

Chapter 3

GENERAL INSTRUCTIONS

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

Important Items to Remember

- The Collaborative Staging Manual must be used to derive stage for cases diagnosed on or after January 1, 2004, through December 31, 2015; Version 2.05 is required for all cases.
- The SEER Summary Staging Manual 2000 must be used to assign the summary stage for all cases diagnosed from January 1, 2001, forward.
- The AJCC Cancer Staging Manual, 7th edition, must be used to assign TNM stage for all eligible cases diagnosed in 2015 for Commission on Cancer accredited facilities. It is recommended for all other reporting facilities for 2015 diagnoses. (Beginning with 2016 diagnoses, TNM staging will be required for all reporting facilities.)
- Completed cases should be submitted to WCRS within six months of date of diagnosis, or date of initial contact if diagnosed elsewhere.
- Electronic reporting is currently required for all hospitals. WCRS will provide free data entry software and data submission software upon request.
- **Hospitals:** All cancer cases diagnosed and/or treated for cancer in your facility after December 31, 1975, must be abstracted and reported to WCRS.
- **Clinics:** All cancer patients receiving cancer-directed treatment in your facility after December 31, 1991, must be abstracted and reported to WCRS.
- **Early Case Capture (ECC) of Pediatric and Young Adult Cancers:** All reportable ECC data items for cancers diagnosed among children and young adults ages 0-19 are required to be submitted to WCRS within 30 days from the date of diagnosis, using one of the three ECC submission options.

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

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

1. Collaborative Stage Manual Version 2.05
<https://cancerstaging.org/cstage/coding/Pages/Version-02.05.aspx>
Use the general instructions (Part I) and site-specific coding (Part II).
2. SEER Summary Stage 2000 Manual
<http://seer.cancer.gov/tools/ssm/SSSM2000-122012.pdf>
Use this manual to determine the summary stage for each reportable case. If you still have a red-cover SEER hard copy, it is outdated. Please download the updated reference from this website.
3. AJCC Cancer Staging Manual, 7th Edition
<http://www.springer.com/us/book/9780387884400>
This manual is required to complete TNM staging for 2015 diagnoses.
4. SEER Multiple Primary and Histology Coding Rules
<http://www.seer.cancer.gov/tools/mphrules/download.html>
Scroll to ‘Complete Manual’ – Download the complete manual with the latest updates. Use this manual to determine the number of reports needed to complete each case.
5. Hematopoietic Multiple Primary and Histology Coding Rules Website
<http://seer.cancer.gov/seertools/hemelymph/>
Use this site to determine the multiple primary status and correct histology and grade for all hematopoietic reportable diseases.
6. Data Collection of Primary Central Nervous System Tumors
<http://www.cdc.gov/cancer/npcr/pdf/btr/braintumorguide.pdf>
Use this manual to learn more about benign brain and CNS tumors (reportable to WCRS beginning January 1, 2004).
7. Site-Specific Surgery Codes
<https://www.facs.org/~media/files/quality%20programs/cancer/ncdb/fords%202016.ashx>
From this site, scroll down the left column and select Appendix B – site-specific surgery codes.
8. International Classification of Diseases for Oncology, 3rd Edition (ICD-O3)
<http://codes.iarc.fr/>
This is the definitive classification of neoplasms and is used to describe the topography, morphology, malignant behavior and grade of all neoplasms.

Please note: All of the above tools (except the AJCC Cancer Staging Manual and ICD-O3 Manual) are available in the Registry Plus Online Help tool (included in the WCRS Abstract Plus software) which can also be downloaded at no cost from:

http://www.cdc.gov/cancer/npcr/tools/registryplus/rpoh_tech_info.htm

General Coding Instructions for Place of Residence at Diagnosis

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

Coding Priorities/Sources

1. Code the **street address** of usual residence as stated by the patient. Definition: *U.S. Census Bureau Instructions*: “The place where he or she lives and sleeps most of the time or the place the person says is his or her usual home.”
2. **Post Office Box** is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographic information for analyzing cancer incidence. Use the post office box address **only if** no street address information is available after follow-back.
3. Use residency information from a death certificate **only when** residency from other sources is coded as unknown. Review each case carefully and apply the U.S. Census Bureau rules for determining residence. The death certificate may give the person’s previous home address rather than the nursing home address as the place of residence; use the nursing home address as the place of residence.
4. Do NOT use **legal status** or **citizenship** to code residence.

Persons with More than One Residence

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

- a. Code the residence where the patient spends the majority of time (usual residence).
- b. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

Persons with No Usual Residence

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

Temporary Residents of the Wisconsin Area

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

- a. Migrant workers
 - b. Educators temporarily assigned to a university in the Wisconsin area
 - c. Persons temporarily residing with family during cancer treatment
 - d. Military personnel on temporary duty assignments (TDY)
 - e. Boarding school students below college level (code the parent's residence)
2. Code the residence where the student is living while he/she is attending college.
 3. Code the address of the institution for Persons in Institutions. *U.S. Census Bureau definition:* "Persons under formally authorized, supervised care or custody are residents of the institution."
 - a. Persons who are incarcerated
 - b. Persons who are physically handicapped, mentally retarded, or mentally ill who are residents of homes, schools, hospitals or wards
 - c. Residents of nursing, convalescent, and rest homes
 - d. Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

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

1. **Armed Forces:** For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.
2. **Personnel Assigned to Navy, Coast Guard, and Maritime Ships:** The U.S. Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and homeport. Refer to U.S. Census Bureau Publications for detailed rules: <http://www.census.gov>

General Coding Instructions for Reporting Race

1. Code the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. The five race fields allow for the coding of multiple races consistent with the U.S. 2000 Census. In Wisconsin, only about 1% of the population is multiracial. Most of the time you will only code one race field for the patient (in the Race 1 field). When there is only one race to be coded, then the Race 2-5 fields will be coded to '88' (meaning no other races listed). For cases diagnosed/reported after January 1, 2000, **all race fields must be coded (using '88's in the 'extra' race fields)**.
2. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white in the next race field.
3. If the person's race is a combination of more than one non-white race, code Race 1 to the first stated non-white race (02-98), Race 2 to the second, etc.

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

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

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

5. The fields Place of Birth, Race, Marital Status, Last Name, Maiden Name, and Hispanic Origin are inter-related. Use the following guidelines in priority order:
 - a. Code the patient's stated race, if possible. Refer to Appendix VI, "Race and Nationality Descriptions from the 2000 Census and National Center for Health Statistics," for guidance.

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

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

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

Exception: When the race is recorded as Oriental, Mongolian, or Asian (coded to 96 Other Asian) and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on **birthplace** information.

- Example 1:** The person's race is recorded as Asian and the place of birth is recorded as Japan. Code Race 1 as '05' Japanese because it is more specific than '96' Asian, NOS (Not Otherwise Specified), and Race 2-5 as '88.'
- Example 2:** The person describes himself as an Asian-American born in Laos. Code Race 1 as '11' Laotian because it is more specific than '96' Asian, NOS, and Race 2-5 as '88.'
6. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to list the non-white race(s) first.
- Example:** The patient is described as Asian-American with Korean parents. Code Race 1 as '08' Korean because it is more specific than '96' Asian, NOS, and Race 2-5 as '88.'
7. If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of a race category.
- Example 1:** Patient described as a black female. Code Race 1 as '02' Black and Race 2-5 as '88.'
- Example 2:** Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code Race 1 as '02' Black and Race 2-5 as '88.'
- Example 3:** Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as '25' Polynesian, Race 2 as '26' Tahitian, and Race 3-5 as '88.'
8. If race is unknown or not stated in the medical record and birthplace is recorded, in some cases race may be inferred from the nationality. Refer to Appendix VI to identify nationalities from which race codes may be inferred.
- Example 1:** Record states: "this native of Portugal..." Code Race 1 as '01,' White per Appendix VI.
- Example 2:** Record states: "this patient was Nigerian..." Code Race 1 as '02,' Black per Appendix VI.
- Exception:** If the patient's name is incongruous with the race inferred on the basis of nationality, code Race 1 through Race 5 as '99,' Unknown.
- Example 1:** Patient's name is Siddhartha Rao and birthplace is listed as England. Code Race 1-5 as '99,' Unknown.

Example 2: Patient's name is Ping Chen and birthplace is Ethiopia. Code Race 1 through Race 5 as '99,' Unknown.

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

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

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

- A patient name may be used to infer Spanish ethnicity or place of birth, but a Spanish name alone (without a statement about race or place of birth) cannot be used to determine the race code. Refer to ethnicity guidelines for further information.

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

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

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

11. When the race is recorded as Negro or African-American, code Race 1 as '02,' Black, and Race 2-5 as '88.'
12. Code '03' should be used for any person stated to be Native American or [Western Hemisphere] Indian, whether from North, Central, South, or Latin America. For Central, South, or Latin American Indians, refer to the additional ethnicity coding guidelines under Spanish Surname or Origin.
13. Death certificate information may be used to supplement ante-mortem race information only when race is coded 'unknown' in the patient record, or when the death certificate information is more specific.

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

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

General Coding Instructions for Reporting Ethnicity

1. Coding Spanish Surname or Origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
2. Portuguese, Brazilians and Filipinos are not Spanish; code non-Spanish (code '0').
3. All information should be used to determine the Spanish/Hispanic Origin, including the stated ethnicity in the medical record, stated Hispanic origin on the death certificate, birthplace, information about life history and/or language spoken found in the abstracting process, and a last name and maiden name found on a list of Hispanic/Spanish names. Assign code '7' when the only evidence of the patient's Hispanic origin is a surname or maiden name and there is no evidence that the patient is not Hispanic. If the origin is not stated in the medical record and the hospital registry does not have a list of Hispanic surnames, assign code '9,' "Unknown whether Spanish/Hispanic or not."

General Coding Rules for Reporting Neoplasm Behavior

1. The behavior of a neoplasm describes the level of malignancy of the tumor.
2. Behavior codes 0 (benign) and 1 (borderline) are reportable for intracranial and CNS sites only, beginning with January 1, 2004, diagnoses.
3. *In situ* noninvasive tumors (code 2): Clinical evidence alone cannot identify the behavior as *in situ* (/2); the code must be based on pathologic examination and documentation.
4. *In situ* and Invasive (code 3) components in the same tumor: Code the behavior as invasive malignant (/3) if any portion of the primary tumor is invasive no matter how limited; i.e., microinvasion.

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

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

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

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

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

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

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

General Coding Instructions for Reporting Grade

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

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

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

Coding Grade for Hematopoietic and Lymphoid Neoplasms

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

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

Important note: for lymphomas, do not code the descriptions ‘high grade,’ ‘low grade,’ or ‘intermediate grade’ in the Grade or Differentiation field. They refer to categories in the Working Formulation of lymphoma diagnoses and do NOT refer to the histologic grade collected by WCRS. Refer to the SEER Hematopoietic manual for the correct grade assignment.

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

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

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

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

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

Pathologists describe the tumor grade using three systems or formats:

- a. Two levels of similarity; also called a two-grade system.
- b. Three levels of similarity; also called a three-grade system.
 - Grade I, well
 - Grade II, moderately
 - Grade III, poorly
- c. Four levels of similarity; also called a four-grade system. The four-grade system describes the tumor as
 - Grade I; also called well-differentiated
 - Grade II; also called moderately differentiated
 - Grade III; also called poorly differentiated
 - Grade IV; also called undifferentiated or anaplastic

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

General Rules for Solid Tumors

1. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code grade based on information **prior to neoadjuvant therapy** even if grade is unknown.
2. Code the grade from the primary tumor only.
 - a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.
 - b. If primary site is unknown, code grade to 9.
3. Code the grade shown below (6th digit) for specific histologic terms that imply a grade.
 - Carcinoma, undifferentiated (8020/34)
 - Carcinoma, anaplastic (8021/34)
 - Follicular adenocarcinoma, well differentiated (8331/31)
 - Thymic carcinoma, well differentiated (8585/31)

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

4. *In situ* and/or combined *in situ*/invasive components:
 - a. If a grade is given for an *in situ* tumor, code it. Do NOT code grade for dysplasia such as high-grade dysplasia.
 - b. If there are both *in situ* and invasive components, code only the grade for the invasive portion, no matter how small the invasive component is, **even if its grade is unknown**.
5. If there is more than one grade, code the highest grade within the applicable system. Code the highest grade even if it is only a focus. Code grade in the following priority order using the first applicable system:
 - a. Special grade systems for the sites listed in rule number 6.
 - b. Differentiation: use rule number 7 (the 2-, 3-, or 4- grade system).
 - c. Nuclear grade: use rule number 7 (the 2-, 3-, or 4- grade system).
 - d. If it isn't clear whether the grade was based on cell differentiation or nuclear grade AND a 2-, 3-, or 4- grade system was used, code the grade as listed.
 - e. Terminology: use rule number 8.
6. Use the information from the special grade systems first. If no special grade can be coded, continue with rules 7-9.

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

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

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

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

a. Two-grade system

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

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

b. Three-grade system

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

c. Four-grade system

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

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

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

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

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

Special Grade Rules for Breast – Bloom Richardson, Nottingham Score

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

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

Code the tumor grade using the following priority order

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

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

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

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

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

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

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

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

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

Special Grade Rules for Kidney Parenchyma – Fuhrman Nuclear Grade

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

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

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

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

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

Special Grade Rules for Soft Tissue Sarcoma

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

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

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

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

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

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

Special Grade Rules for Prostate

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

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

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

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

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

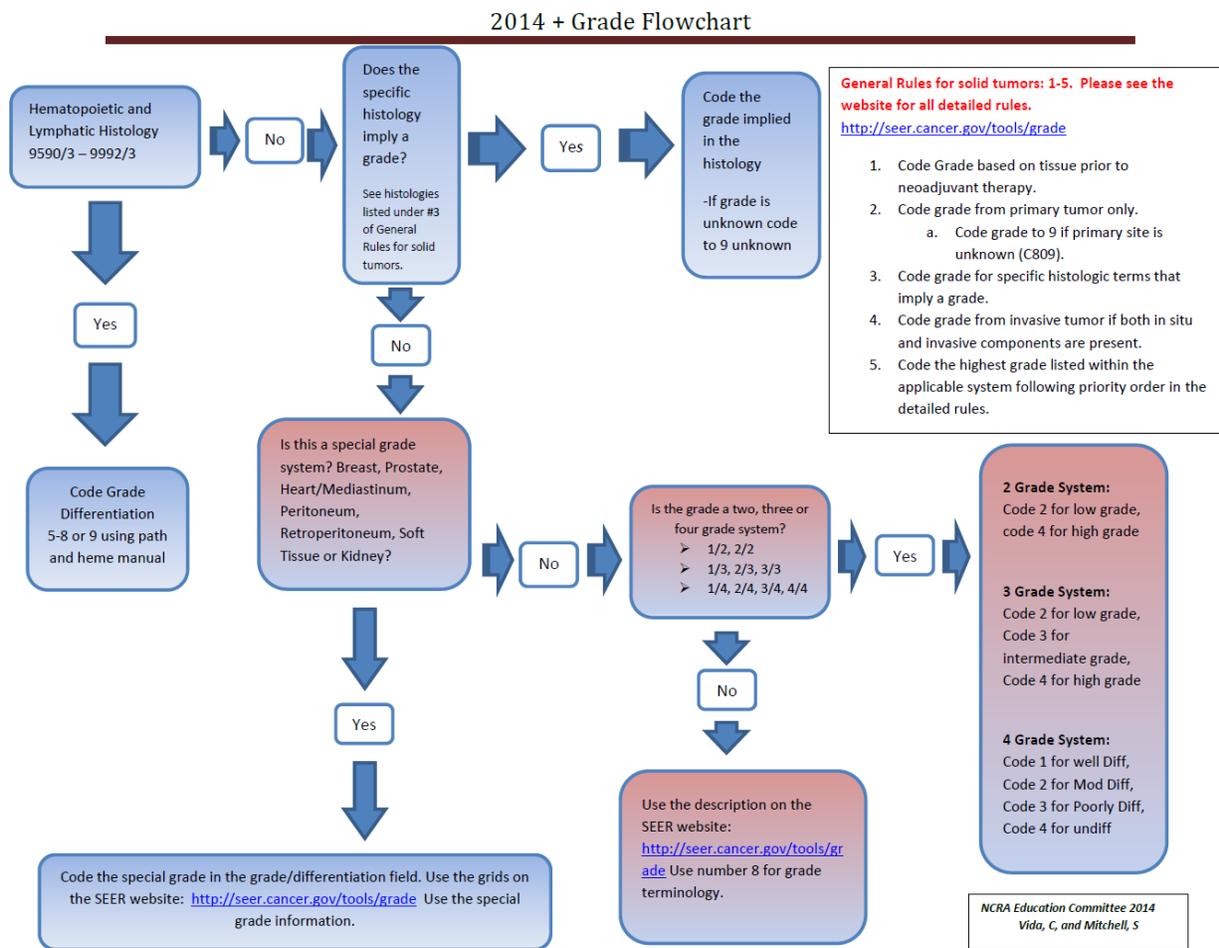
Gleason Score	Differentiation/Nuclear Grade-- 2-, 3- or 4-Grade System Info	Grade Terminology/Descriptions	GRADE CODES:
2,3,4	1/2, 1 of 2; 1/3, 1 of 3; 1/4, 1 of 4	<i>Only stated as Grade I;</i> Low Grade, Grade I-II; Well differentiated, Differentiated NOS, Partially well differentiated	1
5,6			1
7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

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

Grade Flowchart

This flowchart can also be downloaded from the following website:

http://www.cancerregistryeducation.org/Files/Org/f3f3d382a7a242549a9999654105a63b/site/2014_Grade_Flow_Chart.pdf



Changing Information Already Reported to WCRS

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

1. Do not submit changes as a regular new report.
2. Changes to specific reporting fields below should be submitted to WCRS.
 - a. Last name
 - b. First name
 - c. Middle name
 - d. Maiden name
 - e. Address at diagnosis; includes city, county, state and zip code
 - f. Race
 - g. Spanish/Hispanic origin
 - h. Sex
 - i. Birthdate
 - j. Social Security number
 - k. Date of diagnosis
 - l. Primary site
 - m. Morphology type, behavior and grade
 - n. Laterality
 - o. Diagnostic confirmation
 - p. Collaborative Stage (all required fields)
 - q. Type and date of first course definitive treatment
3. Submissions will be accepted in two formats: faxing the change to 608-266-2431 or using the 'M' NAACCR record layout. (Contact your vendor for specific instructions on submitting these changes if using the M layout.)

Paper Abstracts

WCRS urges facilities to meet the electronic reporting requirement and discontinue the practice of abstracting on paper. Paper reports should only be completed when electronic reporting options are not working properly at the reporting facility. A copy of the official reporting form is available from the WCRS website. If it's necessary to use paper, the abstracts should be faxed to WCRS or submitted in a well-sealed envelope, marked "CONFIDENTIAL" and mailed to:

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

Electronic Data Transmissions

Electronic data must be sent using the NAACCR Version 15 layout (see Appendix VI for a complete list of required data items). Data must be sent using Web Plus software. Contact WCRS to obtain a Web Plus account number for secure data submission.

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

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

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