

# Chapter 5

## DATA DICTIONARY

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

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

**Field name**

**Field name** as listed in the **Abstract Plus Version 3.6** software display screen

**Item length** (for electronic submission)

**NAACCR Item Number Version 16 Layout**

**Description**

**Codes** (if applicable)

**Allowable Values**

**Rationale** (if applicable)

**Definition** (if necessary)

**ABSTRACTED BY****Abstract Plus Field Name: Abstracted By****Required  
Item Length: 3  
NAACCR Item #: 570****Description**

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

**Allowable Values**

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

**ACCESSION NUMBER****Abstract Plus Field Name:** Accession Number**Required**  
**Item Length: 9**  
**NAACCR Item #: 550****Description**

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

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

**Rationale**

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

**Allowable values**

Numeric only.

**ADDRESS AT DIAGNOSIS -- CITY****Abstract Field Name:** City at DX**Required**  
**Item Length: 50**  
**NAACCR Item #: 70****Description**

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

**Allowable Values**

Alpha characters and spaces only.

**Codes**

(in addition to valid city)

UNKNOWN. Patient's city is unknown.

**ADDRESS at DIAGNOSIS – Number & Street****Abstract Plus Field Name:** Street Address at DX**Required  
Item Length: 60  
NAACCR Item #: 2330****Description**

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

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

**Rationale**

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

**Allowable Values**

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

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

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

**Codes (in addition to valid street address)**

UNKNOWN Patient's number and street address is unknown

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

**ADDRESS AT DIAGNOSIS – POSTAL CODE**

**Abstract Plus Field Name:** Zip Code at DX

**Required  
Item Length: 9  
NAACCR Item #: 100**

**Description**

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

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

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

When available, enter the postal code for other countries.

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

**ADDRESS AT DIAGNOSIS - STATE****Abstract Plus Field Name:** State at DX**Required  
Item Length: 2  
NAACCR Item #: 80****Description**

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

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

**ADDRESS AT DIAGNOSIS – SUPPLEMENTAL****Abstract Plus Field Name:** Supplemental Address**Required  
Item Length: 60  
NAACCR Item #: 2335****Description**

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

**Rationale**

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

**Allowable values**

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

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

**AGE AT DIAGNOSIS****Abstract Plus Field Name:** Age at Diagnosis**Required  
Item Length: 3  
NAACCR Item #: 230****Description**

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

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

**Notes:**

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

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

**BEHAVIOR CODE -- ICD-O3****Abstract Plus Field Name:** Behavior**Required  
Item Length: 1  
NAACCR Item #: 523**

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

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

<b>Codes</b>	<b>Description</b>
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-STATE****Abstract Plus Field Name:** Birthplace-State**Required  
Item Length: 2  
NAACCR Item #: 252****Description**

State of birth of the patient.

**Description**

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

**Rationale**

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

**Allowable Values**

Alpha-only

**Codes**

See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes at [http://seer.cancer.gov/manuals/2015/SPCSM\\_2015\\_AppendixB.pdf](http://seer.cancer.gov/manuals/2015/SPCSM_2015_AppendixB.pdf)

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

**BIRTHPLACE-COUNTRY****Abstract Plus Field Name:** Birthplace-Country**Required  
Item Length: 3  
NAACCR Item #: 254****Description**

Patient's country of birth.

**Description**

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

**Rationale**

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

**Allowable Values**

Alpha-only

**Codes**

See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes at [http://seer.cancer.gov/manuals/2015/SPCSM\\_2015\\_AppendixB.pdf](http://seer.cancer.gov/manuals/2015/SPCSM_2015_AppendixB.pdf)

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

## CASEFINDING SOURCE

**Abstract Plus Field Name:** Casefinding Source

**Required  
Item Length: 2  
NAACCR Item #: 501**

**Description**

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

**Rationale**

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

**Coding Instructions**

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

Codes	Description
10	Reporting Hospital, NOS
20	Pathology Department Review (surgical pathology reports, autopsies, or cytology reports)
21	Daily Discharge Review (daily screening of charts of discharged patients in the medical records department)
22	Disease Index Review (review of disease index in the medical records department)
23	Radiation Therapy Department/Center
24	Laboratory Reports (other than pathology reports, code 20)
25	Outpatient Chemotherapy
26	Diagnostic Imaging/Radiology (other than radiation therapy, codes 23; includes nuclear medicine)
27	Tumor Board
28	Hospital Rehabilitation Service or Clinic
29	Other Hospital Source (including clinic, NOS or outpatient department, NOS)
30	Physician-Initiated Case
40	Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
50	Independent (non-hospital) Pathology-Laboratory Report
60	Nursing Home-Initiated Case
70	Coroner's Office Records Review
75	Managed Care Organization (MCO) or Insurance Records
80	Death Certificate (case identified through death clearance)
85	Out-of-State Case Sharing
90	Other Non-Reporting Hospital Source
95	Quality Control Review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
99	Unknown

**CAUSE OF DEATH****Abstract Plus Field Name:** Cause of Death**Required  
Item Length: 4  
NAACCR Item #: 1910****Description**

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

**Rationale**

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

**Coding Instructions**

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

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

## CLASS OF CASE

**Abstract Plus Field Name:** Class of Case

**Required  
Item Length: 2  
NAACCR Item #: 610**

**Description**

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

**Rationale**

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

<b>Codes</b>	<b>Description</b>
	<b>Analytic cases (diagnosed and or received first course treatment at your facility) Initial Diagnosis at the Reporting Facility</b>
00	Diagnosis at the reporting facility and all of the <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.
	<b>Analytic cases - Initial Diagnosis at a Staff Physician Office</b>
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.
	<b>Analytic cases - Initial Diagnosis Elsewhere</b>
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.

	<b>Nonanalytic cases (Diagnosis and first course treatment done elsewhere) Patient appears in person at reporting facility</b>
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.
	<b>Nonanalytic cases – Patient does NOT appear in person at reporting facility</b>
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.

**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.

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

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

**CS EXTENSION****Abstract Plus Field Name:** CS Extension**Required for 2004-2015 Diagnosed Cases****Item Length: 3****NAACCR Item #: 2810****Description**

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

**Rationale**

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

**Codes**

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

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

**CS LYMPH NODES****Abstract Plus Field Name:** CS Lymph Nodes**Required for 2004-2015 Diagnosed Cases**  
**Item Length: 3**  
**NAACCR Item #: 2830****Description**

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

**Rationale**

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

**Codes**

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

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

**CS LYMPH NODES EVALUATION****Abstract Plus Field Name:** CS Lymph Nodes Eval**Required for 2004-2015 Diagnosed Cases****Item Length: 1****NAACCR Item #: 2840****Description**

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

**Rationale**

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

**Codes**

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

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

**CS METASTASES AT DIAGNOSIS****Abstract Plus Field Name:** CS Mets at DX**Required for 2004-2015 Diagnosed Cases**  
**Item Length: 2**  
**NAACCR Item #: 2850****Description**

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

**Rationale**

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

**Codes**

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

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

**CS METS AT DIAGNOSIS - BONE**

**Abstract Plus Field Name:** CS Mets at DX—Bone

**Required for 2004-2015 Diagnosed Cases**

**Item Length: 1**

**NAACCR Item #: 2851**

**Description**

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

**Rationale**

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

**Codes**

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

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

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

**CS METS AT DIAGNOSIS - BRAIN****Abstract Plus Field Name:** CS Mets at DX—Brain**Required for 2004-2015 Diagnosed Cases**  
**Item Length: 1**  
**NAACCR Item #: 2852****Description**

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

**Rationale**

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

**Codes**

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

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

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

**CS METS AT DIAGNOSIS - LIVER****Abstract Plus Field Name:** CS Mets at DX—Liver**Required for 2004-2015 Diagnosed Cases****Item Length: 1****NAACCR Item #: 2853****Description**

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

**Rationale**

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

**Codes**

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

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

**CS METS AT DIAGNOSIS - LUNG**

**Abstract Plus Field Name:** CS Mets at DX—Lung

**Required for 2004-2015 Diagnosed Cases**

**Item Length: 1**

**NAACCR Item #: 2854**

**Description**

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

**Rationale**

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

**Codes**

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

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

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

**CS METASTASES EVALUATION****Abstract Plus Field Name:** CS Mets Eval**Required for 2004-2015 Diagnosed Cases**  
**Item Length: 1**  
**NAACCR Item #: 2860****Description**

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

**Rationale**

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

**Codes**

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

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

**CS SITE-SPECIFIC FACTORS 1 - 17****Abstract Plus Field Name:** SSF 1 - 17**Required for 2004-2017 Diagnosed Cases****Item Length: 3****NAACCR Items #: 2861 – 2871, 2880, 2890, 2900, 2910, 2920, 2930****Description**

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

**Rationale**

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

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

**Codes**

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

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

**CS SITE-SPECIFIC FACTORS 18 - 24****Abstract Plus Field Name:** SSF 18 - 24**Recommended  
Item Length: 3  
NAACCR Item #: 2872 - 2878****Description**

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

**Rationale**

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

**Codes**

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

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

**CS SITE-SPECIFIC FACTOR 25****Abstract Plus Field Name:** SSF 25**Required for 2004-2017 Diagnosed Cases**  
**Item Length: 3**  
**NAACCR Item #: 2879****Description**

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

**Rationale**

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

**Codes**

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

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

**CS TUMOR SIZE****Abstract Plus Field Name:** CS Tumor Size**Required for 2004-2015 Diagnosed Cases****Item Length: 3****NAACCR Item #: 2800****Description**

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

**Rationale**

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

**Codes**

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

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

**CS TUMOR SIZE/EXTENSION EVALUATION****Abstract Plus Field Name:** CS Tumor Size/Ext Eval**Required for 2004-2015 Diagnosed Cases****Item Length: 1****NAACCR Item #: 2820****Description**

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

**Rationale**

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

**Codes**

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

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

**CS VERSION DERIVED****Abstract Plus Field Name:** CS Version Derived**Required for 2004-2015 Diagnosed Cases****Item Length: 6****NAACCR Item #: 2936****Description**

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

The correct version for 2015 cases is 020550.

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

**CS VERSION INPUT CURRENT**

**Abstract Plus Field Name:** CS Version Input Current

**Required for 2004-2015 Diagnosed Cases**

**Item Length: 6**

**NAACCR Item #: 2937**

**Description**

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

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

**CS VERSION INPUT ORIGINAL****Abstract Plus Field Name:** CS Version Input Original**Required for 2004-2015 Diagnosed Cases****Item Length: 6****NAACCR Item #: 2935****Description**

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

**DATE CASE COMPLETED**

**Abstract Plus Field Name:** Date Case Completed

**Required**  
**Item Length: 8**  
**NAACCR Item #: 2090**

**Description**

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

**Allowable Values**

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when complete date is unknown

**DATE INITIAL RX SEER****Abstract Plus Field Name:** Initial RX Date**Required  
Item Length: 8  
NAACCR Item #: 1260****Description**

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

**Allowable Values**

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when complete date is unknown

**DATE INITIAL RX SEER FLAG****Abstract Plus Field Name:** Initial RX Date Flag**Required  
Item Length: 2  
NAACCR Item #: 1261****Description**

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

**Allowable Values**

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

**DATE OF 1st CONTACT****Abstract Plus Field Name:** 1<sup>st</sup> Contact Date**Required**  
**Item Length: 8**  
**NAACCR Item #: 580****Description**

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

**Rationale**

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

**Allowable Values**

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when complete date is unknown

**DATE OF 1st CONTACT FLAG****Abstract Plus Field Name:** 1<sup>st</sup> Contact Date Flag**Required**  
**Item Length: 2**  
**NAACCR Item #: 581****Description**

This flag explains why no appropriate value is in the field Date of 1<sup>st</sup> Contact.

**Allowable Values**

12 Date of 1<sup>st</sup> Contact is unknown

Blank A valid date value (complete date, month/year or only year) is provided, or the date was not expected to have been transmitted

**DATE OF BIRTH****Abstract Plus Field Name:** Date of Birth**Required  
Item Length: 8  
NAACCR Item #: 240****Description**

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

**Allowable Values**

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

This field cannot be blank.

**Special Coding Instructions**

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

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

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

**DATE OF BIRTH FLAG**

**Abstract Plus Field Name:** Date of Birth Flag

**Required**  
**Item Length: 2**  
**NAACCR Item #: 241**

**Description**

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

**Allowable Values**

12 Date of Birth is unknown

Blank A valid date value is provided (complete date of birth, month/year or only year)

**DATE OF DIAGNOSIS****Abstract Plus Field Name:** Diagnosis Date**Required  
Item Length: 8  
NAACCR Item #: 390****Description**Date of *initial* diagnosis (clinically or pathologically) by a recognized medical practitioner.**Allowable Values**

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when complete date is unknown

**DATE OF DIAGNOSIS FLAG**

**Abstract Plus Field Name:** Diagnosis Date Flag

**Required**  
**Item Length: 2**  
**NAACCR Item #: 391**

**Description**

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

**Allowable Values**

12 Date of Diagnosis is unknown

Blank A valid date value (complete date of diagnosis, month/year or year only) is provided

**DATE OF LAST CONTACT (DATE OF DEATH)****Abstract Plus Field Name:** Last Contact Date**Required  
Item Length: 8  
NAACCR Item #: 1750****Description**

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

**Rationale**

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

**Allowable Values**

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when complete date is unknown

**DATE OF LAST CONTACT FLAG**

**Abstract Plus Field Name:** Last Contact Date Flag

**Required**  
**Item Length: 2**  
**NAACCR Item #: 1751**

**Description**

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

**Allowable Values**

12 Date of Last Contact is unknown

Blank A valid date value (complete date of last contact, month/year or year only) is provided

**DERIVED SUMMARY STAGE 2000****Abstract Plus Field Name:** Derived SS2000**Required for 2004-2015 Diagnosed Cases/Electronic  
Item Length: 1  
NAACCR Item #: 3020****Description**

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

**Codes**

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

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

**DERIVED SUMMARY STAGE 2000 – FLAG****Abstract Plus Field Name:** Derived SS2000—Flag**Required for 2004-2015 Diagnosed Cases/Electronic****Item Length: 1****NAACCR Item #: 3050****Description**

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

**Codes**

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

## DIAGNOSTIC CONFIRMATION

**Abstract Plus Field Name:** Diagnostic Confirmation

**Required  
Item Length: 1  
NAACCR Item #: 490**

### Description

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

### Rationale

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

### Codes for Solid Tumors

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

### Coding Instructions for Solid Tumors

- 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.
- 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).
- Assign **code 1** when the microscopic diagnosis is based on:
  - Tissue specimens from biopsy, frozen section, surgery, autopsy or D&C.
  - Bone marrow specimens (aspiration and biopsy).
- 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.
- Assign **code 5** when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer.

**Example 1:** The presence of alpha-fetoprotein for liver cancer.

**Example 2:** An abnormal electrophoretic spike for multiple myeloma or Waldenstrom macroglobulinemia.

**Example 3:** If the workup for a prostate cancer patient is limited to a highly elevated PSA and the physician diagnosis and/or treatment of the patient is based only on that PSA, code the diagnostic confirmation to 5.

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

### Codes for Nonsolid Tumors – Hematopoietic and Lymphoid Neoplasms

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

### Coding Instructions for Hematopoietic or Lymphoid Tumors

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

**FOLLOW UP SOURCE****Abstract Plus Field Name:** Not Included in Abstract Plus**Required When Available****Item Length: 1****NAACCR Item #: 1790****Description**

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

**Rationale**

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

**Codes**

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

**GRADE OR DIFFERENTIATION****Abstract Plus Field Name:** Grade**Required  
Item Length: 1  
NAACCR Item #: 440****Description**

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

**Rationale**

This data item is useful for prognosis.

**Instructions for Coding**

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

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

**HISTOLOGIC TYPE – MORPHOLOGY**

**Abstract Plus Field Name:** Histology

**Required  
Item Length: 4  
NAACCR Item #: 522**

**Description**

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

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

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

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

**ICD REVISION NUMBER****Abstract Plus Field Name:** ICD Revision Number**Required  
Item Length: 1  
NAACCR Item #: 1920****Description**

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

<b>Codes</b>	<b>Description</b>
0	Patient alive
1	Patient Deceased (ICD-10)

**INSTITUTION REFERRED FROM****Abstract Plus Field Name:** Referred From**Required  
Item Length: 10  
NAACCR Item #: 2410****Description**

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

**Rationale**

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

**Instructions for Coding**

For hospitals, use the WCRS facility number or the CoC assigned FIN number. For clinics, use the WCRS facility number only. Please visit the WCRS website for a complete list of current reporting facilities and WCRS codes.

<https://www.dhs.wisconsin.gov/wcrs/reporterinfo/index.htm>**Allowable Values**

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

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

**INSTITUTION REFERRED TO****Abstract Plus Field Name:** Referred To**Required  
Item Length: 10  
NAACCR Item #: 2420****Description**

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

**Rationale**

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

**Instructions for Coding**

For hospitals, use the WCRS facility number or the CoC assigned FIN number. For clinics, use the WCRS facility number only. Please visit the WCRS website for a complete list of current reporting facilities and WCRS codes.

<https://www.dhs.wisconsin.gov/wcrs/reporterinfo/index.htm>**Allowable Values**

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

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

## LATERALITY

**Abstract Plus Field Name:** Laterality

**Required  
Item Length: 1  
NAACCR Item #: 410**

### Description

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

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

### Coding Instructions

1. Use code **0** if the site is **not** listed in the following table.
2. Code laterality using codes **1-5, 9** for all of the sites listed in the table below.
3. Code the side where the primary tumor originated.  
Assign **code 3** if the laterality is not known but the tumor is confined to a single side of the paired organ.
4. Code **4** is seldom used EXCEPT for the following diseases:
  - i. Both ovaries involved simultaneously, single histology
  - ii. Bilateral retinoblastomas
  - iii. Bilateral Wilm's tumors

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

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

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

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

### Sites for Which Laterality Codes Must Be Recorded

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

**LYMPH-VASCULAR INVASION****Abstract Plus Field Name:** LVI**Required for 2004-2015 Diagnosed Cases – Site-specific**  
**Item Length: 1**  
**NAACCR Item #: 1182****Description**

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

**Rationale**

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

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

**Codes**

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

**MARITAL STATUS AT DIAGNOSIS****Abstract Plus Field Name:** Marital Status at DX**Required  
Item Length: 1  
NAACCR Item #: 150****Description**

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

**Rationale**

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

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

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

**MEDICAL RECORD NUMBER****Abstract Plus Field Name:** Med. Rec. Number**Required  
Item Length: 11  
NAACCR Item #: 2300****Description**

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

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

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

**Allowable Values**

Alpha-numeric, right justified.

**METS AT DIAGNOSIS - BONE****Abstract Plus Field Name:** Mets at DX—Bone**Required for 2016-2017 Diagnosed Cases****Item Length: 1****NAACCR Item #: 1112****Description**

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

**Rationale**

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

**Instructions for Coding**

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

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

**Codes**

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

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

**METS AT DIAGNOSIS - BRAIN****Abstract Plus Field Name:** Mets at DX—Brain**Required for 2016-2017 Diagnosed Cases****Item Length: 1****NAACCR Item #: 1113****Description**

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

**Rationale**

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

**Instructions for Coding**

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

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

**Codes**

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

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

**METS AT DIAGNOSIS – DISTANT LYMPH NODES****Abstract Plus Field Name:** Mets at DX—DistLN**Required for 2016-2017 Diagnosed Cases****Item Length: 1****NAACCR Item #: 1114****Description**

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

**Rationale**

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

**Instructions for Coding**

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

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

## Codes

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

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

**METS AT DIAGNOSIS - LIVER****Abstract Plus Field Name:** Mets at DX—Liver**Required for 2016-2017 Diagnosed Cases****Item Length: 1****NAACCR Item #: 1115****Description**

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

**Rationale**

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

**Instructions for Coding**

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

**Codes**

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

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

**METS AT DIAGNOSIS - LUNG****Abstract Plus Field Name:** Mets at DX—Lung**Required for 2016-2017 Diagnosed Cases**  
**Item Length: 1**  
**NAACCR Item #: 1116****Description**

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

**Rationale**

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

**Instructions for Coding**

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

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

**Codes**

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

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

**METS AT DIAGNOSIS - OTHER****Abstract Plus Field Name:** Mets at DX—Other**Required for 2016-2017 Diagnosed Cases****Item Length: 1****NAACCR Item #: 1117****Description**

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

**Rationale**

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

**Instructions for Coding**

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

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

Codes

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

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

**NAACCR RECORD VERSION**

**Abstract Plus Field Name:** Hidden from view, Automatically Coded

**Required**  
**Item Length: 3**  
**NAACCR Item #: 50**

**Description**

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

**Allowable Code**

160    Version 16

**NAME -- ALIAS**

**Abstract Plus Field Name:** Name—Alias

**Required**  
**Item Length: 40**  
**NAACCR Item #: 2280**

**Description**

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

**Allowable Values:**

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

**NAME – FIRST****Abstract Plus Field Name:** Name—First**Required  
Item Length: 40  
NAACCR Item #: 2240****Description:**

First name of the patient.

**Allowable Values:**

Characters, hyphens and spaces only. Cannot be blank.

**NAME -- LAST****Abstract Plus Fieldname:** Name—Last**Required**  
**Item Length: 40**  
**NAACCR Item #: 2230****Description:**

Last name of the patient.

**Allowable Values:**

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

**NAME – MAIDEN**

**Abstract Plus Field Name:** Name—Maiden

**Required  
Item Length: 40  
NAACCR Item #: 2390**

**Description**

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

**Allowable Values:**

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

**Rationale**

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

**NAME – MIDDLE**

**Abstract Plus Field Name:** Name—Middle

**Required**  
**Item Length: 40**  
**NAACCR Item #: 2250**

**Description:**

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

**Allowable Values:**

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

**NAME -- SUFFIX****Abstract Plus Field Name:** Name—Suffix**Required  
Item Length: 3  
NAACCR Item #: 2270****Description**

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

**Allowable Values:**

Characters only. Do not use punctuation marks.

**NPI –INSTITUTION REFERRED FROM**

**Abstract Plus Field Name:** Not Available in Abstract Plus

**Recommended  
Item Length: 10  
NAACCR Item #: 2415**

**Description**

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

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

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

**Rationale**

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

**Codes**

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

**NPI –INSTITUTION REFERRED TO**

**Abstract Plus Field Name:** Not Available in Abstract Plus

**Recommended  
Item Length: 10  
NAACCR Item #: 2425**

**Description**

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

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

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

**Rationale**

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

**Codes**

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

**NPI –PHYSICIAN—FOLLOW UP****Abstract Plus Field Name:** Follow-Up Phys. NPI**Required  
Item Length: 10  
NAACCR Item #: 2475****Description**

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

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

**Codes**

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

**NPI –PHYSICIAN—MANAGING**

**Abstract Plus Field Name:** Not Available in Abstract Plus

**Recommended  
Item Length: 10  
NAACCR Item #: 2465**

**Description**

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

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

**Codes**

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

**NPI—REPORTING FACILITY****Abstract Plus Field Name:** NPI—Reporting Facility**Required  
Item Length: 10  
NAACCR Item #: 545****Description**

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

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

**Rationale**

The NPI equivalent of Reporting Facility [540].

**Codes**

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

**OVER-RIDE AGE/SITE/MORPH****Abstract Plus Field Name:** Over-Ride Age/Site/Morph**Required When Necessary**  
**Item Length: 1**  
**NAACCR Item #: 1990****Description**

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

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

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

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

**Over-ride Flag as Used in the EDITS Software Package**

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

**Instructions for Coding**

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

**Codes:**

<b>Code</b>	<b>Description</b>
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 HISTOLOGY

**Abstract Plus Field Name:** Over-Ride Histology

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

### Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

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

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

### Over-ride Flag as Used in the EDITS Software Package

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

### Instructions for Coding

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

### Codes:

Code	Description
1	Reviewed and confirmed that the pathologist states the primary to be " <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:** Over-Ride HospSeq/DxConf**Required When Necessary**  
**Item Length: 1**  
**NAACCR Item #: 1986****Description**

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

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

Diagnostic Confirm, Seq Num--Hosp (CoC)

**Over-ride Flag as Used in the EDITS Software Package**

The edit, Diagnostic Confirm, Seq Num--Hosp (CoC), does the following:

1. If any case is one of multiple primaries and is not microscopically confirmed or lacks a positive lab test/marker study, i.e., Diagnostic Confirmation > 5 and Sequence Number--Hospital > 00 (more than one primary), review is required.
2. If Primary Site specifies an ill-defined or unknown primary (C760-C768, C809), no further checking is done.
3. If Sequence Number--Hospital is in the range of 60-88, this edit is skipped.

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

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

**Instructions for Coding**

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

**Codes:**

<b>Code</b>	<b>Description</b>
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

**OVER-RIDE HOSPSEQ/SITE****Abstract Plus Field Name:** Over-Ride HospSeq/Site**Required When Necessary**  
**Item Length: 1**  
**NAACCR Item #: 1988****Description**

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

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

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

**Over-ride Flag as Used in the EDITS Software Package**

Edits of the type Seq Num--Hosp, Primary Site, Morph force review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site.

1. If Sequence Number--Hospital indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:

- C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-3 histology < 9590. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.
- C770-C779 (lymph nodes) and ICD-O-3 histology not in the range 9590-9729; or C420-C424 and or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.
- Any site and ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.

2. If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

**Instructions for Coding**

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

**Codes:**

<b>Code</b>	<b>Description</b>
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

**OVER-RIDE LEUK, LYMPHOMA****Abstract Plus Field Name:** Over-Ride Leuk, Lymphoma**Required When Necessary**  
**Item Length: 1**  
**NAACCR Item #: 2070****Description**

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

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

Diagnostic Confirmation, Histology ICDO3 (SEER IF48)

**Over-ride Flag as Used in the EDITS Software Package**

Edits of the type Diagnostic Confirmation, Histology check the following:

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

**Instructions for Coding**

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

**Codes:**

<b>Code</b>	<b>Description</b>
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

**OVER-RIDE SITE/BEHAVIOR****Abstract Plus Field Name:** Over-Ride Site/Behavior**Required When Necessary**  
**Item Length: 1**  
**NAACCR Item #: 2071****Description**

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

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

Primary Site, Behavior Code ICDO3 (SEER IF39)

**Over-ride Flag as Used in the EDITS Software Package**

Edits of the type, Primary Site, Behavior Code, require review of the following primary sites with a behavior of *in situ* (ICD-O-3 behavior = 2):

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

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

**Instructions for Coding**

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

**Codes:**

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

**OVER-RIDE SITE/LAT/EOD****Abstract Plus Field Name:** Over-Ride Site/Lat/EOD**Required When Necessary**  
**Item Length: 1**  
**NAACCR Item #: 2073****Description**

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

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

Primary Site, Laterality, CS Extension (SEER IF177)

**Over-ride Flag as Used in the EDITS Software Package**

Edits of this type Primary Site, Laterality, EOD apply to paired organs and do not allow the extent of disease to be specified as *in situ*, localized, or regional by direct extension if laterality is coded as “bilateral, site unknown,” or “laterality unknown.”

**Instructions for Coding**

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

**Codes:**

<b>Code</b>	<b>Description</b>
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

**OVER-RIDE SITE/LAT/MORPH****Abstract Plus Field Name:** Over-Ride Site/Lat/Morph**Required When Necessary**  
**Item Length: 1**  
**NAACCR Item #: 2074****Description**

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

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

Laterality, Primary Site, Morph ICDO3 (SEER IF42)

**Over-ride Flag as Used in the EDITS Software Package**

Edits of the type Laterality, Primary Site, Morph do the following:

1. If the Primary Site is a paired organ and ICD-O-3 behavior is *in situ* (2), then laterality must be 1, 2, or 3.
2. If diagnosis year less than 1988 and ICD-O-3 histology  $\geq$  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.

**Instructions for Coding**

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

**Codes:**

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

**OVER-RIDE SITE/TNM-STGGRP****Abstract Plus Field Name:** Over-Ride Site/TNM-STGGRP**Required When Necessary**  
**Item Length: 1**  
**NAACCR Item #: 1989****Description**

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, AJCC Stage Group - Ed 7, ICDO3 (NPCR)

**Rationale**

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

**Over-ride Flag as Used in the EDITS Software Package**

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

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

**Instructions for Coding**

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

**Codes:**

<b>Code</b>	<b>Description</b>
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

**OVER-RIDE SITE/TYPE****Abstract Plus Field Name:** Over-Ride Site/Type**Required When Necessary**  
**Item Length: 1**  
**NAACCR Item #: 2030****Description**

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

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

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

**Rationale**

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

**Instructions for Coding**

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

**Codes**

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

**OVER-RIDE SUMMARY STAGE/NODES POSITIVE****Abstract Plus Field Name:** Over-Ride SS/Nodes Pos**Required When Necessary**  
**Item Length: 1**  
**NAACCR Item #: 1981****Description**

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

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

Summary Stage 2000, Regional Nodes Pos (NAACCR)

**Rationale**

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error or warning message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

**Over-ride Flag as Used in the EDITS Software Package**

The edit Summary Stage 2000, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 2000 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items.

**Instructions for Coding**

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

**Codes**

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

**OVER-RIDE SURG/DXCONF****Abstract Plus Field Name:** Over-Ride Surg/DxConf**Required When Necessary**  
**Item Length: 1**  
**NAACCR Item #: 2020****Description**

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

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

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

**Over-ride Flag as Used in the EDITS Software Package**

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

**Instructions for Coding**

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

**Codes:**

<b>Code</b>	<b>Description</b>
1	Reviewed and confirmed as reported
Blank	Not reviewed, or reviewed and corrected

**PHYSICIAN—FOLLOW UP****Abstract Plus Field Name:** Follow Up Physician**Required  
Item Length: 8  
NAACCR Item #: 2470****Description**

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

**Allowable Values**

Wisconsin Department of Safety and Professional Services physician license number. Right justified with leading zeros. A list of registered physicians is available on the WCRS web site:

<https://www.dhs.wisconsin.gov/wcrs/reporterinfo/codingresources.htm> The list is available alphabetically or sorted by physician license number.**Codes in addition to medical license numbers:**

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

**PLACE OF DEATH - COUNTRY****Abstract Plus Field Name:** Death Place-Country**Required  
Item Length: 3  
NAACCR Item #: 1944****Description**

Country where patient died.

**Description**

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

**Rationale**

Place of death is helpful for carrying out death clearance.

**Allowable Values**

Alpha-only

**Codes**See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes at [http://seer.cancer.gov/manuals/2015/SPCSM\\_2015\\_AppendixB.pdf](http://seer.cancer.gov/manuals/2015/SPCSM_2015_AppendixB.pdf)

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

**PLACE OF DEATH - STATE****Abstract Plus Field Name:** Death Place-State**Required  
Item Length: 2  
NAACCR Item #: 1942****Description**

State where patient died.

**Description**

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

**Rationale**

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

**Allowable Values**

Alpha-only

**Codes**See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes at:[http://seer.cancer.gov/manuals/2015/SPCSM\\_2015\\_AppendixB.pdf](http://seer.cancer.gov/manuals/2015/SPCSM_2015_AppendixB.pdf)

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

**PRIMARY PAYER AT DIAGNOSIS****Abstract Plus Field Name:** Primary Payer at DX**Required  
Item Length: 2  
NAACCR Item #: 630****Description**

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

**Rationale**

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

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

**PRIMARY SITE****Abstract Plus Field Name:** Primary Site**Required  
Item Length: 4  
NAACCR Item #: 400****Description**

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

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

For cases diagnosed January 1, 2001 and later, code the primary site using the topography section of the *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-0-3, the code C50.4 was found. Enter the code as C504; do not record the decimal point.

**RACE 1 – RACE 5****Abstract Plus Field Names:** Race 1, Race 2, Race 3, Race 4, Race 5**Required  
Item Length: 2  
NAACCR Item #: 160, 161, 162, 163, 164****Description**

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

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

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

**Rationale**

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

Codes			
01	White	20	Micronesian, NOS
02	Black	21	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		

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

**RADIATION—REGIONAL RX MODALITY****Abstract Plus Field Name:** Radiation Modality**Required  
Item Length: 2  
NAACCR Item #: 1570****Description**

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

**Rationale**

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

<b>Codes</b>	<b>Description</b>
00	No radiation treatment
20	External beam, NOS
21	Orthovoltage
22	Cobalt-60, Cesium-137
23	Photons (2-5 MV)
24	Photons (6-10 MV)
25	Photons (11-19 MV)
26	Photons (> 19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons, with or without photons/electrons
31	IMRT
32	Conformal or 3-D therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma Knife
50	Brachytherapy, NOS
51	Brachytherapy, Intracavitary, Low Dose Rate (LDR)
52	Brachytherapy, Intracavitary, High Dose Rate (HDR)
53	Brachytherapy, Interstitial, Low Dose Rate (LDR)
54	Brachytherapy, Interstitial, High Dose Rate (HDR)
55	Radium
60	Radio-isotopes, NOS
61	Strontium - 89
62	Strontium - 90
80	Combination modality, specified
85	Combination modality, NOS
98	Other, NOS
99	Unknown

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

**REASON FOR NO RADIATION****Abstract Plus Field Name:** Reason No Radiation**Required  
Item Length: 1  
NAACCR Item #: 1430****Description**

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

**Rationale**

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

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

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

**REASON FOR NO SURGERY****Abstract Plus Field Name:** Reason No Surgery**Required  
Item Length: 1  
NAACCR Item #: 1340****Description**

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

**Rationale**

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

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

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

**RECORD TYPE**

**Abstract Plus Field Name:** Hidden Field, Automatically Coded

**Required**  
**Item Length: 1**  
**NAACCR Item #: 10**

**Description**

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

**Codes**

- I Incidence-only record type (nonconfidential coded data)  
Length = 3339
- C Confidential record type (incidence record plus confidential data)  
Length = 5564
- A Full case Abstract record type (incidence and confidential data plus text summaries; used for reporting to central registries)**  
Length = 22,824
- U Correction/Update record type (short format record used to submit corrections to data already submitted)  
Length = 1543
- M Record Modified since previous submission to central registry (identical in format to the “A” record type)  
Length = 22,824
- L Pathology Laboratory

**Note:** WCRS accepts record types A and M. M type records must be submitted separately from A records and the file must be identified as a M type file in the Web Plus comments field.

**REGIONAL NODES EXAMINED****Abstract Plus Field Name:** Reg. Nodes Examined**Required  
Item Length: 2  
NAACCR Item #: 830****Description**

The total number of regional lymph nodes that were removed\* and examined by the pathologist.

**Rationale**

This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

<b>Codes</b>	<b>Description</b>
00	No nodes were examined.
01-89	1-89 nodes were examined (code the exact number of regional lymph nodes examined).
90	90 or more nodes were examined.
95	No regional nodes were removed, but aspiration of regional nodes was performed.
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated.
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated.
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown.
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record.

\*Exception is code 95 – no nodes removed, only aspiration.

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

**REGIONAL NODES POSITIVE****Abstract Plus Field Name:** Reg. Nodes Positive**Required  
Item Length: 2  
NAACCR Item #: 820****Description**

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

**Rationale**

This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports as well as the extent of the surgical evaluation and treatment of the patient.

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

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

**REPORTING FACILITY**

**Abstract Plus Field Name:** Reporting Facility

**Required**  
**Item Length: 10**  
**NAACCR Item #: 540**

**Description**

WCRS facility code or CoC facility code for the facility that is reporting the data described in the submitted cases. This is usually the facility that saw, diagnosed or treated the patient, but sometimes it refers to the facility that is reporting for another facility under a reporting agreement between those facilities (hospital cancer registry reporting for affiliated system clinics or physician offices, or even another hospital).

Please visit the WCRS website for a complete list of current reporting facilities and WCRS codes.

<https://www.dhs.wisconsin.gov/wcrs/reporterinfo/index.htm>

**Rationale**

The Reporting Facility identification number or FIN is used to identify a reporting facility in the central registry database and is useful for monitoring data submission, ensuring the accuracy of data and identifying areas for special studies.

**Allowable values**

Numeric and alpha characters. Must be right justified with leading zeroes.

**RX CODING SYSTEM - CURRENT****Abstract Plus Field Name:** Hidden from View, Automatically Coded**Required  
Item Length: 2  
NAACCR Item #: 1460****Description**

Code describing how treatment for this tumor now is coded. This field is often auto-coded by the vendor software.

**Codes**

<b>Codes</b>	<b>Description</b>
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</i> Supplement
05	Treatment data coded according to 1998 <i>SEER Manual</i>
06	Treatment data coded according to <i>FORDS</i> manual
07	Treatment data coded according to 2010 SEER Coding Manual
99	Other coding, including partial or nonstandard coding

**RX DATE -- BIOLOGICAL RESPONSE MODIFIER (BRM)**

**Abstract Plus Field Name:** Immuno Start Date

**Required**  
**Item Length: 8**  
**NAACCR Item #: 1240**

**Description**

Date the BRM was first administered as part of first course of treatment.

**Rationale**

The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

**Allowable Values**

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when complete date is unknown or treatment not provided

Please remember to include the date of BRM treatment in the RX TEXT— BRM text field

**RX DATE BRM FLAG**

**Abstract Plus Field Name:** Immuno Date Flag

**Required**  
**Item Length: 2**  
**NAACCR Item #: 1241**

**Description**

This flag explains why no appropriate value is in the field RX Date-BRM.

**Allowable Values**

- 10 Unknown if BRM therapy was administered
  - 11 No BRM was administered or an autopsy-only case
  - 12 BRM was administered, but all of the date is unknown
  - 15 BRM is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
- Blank A valid date (complete date, month/year or year only) is provided

**RX DATE -- CHEMOTHERAPY****Abstract Plus Field Name:** Chemo Start Date**Required  
Item Length: 8  
NAACCR Item #: 1220****Description**

Date the chemotherapy was first administered as part of first course of treatment.

**Rationale**

The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

**Allowable Values**

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when complete date is unknown or treatment not provided

Please remember to include the date of chemotherapy treatment in the RX TEXT— CHEMO text field

**RX DATE CHEMOTHERAPY FLAG****Abstract Plus Field Name:** Chemo Date Flag**Required  
Item Length: 2  
NAACCR Item #: 1221****Description**

This flag explains why no appropriate value is in the field RX Date-Chemotherapy.

**Allowable Values**

- 10 Unknown if chemotherapy was administered
- 11 No chemotherapy was administered or an autopsy-only case
- 12 Chemotherapy was administered, but all of the date is unknown
- 15 Chemotherapy is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
- Blank A valid date (complete date, month/year or year only) is provided

**RX DATE -- HORMONE**

**Abstract Plus Field Name:** Hormone Start Date

**Required**  
**Item Length: 8**  
**NAACCR Item #: 1230**

**Description**

Date the hormone therapy was first administered as part of first course of treatment.

**Rationale**

The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

**Allowable Values**

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when complete date is unknown or treatment not provided

Please remember to include the date of hormone treatment in the RX TEXT— HORMONE text field

**RX DATE HORMONE FLAG****Abstract Plus Field Name:** Hormone Date Flag**Required  
Item Length: 2  
NAACCR Item #: 1231****Description**

This flag explains why no appropriate value is in the field RX Date-Hormone.

**Allowable Values**

- 10 Unknown if hormone therapy was administered
  - 11 No hormone therapy was administered or an autopsy-only case
  - 12 Hormone therapy was administered, but all of the date is unknown
  - 15 Hormone therapy is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
- Blank A valid date (complete date, month/year or year only) is provided

**RX DATE -- OTHER**

**Abstract Plus Field Name:** Other RX Date

**Required**  
**Item Length: 8**  
**NAACCR Item #: 1250**

**Description**

Date other cancer-directed therapy was first administered as part of first course of treatment.

**Rationale**

The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

**Allowable Values**

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when complete date is unknown or treatment not provided

Please remember to include the date of Other treatment in the RX TEXT— OTHER text field

**RX DATE OTHER FLAG**

**Abstract Plus Field Name:** Other RX Date Flag

**Required**  
**Item Length: 2**  
**NAACCR Item #: 1251**

**Description**

This flag explains why no appropriate value is in the field RX Date-Other.

**Allowable Values**

- 10 Unknown if other therapy was administered
  - 11 No other therapy was administered or an autopsy-only case
  - 12 Other therapy was administered, but all of the date is unknown
  - 15 Other therapy is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
- Blank A valid date (complete date, month/year or year only) is provided

**RX DATE -- RADIATION**

**Abstract Plus Field Name:** Radiation Start Date

**Required  
Item Length: 8  
NAACCR Item #: 1210**

**Description**

Date the radiation treatment was first administered as part of first course of therapy.

**Rationale**

The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

**Allowable Values**

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when complete date is unknown or treatment not provided

Please remember to include the date of Radiation treatment in the appropriate RX TEXT— RADIATION text field

**RX DATE RADIATION FLAG****Abstract Plus Field Name:** Radiation Date Flag**Required  
Item Length: 2  
NAACCR Item #: 1211****Description**

This flag explains why no appropriate value is in the field RX Date-Radiation.

**Allowable Values**

- 10 Unknown if radiation was administered
- 11 No radiation was administered or an autopsy-only case
- 12 Radiation was administered, but all of the date is unknown
- 15 Radiation is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
- Blank A valid date (complete date, month/year or year only) is provided

**RX DATE -- SURGERY****Abstract Plus Field Name:** Surgery Date**Required  
Item Length: 8  
NAACCR Item #: 1200****Description**

Date the first surgery of the type described under Surgery of Primary Site, Scope of Regional Lymph Node Surgery or Surgery of Other Regional Site(s)/Distant site(s) was performed.

**Rationale**

The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

**Allowable Values**

YYYYMMDD	when complete date is known and valid
YYYYMM	when year and month are known and valid, and day is unknown
YYYY	when year is known and valid, and month and day are unknown
Blank	when complete date is unknown or treatment not provided

Please remember to include the date of first surgical treatment in the OP procedures and Surgery text fields

**RX DATE SURGERY FLAG****Abstract Plus Field Name:** Surgery Date Flag**Required  
Item Length: 2  
NAACCR Item #: 1201****Description**

This flag explains why no appropriate value is in the field RX Date-Surgery.

**Allowable Values**

- 10 Unknown if surgery was administered
- 11 No surgery was administered or an autopsy-only case
- 12 Surgery was administered, but all of the date is unknown
- 15 Surgery is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
- Blank A valid date (complete date, month/year or year only) is provided

**RX DATE – MOST DEFINED SURGERY (MST DEFN SRG)****Abstract Plus Field Name:** Definitive Surg. Date**Required 2015 and later Diagnoses**  
**Item Length: 8**  
**NAACCR Item #: 3170****Description**

Date of most definitive surgical resection of the primary site performed as part of the first course of treatment.

**Rationale**

The dates on which different treatment modalities were started are used to evaluate whether the treatments were part of first-course therapy and to reconstruct the sequence of first-course treatment modes.

**Allowable Values**

YYYYMMDD	when complete date is known and valid
YYYYMM	when year and month are known and valid, and day is unknown
YYYY	when year is known and valid, and month and day are unknown
Blank	when complete date is unknown or treatment not provided

Please remember to include the date of the most definitive surgical treatment (if more than one surgical procedure done) in the OP procedures and Surgery text fields

**RX DATE MST DEFN SRG FLAG**

**Abstract Plus Field Name:** Defin. Surg. Date Flag

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

**Description**

This flag explains why no appropriate value is in the field RX Date-Mst Defn Srg.

**Allowable Values**

- 10 Unknown if surgery was administered
- 11 No surgery was administered or an autopsy-only case
- 12 Surgery was administered, but all of the date is unknown
- 15 Surgery is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
- Blank A valid date (complete date, month/year or year only) is provided

**RX DATE -- SYSTEMIC THERAPY****Abstract Plus Field Name:** Systemic Date**Required  
Item Length: 8  
NAACCR Item #: 3230****Description**

Date of initiation of systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormone agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy.

**Rationale**

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

**Allowable Values**

YYYYMMDD	when complete date is known and valid
YYYYMM	when year and month are known and valid, and day is unknown
YYYY	when year is known and valid, and month and day are unknown
Blank	when complete date is unknown or treatment not provided

**RX DATE SYSTEMIC FLAG****Abstract Plus Field Name:** Systemic Date Flag**Required  
Item Length: 2  
NAACCR Item #: 3231****Description**

This flag explains why no appropriate value is in the field RX Date-Systemic.

**Allowable Values**

- 10 Unknown if systemic therapy was administered
  - 11 No systemic therapy was administered or an autopsy-only case
  - 12 Systemic therapy was administered, but all of the date is unknown
  - 15 Systemic therapy is planned as part of the first course of therapy, but it had not been started at the time of most recent follow-up/when this case was abstracted.
- Blank A valid date (complete date, month/year or year only) is provided

**RX SUMM -- BIOLOGICAL RESPONSE MODIFIER – BRM (IMMUNOTHERAPY)****Abstract Plus Field Name:** Immuno Summary**Required  
Item Length: 2  
NAACCR Item #: 1410****Description**

Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at all facilities or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

**Rationale**

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy.

<b>Codes</b>	<b>Description</b>
00	None, immunotherapy was not part of the planned first course of therapy.
01	Immunotherapy administered as first-course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record.

*Note:* For tumors diagnosed on or after 1/1/2003, information on bone marrow transplants and stem cell transplants should be coded in the field, RX SUMM – Transplant/Endocrine.

**Reminder: Make sure to justify the code you enter in this field by completing the associated text field: RX TEXT -- BRM**

**RX SUMM -- CHEMOTHERAPY****Abstract Plus Field Name:** Chemo Summary**Required  
Item Length: 2  
NAACCR Item #: 1390****Description**

Describes the chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Includes treatment given at all facilities as part of the first course.

<b>Codes</b>	<b>Description</b>
00	None, chemotherapy was not part of the planned first course of therapy.
01	Chemotherapy, NOS
02	Chemotherapy, single agent.
03	Chemotherapy, multiple agents.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Chemotherapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record.

**Reminder: Make sure to justify the code you enter in this field by completing the associated text field:  
RX TEXT -- CHEMO**

**RX SUMM -- HORMONE THERAPY****Abstract Plus Field Name:** Hormone Summary**Required  
Item Length: 2  
NAACCR Item #: 1400****Description**

Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

**Rationale**

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy.

<b>Codes</b>	<b>Description</b>
00	None; hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy administered as first-course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in the patient record.

*Note:* For tumors diagnosed on or after 1/1/2003, information on endocrine surgery and/or endocrine radiation should be coded in the field, RX Summ – Transplant/Endocrine.

**Reminder: Make sure to justify the code you enter in this field by completing the associated text field:  
RX TEXT -- HORMONE**

**RX SUMM -- OTHER CANCER-DIRECTED THERAPY****Abstract Plus Field Name:** Other RX Summary**Required  
Item Length: 1  
NAACCR Item #: 1420****Description**

Identifies other treatment given at all facilities that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment modifies, controls, removes, or destroys proliferating cancer tissue. Such treatments include phlebotomy, transfusions, and aspirin.

**Rationale**

Information on other therapy is used to describe and evaluate the quality-of-care and treatment practices.

<b>Codes</b>	<b>Description</b>
0	None
1	Other
2	Other Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended
9	Unknown; unknown if administered

**Reminder: Make sure to justify the code you enter in this field by completing the associated text field:  
RX TEXT -- OTHER**

**RX SUMM -- SCOPE OF REGIONAL LYMPH NODE SURGERY****Abstract Plus Field Name:** Scope Reg. Nodes**Required  
Item Length: 1  
NAACCR Item #: 1292****Description**

This field describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

<b>Codes</b>	<b>Description</b>
0	None
1	Biopsy or aspiration of regional lymph node, NOS
2	Sentinel lymph node biopsy
3	Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
4	1 to 3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted.
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

**Instructions for Coding**

1. This field is collected for each surgical event, even if the surgery of the primary site was not performed.
2. Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item.
3. Codes 0-7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
4. If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the **cumulative** effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7. Do not rely on registry software to determine the cumulative code.
5. Use Code 9 for intracranial and central nervous system primaries, lymphomas with a lymph node primary site, unknown or ill-defined primary site or for hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease,
6. Do **not** code **distant** lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in a different data field.
7. Refer to the AJCC Cancer Staging Manual for site-specific identification of regional lymph nodes.

<b>Codes</b>	<b>Description</b>
0	No effort was made to locate sentinel lymph nodes and no nodes were found in pathologic analysis.
1	(C14.0 – Pharynx) Aspiration of regional lymph node to confirm histology of widely metastatic disease.
2	(C50.1 – Breast) There was an attempt at sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.
2	(C44.5 – Skin of Back) patient has melanoma of the back. A sentinel lymph node dissection was done with the removal of one lymph node. Node was negative for disease.
3	(C61.9 – Prostate) Bilateral pelvic lymph node dissection for prostate cancer.
6	(C50.3 – Breast) Sentinel lymph node biopsy of right axilla (SLNBx), followed by right axillary lymph node dissection (ALND) during same surgical event.
7	(C50.4 – Breast) SLNBx of left axilla, followed in a second procedure 5 days later by a left ALND.
9	(C34.9 – Lung) Patient admitted for radiation therapy following surgery for lung cancer. No documentation on the extent of lymph node surgery in patient record.

**RX SUMM – SURGERY OTHER REGIONAL/DISTANT SITES****Abstract Plus Field Name:** Surgery-Other Sites**Required  
Item Length: 1  
NAACCR Item #: 1294****Description**

This field records the removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

**Rationale**

The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

<b>Codes</b>	<b>Description</b>
0	None; or diagnosed at autopsy
1	Non-primary surgical procedure performed, NOS
2	Non-primary surgical procedure to other regional sites
3	Non-primary surgical procedure to distant lymph node(s)
4	Non-primary surgical procedure to distant site
5	Any combination of codes 2, 3, or 4
9	Unknown or not applicable

**Reminder: Make sure to justify the code you enter in this field by completing the associated text fields:  
RX TEXT – SURGERY, TEXT – DX PROC – OPERATIVE PROCEDURE**

**RX SUMM -- SURGERY PRIMARY SITE****Abstract Plus Field Name:** Surgery-Primary Site**Required  
Item Length: 2  
NAACCR Item #: 1290****Description**

The type of surgery *to the primary site* performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment.

Codes	Description
00	Surgery not performed
10-19	Site-specific surgery performed; tumor destruction*
20-80	Site-specific surgery performed; resection*
90	Surgery, NOS
98	Site-specific codes; special
99	Unknown

\*Specific surgery codes for individual primary sites are located in the FORDS Manual Appendix B, Site-specific Surgery Codes: <https://www.facs.org/~media/files/quality%20programs/cancer/ncdb/fords%202016.ashx> Specific surgery codes are also included in the NPCR Registry Plus Online Help tool: [http://www.cdc.gov/cancer/npcr/tools/registryplus/rpoh\\_tech\\_info.htm](http://www.cdc.gov/cancer/npcr/tools/registryplus/rpoh_tech_info.htm)

**Reminder: Make sure to justify the code you enter in this field by including justification in at least one of the associated text fields: RX TEXT – SURGERY, TEXT – DX PROC – OPERATIVE PROCEDURE**

**RX SUMM -- SURGERY/RADIATION SEQUENCE****Abstract Plus Field Name:** Surgery/Radiation Seq.**Required  
Item Length: 1  
NAACCR Item #: 1380****Description**

Codes for the sequencing of radiation and surgery (primary site or regional/distant site) given as part of the first course of treatment.

<b>Codes</b>	<b>Description</b>
0	No radiation and/or no surgery OR unknown if surgery and/or radiation was given
2	Radiation before surgery
3	Radiation after surgery
4	Radiation both before and after surgery
5	Intraoperative radiation
6	Intraoperative radiation with other radiation given before and/or after surgery
7	Surgery both before and after radiation
9	Sequence unknown, but both surgery and radiation were given

**RX SUMM -- SYSTEMIC/SURGERY SEQUENCE****Abstract Plus Field Name:** Surgery/Systemic Seq.**Required  
Item Length: 1  
NAACCR Item #: 1639****Description**

Records the sequencing of systemic therapy (chemotherapy, hormone therapy, immunotherapy, transplant or endocrine surgery) and surgical procedures given as part of the first course of treatment.

**Rationale**

The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the time of delivery of treatment to the patient.

<b>Codes</b>	<b>Description</b>
0	No systemic therapy and/or surgical procedures OR unknown if surgery and/or systemic therapy was given
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before and/or after surgery
7	Surgery both before and after systemic therapy
9	Sequence unknown, but both surgery and systemic therapy were given

**RX SUMM -- TRANSPLANT/ENDOCRINE THERAPY****Abstract Plus Field Name:** Transplant/Endocrine**Required  
Item Length: 2  
NAACCR Item #: 3250****Description**

Identifies systemic therapeutic procedures administered as part of the first course of treatment at this and all other facilities. If none of these procedures were administered, this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

**Rationale**

This data item allows the evaluation of patterns of treatment that involve the alteration of the immune system or change the patient's response to tumor cells but do not involve the administration of antineoplastic agents.

<b>Codes</b>	<b>Description</b>
00	No transplant procedure or endocrine therapy was administered as part of first course therapy; or diagnosed at autopsy.
10	Bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant—autologous.
12	Bone marrow transplant—allogeneic.
20	Stem cell harvest and infusion.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure (combination of codes 30 and 10, 11, 12 or 20).
82	Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age).
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian; refusal noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record.

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

**TEXT – REMARKS**

**RX SUMM – TREATMENT STATUS****Abstract Plus Field Name:** RX Status Summary**Required  
Item Length: 1  
NAACCR Item #: 1285****Description**

This data item is a summary of the status for all treatment modalities. It also indicates active surveillance (watchful waiting).

**Rationale**

This field will document active surveillance (watchful waiting) and eliminate searching each treatment modality to determine whether treatment was given.

<b>Codes</b>	<b>Description</b>
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment given

**RX TEXT— BRM****Abstract Plus Field Name:** BRM**Required  
Item Length: 1000  
NAACCR Item #: 2660****Description**

Field used to manually document information regarding the biological response modifiers or immunotherapy treatment provided or reason why BRM was not provided.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**Text Requirements:**

- Date BRM began or reason why BRM was not given (patient refused, patient died, contraindicated, etc.)
- Where BRM was given; e.g., at this facility; at another facility.
- Type of BRM agent; e.g., Interferon, BCG.
- BRM procedures; e.g., bone marrow transplant, stem cell transplant.

**Text Recommendation:**

- Other treatment information; e.g., treatment cycle incomplete; unknown if BRM was given.

**Data Item(s) to be verified/validated using the text entered in this field**

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

<b>Item Name</b>	<b>Item Number</b>
RX Summ- BRM	1410
RX Date – BRM	1240
RX Summ – Systemic/Surgery Sequence	1639
RX Date Systemic	3230

**RX TEXT— CHEMOTHERAPY****Abstract Plus Field Name:** Chemo**Required  
Item Length: 1000  
NAACCR Item #: 2640****Description**

Field used to manually document information regarding the chemotherapy treatment provided or reason why no chemotherapy was provided.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**Text Requirements:**

- Date chemotherapy began or reason why it was not given (patient refused, patient died, contraindicated, etc.).
- Where chemotherapy was given; e.g., at this facility; at another facility.
- Type of chemotherapy, e.g. name of agent(s) or protocol.

**Text Recommendation:**

- Other treatment information; e.g., treatment cycle incomplete; unknown if chemotherapy was given.

**Data Item(s) to be verified/validated using the text entered in this field**

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

<b>Item Name</b>	<b>Item Number</b>
RX Summ- Chemotherapy	1390
RX Date – Chemotherapy	1220
RX Summ – Systemic/Surgery Sequence	1639
RX Date Systemic	3230

**RX TEXT — HORMONE****Abstract Plus Field Name:** RX Text—Hormone**Required  
Item Length: 1000  
NAACCR Item #: 2650****Description**

Field used to manually document information regarding the hormone treatment provided or reason why no hormone was provided.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**Text Requirements:**

- Date hormone therapy began or reason why it was not given (patient refused, patient died, contraindicated, etc.).
- Where hormone therapy was given; e.g., at this facility; at another facility.
- Type of hormone or antihormone, e.g., Tamoxifen.

**Text Recommendations:**

- Type of endocrine surgery or radiation, e.g., orchiectomy.
- Other treatment information; e.g., treatment cycle incomplete; unknown if hormones were given.

**Data Item(s) to be verified/validated using the text entered in this field**

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

<b>Item Name</b>	<b>Item Number</b>
RX Summ- Hormone	1400
RX Date – Hormone	1230
RX Summ – Systemic/Surgery Sequence	1639
RX Date Systemic	3230

**RX TEXT— OTHER****Abstract Plus Field Name:** Other RX**Required  
Item Length: 1000  
NAACCR Item #: 2670****Description**

Field used to manually document information regarding the other cancer-directed treatment provided.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.**Text Requirements:**

- Date other treatment began or reason why it was not given (patient refused, patient died, contraindicated, etc.).
- Where other treatment was given; e.g., at this facility; at another facility.
- Type of other treatment, e.g., blinded clinical trial, hyperthermia.

**Text Recommendations:**

- Other treatment information; e.g., treatment cycle incomplete; unknown if other treatment was given.

**Data Item(s) to be verified/validated using the text entered in this field**

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

<b>Item Name</b>	<b>Item Number</b>
RX Summ- Other	1420
RX Date – Other	1250

**RX TEXT— RADIATION (BEAM)****Abstract Plus Field Name:** Rad. Beam**Required  
Item Length: 1000  
NAACCR Item #: 2620****Description**

Field used to manually document information regarding the beam radiation treatment provided or reason why no beam radiation was provided.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**Text Requirements:**

- Date beam radiation began or reason why it was not given (patient refused, patient died, contraindicated, etc.).
- Where beam radiation was given; e.g., at this facility; at another facility.
- Type of beam radiation **as defined in the FORDS Manual** (Photons [MV range], Orthovoltage, Cobalt-60, IMRT, etc.).

**Text Recommendation:**

- Other treatment information; e.g., patient discontinued after 5 treatments; unknown if radiation treatment was given.

**Data Item(s) to be verified/validated using the text entered in this field**

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

<b>Item Name</b>	<b>Item Number</b>
Rad Regional RX Modality	1570
RX Date – Radiation	1210
RX Summ – Surgery/Radiation Sequence	1380

**RX TEXT— RADIATION (OTHER)****Abstract Plus Field Name:** Rad. Other**Required  
Item Length: 1000  
NAACCR Item #: 2630****Description**

Field used to manually document information regarding the other radiation treatment provided or reason why no other radiation treatment was provided.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**Text Requirements:**

- Date non-beam radiation began or reason why it was not given (patient refused, patient died, contraindicated, etc.).
- Where non-beam radiation was given; e.g., at this facility; at another facility.
- Type of non-beam radiation; e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131).

**Text Recommendation:**

- Other treatment information; e.g., unknown if radiation was given.

**Data Item(s) to be verified/validated using the text entered in this field**

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

<b>Item Name</b>	<b>Item Number</b>
Rad Regional RX Modality	1570
RX Date – Radiation	1210
RX Summ – Surgery/Radiation Sequence	1380

**RX TEXT— SURGERY****Abstract Plus Field Name:** Primary Site Surgery**Required  
Item Length: 1000  
NAACCR Item #: 2610****Description**

Field used to manually document information regarding all surgical procedures performed (or reason why not performed) as first-course treatment.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS requests that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**Text Requirements:**

- Date and type of each surgical procedure (incl. excisional biopsies and surgery to other/distant sites).
- Document if lymph nodes, regional tissues or metastatic sites were removed; if so, document LN number or site.
- Facility where each procedure was performed.
- Positive and negative findings. Record positive findings first.
- Other treatment information, e.g., planned procedure aborted; unknown if surgery performed.

**Data Item(s) to be verified/validated using the text entered in this field**

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

<b>Item Name</b>	<b>Item Number</b>	<b>Item Name</b>	<b>Item Number</b>
RX Summ – Surgery Primary Site	1290	Reason for No Surgery	1340
RX Date – Surgery	1200	RX Summ – Surgery/Radiation Sequence	1380
RX Summ – Scope Reg. LN Surgery	1292	RX Summ – Systemic/Surgery Sequence	1639
RX Summ – Surgery Oth/Distant Site	1294		

**SEER SUMMARY STAGE 2000****Abstract Plus Field Name:** Summary Stage**Required for cases diagnosed 2001 and later****Item Length: 1****NAACCR Item #: 759****Description**

This code is for summary stage at the initial diagnosis or treatment of the reportable tumor. For hospital registries, CoC requires its use in the absence of a defined AJCC classification. For site-specific definitions of categories, see SEER *Summary Staging Manual 2000*. Summary stage should include all information available through completion of surgery(ies) as part of the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer. The manual can be downloaded from the SEER website:

<https://seer.cancer.gov/tools/ssm/SSSM2000-122012.pdf>

**Rationale**

Stage information is important when evaluating the effects of cancer control programs. It is crucial in understanding whether changes over time in cancer incidence rates or outcomes are due to earlier detection (detecting cancer at an earlier stage of the disease). In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

<b>Codes</b>	<b>Description</b>
0	<i>In situ</i>
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable <i>Note: Code 8 should only be used for reportable benign tumors (e.g., benign brain or other CNS).</i>
9	Unstaged

**Clarification of WCRS Required Status**

This field is required for ALL cases diagnosed 2001 and later, no exceptions.

## SEQUENCE NUMBER

**Abstract Plus Field Name:** Sequence Number

**Required  
Item Length: 2  
NAACCR Item #: 560**

**Description**

This field indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has only one malignant neoplasm in his/her lifetime (regardless of registry reference date). Sequence Number 01 indicates the first of two or more malignant neoplasms, while 02 indicates the second of two or more malignant neoplasms, and so on. Because the time period of Sequence Number spans a person's lifetime (how many cancers the patient had in his/her life), reportable neoplasms not included in the hospital registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the hospital registry's reference date. Similarly, Sequence Number 60 indicates the patient has only one non-malignant neoplasm, and Sequence Number 61 represents the first of multiple non-malignant neoplasms.

**Timing Rule**

If two or more malignant tumors are diagnosed at the same time, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. Likewise, if two or more non-malignant tumors are diagnosed at the same time, the lowest sequence number is assigned to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

<b>Codes</b>	<b>Description</b>
<b><i>In situ</i> or Malignant Tumors:</b>	
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.)
<b>Nonmalignant Tumors</b>	
<b>Description</b>	
60	Only one non-malignant tumor in the patient's lifetime
61	First of two or more non-malignant tumors
62	Second of two or more non-malignant tumors
...	
88	Unspecified number of non-malignant tumors (When a patient has multiple unspecified neoplasms in this category code, 88 should only be used once.)

The table below shows which sequence number series to use by type of neoplasm:

<b>Neoplasm</b>	<b>SeqNum-Hospital (code range)</b>
<b><i>In situ</i> and Malignant</b>	
One <i>in situ</i> (behavior code = 2) or malignant (behavior code=3) primary tumor only in the patient's lifetime	00
First of multiple <i>in situ</i> or malignant primary tumors in the patient's lifetime	01
Actual sequence of two or more <i>in situ</i> or malignant primary tumors	02-35
Unspecified <i>in situ</i> or malignant sequence number OR unknown	99
<b>Non-Malignant</b>	
One benign (behavior code = 0) or borderline (behavior code = 1) primary tumor only in the patient's lifetime	60
First of two or more benign or borderline primary tumors in the patient's lifetime	61
Actual sequence of two or more non-malignant primary tumors	62-87
Unspecified non-malignant sequence number OR unknown	88

**SEX****Abstract Plus Field Name:** Sex**Required  
Item Length: 1  
NAACCR Item #: 220****Description**

Sex of the patient at the time of diagnosis.

Codes	
1	Male
2	Female
3	Other (hermaphrodite)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not stated/Unknown

**Definition:**

Transsexual: Surgically altered gender.

**Please remember to include the patient's sex in the PE text field.**

**SOCIAL SECURITY NUMBER****Abstract Plus Field Name:** SSN**Required**  
**Item Length: 9**  
**NAACCR Item #: 2320****Description**

The patient's Social Security number. Note: This is not always identical to the Medicare claim number.

**Allowable Values**

Numbers only, no spaces, no dashes or any letter suffix. Cannot be blank.

**Codes (in addition to Social Security number)**

999999999	Unknown
-----------	---------

**Alert:**

This is a required field; it is extremely important for accurate merging of cases submitted on different tumors or from different facilities for the same person. Many new Electronic Health Record systems are not making the SSN available to personnel in the facility system outside the billing staff. If you are unable to access the SSN in your medical chart or through your EHR for WCRS required reporting, you must contact your HIM and IT management immediately to make them aware of the reporting requirement so the software can be updated to allow access for reporting.

## SPANISH/HISPANIC ORIGIN

**Abstract Plus Field Name:** Hispanic Ethnicity

**Required  
Item Length: 1  
NAACCR item #: 190**

**Description**

This data item is used to identify patients with Spanish/Hispanic/Latino surname or of Spanish origin. Persons of Spanish or Hispanic/Latino surname/origin MAY BE OF ANY RACE.

If a patient has a Hispanic name, but there is reason to believe he or she is not Hispanic (e.g., the patient is Filipino, or the patient is a woman known to be non-Hispanic who has a Hispanic married name), the code in this field would be 0 (non-Hispanic).

If the patient has multiple tumors, all records should have the same code.

**Rationale**

See the rationales for Races 1-5. Ethnic origin has a significant association with cancer rates and outcomes. Hispanic populations have patterns of cancer occurrence different from other populations that may be included in the “white” category of Race.

Codes	Description
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS, or Hispanic, NOS, or Latino, NOS  There is evidence, other than surname or maiden name, that the person is Hispanic, but he/she cannot be assigned to any of the categories 1-5.
7	Spanish surname only. The only evidence of the person’s Hispanic origin is the surname or maiden name and there is no contrary evidence that the patient is not Hispanic.
8	Dominican Republic
9	Unknown whether Spanish/Hispanic/Latino or not

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

**Caution!**

Do not use race code ‘98-other’ when the patient is Hispanic. Choose the correct Hispanic code and separately code the appropriate race field (most often ‘01-white,’ but Hispanic persons can be of any race).

**TELEPHONE**

**Abstract Plus Field Name:** Telephone

**Recommended  
Item Length: 10  
NAACCR item #: 2360**

**Description**

Current telephone number with area code for the patient. Number is entered without dashes.

**Rationale**

WCRS uses this field to help determine person matches with record linkages. As SSN and maiden name (which are still required) are not being provided, the patient phone number, readily available in most cases, is used give a potential match more weight, when the incoming number is the same as the number already in the database.

**Codes (in addition to valid telephone number)**

0000000000 Patient does not have a telephone

9999999999 Telephone number unavailable or unknown

**TEXT—DX PROC--LAB TESTS****Abstract Plus Field Name:** Labs**Required  
Item Length: 1000  
NAACCR Item #: 2550****Description**

Text area for manual documentation of information from laboratory examinations other than cytology or histopathology.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.**Suggestions for text:**

- Type of lab test/tissue specimen(s)
- Record both positive and negative findings. Record positive test results first.
- **Date(s) of lab test(s)**

**Text Notes:**

- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Tumor markers include, but are not limited to:
  - Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu.
  - Prostate Cancer – Prostatic Specific Antigen (PSA)
  - Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

**Data Item(s) to be verified/validated using the text entered in this field:**

<b>Item Name</b>	<b>Item Number</b>
Diagnostic Confirmation Required Lab-based SSFs (ER, PR, HER2, for example)	490

**TEXT—DX PROC -- OPERATIVE REPORT****Abstract Plus Field Name:** Op**Required  
Item Length: 1000  
NAACCR Item #: 2560****Description**

Text area for manual documentation of all surgical procedures (not just first-course therapy) that provide information for staging.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**Text Requirements:**

- **Dates** and descriptions of biopsies and all other surgical procedures from which staging information was derived
- **Number of lymph nodes removed**
- **Size of tumor removed**
- Documentation of residual tumor
- **Evidence of invasion of surrounding areas**
- If surgery planned but not performed; reason primary site surgery could not be completed

**Data Item(s) to be verified/validated using the text entered in this field:**

<b>Item Name</b>	<b>Item Number</b>
Reason for No Surgery	1340
CS Extension	2810
CS Extension Evaluation Code	2820, 2840, 2860
CS Lymph Nodes	2830
Mets at DX	2850, (2851-2854 if applicable)
RX Summ – Surgery Primary Site	1290
SEER Summary Stage 2000	759
T, N and M fields	

**TEXT—DX PROC--PATHOLOGY****Abstract Plus Field Name:** Pathology**Required  
Item Length: 1000  
NAACCR Item #: 2570****Description**

Text area for manual documentation of information from cytology and histopathology reports.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.**Text Requirements:**

- **Date(s) of procedure(s)** and type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives, such as predominantly, with features of, with foci of)
- **Tumor size and extent of tumor spread**
- Involvement of resection margins
- **Number of lymph nodes involved and examined**
- Positive and negative findings. Record positive test results first.

**Text Recommendations:**

- Note if pathology report is a slide review or a second opinion from an outside source (AFIP, Mayo, etc.).
- Record any additional comments from the pathologist, including differential diagnoses considered, ruled out or favored.

**Data Item(s) to be verified/validated using the text entered in this field:**

<b>Item Name</b>	<b>Item Number</b>	<b>Item Name</b>	<b>Item Number</b>
Date of Diagnosis	390	SEER Summary Stage 2000	759
Primary Site	400	CS Tumor Size	2800
Laterality	410	CS Extension, Lymph Nodes, Mets	2810, 2830, 2850
Histologic Type	522	CS Extension Evaluation Codes	2820, 2840, 2860
Grade	440	SSFs required, if applicable by site	2880, 2890, 2900
Diagnostic Confirmation	490		2862-2868
Regional Nodes Positive & Examined	820, 830	T, N and M data items	

**TEXT—DX PROC--PE****Abstract Plus Field Name:** PE**Required  
Item Length: 1000  
NAACCR Item #: 2520****Description**

Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**Text Requirements:**

- Age, sex, marital status, race and ethnicity
- Prior cancer history (previous cancers diagnosed and when)
- Date of physical exam
- Impression (when stated and pertains to cancer diagnosis)

**Text Recommendations:**

- Behavioral risk factors (smoking history, etc.)
- Family history of cancer

**Data Item(s) to be verified/validated using the text entered in this field:**

<b>Item Name</b>	<b>Item Number</b>
Sex	220
Sequence Number	560
Age at Diagnosis	230
Race 1-5	160-164
Spanish/Hispanic Origin	190
Marital Status	150

**TEXT—DX PROC--SCOPES****Abstract Plus Field Name:** Scopes**Required  
Item Length: 1000  
NAACCR Item #: 2540****Description**

Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.**Text Requirements:**

- **Date(s) of endoscopic exam(s)**
- Record site and type of endoscopic biopsy
- Tumor location
- **Tumor size**
- Primary site
- Histology (if given)
- Record positive and negative clinical findings. Record positive results first.

**Data Item(s) to be verified/validated using the text entered in this field:**

<b>Item Name</b>	<b>Item Number</b>
Diagnostic Confirmation	490
Primary Site	400
Laterality	410
Applicable Staging Fields	

**TEXT—DX PROC – X-RAY/SCAN****Abstract Plus Field Name:** Imaging**Required  
Item Length: 1000  
NAACCR Item #: 2530****Description**

Text area for manual documentation from all X-rays, scan, and/or other imaging examinations that provide information about staging.

Text is needed to justify coded values and to document supplemental information not transmitted within coded values.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**Text Requirements:**

- Date(s) of X-ray/Scan(s)
- Tumor location and size
- Lymph nodes
- Distant disease or metastasis
- Primary site and Histology (if given)
- Positive and negative clinical findings. Record positive results first.

**Data Item(s) to be verified/validated using the text entered in this field:**

<b>Item Name</b>	<b>Item Number</b>	<b>Item Name</b>	<b>Item Number</b>
Primary Site	400	CS Extension	2810
Laterality	410	CS Lymph Nodes	2830
Histology ICD-O3	522	CS Mets	2850, 2851-54
SEER Summary Stage 2000	759	CS Extension/Tumor Size Evaluation	2820
CS Tumor Size	2800	T, N and M Fields	

**TEXT--HISTOLOGY TITLE****Abstract Plus Field Name:** Histology Title**Required  
Item Length: 100  
NAACCR Item #: 2590****Description**

Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**Text Requirements:**

- Histologic type (adenocarcinoma, sarcoma, CLL, squamous cell, etc.) and behavior (benign, in situ, malignant)
- Grade, differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc.

**Data Item(s) to be verified/validated using the text entered in this field:**

<b>Item Name</b>	<b>Item Number</b>
Histologic Type ICD-O3	522
Behavior Code	523
Grade	440

**TEXT—PLACE OF DIAGNOSIS**

**Abstract Plus Field Name:** Place of Diagnosis

**Recommended  
Item Length: 60  
NAACCR Item #: 2690**

**Description**

Text area for manual documentation of the facility and/or physician office where the diagnosis was made.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- NAACCR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**TEXT--PRIMARY SITE TITLE****Abstract Plus Field Name:** Primary Site Title**Required  
Item Length: 100  
NAACCR Item #: 2580****Description**

Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.**Text Requirements:**

- Location of the primary site of the tumor, **including subsite.**
- **Tumor laterality**

**Data Item(s) to be verified/validated using the text entered in this field:**

<b>Item Name</b>	<b>Item Number</b>
Primary Site	400
Laterality	410

**TEXT—REMARKS****Abstract Plus Field Name:** Remarks**Required  
Item Length: 1000  
NAACCR Item #: 2680****Description**

Text area for information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data can also be placed here. Problematic coding issues can also be discussed in this section.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions**

- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

**Text Requirements:**

- **Justification of over-ride flags** (if an over-ride flag is set)
- **Justification of transplant/endocrine surgery field**
- Information clarifying anything unusual, such as reason for reporting a case seemingly not reportable for that facility, or reason for coding numerous fields as unknown.

**Text recommendations:**

- Smoking history
- Family and personal history of cancer
- Comorbidities
- Information on previous cancers if a person was diagnosed with another cancer out-of-state or before the registry's reference date
- Place of birth if available

**TEXT--STAGING****Abstract Plus Field Name:** Stage**Required  
Item Length: 1000  
NAACCR Item #: 2600****Description**

Additional text area for staging information not already entered in the Text--DX Proc areas.

**Text is needed to justify coded values and to document supplemental information not transmitted within coded values.**

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

**Instructions****• Include enough information to be able to code from the text all applicable staging fields: SEER Summary Stage, Collaborative stage (esp. tumor size, extension, lymph nodes and metastases) and AJCC TNM staging components (clinical and pathologic)**

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- Use NAACCR-approved abbreviations.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

*Note:* For abstracting software that allows unlimited text, WCRS recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.**Text Requirements:**

- Tumor Size
- Date(s) of biopsy and/or other procedure(s) (including clinical) that provided information for assigning stage
- Extent of tumor (depth of spread in primary and other organs involved by direct extension)
- Status of margins
- Number and sites of positive lymph nodes (and condition of nodes if applicable – matted vs. moveable)
- Site(s) of distant metastasis

**Data Item(s) to be verified/validated using the text entered in this field that is not entered in DX PROC text fields:**

<b>Item Name</b>	<b>Item Number</b>
Collaborative Stage Fields	2800-2930
AJCC T, N, M, Stage Group Fields	880-1060
SEER Summary Stage 2000	759
Regional Nodes Positive	820
Regional Nodes Examined	830

**TEXT—USUAL INDUSTRY****Abstract Plus Field Name:** Industry**Required  
Item Length: 100  
NAACCR Item #: 320****Description**

Text description of the patient's usual industry or type of occupational setting. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

If the patient is a child, please put CHILD in this text field.

**Rationale**

Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

**Allowable Values**

Record the primary type of business activity performed by the company/employer or setting where the patient was employed for the most number of years before diagnosis of the tumor. Distinguish whether the industry or setting is involved in manufacturing, wholesale, retail, service, farming, mining, teaching, etc. If the primary activity is unknown, it may be appropriate to record the name of the company/employer or setting and the city or town. The central registry office may use the name of the company/employer or setting and the city or town to determine the type of business activity performed. If the patient is retired and no other information is available, do **not** list retired. Leave field blank if information is unavailable. Example: If the patient was a teacher (occupation) the industry would be the type of school (elementary, high school, technical college, etc.) at which he/she taught.

**TEXT—USUAL OCCUPATION**

**Abstract Plus Field Name:** Occupation

**Required**  
**Item Length: 100**  
**NAACCR Item #: 310**

**Description**

Text description of the patient's usual occupation. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

If the patient is a child, please put CHILD in this text field.

**Rationale**

Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

**Allowable Values**

Record the primary type of employee activity performed by the patient where the patient was employed for the most number of years before diagnosis of the tumor. If the patient was a housewife/househusband and also worked outside the home, record the occupation outside the home. If the patient was a housewife/househusband and never worked outside the home, record "homemaker," "housewife," or "househusband." If the patient was NOT a student or homemaker, and never worked, record "never worked," or "never employed." If the patient is retired and no other information is available, do **not** list retired. Leave field blank if information is unavailable.

**TNM CLINICAL DESCRIPTOR****Abstract Plus Field Name:** TNM Clin Descriptor**Required for 2016-2017 Diagnoses****Item Length: 1****NAACCR Item #: 980****Description**

Identifies the American Joint Commission on Cancer (AJCC) clinical stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

**Codes**

<b>Codes</b>	<b>Description</b>
0	None
1	E (extranodal, lymphomas only)
2	S (spleen, lymphomas only)
3	M (multiple primaries in a single tumor)
5	E & S (extranodal and spleen, lymphomas only)
9	Unknown, not stated in patient record

**TNM CLINICAL M****Abstract Plus Field Name:** TNM Clin M**Required for 2016-2017 Diagnoses****Item Length: 4****NAACCR Item #: 960****Description**

Detailed site-specific codes for the clinical metastases (M) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

**Codes**

The following codes are valid for AJCC 7<sup>th</sup> TNM edition:

c0  
c0I+  
c1  
c1A  
c1B  
c1C  
c1D  
c1E  
p1  
p1A  
p1B  
p1C  
p1D  
p1E  
88  
blank

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

**TNM CLINICAL N**

**Abstract Plus Field Name:** TNM Clin N

**Required for 2016-2017 Diagnoses**  
**Item Length: 4**  
**NAACCR Item #: 950**

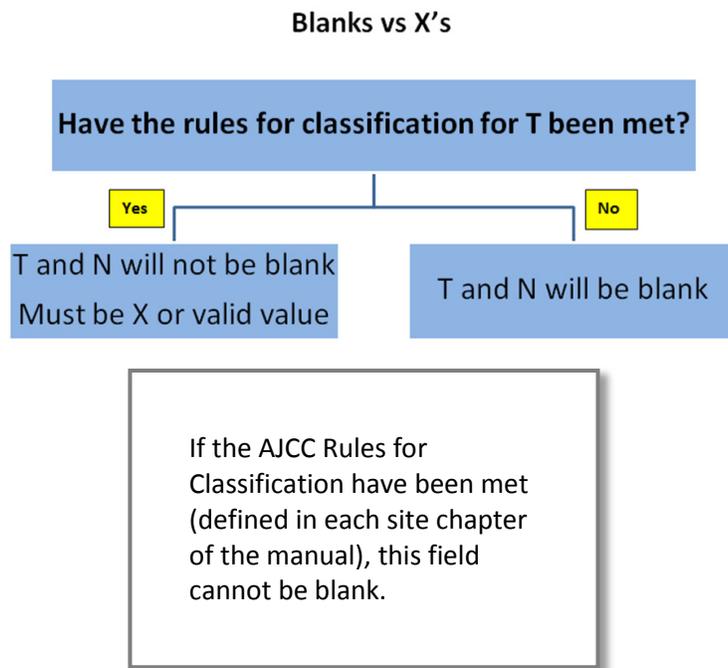
**Description**

Detailed site-specific codes for the clinical nodes (N) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

**Codes**

The following codes are valid for AJCC 7th edition:

- cX
- c0
- c0A
- c0B
- c1
- c1A
- c1B
- c1C
- c2
- c2A
- c2B
- c2C
- c3
- c3A
- c3B
- c3C
- c4
- 88
- Blank



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

**TNM CLINICAL STAGE GROUP****Abstract Plus Field Name:** TNM Clin Stage Grp**Required for 2016-2017 diagnoses****Item Length: 4****NAACCR Item #: 970****Description**

Detailed site-specific codes for the clinical stage group as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

**Rationale**

AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

**Codes**

The following codes are valid for AJCC 7th edition:

0  
0A  
0S  
0IS  
1  
1A  
1A1  
1A2  
1B  
1B1  
1B2  
1C  
1S  
2  
2A  
2A1  
2A2  
2B  
2C  
3  
3A  
3B  
3C  
3C1  
3C2  
4  
4A  
4A1  
4A2  
4B  
4C  
88  
99  
OC

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

**TNM CLINICAL T**

**Abstract Plus Field Name:** TNM Clin T

**Required for 2016-2017 diagnoses**  
**Item Length: 4**  
**NAACCR Item #: 940**

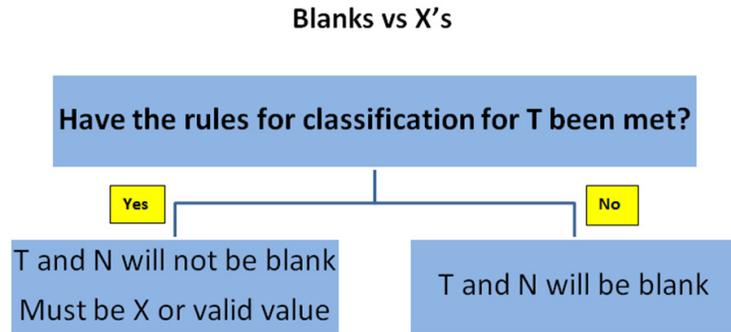
**Description**

Detailed site-specific codes for the clinical tumor (T) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

**Codes**

The following codes are valid for AJCC 7th edition:

- cX
- c0
- c1
- c1A
- c1A1
- c1A2
- c1B
- c1B1
- c1B2
- c1C
- c1D
- c1MI
- c2
- c2A
- c2A1
- c2A2
- c2B
- c2C
- c2D
- c3
- c3A
- c3B
- c3C
- c3D
- c4
- c4A
- c4B
- c4C
- c4D
- c4E
- pA
- pIS
- pISU
- pISD
- 88
- Blank



If the AJCC Rules for Classification have been met (defined in each site chapter of the manual), this field cannot be blank.

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

**TNM EDITION NUMBER****Abstract Plus Field Name:** TNM Edition Number**Required for 2016-2017 diagnoses****Item Length: 2****NAACCR Item #: 1060****Description**

A code that indicates the edition of the American Joint Commission on Cancer (AJCC) manual used to stage the case.

**Rationale**

TNM codes have changed over time and conversion is not always simple. Therefore, a case-specific indicator is needed to allow grouping of cases for comparison.

**Codes**

<b>Codes</b>	<b>Description</b>
00	Not staged (cases that have AJCC staging scheme and staging was not done)
01	First edition
02	Second edition (published 1983)
03	Third edition (published 1988)
04	Fourth edition (published 1992), recommended for use for cases diagnosed 1993-1997
05	Fifth Edition (published 1997), recommended for use for cases diagnosed 1998-2002
06	Sixth Edition (published 2002), recommended for use for cases diagnosed 2003-2009
07	Seventh Edition (published 2009), recommended for use with cases diagnosed 2010+
88	Not applicable (cases that do not have an AJCC staging scheme)
99	Edition Unknown

**TNM PATHOLOGIC DESCRIPTOR****Abstract Plus Field Name:** TNM Path Descriptor**Required for 2016-2017 diagnoses****Item Length: 1****NAACCR Item #: 920****Description**

Identifies the American Joint Commission on Cancer (AJCC) pathologic stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

**Codes**

<b>Codes</b>	<b>Description</b>
0	None
1	E (extranodal, lymphomas only)
2	S (spleen, lymphomas only)
3	M (multiple primaries in a single tumor)
4	Y (Classification during or after initial multimodality therapy)—pathologic staging only
5	E & S (extranodal and spleen, lymphomas only)
6	M & Y (Multiple primary tumors and initial multimodality therapy)
9	Unknown, not stated in patient record

**TNM PATHOLOGIC M****Abstract Plus Field Name:** TNM Path M**Required for 2016-2017 diagnoses****Item Length: 4****NAACCR Item #: 900****Description**

Detailed site-specific codes for the pathologic metastases (M) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

**Codes**

The following codes are valid for AJCC 7th edition:

c0  
c0I+  
c1  
c1A  
c1B  
c1C  
c1D  
c1E  
p1  
p1A  
p1B  
p1C  
p1D  
p1E  
88  
Blank

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

**TNM PATHOLOGIC N**

**Abstract Plus Field Name:** TNM Path N

**Required for 2016-2017 diagnoses**  
**Item Length: 4**  
**NAACCR Item #: 890**

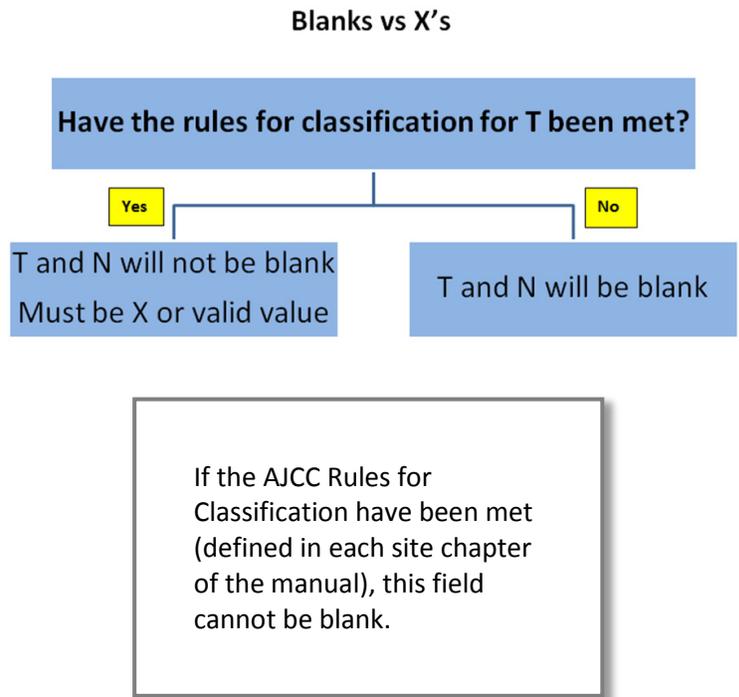
**Description**

Detailed site-specific codes for the pathologic nodes (N) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

**Codes**

The following codes are valid for AJCC 7th edition:

- pX
- p0
- p0I-
- p0I+
- p0M-
- p0M+
- p1
- p1A
- p1B
- p1C
- p1M
- p1MI
- p2
- p2A
- p2B
- p2C
- p3
- p3A
- p3B
- p3C
- p4
- c0
- 88
- p0A
- p0B
- Blank



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

**TNM PATHOLOGIC STAGE GROUP****Abstract Plus Field Name:** TNM Path Stage Group**Required for 2016-2017 diagnoses****Item Length: 4****NAACCR Item #: 910****Description**

Detailed site-specific codes for the pathologic stage group as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

**Codes**

The following codes are valid for AJCC 7th edition:

0  
0A  
0S  
0IS  
1  
1A  
1A1  
1A2  
1B  
1B1  
1B2  
1C  
1S  
2  
2A  
2A1  
2A2  
2B  
2C  
3  
3A  
3B  
3C  
3C1  
3C2  
4  
4A  
4A1  
4A2  
4B  
4C  
88  
99  
OC  
Blank

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

**TNM PATHOLOGIC T**

**Abstract Plus Field Name:** TNM Path T

**Required for 2016-2017 diagnoses**  
**Item Length: 4**  
**NAACCR Item #: 880**

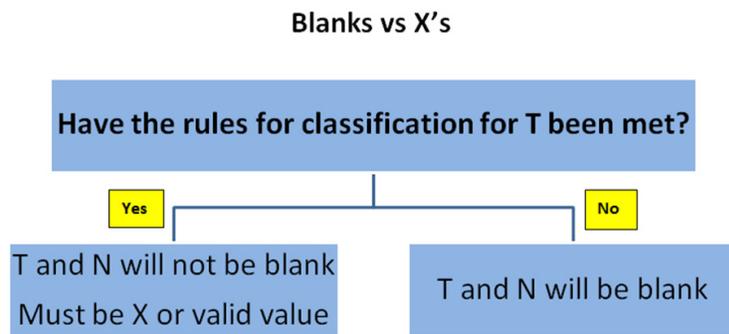
**Description**

Detailed site-specific codes for the pathologic tumor (T) as defined by American Joint Commission on Cancer (AJCC) and recorded by the physician.

**Codes**

The following codes are valid for AJCC 7th edition:

- pX
- p0
- pIS
- pISU
- pISD
- pA
- p1
- p1A
- p1A1
- p1A2
- p1B
- p1B1
- p1B2
- p1C
- p1D
- p1MI
- p2
- p2A
- p2A1
- p2A2
- p2B
- p2C
- p2D
- p3
- p3A
- p3B
- p3C
- p3D
- p4
- p4A
- p4B
- p4C
- p4D
- p4E
- 88
- Blank



If the AJCC Rules for Classification have been met (defined in each site chapter of the manual), this field cannot be blank.

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

**TYPE OF REPORTING SOURCE****Abstract Plus Field Name:** Reporting Source**Required  
Item Length: 1  
NAACCR Item #: 500****Description**

This variable codes the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original case finding (for example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician's office, code this item 4).

**Rationale**

The code in this field can be used to explain why tumor information may be incomplete. For example, death-certificate-only cases have unknown values for many data items, so they may be excluded from some analyses. This field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death-certificate-only cases where no hospital admission was involved. However, too high a percentage can imply shortcomings in case-finding and also that follow-back was incomplete in uncovering missed hospital reports.

**Coding Instructions**

Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This change prioritizes laboratory reports over nursing home reports.

This data item is intended to indicate the completeness of information available to the abstractor. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients. Therefore, these sources are grouped with inpatients and given the code with the highest priority.

Sources coded with '2' usually have complete information on the cancer diagnosis, staging, and treatment.

Sources coded with '8' would include, but would not be limited to, outpatient surgery and nuclear medicine services. A physician's office that calls itself a surgery center should be coded as a physician's office. Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. If a physician's office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

<b>Codes</b>	<b>Description</b>
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3	Laboratory only (hospital-affiliated or independent)
4	Physician's office/private medical practitioner (LMD)
5	Nursing/convalescent home/hospice
6	Autopsy only
7	Death certificate only
8	Other hospital outpatient units/surgery centers

**TUMOR SIZE SUMMARY****Abstract Plus Field Name:** Tumor Size Summary**Required for 2016 and 2017 diagnoses****Item Length: 3****NAACCR Item #: 756****Description**

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen. This data item should only be used for cases diagnoses 2016 or later.

**Rationale**

Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

**Instructions for Coding:** (See the [FORDS](#) manual for specifics and examples.)

1. All measurements should be in millimeters (mm).
2. Record size 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.
  - b. If neoadjuvant therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment, if unknown code size as 999.
  - c. If no surgical resection, then largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment.
  - d. If a, b, and c do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.
3. Tumor size is the diameter of the tumor, not the depth or thickness of the tumor.
4. Recording less than/greater than: If tumor size is reported as less than X mm or X cm, the reported tumor size should be 1mm less. If tumor size is reported as more than X mm or X cm, code size as 1mm more.
5. Rounding: Round the tumor size only if it is described in fractions of millimeters.
6. Priority of imaging techniques: Information on size from imaging techniques can be used to code size when there is no more specific size information from a pathology or operative report. It should be taken over a physical exam.
7. If there is a difference in reported tumor size among imaging/radiographic techniques, record the largest unless the physician specifies which imaging is most accurate.
8. Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis.
9. Record the size of the invasive component, if given.
10. Record the largest dimension or diameter of tumor.
11. Record the size as stated for purely in situ lesions.
12. Disregard microscopic residual or positive surgical margins when coding tumor size.
13. Do not add the size of pieces or chips together to create a whole, unless the pathologist states an aggregate or composite size.
14. If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor (or in situ, if all tumors are in situ).
15. Use tumor size code 999 when the size is unknown or not applicable.

**TUMOR SIZE SUMMARY CODES**

000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2mm-988mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	SITE-SPECIFIC CODES

Alternate descriptions of tumor size for specific sites:

Familial/multiple polyposis:

Rectosigmoid and rectum (C19.9, C20.9)

Colon (C18.0, C18.2-C18.9)

**If no size is documented:**

Circumferential:

Esophagus (C15.0 C15.5, C15.8 C15.9)

Diffuse; widespread: 3/4s or more; linitis plastica:

Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9)

Diffuse, entire lung or NOS:

Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9)

Diffuse:

Breast (C50.0 C50.6, C50.8 C50.9)

999	Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable
-----	--

**VENDOR NAME**

**Abstract Plus Field Name:** Hidden, Automatically Coded

**Required**  
**Item Length: 10**  
**NAACCR Item #: 2170**

**Description**

This is a system-generated field: the abstractor should not need to fill this in manually. It contains the name of the computer services vendor who programmed the system submitting the data. Code is self-assigned by vendor.

**Rationale**

This is used to track which vendor and which software version submitted the case. It helps define the source and extent of a problem discovered in data submitted by a software provider.

**VITAL STATUS****Abstract Plus Field Name:** Vital Status**Required  
Item Length: 1  
NAACCR Item #: 1760****Description**

Vital status of the patient as of the date entered in Date of Last Contact. If the patient has multiple tumors, vital status should be the same for all tumors.

<b>Codes</b>	<b>Description</b>
0	Dead
1	Alive