if assessed

Coding guidelines
Record the pathologist's interpretation of the HER2 test from the tumor specimen. Results from the HER2 test done prior to neoadjuvant therapy take priority. If there are no results prior to neoadjuvant treatment, code the results from a post-treatment specimen. Do not report the results of a HER2 as part of a multigene test such as OncotypeDX or MammaPrint. If assays are performed on more than one specimen and any result is interpreted as positive, code as 1 Positive/elevated.

Exception: If results from both an in situ specimen and an invasive component are given, record the results from the invasive specimen, even if the in situ is positive and the invasive specimen is negative.

- Code 0 when the HER2 is reported as negative or normal
- Code 1 when the HER2 is reported as positive or elevated
- Code 7 when the HER2 test was ordered but the results are not available
- Code 9 when

    a. The HER2 is reported as borderline; undetermined whether positive or negative
    b. The HER2 cannot be determined by the pathologist (e.g. inadequate specimen)
    c. It is unknown whether the HER2 test was performed
    d. The patient has only a clinical diagnosis of breast cancer (no tissue diagnosis)
    e. The tumor tissue is completely in situ

Coding Instructions

1. Physician statement of HER2 Overall Summary can be used to code this data item when no other information is available.
2. The result of the HER2 test performed on the primary breast tissue is to be recorded in this data item.
3. Results from nodal or metastatic tissue may be used ONLY when there is no evidence of primary tumor.
4. In cases where HER2 is reported on more than one breast tumor specimen, record the highest value. If any sample is positive, record as positive.

    Exception: If HER2 is positive on an in situ specimen and HER2 is negative on all tested invasive specimens, code HER2 as negative (code 0).

5. If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy. If neoadjuvant therapy is given and there are no HER2 results from pre-treatment specimens, report the findings from post-treatment specimens.
6. If the patient is HER2 positive and node negative, a multigene test such as Oncotype Dx may be performed, in which case another HER2 test will be performed. Do not record the results of that test in this field. Record only the results of the test which made the patient eligible to be given the multigene test.

SSDI – LDH PRETREATMENT LAB VALUE
NEW FOR 2018 – MELANOMA, SKIN

Abstract Plus Field Name: LDH PreRx Lab Value

Required
Item Length: 7
NAACCR item #: 3932
Standard Source: NAACCR

Description
LDH (Lactate Dehydrogenase) Pretreatment Lab Value, measured in serum, is a predictor of treatment response, progression-free survival and overall survival for patients with Stage IV melanoma of the skin. It was previously collected as Melanoma Skin, CS SSF# 5 (not required by WCRS previously).

Codes	
0.0	0.0 (U/L)
0.1-99999.9	0.1–99,999.9 U/L
XXXXX.1	100,000 U/L or greater
XXXXX.7	Test ordered, results not in chart
XXXXX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XXXXX.8 will result in an edit error.)
XXXXX.9	Not documented in medical record LDH (Lactate Dehydrogenase) Pretreatment Lab Value not assessed or unknown if assessed

Definition
When cells (normal or tumor) are damaged or destroyed, an enzyme called lactate dehydrogenase (LDH) is released into the bloodstream. LDH is an indirect indication of possible tumor burden or damage to an organ, which may be caused by metastatic involvement of liver or lung, or a myocardial infarction. The total LDH should be the test value that is coded, but there are five fractions of LDH that measure tissue specific cellular damage: LD1 and LD2: heart, red blood cells and kidneys; LD3: lung; LD4 and LD5: liver, skin and skeletal muscles. LDH is elevated in 60% of patients with non-seminomatous germ cell tumors of the testis. LDH is not a screening test, nor is it diagnostic of melanoma, ocular adnexal lymphoma, or testicular cancer.

Coding guidelines

- Code 0.0 for a test result of 0 (U/L).
- Code the highest exact LDH lab value prior to treatment in the range 0.1 to 99,999.9
- Code XXXXX.1 for a total LDH lab value of 100,000 or greater.
- Code XXXXX.7 if the test was ordered and the results are not in the medical record.
- Code XXXXX.9 when:
    a. There is no information in the medical record about the LDH lab value
    b. Test is not done or unknown if the test was done

Additional Information

Source documents: clinical laboratory report; may be included in a liver or hepatic panel/profile, a cardiac panel, or a general metabolic panel of tests

Other names: LDH, Lactate dehydrogenase, lactase dehydrogenase, lactic acid dehydrogenase

Coding Instructions

1. Physician statement of LDH (Lactate Dehydrogenase) Pretreatment Lab Value can be used to code this data item when no other information is available.
2. Record the lab value of the highest serum LDH test results documented in the medical record **prior to treatment** or within 6 weeks of diagnosis**.** Give priority to the first test performed. The lab value may be recorded in a lab report, history and physical, or clinical statement in the pathology report.

SSDI – MICROSATELLITE INSTABILITY (MSI)

PREVIOUS SSF 7 – APPENDIX, CARCINOID APPENDIX, COLON AND RECTUM

Abstract Plus Field Name: Microsatellite Instabil.

Required
Item Length: 1
NAACCR item #: 3890
Standard Source: NAACCR

Description

Microsatellite Instability (MSI) is a form of genetic instability manifested by changes in the length of repeated single- to six-nucleotide sequences (known as DNA microsatellite sequences). High MSI, found in about 15% of colorectal carcinomas, is an adverse prognostic factor for colorectal carcinomas and predicts poor response to 5-FU chemotherapy (although the addition of oxaliplatin in FOLFOX regimens negates the adverse effects). High MSI is a hallmark of hereditary nonpolyposis colorectal carcinoma, also known as Lynch syndrome.

Codes	
0	Microsatellite instability (MSI) stable; microsatellite stable (MSS); negative, NOS **AND/OR** Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins
1	MSI unstable low (MSI-L)
2	MSI unstable high (MSI-H) **AND/OR** MMR-D (loss of nuclear expression of one or more MMR proteins, MMR protein deficient)
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record MSI-indeterminate Microsatellite instability not assessed or unknown if assessed

Definition

Describes cancer cells that have a greater than normal number of genetic markers called microsatellites. Microsatellites are short, repeated, sequences of DNA. Cancer cells that have large numbers of microsatellites may have defects in the ability to correct mistakes that occur when DNA is copied in the cell. Microsatellite instability is found most often in colorectal cancer, other types of gastrointestinal cancer, and endometrial cancer. It may also be found in cancers of the breast, prostate, bladder, and thyroid. Knowing whether cancer is microsatellite instability high may help plan the best treatment.

Additional Information

Other names: MSI-H

Note: For further information, refer to the **Colon and Rectum Biomarker Reporting** cancer protocol published by the College of American Pathologists for AJCC 8th edition

Coding Instructions and Codes

1. Physician statement of MSI can be used to code this data item when no other information is available.
2. The microsatellite instability (MSI) test is a genetic test performed on tumor tissue to look for differences in length of certain non-functioning sections of DNA. The differences are caused by problems with the genes that encode proteins that normally repair certain types of DNA damage. A high proportion of colon cancers arising in patients with hereditary nonpolyposis colorectal cancer (HNPCC) (also known as Lynch syndrome) have high MSI and a smaller percentage of colon cancers not associated with Lynch syndrome have high MSI. Patients with colon cancers with high MSI may be further tested to determine if they have HNPCC. In addition, MSI is a useful prognostic marker in that patients with high MSI colon cancers have better response to surgery and survival.

3. Testing for MSI may be done by immunology or genetic testing. Only genetic testing results will specify whether the MSI is low or high.
    - Some laboratories only test for MSI via an immunologic test for Mismatch Repair (MMR) Protein
    - Results from immunology will only provide you with positive or negative results and will not specify whether the MSI is low or high
    - Results of Mismatch Repair (MMR) may be recorded in this data item - see codes 0 and 2
    - MMR proficient (pMMR or MMR-P) should be coded as a 0
4. If both tests are done and one or both are positive, code 2.
5. If all tests done are negative, code 0.

SSDI – PROGESTERONE RECEPTOR SUMMARY
PREVIOUS SSF 2 - BREAST

Abstract Plus Field Name: PR Summary

Required
Item Length: 1
NAACCR item #: 3915
Standard Source: NAACCR

Description
Progesterone Receptor Summary is a summary of results from the progesterone receptor (PR) assay.

Codes	
0	PR negative
1	PR positive
7	Test ordered, results not in chart
9	Not documented in medical record Cannot be determined (indeterminate) PR (Progesterone Receptor) Summary status not assessed or unknown if assessed

Coding guidelines

- Code 0 when the PR is reported as negative or normal
- Code 1 when the PR is reported as positive or elevated
- Code 7 when the PR test was ordered but the results are not available
- Code 9 when
    a. The PR is reported as borderline; undetermined whether positive or negative
    b. The PR cannot be determined by the pathologist (e.g. inadequate specimen)
    c. It is unknown whether the PR test was performed
    d. The patient has only a clinical diagnosis of breast cancer (no tissue diagnosis)

Coding Instructions

1. Physician statement of PR (Progesterone Receptor) Summary status can be used to code this data item when no other information is available.
2. The result of the PR test performed on the primary breast tissue is to be recorded in this data item.
3. Results from nodal or metastatic tissue may be used ONLY when there is no evidence of primary tumor.
4. In cases where PR is reported on more than one breast tumor specimen, record the highest value. If any sample is positive, record as positive.

    Exception: If PR is positive on an in situ specimen and PR is negative on all tested invasive specimens, code PR as negative (code 0).
5. If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy. If neoadjuvant therapy is given and there are no PR results from pre-treatment specimens, report the findings from post-treatment specimens.
6. If the patient is PR positive and node negative, a multigene test such as Oncotype Dx may be performed, in which case another PR test will be performed. Do not record the results of that test in this field. Record only the results of the test which made the patient eligible to be given the multigene test.

SSDI – PROSTATIC SPECIFIC ANTIGEN LAB VALUE (PSA)

PREVIOUS SSF 1 - PROSTATE

Abstract Plus Field Name: PSA Lab Value

Required
Item Length: 5
NAACCR item #: 3920
Standard Source: NAACCR

Description

PSA (Prostatic Specific Antigen) is a protein produced by cells of the prostate gland and is elevated in patients with prostate cancer. This data item pertains to PSA lab value.

Codes	
0.1	0.1 or less nanograms/milliliter (ng/ml) (Exact value to nearest tenth of ng/ml)
0.2-999.9	0.2–999.9 ng/ml (Exact value to nearest tenth of ng/ml)
XXX.1	1,000 ng/ml or greater
XXX.7	Test ordered, results not in chart
XXX.9	Not documented in medical record PSA lab value not assessed or unknown if assessed

Definition

Serum PSA is the most sensitive tumor marker for monitoring individuals with prostate cancer, including progression of disease and response to therapy. Although originally not intended to be a screening test, this relatively simple blood test has become a very common method of detecting new prostate cancer in its earliest stages. PSA can be totally negative when prostate cancer is found on digital rectal exam. In such cases, PSA will not be helpful in monitoring for recurrence.

> **Note**: Serum PSA is not the same as free PSA or precursor PSA—do not record values from either of these tests in this field.

Additional Information

Source documents: clinical laboratory report (blood or serum test), history, clinician note, pathology report

Other names: Prostate specific antigen, serum PSA, total PSA

***Normal reference range*:** varies by age and race of patient.

- The reference range should be shown on the clinical laboratory report. In general, normal findings are 0 – 4.0 nanograms per milliliter (ng/ml).
- Optimal normal range is 0 – 2.6 ng/ml. Nanograms per milliliter may be reported as micrograms per liter (µg/L or ug/L).

Coding Guidelines

Record the last pre-diagnosis PSA lab value prior to diagnostic biopsy of prostate and initiation of treatment in nanograms per milliliter (ng/ml) in the range 0.1 (.1 ng/ml) to 999.9 (999.9 ng/ml).

> **Note**: This is a change from CSv2, where the instructions stated to code the highest PSA value within 3 months prior to diagnostic biopsy

Examples	Code	Explanation
PSA 11.56	11.6	PSA documented in tenths, round up
1/5/2018: PSA 5.8 1/29/2018: PSA 5.2 2/22/2018: Biopsy positive for adenocarcinoma	5.2	PSA lab value closest and prior to the diagnostic biopsy
12/19/2017: PSA 44.3 3/11/2018: PSA 42.8 5/1/2018: DRE positive for bilateral palpable nodularity 5/5/2018: Casodex initiated without needle core biopsy	42.8	PSA lab value closest to the initiation of treatment
2/16/2018: PSA 18.6, adjusted PSA value due to patient taking medication for benign prostatic hypertrphy	18.6	Record the adjusted PSA value only if documented by the cvlinician in the record. Registrar does not adjust the PSA value due to BPH medication use
1,100 ng/ml	XXX.1	XXX.1 is defined for values of 1,000 or greater
No PSA done or unknown if done	XXX.9	Definition of unknown

Coding Instructions

1. Physician statement of prostatic specific antigen (PSA) pre-diagnosis can be used to code this data item when no other information is available.

2. PSA is a prognostic factor required for AJCC staging. It affects the stage group in most cases.

3. Record to the nearest tenth in nanograms/milliliter (ng/ml) the last pre-diagnosis PSA lab value prior to diagnostic biopsy of prostate and treatment. The lab value may be recorded in the lab report, history and physical, or clinical statement in the pathology report, etc.

   A lab value expressed in micrograms per liter (ug/L) is equivalent to the same value expressed in nanograms per milliliter (ng/ml)

   Record 0.1 when the lab results are stated as less than 0.1 ng/ml with no exact value.

   Examples
   PSA of 7.2. Code 7.2
   PSA of 10. Code 10.0
   PSA of 8.56. Code 8.6
   PSA of 110.35. Code 110.4

4. A discrepancy between the PSA documented in the lab report and the PSA documented by the clinician may arise due to the clinician's adjusting the PSA value. Certain medications for benign prostatic hypertrophy (BPH) decrease the PSA.

   If there is documentation by a clinician within the medical record of an adjusted PSA value, record the adjusted value.

   The registrar does not adjust the PSA value based on BPH medication use.

   If there is no documentation by a clinician within the medical record of an adjusted PSA value, record the PSA value provided.

   The fact that an adjusted PSA value is being recorded should be documented in the Dx Proc – Lab Tests text field (NAACCR Item # 2550).

SSDI – SCHEMA DISCRIMINATOR 1

NEW FOR 2018

Abstract Plus Field Name: Schema Discriminator 1

Required
Item Length: 1
NAACCR item #: 3926
Standard Source: NAACCR

Description
Captures additional information needed to generate Schema ID for some anatomic sites. Discriminators can be based on sub site, histology or other features which affect prognosis.

Rationale
A schema discriminator is used to assign Schema ID, which is needed to link each case to the appropriate SSDIs, and Summary Stage 2018.

Codes
The information recorded in Schema Discriminator 1 differs for each anatomic site. See the SSDI manual for most current version of the site-specific codes and coding structures.

The following schemas apply to Schema Discriminator 1:

- BileDuctsDistal/BileDuctsPerihilar/CysticDuct
- EsophagusGEJunction (EGJ)/Stomach
- Histology Discriminator for 9591/3
- Lacrimal Gland/Sac
- Melanoma Ciliary Body/Melanoma Iris
- Nasopharynx/Pharyngeal Tonsil
- Occult Head and Neck Lymph Nodes
- Plasma Cell Myeloma Terminology
- Primary Peritoneum Tumor
- Thyroid Gland/Thyroglossal Duct
- Urethra/Prostatic Urethra

SSDI – SCHEMA DISCRIMINATOR 2

NEW FOR 2018

Abstract Plus Field Name: Schema Discriminator 2

Required
Item Length: 1
NAACCR item #: 3927
Standard Source: NAACCR

Description
Captures additional information needed to generate Schema ID for some anatomic sites. Discriminators can be based on sub site, histology or other features which affect prognosis.

Rationale
A schema discriminator is used to assign Schema ID, which is needed to link each case to the appropriate SSDIs, and Summary Stage 2018.

Codes
The information recorded in Schema Discriminator 2 differs for each anatomic site. See the SSDI manual for most current version of the site-specific codes and coding structures.

The following schemas apply to Schema Discriminator 2:

- Histology Discriminator for 8020/3
- Oropharyngeal p16

SSDI – SCHEMA ID
NEW FOR 2018

Abstract Plus Field Name: Schema ID **(***Derived Field – no manual entry required)*

Required
Item Length: 5
NAACCR item #: 3800
Standard Source: NAACCR

Description
The *derived values* in this data item link Site-Specific Data Items (including grade data items) with the appropriate site/histology grouping and accounts for every combination of primary site and histology. The values for this data item are derived based on primary site, histology, and schema discriminator fields (when required). The derived values link Site-Specific Data Items with the appropriate site/histology grouping.

For example, the Schema ID for a ductal carcinoma of the breast is 00480. This value links the Site-Specific Data Items associated with ductal carcinoma of the breast (those required by WCRS listed here): Estrogen Receptor Summary, Progesterone Receptor Summary, and HER2 Overall Summary. The Schema ID would also link to the appropriate grade data items for a ductal carcinoma of the breast.

Codes
See the specific NAACCR Schema web site to find the coding summary for each schema.
https://apps.naaccr.org/ssdi/list/

SUMMARY STAGE 2018
PREVIOUSLY SUMMARY STAGE 2000

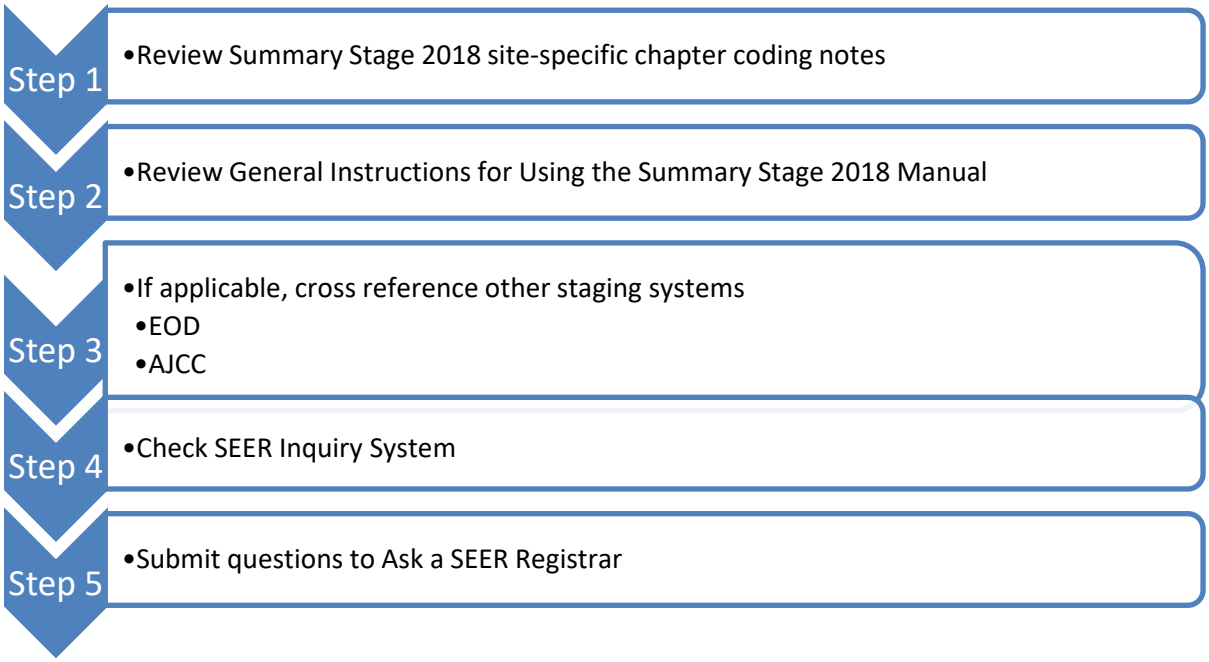
Abstract Plus Field Name: SS2018

Required for cases diagnosed 2018 and later
Item Length: 1
NAACCR Item #: 764
Standard Source: SEER

Description
This code is for summary stage at the initial diagnosis or treatment of the reportable tumor. For site-specific definitions of categories, see SEER *Summary Staging Manual 2018*. 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/2018-Summary-Stage-Manual.pdf

Code	Description
0	*In situ*
1	Localized only
2	Regional, direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND regional lymph nodes
7	Distant site(s)/node(s) involved
8	Benign, borderline **Note:** *Code **8** should only be used for benign/borderline brain or other CNS.*
9	Unstaged, or death certificate only case

Steps for Coding Summary Stage



Step 1
https://seer.cancer.gov/tools/ssm/2018-Summary-Stage-Manual.pdf

Example of Site-Specific Chapter Notes:

Note 1: The following sources were used in the development of this chapter

- SEER Extent of Disease 1988: Codes and Coding Instructions (3rd Edition, 1998) (https://seer.cancer.gov/archive/manuals/EOD10Dig.3rd.pdf)
- SEER Summary Staging Manual-2000: Codes and Coding Instructions (https://seer.cancer.gov/tools/ssm/)
- Collaborative Stage Data Collection System, version 02.05: https://cancerstaging.org/cstage/Pages/default.aspx
- Chapter 16 *Esophagus and Esophagogastric Junction*, in the AJCC Cancer Staging Manual, Eighth Edition (2017) published by Springer International Publishing. Used with permission of the American College of Surgeons, Chicago, Illinois.

Note 2: See the following chapters for the listed histologies

Step 2
https://seer.cancer.gov/tools/ssm/SSM2018-General-Instructions.pdf

Step 3
https://seer.cancer.gov/tools/staging/2018-EOD-General-Instructions.pdf
https://cancerstaging.org/CSE/Registrar/Pages/Eight-Edition-Webinars.aspx

Step 4
https://seer.cancer.gov/seerinquiry/index.php

Step 5
https://seer.cancer.gov/registrars/contact.html

TELEPHONE

Abstract Plus Field Name: Telephone

Required
Item Length: 10
NAACCR item #: 2360

Description
Current telephone number with area code for the patient. Number is entered without dashes. This is a newly required field for WCRS starting with 2018 diagnosed cases.

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*	
0000000000	Patient does not have a telephone
9999999999	Telephone number unavailable or unknown

***in addition to valid telephone number**

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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name
490	Diagnostic Confirmation
(Multiple IDs)	Required Lab-based SSDIs (ER summary, PR summary, HER2 summary, 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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name
1340	Reason for No Surgery
1112-1117	Mets at DX fields
1290	RX Summ – Surgery Primary Site
764	SEER Summary Stage 2018

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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name	Item Number	Item Name
390	Date of Diagnosis	490	Diagnostic Confirmation
400	Primary Site	820, 830	Regional Nodes Positive & Examined
410	Laterality	764	SEER Summary Stage 2018
522	Histologic Type	1112 - 1117	Mets at DX fields
440	Grade	(Multiple IDs)	SSDIs required, if applicable, by site

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 beyond the field item length listed above, WCRS requests the software indicate the portion of the text that will be transmitted to the central registry.

Text Requirements

- **Age, sex, marital status, race and Spanish 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 Number	Item Name
220	Sex
560	Sequence Number
230	Age at Diagnosis
160-164	Race 1-5
190	Spanish/Hispanic Origin
150	Marital Status

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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name
490	Diagnostic Confirmation
400	Primary Site
410	Laterality
(Multiple IDs)	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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name
400	Primary Site
410	Laterality
522	Histology ICD-O3
764	SEER Summary Stage 2018
1112 - 1117	Mets at DX 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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name
522	Histologic Type ICD-O3
523	Behavior Code
440	Grade

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 beyond the field item length listed above, WCRS requests the software indicate 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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name
400	Primary Site
410	Laterality

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 beyond the field item length listed above, WCRS requests the software indicate the portion of the text that will be transmitted to the central registry.

Text Requirement

- **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 2018**
- 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 beyond the field item length listed above, WCRS requests the software indicate 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 Number	Item Name
764	SEER Summary Stage 2018
820	Regional Nodes Positive
830	Regional Nodes Examined
1112 - 1117	Mets at DX Fields

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.

TUMOR SIZE SUMMARY

Abstract Plus Field Name: Tumor Size Summary

Required
Item Length: 3
NAACCR Item #: 756
Standard Source: CoC

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.

Coding Instructions (See the *STORE* manual for specifics and examples.)

1. All measurements should be in millimeters (mm).
2. Record size in 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.

        Example: Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).

        Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).

    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.

        Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22 mm).

    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.

Coding Rules

1. Tumor size is the **diameter** of the tumor, not the depth or thickness of the tumor.
2. Recording less than/greater than:
    a. If tumor size is reported as less than x mm or x cm, the reported tumor size should be 1mm less. For example, if size is <10 mm, code size as 009. Often these are given in cm such as < 1 cm which is coded as 009, < 2 cm is coded as 019, < 3 cm is coded as 029, < 4 cm is coded as 039, < 5 cm is coded as 049. If stated as less than 1 mm, use code 001.

    b. If tumor size is reported as more than x mm or x cm, code size as 1mm more. For example, if size is > 10 mm, size should be coded as 011. Often these are given in cm such as > 1 cm, which is coded as 011, > 2 cm is coded as 021, > 3 cm is coded as 031, > 4 cm is coded as 041, > 5 cm is coded as 051. If described as anything greater than 989 mm (98.9 cm), code as 989.

    c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two (“between 2 and 3 cm” is coded as 025).

3. Rounding: Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 mm (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000). If tumor size is greater than 1 mm, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point one space to the right, converting the measurement to millimeters).

   Example 1: Breast cancer described as 6.5 mm in size. Round up tumor size as 007.
   Example 2: Cancer in polyp described as 2.3 mm in size. Round down tumor size as 002.
   Example 3: Focus of cancer described as 1.4 mm in size. Round down as 001.
   Example 4: 5.2 mm breast cancer. Round down to 5 mm and code as 005.

4. Priority of imaging/radiographic techniques: Information on size from imaging/radiographic 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.

5. Tumor size discrepancies among imaging and radiographic reports: If there is a difference in reported tumor size among imaging/radiographic techniques, record the largest, regardless of which imaging technique reports it, **unless** the physician specifies which imaging is most accurate.

6. Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

7. Record the size of the invasive component, if given.

   a. If both an in situ and an invasive component are present and the invasive component is measured record the size of the invasive component even if it is smaller.

      Example: Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014 (14 mm).

   b. If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

      Example 1: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).

      Example 2: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).

8. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

   Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).

9. Record the size as stated for purely in situ lesions.

10. Disregard microscopic residual or positive surgical margins when coding tumor size. Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data item.

11. Do not add the size of pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.

12. 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).
13. Tumor size code 999 is used when the size is unknown or not applicable. Site/morphologies where tumor size is not applicable are listed here:
    a. Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms – histology codes 9590-9992.
    b. Kaposi Sarcoma
    c. Melanoma choroid
    d. Melanoma ciliary Body
    e. Melanoma Iris
14. Document the information to support coded tumor size in the appropriate text data item of the abstract.

Tumor Size Summary Codes

Code	Description/Notes
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

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).

Code	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

Definitions

***Comprehensive, unified medical record*:** A hospital or managed health care system that maintains a single record for each patient. That record includes all encounters in affiliated locations.

***Stand-alone medical record*:** An independent facility; a facility that is not a part of a hospital or managed care system, or an independent medical record containing only information from encounters with that specific facility

Managed health plan *:* any facility where all of the diagnostic and treatment information is maintained in one unit record (all records for the patient from all departments, clinics, offices, etc. in a single file with the same medical record number). The abstractor is able to use the unit record when abstracting the case

Examples: HMOs or other health plan such as Kaiser, Veterans Administration, or military facilities

Physician office: A physician office performs examinations and tests. Physician offices may perform limited surgical procedures.

Note*:* The category "physician's office" also includes facilities that are called surgery centers when surgical procedures under general anesthesia cannot be performed in these facilities.

Surgery center: Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. The patient usually does not stay overnight

Note: If the facility cannot perform surgical procedures under general anesthesia, code as physician's office.

Coding Instructions

Priority Order for Assigning Type of Reporting Source

1. Code the source that provided the best information used to abstract the case.

   Example*:* The only patient record available for a physician office biopsy is the pathology report identified from a freestanding laboratory. Assign code 3 [Laboratory Only (hospital-affiliated or independent)]. Reporting source should reflect the lab where this case was identified. The MD office added nothing to the case, not even a confirmation of malignancy.

2. When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source: Codes: 1, 2, 8, 4, 3, 5, 6, 7.

   Note*:* Beginning with cases diagnosed 01/01/2006, the definitions for this field have been expanded. Codes 2 and 8 were added to identify outpatient sources that were previously grouped under code 1. Laboratory reports now have priority over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

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.

VENDOR NAME *(Should be defaulted by software)*

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.

Code	Description
0	Dead
1	Alive

Appendix I - WCRS Contacts

(Last Updated January 2020)

Jeff Bond
Data Manager
Phone: 608-266-0633
Email: jeffrey.bond@dhs.wisconsin.gov

Kim Ortman
Data Submission Coordinator/DCO Follow-Up/Web Plus Accounts
Phone: 608-267-0239
Email: kim.ortman@dhs.wisconsin.gov

Mireille Perzan
Epidemiologist/Data Requests
Phone: 608-267-6782
Email: mireille.perzan@dhs.wisconsin.gov

Nancy Sonnleitner, CTR
Education Trainer/Coordinator
Phone/Madison: 608-261-8388
Email: nancy.sonnleitner@dhs.wisconsin.gov

Jenna Staehler
Cancer Analytics Specialist & Software
Phone: 608-267-7264
Email: jenna.staehler@dhs.wisconsin.gov

Angela Whirry-Achten
Population Registries Unit Supervisor
Phone: 608-266-6781
Email: angela.whirryachten1@dhs.wisconsin.gov

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

Express Courier Address
Wisconsin Cancer Reporting System
1 W. Wilson Street, Room 118
Madison WI 53703

Web Plus Login URL: https://webplus.wisconsin.gov/logonen.aspx
WCRS Email Address: DHSWCRSdata@dhs.wisconsin.gov
WCRS Fax Number: 608-266-2431
WCRS Website: www.dhs.wisconsin.gov/wcrs/index.htm
Reporter Page : https://www.dhs.wisconsin.gov/wcrs/reporterinfo/index.htm

Appendix II - Laws Governing Wisconsin Cancer Reporting

Wisconsin Statues

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 presides 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 federal wide 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.—

(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 Reporting Procedures

Item	Hospital	Non-Hospital
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 Version18 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 mostly 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 hospital, 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, but the clinic provides chemotherapy, radiotherapy or any non-surgical cancer-directed therapy before or 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 notification via email or fax to WCRS when first initiated or changes are made.

Appendix IV - WCRS Reference Materials/Websites

Surveillance, Epidemiology, and End Results Program (SEER) Registry Operations

https://seer.cancer.gov/registrars/

- **SEER Program Coding and Staging Manual 2018**
  https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf
  This manual includes data item descriptions, codes, and coding instructions for cases diagnosed January 1, 2018 and forward as reported by SEER registries.
- **SEER Summary Stage 2018 Manual**
  https://seer.cancer.gov/tools/ssm/2018-Summary-Stage-Manual.pdf
  Use this manual to determine the summary stage for each reportable case.
- **Solid Tumor Rules**
  https://seer.cancer.gov/tools/solidtumor/STM_2018.pdf
  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.
- **Hematopoietic and Lymphoid Neoplasm Coding Manual**
  https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf
  Instructions and rules for determining the number of primaries, primary site, histology, and the cell lineage or phenotype.
- **Hematopoietic and Lymphoid Neoplasm Database**
  https://seer.cancer.gov/seertools/hemelymph/
  Use this site to assist in screening for reportable cases and determining reportability requirements. Site contains abstracting and coding information of all hematopoietic and lymphoid neoplasms (9590/3-9992/3).
- **SEER*Rx - Interactive Antineoplastic Drugs Database**
  http://www.seer.cancer.gov/seertools/seerrx/
  One-step lookup for coding oncology drug and regimen treatment categories.
- **Glossary for Registrars**
  https://seer.cancer.gov/seertools/glossary/
  Features definitions for terms used by cancer registrars. Includes information on where the term is uses, as well as any applicable alternative names, abstractor notes, histology and primary sites.
- **SEER*Educate**
  https://educate.fredhutch.org/LandingPage.aspx
  Free online training platform tailored specifically for cancer registry professionals to improve technical skills through applied testing on the latest coding guidelines and concepts
- **SEER Inquiry System (SINQ)**
  https://seer.cancer.gov/seerinquiry/index.php
  Site for a searchable collection of questions on coding cancer cases, specific to solid tumor rules (primary site and histology), hematopoietic cancers, SEER summary stage.
- **Ask a SEER Registrar**
  https://seer.cancer.gov/registrars/contact.html
  Site for members of cancer registrar community to submit questions about coding cancer cases or about the materials for registrars distributed through the SEER site. Use only if the question you want to ask was not already answered in SINQ.

North American Association of Central Cancer Registries
https://www.naaccr.org/data-standards-data-dictionary/

- **NAACCR Data Standards and Data Dictionary**
  https://www.naaccr.org/data-standards-data-dictionary/
  Click on Version 15 Data Standards and Data Dictionary document.
- **Grade Coding Instructions and Tables**
  https://www.naaccr.org/SSDI/Grade-Manual.pdf
  Primary resource for documentation and coding instructions for Grade.
- **Site-Specific Data Item (SSDI) Manual**
  https://www.naaccr.org/SSDI/SSDI-Manual.pdf
  Primary resource for documentation and coding instructions for site-specific data items introduced in 2018.
- **Recommended Abbreviations for Abstractors to Use in Text Fields**
  http://datadictionary.naaccr.org/?c=17
  Consist of two main lists of about 600 word/terms and their recommended abbreviations/symbols, as well as a special table of context-sensitive abbreviations.

Other Resources

- **Site-Specific Surgery Codes**
  https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx
  From this site, scroll down the left column and select Appendix B – site-specific surgery codes.
- **Standards for Oncology Registry Entry (STORE)**
  https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx
  Commission on Cancer, National Cancer Database Data Standards
- **2018 ICD-O-3 Coding Guidelines and Coding Tables**
  https://www.naaccr.org/implementation-guidelines/#ICDO3
  Address implementation of updated histology terms and codes for cases diagnosed on or after January 1, 2018.
- **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.
- **CAnswer Forum**
  http://cancerbulletin.facs.org/forums/
  Site for a searchable collection of questions on coding cancer cases, specific to AJCC TNM staging, grade and SSDIs. New questions can be submitted on this site.

Staging Manuals for AJCC-TNM for 2018 diagnoses (not required by WCRS)

- **AJCC Cancer Staging Manual, 8th Edition Hardcover**
  https://www.springer.com/us/book/9783319406176
- **AJCC Cancer Staging Manual, 8th Edition Kindle Edition**
  https://www.amazon.com/AJCC-Cancer-Staging-Manual-Eighth-ebook/dp/B07H53RZ3S/

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 to White, 01, if one of these descriptions is in the chart and 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*

Code to White, 01, if one of these descriptions is in the chart and no other race information is available		
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 and 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 and no other race information is available	
Alaska Native	Eskimo
Central American Indian	Native American
Mexican American Indian	American Indian
Spanish American Indian	Meso American Indian
Aleut	South American Indian

Specific Asian Codes

Definition	Race Code	Definition	Race Code
Amerasian	96	Kampuchean	13
Asian Indian NOS	15	Korean	08
Asian	96	Laotian	11
Asiatic	96	Maldivian	96
Bangladeshi	96	Madagascar	96
Bhutanese	96	Malaysian	96
Bornean	96	Mongolian	96
Bruneian	96	Montagnard	96
Burmese	96	Nepalese	96
Cambodian	13	Okinawan	05
Celebesian	96	Oriental	96
Ceram	96	Other Asian	96
Ceylonese	96	Pakistani	17
Chinese	04	Sikkimese	96
Eurasian	96	Singaporean	96
Filipino	06	Sri Lankan	96
Hmong	12	Sumatran	96
Indian (from India)	16	Taiwanese	04
Indo-Chinese	96	Thai	14
Indonesian	96	Tibetan	96
Iwo Jiman	05	Vietnamese	10
Japanese	05	Whello	96
Javanese	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
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

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)

Indian Tribes of the United States, Canada and Mexico (Race Code 03)		
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

Indian Tribes of the United States, Canada and Mexico (Race Code 03)		
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

Indian Tribes of the United States, Canada and Mexico (Race Code 03)		
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	

Source: National Center for Health Statistics: Appendix C, *Instruction Manual, part 4: Classification and Coding Instructions for Death Records, 1999-2001*.

NAACCR Ethnicity Description and Codes

Code	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 – 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	Submit all reportable cases to the central registry, regardless of the type of diagnostic confirmation. Due to the requirement for rapid reporting, report cases 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(s)	Collect From Facilities	Comment
Record Type	10	Required	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 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.
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*	

Item Name	NAACCR Item(s)	Collect From Facilities	Comment
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	
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.