

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 (<i>starts on page 439</i>) | https://www.facs.org/~media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx |
| NAACCR | |
| Site-specific Data Items | https://www.naacr.org/SSDI/SSDI-Manual.pdf?v=1552396699 |
| Grade | https://www.naacr.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 | <i>Will be defaulted for Abstract Plus users</i> |
| 90 | County at DX Reported | |
| 2090 | Date Case Completed | <i>Should be defaulted by software</i> |
| 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 | <i>Should be defaulted by software</i> |
| 480 | Morph Coding Sys--Original | <i>Should be defaulted by software</i> |
| 50 | NAACCR Record Version | <i>Should be defaulted by software</i> |
| 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 | <i>Should be defaulted by software</i> |
| 2070 | Over-ride Leuk, Lymphoma | |
| 2078 | Over-ride Name/Sex | |
| 2071 | Over-ride Site/Behavior | |
| 2073 | Over-ride Site/Lat/EOD | <i>Used in a couple of CS extension edits</i> |
| 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 | <i>Should be defaulted by software</i> |
| 180 | Race Coding System--Original | <i>Should be defaulted by software</i> |
| 1430 | Reason for No Radiation | |
| 1340 | Reason for No Surgery | |
| 10 | Record Type | <i>Should be defaulted by software</i> |
| 830 | Regional Nodes Examined | |
| 820 | Regional Nodes Positive | |
| 540 | Reporting Facility | |
| 1460 | RX Coding System--Current | <i>Should be defaulted by software</i> |
| 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 | <i>Should be defaulted by software</i> |
| 460 | Site Coding Sys--Original | <i>Should be defaulted by software</i> |
| 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 | <i>Should be defaulted by software</i> |
| 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 <i>in situ</i> ; 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 <i>Diagnosed and or received first course treatment at your facility. Initial Diagnosis at Reporting Facility.</i> | |
| 00 | Diagnosis at the reporting facility and all <i>first course</i> 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 <i>first course</i> 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 <i>Initial Diagnosis at a Staff Physician Office.</i> | |
| 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 <i>Initial Diagnosis Elsewhere.</i> | |
| 20 | Diagnosis elsewhere and ALL OR PART of the <i>first course</i> 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 <i>Diagnosis and first course treatment done elsewhere. Patient appears in person at reporting facility.</i> | |
|--|---|
| 30 | Diagnosis and all <i>first course</i> 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 <i>first course</i> 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 <i>Patient does not appear in person at reporting facility.</i> | |
| 40 | Diagnosis and all <i>first course</i> 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 | LAFI | 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 1 st 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 recognized medical practitioner says that, in **retrospect**, the patient had cancer at an earlier date.
 - 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) <i>Effective for cases diagnosed 01/01/2010 and later.</i> |
| 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.naacr.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 CodingSee 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 CodingSee 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 CodingSee 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 CodingSee 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 CodingSee 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 <i>in utero</i> |
| 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 " <i>in situ</i> " 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 " <i>in situ</i> ," 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 \geq 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](https://seer.cancer.gov/manuals/2018/SPCSM_2018_AppendixB.pdf) 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](https://seer.cancer.gov/manuals/2018/SPCSM_2018_AppendixB.pdf) 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-O-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 *International 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-O-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 | Chamorroan |
| 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 RADIATION**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 | Incidence-only record type (non-confidential coded data) Length = 4,048 |
| C | Confidential 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 ppdate 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 <i>ROADS Manual</i> |
| 04 | Treatment data coded according to 1998 <i>ROADS Supplement</i> |
| 05 | Treatment data coded according to 1998 <i>SEER Manual</i> |
| 06 | Treatment data coded according to <i>FORDS manual</i> |
| 07 | Treatment data coded according to 2010 SEER Coding Manual |
| 08 | Treatment data coded according to <i>STORE Manual</i> and <i>2018 SEER Coding Manual</i> |
| 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/Erbix | 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/Erbix | 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
- *Nitrosoureas:* 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 **regional** 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.

| <i>In situ</i> 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 | <i>In situ</i> and Malignant |
| 00 | One <i>in situ</i> (behavior code 2) or malignant (code 3) primary tumor only in the patient's lifetime |
| 01 | First of multiple <i>in situ</i> or malignant primary tumors in the patient's lifetime |
| 02-59 | Actual sequence of two or more <i>in situ</i> or malignant primary tumors |
| 99 | Unspecified <i>in situ</i> 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 natively male or transsexuals with primary site of C600-C639
5. Assign code **6** for transsexuals who are natively 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.

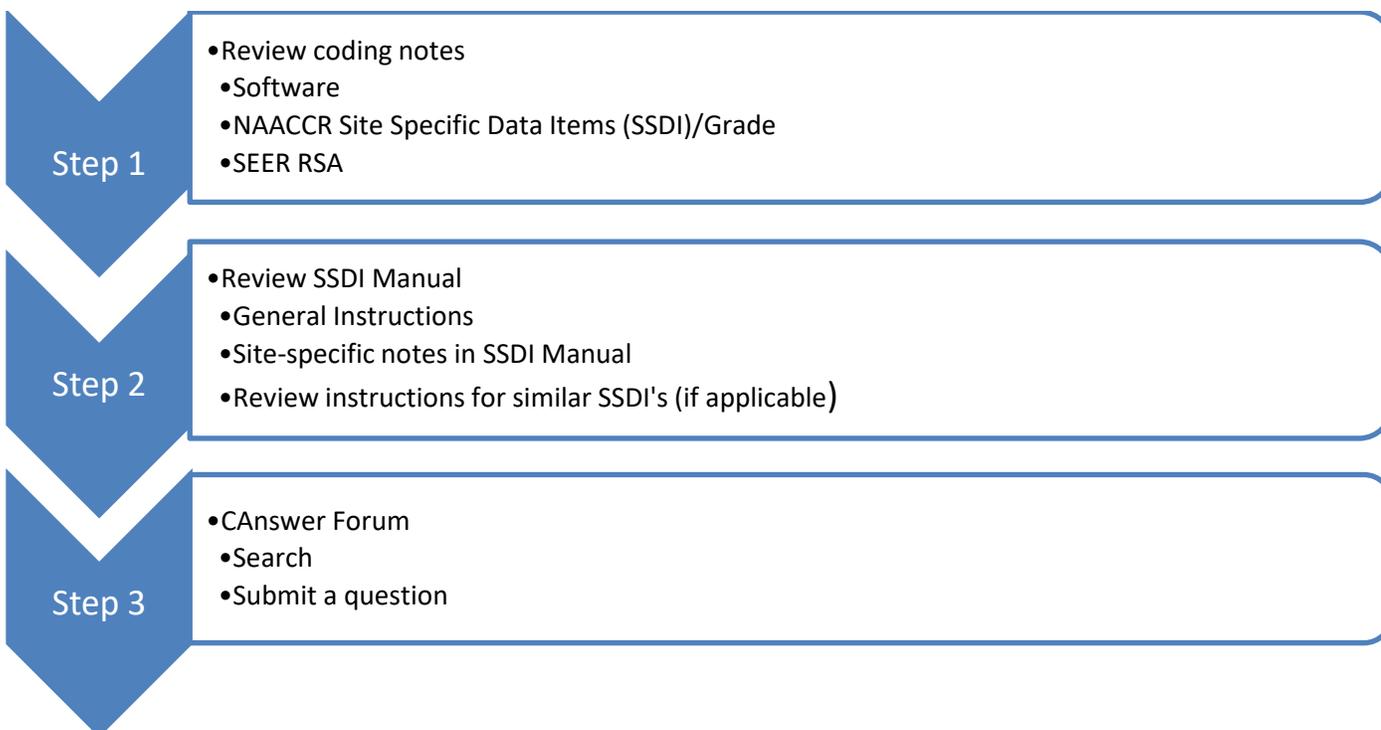
| Code | Description |
|------|--|
| 0 | Non-Spanish; non-Hispanic |
| 1 | Mexican (includes Chicano) |
| 2 | Puerto Rican |
| 3 | Cuban |
| 4 | South or Central American (except Brazil) |
| 5 | Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic) |
| 6 | Spanish, 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 MOLECULAR 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. Used most commonly by US pathologists

METAVIR: uses scores of F0-F4. 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 CLINICAL
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.naacccr.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 hypertrophy | 18.6 | Record the adjusted PSA value only if documented by the clinician 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

- Physician statement of prostatic specific antigen (PSA) pre-diagnosis can be used to code this data item when no other information is available.
- PSA is a prognostic factor required for AJCC staging. It affects the stage group in most cases.
- 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 |

- 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.naacr.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

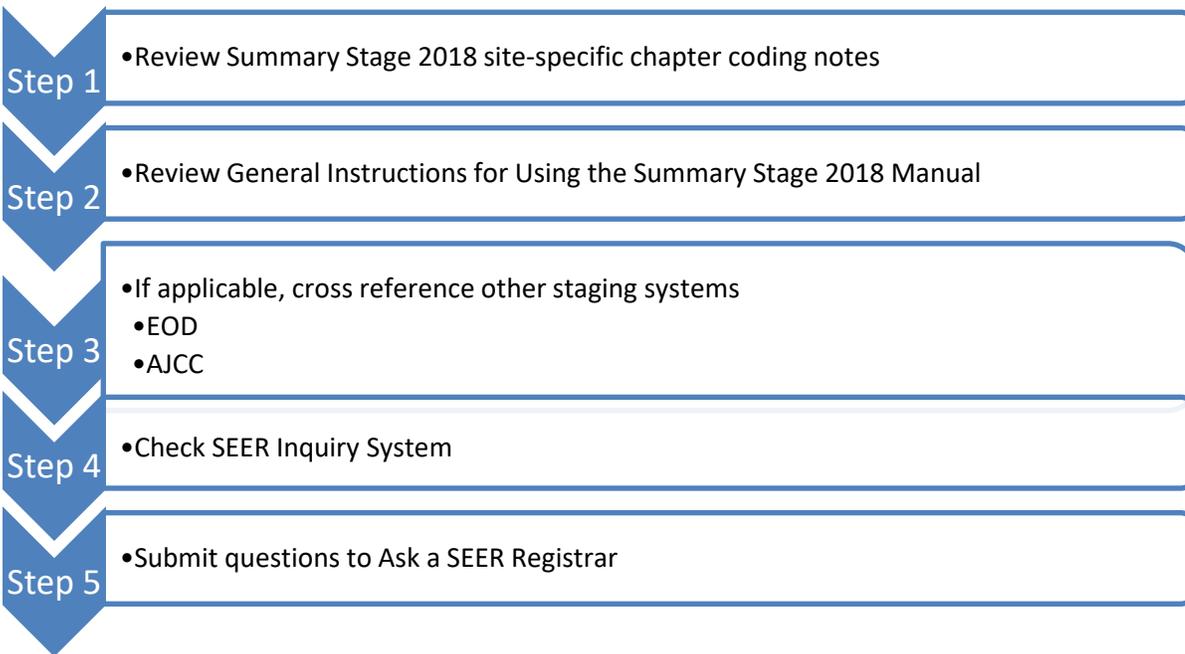
Description

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 | <i>In situ</i> |
| 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: <i>Code 8 should only be used for benign/borderline brain or other CNS.</i> |
| 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/seer inquiry/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 diagnosed 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:
- Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms – histology codes 9590-9992.
 - Kaposi Sarcoma
 - Melanoma choroid
 - Melanoma ciliary Body
 - 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 | <p>Site-Specific Codes Alternate descriptions of tumor size for specific sites:</p> <p>Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9)</p> <p>If no size is documented: Circumferential: Esophagus (C15.0 C15.5, C15.8 C15.9)</p> <p>Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9)</p> <p>Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9)</p> <p>Diffuse: Breast (C50.0 C50.6, C50.8 C50.9)</p> |
| 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 |