Wisconsin Cancer Reporting System

Data Dictionary

Updated for 2021 Diagnoses

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

WISCONSIN DEPARTMENT *of* HEALTH SERVICES

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Introduction

Overview

This data dictionary lists all data items required by Wisconsin Cancer Reporting System (WCRS) along with coding instructions and supplemental information. It has been updated with information for cases diagnosed 2021 and forward. Items are in alphabetical order.

A tabular list of WCRS 2021 required data items is also available for download:
2021 Required Data Items (Excel) | 2021 Required Data Items (PDF)

Each data item entry contains:

- Item Name
- Item Length
- Item Number
- Description
- Codes

In addition, some data item entries contain supplemental items such as:

- Coding Instructions
- Coding Guidelines
- Terms and Definitions
- Rationale
- Standard Source
- Examples
- Additional Information

Transmission Instructions for Dates

- Dates must be transmitted in the year, month, day format (YYYYMMDD). The transmission requirements are intended to improve the interoperability, or communication, of cancer registry data with other electronic record systems. If there are no known date components, the date data item will be completely blank.

  For *Example:*

  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/estimated, and month and day are unknown
  Blank – when no known date applies

- The date flags are used when all eight places of a date data item are blank. The flags explains why the data item is blank. Date flags replace non-date information that had previously been transmitted in date data items. Coding 99999999 to indicate “unknown” is an example of non-date information that was previously transmitted in date data items.
- Date of Diagnosis cannot be entirely blank. See the specific coding instructions for each date data item.

Summary of Changes

Added

- Medicare Beneficiary Identifier
- Name—Birth Surname
- Grade Post Therapy Clin (yc)
- NCDB--COVID19--Tx Impact
- NCDB--SARSCoV2--Pos
- NCDB--SARSCoV2--Pos Date
- NCDB--SARSCoV2--Test
- AJCC Cancer Surveillance API Version Current
- AJCC Cancer Surveillance API Version Original
- Gleason Patterns Clinical
- Gleason Patterns Pathological
- Gleason Score Clinical
- Gleason Score Pathological
- Gleason Tertiary Pattern

Removed

- Name—Maiden

Name Changes

- Grade Post Therapy renamed to Grade post Therapy Path (yp)
- LDH Pretreatment Lab Value renamed to LDH Lab Value

ABSTRACTED BY

Item #	Length
570	3

Alternate Name:	
XML NAACCR ID:	abstractedBy
PARENT XML ELEMENT:	Tumor

Description

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

Additional Information

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--HOSP

Item #	Length
550	9

Alternate Name:	Accession Number (CoC)
XML NAACCR ID:	accessionNumberHosp
PARENT XML ELEMENT:	Tumor

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 primaries for an individual must have the same accession number. The first four digits must be greater than or equal to 1944.

Example: The 31st patient abstracted at facility X in calendar year 2018 will have a hospital accession number of 201800031. If this same patient is seen in later in 2018 with a new primary cancer, the accession number will still stay the same as the original, first time seen in that facility (201800031). The sequence number field will change to indicate the new primary cancer.

Rationale

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

ADDR AT DX--CITY

Item #	Length
70	50

Alternate Name:	City or Town (pre-96 CoC) City/Town at Diagnosis (CoC)
XML NAACCR ID:	addrAtDxCity
PARENT XML ELEMENT:	Tumor

Description

Name of the city 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.

Codes (in addition to valid City)

UNKNOWN	City at diagnosis unknown

ADDR AT DX--NO & STREET

Item #	Length
2330	60

Alternate Name:	Patient Address (Number and Street) at Diagnosis (CoC) Number and Street (pre-96 CoC)
XML NAACCR ID:	addrAtDxNoStreet
PARENT XML ELEMENT:	Tumor

Description

The number and street address or rural mailing address of the patient's residence at the time the reportable tumor was diagnosed. Residential street address should not include PO Boxes.

IMPORTANT: PO Box mailing address should only be recorded when no other address information is available in the medical record and no other information sources are available.

Rationale

The address is part of the patient's demographic data and has multiple uses. It can be used to evaluate referral patterns, allows for the analysis of cancer cluster concerns, and supports epidemiological studies that use area-based social measures.

Codes (in addition to valid street address)

UNKNOWN	Patient's address is unknown

Coding Instructions and Summary of USPS Guidelines.

- This field is intended to store street address information for the patient’s physical, residential address. All efforts should be made to find the patient’s true street address and postal code, including reviewing relevant sources outside the medical record if available.
- If the patient has multiple tumors, address at diagnosis may be different for each tumor.
- Do not update this item if the patient’s residential address changes. Store updated address information in the affiliated current address data items. Only update based on improved information on the residential address at time of diagnosis.
- Additional address information such as facility, nursing home, name of apartment complex, or a PO Box used for mailing purposes, should be entered in Addr At Dx--Supplementl [2335].
- U.S. addresses should conform to the U.S. Postal Service (USPS) Postal Addressing Standards. These standards are referenced in USPS Publication 28, Postal Addressing Standards. The current USPS Pub. 28 may be found and downloaded here: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.
- The address should be fully spelled out with standardized use of abbreviations and

punctuation per USPS postal addressing standards (USPS Pub. 28, available at link above). Mixed case allowed.

- Canadian addresses should conform to the Canada Postal Guide. The current Canadian Postal Address Standards may be found here: https://www.canadapost.ca/tools/pg/manual/PGaddress- e.pdf.
- Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning. Punctuation normally is limited to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 1/2 Main St), and hyphens when the hyphen carries meaning (e.g., 289-01 Montgomery Ave). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 Main St Apt 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 Flower Blvd # 72).
- Abbreviations should be limited to those recognized by USPS standard abbreviations, these include, but are not limited, to the list below: (A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub. 28 available at link above):

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

Additional Information

The address should be fully spelled out with standardized use of abbreviations and punctuation per USPS postal addressing standards. Upper case is required.

ADDR AT DX--POSTAL CODE

Item #	Length
100	9

Alternate Name:	Zip Code (pre-CoC) Postal Code (CCCR) Postal Code at Diagnosis (CoC)
XML NAACCR ID:	addrAtDxPostalCode
PARENT XML ELEMENT:	Tumor

Description

Identifies the postal code of the patient's address at diagnosis.

Rationale

The postal code is part of the patient's demographic data and has multiple uses. It can be used to evaluate referral patterns, allows for the analysis of cancer cluster concerns, and supports epidemiological studies that use area-based social measures.

Codes (in addition to known US and Canadian or other postal codes)

888888888	Resident of country other than the United States, U.S. possessions or territories, or Canada and the postal code is unknown
999999999	Resident of the United States (including its possessions, etc.) and the postal code is unknown
999999	Resident of Canada and postal code is unknown

Coding Instructions

- This field is intended to store ZIP Code or other postal code for the patient's physical, residential address. The postal code for PO Box mailing address should not be entered into this data item except in the infrequent case when no other address information is available.
- If the patient has multiple tumors, the postal code at diagnosis may be different for each tumor.
- Do not update this item if the patient's residential address changes. Store address update information in the affiliated current address data items. Only update based on improved information on the residential address at time of diagnosis.
- 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.
- For Canadian residents, use the 6-character alphanumeric postal code.
- When available, enter the postal code for other countries for out-of-country addresses.

ADDR AT DX--STATE

Item #	Length
80	2

Alternate Name:	State at Diagnosis (CoC) State (pre-96 CoC)
XML NAACCR ID:	addrAtDxState
PARENT XML ELEMENT:	Tumor

Description

Identifies the patient's state or province of residence at the time of diagnosis as identified by the Reporting Source.

Rationale

The state of residence is part of the patient's demographic data and has multiple uses. It can be used to evaluate referral patterns, allows for the analysis of cancer cluster concerns, and supports epidemiological studies that use area-based social measures.

Codes (in addition to USPS abbreviations)

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

Coding Instructions

- This field is intended to store residential state for the patient's physical, residential address. The state for PO Box mailing address should not be entered into this data item except in the infrequent case when no other address information is available.
- If the patient has multiple tumors, state at diagnosis may be different for each tumor.
- Do not update this item if the patient's residential address changes. Store address update information in the affiliated current address data items. Only update based on improved information on the residential address at time of diagnosis.
- Use the U.S. Postal Service abbreviation or Canada Post abbreviation in which the patient resides at the time the reportable tumor is diagnosed.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.

ADDR AT DX--SUPPLEMENTL

Item #	Length
2335	60

Alternate Name:	Patient Address (Number and Street) at Diagnosis--Supplemental (CoC)
XML NAACCR ID:	addrAtDxSupplementl
PARENT XML ELEMENT:	Tumor

Description

Provides the ability to store additional address information such as the name of a place or facility (for example a nursing home, apartment complex, jail or PO Box residential or other mailing address) at the time of diagnosis.

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. By having a second street address field to hold address information, the registry can look up, store the street address, and not lose the facility name due to a shortage of space.

The presence of a second street address field to hold additional address information also aids in follow-up. For instance, Addr At DX--No & Street [2330] should contain a street address only. However, it is important to retain any known PO Box information when linking for cohort studies or patient contact studies.

Retaining facility name can also help correct errors in Addr At DX--No & Street [2330] or assist with geocoding or consolidation. Additionally, researchers can use this field to verify if geographic areas of high risk are driven by location of facilities, such as jails, nursing homes, or homeless shelters.

Coding Instructions

- Record the name of the place or facility (for example nursing home, apartment complex, prison/jail or group home) of the patient's residence when the tumor was diagnosed. Do not use this item for information stored in other address items such as Addr At DX--NO & Street.
- Record a full residential PO Box here (including city & zip code) or other non-physical, residential mailing address here.
- Record HOMELESS here when the street address used is a shelter or diagnosing facility for persons with no usual residence.
- If the patient has multiple tumors, address at diagnosis supplemental may be different for each tumor.
- Do not update this item if the patient's residential address changes. Store updated address information in the affiliated current address data items. Only update based on improved information on the residential address at time of diagnosis.
- Refer to STORE Manual for residency rules.

Additional Information

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

AGE AT DIAGNOSIS

Item #	Length
230	3

Alternate Name:	
XML NAACCR ID:	ageAtDiagnosis
PARENT XML ELEMENT:	Tumor

Description

Age of the patient at diagnosis in complete years. Different tumors for the same patient may have different values.

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

Codes

000	Less than 1 year old; diagnosed in utero
001	1 year old, but less than 2 years
002	2 years old
...	
101	101 years old
...	
120	120 years old
999	Unknown age

Additional Information

Many software programs, including Abstract Plus, calculate this field automatically upon entry of the date of birth and date of diagnosis.

Unknown age should only be used when the date of birth or complete date of diagnosis is unknown.

AJCC CANCER SURVEILLANCE API VERSION CURRENT

Item #	Length
2158	13

Alternate Name:	
XML NAACCR ID:	ajccCancerSurvApiVersionCurrent
PARENT XML ELEMENT:	Tumor

Description

This item indicates the most recently accessed version of the Cancer Surveillance .dll incorporated into the cancer registry software that created the record with stage data diagnosed 2018 and later. AJCC Cancer Surveillance API Version Current will be assigned based on the version of the AJCC Cancer Surveillance API in use in the registry software system. It must be updated every time a new version is incorporated into your system and all relevant cases should be updated to reflect the same value.

- For cases diagnosed prior to 2018, this field should remain blank.
- For cases diagnosed in 2018-2020, this field should be set to the AJCC Cancer Surveillance API version in use at the time of implementation.
- For cases diagnosed in 2018 and later abstracted after implementation, use the AJCC Cancer Surveillance API version in use at the time the case is being abstracted.

Rationale

Over time, the definitions and other content contained in the .dll may change. This item identifies the current API content used to code the items.

Codes

This data item will be generated by registry software. The value is obtained from the .dll.The AJCC Cancer Surveillance API contains contents to support collection of AJCC's TNM, EOD, SSDI's, and directly entered Summary Stage 2018. The underlying contents are loaded from AJCC's API and SEER's web service. The API is versioned independently from the imported contents. The value indicates the version of the Cancer Surveillance API used most recently to code the items listed below and is obtained from the API. It should be recorded the first time the AJCC ID (including a value of XX) and/or Schema ID is determined and should be updated each time an updated AJCC Cancer Surveillance API is implemented.

Related Input Fields

AJCC TNM Clin T (also Path and Post Therapy T) [1001, 1011, 1021]
AJCC TNM Clin N (also Path and Post Therapy N) [1002, 1012, 1022]
AJCC TNM Clin M (also Path and Post Therapy M) [1003, 1013, 1023]
AJCC TNM Clin Stage Group (also Path and Post Therapy Stage Group [1004, 1014, 1024])
Summary Stage 2018 [764]

EOD Primary Tumor [772]
EOD Regional Nodes [774]
EOD Mets [776]
All SSDIs (see SSDI manual for complete list)

AJCC CANCER SURVEILLANCE API VERSION ORIGINAL

Item #	Length
2159	13

Alternate Name:	
XML NAACCR ID:	ajccCancerSurvApiVersionOriginal
PARENT XML ELEMENT:	Tumor

Description

This item indicates the version of the AJCC Cancer Surveillance .dll incorporated into the cancer registry software that created the record with stage data diagnosed 2018 and later. It should be recorded the first time the AJCC ID (including a value of XX) and/or Schema ID are determined using the .dll. The value is obtained from the .dll.

Rationale

Over time, the definitions and other content contained in the .dll may change. This item identifies the original content used to code the items.

Codes

This data item will be generated by registry software.

The AJCC Cancer Surveillance API contains contents to support collection of AJCC's TNM, EOD, and directly entered Summary Stage 2018. The underlying contents are loaded from AJCC's API and SEER's web service. The API is versioned independently from the imported contents.

The value indicates the version of the AJCC Cancer Surveillance API originally used to code the items listed below and is obtained from the API. It should be recorded the first time the AJCC ID (including a value of XX) and/or Schema ID is determined and should not be updated each time the related input fields are modified. However, if changes made to the diagnosis and/or date of diagnosis result in a different AJCC ID and/or Schema ID, the value for Cancer Surveillance API Version Original should be reset.

Related Input Fields

AJCC TNM Clin T (also Path and Post Therapy T) [1001, 1011, 1021]
AJCC TNM Clin N (also Path and Post Therapy N) [1002, 1012, 1022]
AJCC TNM Clin M (also Path and Post Therapy M) [1003, 1013, 1023]
AJCC TNM Clin Stage Group (also Path and Post Therapy Stage Group [1004, 1014, 1024])
Summary Stage 2018 [764]
EOD Primary Tumor [772]
EOD Regional Nodes [774]
EOD Mets [776]
All SSDIs (see SSDI manual for complete list)

AJCC ID

Item #	Length
995	4

Alternate Name:	
XML NAACCR ID:	ajccId
PARENT XML ELEMENT:	Tumor

Description

The values for this data item are based on the chapters of the AJCC manual and will be derived primarily from the site/histology fields and other data items as required. IDs are assigned to cases for which AJCC staging is applicable. When staging is not applicable, code ‘XX’ is used.

Rationale

This data item will be used to create an efficient process for running TNM Edits.

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

BEHAVIOR CODE ICD-O-3

Item #	Length
523	1

Alternate Name:	Behavior Code (CoC) ICD-O-3 Behaviour (CCCR)
XML NAACCR ID:	behaviorCodeIcdO3
PARENT XML ELEMENT:	Tumor

Description

Code for the behavior of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for tumors diagnosed beginning January 1, 2001, and later recommended that prior cases be converted from ICD-O-2. See Behavior (92-00) ICD-O-2 [430], for ICD-O-2 codes.

Juvenile astrocytoma is coded as borderline in ICD-O-3; North American registries report as 9421/3.

Codes

0	Benign (Reportable for intracranial and CNS sites only)
1	Uncertain whether benign or malignant, borderline malignancy, low malignant potential, and uncertain malignant potential (Reportable for intracranial and CNS sites only)
2	Carcinoma in situ; intraepithelial; noninfiltrating; non-invasive (carcinoma)
3	Malignant, primary site (invasive)

Coding Instructions

Intracranial and CNS tumors

1. Intracranial and CNS tumors with behavior codes 0 (benign) and 1 (borderline malignancy) are reportable beginning with January 1, 2004 diagnoses.
2. Code the behavior from CT scan, Magnetic Resonance Imaging (MRI), or Positron Emission Tomography (PET) report when there is no tissue diagnosis (pathology or cytology report). Code the behavior listed on the scan. Do not use the WHO grade to code behavior.

Metastatic or Non-primary Sites

1. Cases reported to WCRS cannot have a metastatic (/6) behavior code. If the only pathologic specimen is from a **metastatic** site, code the appropriate histology code and the malignant behavior code (/3). The primary site and its metastatic site(s) have the same histology.
2. Code the behavior as malignant (/3) when malignant metastasis is present. Metastasis could be regional, nodal, or distant.
    a. ***Example:*** Adenocarcinoma in situ with lymph nodes positive for malignancy. Code the behavior as malignant (/3).

b. ***Exception:*** For in situ breast cancer, code as non-invasive (/2) in the presence of isolated tumor cells or if cells are artifactually displaced from a previous procedure.

In Situ

1. Clinical evidence alone cannot identify the behavior as in situ; a behavior code of /2 (in situ) must be based on pathologic examination.

In Situ and Invasive

1. Code the behavior as malignant (/3) if any portion of the primary tumor is invasive no matter how limited, i.e., microinvasion.
    a. ***Example:*** Pathology from mastectomy: Large mass composed of intraductal carcinoma with a single focus of invasion. Code the behavior as malignant (/3).
2. Re-code the behavior as malignant (/3) when metastases are attributed to a tumor originally thought to be in situ.
    a. ***Example:*** Right colon biopsy reveals tubulovillous adenoma with microfocal carcinoma in situ; right hemicolectomy is negative for residual disease. Later core liver biopsy consistent with metastatic adenocarcinoma of gastrointestinal origin. Oncologist states most likely colon primary. Change the behavior code for the colon primary from /2 to /3. There were no other colon primaries in this case.

ICD-O-3.2 Histology/Behavior Code Listing

Behavior is the fifth digit of the morphology code after the slash (/). The standard reference for coding behavior is the ICD-O-3.2. Pages 27 through 30 in ICD-O-3 discuss behavior. The following general rules are found on pages 29-30 in ICD-O-3.

1. Usually a histologic term carries a clear indication of the likely behavior of the tumor, whether malignant or benign, and this is reflected in the behavior code assigned to it in the ICD-O.
2. Although only a few histologic types of in situ neoplasms are actually listed in the ICD-O, the behavior code /2 could be attached to any histology code if an in situ form of the neoplasm is diagnosed.
3. If the pathologist disagrees with the ICD-O behavior assignment in a particular case, code the behavior according to the pathologist's description of the behavior even if that histology/behavior combination is not listed in the ICD-O.
4. The pathologist has the final say on the behavior of the tumor. ICD-O-3 may have only one behavior code, in situ (/2) or malignant (/3), listed for a specific histology. If the pathology report describes the histology as in situ and the ICD-O-3 histology code is listed only with a malignant behavior code (/3), assign the in situ behavior code (/2). If the pathology report describes histology as malignant and the ICD-O-3 histology code is listed only with an in situ behavior code (/2), assign the malignant behavior code (/3). See the Morphology and Behavior Code Matrix discussion on page 29 in ICD-O-3.
    a. ***Example:*** The pathology report says large cell carcinoma in situ. The ICD-O-3 lists large cell carcinoma only with a malignant behavior (8012/3). Code the histology and behavior as 8012/2 as specified by the pathologist.

Synonyms for In Situ Behavior

- Behavior code ‘2’
- Bowen disease (not reportable for C440-C449)
- Clark level I for melanoma (limited to epithelium)
- Confined to epithelium
- Hutchinson melanotic freckle, NOS (C44_)
- Intracystic, noninfiltrating (carcinoma)
- Intraductal (carcinoma)
- Intraepidermal, NOS (carcinoma)
- Intraepithelial neoplasia, Grade III (e.g., AIN III, LIN III, SIN III, VAIN III, VIN III)
- Intraepithelial, NOS (carcinoma)
- Involvement up to, but not including the basement membrane
- Lentigo maligna (C44_)
- Lobular, noninfiltrating (C50_) (carcinoma)
- Noninfiltrating (carcinoma)
- Non-invasive (carcinoma)
- No stromal invasion/involvement
- Papillary, noninfiltrating or intraductal (carcinoma)
- Precancerous melanosis (C44_)
- Queyrat erythroplasia (C60_)
- Stage 0 (except Paget’s disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)

BIRTHPLACE--COUNTRY

Item #	Length
254	3

Alternate Name:	
XML NAACCR ID:	birthplaceCountry
PARENT XML ELEMENT:	Patient

Description

Code for the country in which the patient was born. If the patient has multiple tumors, all records should contain the same code.

Rationale

Place of Birth is helpful for patient matching and can be used when reviewing race and ethnicity. It is an important item in algorithms for imputing race and ethnicity. In addition, adding birthplace data to race and ethnicity 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.

Codes (in addition to Valid County Codes)

For numeric and alphabetic lists of places and codes, see Appendix B of the SEER Program and Staging Manual.

ZZN	North America NOS
ZZC	Central American NOS
ZZS	South America NOS
ZZP	Pacific NOS
ZZE	Europe NOS
ZZF	Africa NOS
ZZA	Asia NOS
ZZX	Non-US NOS
ZZU	Unknown

BIRTHPLACE--STATE

Item #	Length
252	2

Alternate Name:	
XML NAACCR ID:	birthplaceState
PARENT XML ELEMENT:	Patient

Description

USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient was born. If the patient has multiple primaries, the state of birth is the same for each tumor.

Rationale

This is a modification of the current item Birthplace [250] item in order to make use of standard codes, rather than using geographic codes that are only used by cancer registries.

Codes (in addition to USPS Abbreviations)

For numeric and alphabetic lists of places and codes, see Appendix B of the SEER Program and Staging Manual.

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

BRAIN MOLECULAR MARKERS

Item #	Length
3816	2

Alternate Name:	
XML NAACCR ID:	brainMolecularMarkers
PARENT XML ELEMENT:	Tumor

Description

Multiple brain molecular markers have become standard pathology components necessary for diagnosis. This data item captures clinically important brain cancer subtypes identified by molecular markers that are not distinguishable by ICD-O-3 codes.

Rationale

Collection of these clinically important brain cancer subtypes has been recommended by Central Brain Tumor Registry of the United States (CBTRUS).

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

01	Diffuse astrocytoma, IDH-mutant (9400/3)
02	Diffuse astrocytoma, IDH-wildtype (9400/3)
03	Anaplastic astrocytoma, IDH-mutant (9401/3)
04	Anaplastic astrocytoma, IDH-wildtype (9401/3)
05	Glioblastoma, IDH-wildtype (9440/3)
06	Oligodendroglioma, IDH-mutant and 1 p/19q co-deleted (9450/3)
07	Anaplastic oligodendroglioma, IDH-mutant and 1 p/19q co-deleted (9451/3)
08	Medulloblastoma, SHH-activated and TP53-wildtype (9471/3)
09	Embryonal tumor with multilayered rosettes, C19MC-altered (9478/3)
85	Not applicable: Histology not 9400/3, 9401/3, 9440/3, 9450/3, 9451/3, 9471/3, 9478/3
86	Benign or borderline tumor
87	Test ordered, results not in chart
88	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 88 will result in an edit error.)

99	Not documented in patient record No microscopic confirmation Brain molecular markers not assessed or unknown if assessed

Coding Instructions

1. This data item applies only to ICD-O-3 histology codes:
    - 9400/3, 9401/3, 9440/3, 9450/3, 9451/3, 9471/3, 9478/3.
    - ***Note:*** If a histology is not included in this list, assign, code 85.
2. Physician statement of histologic subtype can be used to code this data item.
3. Only one code is applicable for each tumor.
    - IDH mutation status distinguishes between clinically important subtypes within ICD-O-3 9400/3, Diffuse astrocytoma and 9401/3, Anaplastic astrocytoma.
    - IDH mutant and 1p/19q co-deletion distinguishes between clinically important subtypes within ICD-O-3 code 9450/3, Oligodendroglioma and 9451/3, Anaplastic Oligodendroglioma.
    - IDH-wildtype distinguishes clinically important subtypes within ICD-O-3 9400/3, Diffuse astrocytoma, 9401/3, Anaplastic astrocytoma and 9440/3, Glioblastoma, Epithelioid glioblastoma and Glioblastoma, NOS (note that the new ICD-O-3 code 9445/3 applies to Glioblastoma, IDH-mutant; information regarding this subtype is not collected using this data item).
    - SHH-activation and TP53-wildtype distinguishes between clinically important subtypes within ICD-O-3 histology code 9471/3, Medulloblastoma.
    - C19MC alteration status distinguishes a clinically important highly aggressive subtype within ICD-O-3 9478/3, Embryonal tumor with multilayered rosettes.
    - ***Example 1:*** Biopsy of brain tumor, microscopic confirmation diagnosis: Diffuse Astrocytoma (9400/3). Additional testing done and IDH-mutant is identified. Code 01. Biopsy of brain tumor, microscopic confirmation diagnosis: Anaplastic astrocytoma (9401/3). No further testing or results unknown. Code 99.
    - ***Example 2:*** MRI of brain tumor, clinical diagnosis: glioblastoma. No further workup. Code 99.
    - ***Example 3:*** Biopsy of brain tumor, microscopic confirmation diagnosis: Mixed glioma (9382/3). Code 85.

BRESLOW TUMOR THICKNESS

Item #	Length
3817	4

Alternate Name:	
XML NAACCR ID:	breslowTumorThickness
PARENT XML ELEMENT:	Tumor

Description

Breslow Tumor Thickness, the measurement of the thickness of a melanoma as defined by Dr. Alexander Breslow, is a prognostic factor for Melanoma of the Skin.

Definition

A measure of how deeply a melanoma tumor has grown into the skin. The tumor thickness (depth) is usually measured from the top of the tumor to the deepest tumor cells. If the tumor is ulcerated (the skin is broken), it is measured from the base of the ulcer to the deepest tumor cells. Breslow thickness is used to help determine the stage of cancer. Thicker tumors are linked with lower survival rates.

Rationale

Breslow Tumor Thickness is a Registry Data Collection Variable in AJCC. It was previously collected as Melanoma Skin, CS SSF# 1.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

0.0	No mass/tumor found
0.1	Greater than 0.0 and less than or equal to 0.1
0.2-99.9	0.2 - 99.9 millimeters
XX.1	100 millimeters or larger
A0.1-A9.9	Stated as "at least" some measured value of 0.1 to 9.9
AX.0	Stated as greater than 9.9 mm
XX.8	Not applicable: Information not collected for this schema (If required by your standard setter, use of code XX.8 will result in an edit error)
XX.9	Not documented in medical record Microinvasion; microscopic focus or foci only and no depth given Cannot be determined by pathologist In situ melanoma Breslow Tumor Thickness not assessed or unknown if assessed

Coding Guidelines

1. Code a measurement specifically labeled as “thickness” or “depth” or “Breslow depth of invasion” from the pathology report. In the absence of this label, a measurement described as taken from the cut surface of the specimen may be coded. In the absence of either of these labels, the third dimension in a statement of tumor size can be used to code this field.
2. Code the greatest measured thickness from any procedure performed on the lesion, whether it is described as a biopsy or an excision. Do not add measurements together from different procedures.
    a. ***Example:*** A punch biopsy with a thickness of 0.5 mm is followed by a re-excision with a thickness of residual tumor of 0.2 mm. Code 0.5 mm.
3. If the tumor is excised post-neoadjuvant treatment, tumor measurements cannot be compared before and after treatment to determine which would indicate the greater involvement. The same code (XX.9) is used for cases with no surgical procedure of the primary site and cases with surgical procedure of the primary site after neoadjuvant treatment.
4. Because the thickness table is similar to many other tables that collect a measurement, it is important to identify the correct unit of measurement.
5. In the range 0.1-99.9, code the actual tumor thickness, tumor depth, or Breslow measurement in tenths of millimeters as stated in the pathology report. If the measurement is given in hundredths of millimeters, use the general rules for rounding to determine the value in tenths of millimeters. This is a four-digit field with a decimal point in the third digit.
    a. ***Example 1:*** Tumor described as 0.5 mm in depth – code as 0.5
    b. ***Example 2:*** Lesion 1 mm thick – code as 1.0.
    c. ***Example 3:*** Breslow 2.5 mm – code as 2.5
    d. ***Example 4:*** Thickness of 10 mm (1 cm) – code as 10.0

Coding Instructions

Physician statement of Breslow Tumor Thickness can be used to code this data item when no other information is available, or the available information is ambiguous.

1. Code Breslow tumor thickness, not size. Record actual measurement in tenths of millimeters from the pathology report. Measurement given in hundredths of millimeters should be rounded to the nearest tenth.
    a. ***Examples***:
        - 0.4 mm – 0.4
        - 1.0 mm- 1.0
        - 2.5 mm – 2.5
        - 2.56 mm- 2.6
        - 11 mm – 11.0
        - 12.35 mm – 12.4 mm
2. Code the greatest measured thickness from any procedure performed on the lesion, whether it is described as a biopsy or an excision.
    a. ***Example:*** If a punch biopsy with a thickness of 1.5 mm is followed by a re-excision with a thickness of residual tumor of 0.2 mm, code 1.5.

3. Do not add measurements together from different procedures (even in the rare circumstance that the pathologist adds the measurements from two specimens).
4. If the pathologist describes the thickness as “at least,” use the appropriate A code. An exact measurement takes precedence over A codes.
5. If the pathologist states “greater than” instead of “at least”, code to XX.9, unless it is greater than 9.9 mm (Code AX.0).
    a. ***Example 1:*** Pathologist states the thickness is “at least 2.0 mm.” Code A2.0.
    b. ***Example 2:*** Pathologist states the thickness is “greater than 4 mm.” Code XX.9.

Additional Information

Source documents: pathology report

For further information, refer to the Melanoma cancer protocol published by the College of American Pathologists for AJCC 8th edition.

Other names: maximum tumor thickness, Breslow depth of invasion, Breslow thickness, Breslow measurement, Breslow’s microstaging.

CASEFINDING SOURCE

Item #	Length
501	2

Alternate Name:	
XML NAACCR ID:	casefindingSource
PARENT XML ELEMENT:	Tumor

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 the coded value of 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."

Codes

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

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. At the regional or central level, if a hospital and a non- hospital source identified the case independently of each other, enter the code for the non-hospital source (i.e., codes 30-95 have priority over codes 10-29). If the case was first identified at a reporting facility (codes 10-29), code the earliest source (based on patient or specimen contact at the facility) of identifying information.

If a death certificate, independent pathology laboratory report, consultation-only report from a hospital, or other report was used to identify a case that was then abstracted from a different source, enter the code for the source that first identified the case, not the source from which it was subsequently abstracted. If a regional or central registry identifies a case and asks a reporting facility to abstract it, enter the code that corresponds to the initial source, not the code that corresponds to the eventual reporting facility.

CAUSE OF DEATH

Item #	Length
1910	4

Alternate Name:	Underlying Cause of Death (SEER) Underlying Cause of Death (ICD Code) (pre-96 CoC)
XML NAACCR ID:	causeOfDeath
PARENT XML ELEMENT:	Patient

Description

Official cause of death as coded from the death certificate in valid ICD-7, ICD-8, ICD-9, and ICD-10 codes.

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.

Codes (in addition to ICD-7, ICD-8, ICD-9, and ICD-10)

Refer to SEER Program Coding and Staging Manual for additional instructions.

0000	Patient alive at last contact
7777	State death certificate not available
7797	State death certificate available but underlying cause of death is not coded

CLASS OF CASE

Item #	Length
610	2

Alternate Name:	
XML NAACCR ID:	classOfCase
PARENT XML ELEMENT:	Tumor

Description

Class of Case divides cases into two groups. Analytic cases (codes 00-22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and treatment. Treatment and outcome reports may be limited to analytic cases. Nonanalytic cases (codes 30-49 and 99) may be abstracted by the facility to meet central registry requirements or because of a request by the facility's cancer program. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.

Class of Case can be used in conjunction with Type of Reporting Source [500]. Type of Reporting Source is designed to document the source of documents used to abstract the cancer being reported.

Rationale

Class of Case reflects the facility's role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program's Reference Date.

Codes

Analytic Classes of Case	
Initial diagnosis at reporting facility or in a staff physician's office	
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility
12	Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility

13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
Initial diagnosis elsewhere	
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility
Non-Analytic Classes of Case	
Patient appears in person at reporting facility	
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)
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 disease history only (disease not active)
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 by reporting facility
35	Case diagnosed before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death

Patient does not appear in person at reporting facility	
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more different offices of physicians with admitting privileges
42	Nonstaff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

Examples

Code	Reason
00	Leukemia was diagnosed at the facility, and all care was given in an office of a physician with practice privileges. The treatment may be abstracted if the cancer committee desires, but the case is Class of Case 00.
13	Breast cancer was diagnosed at the reporting hospital and surgery performed there. Radiation was given at the hospital across the street with which the reporting hospital has an agreement.
10	Reporting hospital found cancer in a biopsy, but was unable to discover whether the homeless patient actually received any treatment elsewhere.
32	After treatment failure, the patient was admitted to the facility for supportive care.
11	Patient was diagnosed by a physician with practice privileges, received neoadjuvant radiation at another facility, and then underwent surgical resection at the reporting facility.
42	Patients from an unaffiliated, free-standing clinic across the street that hospital voluntarily abstracts with its cases because many physicians work at both the clinic and the hospital.
31	Patient received chemotherapy while attending daughter's wedding in the reporting hospital's city, then returned to the originating hospital for subsequent treatments.

COC ACCREDITED FLAG

Item #	Length
2152	1

Alternate Name:	
XML NAACCR ID:	cocAccreditedFlag
PARENT XML ELEMENT:	Tumor

Description

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

Rationale

CoC-accredited facilities are required to collect certain data items including TNM staging. It is burdensome for central registries to maintain a list of accredited facilities, and the list changes frequently. The flag is a means of incorporating the accredited status into abstracts at the time of abstraction by someone who has knowledge of the status. The flag thus simplifies validating that required items have been abstracted by CoC-accredited facilities. The flag also allows cases to be stratified during analyses to identify those never seen at a CoC-accredited facility; e.g., percentage of all cases seen in at least one CoC-accredited facility, evaluation of outcomes by facility status. NPCR will use this flag for facility status stratification.

Codes

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

Coding Instructions

1. Assign at the time of data abstraction.
2. Assign manually or automatically assign using registry software.

COUNTY AT DX REPORTED

Item #	Length
90	3

Alternate Name:	County (pre-96 SEER/CoC) County at Diagnosis (CoC) County at DX
XML NAACCR ID:	countyAtDx
PARENT XML ELEMENT:	Tumor

Description

Code for the county of the patient's residence at the time of diagnosis as identified by the Reporting Source. For U.S. residents, standard codes are those of the FIPS publication Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas or their equivalent INCITS codes.

Rationale

This data item may be used for epidemiological purposes. For example, to measure cancer incidence in a particular geographic area.

Codes (in addition to valid FIPS codes)

998	Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria). Use this code for Canadian residents.
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

FIPS Codes

See the NAACCR Data Dictionary, Version 21, for a list of county FIPS codes for all states: http://datadictionary.naaccr.org/default.aspx?c=11&Version=21

Wisconsin County FIPS CODES					
Adams	001	Iowa	049	Polk	095
Ashland	003	Iron	051	Portage	097
Barron	005	Jackson	053	Price	099
Bayfield	007	Jefferson	055	Racine	101
Brown	009	Juneau	057	Richland	103
Buffalo	011	Kenosha	059	Rock	105

Burnett	013	Kewaunee	061	Rusk	107
Calumet	015	La Crosse	063	St. Croix	109
Chippewa	017	Lafayette	065	Sauk	111
Clark	019	Langlade	067	Sawyer	113
Columbia	021	Lincoln	069	Shawano	115
Crawford	023	Manitowoc	071	Sheboygan	117
Dane	025	Marathon	073	Taylor	119
Dodge	027	Marinette	075	Trempealeau	121
Door	029	Marquette	077	Vernon	123
Douglas	031	Menominee	078	Vilas	125
Dunn	033	Milwaukee	079	Walworth	127
Eau Claire	035	Monroe	081	Washburn	129
Florence	037	Oconto	083	Washington	131
Fond du Lac	039	Oneida	085	Waukesha	133
Forest	041	Outagamie	087	Waupaca	135
Grant	043	Ozaukee	089	Waushara	137
Green	045	Pepin	091	Winnebago	139
Green Lake	047	Pierce	093	Wood	141

Coding Instructions

1. This field is intended to store address information for the patient's physical, residential address. All efforts should be made to find the patient's true street address and postal code, including reviewing relevant sources outside the medical record if available. The county for a PO Box mailing address should only be recorded when no other address information is available in the medical record and no other information sources are available.
2. If the patient has multiple tumors, county at diagnosis may be different for each tumor.
3. Do not update this item if the patient's county of residence changes. Store updated address information in the affiliated current address data items. Only update based on improved information on the residential address at time of diagnosis.
4. This variable is coded at time of abstracting and is considered less accurate than the derived, geocoded county at diagnosis variables: County at Diagnosis 1990, 2000, 2010, & 2020.
5. Detailed standards have not been set for Canadian provinces/territories. Use code 998 for Canadian residents.

DATE CASE COMPLETED

Item #	Length
2090	8

Alternate Name:	
XML NAACCR ID:	dateCaseCompleted
PARENT XML ELEMENT:	Tumor

Description

The date that: (1) the abstractor decided that the tumor report was complete and (2) the case passed all edits that were applied. Definitions may vary among registries and software providers. This field is locally used by central registries. Standard edits check that no dates are later than the current date. These specifications will not necessarily be the same as those used for Date Case Completed--CoC [2092].

DATE INITIAL RX SEER

Item #	Length
1260	8

Alternate Name:	Date Therapy Initiated (SEER) Date Started (SEER) Date of Initial RX--SEER
XML NAACCR ID:	dateInitialRxSeer
PARENT XML ELEMENT:	Tumor

Description

Record the start date of the first course of therapy. This is the start date of any type of treatment for this tumor; surgery, chemotherapy, radiation therapy, or other types of therapy. Treatment may be given in a hospital or non-hospital setting. Must be transmitted in the YYYYMMDD format.

Coding Instructions

1. Code the start date of the first therapy. The first therapy may be recorded in the following data items:
    - Surgery of Primary Site
    - Scope of Regional Lymph Node Surgery (excluding code 1)
    - Surgical Procedure of Other Site
    - Radiation Treatment Modality--Phase I, II, III
    - Chemotherapy
    - Hormone Therapy
    - Immunotherapy
    - Hematologic Transplant and Endocrine Procedures
    - Other Therapy
2. Code the date of excisional biopsy when it is the first treatment. Code the date of a biopsy documented as incisional when further surgery reveals no residual or only microscopic residual.
    - ***Example:*** Breast biopsy with diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual tumor noted. Code the date of the biopsy.
3. Record the actual date of treatment when treatment is performed prior to birth. Record the type of treatment in the appropriate data item, for example, Surgery of Primary Site.
    - ***Example:*** On 01/03/2021, fetus is diagnosed with malignant teratoma. The teratoma is resected in utero on 01/10/2021. Live birth on 04/18/2021. Code the date as January 10, 2021 (20210110).
4. Code the date unproven therapy was initiated as the date therapy initiated.
5. Code the date of admission to the hospital for inpatient or outpatient treatment when the exact date of the first treatment is unknown.

6. Leave blank when:
    - No treatment is given during the first course.
    - Treatment Status is coded 2, Active surveillance/watchful waiting.
    - It is known the patient had first course therapy, but it is impossible to estimate the date.
    - It is unknown whether the patient had treatment.
    - It is a death certificate only (DCO) case where the date is unknown and cannot be estimated.
    - It is an autopsy only case.

Estimating Dates

Estimating the month

1. Code “spring of” to April.
2. Code “summer” or “middle of the year” to July.
3. Code “fall” or “autumn” as October.
4. For “winter of,” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.
5. Code “early in year” to January.
6. Code “late in year” to December.
7. Use whatever information is available to calculate the month.
8. Code the month of admission when there is no basis for estimation.
9. Leave month blank if there is no basis for approximation.

Estimating the year

1. Code “a couple of years” to two years earlier.
2. Code “a few years” to three years earlier.
3. Use whatever information is available to calculate the year.
4. Code the year of admission when there is no basis for estimation.

DATE INITIAL RX SEER FLAG

Item #	Length
1261	2

Alternate Name:	Date of Initial RX Flag
XML NAACCR ID:	dateInitialRxSeerFlag
PARENT XML ELEMENT:	Tumor

Description

This flag explains why no appropriate value is in the field, Date Initial RX SEER [1260].

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non- date information that had previously been transmitted in date fields.

Codes

Blank	A valid date value is provided in Date Initial RX SEER
10	No information whatsoever can be inferred
11	No proper value is applicable in this context
12	Unknown; A proper value is applicable but not known

Coding Instructions

1. Leave this item blank if Date Initial RX SEER has a full or partial date recorded.
2. Assign code **10** when it is unknown whether any treatment was administered.
    a. For death certificate only (DCO) cases.
3. Assign code **11** when no treatment is given during the first course, the first course is active surveillance/watchful waiting, or the initial diagnosis was at autopsy.
4. Assign code **12** if the Date Initial RX SEER cannot be determined, and the patient did receive first course treatment.

DATE OF 1ST CONTACT

Item #	Length
580	8

Alternate Name:	Date of Adm/First Contact
XML NAACCR ID:	dateOf1stContact
PARENT XML ELEMENT:	Tumor

Description

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

When pathology-specimen-only tumors are collected (Class of Case 43, Type of Reporting Source 3), the date of specimen collection from the pathology report should be used as the Date of 1st Contact. If a pathology-specimen-only case is followed by patient contact with a facility for diagnosis and/or treatment of the respective tumor, ACoS coding rules require the hospital registry to change the Date of 1st Contact to reflect the date the patient first registered at that facility. Central registries, however, should retain the earlier date in their consolidated files, as that shows the patient's first recorded contact with the healthcare system for this disease.

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

Rationale

Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations. Date of 1st Contact is one of several data items that can be used to measure timeliness of reporting to central cancer registries by individual facilities. For tumors that are not diagnosed at the reporting facility following its Reference Date (Class of Case 20-22, 30-37), the Date of 1st Contact [580] can be used in conjunction with the Date Case Report Received [2111] to measure timeliness of reporting by individual facilities.

Comment: To accurately measure the timeliness of data collection and submission of abstracts that are first diagnosed at autopsy (Class of Case 38, Type of Reporting Source 6) the date of death should be used as the Date of 1st Contact since the diagnosis was not determined until the autopsy was performed. Death Certificate Only cases (Class of Case 49, Type of Reporting Source 7) are created only by the central registry. For these cases, Date of 1st Contact should be filled with the date of death, and timeliness for DCO cases should be measured by different criteria.

Coding Instructions

1. Record the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or first course treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, x-ray, or laboratory test, or the date a pathology specimen was collected at the hospital.
2. For analytic cases (Class of Case 00-22), the Date of First Contact is the date the patient became analytic. For non-analytic cases, it is the date the patient first qualified for the Class of Case that causes the case to be abstracted.
3. If this is an autopsy-only or death certificate-only case, then use the date of death.
4. When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.
5. Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for Date of First Contact is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of Date of First Contact transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date. The Date of First Contact Flag [581] is used to explain why Date of First Contact is not a known date. See Date of First Contact Flag for an illustration of the relationships among these items.

Examples

Code	Label	Definition
20090914	September 14, 2009	Patient undergoes a biopsy in a staff physician's office on September 8, 2009. The pathology specimen was sent to the reporting facility and was read as malignant melanoma. The patient enters that same reporting facility on September 14, 2009 for wide re-excision.
20101207	December 7, 2010	Patient has an MRI of the brain on December 7, 2010, for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19 removes all gross tumor.
20110499	April 2011	Information is limited to the description "Spring," 2011.
20110799	July 2011	Information is limited to the description "The middle of the year," 2011.
20111099	October 2011	Information is limited to the description "Fall," 2011.
CCYY1299 or CCYY0199	December or January	If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year.

DATE OF 1ST CONTACT FLAG

Item #	Length
581	2

Alternate Name:	Date of First Contact Flag
XML NAACCR ID:	dateOf1stContactFlag
PARENT XML ELEMENT:	Tumor

Description

This flag explains why no appropriate value is in the field Date of 1st Contact [580]. This data item was first available in Volume II Version 12.

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non- date information that had previously been transmitted in date fields.

Codes

Blank	A valid date value is provided in Date of 1st Contact
12	Unknown; A proper value is applicable but not known

Coding Instructions

1. Leave this item blank if Date of First Contact [580] has a full or partial date recorded.
2. Code 12 if the Date of First Contact cannot be determined at all.
3. Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

DATE OF BIRTH

Item #	Length
240	8

Alternate Name:	Birth Date(SEER/CoC/CCCR)
XML NAACCR ID:	dateOfBirth
PARENT XML ELEMENT:	Patient

Description

Date of birth of the patient. 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. Only the year should be entered, left-justified. Estimate date of birth when information is not available. It is better to estimate than to leave birth date unknown.

Coding Instructions

1. Code the date of birth.
2. If date of birth is unknown, but the age at Diagnosis and Date of Diagnosis are known:
    a. Calculate the year of birth by subtracting the patient's age at diagnosis from the year of diagnosis.
    b. Leave the month and day blank.

Note: A zero must precede a single-digit month and a single digit day. ***Example:*** September 5, 1970 would be transmitted as 19700905.

DATE OF BIRTH FLAG

Item #	Length
241	2

Alternate Name:	
XML NAACCR ID:	dateOfBirthFlag
PARENT XML ELEMENT:	Patient

Description

This flag explains why no appropriate value is in the field, Date of Birth [240]. This data item was first available in Volume II Version 12.

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non- date information that had previously been transmitted in date fields.

Codes

Blank	A valid date value is provided in Date of Birth
12	Unknown; A proper value is applicable but not known

Coding Instructions

1. Leave this item blank when Date of Birth has a full or partial date recorded.
2. Assign code 12 when the date of birth cannot be determined.
    a. Assign code 12 for death certificate only (DCO) cases when the date of birth is unknown and cannot be calculated.

DATE OF DIAGNOSIS

Item #	Length
390	8

Alternate Name:	Date of Initial Diagnosis (CoC)
XML NAACCR ID:	dateOfDiagnosis
PARENT XML ELEMENT:	Tumor

Description

Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed.

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

Coding Instructions

1. Code the month, day and year the tumor was first diagnosed, clinically or microscopically, by a recognized medical practitioner.
    a. When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis.
        i. ***Source documents:*** Do not use the date of diagnosis from a cytology report using ambiguous terminology. See Coding Instruction #5 below.
        ii. ***Example:*** Area of microcalcifications in breast suspicious for malignancy on 02/13/2021. Biopsy positive for ductal carcinoma on 02/28/2021. The date of diagnosis 02/13/2021.
2. When the only information available is a positive pathology or cytology report, code the date the biopsy was done, not the date the report was dictated or transcribed.
3. The first diagnosis of cancer may be clinical (i.e., based on clinical findings or physician's documentation).
    a. ***Note:*** Do not change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology.
    b. ***Example:*** On May 15, 2021, physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung in June 3, 2021. The date of diagnosis remains May 15, 2021.
4. Positive tumor markers alone are not diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.
    a. ***Example 1:*** The patient has an elevated PSA and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the prostate. The biopsy is positive for adenocarcinoma. The date of diagnosis is the date of the biopsy (do not code the date of PSA or date procedure was dictated or transcribed).

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

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

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

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

    b. ***Note 2*****:** Do not use ambiguous cytology alone for case ascertainment. SEER Program Coding and Staging Manual 2021 Section IV: Description of this Neoplasm 82.

6. Code the earlier date as the date of diagnosis when:

    a. A medical practitioner says that, in retrospect, patient had cancer at an earlier date **or**

    b. The original slides are reviewed and the pathologist documents that cancer was present. Code the date of the original procedure as the diagnosis date.

        i. ***Example:*** The patient had an excision of a benign fibrous histiocytoma in January 2021. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The physician documents in the chart that the previous tumor must have been malignant. Code the diagnosis date as January 2021.

        ii. ***Note:*** Do not back-date the diagnosis when:

            1. The information on the previous tumor is unclear **AND/OR**

            2. There is no review of previous slides **AND/OR**

            3. There is no physician's statement that, in retrospect, the previous tumor was malignant.

        iii. ***Example:*** The patient had a total hysterectomy and a bilateral salpingo-oophorectomy (BSO) in June 2021 with pathology diagnosis of papillary cystadenoma of the ovaries. In December 2021, the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2021 are not reviewed and there is no physician statement saying the previous tumor was malignant. The date of diagnosis is December 2021.

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

8. Death certificate only (DCO) Cases.

    a. Use information on the death certificate to estimate the date of diagnosis.

    b. Record the date of death as the date of diagnosis when there is not enough information available to estimate the date of diagnosis; for example, the time from onset to the date of death is described as 'years'.

    c. If no information is available, record the date of death as the date of diagnosis.

9. Estimate the date of diagnosis if an exact date is not available. Use all information available to calculate the month and year of diagnosis.

a. Estimating the **month**
    i. Code “spring” to April.
    ii. Code “summer” or “middle of the year” to July.
    iii. Code “fall” or “autumn” as October.
    iv. For “winter” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month of diagnosis.
    v. Code “early in year” to January.
    vi. Code “late in year” to December.
    vii. Use whatever information is available to calculate the month of diagnosis.
        1. ***Example 1:*** Admitted October 2021. History states that the patient was diagnosed 7 months ago. Subtract 7 from the month of admission and code date of diagnosis to March 2021. SEER Program Coding and Staging Manual 2021 Section IV: Description of this Neoplasm 83.
        2. ***Example 2:*** Outpatient bone scan done January 2021 that states history of prostate cancer. The physician says the patient was diagnosed in 2021. Assume bone scan was part of initial work-up and code date of diagnosis to January 2021.
    viii. Code the month of admission when there is no basis for estimation.
    ix. Leave month blank (or convert 99 to blank) if there is no basis for approximation.

b. Estimating the **year.**
    i. Code “a couple of years” to two years earlier.
    ii. Code “a few years” to three years earlier.
    iii. Use whatever information is available to calculate the year of diagnosis.
    iv. Code the year of admission when there is no basis for estimation.

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

1. Use the best approximation for the date of diagnosis when the only information available is that the patient had cancer while in the nursing home and it is unknown whether the patient had cancer when admitted.
2. Code the date of admission to the nursing home as the date of diagnosis when:
    a. The only information available is that the patient had cancer when admitted to the nursing home.
    b. The only information available is that the patient had cancer while in the nursing home, it is unknown whether the patient had cancer when admitted, and there is no basis for approximation.

Cases Diagnosed Before Birth

1. Record the actual date of diagnosis for diagnoses made in utero even though this date will precede the date of birth.
    a. ***Example:*** Fetal intrahepatic mass consistent with hepatoblastoma diagnosed via ultrasound at 39 weeks gestation (01/30/2021). Live birth by C-section 02/04/2021. Code the date of diagnosis as 01/30/2021.
    b. ***Note:*** Prenatal diagnoses are reportable when there is a live birth.

DATE OF DIAGNOSIS FLAG

Item #	Length
391	2

Alternate Name:	
XML NAACCR ID:	dateOfDiagnosisFlag
PARENT XML ELEMENT:	Tumor

Description

This flag explains why no appropriate value in in the field, Date of Diagnosis [390]. This data item was first available in Volume II Version 12.

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non- date information that had previously been transmitted in date fields.

Coding Instructions

Always leave blank. Date of Diagnosis will always have a full or partial date recorded.

DATE OF LAST CONTACT

Item #	Length
1750	8

Alternate Name:	Date of Last Contact or Death (CoC) Date of Last Follow-Up or of Death (SEER)
XML NAACCR ID:	dateOfLastContact
PARENT XML ELEMENT:	Patient

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 recording Date of Last Contact from active or passive follow-up. Used to record date of death and to calculate survival.

Coding Instructions

1. Code the date the patient was actually seen by the physician or contacted by the hospital registry as the follow-up date. Do not code the date the follow-up report was received.
2. Do not change the follow-up date unless new information is available.
3. The data item is associated with the patient, not the cancer, so all records (primary sites) for the same patient will have the same follow-up date.
4. Record the date of death for:
    a. Deceased patients.
    b. Death certificate only (DCO) cases.
    c. Autopsy only cases.

Estimating Dates

Estimating the month

1. Code “spring of” to April.
2. Code “summer” or “middle of the year” to July.
3. Code “fall” or “autumn” as October.
4. For “winter of,” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.
5. Code “early in year” to January.

6. Code “late in year” to December.
7. Use whatever information is available to calculate the month.
8. Code the month of admission when there is no basis for estimation.
9. Leave month blank if there is no basis for approximation.

Estimating the year

1. Code “a couple of years” to two years earlier.
2. Code “a few years” to three years earlier.
3. Use whatever information is available to calculate the year.

DATE OF LAST CONTACT FLAG

Item #	Length
1751	2

Alternate Name:	
XML NAACCR ID:	dateOfLastContactFlag
PARENT XML ELEMENT:	Patient

Description

This flag explains why no appropriate value is in the field, Date of Last Contact [1750].

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

Blank	A valid date value is provided in Date of Last Contact
12	Unknown; A proper value is applicable but not known

Coding Instructions

1. Leave this item blank when Date of Last Contact has a full or partial date recorded.
2. Assign code 12 when the date of last contact or death cannot be determined.

DIAGNOSTIC CONFIRMATION

Item #	Length
490	1

Alternate Name:	
XML NAACCR ID:	diagnosticConfirmation
PARENT XML ELEMENT:	Tumor

Description

Code for the best method of diagnostic confirmation of the cancer being reported at any time throughout 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 not microscopically confirmed is an indication of whether case finding is including sources outside of pathology reports.

Codes for Solid Tumors

Microscopically Confirmed

Code	Description
1	Positive histology
2	Positive cytology
4	Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

Code	Description
5	Positive laboratory test/marker study
6	Direct visualization without microscopic confirmation
7	Radiography and/or other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6, or 7)

Confirmation Unknown

Code	Description
9	Unknown whether or not microscopically confirmed; death certificate only

Coding Instructions for Solid Tumors

1. The codes are in **priority order**; code **1** has the **highest** priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods.
2. Change to a higher-priority code, if at **ANY TIME** during the course of disease the patient has a diagnostic confirmation with a **higher priority**. Change to the higher-priority code even when diagnostic confirmation is based on the result of subsequent treatment.
    a. ***Example:*** Benign brain tumor diagnosed on MRI. Assign diagnostic confirmation code 7. Patient later becomes symptomatic and the tumor is surgically removed. Change diagnostic confirmation code to 1.
3. Assign code **1** when the microscopic diagnosis is based on:
    a. **Tissue** specimens from fine needle aspirate, biopsy, surgery, autopsy, or D&C.
    b. Bone marrow specimens (aspiration and biopsy).
4. Assign code **2** when the microscopic diagnosis is based on:
    a. Examination of **cells** (rather than tissue) including but not limited to: sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears, or vaginal smears.
    b. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.
5. Assign code **4** when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.
6. Assign code **5** when the diagnosis of cancer is based on laboratory tests or tumor marker studies that are clinically diagnostic for that specific cancer and there is no other diagnostic work up (e.g., imaging).
    a. ***Example:*** If the workup for a prostate cancer patient is limited to a highly elevated PSA (no DRE and no imaging) and the physician **diagnoses and/or treats** the patient based only on that PSA, code the diagnostic confirmation to 5.
    b. ***Note:*** For tests and tumor markers that may be used to help diagnose cancer, see http://www.cancer.gov/cancertopics/factsheet/detection http://www.cancer.gov/cancertopics/factsheet/detection/tumor-markers
7. Assign code **6** when the diagnosis is based only on:
    a. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined.
    b. Gross autopsy findings (no tissue or cytologic confirmation).
    c. Assign code **7** when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/sonography.
8. 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.
    a. ***Example:*** CT diagnosis is possible lung cancer. Patient returns to the nursing home with a Do Not Resuscitate (DNR) order. Physician enters a diagnosis of lung cancer in

the medical record. Code the diagnostic confirmation to 8: there is a physician's clinical diagnosis – clinical diagnosis made by the physician using the information available for the case.

9. Assign code **9.**
    a. When it is unknown if the diagnosis was confirmed microscopically.
    b. For death certificate only case.

Codes for Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3)

Microscopically Confirmed

Code	Description
1	Positive histology
2	Positive cytology
3	Positive histology PLUS - positive immunophenotyping AND/OR positive genetic studies (Used only for hematopoietic and lymphoid neoplasms M-9590/3-9992/3)
4	Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

Code	Description
5	Positive laboratory test/marker study
6	Direct visualization without microscopic confirmation
7	Radiography and/or other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6, or 7)

Confirmation Unknown

Code	Description
9	Unknown whether or not microscopically confirmed; death certificate only

Coding Instructions for Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3)

See the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database for coding instructions.

ESTROGEN RECEPTOR SUMMARY

Item #	Length
3827	1

Alternate Name:	
XML NAACCR ID:	estrogenReceptorSummary
PARENT XML ELEMENT:	Tumor

Description

ER (Estrogen Receptor) Summary is a summary of results of the estrogen receptor (ER) assay.

Rationale

This data item is required for prognostic stage grouping in AJCC 8th edition, Chapter 48, Breast. It was previously collected as Breast CS SSF # 1.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

0	ER negative (0.0% or less than 1%)
1	ER positive
7	Test ordered, results not in chart
9	Not documented in medical record Cannot be determined (indeterminate) ER (Estrogen Receptor) Summary status not assessed or unknown if assessed

Coding Guidelines

Record the pathologist's interpretation of the assay value from the tumor specimen. Results from the ER assay done prior to neoadjuvant therapy take priority. If there are no results prior to neoadjuvant treatment, code the results from a post-treatment specimen. Do not report the results of an ER or PR done as part of a multigene test such as OncotypeDX or MammaPrint.

- Code 0 when the ER is reported as negative or normal.
- Code 1 when the ER is reported as positive or elevated.
- Code 7 when the ER test was ordered but the results are not available.
- Code 9 when the ER is:
    - Reported as borderline, undetermined whether positive or negative.

- Cannot be determined by the pathologist (e.g. inadequate specimen).
- It is unknown whether the ER test was performed.
- The patient has only a clinical diagnosis of breast cancer (no tissue diagnosis).

Coding Instructions

- ***Note 1*:** Physician statement of ER (Estrogen Receptor) Summary status can be used to code this data item when no other information is available.
- ***Note 2*:** The result of the ER test performed on the primary breast tissue is to be recorded in this data item.
- ***Note 3*:** Results from nodal or metastatic tissue may be used ONLY when there is no evidence of primary tumor.
- ***Note 4*:** In cases where there are invasive and in situ components and ER is done on both, ignore the in situ results.
  - If ER is positive on an in situ component and ER is negative on all tested invasive components, code ER as negative (code 0.)
  - If in situ and invasive components present and ER only done on the in situ component, code unknown (code 9).
- ***Note 5*:** In cases where there is a single tumor with multiple biopsies and/or surgical resection with different ER results.
  - Use the highest (positive versus negative).
- ***Note 6*:** In cases where there are multiple tumors with different ER results, code the results from the largest tumor size (determined either clinically or pathologically) when multiple tumors are present.
  - Do not use specimen size to determine the largest tumor size.
- ***Note 7*:** If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy. If neoadjuvant therapy is given and there are no ER results from pre-treatment specimens, report the findings from post-treatment specimens.
- ***Note 8*:** If the patient is ER positive and node negative, a multigene test such as Oncotype Dx may be performed, in which case another ER test will be performed. Do not record the results of that test in this field.
  - Record only the results of the test which made the patient eligible to be given the multigene test.

FIBROSIS SCORE

Item #	Length
3835	1

Alternate Name:	
XML NAACCR ID:	fibrosisScore
PARENT XML ELEMENT:	Tumor

Description

Fibrosis Score, the degree of fibrosis of the liver based on pathological examination, is a prognostic factor for liver cancer.

Definition

The Fibrosis Score is based on degree of parenchymal fibrosis or cirrhosis of the nontumorous liver as defined in the surgical pathology report. Multiple fibrosis scoring systems have been described for use in pathological evaluation of liver disease.

- Ishak system uses a scale of 0-6 with 6 indicating cirrhosis.
    - Recommended by AJCC and CAP.
- Batts-Ludwig system uses a score of 0-4, with a score of 3 defined as fibrous septa with architectural distortion but no obvious cirrhosis, and a score of 4 defined as cirrhosis.
    - Used most commonly by US pathologists.
- METAVIR uses scores of F0-F4.
    - Used mostly in Europe.

Rationale

Fibrosis Score is a Registry Data Collection Variable in AJCC. This data item was previously collected for Liver, CS SSF# 2.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

0	Any of the following histologically confirmed No to moderate fibrosis Ishak fibrosis score 0-4 METAVIR score F0-F3 Batt-Ludwig score 0-3

1	Any of the following histologically confirmed Advanced/severe fibrosis Developing cirrhosis Incomplete cirrhosis Transition to cirrhosis Cirrhosis, probably or definite Cirrhosis, NOS Ishak fibrosis score 5-6 METAVIR score F4 Batt-Ludwig score 4
7	Clinical statement of advanced/severe fibrosis or cirrhosis, AND Not histologically confirmed or unknown if histologically confirmed
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error)
9	Not documented in medical record Stated in medical record that patient does not have advanced cirrhosis/advanced fibrosis, not histologically confirmed or unknown if histologically confirmed Fibrosis score stated but cannot be assigned to codes 0 or 1 Fibrosis score stated but scoring system not recorded Fibrosis Score not assessed or unknown if assessed

Coding Instructions

- ***Note 1*:** Physician statement of fibrosis score can be used to code this data item when no other information is available. However, code 7 when the physician statement of fibrosis score is not based on histologic examination of the liver.
- ***Note 2*:** FIB-4 is NOT a pathological fibrosis score of 4. It is a scoring method using the patient's age and relevant lab values to calculate a score. The medical record may show something like "FIB-4 = 3.52." Do not code FIB-4 values in this data item.
- ***Note 3*:** AJCC classifies Ishak fibrosis scores 0-4 (none to moderate fibrosis) as F0, and Ishak fibrosis scores 5-6 (cirrhosis/severe fibrosis) as F1. This is not the same as METAVIR score F0 or F1.
- ***Note 4*:** Record the results based on information collected during the initial work-up. If multiple biopsies are taken and have conflicting scores, use the results from the biopsy closest to the start of treatment. Information collected after the start of treatment may not be used to code this data item.
- **Note 5:** To use codes 0 and 1, you must have a histological (microscopic) confirmation of fibrosis/cirrhosis. Code the absence (code 0) or presence (code 1) of fibrosis as documented in the pathology report.

- **Note 6:** Use code 7 if there is a clinical diagnosis (no microscopic confirmation) of severe fibrosis or cirrhosis.
- **Note 7:** If no score is mentioned, descriptive terms may be used to assign codes 0 and 1 – see specific terms in the code table.
- **Note 8:** If a fibrosis score is stated but the scoring system is not recorded, consult with the physician. If no further information is available, code 9.

Additional Information

Source documents: pathology report (biopsy or FNA path report)

Other names: Nontumoral hepatic parenchymal fibrosis/cirrhosis (Intrahepatic Bile Duct Tumors)

FOLLOW-UP SOURCE

Item #	Length
1790	1

Alternate Name:	Follow-Up Method (pre-96 CoC)
XML NAACCR ID:	followUpSource
PARENT XML ELEMENT:	Tumor

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

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

GLEASON PATTERNS CLINICAL

Item #	Length
3838	2

Alternate Name:	
XML NAACCR ID:	gleasonPatternsClinical
PARENT XML ELEMENT:	Tumor

Description

Prostate cancers are graded using Gleason score or pattern. This data item represents the Gleason primary and secondary patterns from needle core biopsy or TURP.

Rationale

Gleason Patterns Clinical is a Registry Data Collection Variable for Clinical Stage for AJCC. This data item was previously collected as Prostate, CS SSF# 7.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

11	Primary pattern 1, secondary pattern 1
12	Primary pattern 1, secondary pattern 2
13	Primary pattern 1, secondary pattern 3
14	Primary pattern 1, secondary pattern 4
15	Primary pattern 1, secondary pattern 5
19	Primary pattern 1, secondary pattern unknown
21	Primary pattern 2, secondary pattern 1
22	Primary pattern 2, secondary pattern 2
23	Primary pattern 2, secondary pattern 3
24	Primary pattern 2, secondary pattern 4
25	Primary pattern 2, secondary pattern 5
29	Primary pattern 2, secondary pattern unknown
31	Primary pattern 3, secondary pattern 1
32	Primary pattern 3, secondary pattern 2

33	Primary pattern 3, secondary pattern 3
34	Primary pattern 3, secondary pattern 4
35	Primary pattern 3, secondary pattern 5
39	Primary pattern 3, secondary pattern unknown
41	Primary pattern 4, secondary pattern 1
42	Primary pattern 4, secondary pattern 2
43	Primary pattern 4, secondary pattern 3
44	Primary pattern 4, secondary pattern 4
45	Primary pattern 4, secondary pattern 5
49	Primary pattern 4, secondary pattern unknown
51	Primary pattern 5, secondary pattern 1
52	Primary pattern 5, secondary pattern 2
53	Primary pattern 5, secondary pattern 3
54	Primary pattern 5, secondary pattern 4
55	Primary pattern 5, secondary pattern 5
59	Primary pattern 5, secondary pattern unknown
X6	TURP and/or Biopsy done, primary pattern unknown, secondary pattern unknown
X7	No needle core biopsy/TURP performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error)
X9	Not documented in medical record Gleason Patterns Clinical not assessed or unknown if assessed Unknown whether TURP and/or Biopsy done

Coding Instructions

- ***Note 1*:** Physician statement of Gleason Patterns Clinical can be used to code this data item when there is no other information available.
- ***Note 2*:** Code the Gleason primary and secondary patterns from needle core biopsy or transurethral resection of prostate (TURP) in this field. Gleason primary and secondary patterns provided for any prostate tissue identified from a transurethral resection of a bladder tumor (TURBT) specimen can also be used in this field.
- ***Note 3*:** Code the Gleason primary and secondary patterns prior to neoadjuvant treatment.
- ***Note 4*:** Usually prostate cancers are graded using Gleason score or pattern. Gleason grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic

cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score.

- If there are two numbers, assume that they refer to two patterns (the first number being theprimary pattern and the second number the secondary pattern), and sum them to obtain the score.
- If only one number is given, and it is less than or equal to 5, assume that it describes a pattern (since scores of 5 or less would reflect Primary or Secondary Pattern Scores of 1 or 2). Code the number as the primary pattern and code the secondary pattern as Unknown.
    - For ***example***, if only one number is given, and it is a 3, code “39” for Gleason Patterns and “X9” for Gleason Score.
- If only one number is given, and it is greater than 5, assume that it is a score
    - For ***example***, if only one number is given, and it is a 7, code “X6” for Gleason Patterns and “07” for Gleason Score.
- If the pathology report specifies a specific number out of a total of 10, the first number given is the score.
    - For ***example***, if the pathology report says Gleason 7/10, code “07’ for Gleason Score and “X6” for Gleason Patterns.

- ***Note 5*****:** If different patterns are documented on multiple needle core biopsies, code the pattern that reflects the highest or most aggressive score regardless if the pathologist provides an overall pattern in a final summary. If different patterns equal the same high score, give priority to the highest primary pattern and then the highest secondary pattern.
    - For ***example***, both Gleason 3, 4 and Gleason 4, 3 equal Gleason score 7; code 43. Do not mix patterns from multiple specimens.
- ***Note 6*****:** If needle core biopsy and TURP are both performed, code the pattern that reflects the highest score.
- ***Note 7*****:** Do not infer Gleason Primary and Secondary Pattern from Grade Group (Code X9).
- ***Note 8*****:** The clinical score is recorded in Gleason Score Clinical [NAACCR Data Item #3840].

GLEASON PATTERNS PATHOLOGICAL

Item #	Length
3839	2

Alternate Name:	
XML NAACCR ID:	gleasonPatternsPathological
PARENT XML ELEMENT:	Tumor

Description

Prostate cancers are graded using Gleason score or pattern. This data item represents the Gleason primary and secondary patterns from prostatectomy or autopsy.

Rationale

Gleason Patterns Pathological is a Registry Data Collection Variable for AJCC. This data item was previously collected as Prostate, CS SSF# 9.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

11	Primary pattern 1, secondary pattern 1
12	Primary pattern 1, secondary pattern 2
13	Primary pattern 1, secondary pattern 3
14	Primary pattern 1, secondary pattern 4
15	Primary pattern 1, secondary pattern 5
19	Primary pattern 1, secondary pattern unknown
21	Primary pattern 2, secondary pattern 1
22	Primary pattern 2, secondary pattern 2
23	Primary pattern 2, secondary pattern 3
24	Primary pattern 2, secondary pattern 4
25	Primary pattern 2, secondary pattern 5
29	Primary pattern 2, secondary pattern unknown
31	Primary pattern 3, secondary pattern 1

32	Primary pattern 3, secondary pattern 2
33	Primary pattern 3, secondary pattern 3
34	Primary pattern 3, secondary pattern 4
35	Primary pattern 3, secondary pattern 5
39	Primary pattern 3, secondary pattern unknown
41	Primary pattern 4, secondary pattern 1
42	Primary pattern 4, secondary pattern 2
43	Primary pattern 4, secondary pattern 3
44	Primary pattern 4, secondary pattern 4
45	Primary pattern 4, secondary pattern 5
49	Primary pattern 4, secondary pattern unknown
51	Primary pattern 5, secondary pattern 1
52	Primary pattern 5, secondary pattern 2
53	Primary pattern 5, secondary pattern 3
54	Primary pattern 5, secondary pattern 4
55	Primary pattern 5, secondary pattern 5
59	Primary pattern 5, secondary pattern unknown
X6	Prostatectomy done, primary pattern unknown, secondary pattern unknown
X7	No prostatectomy/autopsy performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error)
X9	Not documented in medical record Gleason Patterns Pathological not assessed or unknown if assessed Unknown if prostatectomy done

Coding Instructions

- ***Note 1*:** Physician statement of Gleason Patterns Pathological can be used to code this data item when there is no other information available.
- ***Note 2*:** Code the Gleason primary and secondary patterns from prostatectomy or autopsy only in this field. Unlike Grade Group Pathological, do not include patterns from tissues taken prior to prostatectomy.
- ***Note 3*:** Usually prostate cancers are graded using Gleason score or pattern. Gleason grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, the pattern

occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score.

- If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score.
- If only one number is given, and it is less than or equal to 5, assume that it describes a pattern (since scores of 5 or less would reflect Primary or Secondary Pattern Scores of 1 or 2). Code the number as the primary pattern and code the secondary pattern as Unknown.
    - For ***example***, if only one number is given, and it is a 3, code “39” for Gleason Patterns and “X9” for Gleason Score.
- If only one number is given, and it is greater than 5, assume that it is a score.
    - For ***example***, if only one number is given, and it is a 7, code “X6” for Gleason Patterns and “07” for Gleason Score.
- If the pathology report specifies a specific number out of a total of 10, the first number given is the score.
    - For ***example***, if the pathology report says Gleason 7/10, code “07” for Gleason Score and “X6” for Gleason Patterns.

- ***Note 4*****:** If neoadjuvant therapy was given, code Gleason pathological patterns as X9.
- ***Note 5*****:** Do not infer Gleason Primary and Secondary Pattern from Grade Group (Code X9).
- ***Note 6*****:** If a tertiary pattern is documented on prostatectomy or autopsy, code in Gleason Tertiary Pattern [NAACCR Data Item #3842].
- ***Note 7*****:** The pathological score is recorded in Gleason Score Pathological [NAACCR Data Item #3841].

GLEASON SCORE CLINICAL

Item #	Length
3840	2

Alternate Name:	
XML NAACCR ID:	gleasonScoreClinical
PARENT XML ELEMENT:	Tumor

Description

This data item records the Gleason score based on adding the values for primary and secondary patterns in Needle Core Biopsy or TURP.

Rationale

Gleason Score Clinical is a Registry Data Collection Variable for AJCC. This data item was previously collected as Prostate, CS SSF# 8.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

02	Gleason score 2
03	Gleason score 3
04	Gleason score 4
05	Gleason score 5
06	Gleason score 6
07	Gleason score 7
08	Gleason score 8
09	Gleason score 9
10	Gleason score 10
X7	No needle core biopsy/TURP performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error)
X9	Not documented in medical record Gleason Score Clinical not assessed or unknown if assessed

Coding Instructions

- ***Note 1*:** Physician statement of Gleason Score Clinical can be used to code this data item when there is no other information available.
- ***Note 2*:** Code the Gleason Score Clinical from needle core biopsy or transurethral resection of prostate (TURP) in this field. Gleason primary and secondary patterns provided for any prostate tissue identified from a transurethral resection of a bladder tumor (TURBT) specimen can also be used in this field.
- ***Note 3*:** Code the Gleason Score prior to neoadjuvant treatment.
- ***Note 4*:** Usually prostate cancers are graded using Gleason's score or pattern. Gleason's grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason's grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10.
    - If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score.
    - If only one number is given, and it is less than or equal to 5, code the total score to X9, unknown or no information.
    - If only one number is given, and it is greater than 5, assume that it is a score and code as stated.
    - If the pathology report specifies a specific number out of a total of 10, the first number given is the score.
        - ***Example:*** The pathology report says Gleason's 3/10. The Gleason's score would be 3 and coded as 03.
- ***Note 5*:** If different scores are documented on multiple needle core biopsies, code the highest or most aggressive score.
- ***Note 6*:** If needle core biopsy and TURP are both performed, code the highest score.
- ***Note 7*:** Do not infer the Gleason Score from Grade Group (Code X9).
- ***Note 8*:** Record the Gleason score based on the addition of the primary and secondary patterns coded in Gleason Patterns Clinical [NAACCR Data Item #3838].

GLEASON SCORE PATHOLOGICAL

Item #	Length
3841	2

Alternate Name:	
XML NAACCR ID:	gleasonScorePathological
PARENT XML ELEMENT:	Tumor

Description

This data item records the Gleason score based on adding the values for primary and secondary patterns from prostatectomy or autopsy.

Rationale

Gleason Score Pathological is a Registry Data Collection Variable for AJCC. This data item was previously collected as Prostate, CS SSF# 10.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

02	Gleason score 2
03	Gleason score 3
04	Gleason score 4
05	Gleason score 5
06	Gleason score 6
07	Gleason score 7
08	Gleason score 8
09	Gleason score 9
10	Gleason score 10
X7	No prostatectomy done/autopsy performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error)
X9	Not documented in medical record Gleason Score Pathological not assessed or unknown if assessed

Coding Instructions

- ***Note 1*:** Physician statement of Gleason Score Pathological can be used to code this data item when there is no other information available.
- ***Note 2*:** Code the Gleason Score Pathological from prostatectomy or autopsy only in this field. Unlike Grade Group Pathological, do not include patterns from tissues taken prior to prostatectomy.
- ***Note 3*:** Usually prostate cancers are graded using Gleason's score or pattern. Gleason's grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason's grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10.
    - If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score.
    - If only one number is given, and it is less than or equal to 5, code the total score to X9, unknown or no information.
    - If only one number is given, and it is greater than 5, assume that it is a score and code as stated.
    - If the pathology report specifies a specific number out of a total of 10, the first number given is the score.
        - ***Example:*** The pathology report says Gleason's 3/10. The Gleason's score would be 3 and coded as 03.
- ***Note 4*:** If neoadjuvant therapy was given, code Gleason pathological score as X9.
- ***Note 5*:** Do not infer the Gleason Score from Grade Group (Code X9).
- ***Note 6*:** Record the Gleason score based on the addition of the primary and secondary patterns coded in Gleason Patterns Pathological [NAACCR Data Item #3839].

GLEASON TERTIARY PATTERN

Item #	Length
3842	2

Alternate Name:	
XML NAACCR ID:	gleasonTertiaryPattern
PARENT XML ELEMENT:	Tumor

Description

Prostate cancers are graded using Gleason score or pattern. This data item represents the tertiary pattern value from prostatectomy or autopsy.

Rationale

Tertiary Gleason pattern on prostatectomy is a Registry Data Collection Variable for AJCC. This data item was previously collected as Prostate, CS SSF# 11.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

10	Tertiary pattern 1
20	Tertiary pattern 2
30	Tertiary pattern 3
40	Tertiary pattern 4
50	Tertiary pattern 5
X7	No prostatectomy/autopsy performed
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Gleason Tertiary Pattern not assessed or unknown if assessed

Coding Instructions

- ***Note 1*:** Physician statement of Gleason tertiary pattern can be used to code this data item when there is no other information available.
- ***Note 2*:** If present, a high Gleason Tertiary Pattern appears to be an indication for a worse outcome.

- ***Note 3*:** Record the tertiary pattern documented on prostatectomy or autopsy only. Record the tertiary pattern prior to neoadjuvant treatment.
    - If a tertiary pattern is documented on needle core biopsy or transurethral resection of prostate (TURP), it should be disregarded.
    - Do not code the tertiary pattern on prostatectomy or autopsy in Gleason Patterns Pathological.
- ***Note 4*:** The CAP Prostate protocol does not include Patterns 1 and 2 for Tertiary Pattern.
- ***Note 5*:** If neoadjuvant therapy was given, code Gleason patterns as X9.

GRADE CLINICAL

Item #	Length
3843	1

Alternate Name:	
XML NAACCR ID:	gradeClinical
PARENT XML ELEMENT:	Tumor

Description

This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant).

For cases diagnosed January 1, 2018, and later, this data item, along with Grade Pathological and Grade Post-Neoadjuvant, replaces NAACCR Data Item Grade [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the clinical stage group.

For those cases that are eligible AJCC staging, the recommended grading system is specified in the AJCC Chapter. The AJCC Chapter-specific grading systems (codes 1-5) take priority over the generic grade definitions (codes A-E, L, H, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Codes

Refer to the Grade Manual for site-specific instructions.

Coding Guidelines

- ***Note 1*:** Grade Clinical must not be blank.
- ***Note 2*:** Assign the highest grade from the primary tumor assessed during the clinical time frame.
- ***Note 3*:** If there are multiple tumors with different grades abstracted as one primary, code the highest grade.
- ***Note 4*:** Code 9 (unknown) when:
    - Grade from primary site is not documented.
    - Clinical workup is not done (for example, cancer is an incidental finding during surgery for another condition).
    - Grade checked "not applicable" on CAP Protocol (if available) and no other grade information is available.

- ***Note 5*:** If there is only one grade available and it cannot be determined if it is clinical or pathological, assume it is a Grade Clinical and code appropriately per Grade Clinical categories for that site, and then code unknown (9) for Grade Pathological, and blank for Grade Post Therapy Clin (yc) and Grade Post Therapy Path (yp).

See the individual site-specific Grade Clinical tables for additional notes (Grade Tables).

GRADE PATHOLOGICAL

Item #	Length
3844	1

Alternate Name:	
XML NAACCR ID:	gradePathological
PARENT XML ELEMENT:	Tumor

Description

This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup. Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical workup or the surgical resection.

For cases diagnosed January 1, 2018, and later, this data item, along with Grade Clinical and Grade Post- Neoadjuvant, replaces NAACCR Data Item Grade [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the pathological stage group.

For those cases that are eligible AJCC staging, the recommended grading system is specified in the AJCC Chapter. The AJCC Chapter-specific grading systems (codes 1-5) take priority over the generic grade definitions (codes A-E, L, H, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Codes

Refer to the Grade Manual for site-specific instructions.

Coding Guidelines

- ***Note 1*:** Pathological grade is recorded for cases where a surgical resection has been done.
- ***Note 2*:** Pathological grade must not be blank.
- ***Note 3*:** Assign the highest grade from the primary tumor. If the clinical grade is the highest grade identified, use the grade that was identified during the clinical time frame for both the clinical grade and the pathological grade. (This follows the AJCC rule that pathological time frame includes all of the clinical time frame information plus information from the resected specimen.)
    - If a resection is done of a primary tumor and there is no grade documented from the surgical resection, use the grade from the clinical workup.

- If a resection is done of a primary tumor and there is no residual cancer, use the grade from the clinical workup.

- ***Note 4*:** Code 9 (unknown) when:
  - Grade not documented.
  - No resection of the primary site.
  - Neoadjuvant therapy followed by a resection (see post therapy grade.)
  - Clinical case only (see clinical grade).
  - There is only one grade available and it cannot be determined if it is clinical or pathological.
  - Grade checked “not applicable” on CAP Protocol (if available) and no other grade information is available.

See the individual site-specific Grade Pathological tables for additional notes (Grade Tables).

GRADE POST THERAPY CLIN (YC)

Item #	Length
1068	1

Alternate Name:	
XML NAACCR ID:	gradePostTherapyClin
PARENT XML ELEMENT:	Tumor

Description

This data item records the grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy or primary systemic/radiation therapy. If AJCC staging is being assigned, the tumor must have met the neoadjuvant therapy or primary systemic/radiation therapy requirements in the AJCC manual or according to national treatment guidelines.

Record the highest grade documented from the microscopically sampled specimen of the primary site following neoadjuvant therapy or primary systemic/radiation therapy.

For cases diagnosed January 1, 2020, and later, this data item, along with Grade Clinical, Grade Pathological, and Grade Post Therapy Path (yp), replaces NAACCR Data Item Grade [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the post therapy stage group.

For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC Chapter. The AJCC Chapter-specific grading systems (codes 1-5, L, H, M, S) take priority over the generic grade definitions (codes A-E, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Codes

Refer to the Grade Manual for site-specific instructions.

Coding Guidelines

- ***Note 1*:** Leave Grade Post Therapy Clin (yc) blank when:
  - No neoadjuvant therapy.
  - Clinical or pathological case only.
  - Neoadjuvant therapy completed, no microscopic exam is done prior to surgery/resection of primary tumor.
  - There is only one grade available and it cannot be determined if it is clinical,

pathological, post therapy clin or post therapy path.

- ***Note 2*:** Assign the highest grade from the microscopically sampled specimen of the primary site following neoadjuvant therapy or primary systemic/radiation therapy.
- ***Note 3*:** If there are multiple tumors with different grades abstracted as one primary, code the highest grade.
- ***Note 4*:** Code 9 (unknown) when:
    - Microscopic exam is done after neoadjuvant therapy and grade from the primary site is not documented.
    - Microscopic exam is done after neoadjuvant therapy and there is no residual cancer.
    - Grade checked “not applicable” on CAP Protocol (if available) and no other grade information is available.

See the individual site-specific Grade Post Therapy Clin (yc) tables for additional notes (Grade Tables).

GRADE POST THERAPY PATH (YP)

Item #	Length
3845	1

Alternate Name:	
XML NAACCR ID:	gradePostTherapy
PARENT XML ELEMENT:	Tumor

Description

This data item records the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. Record the highest grade documented from the surgical treatment resection specimen of the primary site following neoadjuvant therapy.

For cases diagnosed January 1, 2018, and later, this data item, along with Grade Clinical and Grade Pathological, replaces NAACCR Data Item Grade [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the post-neoadjuvant stage group. For those cases that are eligible AJCC staging, the recommended grading system is specified in the AJCC Chapter. The AJCC Chapter-specific grading systems (codes 1-5) take priority over the generic grade definitions (codes A-E, L, H, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Codes

Refer to the Grade Manual for site-specific instructions.

Coding Guidelines

- ***Note 1*:** Leave Grade Post Therapy Path (yp) blank when:
  - No neoadjuvant therapy.
  - Clinical or pathological case only.
  - Neoadjuvant therapy completed; surgical resection not done.
  - There is only one grade available and it cannot be determined if it is clinical, pathological, post therapy clin or post therapy path.
- ***Note 2*:** There is a preferred grading system for this schema. If the post therapy clinical grade given uses the preferred grading system and the post therapy pathological grade does not use the preferred grading system, do not record the Grade Post Therapy Clin (yc) in the Grade Post Therapy Path (yp) field.

- ***Example:*** Neoadjuvant therapy completed. Biopsy of primary site shows a moderately differentiated adenocarcinoma. The surgical resection states a high grade adenocarcinoma.
    - Grade Clinical Post Therapy (yc) would be coded as G2 (code 2) since Moderately Differentiated is the preferred grading system.
    - Grade Path Post Therapy (yp) would be coded as 9 since the preferred grading system was not used and the Generic Grade Categories do not apply to this grade table.

- ***Note 3*****:** Assign the highest grade from the resected primary tumor assessed after the completion of neoadjuvant therapy.
- ***Note 4*****:** If there are multiple tumors with different grades abstracted as one primary, code the highest grade.
- ***Note 5*****:** Use the grade from the post therapy clinical work up from the primary tumor in different scenarios based on behavior or surgical resection.
    - **Behavior**
        - Tumor behavior for the post therapy clinical and the post therapy pathological diagnoses are the same AND the post therapy clinical grade is the highest grade.
        - Tumor behavior for post therapy clinical diagnosis is invasive, and the tumor behavior for the post therapy pathological diagnosis is in situ.
    - **Surgical Resection**
        - Surgical resection is done of the primary tumor after neoadjuvant therapy is completed and there is no grade documented from the surgical resection.
        - Surgical resection is done of the primary tumor after neoadjuvant therapy is completed and there is no residual cancer.
        - Surgical resection of the primary tumor after neoadjuvant therapy is completed is not done, but there is positive microscopic confirmation of distant metastases during the post therapy clinical time frame.
- ***Note 6*****:** Code 9 (unknown) when:
    - Surgical resection is done after neoadjuvant therapy and grade from the primary site is not documented.
    - Surgical resection is done after neoadjuvant therapy and there is no residual cancer.
    - Grade checked “not applicable” on CAP Protocol (if available) and no other grade information is available.

See the individual site-specific Grade Post Therapy Path (yp) tables for additional notes (Grade Tables)

HER2 OVERALL SUMMARY

Item #	Length
3855	1

Alternate Name:	
XML NAACCR ID:	her2OverallSummary
PARENT XML ELEMENT:	Tumor

Description

HER2 Overall Summary is a summary of results from HER2 testing.

Rationale

This data item is required for prognostic stage grouping in AJCC 8th edition, Chapter 48, Breast. It was previously collected as Breast, CS SSF # 15.Experts recommend that every invasive breast cancer be tested for the presence of HER2 because anti-HER2 treatments are highly effective for these tumors.

HER2 overall summary It will be collected for Esophagus and Esophagogastric Junction and Stomach for cases diagnosed 1/1/21+ because NCCN guidelines recommend HER2 testing at time of diagnosis if patients are documented or suspected of having metastatic disease. HER2 monoclonal antibodies may be added to chemotherapy for patients with HER2 positive disease.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

0	HER2 negative; equivocal
1	HER2 positive
7	Test ordered, results not in chart
9	Not documented in medical record Cannot be determined (indeterminate) HER2 Overall Summary status not assessed or unknown if assessed

Coding Guidelines

- Record the pathologist's interpretation of the HER2 test from the tumor specimen. Results from the HER2 test done prior to neoadjuvant therapy take priority. If there are no results prior to neoadjuvant treatment, code the results from a post-treatment specimen. Do not report the results of a HER2 as part of a multigene test such as OncotypeDX or MammaPrint.
- If assays are performed on more than one specimen and any result is interpreted as positive, code as 1 Positive/elevated.

- ***Exception:*** If results from both an in situ specimen and an invasive component are given, record the results from the invasive specimen, even if the in situ is positive and the invasive specimen is negative.
    - Code 0 when the HER2 is reported as negative or normal.
    - Code 1 when the HER2 is reported as positive or elevated.
    - Code 7 when the HER2 test was ordered but the results are not available.
    - Code 9 when the HER2 is:
        - Reported as borderline, undetermined whether positive or negative.
        - Cannot be determined by the pathologist (e.g. inadequate specimen).
        - It is unknown whether the HER2 test was performed.
        - The patient has only a clinical diagnosis of breast cancer (no tissue diagnosis).

Coding Instructions

- ***Note 1*****:** Physician statement of HER2 Overall Summary can be used to code this data item when no other information is available.
- ***Note 2*****:** The result of the HER2 test performed on the primary breast tissue is to be recorded in this data item.
- ***Note 3*****:** Results from nodal or metastatic tissue may be used ONLY when there is no evidence of primary tumor.
- ***Note 4*****:** In cases where there are invasive and in situ components and HER2 is done on both, ignore the in situ results.
    - If HER2 is positive on an in situ component and HER2 is negative on all tested invasive components, code HER2 as negative (code 0).
    - If in situ and invasive components present and HER2 only done on the in situ component, code unknown (code 9).
- ***Note 5*****:** In cases where there is a single tumor with multiple biopsies and/or surgical resection with different HER2 results.
    - Use the highest (positive versus negative).
- ***Note 6*****:** In cases where there are multiple tumors with different HER2 results, code the results from the largest tumor size (determined either clinically or pathologically) when multiple tumors are present.
    - Do not use specimen size to determine the largest tumor size.
- ***Note 7*****:** If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy.
    - If neoadjuvant therapy is given and there are no HER2 results from pre-treatment specimens, report the findings from post-treatment specimens.
- ***Note 8*****:** If the patient is HER2 positive and node negative, a multigene test such as Oncotype Dx may be performed, in which case another HER2 test will be performed. Do not record the results of that test in this field.

    - Record only the results of the test which made the patient eligible to be given the multigene test.

- **Note 9:** HER2 is not routinely done on pure in situ tumors (behavior /2); however, if you have an in situ tumor and there are HER2 results, record it. Otherwise, code 9.

HISTOLOGIC TYPE ICD-O-3

Item #	Length
522	4

Alternate Name:	ICD-O-3 Histology (CCCR)
XML NAACCR ID:	histologicTypeIcdO3
PARENT XML ELEMENT:	Tumor

Description

Codes for the histologic type of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for tumors diagnosed in 2001 and later, and recommended that prior tumors be converted from ICD-O-2. Effective with 2010 diagnoses, this item also includes histology codes as per the 2008 WHO Hematopoietic/Lymphoid publication39, which are listed on pages 3-5 of the NAACCR 2010 Implementation Guidelines.

Note: See Histology (92-00) ICD-O-2 [420] for ICD-O-2 codes. Effective with 2010 diagnoses, this item also includes histology codes as per the 2008 WHO Hematopoietic/Lymphoid publication 39, which are listed on pages 3-5 of the NAACCR 2010 Implementation Guidelines.

ICD-O-3.2

For 2021, standard setters have agreed to implement new histology terms and codes for ICD-O-3 based on the current versions of the World Health Organization Classification of Tumors. The update, referred to as ICD-O-3.2, includes comprehensive tables listing histology codes and behavior codes in effect beginning with cases diagnosed in 2021. The new codes, new terms, and codes with changes to behavior are available at the NAACCR Website.

Histology Coding for Solid Tumors

- Apply the general instructions and Coding Instructions histologic type in the current Solid Tumor Rules.
- Apply the site-specific histology coding rules in the current Solid Tumor Rules.
- Site-specific histology coding rules cover the following:

Primary Site	**Topography**
Head and Neck	C000-C148, C300-C329, C410, C411, C442
Colon, Rectosigmoid, Rectum	C180-C189, C199, C209
Lung	C340-C349
Cutaneous Melanoma	C440-C449 with Histology 8720-8780

Breast	C500-C506, C508-C509
Kidney	C649
Urinary Sites	C659, C669, C670-C679, C680-C681, C688-C689
Non-malignant CNS	C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
Malignant CNS and Peripheral Nerves	C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
Other Sites	Excludes Head and Neck, Colon, Rectosigmoid, Rectum, Lung, Cutaneous Melanoma, Breast, Kidney, Urinary Sites, Peripheral Nerves, CNS

Histology Coding for Hematopoietic and Lymphatic Primaries

Apply the Histology Coding Rules in the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database.

ICD REVISION NUMBER

Item #	Length
1920	1

Alternate Name:	ICD Code Revision Used for Cause of Death (SEER)
XML NAACCR ID:	icdRevisionNumber
PARENT XML ELEMENT:	Patient

Description

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

Codes

0	Patient alive at last follow up
1	ICD-10 (1999+ deaths)
7	ICD-7 (1958-1967)
8	ICDA-8 (1968-1978)
9	ICD-9 (1979-1998)

Coding instructions

Assign code 1 for death certificate only (DCO) cases.

ICD-O-3 CONVERSION FLAG

Item #	Length
2116	1

Alternate Name:	
XML NAACCR ID:	icdO3ConversionFlag
PARENT XML ELEMENT:	Tumor

Description

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

Codes

0	Morphology (Morph--Type&Behav ICD-O-3) originally coded in ICD-O-3
1	Morphology (Morph--Type&Behav ICD-O-3) converted from (Morph--Type&Behav ICD-O-2) without review
3	Morphology (Morph--Type&Behav ICD-O-3) converted from (Morph--Type&Behav ICD-O-2) with review
Blank	Not converted

INSTITUTION REFERRED FROM

Item #	Length
2410	10

Alternate Name:	Facility Referred From
XML NAACCR ID:	institutionReferredFrom
PARENT XML ELEMENT:	Tumor

Description

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

Rationale

This number is used to document and monitor referral patterns.

Codes (in addition to CoC or WCRS assigned codes)

0000000000	Case not referred from a facility
0099999999	Case referred from a facility, but facility number is unknown

Coding Instructions

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.

INSTITUTION REFERRED TO

Item #	Length
2420	10

Alternate Name:	Facility Referred To
XML NAACCR ID:	institutionReferredTo
PARENT XML ELEMENT:	Tumor

Description

Identifies the facility to which the patient was referred for further care.

Rationale

This number is used to document and monitor referral patterns.

Codes (in addition to CoC or WCRS assigned codes)

0000000000	Case not referred to a facility
0099999999	Case referred to a facility, but facility number is unknown

Coding Instructions

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.

LATERALITY

Item #	Length
410	1

Alternate Name:	Laterality at Diagnosis (SEER)
XML NAACCR ID:	laterality
PARENT XML ELEMENT:	Tumor

Description

Code for the side of a paired organ, or the side of the body on which the reportable tumor originated. This applies to the primary site only.

Codes

0	Not a paired site
1	Right: origin of primary
2	Left: origin of primary
3	Only one side involved, right or left origin unspecified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor (effective with 01/01/2010 dx)
9	Paired site, but no information concerning laterality

Coding Instructions

1. Assign code 0 when:
    a. The primary site is not a paired site.
    b. Primary site is unknown (C809), **or**
    c. Laterality is unknown for a death certificate only (DCO) case and the primary site is NOT C079-C081, C098-C099, C301, C310, C312, C341-C349, C384, C400-C403, C441-C443, C445-C447, C471-C472, C491-C492, C500-C509, C569, C570, C620-C629 C630-C631, C649, C659, C669, C690-C699, C700, C710-C714, C722-C725, C740-C749, or C754.
2. Code laterality using codes 1-9 for all sites listed in the table: Sites for Which Laterality Codes Must Be Recorded.
    a. Laterality may be coded for sites other than those required, for example, thyroid.

3. Code the side where the primary tumor **originated.**
    a. Assign code **3** if the laterality is not known but the tumor is confined to a single side of the paired organ.
        i. ***Example:*** Pathology report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.
4. Code **4** is seldom used EXCEPT for the following:
    a. Both ovaries involved simultaneously with a **single histology**, or **epithelial histologies** (8000-8799).
    b. Diffuse bilateral lung nodules.
    c. Bilateral retinoblastomas.
    d. Bilateral Wilms tumors.
5. Assign code **5** when the tumor originates in the midline of a site listed in 5.a.
    a. C700, C710-C714, C722-C725, C443, C445.
        i. Do not assign code 5 to sites not listed in 5.a.
            1. ***Example 1:*** Patient has an excision of a melanoma located just above the umbilicus (C445, laterality code 5).
            2. ***Example 2:*** Patient has a midline meningioma of the cerebral meninges (C700, laterality code 5).
6. Assign code **9** when:
    a. The neoplasm originated in a paired site AND
    b. Laterality is unknown, AND
        i. There is no statement that only one side of the paired organ is involved.
            1. ***Example 1:*** Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer.
            2. ***Example 2:*** Widely metastatic ovarian carcinoma surgically debulked. Ovaries could not be identified in the specimen.
    c. Laterality is unknown for a death certificate only (DCO) case with primary site C079-C081, C098-C099, C301, C310, C312, C341-C349, C384, C400-C403, C441-C443, C445-C447, C471-C472, C491-C492, C500-C509, C569, C570, C620-C629 C630-C631, C649, C659, C669, C690-C699, C700, C710-C714, C722-C725, C740- C749, or C754.
7. Document the laterality in a text field.

Sites for Which Laterality Codes Must Be Recorded

Starting with cases diagnosed January 1, 2004 and later, laterality is coded for select invasive, benign, and borderline primary intracranial and CNS tumors.

A laterality code other than 0 must be assigned for the sites listed in the table below. There is an effective date for assigning laterality for some of the sites. If the site is not listed on the table, code 0 may be assigned for laterality. Laterality may be coded for sites other than those required below.

Example: Code 2 may be assigned for a tumor originating in the left lobe of the thyroid.

ICD-O-3 Code	Site or Subsite
C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
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
C445	Skin of the trunk
C446	Skin of upper limb and shoulder

C447	Skin of the lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of the lower limb and hip
C491	Connective, subcutaneous, and 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 01/01/2004)
C710	Cerebrum (Effective with cases diagnosed 01/01/2004)
C711	Frontal lobe (Effective with cases diagnosed 01/01/2004)
C712	Temporal lobe (Effective with cases diagnosed 01/01/2004)
C713	Parietal lobe (Effective with cases diagnosed 01/01/2004)
C714	Occipital lobe (Effective with cases diagnosed 01/01/2004)
C722	Olfactory nerve (Effective with cases diagnosed 01/01/2004)
C723	Optic nerve (Effective with cases diagnosed 01/01/2004)
C724	Acoustic nerve (Effective with cases diagnosed 01/01/2004)
C725	Cranial nerve, NOS (Effective with cases diagnosed 01/01/2004)
C740-C749	Adrenal gland
C754	Carotid body

LDH LAB VALUE

Item #	Length
3932	7

Alternate Name:	
XML NAACCR ID:	ldhPretreatmentLabValue
PARENT XML ELEMENT:	Tumor

Description

LDH (Lactate Dehydrogenase) Lab Value, measured in serum, is a predictor of treatment response, progression-free survival and overall survival for patients with Stage IV melanoma of the skin.

Definition

When cells (normal or tumor) are damaged or destroyed, an enzyme called lactate dehydrogenase (LDH) is released into the bloodstream. LDH is an indirect indication of possible tumor burden or damage to an organ, which may be caused by metastatic involvement of liver or lung, or a myocardial infarction. The total LDH should be the test value that is coded, but there are five fractions of LDH that measure tissue specific cellular damage: LD1 and LD2: heart, red blood cells and kidneys; LD3: lung; LD4 and LD5: liver, skin and skeletal muscles. LDH is elevated in 60% of patients with non-seminomatous germ cell tumors of the testis. LDH is not screening test, nor is it diagnostic of melanoma, ocular adnexal lymphoma, or testicular cancer.

Rationale

LDH (Lactate Dehydrogenase) Lab Value is a Registry Data Collection Variable in AJCC. It was previously collected as LDH Pretreatment Lab Value and Melanoma Skin, CS SSF# 5.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

0.0	0.0 (U/L)
0.1- 99999.9	0.1 – 99,999.9 U/L
XXXXX.1	100,000 U/L or greater
XXXXX.7	Test ordered, results not in chart
XXXXX.8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code XXXXX.8 will result in an edit error)

XXXXX.9	Not documented in medical record LDH (Lactate Dehydrogenase) Lab Value not assessed or unknown if assessed

Coding Guidelines

- Code 0.0 for a test result of 0 (U/L).
- Code the highest exact LDH lab value prior to systemic (chemo, immunotherapy, hormone), radiation therapy or surgery to a metastatic site in the range 0.1 to 99,999.9.
- Code XXXXX.1 for a total LDH lab value of 100,000 or greater.
- Code XXXXX.7 if the test was ordered and the results are not in the medical record.
- Code XXXXX.9 when:
    - There is no information in the medical record about the LDH lab value.
    - Test is not done or unknown if the test was done.

Coding Instructions

- ***Note 1*****:** Physician statement of LDH (Lactate Dehydrogenase) Lab Value can be used to code this data item when no other information is available.
- ***Note 2*****:** LDH is important in melanoma staging in the setting of DISTANT metastasis. LDH level might only be ordered after re-excision/wide excision and/or nodal evaluation indicates a higher risk of distant metastasis. Imaging may then be performed and if distant metastasis are identified, LDH is ordered.
- ***Note 3*****:** Record the lab value of the highest serum LDH test results documented in the medical record either before or after surgical resection of the primary tumor with or without regional lymph node dissection. The LDH must be taken prior to systemic (chemo, immunotherapy, hormone), radiation therapy or surgery to a metastatic site. The lab value may be recorded in a lab report, history and physical, or clinical statement in the pathology report.
- ***Note 4*****:** The same laboratory test should be used to record information in LDH Level [NAACCR Data Item #3869] and LDH Upper Limits of Normal [NAACCR Data Item #3870].

Additional Information

Source documents: clinical laboratory report; may be included in a liver or hepatic panel/profile, a cardiac panel, or a general metabolic panel of tests

Other names: LDH, Lactate dehydrogenase, lactase dehydrogenase, lactic acid dehydrogenase

LYMPHOVASCULAR INVASION

Item #	Length
1182	1

Alternate Name:	Lymph-vascular Invasion
XML NAACCR ID:	lymphVascularInvasion
PARENT XML ELEMENT:	Tumor

Description

Lymphovascular invasion (LVI) indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. LVI includes lymphatic invasion, vascular invasion, and lymphovascular invasion.

Rationale

Presence or absence of cancer cells in the lymphatic ducts or blood vessels is useful for prognosis. CAP Protocols for some disease sites will be expanded to distinguish between lymphatic and small vessel invasion only, venous (large vessel) invasion only, and BOTH lymphatic and small vessel AND venous (large vessel) invasion.

Codes

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

Coding Instructions

1. **Code from pathology report(s).** If not available, code the absence or presence of lymphovascular invasion as described in the medical record.
    a. The primary source of information about lymphovascular invasion is the pathology check list (synoptic report) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from other sections of the pathology report or a physician's statement, in that order.
2. Do not code perineural invasion in this data item.

3. Use the pathology report for any specimen from the primary site to code this data item (biopsy or resection).
4. Code as present/identified when lymphovascular invasion is identified in any primary tumor specimen.
5. Use the table below for cases treated with neoadjuvant (preoperative) therapy. Code lymphovascular invasion based on the documentation in the medical record when documentation in the medical record conflicts with this table.

LVI on pathology report PRIOR to neoadjuvant (preoperative) therapy	**LVI on pathology report AFTER neoadjuvant (preoperative) therapy**	**Code LVI to**
0 – Not present/Not identified	0 – Not present/Not identified	0 – Not present/Not identified
0 – Not present/Not identified	1 – Present/Identified	1 – Present/Identified
0 – Not present/Not identified	9 – Unknown/Indeterminate	9 – Unknown/Indeterminate
1 – Present/Identified	0 – Not present/Not identified	1 – Present/Identified
1 – Present/Identified	1 – Present/Identified	1 – Present/Identified
1 – Present/Identified	9 – Unknown/Indeterminate	1 – Present/Identified
9 – Unknown/Indeterminate	0 – Not present/Not identified	9 – Unknown/Indeterminate
9 – Unknown/Indeterminate	1 – Present/Identified	1 – Present/Identified
9 – Unknown/Indeterminate	9 – Unknown/Indeterminate	9 – Unknown/Indeterminate

6. Use code **0:**
    a. When the pathology report indicates that there is **no** lymphovascular invasion.
    b. For **in situ** cases.
7. Use code **1** when the pathology report or a physician's statement indicates that lymphovascular invasion (or one of its synonyms) is present in the specimen.
    a. **Synonyms** include, but are not limited to:
        i. Angiolymphatic invasion
        ii. Blood vessel invasion
        iii. Lymph vascular emboli
        iv. Lymphatic invasion
        v. Lymphvascular invasion
        vi. Vascular invasion
8. Use code **8:**
    a. For the following Schemas/Schema IDs:

i. GIST 00430
ii. HemeRetic 00830
iii. Lymphoma 00790
iv. Lymphoma (CLL/SLL) 00795
v. Lymphoma Ocular Adnexa 00710
vi. Mycosis Fungoides (MF) 00811
vii. Plasma Cell Disorder 00822
viii. Plasma Cell Myeloma 00821
ix. Primary Cutaneous Lymphoma (excluding MF and SS) 00812
x. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.

b. When standard-setter does not require this item and state/central registry is not collecting it.

9. Use code **9** when:
   a. There is no microscopic examination of a primary tissue specimen.
   b. The primary site specimen is cytology only or a fine needle aspiration.
   c. The biopsy is only a very small tissue sample.
   d. It is not possible to determine whether lymphovascular invasion is present.
   e. The pathologist indicates the specimen is insufficient to determine lymphovascular invasion.
   f. Lymphovascular invasion is not mentioned in the pathology report.
   g. There is no information/documentation from the pathology report or other sources.
   h. Primary site is unknown.

MARITAL STATUS AT DX

Item #	Length
150	1

Alternate Name:	Marital Status at Diagnosis (SEER/CoC) Marital Status at Initial Diagnosis (pre-96 CoC)
XML NAACCR ID:	maritalStatusAtDx
PARENT XML ELEMENT:	Tumor

Description

Code for the patient's marital status at the time of diagnosis for the reportable tumor.

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

Rationale

Incidence and survival with certain cancers vary by marital status. The item also helps in patient identification.

Codes

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, other than common law marriage) (effective for cases diagnosed 01/01/11 and forward)
9	Unknown

Definitions

Common Law Marriage. A couple living together for a period of time and declaring themselves as married to friends, family, and the community, having never gone through a formal ceremony or obtained a marriage license.

Coding Instructions

1. Assign code 2 [Married (including common law)] when the patient declares him/herself as married. Marriage is self-reported.
2. Assign code 6 when the patient is not married and is in a domestic partner relationship other than common law marriage.
3. Assign code 9 for DCO cases when marital status at the time of diagnosis is unknown.

MEDICAL RECORD NUMBER

Item #	Length
2300	15

Alternate Name:	
XML NAACCR ID:	medicalRecordNumber
PARENT XML ELEMENT:	Tumor

Description

Records medical record number used by the facility to identify the patient.

Rationale

This number identifies the patient in a facility. It can be used by a central registry to point back to the patient record, and it helps identify multiple reports on the same patient.

Codes (in addition to the medical record number)

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 HIM numbers assigned.

MEDICARE BENEFICIARY IDENTIFIER

Item #	Length
2315	11

Alternate Name:	
XML NAACCR ID:	medicareBeneficiaryIdentifier
PARENT XML ELEMENT:	Patient

Description

Congress passed the Medicare Access and CHIP Reauthorization ACT to remove Social Security Number (SSN) from Medicare ID card and replace the existing Medicare Health Insurance Claim Numbers with a Medicare Beneficiary Identifier (MBI). The MBI will be a randomly generated identifier that will not include a SSN or any personal identifiable information.

Rationale

The MBI is a step to minimize the risk of identity theft for Medicare beneficiaries and reduce opportunities for fraud. In early 2018, CMB plans to issue new Medicare cards with an MBI. A Health Insurance Claim Number will still be assigned to each Medicare beneficiary and will still be used for internal data exchanges between CMS and the states, but the new MBI must be used in all interactions with the beneficiary, the provider community and all external partners. The collection of the MBI should not change how registries currently collect SSN.

Codes (in addition to MBI)

Blank	Not Available, Non-Medicare Patient, Not Applicable, or Unknown

Note: The Medicare Beneficiary Identifier (MBI) is randomly generated and has 11 characters, consisting of numbers and letters, entered without dashes.

The MBI format: https://www.cms.gov/Medicare/New- Medicare-Card/Understanding-the-MBI-with-Format.pdf

METS AT DX-BONE

Item #	Length
1112	1

Alternate Name:	
XML NAACCR ID:	metsAtDxBone
PARENT XML ELEMENT:	Tumor

Description

This field identifies whether bone is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

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

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Codes

0	None; no bone metastases
1	Yes; distant bone metastases
8	Not applicable
9	Unknown whether bone is involved metastatic site. Not documented in patient record.

Coding Instructions

1. **Code information about bone metastases only** (discontinuous or distant metastases to bone) identified at the time of diagnosis. Do ***not*** code bone marrow involvement in this data item. Do **not** record contiguous bone invasion by primary tumor in this data item.

   Note: See code **1** in "Mets at Diagnosis--Other" for bone marrow involvement.

   a. Bone involvement may be single or multiple.

   b. Information about bone involvement may be clinical or pathological.

   c. Code this data item for bone metastases even if the patient had neoadjuvant (preoperative) systemic therapy unless determined to be disease progression.

   d. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas.

i. Lymphoma Ocular Adnexa 00710
ii. Lymphoma (excluding CLL/SLL) 00790 (excluding primary sites C770-C779; see 2.c)
iii. Lymphoma (CLL/SLL) 00795 (excluding primary sites C770-C779; see 2.c)
iv. Mycosis Fungoides (MF) 00811
v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812

2. **Use of codes:** Assign the code that best describes whether the case has bone metastases at diagnosis.
   a. Use code **0** when the medical record:
      i. Indicates that there are no distant (discontinuous) metastases at all.
      ii. Confirms the tumor is benign (/0), borderline (/1), or in situ (/2).
      iii. Includes a clinical or pathologic statement that there are no bone metastases.
      iv. Includes imaging reports that are negative for bone metastases.
      v. Indicates that the patient has distant (discontinuous) metastases but bone is not mentioned as an involved site.
      vi. ***Example:*** **Use code 0** when the patient has metastasis to lung and liver but not bone.
   b. Use code **1** when the medical record:
      i. Indicates that the patient has distant (discontinuous) metastases and bone is mentioned as an involved site.
      ii. Indicates that bone is the primary site and there are metastases in a different bone or bones.
         1. Do ***not*** assign code 1 for a bone primary with multifocal bone involvement of the same bone.
      iii. Indicates that the patient is diagnosed with an unknown primary (C80.9) and bone is mentioned as a distant metastatic site.
   c. Use code **8** (Not applicable) for the following:
      i. Any case coded to primary site C420, C421, C423, C424, or C770-C779
      ii. Plasma Cell Disorders 00822
      iii. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
   d. Use code **9** when it cannot be determined whether the patient specifically has bone metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include bone.

METS AT DX-BRAIN

Item #	Length
1113	1

Alternate Name:	
XML NAACCR ID:	metsAtDxBrain
PARENT XML ELEMENT:	Tumor

Description

This field identifies whether brain is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

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

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Codes

0	None; no brain metastases
1	Yes; distant brain metastases
8	Not applicable
9	Unknown whether brain is involved metastatic site. Not documented in patient record.

Coding Instructions

1. **Code information about brain metastases only** (discontinuous or distant metastases to brain) identified at the time of diagnosis. Do ***not*** code involvement of spinal cord or other parts of the central nervous system in this data item. ***Note:*** See code **1** in "Mets at Diagnosis--Other" for mets to spinal cord or other parts of the central nervous system.
    a. Brain involvement may be single or multiple.
    b. Information about brain involvement may be clinical or pathological.
    c. Code this data item whether or not the patient had neoadjuvant (preoperative) systemic therapy unless determined to be disease progression.
    d. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas.

i. Lymphoma Ocular Adnexa 00710
ii. Lymphoma (excluding CLL/SLL) 00790 (excluding primary sites C770-C779; see 2.c)
iii. Lymphoma (CLL/SLL) 00795 (excluding primary sites C770-C779; see 2.c)
iv. Mycosis Fungoides (MF) 00811
v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812

2. **Use of codes.** Assign the code that best describes whether the case has brain metastases at diagnosis.
    a. Use code **0** when the medical record:
        i. Indicates that there are no distant (discontinuous) metastases at all
        ii. Confirms the tumor is benign (/0), borderline (/1), or in situ (/2)
        iii. Includes a clinical or pathologic statement that there are no brain metastases
        iv. Includes imaging reports that are negative for brain metastases
        v. Indicates that the patient has distant (discontinuous) metastases but brain is not mentioned as an involved site
            1. ***Example:*** **Use code 0** when the patient has metastasis to lung and liver but not brain.
    b. Use code **1** when the medical record:
        i. Indicates that the patient has distant (discontinuous) metastases and brain is mentioned as an involved site
        ii. Indicates that the patient is diagnosed with an unknown primary (C809) and brain is mentioned as a distant metastatic site
    c. Use code **8** (Not applicable) for the following:
        i. Any case coded to primary site C420, C421, C423, C424, or C770-C779
        ii. Plasma Cell Disorders 00822
        iii. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
    d. Use code **9** when it cannot be determined whether the patient specifically has brain metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include brain.

METS AT DX-DISTANT LN

Item #	Length
1114	1

Alternate Name:	
XML NAACCR ID:	metsAtDxDistantLn
PARENT XML ELEMENT:	Tumor

Description

This field identifies whether distant lymph node(s) are an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

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

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Codes

0	None; no distant lymph node metastases
1	Yes; distant lymph node metastases
8	Not applicable
9	Unknown whether distant lymph node(s) are involved metastatic site. Not documented in patient record.

Coding Instructions

- ***Note 1:*** Use AJCC TNM to determine regional versus distant lymph nodes.
- ***Note 2:*** Assign code **0** (None) for unknown primaries, unless involved lymph nodes are stated to be distant lymph nodes.
- ***Note 3:*** Placental lymph node involvement for placental primaries is classified as distant lymph node involvement (M1) and recorded in this data item.

1. **Code information about distant lymph node(s) metastases only** (metastases to distant lymph nodes) identified at the time of diagnosis.
    a. Distant lymph node involvement may be single or multiple.

b. Information about distant lymph node involvement may be clinical or pathological.

c. Code this data item whether or not the patient had neoadjuvant (preoperative) systemic therapy unless determined to be disease progression.

d. Do ***not*** code this data item for regional lymph node involvemen.t

e. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas.

   i. Lymphoma Ocular Adnexa 00710

   ii. Lymphoma (excluding CLL/SLL) 00790 (excluding primary sites C770-C779; see 2.c.)

   iii. Lymphoma (CLL/SLL) 00795 (excluding primary sites C770-C779; see 2.c)

   iv. Mycosis Fungoides (MF) 00811

   v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812

2. **Use of codes:** Assign the code that best describes whether the case has distant lymph node metastases at diagnosis.

   a. Use code **0** when the medical record:

      i. Indicates that there are no distant (discontinuous) metastases at all

      ii. Confirms the tumor is benign (/0), borderline (/1), or in situ (/2)

      iii. Includes a clinical or pathologic statement that there are no distant lymph node metastases

      iv. Includes imaging reports that are negative for distant lymph node metastases

      v. Indicates lymph nodes are involved, but there is no indication whether they are regional or distant

      vi. Indicates that the patient has distant (discontinuous) metastases but distant lymph node(s) are not mentioned as an involved site

         1. ***Example:*** **Use code 0** when the patient has metastasis to lung and liver but not distant lymph node(s).

   b. Use code **1** when the medical record:

      i. Indicates that the patient has distant (discontinuous) metastases and distant lymph node(s) are mentioned as an involved site

   c. Use code **8** (Not applicable) for the following:

      i. Any case coded to primary site C420, C421, C423, C424, or C770-C779

      ii. Plasma Cell Disorders 00822

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

   d. Use code **9** when it cannot be determined whether the patient specifically has distant lymph node metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include distant lymph node(s).

METS AT DX-LIVER

Item #	Length
1115	1

Alternate Name:	
XML NAACCR ID:	metsAtDxLiver
PARENT XML ELEMENT:	Tumor

Description

This field identifies whether liver is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

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

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Codes

0	None; no liver metastases
1	Yes; distant liver metastases
8	Not applicable
9	Unknown whether liver is involved metastatic site. Not documented in patient record.

Coding Instructions

1. **Code information about liver metastases only** (discontinuous or distant metastases to liver) identified at the time of diagnosis. Do **not** record **contiguous involvement of liver by primary tumor** in this data item.
    a. Liver involvement may be single or multiple.
    b. Information about liver involvement may be clinical or pathological.
    c. Code this data item whether or not the patient had neoadjuvant (preoperative) systemic therapy unless determined to be disease progression.
    d. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas.

i. Lymphoma Ocular Adnexa 00710
ii. Lymphoma (excluding CLL/SLL) 00790 (excluding primary sites C770-C779; see 2.c)
iii. Lymphoma (CLL/SLL) 00795 (excluding primary sites C770-C779; see 2.c)
iv. Mycosis Fungoides (MF) 00811
v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812

2. **Use of codes:** Assign the code that best describes whether the case has liver metastases at diagnosis.
   a. Use code **0** when the medical record:
      i. Indicates that there are no distant (discontinuous) metastases at all
      ii. Confirms the tumor is benign (0/), borderline (/1), or in situ (/2)
      iii. Includes a clinical or pathologic statement that there are no liver metastases
      iv. Includes imaging reports that are negative for liver metastases
      v. Indicates that the patient has distant (discontinuous) metastases but liver is not mentioned as an involved site
         1. ***Example:*** **Use code 0** when the patient has metastasis to lung and brain but not liver.
   b. Use code **1** when the medical record:
      i. Indicates that the patient has distant (discontinuous) metastases and liver is mentioned as an involved site
      ii. Indicates that the patient is diagnosed with an unknown primary (C80.9) and liver is mentioned as a distant metastatic site
   c. Use code **8** (Not applicable) for the following:
      i. Any case coded to primary site C420, C421, C423, C424, or C770-C779
      ii. Plasma Cell Disorders 00822
      iii. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
   d. Use code **9** when it cannot be determined whether the patient specifically has liver metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include liver.

METS AT DX-LUNG

Item #	Length
1116	1

Alternate Name:	
XML NAACCR ID:	metsAtDxLung
PARENT XML ELEMENT:	Tumor

Description

This field identifies whether lung is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

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

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Codes

0	None; no lung metastases
1	Yes; distant lung metastases
8	Not applicable
9	Unknown whether lung is involved metastatic site. Not documented in patient record

Coding Instructions

1. **Code information about lung metastases only** (discontinuous or distant metastases to lung) identified at the time of diagnosis. Do ***not*** code pleural or pleural fluid involvement in this data item. ***Note:*** See code **1** in "Mets at Diagnosis--Other" for pleural nodules, malignant pleural or pericardial effusion.
    a. Lung involvement may be single or multiple.
    b. Information about lung involvement may be clinical or pathological.
    c. Code this data item whether or not the patient had neoadjuvant (preoperative) systemic therapy unless determined to be disease progression.
    d. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the Hematopoietic schemas below.

i. Lymphoma Ocular Adnexa 00710
ii. Lymphoma (excluding CLL/SLL) 00790 (excluding primary sites C770-C779; see 2.c)
iii. Lymphoma (CLL/SLL) 00795 (excluding primary sites C770-C779; see 2.c)
iv. Mycosis Fungoides (MF) 00811
v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812

2. **Use of codes:** Assign the code that best describes whether the case has lung metastases at diagnosis.
   a. Use code **0** when the medical record:
      i. Indicates that there are no distant (discontinuous) metastases at all
      ii. Confirms the tumor is benign (/0), borderline (/1), or in situ (/2)
      iii. Includes a clinical or pathologic statement that there are no lung metastases
      iv. Includes imaging reports that are negative for lung metastases
      v. Indicates that the patient has distant (discontinuous) metastases but lung is not mentioned as an involved site
         1. ***Note:*** A single tumor in each lung is two primaries, unless proven to be metastatic (see Solid Tumor Rules for Lung).
         2. ***Example:*** **Use code 0** when the patient has metastasis to liver and brain but not lung.
   b. Use code **1** when the medical record:
      i. Indicates that the patient has distant (discontinuous) metastases and lung is mentioned as an involved site
      ii. Indicates that lung is the primary site and there are metastases in the contralateral lung
      iii. Indicates that the patient is diagnosed with an unknown primary (C809) and lung is mentioned as a distant metastatic site
         1. ***Note:*** Do ***not*** assign **code 1** for a lung primary with multifocal involvement of the same lung.
   c. Use code **8** (Not applicable) for the following:
      i. Any case coded to primary site C420, C421, C423, C424, or C770-C779
      ii. Plasma Cell Disorders 00822
      iii. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
   d. Use code **9** when it cannot be determined whether the patient specifically has lung metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include lung.

METS AT DX-OTHER

Item #	Length
1117	1

Alternate Name:	
XML NAACCR ID:	metsAtDxOther
PARENT XML ELEMENT:	Tumor

Description

The six Mets at Dx-Metastatic Sites fields provide information on metastases for data analysis. This field identifies any type of distant involvement not captured in the Mets at Dx-Bone [1112], Mets at Dx-Brain [1113], Mets at Dx-Liver [1115], Mets at Dx-Lung [1116], and Mets at Dx-Distant LN [1114] fields. It includes involvement of other specific sites and more generalized metastases such as carcinomatosis. Some examples include but are not limited to the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum, and skin.

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

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Codes

0	None; no other metastases
1	Yes; distant metastases in known site(s) other than bone, brain, liver, lung or distant lymph nodes (***Note:*** includes bone marrow involvement for lymphomas)
2	Generalized metastases such as carcinomatosis
8	Not applicable
9	Unknown whether any other metastatic site or generalized metastases. Not documented in patient record

Coding Instructions

1. **Code information about other metastases only** (discontinuous or distant metastases) identified at the time of diagnosis. This data item should not be coded for bone, brain, liver, lung, or distant lymph node metastases.

a. Other involvement may be single or multiple.

b. Information about other involvement may be clinical or pathological.

c. Code this data item whether or not the patient had any preoperative (neoadjuvant) systemic therapy unless determined to be disease progression.

d. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas.

   i. Lymphoma Ocular Adnexa 00710

   ii. Lymphoma (excluding CLL/SLL) 00790 (excluding primary sites C770-C779; see 2.d)

   iii. Lymphoma (CLL/SLL) 00795 (excluding primary sites C770-C779; see 2.d)

   iv. Mycosis Fungoides (MF) 00811

   v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812

2. **Use of codes:** Assign the code that best describes whether the case has other metastases at diagnosis.

   a. Use code **0** when the medical record:

      i. Indicates that there are no distant (discontinuous) metastases at all

      ii. Confirms the tumor is benign (/0), borderline (/1), or in situ (/2)

      iii. Includes a clinical or pathologic statement that there are no other metastases

      iv. Includes imaging reports that are negative for other metastases

      v. Indicates that the patient has distant (discontinuous) metastases but other sites are not mentioned as involved

         1. ***Example:*** **Use code 0** when the patient has metastasis to lung and liver only.

   b. Use code **1** when the medical record indicates:

      i. Distant (discontinuous) metastases in any site(s) other than bone, brain, liver, lung, or distant lymph node(s)

         1. Includes, but not limited to, the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum, and skin.

      ii. Lymphomas with bone marrow involvement (Stage IV disease)

         1. ***Note:*** Does ***not*** include lymphomas or lymphoma/leukemias where primary site is C421 (bone marrow).

   c. Use code **2** when the medical record:

      i. Indicates that the patient has carcinomatosis

         1. Carcinomatosis is a condition in which cancer is spread widely throughout the body, or, in some cases, to a relatively large region of the body.

         2. ***Note:*** It is possible to have metastatic disease to a specific organ AND also have carcinomatosis. If a patient has metastatic disease to bone, brain, liver, lung or distant nodes AND carcinomatosis, use code 1 for the

appropriate data item (bone, brain, liver, lung, or distant nodes) and use code 2 for carcinomatosis. If a patient has metastatic disease to a site other than bone, brain, liver, lung or distant nodes AND carcinomatosis, assign code 2 for carcinomatosis. Code 2 for carcinomatosis takes priority.

a. ***Example 1:*** Patient with breast cancer noted to have mets to the liver and carcinomatosis. Code “Mets at Diagnosis--Liver” as 1 and “Mets at Diagnosis--Other” as 2.

b. ***Example 2:*** Patient with colon cancer noted to have mets to the stomach and carcinomatosis. Code “Mets at Diagnosis--Other” as 2 for carcinomatosis.

d. Use code **8** (Not applicable) for the following:

i. Any case coded to primary site C420, C421, C423, C424, or C770-C779

ii. Plasma Cell Disorders 00822

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

e. Use code **9** when it cannot be determined whether the patient has metastases other than bone, brain, liver, lung, or distant lymph node(s).

MICROSATELLITE INSTABILITY (MSI)

Item #	Length
3890	1

Alternate Name:	
XML NAACCR ID:	microsatelliteInstability
PARENT XML ELEMENT:	Tumor

Description

Microsatellite Instability (MSI) is a form of genetic instability manifested by changes in the length of repeated single- to six-nucleotide sequences (known as DNA microsatellite sequences). High MSI, found in about 15% of colorectal carcinomas, is an adverse prognostic factor for colorectal carcinomas and predicts poor response to 5-FU chemotherapy (although the addition of oxaliplatin in FOLFOX regimens negates the adverse effects [page 266 AJCC manual]). High MSI is a hallmark of hereditary nonpolyposis colorectal carcinoma, also known as Lynch syndrome.

Definition

Describes cancer cells that have a greater than normal number of genetic markers called microsatellites.

Microsatellites are short, repeated, sequences of DNA. Cancer cells that have large numbers of microsatellites may have defects in the ability to correct mistakes that occur when DNA is copied in the cell. Microsatellite instability is found most often in colorectal cancer, other types of gastrointestinal cancer, and endometrial cancer. It may also be found in cancers of the breast, prostate, bladder, and thyroid. Knowing whether cancer is microsatellite instability high may help plan the best treatment.

Rationale

Microsatellite Instability (MSI) is a Registry Data Collection Variable in AJCC. It was previously collected as Colon and Rectum, CS SSF# 7.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

0	Microsatellite instability (MSI) stable; microsatellite stable (MSS); negative, NOS AND/OR Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins MMR proficient (pMMR or MMR-P)
1	MSI unstable low (MSI-L)

2	MSI unstable high (MSI-H) AND/OR MMR-D (dMMR or MMR-D), loss of nuclear expression of one or more MMR proteins, MMR protein deficient
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error)
9	Not documented in medical record MSI-indeterminate Microsatellite instability not assessed or unknown if assessed

Coding Instructions

- ***Note 1*:** Physician statement of MSI can be used to code this data item when no other information is available.
- ***Note 2*:** The microsatellite instability (MSI) test is a genetic test performed on tumor tissue to look for differences in length of certain non-functioning sections of DNA. The differences are caused by problems with the genes that encode proteins that normally repair certain types of DNA damage. A high proportion of colon cancers arising in patients with hereditary nonpolyposis colorectal cancer (HNPCC) (also known as Lynch syndrome) have high MSI and a smaller percentage of colon cancers not associated with Lynch syndrome have high MSI. Patients with colon cancers with high MSI may be further tested to determine if they have HNPCC. In addition, MSI is a useful prognostic marker in that patients with high MSI colon cancers have better response to surgery and survival.
- ***Note 3*:** Testing for MSI may be done by immunology or genetic testing. Only genetic testing results will specify whether the MSI is low or high.
    - MSI is looking at instability in informative marker
    - MSI results are recorded as
        - MSS (Code 0)
        - Stable (Code 0)
        - Negative (Code 0)
        - Low probability of MSI-H (Code 0)
        - MSS/MSI-L (Code 0)
        - MSI-L (Code 1)
        - Unstable, high (Code 2)
        - Unstable, NOS (no designation of high or low) (Code 2)
        - MSI-H (Code 2)
        - MSI-I (intermediate) (Code 9)
- ***Note 4*:** Testing for Mismatch Repair (MMR) is usually done by immunohistochemistry (IHC).
    - Most common markers are MLH1, MSH2, MSH6, PMS2

- MMR results are recorded as
    - No loss of nuclear expression (code 0)
    - Mismatch repair (MMR) intact (code 0)
    - MMR proficient (pMMR or MMR-P) (code 0)
    - MMR normal (code 0)
    - Loss of nuclear expression (code 2)
    - MMR deficient (dMMR or MMR-D) (code 2)
    - MMR abnormal (code 2)

- ***Note 5*:** If both tests are done and one or both are positive, code 2.
- ***Note 6*:** If all tests done are negative, code 0.

Additional Information

Other names: MSI-H

For further information, refer to the Colon and Rectum Biomarker Reporting cancer protocol published by the College of American Pathologists for AJCC 8th edition

MORPH CODING SYS--CURRENT

Item #	Length
470	1

Alternate Name:	
XML NAACCR ID:	morphCodingSysCurrent
PARENT XML ELEMENT:	Tumor

Description

Code that best describes how morphology is currently coded. If converted, this field shows the system it is converted to. An update or new Morphology Coding System code incorporates all previous coding updates.

Codes

1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/1995
6	ICD-O, Second Edition, plus FAB codes effective 1/1/1998
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms used for conditions diagnosed 1/1/2010
9	Other
A	ICD-O, Third Edition, plus WHO new terms used for conditions, effective 1/1/2018
B	ICD-O 3.2, effective 1/1/2021

NAACCR RECORD VERSION

Item #	Length
50	3

Alternate Name:	
XML NAACCR ID:	naaccrRecordVersion
PARENT XML ELEMENT:	NaaccrData

Description

This item applies only to record types I, C, A, and M. Code the NAACCR record version used to create the record. The correction record (U) has its own record version data item.

Rationale

The NAACCR Layout version is necessary to communicate to the recipient of data in NAACCR form where the various items are found and how they are coded. It should be added to the record when the recorded is created.

Codes

120	2010 Version 12
121	2011 Version 12.1
122	2012 Version 12.2
130	2013 Version 13
140	2014 Version 14
150	2015 Version 15
160	2016 Version 16
180	2018 Version 18
210	2021 Version 21

NAME--ALIAS

Item #	Length
2280	40

Alternate Name:	Alias (CoC)
XML NAACCR ID:	nameAlias
PARENT XML ELEMENT:	Patient

Description

Records an alternate name or “AKA” (also known as) used by the patient, if known. Note that the birth surname (AKA maiden name) is entered in Name--Birth Surname [2232].

Rationale

The update is needed to reflect that Maiden Name is no longer going to be used as of 2021.

NAME--BIRTH SURNAME

Item #	Length
2232	40

Alternate Name:	
XML NAACCR ID:	nameBirthSurname
PARENT XML ELEMENT:	Patient

Description

Last name (surname) of patient at birth, regardless of gender or marital status. Other alternate names should be recorded in the data item, Name--Alias [2280].

Rationale

This can be used to link reports on a person whose surname might be different on different documents. It is also useful when using a Spanish surname algorithm to categorize ethnicity.

Codes

The field should be left blank if the birth surname is not known or not applicable. Since a value in this field may be used by linkage software or other computer algorithms, only legitimate surnames are allowable, and any variation of “unknown” or “not applicable” is not allowable.

Note: This data item was introduced to be a gender-neutral birth-surname data item, analogous to Name-- Maiden [2390]. It is to have been populated in the 2021 conversion by values in [2390]. The original (Name--Maiden) data item had been supported by CoC until January 1, 2003.

Coding Instructions

1. Truncate name if longer than 40 characters.
2. Record when known regardless of value in the Sex data item.
3. Leave blank if the birth surname is not known or not applicable.
4. Blank spaces, hyphens, and apostrophes are allowed; do not use other punctuation.

Examples

1. Mc Donald: Recorded with space as Mc Donald.
2. O’Hara: Recorded with apostrophe as O’Hara.

NAME--FIRST

Item #	Length
2240	40

Alternate Name:	First Name (CoC)
XML NAACCR ID:	nameFirst
PARENT XML ELEMENT:	Patient

Description

First name of the patient.

Coding Instructions

1. Truncate first name if longer than 40 characters.
2. Blank spaces, hyphens, and apostrophes are allowed; do not use other punctuation.
3. Leave blank if the patient's first name is unknown.
4. Record the most current name and update this data item if the first name changes. Enter previous names in the Alias data item.
5. Do not record nicknames in First Name.
6. Record nicknames in the Alias data item (not included in this manual).
    a. ***Example:*** The patient's nickname is Bill and the first name is William. Record William in First Name.

NAME--LAST

Item #	Length
2230	40

Alternate Name:	Last Name (CoC)
XML NAACCR ID:	nameLast
PARENT XML ELEMENT:	Patient

Description

Last name of the patient.

Coding Instructions

1. Truncate name if longer than 40 characters.
2. Blank spaces, hyphens, and apostrophes are allowed; do not use other punctuation.
3. Code UNKNOWN if the patient's last name is unknown; do not leave blank.
4. Record the most current name and update this data item if the last name changes. Enter previous names in the Alias data item.

Examples

1. Mc Donald: Recorded with space as Mc Donald.
2. O'Hara: Recorded with apostrophe as O'Hara.
3. Smith-Jones: Janet Smith marries Fred Jones and changes her last name to Smith-Jones.

NAME--MIDDLE

Item #	Length
2250	40

Alternate Name:	Middle Name (CoC) Middle Initial (pre-96 CoC)
XML NAACCR ID:	nameMiddle
PARENT XML ELEMENT:	Patient

Description

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

Coding Instructions

1. Truncate middle name if longer than 40 characters.
2. Blank spaces, hyphens, and apostrophes are allowed; do not use other punctuation.
3. Record the middle initial if the full middle name is not known.
4. Leave blank if the patient's middle name is unknown or patient has no middle name.
5. Record the most current name and update this data item if the middle name changes. Enter previous names in the Alias data item.

NAME--SUFFIX

Item #	Length
2270	3

Alternate Name:	Name Suffix (CoC)
XML NAACCR ID:	nameSuffix
PARENT XML ELEMENT:	Patient

Description

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

NCDB--COVID19--TX IMPACT

Item #	Length
3946	1

Alternate Name:	
XML NAACCR ID:	ncdbCovid19TxImpact
PARENT XML ELEMENT:	Tumor

Description

Was the first course of treatment (diagnosis, staging, treatment or other cancer management events) impacted by hospital availability (limited access to facilities or postponement of non-essential procedures) due to COVID-19 pandemic? (No; First Course Delayed; First Course Altered; First Course Cancelled).

Collection based on diagnosis years 2020 and 2021.

Rationale

To evaluate the impact of COVID-19 pandemic on cancer patients.

Codes

1	Treatment not affected; active surveillance, no change
2	First Course of Treatment timeline delayed
3	First Course of Treatment plan altered
4	Cancelled First Course of Treatment
5	Patient refused treatment due to COVID-19
9	Not known if treatment affected

Coding Instructions

- Patient’s SARS-CoV-2 test (viral RNA or serologic antibody) and patient’s COVID-19 status do not affect coding of this data item.
- Code the impact of first course of treatment during COVID pandemic.
- If a patient has multiple primaries under active treatment, each primary will be coded for Tx impact of treatment due to COVID.
- Data items are coded in hierarchy, if a patient’s timeline is delayed which forces a regimen alteration, code 3.
- This item may be left blank.

NCDB--SARSCOV2--POS

Item #	Length
3944	1

Alternate Name:	
XML NAACCR ID:	ncdbSarsCov2Pos
PARENT XML ELEMENT:	Patient

Description

Data item is designed to track whether patient received a POSITIVE SARS-CoV-2 test or not. Collection based on diagnosis years 2020 and 2021.

Rationale

To evaluate the impact of COVID-19 diagnosis on cancer patients.

Codes

0	Patient did not test positive for active SARS-CoV-2: No positive test
1	Patient tested positive for active SARS-CoV-2: test positive on at least one test
9	Unknown if tested; test done, results unknown

Coding Instructions

- Code a confirmed diagnostic SARS-CoV-2 test was performed to diagnose the 2019 novel coronavirus disease (COVID-19) as documented by a medical provider (i.e. lab report).
- Diagnostic tests [reverse transcriptase-polymerase chain reaction (RT-PCR) tests] are based on detection of viral ribonucleic acid (RNA). Serologic antibody tests (for total antibody or IgM, IgA, and/or IgG antibodies) are not diagnostic tests for active SARS-CoV-2 infection.
- Testing can be either inpatient, outpatient or emergency room visit.
- This item may be left blank.

NCDB--SARSCOV2--POS DATE

Item #	Length
3945	8

Alternate Name:	
XML NAACCR ID:	ncdbSarsCov2PosDate
PARENT XML ELEMENT:	Patient

Description

What was the date of the first positive test? Collection based on diagnosis years 2020 and 2021. Records date the patient had a positive test for SARS-CoV-2, the virus that causes the 2019 novel coronavirus disease (COVID-19), as documented by a medical provider.

Rationale

To evaluate the impact of COVID-19 diagnosis on cancer patients.

Codes (in addition to valid date)

Blank	Date of the test is unknown or the date of a positive (diagnostic or serologic) test is unknown for SARS-CoV-2

Coding Instructions

- Record the date the patient had a positive test for SARS-CoV-2, the virus that causes the 2019novel coronavirus disease (COVID-19), as documented by a medical provider.
- When multiple interpretations are available for multiple viral tests, record the date of the first positive diagnostic SARS-CoV-2 test. Diagnostic tests [reverse transcriptase-polymerase chain reaction (RT-PCR) tests] are based on detection of viral ribonucleic acid (RNA). Serologic antibody tests (for total antibody or IgM, IgA, and/or IgG antibodies) are not diagnostic tests for active SARS-CoV-2 infection.
- If both positive diagnostic tests and positive serologic tests are reported in the medical record, code the date for the first positive diagnostic test.
- Leave the field blank when a date of the test is unknown or the date of a positive (diagnostic or serologic) test is unknown for SARS-CoV-2.

NCDB--SARSCOV2--TEST

Item #	Length
3943	1

Alternate Name:	
XML NAACCR ID:	ncdbSarsCov2Test
PARENT XML ELEMENT:	Patient

Description

Data item is designed to track whether patient received a SARS-CoV-2 test or not. Collection based on diagnosis years 2020 and 2021.

Rationale

To evaluate the impact of COVID-19 diagnosis on cancer patients.

Codes

0	Patient not tested for SARS-CoV-2: facility records support that patient did not undergo pre-admit or in-hospital testing
1	Patient tested for Active SARS-CoV2
9	Unknown if patient tested for SARS-CoV-2/No facility record of preadmit hospital testing of SARS-CoV-2

Coding Instructions

- Collection based on diagnosis years 2020 and 2021.
- Code only a confirmed diagnostic test for SARS-CoV-2, the virus that causes the 2019 novel coronavirus disease (COVID-19), as documented by a medical provider (i.e. lab report);preadmission or hospital testing is in the record.
- Diagnostic tests [reverse transcriptase-polymerase chain reaction (RT-PCR) tests] are based on detection of viral ribonucleic acid (RNA). Serologic antibody tests (for total antibody or IgM, IgA, and/or IgG antibodies) are not diagnostic tests for active SARS-CoV-2 infection.
- Testing can be either inpatient, outpatient or emergency room visit.
- This item may be left blank.

NPI--PHYSICIAN--FOLLOW-UP

Item #	Length
2475	10

Alternate Name:	
XML NAACCR ID:	npiPhysicianFollowUp
PARENT XML ELEMENT:	Tumor

Description

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

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.

Rationale

Used to monitor post-treatment patient care.

Codes

[Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit).

The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

NPI--PHYSICIAN--MANAGING

Item #	Length
2465	10

Alternate Name:	
XML NAACCR ID:	npiPhysicianManaging
PARENT XML ELEMENT:	Tumor

Description

The NPI (National Provider Identifier) code that identifies 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 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.

Rationale

Used to monitor patient care.

Codes

[Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit).

The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

NPI--REPORTING FACILITY

Item #	Length
545	10

Alternate Name:	
XML NAACCR ID:	npiReportingFacility
PARENT XML ELEMENT:	Tumor

Description

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

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.

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://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

OVER-RIDE AGE/SITE/MORPH

Item #	Length
1990	1

Alternate Name:	Age/Site/Histology Interfield Review (Interfield Edit 15) (SEER #3)
XML NAACCR ID:	overRideAgeSiteMorph
PARENT XML ELEMENT:	Tumor

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:
Age, Primary Site, Morphology ICDO2 (SEER IF15)
Age, Primary Site, Morphology ICDO3 (SEER IF15)
Age, Primary Site, Morph ICDO3--Adult (SEER)
Age, Primary Site, Morph ICDO3--Pediatric (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 over-ride flag is used to skip the edit in the future.

Codes

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

Coding Instructions

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

OVER-RIDE HISTOLOGY

Item #	Length
2040	1

Alternate Name:	Histology/Behavior Interfield Review (Field Item Edit Morph)
XML NAACCR ID:	overRideHistology
PARENT XML ELEMENT:	Tumor

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 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:
Diagnostic Confirmation, Behavior ICDO2 (SEER IF31)
Diagnostic Confirmation, Behavior ICDO3 (SEER IF31)
Morph (1973-91) ICD-O-1 (SEER MORPH)
Morphology--Type/Behavior ICDO2 (SEER MORPH)
Morphology--Type/Behavior ICDO3 (SEER MORPH)

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.

Codes

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

Coding Instructions

1. Leave blank if the program does not generate an error message for the edits of the types, Diagnostic Confirmation, Behav Code or Morphology--Type/Behavior.
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.

OVER-RIDE LEUK, LYMPHOMA

Item #	Length
2070	1

Alternate Name:	Leukemia or Lymphoma/Diagnostic Confirmation Interfield Review
XML NAACCR ID:	overRideLeukLymphoma
PARENT XML ELEMENT:	Tumor

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:
Diagnostic Confirmation, Histology ICDO2 (SEER IF48)
Diagnostic Confirmation, Histology ICDO3 (SEER IF48)

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.

Codes

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

Coding Instructions

1. Leave blank if the program does not generate an error message for the edits of the type Diagnostic Confirmation, Histology.
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.
3. If the edit produces an error or warning message, verify that the ICD-O-2 or 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.

OVER-RIDE NAME/SEX

Item #	Length
2078	1

Alternate Name:	
XML NAACCR ID:	overRideNameSex
PARENT XML ELEMENT:	Patient

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 NAACCR Metafile of the EDITS software:
Sex, Name-First, Date of Birth (NAACCR)

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.

Codes

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

Note: Leave blank if the program does not generate an error message for the edit Sex, Name-First, Date of Birth (NAACCR).

OVER-RIDE SITE/BEHAVIOR

Item #	Length
2071	1

Alternate Name:	Over-ride Flag for Site/Behavior (IF39)
XML NAACCR ID:	overRideSiteBehavior
PARENT XML ELEMENT:	Tumor

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, Behavior Code ICDO2 (SEER IF39)
Primary Site, Behavior Code ICDO3 (SEER IF39)

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.

Codes

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

Note: The IF 39 edit does not allow in situ cases of nonspecific sites, such as gastrointestinal tract, NOS; uterus, NOS; female genital tract, NOS; male genital organs, NOS; and others. The over-ride indicates that the conflict has been reviewed.

Coding Instructions

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

OVER-RIDE SITE/LAT/EOD

Item #	Length
2073	1

Alternate Name:	Over-ride Flag for Site/Laterality/CS Extension (IF177) Over-ride Flag for Site/Laterality/EOD (IF41)
XML NAACCR ID:	overRideSiteLatEod
PARENT XML ELEMENT:	Tumor

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, Laterality, EOD, ICDO2 (SEER IF41)
Primary Site, Laterality, EOD, ICDO3 (SEER IF41)
Primary Site, Laterality, CS Extension (SEER IF177)

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.

Codes

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

Coding Instructions

1. Leave blank if the program does not generate an error message for the edit Primary Site, Laterality, EOD, ICDO2 (SEER IF41) and/or Primary Site, Laterality, EOD, ICDO3 (SEER IF41).
2. Code 1 if the case has been reviewed and it has been verified that the patient had laterality coded nonspecifically and EOD coded specifically.

OVER-RIDE SITE/LAT/MORPH

Item #	Length
2074	1

Alternate Name:	Over-ride Flag for Site/Laterality/Morphology (IF42)
XML NAACCR ID:	overRideSiteLatMorph
PARENT XML ELEMENT:	Tumor

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:
Laterality, Primary Site, Morph ICDO2 (SEER IF42)
Laterality, Primary Site, Morph ICDO3 (SEER IF42)

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.

Codes

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

Coding Instructions

1. Leave blank if the program does not generate an error message for the edit Laterality, Primary site, Morph ICDO2 (SEER IF 42) and/or the edit Laterality, Primary site, Morph ICDO3 (SEER IF42).
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.
3. Code 1 if review of site, laterality and morphology verifies that the case had behavior code of “in situ” and laterality is not stated as “right: origin of primary;” “left: origin of primary;” or “only one side involved, right or left origin not specified”.

OVER-RIDE SITE/TYPE

Item #	Length
2030	1

Alternate Name:	Site/Type Interfield Review (Interfield Edit 25)
XML NAACCR ID:	overRideSiteType
PARENT XML ELEMENT:	Tumor

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, Morphology-Type ICDO2 (CoC)
Primary Site, Morphology-Type ICDO3 (CoC)
Primary Site, Morphology-Type ICDO2 (SEER IF25)
Primary Site, Morphology-Type ICDO3 (SEER IF25)
Primary Site, Morphology-Type, Behavior ICDO3 (SEER IF25)
Primary Site, Morphology-Type, Behavior ICDO3 (CoC)

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.

Codes

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

Coding Instructions

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

OVER-RIDE SURG/DXCONF

Item #	Length
2020	1

Alternate Name:	Surgery/Diagnostic Confirmation Interfield Review (Interfield Edit 46)
XML NAACCR ID:	overRideSurgDxconf
PARENT XML ELEMENT:	Tumor

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:
RX Summ--Surg Prim Site, Diag Conf (SEER IF76)
RX Summ--Surg Site 98-02, Diag Conf (SEER IF106)
RX Summ--Surgery Type, Diag Conf (SEER IF46)

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.

Codes

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

Coding Instructions

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

PHASE I RADIATION TREATMENT MODALITY

Item #	Length
1506	2

Alternate Name:	
XML NAACCR ID:	phase1RadiationTreatmentModality
PARENT XML ELEMENT:	Tumor

Description

Identifies the radiation modality administered during the first phase of radiation treatment delivered as part of the first course of treatment.

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

Rationale

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

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

Codes

00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions

07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, interstitial, LDR
11	Brachytherapy, interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, radium-223
15	Radioisotopes, strontium-89
16	Radioisotopes, strontium-90
98	Radiation therapy administered but treatment modality is not specified or unknown
99	Unknown if radiation treatment administered

Coding Instructions

1. Radiation treatment modality will typically be found in the radiation oncologist's treatment summary for the first course of treatment. Segregation of treatment components into Phases and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
2. For purposes of this data item, photons, x-rays and gamma-rays are equivalent.
3. Use code 13 - Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90 for cases diagnosed January 1, 2018 or later. For cases diagnosed prior January 1, 2018, use code 07-Brachytherapy, NOS.
4. This data item intentionally does not include reference to various MV energies because this is not a clinically important aspect of technique. A change in MV energy (e.g., 6MV to 12MV) is not clinically relevant and does not represent a change in treatment technique. It is rare for change in MV energy to occur during any phase of radiation therapy.
5. If this data item is coded to any of the External beam codes (01-06 or 12), the planning technique must be recorded in the data item Phase I-II-III External Beam Radiation Planning Technique [1502, 1512, 1522].
6. If Radiation Treatment Modality is coded to any of the Brachytherapy or Radioisotopes codes (07-16) the code of 88 must be recorded in the data item Phase I-II-III External Beam Radiation Planning Technique [1502, 1512, 1522].
    a. ***Note:*** Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.
7. Phase I must be coded however blanks allowed for Phase II-III if no treatment administered.

PHYSICIAN--FOLLOW-UP

Item #	Length
2470	8

Alternate Name:	Follow-Up Physician (pre-96 CoC) Following Physician (CoC)
XML NAACCR ID:	physicianFollowUp
PARENT XML ELEMENT:	Tumor

Description

Code for the physician currently responsible for the patient's medical care. WCRS uses DSPS Assigned codes.

Rationale

Used to monitor post-treatment patient care.

Codes in addition DSPS Physician Number

99999999	Follow-up physician unknown or ID number not assigned

PHYSICIAN--MANAGING

Item #	Length
2460	8

Alternate Name:	Managing Physician (CoC) Attending Physician (pre-96 CoC)
XML NAACCR ID:	physicianManaging
PARENT XML ELEMENT:	Tumor

Description

Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer. WCRS uses DSPS Assigned codes.

Rationale

Used to monitor patient care.

Codes in addition to DSPS Physician Number

99999999	Managing physician unknown or ID number not assigned

PLACE OF DEATH--COUNTRY

Item #	Length
1944	3

Alternate Name:	
XML NAACCR ID:	placeOfDeathCountry
PARENT XML ELEMENT:	Patient

Description

Code for the country in which the patient died and where certificate of death is filed. If the patient has multiple tumors, all records should contain the same code. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item Place of Death--State [1942]. It replaces the use of Place of Death [1940].

Rationale

Place of death is helpful for carrying out death clearance. When a reporting facility reports a place of death that is outside of the registry's country, the information can signal a death for which the death certificate will not be available from another state or through the NDI linkage.

Codes (In addition to valid County Codes)

Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes. See SEER Manual, Appendix B for complete list of country names and corresponding three character alpha codes.

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-US NOS
ZZU	Unknown

PLACE OF DEATH--STATE

Item #	Length
1942	2

Alternate Name:	
XML NAACCR ID:	placeOfDeathState
PARENT XML ELEMENT:	Patient

Description

State or Province where the patient died and where certificate of death is filed. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item PLACE OF DEATH--COUNTRY [1944]. It replaces the use of PLACE OF DEATH [1940].

Rationale

This field also helps carry out death clearance. When a reporting facility reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate is to be requested.

Codes (in addition to Valid State Code)

Blank	Not applicable, patient alive

See Appendix B of the SEER Program and Staging Manual for numeric and alphabetic lists of places and codes.

PRIMARY PAYER AT DX

Item #	Length
630	2

Alternate Name:	Primary Payer at Diagnosis (CoC)
XML NAACCR ID:	primaryPayerAtDx
PARENT XML ELEMENT:	Tumor

Description

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

Rationale

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

Codes

Code	Label	Definition
01	Not insured	Patient has no insurance and is declared a charity write-off
02	Not insured, self-pay	Patient has no insurance and is declared responsible for charges
10	Insurance, NOS	Type of insurance is unknown or other than types listed in codes 20, 21, 31, 35, 60-68
20	Private Insurance: Managed care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. “Gate-keeper model” is another term for describing this type of insurance.
21	Private Insurance: Fee-for-service	An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs Medicaid other than Medicaid described in code 35

35	Medicaid – administered through a Managed Care plan	Patient is enrolled in Medicaid through a Managed Care program (e.g., HMO or PPO). The managed care plan pays for all incurred costs.
60	Medicare/Medicare, NOS	Federal government funded insurance generally for persons who are 65 years of age or older, are chronically disabled (social security insurance eligible), or are dialysis patients. Includes Medicare without supplement. Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare. (See also, codes 63 and 64.)
62	Medicare – Administered through a Managed Care Plan	Patient is enrolled in Medicare through a Managed Care plan (e.g., HMO or PPO). The Managed Care plan pays for all incurred costs.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare.
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with state-administered Medicaid supplement.
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents Formerly known as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
66	Military	Military personnel or their dependents treated at a military facility
67	Veterans Affairs	Veterans treated in Department of Veterans Affairs facilities
68	Indian/Public Health Service	Patient receives care at an Indian Health Service facility or at another facility and medical costs are reimbursed by the Indian Health Service Patient receives care at a Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service
99	Insurance status unknown	Patient's medical record does not indicate whether or not the patient is insured

Coding Instructions

1. Code the type of insurance reported on the patient's admission record.
2. Code the **first** insurance mentioned when multiple insurance carriers are listed on one admission record.

3. Code the type of insurance reported **closest to the date of diagnosis** when there are multiple insurance carriers reported for multiple admissions and/or multiple physician encounters.
4. Code the patient's insurance at the time of **initial diagnosis and/or treatment**. Do not change the insurance information based on subsequent information. a. Code the first insurance mentioned when there is more than one type of insurance specified during the initial diagnosis and/or treatment.
5. Use code **02** when the only information available is "self-pay".
6. Use code **10** for prisoners when no further information is available.
7. Assign code **99** for death certificate only (DCO) cases when the primary payer at diagnosis is unknown.

PRIMARY SITE

Item #	Length
400	4

Alternate Name:	IDC-O-2/3 Topography (CCCR)
XML NAACCR ID:	primarySite
PARENT XML ELEMENT:	Tumor

Description

Code for the primary site of the tumor being reported using either ICD-O-2 or ICD-O-3. NAACCR adopted ICD-O-2 as the standard coding system for tumors diagnosed beginning January 1, 1992. In addition, NAACCR recommended that tumors diagnosed prior to 1992 be converted to ICD-O-2. The topography (primary site) codes did not change between ICD-O-2 and ICD-O-3.

Codes

Valid ICD-O-3 Codes.

Coding Instructions for Solid Tumors

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

1. Unless otherwise instructed, use all available information in the medical record to code the site.
2. Code the site in which the primary tumor originated, even if it extends onto/into an adjacent subsite.
    a. Primary site should always be coded to reflect the site of origin according to the medical opinion on the case. Look for information about where the neoplasm originated. Always code the primary site based on where the tumor arose / site of origin.
    b. Site of origin may be indicated by terms such as "tumor arose from…," "tumor originated in…," or similar statements.
    c. Site of origin is not necessarily the site of a biopsy.
    d. Tumors may involve many sites. The primary site code should reflect the site where the tumor arose rather than all of the sites of involvement.
        i. ***Example 1:*** Final diagnosis is adenocarcinoma of the upper lobe of the right lung. Code the topography to lung, upper lobe (C341).
        ii. ***Example 2:*** The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. Code the primary site to upper inner quadrant of breast (C502).
        iii. ***Example 3:*** Patient has a right branchial cleft cyst; the pathology report identifies

an adenocarcinoma arising in an ectopic focus of thyroid tissue within the branchial cleft cyst. Thyroidectomy pathology is negative. Code the primary site to branchial cleft (C104).

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

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

vi. ***Example 6:*** The patient has a left lower lip wedge excision showing invasive squamous cell carcinoma at the mucocutaneous junction. There is no further information in operative report or pathology report regarding the location of this tumor that would indicate this is a skin primary. Assign C001, external lower lip. C001 includes vermilion border of lower lip. Vermilion border is synonymous with mucocutaneous junction.

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

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

    b. ***Note:*** Skin cancers overlapping sites in the head and neck ONLY. Assign the primary site code for the site where the bulk of the tumor is or where the epicenter is; do not use code C448.

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

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

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

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

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

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

6. Some histology/behavior terms in ICD-O-3.2 have a **related site code** in parentheses; for example, hepatoma (C220).

a. Code the site as documented in the medical record and ignore the suggested ICD-O-3.2 code when a primary site is specified in the medical record.
    i. ***Example:*** The path report says “infiltrating duct carcinoma of the head of pancreas.” The listing in ICD-O-3.2 is infiltrating duct carcinoma 8500/3 (C50_). Code the primary site to head of pancreas (C250), NOT to breast (C50_) as suggested by the ICD-O-3.2.
b. Use the site code suggested by ICD-O-3.2 when the primary site is the same as the site code suggested or the primary site is unknown.
    i. ***Example 1:*** The biopsy is positive for hepatoma, and no information is available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.2.
    ii. ***Example 2:*** Excision of the right axillary nodes reveals metastatic infiltrating duct carcinoma. The right breast is negative. ICD-O-3.2 shows infiltrating duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).
c. Use the site code suggested by ICD-O-3.2 when there is no information available indicating a different primary site.
    i. ***Example:*** Biopsy of lymph node diagnosed as metastatic non-small cell carcinoma. Patient expired and there is no information available about the primary site. Assign C349 based on the site code suggested in ICD-O-3.2.

7. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).
8. 8. See the site-specific Coding Guidelines in SEER Manual, Appendix C for primary site Coding Guidelines for the following sites:
    a. Bladder Kaposi Sarcoma of All Sites
    b. Breast Lung
    c. Colon Rectosigmoid Junction
    d. Esophagus
9. See section below for primary site Coding Guidelines for sarcoma
10. Angiosarcoma
    a. Code C422 (spleen) as the primary site for angiosarcoma of spleen.
    b. Code C50_ (breast) for angiosarcoma of breast. Although angiosarcoma actually originates in the lining of the blood vessels, an angiosarcoma originating in the breast has a poorer prognosis than many other breast tumors.
11. Gastrointestinal Stromal Tumors (GIST): Code the primary site to the location where the GIST originated.
12. Transplants
    a. Code the primary site to the location of the transplanted organ when a malignancy arises in a transplanted organ, i.e., code the primary site to where the malignancy resides or lies.

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

b. For information about organ or tissue transplants, see the section Determining Multiple Primaries.

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

13. Assign primary site code C449, skin NOS, for a Merkel cell carcinoma presenting in a nodal or distant metastatic site and site of origin is **unknown.**

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

Primary Site/Histology	**Topography Code**
Ampullary/peri-ampullary	C241
Anal margin	C445
Anal verge	C211
Angle of the stomach	C162
Angular incisura of stomach	C163
Book-leaf lesion (mouth)	C068
Clavicular skin	C445
Colored / lipstick portion of upper lip	C000
Cutaneous leiomyosarcoma	C44_
Distal conus	C720
Edge of tongue	C021
Frontoparietal (brain)	C718
Gastric angular notch (incisura)	C163
Gastrohepatic ligament Genu of pancreas	C481 C250
Glossotonsillar sulcus	C109
Incisura, incisura angularis	C163
Infrahilar area of lung	C349
Interhemispheric fissure (cerebrum)	C710
Lateral tongue	C023
Leptomeninges	C709

Masticator space	C760
Melanoma, NOS	C449
Nail bed, thumb	C446
Pancreatobiliary	C269
Parapharyngeal space	C490
Perihilar bile duct	C240
Testis, descended post orchiopexy	C621
Uncinate of pancreas	C250

15. When the medical record does **not** contain **enough information** to assign a primary.
    a. Consult a physician advisor to assign the site code.
    b. Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site.
        i. Occult Tumors of the Head and Neck
            1. Assign primary site C119 (nasopharynx) for occult head and neck tumors with cervical lymph node metastasis in Levels I-VII, and other group lymph nodes positive for Epstein–Barr virus (EBV+) (regardless of p16 status) encoded small RNAs (EBER) identified by in situ hybridization.
            2. Assign primary site C109 (oropharynx) for occult head and neck tumors with cervical lymph node metastasis in Levels I-VII, and other group lymph nodes, p16 positive with histology consistent with HPV-mediated oropharyngeal carcinoma (OPC).
            3. Assign C760 for Occult Head and Neck primaries with positive cervical lymph nodes. Schema Discriminator 1: Occult Head and Neck Lymph Nodes is used to discriminate between these cases and other uses of C760.
            4. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
    c. Assign the NOS code for the body system when there are two or more possible primary sites documented and all are within the same system.
        i. ***Example:*** Two possible sites are documented in the GI system such as colon and small intestine; code to the GI tract, NOS (C269). Document the possible primary sites in a text field.
    d. Code unknown primary site when there is a physician statement of unknown primary site **ONLY** when **none of the above instructions can be applied.**
    e. Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category.

Sarcoma

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

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

Example 1: The pathology identifies a carcinosarcoma of the uterine corpus. Code the primary site to corpus uteri (C549).

Example 2: Rhabdomyosarcoma of ethmoid sinus. Code primary site to C311. Code the organ of origin as the primary site when leiomyosarcoma arises in an organ. Do not code soft tissue as the primary site in this situation.

Example 1: Leiomyosarcoma arises in kidney. Code the primary site to kidney (C649).

Example 2: Leiomyosarcoma arises in prostate. Code primary site to prostate (C619).

Coding Instructions for Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3)

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

PROGESTERONE RECEPTOR SUMMARY

Item #	Length
3915	1

Alternate Name:	
XML NAACCR ID:	progesteroneRecepSummary
PARENT XML ELEMENT:	Tumor

Description

PR (Progesterone Receptor) Summary is a summary of results from the progesterone receptor (PR) assay.

Rationale

This data item is required for prognostic stage grouping in AJCC 8th edition, Chapter 48, Breast. It was previously collected as Breast CS SSF # 2.

Codes

0	PR negative (0.0% or less than 1%)
1	PR positive
7	Test ordered, results not in chart
9	Not documented in medical record Cannot be determined (indeterminate) PR (Progesterone Receptor) Summary status not assessed or unknown if assessed

Coding Guidelines

- Code 0 when the PR is reported as negative or normal.
- Code 1 when the PR is reported as positive or elevated.
- Code 7 when the PR test was ordered but the results are not available.
- Code 9 when the PR is:
    - Reported as borderline; undetermined whether positive or negative
    - Cannot be determined by the pathologist (e.g. inadequate specimen)
    - It is unknown whether the PR test was performed
    - The patient has only a clinical diagnosis of breast cancer (no tissue diagnosis)

Coding Instructions

- ***Note 1*:** Physician statement of PR (Progesterone Receptor) Summary status can be used to code this data item when no other information is available.
- ***Note 2*:** The result of the PR test performed on the primary breast tissue is to be recorded in this data item.
- ***Note 3*:** Results from nodal or metastatic tissue may be used ONLY when there is no evidence of primary tumor.
- ***Note 4*:** In cases where there are invasive and in situ components and PR is done on both, ignore the in situ results.
    - If PR is positive on an in situ component and PR is negative on all tested invasive components, code PR as negative (code 0).
    - If in situ and invasive components present and PR only done on the in situ component, code unknown (code 9).
- ***Note 5*:** In cases where there is a single tumor with multiple biopsies and/or surgical resection with different PR results.
    - Use the highest (positive versus negative).
- ***Note 6*:** In cases where there are multiple tumors with different PR results, code the results from the largest tumor size (determined either clinically or pathologically) when multiple tumors are present.
    - Do not use specimen size to determine the largest tumor size.
- ***Note 7*:** If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy. If neoadjuvant therapy is given and there are no PR results from pre-treatment specimens, report the findings from post-treatment specimens.
- ***Note 8*:** If the patient is PR positive and node negative, a multigene test such as Oncotype Dx may be performed, in which case another PR test will be performed. Do not record the results of that test in this field.
    - Record only the results of the test which made the patient eligible to be given the multigene test.
    - Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

PSA (PROSTATIC SPECIFIC ANTIGEN) LAB VALUE

Item #	Length
3920	5

Alternate Name:	
XML NAACCR ID:	psaLabValue
PARENT XML ELEMENT:	Tumor

Description

PSA (Prostatic Specific Antigen) is a protein produced by cells of the prostate gland and is elevated in patients with prostate cancer. This data item pertains to PSA lab value.

Rationale

This data item is required for prognostic stage grouping in AJCC 8th edition, Chapter 58, Prostate. It was previously collected as Prostate, CS SSF# 1.

Codes

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

0.1	0.1 or less nanograms/milliliter (ng/ml) (Exact value to nearest tenth of ng/ml)
0.2-999.9	0.2–999.9 ng/ml (Exact value to nearest tenth of ng/ml)
XXX.1	1,000 ng/ml or greater
XXX.7	Test ordered, results not in chart
XXX.9	Not documented in medical record PSA lab value not assessed or unknown if assessed

Definitions

Serum PSA is the most sensitive tumor marker for monitoring individuals with prostate cancer, including progression of disease and response to therapy. Although originally not intended to be a screening test, this relatively simple blood test has become a very common method of detecting new prostate cancer in its earliest stages. PSA can be totally negative when prostate cancer is found on digital rectal exam. In such cases, PSA will not be helpful in monitoring for recurrence.

- ***Note:*** Serum PSA is not the same as free PSA or precursor PSA—do not record values from either of these tests in this field.

Additional Information

- ***Source documents:*** clinical laboratory report (blood or serum test), history, clinician note, pathology report
- ***Other names:*** Prostate specific antigen, serum PSA, total PSA
- ***Normal reference range***: varies by age and race of patient.
    - The reference range should be shown on the clinical laboratory report. In general, normal findings are 0 – 4.0 nanograms per milliliter (ng/ml).
    - Optimal normal range is 0 – 2.6 ng/ml. Nanograms per milliliter may be reported as micrograms per liter (Pg/L or ug/L).

Coding Guidelines

Record the last pre-diagnosis PSA lab value prior to diagnostic biopsy of prostate and initiation of treatment in nanograms per milliliter (ng/ml) in the range 0.1 (.1 ng/ml) to 999.9 (999.9 ng/ml).

- ***Note:*** This is a change from CSv2, where the instructions stated to code the highest PSA value within 3 months prior to diagnostic biopsy.

Coding Instructions and Codes

- ***Note 1*****:** Physician statement of prostatic specific antigen (PSA) pre-diagnosis can be used to code this data item when no other information is available.
- ***Note 2*****:** PSA is a prognostic factor required for staging. It affects stage group in most cases.
- ***Note 3*****:** Record to the nearest tenth in nanograms/milliliter (ng/ml) the last pre-diagnosis PSA lab value prior to diagnostic biopsy of prostate and treatment. The lab value may be recorded in the lab report, history and physical, or clinical statement in the pathology report, etc.
    - A lab value expressed in micrograms per liter (ug/L) is equivalent to the same value expressed in nanograms per milliliter (ng/ml).
    - Record 0.1 when the lab results are stated as less than 0.1 ng/ml with no exact value.
        - ***Examples:***
            - PSA of 7.2. Code 7.2
            - PSA of 10. Code 10.0
            - PSA of 8.56. Code 8.6
            - PSA of 110.35. Code 110.4
- ***Note 4*****:** A discrepancy between the PSA documented in the lab report and the PSA documented by the clinician may arise due to the clinician's adjusting the PSA value. Certain medications for benign prostatic hypertrophy (BPH) decrease the PSA.
- If there is documentation by a clinician within the medical record of an adjusted PSA value, record the adjusted value.
- The registrar does not adjust the PSA value based on BPH medication use.
- If there is no documentation by a clinician within the medical record of an adjusted PSA value, record the PSA value provided.
- The fact that an adjusted PSA value is being recorded should be documented in the Dx Proc – Lab Tests text field (NAACCR Item #2550).

RACE 1, 2, 3, 4, 5

Item #	Length
160, 161, 162, 163, 164	2

Alternate Name:	Race1…Race5
XML NAACCR ID:	race1…race5
PARENT XML ELEMENT:	Patient

Description

Race and ethnicity are 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.

The five race data items (Race 1 – Race 5) make it possible to code multiple races for one person, consistent with the 2000 Census. 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 electronic form, the electronic data must also be reviewed.

Recommendation: Document how the race code(s) was (were) determined in a text field.

Codes

01	White
02	Black
03	American Indian, Aleutian, Alaskan Native or Inuit (includes all indigenous populations of the western hemisphere)
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (including Khmer and Cambodian)

14	Thai
15	Asian Indian or Pakistani, NOS (Effective with 01/01/2010 dx)
16	Asian Indian (Effective with 01/01/2010 dx)
17	Pakistani (Effective with 01/01/2010 dx)
20	Micronesian, NOS
21	Chamorro/Chamoru
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No additional races (Race 2 – Race 5)
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown

Priorities for Coding Multiple Races

1. Code **07** takes priority over all other codes.
    a. ***Example:*** Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Hawaiian), Race 2 as 05 (Japanese).
2. Codes **02-32, 96-98** take priority over code **01.**
3. Code only the specific race when both a specific race code and a non-specific race code apply.
4. Codes 04-17 take priority over code 96.
5. Codes 16-17 take priority over code 15.
6. Codes 20-32 take priority over code 97.
7. Codes 02-32 and 96-97 take priority over code 98.
8. Code 98 takes priority over code 99.

Coding Instructions

1. Do **not** use patient name as the basis for coding race.
    a. See Coding Instruction 15, Exception, for the only situation in which name is taken into account when coding race.
2. Code race using the highest priority source available according to the list below (a is the highest and c is the lowest) when race is reported differently by two or more sources. Use self-reported information as first priority.
    a. Self-reported race information takes precedence over genetic testing and over information obtained through linkages. Generally, race information is used from linkages when race data are missing or unknown, or to enhance data. Self-reported information is the highest priority for coding race because the race information for the U.S. population comes from census data and that information is self-reported. For national cancer statistics, in order for the numerator (cancer cases) and the denominator (population) to be comparable, use self-reported race information whenever it is available.
    b. Sources in Priority Order:
        i. The patient's self-declared identification
        ii. Documentation in the medical record
        iii. Death certificate
3. Assign the same race code(s) for all tumors for one patient.
4. Code the race(s) of the patient in data items Race 1, Race 2, Race 3, Race 4, and Race 5.
    a. Code **88** for the remaining race data items (Race 2 – Race 5) when at least one race, but fewer than five races, are reported.
5. Use the associated text field to document.
    a. Why a particular race code was chosen when there are discrepancies in race information.
        i. ***Example:*** The patient is identified as Black in nursing notes and White in a dictated physical exam. Use a text field to document why one race was coded rather than the other.
    b. That no race information is available.
6. Code as **01** (White) when:
    a. The race is described as White or Caucasian regardless of place of birth.
    b. There is a statement that the patient is Hispanic or Latino(a) and **no further information** is available.
        i. A person of Spanish origin may be any race; however, for coding race when there is no further information other than "Hispanic" or "Latino(a)," assign race as White as a last resort instead of coding unknown.
        ii. ***Example:*** Sabrina Fitzsimmons is a Latina. No further information is available. Code race as 01 (White).
        iii. ***Note 1:*** Do not code 98 (Other) in this situation.

iv. ***Note 2:*** Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually White.

7. Code race as **02** (Black) when the stated race is African-American, Black, or Negro.
8. Assign code **03** for any person stated to be:
    a. Native American (western hemisphere) **OR**
    b. Indian, whether from North, Central, South, or Latin America.
9. Assign a specific code when a specific Asian race is stated. Do not use code 96 when a specific race is known.
    a. ***Example:*** Patient is described as Asian in a consult note and as second generation Korean-American in the history. Code Race 1 as 08 (Korean) and Race 2 through Race 5 as 88.
    b. ***Note:*** Do not code 96 (Other Asian including Asian, NOS and Oriental, NOS) in a subsequent race data item when a specific Asian race has been coded.
10. Code the race based on birthplace information when the race is recorded as Oriental, Mongolian, or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation.
    a. ***Example 1:*** Race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 (Japanese) because it is more specific than 96.
    b. ***Example 2:*** The person describes himself as an Asian-American born in Laos. Code race as 11 (Laotian) because it is more specific than 96.
11. Use the appropriate non-specific code 96 (Other Asian including Asian, NOS and Oriental, NOS), 97 (Pacific Islander, NOS), or 98 (Other) when there is no race code for a specific race.
    a. ***Note:*** Document the specified race in a text field.
12. Do not use code 96, 97, or 98 for “multi-racial.” See Coding Examples below.
13. All race data items must be coded 99 (Unknown) when Race 1 is coded 99 (Unknown).
    a. ***Note:*** Assign code 99 in Race 2-5 *only when* Race 1 is coded 99.
14. Assign code 99 for death certificate only (DCO) cases when race is unknown.
15. Refer to the Seer Manual, Appendix D “Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics “when race is unknown or not stated in the medical record and birth place is recorded.
    a. In some cases, race may be inferred from the nationality. Use Appendix D to identify nationalities from which race codes may be inferred.
    b. ***Example 1:*** Record states: “this native of Portugal...”Code race as 01 (White) per the Appendix.
    c. ***Example 2:*** Record states: “this patient was Nigerian...”Code race as 02 (Black) per the Appendix.
    d. ***Exception:*** Code Race 1 through Race 5 as 99 (Unknown) when patient’s name is incongruous with the race inferred on the basis of nationality. Do not code the inferred race when the patient’s name is incongruent with the race inferred on the basis of nationality.

i. ***Example 1:*** Patient's name is Siddhartha Rao and birthplace is listed as England. Code Race 1 through Race 5 as 99 (Unknown).

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

16. When the patient face-sheet indicates "Race Other," look for other descriptions of the patient's race. When no further race information is available, code race as 99 (Unknown) and document that patient face-sheet indicates "Race Other," and no further race information is available.
17. Patient photographs may be used with caution to determine race in the absence of any other information.
    a. Use caution when interpreting a patient photograph to assist in determining race. Review the patient record for a statement to verify race. The use of photographs alone to determine race may lead to misclassification of race.
18. Code the race data items in the order stated when no other priority applies.
19. The race of parents, when known, may be used with caution to determine patient's race in the absence of other more specific information(see coding examples 5 and 7).

Coding Examples

- ***Example 1:*** Patient is stated to be Japanese. Code as 05 (Japanese).
- ***Example 2:*** Patient is stated to be German-Irish. Code as01 (White).
- ***Example 3:*** Patient is described as Arabian. Code as 01 (White).
- ***Example 4:*** Patient described as a black female. Code as 02 (Black).
- ***Example 5:*** Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as 25 (Polynesian), Race 2 as 26 (Tahitian) and Race 3 through Race 5 as 88.
- ***Example 6:*** Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code Race 1as 02 (Black) and Race 2 through Race 5 as 88.
- ***Example 7:*** The patient is described as Asian-American with Korean parents. Code race as 08 (Korean) because it is more specific than 96 (Asian) [-American].
- ***Example 8:*** Race 1 through Race 5 in the cancer record are coded as 99 (Unknown). The death certificate states race as black. Change cancer record for Race 1 to 02 (Black) and Race 2 through Race 5 to 88.
- ***Example 9:*** Race 1 is coded in the cancer record as 96 (Asian). Death certificate gives birthplace as China. Change Race 1 in the cancer record to 04 (Chinese) and code Race 2 through Race 5 as 88.
- ***Example 10:*** Patient is stated to be Chinese and black. Code Race 1 as 04 (Chinese), code Race 2 as 02 (Black). Code in the order stated when no other priority applies.
- ***Example 11:*** Patient described as Middle Eastern. Code as 01 (White).
- ***Example 12:*** Patient described as Greek. Code as 01 (White).

REASON FOR NO RADIATION

Item #	Length
1430	1

Alternate Name:	Reason for No Regional Radiation Therapy
XML NAACCR ID:	reasonForNoRadiation
PARENT XML ELEMENT:	Tumor

Description

Code the reason the patient did not receive radiation treatment as part of first course of therapy.

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

Codes

0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first-course treatment. Diagnosed at autopsy.
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 treatment.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered 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 administered.
9	It is unknown if radiation therapy was recommended or administered. DCO

Coding Instructions

1. Assign code **0** if the patient received regional radiation as part of first course of therapy.
2. Assign code **1** if the treatment plan offered multiple alternative treatment options but the patient selected treatment that did not include radiation therapy.
3. Assign code **7** if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

4. Assign code **8**:
    a. If it is known that a physician recommended radiation treatment, but no further documentation is available to confirm it was given.
    b. To indicate referral to a radiation oncologist was made and the registry should follow to determine whether radiation was administered.
    c. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, assign Code **1.**
    d. ***Note:*** Cases coded **8** should be followed and updated to a more definitive code as appropriate.
5. Assign code **9:**
    a. If the treatment plan offered multiple alternative treatment options, but it is unknown which treatment, if any, was provided.
    b. If a DCO case.

REASON FOR NO SURGERY

Item #	Length
1340	1

Alternate Name:	Reason for No Cancer-Directed Surgery (SEER) Reason for No CA Dir Surgery (CoC) Reason for No Surgery to Primary Site
XML NAACCR ID:	reasonForNoSurgery
PARENT XML ELEMENT:	Tumor

Description

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

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

Rationale

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

Codes

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.

Coding Instructions

1. Assign code **0** when Surgery of Primary Site is coded in the range of 10-90 (surgery of the primary site was performed).
2. Assign code **1** when Surgery of Primary Site is coded 98 (not applicable).
3. Assign a code in the **range of 1-8** when Surgery of Primary Site is coded 00.

Note: **Referral** to a surgeon **is equivalent** to a recommendation for surgery.

a. Assign code **1** when:
    i. Primary site is C420, C421, C423, C424, C760-C768, or C809
        1. ***Note:*** Surgery is not standard treatment for these cases.
    ii. There is no information in the patient's medical record about surgery, **AND**
        1. It is known that surgery is not usually performed for this type and/or stage of cancer **OR**
        2. There is no reason to suspect that the patient would have had surgery of primary site.
            a. ***Example:*** The patient would not be a surgical candidate because of advanced stage.
    iii. The treatment plan offered multiple treatment options and the patient selected treatment that did not include surgery of the primary site.
        1. ***Example:*** Prostate cancer patient is offered three treatment options: a. Radical prostatectomy, b. Radiation therapy, or c. Hormone therapy. The patient chose to have radiation therapy. Assign code 1. Surgery of the primary site was not performed because it was **not part of the planned** first course of treatment. The treatment plan was for the patient to receive **ONE** of three treatment modality options: surgery, OR radiation, OR hormone therapy. At no time did the physician recommend that the patient have surgery AND radiation therapy AND hormone therapy. The patient chose radiation. This does not mean he refused surgery because at no time did the treatment plan include both radiation AND surgery. Recording that a patient refused the treatment modality means that the patient refused recommended therapy. This is a quality control check explaining why the patient did not receive the expected treatment for their cancer (patient's choice versus physician's choice, or facility's lack of providing quality care).
    iv. Surgery was part of the first course of treatment but was cancelled due to complete response to radiation and/or systemic therapy.
    v. Patient elected to pursue no treatment following the discussion of surgery. Discussion does not equal a recommendation. Patient's decision not to pursue surgery is not a refusal of surgery in this situation.
    vi. Active surveillance/watchful waiting is the first course (e.g., prostate).
b. Assign code **6** when
    i. It is **KNOWN** that surgery was recommended **AND**
    ii. It is **KNOWN** that surgery was **not** performed **AND**

iii. There is no documentation explaining why surgery was not done.

iv. ***Example:*** The medical record has a recommendation that the patient have surgery. No further admissions or documentation of surgery found; the primary care physician replies that the patient did **NOT have surgery. No further information is given; it is unknown if the patient refused surgery or if there were co-morbid conditions that prevented the surgical procedure.**

c. Assign code **7** when the patient

i. Refuses recommended surgery **OR**

ii. Makes a blanket statement that he/she refused all treatment when surgery is a customary option according to NCCN guidelines and/or the NCI PDQ for the primary site/histology

1. Assign code 1 when surgery is not normally performed for the site/histology

iii. ***Note:*** Coding Reason for No Surgery of Primary Site as “refused” does not affect the coding of the other treatment data items (e.g., Radiation, Chemotherapy, Hormone Therapy, etc.). Code 7 means surgery is exactly what was recommended by the physician and the patient refused. If two treatment alternatives were offered and surgery was not chosen, code Reason no surgery of primary site as 1 [Surgery of the primary site was not performed because it was not part of the planned first-course treatment].

d. Assign code **8** when surgery is recommended, but it is unknown if the patient actually had the surgery.

i. ***Example:*** There is documentation in the medical record that the primary care physician referred the patient to a surgical oncologist. Follow-back to the surgical oncologist and primary care physician yields no further information. Assign code 8, it is known that surgery was recommended but there is no information on whether or not the patient actually had the surgical procedure.

ii. ***Note:*** Review cases coded 8 periodically for later confirmation of surgery.

4. Assign code **9:**

a. When there is no documentation that surgery was recommended or performed.

b. For death certificate only (DCO) cases.

c. Autopsy only cases.

RECORD TYPE

Item #	Length
10	1

Alternate Name:	
XML NAACCR ID:	recordType
PARENT XML ELEMENT:	NaaccrData

Description

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

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

Codes

I	Incidence-only record type (nonconfidential coded data) Length = 4048
C	Confidential record type (incidence record plus confidential data) Length = 6154
A	Full case Abstract record type (incidence and confidential data plus text summaries; used for reporting to central registries) Length = 24194
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; used to submit changes to data already submitted) Length = 24194
L	Pathology Laboratory

REGIONAL NODES EXAMINED

Item #	Length
830	2

Alternate Name:	Number of Regional Lymph Nodes Examined (SEER) Regional Lymph Nodes Examined Pathologic Review of Regional Lymph Nodes (SEER)
XML NAACCR ID:	regionalNodesExamined
PARENT XML ELEMENT:	Tumor

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologist.

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

Rationale

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

Codes

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 stated in patient record

Coding Instructions

1. Regional lymph nodes only. Record information only about regional lymph nodes in this data item.
    a. Include lymph nodes that are regional in the current AJCC Staging Manual.
2. This data item is based on pathologic information only. This data item is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.
3. Use code 00 when:
    a. The assessment of lymph nodes is clinical.
    b. No lymph nodes are removed and examined.
    c. A “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
    d. ***Note:*** When Regional Nodes Examined is coded 00, Regional Nodes Positive is coded 98.
4. Nodes removed and examined is cumulative. Record the total number of regional lymph nodes removed and examined by the pathologist. Record lymph nodes removed during an autopsy for autopsy-only cases.
    a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
    b. Do not count an aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.
    c. ***Example:*** Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.
    d. Include the node in the count of Regional Nodes Examined when the positive aspiration or core biopsy is from a node in a different node region.
        i. ***Example:*** Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.
    e. Assume the lymph node that is aspirated or core-biopsied is part of the lymph node chain surgically removed and do not include it in the count of Regional Nodes Examined when its location is not known.
        i. ***Example:*** Patient record states that lymph node core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.
5. Priority of lymph node counts. Use information in the following priority when there is a discrepancy regarding the number of lymph nodes examined:
    a. Final diagnosis.

b. Synoptic report (also known as CAP protocol or pathology report checklist; the consolidated findings on the CAP protocol).

c. Microscopic description.

d. Gross description.

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

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

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

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

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

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

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

12. Use code 99 for:

    a. Any case coded to primary site C420, C421, C423-C424, C589, C700-C709, C710-C729, C751-C753, C761-C768, C770-C779, or C809

    b. Lymphoma (excluding CLL/SLL) 00790

    c. Lymphoma (CLL/SLL) 00795

    d. Plasma Cell Disorders (excluding 9734/3) 00822

    e. Cases with no information about the examination of regional lymph nodes

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

REGIONAL NODES POSITIVE

Item #	Length
820	2

Alternate Name:	Pathologic Review of Regional Lymph Nodes (SEER) Regional Lymph Nodes Positive Number of Positive Regional Lymph Nodes (SEER)
XML NAACCR ID:	regionalNodesPositive
PARENT XML ELEMENT:	Tumor

Description

Records the exact number of regional nodes examined by the pathologist and found to contain metastases. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system. For tumors diagnosed from 1988 through 2003, this item was part of the 10-digit EOD [779], detailed site-specific codes for anatomic EOD.

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

Rationale

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

Codes

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
00	All nodes examined are negative

Coding Instructions

1. **Regional lymph nodes only.** Record information only about regional lymph nodes in this data item.
    a. Include lymph nodes that are regional in the current AJCC Staging Manual.
2. **This data item is based on pathological information only.** This data item is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.
3. True **in situ cases** cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are **not** allowed.
4. **Nodes positive is cumulative.** Record the total number of regional lymph nodes removed and found to be positive by pathologic examination. Record lymph nodes removed and found to be positive during an autopsy for autopsy-only cases.
    a. The number of regional nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.
    b. Do **not** count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, when there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Use of Code 95 below.
        i. ***Example 1:*** Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. **Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.**
        ii. ***Example 2:*** Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive. **Code Regional Nodes Positive as 01 and Regional Nodes Examined as 06.**
    c. Include the node in the count of Regional Nodes Positive when the positive aspiration or core biopsy is from a node in a **different** node region.
        i. ***Example:*** Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. **Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.**
    d. Assume the lymph node that is core-biopsied or aspirated is part of the lymph node chain surgically removed and do **not** include it in the count of Regional Nodes Positive when its location is **not known.**
        i. ***Example:*** Patient record states that lymph node core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. **Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.**
5. **Priority of lymph node counts.** Use information in the following priority when there is a discrepancy regarding the number of positive lymph nodes.
    a. Final diagnosis.

b. Synoptic report (also known as CAP protocol or pathology report checklist; the consolidated findings on the CAP protocol).

c. Microscopic description.

d. Gross description.

6. Positive nodes in multiple primaries in same organ.

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

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

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

7. Isolated Tumor Cells (ITCs) in lymph nodes.

   a. For all cases except cutaneous melanoma and Merkel cell carcinoma of skin:

      i. Count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size)

      ii. Assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive when the path report indicates that nodes are positive but the size of metastasis is not stated

      iii. Do **not** include in the count of lymph nodes positive any nodes that are identified as containing ITCs

   b. For cutaneous melanoma and Merkel cell carcinoma of skin:

      i. Count nodes with ITCs as positive lymph nodes

8. Use code **95** when:

   a. The only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

   b. A positive lymph node is aspirated and there are no surgically resected lymph nodes.

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

   c. A positive lymph node is aspirated and surgically resected lymph nodes are negative.

      i. ***Example:*** Lung cancer patient has aspiration of suspicious hilar mass that shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes neoadjuvant (preoperative) radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes. **Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected.**

9. Code **97**. Use code 97 for any combination of positive aspirated, biopsied, sampled, or dissected lymph nodes when the number of involved nodes cannot be determined on the basis

of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.

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

b. ***Note:*** If the aspirated node is the only one that is microscopically positive, use code 95.

10. Use code **98** when:

    a. The assessment of lymph nodes is clinical only.

    b. No lymph nodes are removed and examined.

    c. A "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

    d. Regional Nodes Positive is coded 98, Regional Nodes Examined is usually coded 00.

11. Use code **99** for:

    a. Any case coded to primary site C420, C421, C423, C424, C589, C700-C709, C710-C729, C751-C753, C761-C768, C770-C779, or C809

    b. Lymphoma (excluding CLL/SLL) 00790

    c. Lymphoma (CLL/SLL) 00795

    d. Plasma Cell Disorders (excluding 9734/3) 00822

    e. Cases with no information about positive regional lymph nodes

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

REPORTING FACILITY

Item #	Length
540	10

Alternate Name:	Facility Identification Number (CoC) Reporting Hospital Institution ID Number (CoC)
XML NAACCR ID:	reportingFacility
PARENT XML ELEMENT:	Tumor

Description

CoC code for the facility whose data are described in the record.

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.

Codes (in addition to CoC assigned codes)

0000000000	Case not reported by a facility
0099999999	Case reported, but facility number is unknown

Note: When this special code is being used, the length in 9s should correspond to the length indicated bythe code in FIN coding system [35]. The 9s must be right justified in the field, and the remaining spaces should be filled with leading zeroes to a total length of 10.

RX CODING SYSTEM--CURRENT

Item #	Length
1460	2

Alternate Name:	
XML NAACCR ID:	rxCodingSystemCurrent
PARENT XML ELEMENT:	Tumor

Description

Code describing how treatment for this tumor now is coded.

Codes

00	Treatment data not coded/transmitted (i.e., all treatment fields [items 1200-1450 and 1500-1645] blank)
01	Treatment data coded using 1-digit surgery codes (obsolete)
02	Treatment data coded according to 1983-1992 SEER manuals and 1983-1995 CoC manuals
03	Treatment data coded according to 1996 ROADS Manual
04	Treatment data coded according to 1998 ROADS Supplement
05	Treatment data coded according to 1998 SEER Manual
06	Treatment data coded according to FORDS manual
07	Treatment data coded according to 2010 SEER Coding Manual
08	Treatment data coded according to STORE Manual and 2018 SEER Coding Manual
99	Other coding, including partial or nonstandard coding

RX DATE BRM

Item #	Length
1240	8

Alternate Name:	Date Immunotherapy Started (CoC) RX Date--BRM
XML NAACCR ID:	rxDateBrm
PARENT XML ELEMENT:	Tumor

Description

Date of initiation for immunotherapy (a.k.a. biological response modifier) that is part of the first course of treatment. See also RX Summ--BRM [1410].

IMPORTANT: Remember to include the date of BRM treatment in the RX TEXT— BRM text field

Rationale

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

Coding Instructions

1. Record the date of the first/earliest immunotherapy if immunotherapy was given and recorded as part of the first course of therapy.
    a. Code the date that the prescription was written if date administered unknown.
2. Immunotherapy date should be the same as the Date Therapy Initiated when immunotherapy is the only treatment administered.
3. Transmit date data items in the year, month, day format (YYYYMMDD).

RX DATE BRM FLAG

Item #	Length
1241	2

Alternate Name:	RX Date--BRM Flag
XML NAACCR ID:	rxDateBrmFlag
PARENT XML ELEMENT:	Tumor

Description

This flag explains why no appropriate value is in the field, RX Date BRM [1240].

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non- date information that had previously been transmitted in date fields.

Codes

Blank	A valid date value is provided in Date Immunotherapy Started
10	No information whatsoever can be inferred
11	No proper value is applicable in this context
12	Unknown; A proper value is applicable but not known
15	Treatment planned but not yet started

Coding Instructions

1. Leave this item blank if Date Immunotherapy Started has a full or partial date recorded.
2. Assign code 10 when it is unknown whether any treatment was administered.
    a. For death certificate only (DCO) cases.
3. Assign code 11 when no immunotherapy was given during the first course of therapy or initial diagnosis was at autopsy.
4. Assign code 12 if the Date Immunotherapy Started cannot be determined, and the patient did receive first course treatment.
5. Assign code 15 if immunotherapy is planned but has not started and date is not available. If immunotherapy was expected to be given or was planned as part of the first course of therapy, but information was not known if the immunotherapy had been started or had not been started at the time of the most recent follow-up, attempt to follow-up to assure complete information is collected. As information is learned, update this item and Date Immunotherapy Started.

RX DATE CHEMO

Item #	Length
1220	8

Alternate Name:	Date Chemotherapy Started (CoC) RX Date--Chemo
XML NAACCR ID:	rxDateChemo
PARENT XML ELEMENT:	Tumor

Description

Date of initiation of chemotherapy that is part of the first course of treatment. See also RX Summ--Chemo [1390].

IMPORTANT: Remember to include the date of chemotherapy treatment in the RX TEXT— CHEMO text field

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.

Coding Instructions

1. Record the date of the first/earliest chemotherapy if chemotherapy was given and recorded as part of the first course of therapy.
    a. Code the date that the prescription or physician order was written if date administered unknown.
2. Chemotherapy date should be the same as the Date Therapy Initiated when chemotherapy is the only treatment administered.
3. Transmit date data items in the year, month, day format (YYYYMMDD).

RX DATE CHEMO FLAG

Item #	Length
1221	2

Alternate Name:	RX Date--Chemo Flag
XML NAACCR ID:	rxDateChemoFlag
PARENT XML ELEMENT:	Tumor

Description

This flag explains why no appropriate value is in the field, RX Date Chemo [1220]. Formerly RX Date--Chemo Flag

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

10	No information whatsoever can be inferred
11	No proper value is applicable in this context
12	A proper value is applicable but not known
15	Treatment planned but not yet started
Blank	A valid date value is provided in Date Chemotherapy Started

Coding Instructions

1. Leave this item blank if Date Chemotherapy Started has a full or partial date recorded.
2. Assign code **10** when it is unknown whether any treatment was administered.
    a. For death certificate only (DCO) cases.
3. Assign code **11** when no chemotherapy was given as part of the first course of therapy or initial diagnosis was at autopsy.
4. Assign code **12** if the Date Chemotherapy Started cannot be determined, and the patient did receive first course treatment.
5. Assign **15** if chemotherapy is planned but has not started and date is not available. If chemotherapy was expected to be given or was planned as part of the first course of therapy, but information was not known if the chemotherapy had been started or had not been started at the time of the most recent follow-up, attempt to follow-up to assure complete information is collected. As information is learned, update this item, Date Chemotherapy Started, and Chemotherapy.

RX DATE HORMONE

Item #	Length
1230	8

Alternate Name:	Date Hormone Therapy Started (CoC) RX Date--Hormone
XML NAACCR ID:	rxDateHormone
PARENT XML ELEMENT:	Tumor

Description

Date of initiation for hormone therapy that is part of the first course of treatment. See also RX Summ--Hormone [1400].

IMPORTANT: Remember to include the date of chemotherapy treatment in the RX TEXT—HORMONE text field

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.

Coding Instructions

1. Record the date of the first/earliest hormone therapy if hormone therapy was given as part of the first course of therapy.
    a. Code the date that the prescription was written if date administered unknown.
2. Hormone therapy date should be the same as the Date Therapy Initiated when hormone therapy is the only treatment administered.
3. Transmit date data items in the year, month, day format (YYYYMMDD).

RX DATE HORMONE FLAG

Item #	Length
1231	2

Alternate Name:	RX Date--Hormone Flag
XML NAACCR ID:	rxDateHormoneFlag
PARENT XML ELEMENT:	Tumor

Description

This flag explains why no appropriate value is in the field, RX Date Hormone [1230]. Formerly RX Date--Hormone Flag.

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non- date information that had previously been transmitted in date fields.

Codes

Blank	A valid date value is provided in Date Hormone Therapy Started
10	No information whatsoever can be inferred
11	No proper value is applicable in this context
12	A proper value is applicable but not known
15	Treatment planned but not yet started

Coding Instructions

1. Leave this item blank if Date Hormone Therapy Started has a full or partial date recorded.
2. Assign code 10 when it is unknown whether any treatment was administered.
    a. For death certificate only (DCO).
3. Assign code 11 when no hormone therapy was given as part of the first course of therapy or initial diagnosis was at autopsy
4. Assign code 12 if the Date Hormone Therapy Started cannot be determined, and the patient did receive first course treatment.
5. Assign code 15 if hormone therapy is planned but has not started and date is not available. If hormone therapy was expected to be given or was planned as part of the first course of therapy, but information was not known if the hormone therapy had been started or had not been started at the time of the most recent follow-up, attempt to follow-up to assure complete information is collected. As information is learned, update this item and Date Hormone Therapy Started.

RX DATE MST DEFN SRG

Item #	Length
3170	8

Alternate Name:	Date of Most Definitive Surgical Resection of the Primary Site RX Date--Most Defin Surg
XML NAACCR ID:	rxDateMostDefinSurg
PARENT XML ELEMENT:	Tumor

Description

Date of most definitive surgical resection of the primary site performed as part of the first course of treatment. Use RX DATE MST DEFN SRG FLAG [3171] if there is no appropriate or known date for this item.

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

Rationale

This item is used to measure lag time between diagnosis and the most definitive surgery of the primary site or survival following the procedure. It also is used in conjunction with RX Date Surg Disch [3180] to calculate the duration of hospitalization following the most definitive primary site surgical procedure to evaluate treatment efficacy.

Coding Instructions

1. Record the date of the most invasive, extensive, or definitive surgery when Surgery of Primary Site was recorded as part of the first course of therapy.
    a. This is the date of the procedure coded in Surgery of Primary Site.
2. Transmit date data items in the year, month, day format (YYYYMMDD).

RX DATE MST DEFN SRG FLAG

Item #	Length
3171	2

Alternate Name:	
XML NAACCR ID:	rxDateMostDefinSurgFlag
PARENT XML ELEMENT:	Tumor

Description

This flag explains why no appropriate value is in the field, RX Date Mst Defn Srg [3170].

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non- date information that had previously been transmitted in date fields.

Codes

Blank	A valid date value is provided in Date of Most Definitive Surgical Resection of the Primary Site
10	No information whatsoever can be inferred
11	No proper value is applicable in this context
12	A proper value is applicable but not known

Coding Instructions

1. Leave this item blank if Date of Most Definitive Surgical Resection of the Primary Site has a full or partial date recorded.
2. Assign code 10:
    a. When it is unknown whether the patient had any surgery.
    b. For death certificate only (DCO) cases.
3. Assign code 11 when no surgical procedure was performed as part of the first course of therapy or the initial diagnosis was at autopsy.
4. Assign code 12 when the Date of Most Definitive Surgical Resection of the Primary Site cannot be determined, and first course surgery was performed.

RX DATE OTHER

Item #	Length
1250	8

Alternate Name:	Date Other Treatment Started (CoC) RX Date--Other
XML NAACCR ID:	rxDateOther
PARENT XML ELEMENT:	Tumor

Description

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

Date Other Treatment Started must be transmitted in the YYYYMMDD format.

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

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.

Coding Instructions

1. Record the date of the first/earliest other treatment if an alternative treatment was given and recorded as part of the first course of therapy.
2. Other treatment date should be the same as the Date Therapy Initiated when an alternative treatment is the only treatment administered.
3. Transmit date data items in the year, month, day format (YYYYMMDD).

RX DATE OTHER FLAG

Item #	Length
1251	2

Alternate Name:	RX Date--Other Flag
XML NAACCR ID:	rxDateOtherFlag
PARENT XML ELEMENT:	Tumor

Description

This flag explains why no appropriate value is in the field, RX Date Other [1250]. Formerly RX Date--Other Flag.

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

Blank	A valid date value is provided in Date of Initial Treatment
10	No information whatsoever can be inferred
11	No proper value is applicable in this context
12	A proper value is applicable but not known
15	Treatment planned but not yet started

Coding Instructions

1. Leave this item blank if RX Date Other has a full or partial date recorded.
2. Assign code 10 when it is unknown whether any other treatment was administered.
    a. For death certificate only (DCO) cases.
3. Assign code 11 when no alternative treatment is given during the first course of therapy or initial diagnosis is at autopsy.
4. Assign code 12 if the RX Date Other cannot be determined, and the patient did receive first course treatment.
5. Assign code 15 if an alternative treatment is planned but has not started and date is not available. If an alternative treatment was expected to be given or was planned as part of the first course of therapy, but information was not known if the treatment had been started or had not been started at the time of the most recent follow-up, attempt to follow-up to assure complete information is collected. As information is learned, update this item and RX Date Other.

RX DATE RADIATION

Item #	Length
1210	8

Alternate Name:	Date Radiation Started (CoC) RX Date--Radiation
XML NAACCR ID:	rxDateRadiation
PARENT XML ELEMENT:	Tumor

Description

Records the date on which radiation therapy began at any facility that is part of the first course of treatment. Use RX DATE RADIATION FLAG [1211] if there is no appropriate or known date for this item.

RX Date Radiation is the date when radiation therapy began as part of the first course of therapy.

The RX Date Radiation will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the RX Date Radiation may require assistance from the radiation oncologist for consistent coding.

RX Date Radiation must be transmitted in the YYYYMMDD format. RX Date Radiation may be recorded in the transmission format, or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

IMPORTANT: Remember to include the date of Radiation treatment in the appropriate RX TEXT—RADIATION text field

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.

Coding Instructions

1. Record the date of the first/earliest radiation treatment if radiation was given and recorded as part of the first course of therapy.
    a. Do not record the date of the initial radiation planning session.
2. Radiation date should be the same as the Date Therapy Initiated when radiation is the only treatment administered.
3. There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
4. Transmit date data items in the year, month, day format (YYYYMMDD).

RX DATE RADIATION FLAG

Item #	Length
1211	2

Alternate Name:	RX Date--Radiation Flag
XML NAACCR ID:	rxDateRadiationFlag
PARENT XML ELEMENT:	Tumor

Description

This flag explains why no appropriate value is in the field, RX Date Radiation [1210].

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non- date information that had previously been transmitted in date fields.

Codes

Blank	A valid date value is provided in Date Radiation Started
10	No information whatsoever can be inferred from this exceptional value (that is, unknown whether any radiation therapy was given)
11	No proper value is applicable in this context (e.g., no radiation given)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation therapy administered but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up)

Coding Instructions

1. Leave this item blank if Date Radiation Started has a full or partial date recorded.
2. Assign code 10 when it is unknown whether any treatment was administered.
    a. For death certificate only (DCO) cases.
3. Assign code 11 if radiation was not planned or given as part of the first course of therapy or the initial diagnosis was at autopsy.
4. Assign code 12 if the Date Radiation Started cannot be determined but the patient did receive first course of radiation.
5. Assign code 15 if radiation treatment is planned but has not started and date is not available. If radiation was expected to be given or was planned as part of the first course of therapy, but

information was not known if the radiation had been started or had not been started at the time of the most recent follow-up, attempt to follow-up to assure complete information is collected. As information is learned, update this item, Date Radiation Started, and all other radiation items.

RX DATE SURGERY

Item #	Length
1200	8

Alternate Name:	Date of Cancer-Directed Surgery (CoC) Date of Surgery Date of First Surgical Procedure (CoC) RX Date--Surgery
XML NAACCR ID:	rxDateSurgery
PARENT XML ELEMENT:	Tumor

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) or Distant Lymph Nodes was performed. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope Reg LN Sur [1292], and RX Summ--Surg Oth Reg/Dis [1294].

Date of First Surgical Procedure is the date the first surgery was performed as part of first course of therapy. This is either the date of the Surgery of Primary Site, Sentinel Lymph Node Biopsy, Scope of Regional Lymph Node Surgery, or Surgical Procedure of Other Site, whichever is earliest.

IMPORTANT: Remember to include the date of first surgical treatment in the OP procedures and Surgery text fields

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.

Coding Instructions

1. Record the date of the first/earliest surgery if Surgery of Primary Site, Sentinel Lymph Node Biopsy, Scope of Regional Lymph Node Surgery (excluding cases coded to 1), or Surgical Procedure of Other Site was recorded as part of the first course of therapy.
2. Surgery date should be the same as the Date Therapy Initiated when surgery is the only treatment administered.
3. Transmit date data items in the year, month, day format (YYYYMMDD).
4. Record the polypectomy date as the date of first surgical procedure when a surgical procedure to remove polyps is performed without removing the entire tumor, and a subsequent surgery is performed.
    a. When reportable tumor is found in the specimen, polypectomies are surgery for the purposes of cancer registry data collection regardless of whether or not there is residual tumor after the polypectomy.

RX DATE SURGERY FLAG

Item #	Length
1201	2

Alternate Name:	RX Date--Surgery Flag
XML NAACCR ID:	rxDateSurgeryFlag
PARENT XML ELEMENT:	Tumor

Description

This flag explains why no appropriate value is in the field, RX Date Surgery [1200].

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non- date information that had previously been transmitted in date fields.

Codes

Blank	A valid date value is provided in Date of First Surgical Procedure
10	No information whatsoever can be inferred
11	No proper value is applicable in this context
12	A proper value is applicable but not known

Coding Instructions

1. Leave this item blank if Date of First Surgical Procedure has a full or partial date recorded.
2. Assign code 10 when it is unknown whether the patient had any surgery.
    a. For death certificate only (DCO) cases.
3. Assign code 11 when no surgical procedure was performed as part of the first course of therapy or the initial diagnosis was at autopsy.
4. Assign code 12 when the Date of First Surgical Procedure cannot be determined, and surgery was performed.

RX DATE SYSTEMIC

Item #	Length
3230	8

Alternate Name:	Date Systemic Therapy Started RX Date--Systemic
XML NAACCR ID:	rxDateSystemic
PARENT XML ELEMENT:	Tumor

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. Use RX DATE SYSTEMIC FLAG [3231] if there is no appropriate or known date for this item.

The earliest date of administration of chemotherapy agents, hormonal agents, biological response modifiers (BRMs), bone marrow transplants, stem cell harvests, or surgical and/or radiation endocrine therapy is recorded in this data item.

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.

Coding Instructions

1. Record the date of the first/earliest systemic therapy if Chemotherapy, Hormone Therapy, Immunotherapy, or Hematologic Transplant or Endocrine Procedure was recorded as part of the first course of therapy.
2. Transmit date data items in the year, month, day format (YYYYMMDD).

RX DATE SYSTEMIC FLAG

Item #	Length
3231	2

Alternate Name:	
XML NAACCR ID:	rxDateSystemicFlag
PARENT XML ELEMENT:	Tumor

Description

This flag explains why no appropriate value is in the field, RX Date Systemic [3230].

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

Blank	A valid date value is provided in Date Systemic Therapy Started
10	No information whatsoever can be inferred
11	No proper value is applicable in this context
12	A proper value is applicable but not known
15	Treatment planned but not yet started

Coding Instructions

1. Leave this item blank if RX Date Systemic has a full or partial date recorded.
    a. Assign code 10 when it is unknown whether any treatment was administered.
    b. For death certificate only (DCO) cases.
    c. Assign code 11 when no systemic therapy was given during the first course of therapy or initial diagnosis was at autopsy.
    d. Assign code 12 if the RX Date Systemic cannot be determined, and the patient did receive first course treatment.
    e. Assign code 15 if systemic therapy is planned but has not started and date is not available. If systemic therapy was expected to be given or was planned as part of the first course of therapy, but information was not known if the systemic therapy had been started or had not been started at the time of the most recent follow-up, attempt to follow-information is collected. As information is learned, update this item and RX Date Systemic.

RX SUMM--BRM

Item #	Length
1410	2

Alternate Name:	Biological Response Modifiers (pre-96 SEER) Immunotherapy (SEER/CoC)
XML NAACCR ID:	rxSummBrm
PARENT XML ELEMENT:	Tumor

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.

Records immunotherapeutic (biological therapy, biotherapy, or biological response modifier (BRM)) agents administered as first course of therapy. See SEER*Rx for immunotherapy drug codes.

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

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

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.

Note: Prior to 2013, targeted therapies that invoke an immune response, such as Herceptin, had been coded as chemotherapy. Effective with cases diagnosed January 1, 2013, and forward these therapies are classified as biological response modifiers. Coding instructions for these changes have been added to the remarks field for the applicable drugs in the SEER*Rx Interactive Drug Database.

Codes

Refer to the most recent version of STORE Manual and SEER Program Code Manual for additional instructions.

00	None, immunotherapy was not part of the planned first course of therapy
01	Immunotherapy was administered as first course therapy
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)

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 the first-course of therapy. No reason was noted in the patient's record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a 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 if immunotherapy was recommended or administered because it is not stated in patient record

Definitions

Immunotherapy is designed to:

1. Make cancer cells more recognizable and therefore more susceptible to destruction by the immune system.
2. Boost the killing power of immune system cells, such as T-cells, NK-cells, and macrophages.
3. Alter the growth patterns of cancer cells to promote behavior like that of healthy cells.
4. Block or reverse the process that changes a normal cell or a pre-cancerous cell into a cancerous cell.
5. Enhance the body's ability to repair or replace normal cells damaged or destroyed by other forms of cancer treatment, such as chemotherapy or radiation.
6. Prevent cancer cells from spreading to other parts of the body.

Types of Immunotherapy

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

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

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

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

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

Monoclonal Antibodies: Monoclonal antibodies (Mab) are produced in a laboratory. The artificial antibodies are used in a variety of ways in systemic therapy and can be chemotherapy, immunotherapy, or ancillary drugs. Some are injected into the patient to seek out and disrupt cancer

cell activities. When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy. Other Mabs are linked to radioisotopes (conjugated monoclonal antibodies). The Mab finds and attaches to the target tumor cells and brings with it the radioisotope that actually kills the tumor cell. The monoclonal antibody itself does nothing to enhance the immune system. Conjugated monoclonal antibodies such as tositumomab (Bexxar) or ibritumomab (Zevalin) are coded to the part of the drug that actually kills the cells, usually radioisotopes. A third function of Mab is to enhance the immune response against the cancer, either by identifying tumor cells that are mimicking normal cells, or by boosting the body's natural defenses that destroy foreign cells.

Consult SEER*Rx for the treatment category in which each monoclonal antibody should be coded.

Coding Instructions

1. Assign code 00 when:
    a. The medical record states that immunotherapy was not given, not recommended, or not indicated.
    b. There is no information in the patient's medical record about immunotherapy AND
        i. It is known that immunotherapy is not usually given for this type and/or stage of cancer **OR**
        ii. There is no reason to suspect that the patient would have had immunotherapy.
    c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include immunotherapy.
    d. Patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation. Patient's decision not to pursue immunotherapy is not a refusal of immunotherapy in this situation.
    e. Active surveillance, watchful waiting is the first course of treatment (e.g., prostate).
    f. Patient diagnosed at autopsy.
    g. Anti-thymocyte globulin treatment is given. Anti-thymocyte globulin is used to treat transplant rejection. Do not code as immunotherapy.
2. Assign code 87 when:
    a. The patient refused recommended immunotherapy.
    b. The patient made a blanket refusal of all recommended treatment and immunotherapy is a customary option for the primary site/histology.
    c. The patient refused all treatment before any was recommended and immunotherapy is a customary option for the primary site/histology.
3. Assign code 88 when the only information available is that the patient was referred to an oncologist.
    d. ***Note:*** Review cases coded 88 periodically for later confirmation of immunotherapy.
4. Assign code 99:
    a. When there is no documentation that immunotherapy was recommended or performed **AND**
    b. Immunotherapy is usually given for this type and/or stage of cancer **OR**
    c. For death certificate only (DCO) cases.

RX SUMM--CHEMO

Item #	Length
1390	2

Alternate Name:	Chemotherapy (SEER/CoC)
XML NAACCR ID:	rxSummChemo
PARENT XML ELEMENT:	Tumor

Description

Codes for 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.

Note: Prior to 2013, targeted therapies that invoke an immune response, such as Herceptin, had been coded as chemotherapy. Effective with cases diagnosed January 1, 2013, and forward these therapies are classified as biological response modifiers. Coding instructions for these changes have been added to the remarks field for the applicable drugs in the SEER*Rx Interactive Drug Database.

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

Codes

Refer to the most recent version of STORE Manual and SEER Program Code Manual for additional instructions.

See SEER*Rx for chemotherapy drug codes and for information on the drug's function.

00	None, chemotherapy was not part of the planned first course of therapy; diagnosed at autopsy
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in the patient record
02	Single agent chemotherapy administered as first course therapy
03	Multi-agent chemotherapy administered as first course therapy
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
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 the first course of therapy. No reason was stated in patient record.

87	Chemotherapy was not administered. It was recommended by the patient's physician, but the treatment was refused by the patient, a 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 the patient record

Definitions

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

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

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

Coding Instructions

1. Code the chemotherapeutic agents whose actions are chemotherapeutic only; do not code the method of administration.
2. When chemotherapeutic agents are used as radiosensitizers or radioprotectants, they are given at a much lower dosage and do not affect the cancer. Radiosensitizers and radioprotectants are classified as ancillary drugs. See SEER*Rx. Do not code as chemotherapy. Review the radiation-oncology progress notes for information about radiosensitizing chemotherapy.
    a. ***Note:*** Do not assume that a chemo agent given with radiation therapy is a radiosensitizer. Seek additional information. Compare the dose given to the dose normally given for treatment.
    b. For additional information, see:
        i. The National Cancer Institute Physician Data Query (PDQ), Health Professional Version **AND/OR**
        ii. The National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology
3. The physician may change a drug during the first course of therapy because the patient cannot tolerate the original agent.
    a. This is a continuation of the first course of therapy when the chemotherapeutic agent that is substituted belongs to the same group (alkylating, antimetabolites, natural products, targeted therapy, or other miscellaneous).
    b. Do not code the new agent as first course therapy when the original chemotherapeutic agent is changed to one that is NOT in the same group. Code only the original agent as

first course. When the new agent is in a different group, it is second course therapy.

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

4. Code as treatment for both primaries when the patient receives chemotherapy for invasive carcinoma in one breast and also has an invasive or in situ carcinoma in the other breast. Chemotherapy would likely affect both primaries.
    a. ***Example:*** Patient is diagnosed with infiltrating duct carcinoma, stage III, in the right breast and infiltrating duct carcinoma, stage I, in the left breast. Neoadjuvant chemotherapy is administered for the stage III neoplasm in the right breast per the breast surgeon consult, but not for the left breast. Code the chemotherapy on both abstracts for both primaries in this case (simultaneous bilateral breast primaries).
5. Assign code 00 when:
    a. The medical record documents chemotherapy was not given, was not recommended, or was not indicated.
    b. There is no information in the patient’s medical record about chemotherapy, **AND**
        i. It is known that chemotherapy is not usually performed for this type and/or stage of cancer **OR**
        ii. There is no reason to suspect that the patient would have had chemotherapy.
    c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include chemotherapy.
    d. Patient elects to pursue no treatment following the discussion of chemotherapy. Discussion does not equal a recommendation. Patient's decision not to pursue chemotherapy is not a refusal of chemotherapy in this situation.
    e. Active surveillance/watchful waiting is the first course of treatment (e.g., CLL).
    f. Patient diagnosed at autopsy.
    g. ***Example:*** Patient is diagnosed with plasma cell myeloma. There is no mention of treatment or treatment plans in the medical record. Follow-back finds that the patient died three months after diagnosis. There are no additional medical records or other pertinent information available. Assign code 00 since there is no reason to suspect that the patient had been treated.
6. Do not code combination of ancillary drugs administered with single agent chemotherapeutic agents as multiple chemotherapy. For example, the administration of 5-FU (antimetabolite) and Leucovorin (ancillary drug) is coded to single agent (Code 02).
7. Assign code 82 when chemotherapy is a customary option for the primary site/histology but it was not administered due to patient risk factors, such as:
    a. Advanced age.
    b. Comorbid condition(s) (heart disease, kidney failure, other cancer, etc.).
8. Assign code 87 when:
    a. The patient refused recommended chemotherapy.
    b. The patient made a blanket refusal of all recommended treatment and chemotherapy is

a customary option for the primary site/histology.

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

9. Assign code 88 when the only information available is:
    a. The patient was referred to an oncologist.
    b. Insertion of port-a-cath.
    c. ***Note:*** Review cases coded 88 periodically for later confirmation of chemotherapy.
10. Assign code 99 when there is no documentation that chemotherapy was recommended or administered.
    a. For death certificate only (DCO) cases.

Chemotherapeutic Agents

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

- Alkylating agents
- Antimetabolites
- Natural products
- Targeted therapy
- Miscellaneous

Alkylating Agents

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

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

Antimetabolites

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

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

Natural Products

1. Plant Alkaloids are cell-cycle specific which means they attack the cells during various phases of division. They block cell division by preventing microtubule function. Microtubules are vital for cell division. Without them, division cannot occur. Plant alkaloids, as the name implies, are derived from certain types of plants.
    - Vinca alkaloids: vincristine, vinblastine, and vinorelbine
    - Taxanes: paclitaxel and docetaxel
    - Podophyllotoxins: etoposide and teniposide
    - Camptothecan analogs: irinotecan and topotecan
2. Antitumor antibiotics are also cell-cycle specific and act during multiple phases of the cell cycle. They are made from natural products and were first produced by the soil fungus Streptomyces. Antitumor antibiotics form free radicals that break DNA strands, stopping the multiplication of cancer cells.
    - Anthracyclines: doxorubicin, daunorubicin, epirubicin, mitotane, and idarubicin
    - Chromomycins: dactinomycin and plicamycin
    - Miscellaneous: mitomycin and bleomycin
3. Topoisomerase inhibitors interfere with the action of topoisomerase enzymes (topoisomerase I and II). They control the manipulation of the structure of DNA necessary for replication.
    - Topoisomerase I inhibitors: irinotecan, topotecan
    - Topoisomerase II inhibitors: amsacrine, etoposide, etoposide phosphate, teniposide

Targeted Therapy

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

Miscellaneous

Miscellaneous antineoplastics that are unique

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

Coding for Tumor Embolization

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

Definitions

- **Chemoembolization:** A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.
- **Radioembolization:** Tumor embolization combined with the injection of small radioactive beads or coils into an organ or tumor.
- **Tumor embolization:** The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Coding Instructions

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

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

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

RX SUMM--HORMONE

Item #	Length
1400	2

Alternate Name:	Hormone Therapy (SEER/CoC) Endocrine (Hormone/Steroid) Therapy (pre-96 SEER)
XML NAACCR ID:	rxSummHormone
PARENT XML ELEMENT:	Tumor

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.

The data item Hormone Therapy records therapy administered as first course treatment that affects cancer tissue by adding, blocking, or removing the action or production of hormones.

See SEER*Rx for hormone therapy drug codes.

Note: Surgical removal of organs for hormone manipulation is not coded in this data item. Code these procedures in the data item Hematologic Transplant and Endocrine Procedures.

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

Rationale

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

Codes

Refer to the most recent version of STORE Manual and SEER Program Code Manual for additional instructions.

00	None, hormone therapy was not part of the planned first course of therapy; not usually administered for this type and/or stage of cancer; diagnosed at autopsy only
01	Hormone therapy administered as first course therapy
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
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 the first course of 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, a 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

Coding Instructions

1. Code the hormonal agent given as part of combination chemotherapy (e.g., R-CHOP), whether it affects the cancer cells or not.
    a. Check SEER*Rx to determine if a hormone agent is part of a combination chemotherapy regimen.
2. Assign code 00 when:
    a. The medical record states that hormone therapy was not given, was not recommended, or was not indicated.
    b. There is no information in the patient's medical record about hormone therapy **AND**
        i. It is known that hormone therapy is not usually performed for this type and/or stage of cancer **OR**
        ii. There is no reason to suspect that the patient would have had hormone therapy.
    c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include hormone therapy.
    d. Patient elected to pursue no treatment following the discussion of hormone therapy treatment. Discussion does not equal a recommendation. Patient's decision not to pursue hormone therapy is not a refusal of hormone therapy in this situation.
    e. Active surveillance/watchful waiting (e.g., prostate).
    f. Patient diagnosed at autopsy.
    g. Hormone treatment was given for a non-reportable condition or as chemoprevention prior to diagnosis of a reportable condition.
        i. ***Example 1:*** Tamoxifen given for hyperplasia of breast four years prior to breast cancer diagnosis. Code 00 in Hormone Therapy. Do not code tamoxifen given for hyperplasia as treatment for breast cancer.
        ii. ***Example 2:*** Patient with a genetic predisposition to breast cancer is on preventative hormone therapy. Do not code hormone therapy given before cancer is diagnosed.
3. Assign code 87 when:
    a. The patient refused recommended hormone therapy.
    b. The patient made a blanket refusal of all recommended treatment and hormone therapy is a customary option for the primary site/histology.

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

4. Assign code 88 when the only information available is that the patient was referred to an oncologist.
    a. ***Note:*** Review cases coded 88 periodically for later confirmation of hormone therapy.
5. Assign code 99 when there is no documentation that hormone therapy was recommended or performed.
    a. For death certificate only (DCO) cases.

Coding Examples

- ***Example 1:*** Endometrial cancer may be treated with progesterone. Code all administration of progesterone to patients with endometrial cancer in this data item. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer.
- ***Example 2:*** Follicular and papillary cancers of the thyroid are often treated with thyroid hormone to suppress serum thyroid-stimulating hormone (TSH). If a patient with papillary and/or follicular cancer of the thyroid is given a thyroid hormone, code the treatment in this data item.
- ***Example 3:*** Bromocriptine suppresses the production of prolactin, which causes growth in pituitary adenoma. Code bromocriptine as hormone treatment for pituitary adenoma.
- ***Example 4:*** Lupron is a hormonal treatment for prostate cancer. Code as hormonal treatment when Lupron is given for prostate cancer.
- ***Example 5:*** Lupron is hormone therapy that has been approved as an ovarian suppressor for pre-menopausal breast cancer.

Hormone Categories

Hormones may be divided into several categories

- Androgens: fluoxymesterone
- Anti-androgens: bicalutamide (Casodex), flutamide (Eulexin), and nilutamide (Nilandron)
- Corticosteroids: adrenocorticotrophic agents
- Estrogens
- Progestins
- Estrogen antagonists, anti-estrogens: fulvestrant (Faslodex), tamoxifen, and toremifene (Fareston)
- Aromatase inhibitors, anti-aromatase: anastrozole (Arimidex), exemestane (Aromasin), and letrozole (Femara)
- GnRH or LH-RH: Lupron, Zoladex
- Polypeptide hormone release suppression
- Somatostatin analog
- Thyroid hormones: levothyroxine, liothyronine, Synthroid

RX SUMM--OTHER

Item #	Length
1420	1

Alternate Name:	Other Treatment (CoC) Other Cancer-Directed Therapy (SEER/pre-96 CoC)
XML NAACCR ID:	rxSummOther
PARENT XML ELEMENT:	Tumor

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.

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

Rationale

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

Codes

Refer to the most recent version of STORE Manual and SEER Program Code Manual for additional instructions.

0	None
1	Other
2	Other-Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended, unknown if administered
9	Unknown

Coding Instructions

1. Assign code 0 when:
    a. There is no information in the patient's medical record about other therapy **AND**
        i. It is known that other therapy is not usually performed for this type and/or stage of cancer **OR**
        ii. There is no reason to suspect that the patient would have had other therapy.
    b. The treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy.
    c. Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation. Patient's decision not to pursue other therapy is not a refusal of other therapy in this situation.
    d. First course of treatment was active surveillance/watchful waiting.
    e. Patient diagnosed at autopsy.
2. Assign code 1 for:
    a. Hematopoietic treatments such as: phlebotomy or aspirin (See SEER*Rx and Hematopoietic and Lymphoid Neoplasm Coding Manual and Database for specific guidance on coding)
        i. ***Note:*** Do not code blood transfusion as treatment.
            1. Rationale: Blood transfusions may be used for any medical condition that causes anemia. It would be virtually impossible for the registrar to differentiate between blood transfusions used for a co-morbidity (i.e., anemia) from those given as prophylactic treatment of a hematopoietic neoplasm.
    b. PUVA (Psoralen (P) and long-wave ultraviolet radiation (UVA)) in the RARE event that it is used as treatment for extremely thin melanomas or cutaneous T-cell lymphomas (e.g., mycosis fungoides).
        i. ***Note:*** Code UVB phototherapy for mycosis fungoides as photodynamic therapy under Surgery of Primary Site for skin. Assign code 11 [Photodynamic therapy (PDT)] if there is no pathology specimen. Assign code 21 [Photodynamic therapy (PDT)] if there is a pathology specimen.
    c. Photophoresis. This treatment is used ONLY for thin melanoma or cutaneous T-cell lymphoma (mycosis fungoides).
    d. Peptide Receptor Radionuclide Therapy (PRRT).
    e. Cancer treatment that could not be assigned to the previous treatment data items (surgery, radiation, chemotherapy, immunotherapy, or systemic therapy).
3. Assign code 2 for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy.
    a. ***Note:*** Hyperbaric oxygen has been used to treat cancer in clinical trials, but it is also used to promote tissue healing following head and neck surgeries. Do not code the administration of hyperbaric oxygen to promote healing as an experimental treatment.

4. Assign code 3 when the patient is enrolled in a double blind clinical trial. When the trial is complete and the code is broken, review and recode the therapy.
5. Assign code 6 for:
    a. Cancer treatment administered by nonmedical personnel.
        i. ***Example:*** Cannabis oil or medical marijuana that is used for treatment.
    b. Unconventional methods whether they are the only therapy or are given in combination with conventional therapy.
        i. ***Example:*** DC vax given for brain cancer. Assign code 6. DC vax is not an approved treatment for brain cancer and should not be coded in the immunotherapy or any of the other treatment data items.
    c. Complementary and Alternative Medicine (CAM) as any medical system, practice, or product that is not thought of as “western medicine” or standard medical care. CAM treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation.
        i. Alternative medicine is treatment that is used instead of standard medical treatments. Alternative therapy is when the patient receives no other type of standard treatment.
        ii. Complementary medicine. Treatments that are used along with standard medical treatments but are not standard treatments; also called conventional medicine. One example is using acupuncture to help lessen some side effects of cancer treatment in conjunction with standard treatment.
    d. Integrative medicine. A total approach to medical care that combines standard medicine with the CAM practices that have shown to be safe and effective. They treat the patient's mind, body, and spirit.
        i. ***Note:*** See complete information on types of complementary and alternative medicine specific to cancer at NCI Office of Cancer Complementary and Alternative Medicine. For additional information on cancer and other diseases, please visit NIH National Center for Complementary and Integrative Health.
6. Assign code 8 when other therapy was recommended by the physician but there is no information that the treatment was given.
7. Assign code 9 when there is no documentation that other therapy was recommended or performed.
    a. For death certificate only (DCO) cases.

Coding for Tumor Embolization

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

Definitions

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

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

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

Coding Instructions

Code as “Other Therapy” when tumor embolization is performed using **alcohol** as the embolizing agent. Use code 1.

Example: For head and neck primaries: Ideally, an embolic agent is chosen that will block the very small vessels within the tumor but spare the adjacent normal tissue. Liquid embolic agents, such as ethanol or acrylic, and powdered particulate materials can penetrate into the smallest blood vessels of the tumor.

Use code 1 for embolization of a tumor in a site other than the liver when the embolizing agent is unknown.

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

RX SUMM--SCOPE REG LN SUR

Item #	Length
1292	1

Alternate Name:	Scope of Regional Lymph Node Surgery (SEER/CoC)
XML NAACCR ID:	rxSummScopeRegLnSur
PARENT XML ELEMENT:	Tumor

Description

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 at all facilities.

Scope of Regional Lymph Node Surgery describes the procedure of removal, biopsy, or aspiration of regional lymph nodes performed during the initial work-up or first course of therapy.

Coding Instructions sentinel lymph node biopsies (SLNBx) have been clarified for 2012 and later, diagnoses.

Additional instructions for breast primaries (C500-C509) are described below, following the general coding instructions.

Rationale

In evaluating quality-of-care and treatment practices, it is important to identify the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

Codes

Refer to the most recent version of STORE Manual and SEER Program Code Manual for additional instructions.

The treatment of breast and skin cancers are where the distinction between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered. For all other sites, non-sentinel regional node dissections are typical, and codes 2, 6 and 7 are infrequently used.

0	No regional lymph nodes removed or aspirated; diagnosed at autopsy
1	Biopsy or aspiration of regional lymph node, NOS
2	Sentinel lymph node biopsy [only]
3	Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
4	1 to 3 regional lymph nodes removed

5	4 or more regional lymph nodes removed
6	Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

Coding Instructions

1. Use the entire operative report as the primary source document to determine whether the operative procedure was a SLNBx, or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.
2. Code r**egiona**l lymph node procedures in this data item. Record distant lymph node removal in Surgical Procedure of Other Site.
    a. Include lymph nodes that are regional in the current AJCC Staging Manual.
3. Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site. The regional lymph node surgical procedure(s) may be done to **diagnose** cancer, **stage** the disease, or as a part of the initial **treatment**.
    b. ***Example:*** Patient has a sentinel node biopsy of a single lymph node. Assign code 2 (Sentinel lymph node biopsy [only]).
4. Include lymph nodes obtained or biopsied during any procedure within the first course of treatment. A separate lymph node surgery is not required.
    a. Code the removal of intra-organ lymph nodes in Scope of Regional Lymph Node Surgery.
    b. ***Example:*** Local excision of breast cancer. Specimen includes an intra-mammary lymph node. Assign code 4 (1 to 3 regional lymph nodes removed).
5. Add the number of all of the lymph nodes removed during each surgical procedure performed as part of the first course of treatment. The Scope of Regional Lymph Node data item is **cumulative**.
    a. ***Example:*** Patient has excision of a positive cervical node. The pathology report from a subsequent node dissection identifies three cervical nodes. Assign code 5 (4 or more regional lymph nodes removed).
    b. Lymph node aspirations:
        i. Do **not** double-count when a regional lymph node is aspirated and that node is in the resection field. Do **not** add the aspirated node to the total number.
        ii. Count as an additional node when a regional lymph node is aspirated and that node is **NOT** in the resection field. **Add** it to the total number.

iii. Assume the lymph node that is aspirated is part of the lymph node chain surgically removed and do **not** include it in the count when its location is **not known.**

6. Code the removal of regional nodes for both primaries when the patient has **two primaries with common regional lymph nodes.**
    a. ***Example:*** Patient has a cystoprostatectomy and pelvic lymph node dissection for bladder cancer. Pathology identifies prostate cancer as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. Code Scope of Regional Lymph Node Surgery to 5 (4 or more regional lymph nodes removed) for both primaries.
7. Assign the appropriate code for **occult head and neck primaries with positive cervical lymph nodes** (schema 00060). Do not default to code 9 for this schema.
8. Assign code **0** when:
    a. Regional lymph node removal procedure was **not** performed **OR**
        i. ***Note:*** Excludes all sites and histologies that would be coded 9. (See Coding Instruction #13 below.)
        ii. First course of treatment was active surveillance/watchful waiting **OR**
        iii. The operative report lists a lymph node dissection, but no nodes were found by the pathologist.
9. Assign code **2** when:
    a. The operative report states that a **SLNBx was performed OR**
    b. The operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination
    c. ***Note:*** When a SLNBx is performed, additional **non-sentinel nodes can be taken** during the same operative procedure. These additional non-sentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code **2**). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as **6**.
10. Codes **3, 4, and 5**: The operative report states that a regional lymph node dissection was performed (a SLNBx was **not** done during this procedure or in a prior procedure).
    a. Code **3**: Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7).
    b. Code **4** should be used infrequently. Review the operative report to ensure the procedure was **not** a SLNBx only.
    c. Code **5:** If a relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was **not** a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was **not** a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7).
    d. ***Note:*** Infrequently, a SLNBx is attempted and the patient **fails to map** (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. **Code these cases as 2** if no further dissection of regional lymph nodes was undertaken, **or 6**

when regional lymph nodes were dissected during the same operative event.

11. Code **6**: SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known.
    a. Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes.
    b. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.
    c. Infrequently, a SLNBx is attempted and the patient **fails to map** (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. **Code these cases as 6**.
12. Code 7: SLNBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events.
    a. Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes.
    b. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.
13. Code **9:** The status of regional lymph node evaluation should be known for surgically treated cases (i.e., cases coded 19-90 in the data item Surgery of Primary Site [NAACCR Item #1290]). Review surgically treated cases coded as 9 in Scope of Regional Lymph Node Surgery to confirm the code.
    a. Assign code **9** for
        i. Any case coded to primary site: C420, C421, C423, C424, C589, C700-C709,
        ii. C710-C729, C751-C753, C761-C768, C770-C779, or C809
        iii. Lymphoma (excluding CLL/SLL) 00790
        iv. Lymphoma (CLL/SLL) 00795
        v. Plasma Cell Disorders (excluding histology 9734/3) 00822

Coding Instructions – Sentinel lymph node biopsy (SLNBx), Breast (C500-C509)

1. Use the **entire operative report** as the primary source document to determine whether the operative procedure was a SLNBx, an axillary node dissection (ALND), or a combination of both SLNBx and ALND. The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and an ALND.
2. Code **1**:
    a. Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report to confirm whether an excisional biopsy or aspiration of

regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.

3. Code **2**
    a. If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND).
    b. Infrequently, a SLNBx is attempted and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Use code 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items Regional Lymph Nodes Examined (NAACCR Item #830) and Regional Lymph Nodes Positive (NAACCR Item #820).
4. Codes **3, 4,** and **5**: Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).
5. Code **6**:
    a. Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes.
    b. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.
6. Code **7**
    a. Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes.
    b. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a SLNBx plus an ALND was performed.

RX SUMM--SURG OTH REG/DIS

Item #	Length
1294	1

Alternate Name:	Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes (SEER/CoC) Surgical Procedure/Other Site
XML NAACCR ID:	rxSummSurgOthRegDis
PARENT XML ELEMENT:	Tumor

Description

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

IMPORTANT: Justify the code you enter in this field by completing the associated text fields: RX TEXT – SURGERY, TEXT – DX PROC – OPERATIVE PROCEDURE

Rationale

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

Codes

Refer to the most recent version of STORE Manual and SEER Program Code Manual for additional instructions.

0	None; diagnosed at autopsy
1	Non-primary surgical procedure performed
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	Combination of codes 2, 3, or 4
9	Unknown

Coding Instructions

1. Do not code tissue or organs such as an appendix that were removed incidentally, and the organ was not involved with cancer
    a. ***Note:*** Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer. Examples of incidental

removal of organ(s) would be removal of appendix, gallbladder, etc., during abdominal surgery.

2. Do not code removal of uninvolved contralateral breast in this data item. See Surgery Codes for Breast in Appendix A of the STORE Manual**.**
3. Assign code 0 when:
    a. No surgical procedures were performed that removed distant lymph node(s) or other tissue(s) or organ(s) beyond the primary site, **or**
    b. First course of treatment was active surveillance/watchful waiting.
4. The codes are hierarchical.
    a. Codes 1-5 have priority over codes 0 and 9.
5. Assign code 1:
    a. When the involved contralateral breast is removed for a single primary breast cancer.
        i. ***Note:*** See also notes and codes in Appendix C of SEER Coding and Staging Manual, Breast surgery codes.
    b. When any surgery is performed to remove tumors for any case coded to primary site C420, C421, C423, C424, C760-C768, C770-C779, or C809.
        i. Excluding cases coded to the schema Cervical Lymph Nodes and Unknown Primary 00060
    c. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.
6. Assign code 2 for sites that are regional. Include sites that are regional in the current AJCC Staging Manual or EOD 2018.
7. Assign code 4 for sites that are distant. Include sites that are distant in the current AJCC Staging Manual or EOD 2018.
8. Assign code 9 for death certificate only (DCO) cases.

RX SUMM--SURG PRIM SITE

Item #	Length
1290	1

Alternate Name:	Surgery of Primary Site (SEER/CoC) Cancer-Directed Surgery (pre-96 CoC)
XML NAACCR ID:	rxSummSurgPrimSite
PARENT XML ELEMENT:	Tumor

Description

Site-specific codes for 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.

Surgery of Primary Site describes a surgical procedure that removes and/or destroys tissue of the primary site that is performed as part of the initial diagnostic and staging work-up or first course of therapy. Site-specific surgery codes are included under Appendix C of the SEER Program Coding and Staging Manual.

IMPORTANT: Justify the code you enter in this field by including justification in at least one of the associated text fields: RX TEXT – SURGERY, TEXT – DX PROC – OPERATIVE PROCEDURE

Codes (in addition to the site-specific codes)

Refer to the most recent version of STORE Manual and SEER Program Code Manual for additional instructions.

00	None; no surgical procedure of primary site; diagnosed at autopsy only
10-19	Site-specific codes. Tumor destruction; no pathologic specimen or unknown whether there is a pathologic specimen
20-80	Site-specific codes. Resection; pathologic specimen
90	Surgery, NOS. A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided
98	Special codes for hematopoietic neoplasms; ill-defined sites; and unknown primaries (See site-specific codes for the sites and histologies), except death certificate only
99	Unknown if surgery performed

Use the **entire operative report** as the primary source document to determine the best surgery of primary site code. The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the **operative report takes precedence.**

Coding Instructions

1. Code 00 when:
    a. No surgery was performed on the primary site, **OR**
    b. First course of treatment was active surveillance/watchful waiting, **OR**
    c. Case was diagnosed at autopsy.
    d. ***Note:*** Code 00 excludes all sites and histologies that would be coded as 98. (See Instruction 10 below.)
2. Use the site-specific coding scheme corresponding to the primary site or histology.
3. Code the most invasive, extensive, or definitive surgery if the patient has multiple surgical procedures of the primary site even if there is no residual tumor found in the pathologic specimen from the more extensive surgery.
    a. ***Example:*** Patient has a needle biopsy of prostate that is positive for adenocarcinoma. The patient chooses to have a radical prostatectomy. The pathologic examination of the prostatectomy specimen shows no residual tumor. Code the radical prostatectomy.
4. Code an excisional biopsy, even when documented as incisional, when:
    a. All disease is removed (margins free), **OR**
    b. All gross disease is removed and there is only microscopic residual at the margin.
    c. ***Note 1*****:** Do not code an incisional biopsy as an excisional biopsy when there is macroscopic residual disease.
    d. ***Note 2*****:** Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins meet the criteria in either 4.a or 4.b above.
        i. ***Example:*** Shave biopsy performed for a suspicious lesion on the skin of the right arm that has been changing in size and color. The shave biopsy pathology report showed malignant melanoma with only microscopically positive margins. Code the shave biopsy as an excisional biopsy.
5. Code total removal of the primary site when a previous procedure resected a portion of the site and the current surgery removed the rest of the organ. The previous procedure may have been cancer directed or non-cancer directed surgery.
    a. ***Example:*** Left thyroidectomy for suspicious nodules. Path showed papillary carcinoma. Completion thyroidectomy was performed. Code surgery of primary site as total thyroidectomy (50).
6. Code the removal of regional or distant tissue/organs when they are resected in continuity with the primary site (en bloc) and that regional organ/tissue is listed in the Surgery of Primary Site codes. Specimens from an en bloc resection may be submitted to pathology separately.
    a. ***Example:*** Code an en bloc removal when the patient has a hysterectomy and an omentectomy.
7. Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme for the primary site. Do not use the lymph node scheme.
8. Assign the surgery code(s) that best represents the extent of the surgical procedure that was actually carried out when surgery is aborted. If the procedure was aborted before anything took

place, assign code 00. See 1.a. above.

9. Code 80 or 90 only when there is no specific information.
10. Code 98 for the following primary sites unless the case is death certificate only (see #12 below).
    a. Any case coded to C420, C421, C423, C424, C760-C768, or C809.
11. When Surgery of Primary Site is coded 98.
    a. Code Surgical Margins of the Primary Site (#1320) to 9.
    b. Code Reason for No Surgery of Primary Site (#1340) to 1.
    c. Code 99 for death certificate only (DCO) cases or if patient record does not state whether a surgical procedure of the primary site was performed (i.e., is unknown).
12. Code 99 for death certificate only (DCO) cases or if patient record does not state whether a surgical procedure of the primary site was performed (i.e., is unknown).

RX SUMM--SURG/RAD SEQ

Item #	Length
1380	1

Alternate Name:	Radiation Sequence with Surgery (pre-96 SEER/CoC) Radiation/Surgery Sequence (CoC)
XML NAACCR ID:	rxSummSurgRadSeq
PARENT XML ELEMENT:	Tumor

Description

Codes for the sequencing of radiation and surgery given as part of the first course of treatment. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope LN Surg [1292], RX Summ--Surg Oth Reg/Dis [1294], and RX Summ--Radiation [1360].

Codes

0	No radiation and/or surgery as defined above; Unknown if surgery and/or radiation given
2	Radiation before surgery
3	Radiation after surgery
4	Radiation both before and after surgery
5	Intraoperative radiation therapy
6	Intraoperative radiation with other radiation given before and/or after surgery
7	Surgery both before and after radiation (for cases diagnosed 01/01/2012 and later)
9	Sequence unknown, but both surgery and radiation were given

Coding Instructions

1. Assign code 0 when:
    a. The patient did not have either surgery or radiation.
    b. The patient had surgery but not radiation.
    c. The patient had radiation but not surgery.
    d. It is unknown whether or not the patient had surgery and/or radiation.
        i. For death certificate only (DCO) cases.
2. Assign codes 2-9 when first course of therapy includes both cancer-directed surgery and radiation therapy.

a. Assign code 4 when there are at least two courses, episodes, or fractions of radiation therapy given before and at least two more after surgery to the primary site, scope of regional lymph node surgery (excluding code 1), surgery to other regional site(s), distant site(s), or distant lymph node(s).

    i. Example

        1. Preoperative radiation therapy was administered to shrink a large, bulky lesion.
        2. Resection was performed.
        3. Postoperative radiation therapy was administered after resection.

b. Assign code 7 when there are at least two surgeries; radiation was administered between one surgical procedure and a subsequent surgical procedure.

    i. Example 1

        1. Sentinel lymph node biopsy
        2. Radiation therapy
        3. Surgery of primary site

c. Code Radiation Sequence with Surgery as 7 (surgery both before and after radiation).

    i. Example 2

        1. Two regional lymph nodes removed
        2. Radiation
        3. Surgery of primary site

d. Code Radiation Sequence with Surgery as 7 (surgery both before and after radiation) because regional lymph node removal is coded in Scope of Regional Lymph Node Surgery.

RX SUMM--SYSTEMIC/SUR SEQ

Item #	Length
1639	1

Alternate Name:	Systemic/Surgery Sequence
XML NAACCR ID:	rxSummSystemicSurSeq
PARENT XML ELEMENT:	Tumor

Description

Records the sequencing of systemic therapy (RX Summ-Chemo [1390], RX Summ-Hormone [1400], RX Summ-BRM [1410], and RX Summ-Transplnt/Endocr [3250]) and surgical procedures given as part of the first course of treatment. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope LN Surg [1292], and RX Summ--Surg Oth Reg/Dis [1294]. Systemic therapy is defined as:

- Chemotherapy
- Hormone therapy
- Biological response therapy/immunotherapy
- Bone marrow transplant
- Stem cell harvests
- Surgical and/or radiation endocrine therapy

Rationale

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

Codes

Code	Label	Definition	Example(s)/Notes
0	No systemic therapy and/or surgical treatment; Unknown if surgery and/or systemic therapy given	The patient did not have both systemic therapy and surgery. It is unknown whether or not the patient had surgery and/or systemic therapy.	***Example:*** Death certificate only (DCO) case
2	Systemic therapy before surgery	The patient had systemic therapy prior to surgery	

3	Systemic therapy after surgery	The patient had systemic therapy after surgery	
4	Systemic therapy both before and after surgery	Systemic therapy was administered prior to surgery and also after surgery	***Note:*** Code 4 is intended for situations with at least two episodes or courses of systemic therapy.
5	Intraoperative systemic therapy	The patient had intraoperative systemic therapy	
6	Intraoperative systemic therapy with other systemic therapy administered before and/or after surgery	The patient had intraoperative systemic therapy and also had systemic therapy before and/or after surgery	***Note:*** The systemic therapy administered before and/or after surgery does not have to be the same type as the intraoperative systemic therapy.
7	Surgery both before and after systemic therapy (effective for cases diagnosed 01/01/2012 and later)	Systemic therapy was administered between two separate surgical procedures	***Example:*** Patient has LN dissection, followed by chemo, followed by primary site surgery.
9	Sequence unknown	The patient had systemic therapy and also had surgery. It is unknown whether the systemic therapy was administered prior to surgery, after surgery, or intraoperatively	

RX SUMM--TRANSPLNT/ENDOCR

Item #	Length
3250	2

Alternate Name:	Hematologic Transplant and Endocrine Procedures
XML NAACCR ID:	rxSummTransplntEndocr
PARENT XML ELEMENT:	Tumor

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 then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

IMPORTANT: Justify code you enter in this field by completing the associated text field: TEXT – REMARKS

Rationale

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

Codes

Refer to the most recent version of STORE Manual and SEER Program Code Manual for additional instructions.

00	None, transplant procedure or endocrine therapy was not a part of the first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only
10	Bone marrow transplant, NOS. A bone marrow transplant procedure was administered as first course of therapy, but the type was not specified
11	Bone marrow transplant autologous
12	Bone marrow transplant allogeneic
20	Stem cell harvest and infusion (stem cell transplant)
30	Endocrine surgery and/or endocrine radiation therapy as first course therapy
40	Combination of transplant procedure with endocrine surgery and/or endocrine radiation (Code 30 in combination with 10, 11, 12, or 20) as first course of therapy
82	Transplant procedure and/or endocrine therapy was not recommended/administered because it was contradicted due to patient risk factors (comorbid conditions/adv. age/etc)

85	Transplant procedure and/or endocrine therapy was not administered because the patient died prior to planned or recommended therapy
86	Transplant procedure and/or endocrine 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 noted in the planned or recommended therapy.
87	Transplant procedure and/or endocrine therapy were not administered; this treatment was recommended by the patient's physician but was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Transplant procedure and/or endocrine therapy was recommended, but it is unknown if it was administered
99	It is unknown if a transplant procedure or endocrine therapy was recommended or administered because it is not stated in patient record

Definitions

Bone marrow transplant (BMT): Procedure where bone marrow is used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.

BMT Allogeneic: Receives bone marrow from a donor. This includes haploidentical transplants.

BMT Autologous: Uses the patient's own bone marrow. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.

BMT Syngeneic: Bone marrow received from an identical twin.

Conditioning: High-dose chemotherapy with or without radiation administered prior to transplant such as BMT and stem cells to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field and the radiation is coded in the Rad. Treatment Modality--Phase I, II, III fields.

Hematopoietic growth factors: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.

Non-myeloablative therapy: Uses immunosuppressive drugs pre- and post-transplant to ablate (destroy) the bone marrow. These are not recorded as therapeutic agents.

Peripheral Blood Stem Cell Transplantation (PBSCT): Rescue that uses peripheral blood stem cells to replace stem cells after conditioning.

Rescue: Rescue is the actual BMT or PBSCT done after conditioning.

Stem cells: Immature cells found in bone marrow, blood stream, placenta, and umbilical cords. The stem cells mature into blood cells.

Stem cell transplant: Procedure to replenish supply of healthy blood-forming cells. Also known as bone marrow transplant, PBSCT, or umbilical cord blood transplant, depending on the source of the stem cells. When stem cells are collected from bone marrow and transplanted into a patient, the procedure is known as a **bone marrow transplant**. If the transplanted stem cells came from the bloodstream, the procedure is called a **peripheral blood stem cell transplant**, sometimes shortened to stem cell transplant.

Umbilical cord stem cell transplant: Treatment with stem cells harvested from umbilical cord blood.

Coding Instructions

1. Assign code 00 when:
    a. The medical record states that there was no hematologic transplant or endocrine therapy, or these were not recommended, or not indicated.
    b. There is no information in the patient's medical record about transplant procedure or endocrine therapy **AND**
        i. It is known that transplant procedure or endocrine therapy is not usually performed for this type and/or stage of cancer **OR**
        ii. There is no reason to suspect that the patient would have had transplant procedure or endocrine therapy.
    c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include transplant procedure or endocrine therapy.
    d. Patient elects to pursue no treatment following the discussion of transplant procedure or endocrine therapy. Discussion does not equal a recommendation. Patient's decision not to pursue transplant procedure or endocrine therapy is not a refusal of transplant procedure or endocrine therapy in this situation.
    e. Active surveillance/watchful waiting is the first course of treatment (e.g., CLL).
    f. Patient diagnosed at autopsy.
2. Assign code 10 if the patient has a bone marrow transplant and it is unknown if autologous or allogeneic (BMT, NOS) or "mixed chimera transplant (mini-transplant or non- myeloablative transplant). These transplants are a mixture of the patient's cells and donor cells.
3. Codes 11 (Bone marrow transplant autologous) and 12 (Bone marrow transplant allogeneic) have priority over code 10 (BMT, NOS).
4. Assign code 12 (allogeneic) for a syngeneic bone marrow transplant (from an identical twin) or for a transplant from any person other than the patient.
5. Assign code 20 for:
    a. Allogeneic stem cell transplant
    b. Peripheral blood stem cell transplant
    c. Umbilical cord stem cell transplant (single or double)
        i. ***Note:*** If the patient does not have a rescue, code the stem cell harvest as 88, (recommended, unknown if administered) or if harvested but unknown if infused.
6. Assign code 30 for endocrine radiation and/or surgery. Endocrine organs are testes and ovaries. Endocrine radiation and/or surgical procedures must be bilateral, or must remove the remaining paired organ for hormonal effect.
7. Assign code 87:
    a. If the patient refused recommended transplant or endocrine procedure.
    b. If the patient made a blanket refusal of all recommended treatment and the treatment coded in this data item is a customary option for the primary site/histology.
    c. If the patient refused all treatment before any was recommended.
8. Assign code 88 when:

a. The only information available is that the patient was referred to an oncologist for consideration of hematologic transplant or endocrine procedure.

b. A bone marrow or stem cell harvest was undertaken, but it was not followed by a rescue or reinfusion as part of first course treatment.

c. ***Note:*** Review cases coded 88 periodically for later confirmation of transplant procedure or endocrine therapy.

9. Assign code 99 when there is no documentation that transplant procedure or endocrine therapy was recommended or performed.

    a. For death certificate only (DCO) cases.

RX SUMM--TREATMENT STATUS

Item #	Length
1285	1

Alternate Name:	
XML NAACCR ID:	rxSummTreatmentStatus
PARENT XML ELEMENT:	Tumor

Description

This data item is a summary of the status for all treatment modalities. It is used in conjunction with Date Initial RX SEER [1260] and/or Date 1st Crs RX CoC [1270] and each modality of treatment with their respective date field to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date. Also indicates active surveillance (watchful waiting).

Rationale

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

Codes

0	The patient did not receive any treatment
1	The patient received treatment
2	The patient was under active surveillance or watchful waiting during the first course of treatment
9	It is unknown whether or not the patient received treatment

Coding Instructions

1. Assign code **0** when the patient does not receive any treatment.
    a. Scope of Regional Lymph Node Surgery may be coded 0, 1-7, or 9.
2. Assign code **1** when the patient receives treatment collected in any of the following data items:
    a. Surgery of Primary Site
    b. Surgical Procedure of Other Site
    c. Radiation Treatment Modality, Phase I, II, III
    d. Chemotherapy
    e. Hormone Therapy

f. Immunotherapy
g. Hematologic Transplant and Endocrine Procedures
h. Other Therapy

3. Assign code **2** when there is documentation that the patient is being monitored using **active surveillance/watchful waiting/deferred therapy or other similar options.**
4. Assign code **9** for death certificate only (DCO) cases.
5. Leave **blank** for cases diagnosed prior to January 1, 2010.

RX TEXT--BRM

Item #	Length
2660	1000

Alternate Name:	
XML NAACCR ID:	rxTextBrm
PARENT XML ELEMENT:	Tumor

Description

Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

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

Recommendations for text

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

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

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

Item name	**Item #**
Date Initial RX SEER	1260
Date 1st Crs RX CoC	1270
RX Hosp--BRM	720
RX Date Systemic	3230
RX Summ-- Tranplnt/Endocr	3250
RX Summ--BRM	1410
RX Date BRM	1240
RX Summ-- Systemic/Sur Seq	1639

RX TEXT--CHEMO

Item #	Length
2640	1000

Alternate Name:	
XML NAACCR ID:	rxTextChemo
PARENT XML ELEMENT:	Tumor

Description

Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Date chemotherapy began.
- Where treatment was given, e.g., at this facility, at another facility

- Type of chemotherapy, e.g., name of agent(s) or protocol.
- Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given.

Recommendations for Text

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

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

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

Item name	**Item #**
Date Initial RX SEER	1260
Date 1st Crs RX CoC	1270
RX Hosp--Chemo	700
RX Date Systemic	3230
RX Summ-- Tranplnt/Endocr	3250
RX Summ--Chemo	1390
RX Date Chemo	1220
RX Summ-- Systemic/Sur Seq	1639

RX TEXT--HORMONE

Item #	Length
2650	1000

Alternate Name:	
XML NAACCR ID:	rxTextHormone
PARENT XML ELEMENT:	Tumor

Description

Text area for information about hormonal treatment.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Date treatment was started.
- Where treatment was given, e.g., at this facility, at another facility

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

Recommendations for Text

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

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

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

Item name	**Item #**
Date Initial RX SEER	1260
Date 1st Crs RX CoC	1270
RX Hosp--Hormone	710
RX Date Systemic	3230
RX Summ-- Tranplnt/Endocr	3250
RX Summ--Hormone	1400
RX Date Hormone	1230
RX Summ-- Systemic/Sur Seq	1639

RX TEXT--OTHER

Item #	Length
2670	1000

Alternate Name:	
XML NAACCR ID:	rxTextOther
PARENT XML ELEMENT:	Tumor

Description

Text area for manual documentation of information regarding the treatment of the tumor being reported withtreatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Date treatment was started.
- Where treatment was given, e.g., at this facility, at another facility
- Type of other treatment, e.g., blinded clinical trial, hyperthermia.
- Other treatment information, e.g., treatment cycle incomplete; unknown if other treatment was given.

Recommendations for Text

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

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

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

Item Name	Item #
Date Initial RX SEER	1260
RX Summ--Other	1420
RX Date Other	1250
RX Hosp--Other	730

RX TEXT--RADIATION (BEAM)

Item #	Length
2620	1000

Alternate Name:	
XML NAACCR ID:	rxTextRadiation
PARENT XML ELEMENT:	Tumor

Description

Text area for manual documentation of information regarding treatment of the tumor being reported withbeam radiation.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Date radiation treatment began.
- Where treatment was given, e.g., at this facility, at another facility.

- Type(s) of beam radiation, e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities
- Other treatment information, e.g., patient discontinued after 5 treatments; unknown if radiation was given.

Recommendations for Text

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

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

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

Item name	Item #
Date Initial RX SEER	1260
RX Summ--Radiation	1360
RX Summ--Surg/Rad Seq	1380
Reason For No Radiation	1430
RX Date Radiation	1210
Phase I Radiation Treatment Modality	1506

RX TEXT--RADIATION OTHER

Item #	Length
2630	1000

Alternate Name:	
XML NAACCR ID:	rxTextRadiationOther
PARENT XML ELEMENT:	Tumor

Description

Text area for manual documentation of information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values**. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Date treatment was started.
- Where treatment was given, e.g., at this facility, at another facility.

- Type(s) of nonbeam radiation, e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I- 131).
- 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:

Item name	Item #
Date Initial RX SEER	1260
RX Summ--Radiation	1360
RX Summ--Surg/Rad Seq	1380
Reason For No Radiation	1430
RX Date Radiation	1210
Phase I Radiation Treatment Modality	1506

RX TEXT--SURGERY

Item #	Length
2610	1000

Alternate Name:	
XML NAACCR ID:	rxTextSurgery
PARENT XML ELEMENT:	Tumor

Description

Text area for information describing all surgical procedures performed as part of treatment.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Date of each procedure.
- Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites.

- Lymph nodes removed. Regional tissues removed. Metastatic sites.
- Facility where each procedure was performed.
- Record positive and negative findings. Record positive findings first.
- Other treatment information, e.g., planned procedure aborted; unknown if surgery performed.

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

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

Item name	**Item #**
Date Initial RX SEER	1260
RX Date Surgery	1200
RX Summ--Surg Prim Site	1290
RX Summ--Scope Reg LN Sur	1292
RX Summ--Surg Oth Reg/Dis	1294
Reason for No Surgery	1340
Text--Place of Diagnosis	2690
RX Summ--Surg/Rad Seq	1380
RX Summ-- Systemic/Sur Seq	1639

SCHEMA DISCRIMINATOR 1

Item #	Length
3926	1

Alternate Name:	
XML NAACCR ID:	schemaDiscriminator1
PARENT XML ELEMENT:	Tumor

Description

Captures additional information needed to generate AJCC ID [995] and Schema ID [3800] for some anatomic sites. Discriminators can be based on sub site, histology or other features which affect prognosis.

Rationale

A schema discriminator is used to assign AJCC ID [995] when site and histology alone are insufficient to identify the applicable AJCC staging method and to assign Schema ID [3800], which links each case to the appropriate SSDIs, Summary Stage and EOD data collection system.

Codes

(The information recorded in Schema Discriminator differs for each anatomic site. See the SSDI manual for most current version of the site-specific codes and coding structures.)

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

The following schemas apply to Schema Discriminator 1:

- BileDuctsDistal/BileDuctsPerihilar/CysticDuct
- EsophagusGEJunction (EGJ)/Stomach
- (Histology Discriminator for 9591/3)
- Lacrimal Gland/Sac
- Melanoma Ciliary Body/Melanoma Iris
- Nasopharynx/Pharyngeal Tonsil
- Occult Head and Neck Lymph Nodes
- Plasma Cell Myeloma Terminology
- Primary Peritoneum Tumor
- Thyroid Gland/Thyroglossal Duct
- Urethra/Prostatic Urethra

SCHEMA DISCRIMINATOR 2

Item #	Length
3927	1

Alternate Name:	
XML NAACCR ID:	schemaDiscriminator2
PARENT XML ELEMENT:	Tumor

Description

Captures additional information needed to generate AJCC ID [995] and Schema ID [3800] for some anatomic sites. Discriminators can be based on sub site, histology or other features which affect prognosis.

Rationale

A schema discriminator is used to assign AJCC ID [995] when site and histology alone are insufficient to identify the applicable AJCC staging method and to assign Schema ID [3800], which links each case to the appropriate SSDIs and Summary Stage.

Codes

(The information recorded in Schema Discriminator differs for each anatomic site. See the SSDI manual for most current version of the site-specific codes and coding structures.)

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

The following schemas apply to Schema Discriminator 2:

- Histology Discriminator for 8020/3
- Oropharyngeal p16
- Soft Tissue Sarcoma (C473, C475, C493-C495) (Schema IDs: 00410, 00421

SCHEMA ID

Item #	Length
3800	5

Alternate Name:	
XML NAACCR ID:	schemaId
PARENT XML ELEMENT:	Tumor

Description

The derived values in this data item link Site-Specific Data Items (including grade data items) with the appropriate site/histology grouping and accounts for every combination of primary site and histology. The values for this data item are derived based on primary site, histology, and schema discriminator fields (when required). The derived values link Site-Specific Data Items with the appropriate site/histology grouping.

For example, the Schema ID for an adenocarcinoma of the lung is 00360. This value links the Site-Specific Data Items associated with adenocarcinoma of the lung: Separate Tumor Nodules [3929], Visceral and Parietal Pleural Invasion [3937], and Pleural Effusion [3913]. The Schema ID would also link to the appropriate grade data items an adenocarcinoma of the lung. The AJCC ID [995] code for Lung is 36. The AJCC ID [995] would link to the AJCC TNM Data items (Clin T, Clin N, Etc.) specific to Lung.

AJCC ID [995] will not be assigned when a site/histology combination is not eligible for TNM staging.

Rationale

The purpose of the derived Schema ID is to link the appropriate Site-Specific Data Items with the patient's primary site/histology. This data item is similar to AJCC ID [995], but includes additional site/histologies that may not be eligible for TNM staging using the current AJCC Staging Manual. AJCC ID [995] is left blank if a case is not eligible for TNM Staging using the current AJCC Staging Manual. Separating AJCC ID [995] and the Schema ID allows coding of Site-Specific Data Items for site/histology combinations that are not eligible for an AJCC Stage, but are eligible for Summary Stage.

This data item will also be used to develop edits and could potentially be used for analysis.

Codes

See the NAACCR Site-Specific Data Item webpage for codes.

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

SCHEMA ID VERSION CURRENT

Item #	Length
2117	5

Alternate Name:	
XML NAACCR ID:	schemaIdVersionCurrent
PARENT XML ELEMENT:	Tumor

Description

This item indicates the version of EOD component of the SEER Staging API used to assign the 2018 and later staging fields of Schema ID, Grades, EOD input fields, SS2018, and SSDIs. This data item is recorded the first time the Schema ID is determined and should be updated each time the related input fields are modified.

Rationale

Over time, the definitions for Schema ID and the input codes and instructions for Grades, EOD, SS2018, and SSDI items may change. This item identifies the correct interpretation of information recorded.

Codes

Schema ID Version Current is a code with up to 2 digits, a decimal and then up to 2 more digits. (e.g., 1.5, 10.12). The first two digits represent the major version number related to diagnosis year; the second two digits represent minor version changes with the diagnosis years. Minimum allowable value would be “1.0”. Maximum allowable value would be “99.99”. Blanks would not be allowed.

This data item will be generated by registry software. No coding instructions are required.

SCHEMA ID VERSION ORIGINAL

Item #	Length
2118	5

Alternate Name:	
XML NAACCR ID:	schemaIdVersionOriginal
PARENT XML ELEMENT:	Tumor

Description

This item indicates the version of EOD component of the SEER Staging API used to assign the 2018 and later staging fields of Schema ID, Grades, EOD input fields, SS2018, and SSDIs. This data item is recorded the first time the Schema ID is determined. This data item should not be updated each time the related input fields are modified.

Rationale

Over time, the definitions for Schema ID and the input codes and instructions for Grades, EOD, SS2018, and SSDI items may change. This item identifies the original instructions used to code these items.

Codes

Schema ID Version Original is a code with up to 2 digits, a decimal and then up to 2 more digits. (e.g., 1.5, 10.12). The first two digits represent the major version number related to diagnosis year; the second two digits represent minor version changes with the diagnosis years. Minimum allowable value would be “1.0”. Maximum allowable value would be “99.99”. Blanks would not be allowed.

This data item will be generated by registry software. No coding instructions are required.

SEQUENCE NUMBER--HOSPITAL

Item #	Length
560	2

Alternate Name:	Sequence Number (CoC)
XML NAACCR ID:	sequenceNumberHospital
PARENT XML ELEMENT:	Tumor

Description

Item indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient. The code may differ from the Sequence Number--Central [380] because the definitions of reportable neoplasms often vary between a hospital and a central registry. The two items also handle some types of tumors differently. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has only one malignant neoplasm in his lifetime (regardless of hospital 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 is a person's lifetime, 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.

Sequence numbers should be reassigned if the facility subsequently learns of an unaccessioned tumor that affects sequencing. Sequence Number-Central [380] does not affect Sequence Number-Hospital. The two notational systems are independent.

Rationale

This data item is used to distinguish among cases having the same accession numbers, to select patients with only one malignant primary tumor for certain follow-up studies, and to analyze factors involved in the development of multiple tumors.

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 worse prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Codes

Malignant or In Situ Primaries	
00	One malignant or in situ primary only in the patient's lifetime
01	First of two or more independent malignant or in situ primaries
02	Second of two or more independent or in situ primaries
…	(Actual sequence of this malignant or in situ primary)
59	Fifty-ninth of 59 or more independent malignant or in situ primaries
Non-Malignant Primaries	
60	One nonmalignant primary only in the patient's lifetime
61	First of two or more independent nonmalignant primaries
62	Second of two or more independent nonmalignant primaries
…	(Actual sequence of this nonmalignant primary)
87	Twenty-seventh of 27 or more independent nonmalignant primaries
88	Unspecified number of independent nonmalignant primaries

Coding Instructions

- Codes 00–59 and 99 indicate neoplasms of malignant (in situ or invasive) behavior (Behavior equals 2 or 3). Codes 60–88 indicate neoplasms of non-malignant behavior (Behavior equals 0 or 1).
- Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent invasive or in situ primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.
- Code 60 only if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant primaries sequentially.
- If two or more invasive or in situ neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- Any tumor in the patient's past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes non-reportable later.
- Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

Examples

Code	Reason
00	Patient with no previous history of cancer diagnosed with in situ breast carcinoma on June 13, 2003
01	The sequence number is changed when the patient with an in situ breast carcinoma diagnosed June 13, 2003, is diagnosed with a subsequent melanoma on August 30, 2003
02	Sequence number assigned to the melanoma diagnosed on August 30, 2003, following a breast cancer in situ diagnosis on June 13, 2003
04	A nursing home patient is admitted to the hospital for first course surgery for a colon adenocarcinoma. The patient has a prior history of three malignant cancers of the type the registry is required to accession, though the patient was not seen for these cancers at the hospital. No sequence numbers 01, 02 or 03 are accessioned for this patient.
60	The sequence number assigned to a benign brain tumor diagnosed on November 1, 2005, following a breast carcinoma diagnosed on June 13, 2003, and a melanoma on August 30, 2003
63	Myeloproliferative disease (9975/1) is diagnosed by the facility in 2003 and accessioned as Sequence 60. A benign brain tumor was diagnosed and treated elsewhere in 2002; the patient comes to the facility with a second independent benign brain tumor in 2004. Unaccessioned earlier brain tumor is counted as Sequence 61, myeloproliferative disease is resequenced to 62, and second benign brain tumor is Sequence 63

SEX

Item #	Length
220	1

Alternate Name:	
XML NAACCR ID:	sex
PARENT XML ELEMENT:	Patient

Description

Code for the sex of the patient.

IMPORTANT: Remember to include the patient's sex in the PE text field.

Rationale

This data item is used to compare cancer rates and outcomes by site. The same sex code should appear in each medical record for a patient with multiple tumors.

Codes

1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD). The word hermaphrodite formerly classified under this code is an outdated term.
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not stated/Unknown

Definitions

Intersex: A person born with ambiguous reproductive or sexual anatomy; chromosomal genotype and sexual phenotype other than XY-male and XX-female. An example is 45,X/46,XY mosaicism, also known as X0/XY mosaicism.

Transsexual: A person who was assigned one gender at birth based on physical characteristics but who self-identifies psychologically and emotionally as the other gender.

Coding Instructions

1. Assign code 3 for:
    a. Intersexed (persons with sex chromosome abnormalities.)
    b. Hermaphrodite.
    c. ***Note:*** Hermaphrodite is an outdated term.
2. Codes 5 and 6 may be used for cases diagnosed prior to 2015.
3. Codes 5 and 6 have priority over codes 1 and 2.
4. Assign code **5** for transsexuals who are natally male or transsexuals with primary site of C600-C639.
5. Assign code **6** for transsexuals who are natally female or transsexuals with primary site of C510-C589.
6. Assign code **4** for transsexuals with unknown natal sex and primary site is not C510-C589 or C600-C639.
7. When gender is not known:
    a. Assign code **1** when the primary site is C600-C639.
    b. Assign code **2** when the primary site is C510-C589.
    c. Assign code **9** for primary sites not included above.

SITE CODING SYS--CURRENT

Item #	Length
450	1

Alternate Name:	
XML NAACCR ID:	siteCodingSysCurrent
PARENT XML ELEMENT:	Tumor

Description

Code that best describes how the primary site currently is coded. If converted, this field shows the system to which it is converted.

Codes

1	ICD-8 and MOTNAC
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

SOCIAL SECURITY NUMBER

Item #	Length
2320	1

Alternate Name:	
XML NAACCR ID:	socialSecurityNumber
PARENT XML ELEMENT:	Patient

Description

Records patient's social security number. The number is entered without dashes and without any letter suffix. This is not always identical to the Medicare claim number.

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

Codes (in addition to social security number)

999999999	Unknown

Coding Instructions

1. Code the patient's Social Security number.
2. Do not automatically enter a patient's Medicare claim number; it may not always be identical to the person's Social Security number.
3. See https://www.ssa.gov for more information.

SPANISH/HISPANIC ORIGIN

Item #	Length
190	1

Alternate Name:	Spanish Origin--All Sources (96 CoC) Spanish Surname or Origin (SEER)
XML NAACCR ID:	spanishHispanicOrigin
PARENT XML ELEMENT:	Patient

Description

Code identifying persons of Spanish or Hispanic origin. This code is used by hospital and central registries to show the “best guess” as to whether or not the person should be classified as Hispanic for purposes of calculating cancer rates. If the patient has multiple tumors, all records should have the same code.

IMPORTANT: Justify the code you enter in this field by including Hispanic information in the PE text field. 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).

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf. All information resources should be used to determine the correct code, including:

- Stated ethnicity in the medical record
- Stated Hispanic origin on the death certificate Birthplace
- Information about life history and/or language spoken found during the abstracting process Patient’s last name [2230] or maiden name [2390] found on a list of Hispanic names

Some registries code the information from the medical record, others code ethnicity based on Spanish names, and others use a combination of methods.

Persons of Spanish or Hispanic origin may be of any race, but these categories generally are not used for Native Americans, Filipinos, etc., who may have Spanish names. If a patient has a Hispanic name, but there is reason to believe they are 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 should be 0 (non- Spanish, non-Hispanic). The code in item Computed Ethnicity [200], however, would reflect the Hispanic name.

Assign code 7 if Hispanic ethnicity is based strictly on a computer list or algorithm (unless contrary evidence is available) and also code in Computed Ethnicity [200].

Note: NAACCR recognizes that available definitions and abstracting instructions for Name--Last [2230] and Name--Maiden [2390] may be inadequate for describing names used in some cultures, including Hispanic cultures. Explicit instructions have not been provided for entering compound names, with or without hyphens or “De.” Order of names, use of maternal and paternal names, and

use of hyphens can vary across cultures. It is likely that abstracting and coding practice for these items varies across registries. Limitations inherent in these definitions should be kept in mind when using the data.

Rationale

See the rationales for the Race 1-5 [160-164] and Computed Ethnicity [200]. Ethnic origin has a significant association with cancer rates and outcomes. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the “white” category of Race [160].

Codes

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; Hispanic, NOS; 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 (effective with diagnosis on or after 01/01/1994) The only evidence of the person’s Hispanic origin is the surname or maiden name (birth surname) and there is no evidence that he/she is not Hispanic
8	Dominican Republic (effective with diagnosis on or after 01/01/2005)
9	Unknown whether Spanish/Hispanic or not

Coding Instructions

1. Coding Spanish Surname or Origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
2. Use all information to determine the Spanish/Hispanic Origin including:
    a. The ethnicity stated in the medical record.
        i. Self-reported information takes priority over other sources of information.
    b. Hispanic origin stated on the death certificate.
    c. Birthplace.
    d. Information about life history and/or language spoken found in the abstracting process.
    e. A last name or maiden name (birth surname) found on a list of Hispanic/Spanish names.

3. Assign code 6 when there is more than one ethnicity/origin (multiple codes), such as Mexican (code 1) and Dominican Republic (code 8). There is no hierarchy among the codes 1-5 or 8.
4. Assign code 7 when the only evidence of the patient's Hispanic origin is a surname or maiden name (birth surname) and there is no evidence that the patient is not Hispanic. Code 7 is ordinarily for central registry use only.
5. Portuguese, Brazilians, and Filipinos are not presumed to be Spanish or non-Spanish.
    a. Assign code 7 when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list.
    b. Assign code 0 when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list.

Coding Examples

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

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

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

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

SUMMARY STAGE 2018

Item #	Length
764	1

Alternate Name:	Directly Assigned SS2018
XML NAACCR ID:	summaryStage2018
PARENT XML ELEMENT:	Tumor

Description

This item stores the directly assigned Summary Stage 2018. Effective for cases diagnosed 1/1/2018+.

For site-specific definitions of categories, see SEER Summary Staging Manual 2018. Summary stage should include all information available through completion of surgery(ies) as part of the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer. The manual can be downloaded from the SEER website: https://seer.cancer.gov/tools/ssm/2018-Summary-Stage-Manual.pdf

Rationale

The SEER program has collected staging information on cases since its inception in 1973. Summary Stage groups cases into broad categories of in situ, local, regional, and distant. Summary Stage can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time.

Codes

0	In situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND regional lymph nodes
7	Distant site(s)/node(s) involved
8	Benign, borderline*
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death certificate only (DCO) case

*Applicable for the following SS2018 chapters: Brain, CNS Other, Intracranial Gland.

Note: For SS2018, code 5 for “Regional, NOS” can no longer be coded. Code 5 (Regional, NOS) is still applicable.

TELEPHONE

Item #	Length
2360	10

Alternate Name:	
XML NAACCR ID:	telephone
PARENT XML ELEMENT:	Patient

Description

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

Codes (in addition to valid telephone number)

0000000000	Patient does not have a telephone
9999999999	Telephone number unavailable or unknown

Coding Instructions

1. Record the current telephone number including area code of the patient without dashes.
2. Update the telephone number if the telephone number changes.

TEXT--DX PROC--LAB TESTS

Item #	Length
2550	1000

Alternate Name:	
XML NAACCR ID:	textDxProcLabTests
PARENT XML ELEMENT:	Tumor

Description

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

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

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

- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Date(s) of lab test(s)
- Tumor markers included, 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:

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

Item name	**Item #**
Primary Site	400
Grade	440
Diagnostic Confirmation	490
Collaborative Stage variables	2800-2930
Date of Diagnosis	390
Summary Stage 2018	764
AJCC TNM Data Items	1001-1036
EOD Data Items	772-776
Site-specific SSDI Data Items	3801-3937

TEXT--DX PROC--OP

Item #	Length
2560	1000

Alternate Name:	
XML NAACCR ID:	textDxProcOp
PARENT XML ELEMENT:	Tumor

Description

Text area for manual documentation of all surgical procedures that provide information for staging.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Dates and descriptions of biopsies and 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
- Reason primary site surgery could not be completed

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

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

Item name	Item #
Date of Diagnosis	390
RX Summ--Dx/Stg Proc	1350
Diagnostic Confirmation	490
Primary Site	400
RX Hosp--Dx/Stg Proc	740
RX Summ--Surg Prim Site	1290
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
Reason for No Surgery	1340
Summary Stage 2018	764
AJCC TNM Data Items	1001-1036
EOD Data Items	772-776
Site-specific SSDI Data Items	3801-3937

TEXT--DX PROC--PATH

Item #	Length
2570	1000

Alternate Name:	
XML NAACCR ID:	textDxProcPath
PARENT XML ELEMENT:	Tumor

Description

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

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Date(s) of procedure(s)
- Anatomic source of specimen

- Type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.)
- Gross tumor size
- Extent of tumor spread
- Involvement of resection margins
- Number of lymph nodes involved and examined
- Record both positive and negative findings. Record positive test results first

Recommendations for text

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

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

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

Item name	**Item #**
Date of Diagnosis	390
Primary Site	400
Laterality	410
Histologic Type ICD-O-3	522
Grade	440
Collaborative Stage variables	2800-2930
Diagnostic confirmation	490
RX Hosp--Surg Prim Site	670
RX Hosp--Scope Reg LNSur	672
RX Hosp--Surg Oth Rg/Dis	674
RX Summ--Surg Prim Site	1290
RX Summ--Scope Reg LNSur	1292
RX Summ--Surg OthReg/Dis	1294
SEER Summary Stage2000	759
SEER Summary Stage1977	760

Regional Nodes Positive	820
Regional Nodes Examined	830
RX Date Surgery	1200
Reason for No Surgery	1340
RX Summ--Surg/Rad Seq	1380
RX Summ--Systemic/SurSeq	1639
Summary Stage 2018	764
AJCC TNM Data Items	1001-1036
Directly-assigned EOD Data Items	772-776
Site-specific SSDI DataItems	3801-3937

TEXT--DX PROC--PE

Item #	Length
2520	1000

Alternate Name:	
XML NAACCR ID:	textDxProcPe
PARENT XML ELEMENT:	Tumor

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.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Date of physical exam
- Age, sex, race/ethnicity

- History that relates to cancer diagnosis
- Primary site
- Histology (if diagnosis prior to this admission)
- Tumor location
- Tumor size
- Palpable lymph nodes
- Record positive and negative clinical findings. Record positive results first Impression (when stated and pertains to cancer diagnosis)
- Treatment plan

Recommendations for Text

- Behavioral risk factors (smoking history, etc.)
- Family history of cancer

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

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

Item name	Item #
Date of Diagnosis	390
Primary Site	400
Laterality	410
Histologic Type ICD- O-3	522
Grade	440
Collaborative Stage variables	2800-2930
Diagnostic confirmation	490
RX Hosp--Surg Prim Site	670
RX Hosp--Scope Reg LN Sur	672
RX Hosp--Surg Oth Rg/Dis	674
RX Summ--Surg Prim Site	1290
RX Summ--Scope Reg LN Sur	1292
RX Summ--Surg Oth Reg/Dis	1294
SEER Summary Stage 2000	759
SEER Summary Stage 1977	760

Regional Nodes Positive	820
Regional Nodes Examined	830
RX Date Surgery	1200
AJCC TNM Data Items	1001-1036
EOD Data Items	772-776
Site-specific SSDI Data Items	3801-3937
Reason for No Surgery	1340
RX Summ--Surg/Rad Seq	1380
RX Summ-- Systemic/Sur Seq	1639
Summary Stage 2018	764

TEXT--DX PROC--SCOPES

Item #	Length
2540	1000

Alternate Name:	
XML NAACCR ID:	textDxProcScopes
PARENT XML ELEMENT:	Tumor

Description

Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Date(s) of endoscopic exam(s)
- Primary site

- Histology (if given)
- Tumor location
- Tumor size
- Record site and type of endoscopic biopsy
- Record positive and negative clinical findings. Record positive results first

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

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

Item name	**Item #**
Date of Diagnosis	390
RX Summ--Dx/Stg Proc	1350
Diagnostic Confirmation	490
Primary Site	400
Laterality	410
Histology (92-00) ICD-O-2	420
Histologic Type ICD- O-3	522
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
RX Hosp--Surg Prim Site	670
RX Date Surgery	1200
Summary Stage 2018	764
Ajcc TNM Data Items	1001-1036
EOD Data Items	772-776
Site-specific SSDI Data Items	3801-3937

TEXT--DX PROC--X-RAY/SCAN

Item #	Length
2530	1000

Alternate Name:	
XML NAACCR ID:	textDxProcXRayScan
PARENT XML ELEMENT:	Tumor

Description

Text area for manual documentation from all X-rays, scan, and/or other imaging examinations that provide information about staging.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Date(s) and type(s) of X-ray/Scan(s)
- Primary site

- Histology (if given)
- Tumor location
- Tumor size
- Lymph nodes
- Record positive and negative clinical findings.
- Record positive results first
- Distant disease or metastasis

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

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

Item name	**Item #**
Date of Diagnosis	390
RxSumm--Dx/Stg Proc	1350
Primary Site	400
Laterality	410
Histology (92-00) ICD-O-2	420
Histologic Type ICD- O-3	522
Collaborative Stage variables	2800-2930
SEER Summary Stage 2000	759
SEER Summary Stage 1977	760
Summary Stage 2018	764
AJCC TNM Data Items	1001-1036
EOD Data Items	772-776
Site-specific SSDI Data Items	3901-3937

TEXT--HISTOLOGY TITLE

Item #	Length
2590	100

Alternate Name:	
XML NAACCR ID:	textHistologyTitle
PARENT XML ELEMENT:	Tumor

Description

Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- Information on histologic type and behavior
- Information on differentiation from scoring systems (e.g. Gleason, Bloom-Richardson Grade)

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

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

Item name	Item #
Histologic Type ICD- O-3	522
Behavior Code ICD- O-3	523
Grade	440

TEXT--PLACE OF DIAGNOSIS

Item #	Length
2690	60

Alternate Name:	Place of Diagnosis
XML NAACCR ID:	textPlaceOfDiagnosis
PARENT XML ELEMENT:	Tumor

Description

Text area for manual documentation of the facility, physician office, city, state, or county where the diagnosis was made.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- The complete name of the hospital or the physician office where diagnosis occurred. The initials of a hospital are not adequate
- For out-of-state residents and facilities, include the city and the state where the medical facility is located

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 Item Numbers**:** 2410, 2420, 500, 540, 610, 670, 740

TEXT--PRIMARY SITE TITLE

Item #	Length
2580	100

Alternate Name:	
XML NAACCR ID:	textPrimarySiteTitle
PARENT XML ELEMENT:	Tumor

Description

Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

- State the specific location of the primary site, including subsite. Include available information on tumor laterality

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

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

Item name	Item #
Primary Site	400
Laterality	410

TEXT--REMARKS

Item #	Length
2680	1000

Alternate Name:	
XML NAACCR ID:	textRemarks
PARENT XML ELEMENT:	Tumor

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.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values.** High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Recommendations for Text

- Smoking history
- Family and personal history of cancer
- Comorbidities

- Information on sequence numbers if a person was diagnosed with another primary out-of-state or before the registry's reference date
- Place of birth
- Justification of over-ride flags
- 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--STAGING

Item #	Length
2600	1000

Alternate Name:	
XML NAACCR ID:	textStaging
PARENT XML ELEMENT:	Tumor

Description

Additional text area for staging information not already entered in other Text fields.

Rationale

Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. **Text is needed to justify coded values and to document supplemental information not transmitted within coded values**. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the reporter independently from the code(s). If software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Instructions

- Prioritize entered information in the order of the fields listed below. Text automatically generated from coded data is not acceptable.
- 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 software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Requirements for Text

Include enough information to be able to code, from the text, all applicable staging fields for SEER Summary Stage 2018

- Date(s) of procedure(s), including clinical procedures, that provided information for assigning stage
- Organs involved by direct extension
- Size of tumor Status of margins
- Number and sites of positive lymph nodes
- Site(s) of distant metastasis
- Physician's specialty and comments

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

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

Item Name	**Item #**
RxDate Dx/Stg Proc	1280
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
Regional Nodes Positive	820
Regional Nodes Examined	830
RX Hosp--Surg Prim Site	670
RX Summ--Surg Prim Site	1290
RX Hosp--Scope Reg LN Sur	672
RX Summ--Scope Reg LN Sur	1292
RX Hosp--Surg Oth Rg/Dis	674
RX Summ--Surg Oth Reg/Dis	1294
Mult Tum Rpt as One Prim	444
Laterality	410

TEXT--USUAL INDUSTRY

Item #	Length
320	100

Alternate Name:	
XML NAACCR ID:	textUsualIndustry
PARENT XML ELEMENT:	Tumor

Description

Text area for information about the patient's usual industry, also known as usual kind of business/industry.

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.

The data item "usual industry" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death.25 See related materials in reference list, Chapter VII.

Abstracting Instructions

Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components.

If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual industry. In these situations, if resources permit, a central or regional registry may be able to use the employer name and city/town to determine the type of activity conducted at that location.

As noted in the Text--Usual Occupation [310] section, in those situations where the usual occupation is not available or is unknown, the patient's current or most recent occupation is recorded, if available. The information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry.

If later documentation in the patient's record provides an industry that is more likely to be the usual industry than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

There should be an entry for Text--Usual Industry if any occupation is recorded. If no information is available regarding the industry in which the reported occupation was carried out, record “unknown.” If the patient was not a student or homemaker and had never worked, record “never worked” as the usual industry. This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TEXT--USUAL OCCUPATION

Item #	Length
310	100

Alternate Name:	
XML NAACCR ID:	textUsualOccupation
PARENT XML ELEMENT:	Tumor

Description

Text area for information about the patient's usual occupation, also known as usual type of job or work.

Rationale

Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Abstracting Instructions

Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do not record "retired." If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation.

If later documentation in the patient's record provides an occupation that is more likely to be the usual occupation than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with occupation information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

If the patient was a homemaker and also worked outside the home during most of his/her adult life, record the usual occupation outside the home; if the patient was a homemaker and did not work outside the home for most of his/her adult life, record "homemaker." If the patient was not a student or homemaker and had never worked, record "never worked" as the usual occupation.

If no information is available, record "unknown."

This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TUMOR SIZE SUMMARY

Item #	Length
756	3

Alternate Name:	
XML NAACCR ID:	tumorSizeSummary
PARENT XML ELEMENT:	Tumor

Description

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

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.

Codes

Seethe most recent version of the STORE Manual manual for additional instructions.

000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2 mm to 988 mm)
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

Coding Instructions

Note: *all measurements should be in millimeters (mm)*

Record size in specified order:

1. Size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.
    a. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report checklist). If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.
        - ***Example:*** Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).
        - ***Example:*** Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).
2. If neoadjuvant therapy followed by surgery, do not record the size from the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.
    a. ***Example:*** Patient has a 2.2 cm mass in the oropharynx; find needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22mm).
3. If no surgical resection, then largest measurement of the tumor from the imaging, physical exam, or other diagnostic procedures in this order of priority prior to any other form of treatment (See Coding Rules below).
4. If 1, 2, and 3 do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Coding Rules

1. Tumor size is the **diameter** of the tumor, **not the depth or thickness** of the tumor.
2. Recording less than/greater than Tumor Size:
    a. If tumor size is reported as less than x mm or less than x cm, the reported tumor size should be 1 mm less; for example if size is <10 mm, code size as 009. Often these are given in cm such as < 1 cm which is coded as 009, < 2 cm is coded as 019, < 3 cm is coded as 029, < 4 cm is coded as 039, < 5 cm is coded as 049. If stated as less than 1 mm, use code 001.
    b. If tumor size is reported as more than x mm or more than x cm, code size as 1 mm more; for example if size is >10 mm, size should be coded as 011. Often these are given in cm such as > 1 cm, which is coded as 011, > 2 cm is coded as 021, > 3 cm is coded as 031, > 4 cm is coded as 041, > 5 cm is coded as 051. If described as anything greater than 989 mm (98.9 cm) code as 989.
    c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two (“between 2 and 3 cm” is coded as 025).

3. **Rounding**: Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000). If tumor size is greater than 1millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point one space to the right, converting the measurement to millimeters). For breast cancer, follow the AJCC 8th Edition, Breast Chapter.
    a. ***Examples***
        - Breast cancer described as 6.5 millimeters in size. Round up *Tumor Size as 007*.
        - Cancer in polyp described as 2.3 millimeters in size. Round down *Tumor Size as 002*.
        - Focus of cancer described as 1.4 mm in size. *Round down as 001*.
        - 5.2 mm breast cancer. *Round down to 5 mm and code as 005*.
4. **Priority of imaging/radiographic techniques**: Information on size from imaging/radiographic techniques can be used to code the tumor size when there is no more specific size information from pathology or operative report. It should be taken as a lower priority, but over a physical exam.
5. **Tumor size discrepancies among imaging and radiographic reports**: If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.
6. **Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis**. However, if the tumor is described as a “cystic mass,” and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.
7. Record the size of the invasive component, if given.
    a. If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller.
        - ***Example:*** Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014 (14 mm).
    b. If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.
        - ***Example:*** A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).
        - ***Example:*** Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).
8. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.
    a. ***Example:*** Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).
9. Record the size as stated for purely in situ lesions.

10. **Disregard microscopic residual or positive surgical margins when coding tumor size**. Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data item.
11. **Do not add the size of pieces or chips together to create a whole**; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.
12. **Multifocal/multicentric tumors**: 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 if all of the tumors are in situ, code the size of the largest in situ tumor.
13. **Tumor size code 999 is used when size is unknown or not applicable**. Sites/morphologies where tumor size is not applicable are listed here.
    a. Primary sites: C420, C421, C423-C424, C770-C779 or C809.
    b. Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: histology codes 9590-9993.
        - Excludes cases collected in the following schemas: Lymphoma Ocular Adnexa, Primary Cutaneous Lymphomas, Mycosis Fungoides and lymphomas that are collected in the Brain, CNS Other and Intracranial Gland Schemas
    c. Kaposi Sarcoma
    d. Melanoma Choroid
    e. Melanoma Ciliary Body
    f. Melanoma Iris
14. Tumor size code 000 is used for the following schema:
    a. Schema is Cervical Lymph Nodes and Unknown Primary 00060..
    b. Occult Cervical Lymph Node (See STORE Manual, Overview of Coding Principles, page 44).
15. Document the information to support coded tumor size in the appropriate text data item of the abstract.
16. Tumor size is also important for staging for the some sites/schemas and schema IDs. See the STORE Manual for a full list.

TYPE OF REPORTING SOURCE

Item #	Length
500	1

Alternate Name:	
XML NAACCR ID:	typeOfReportingSource
PARENT XML ELEMENT:	Tumor

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 information may be incomplete on a tumor. For example, death certificate only cases have unknown values for many data items, so one may want to exclude them from some analyses. The 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, but too high a percentage can imply both shortcomings in case- finding and that follow-back to uncover missed hospital reports was not complete.

Codes

1	Hospital inpatient; Managed health plans with comprehensive, unified medical records
2	Radiation Treatment Centers or Medical Oncology Centers (hospital affiliated or independent)
3	Laboratory Only (hospital affiliated or independent)
4	Physician's Office/Private Medical Practitioner (LMD)
5	Nursing/Convalescent Home/Hospice
6	Autopsy Only
7	Death Certificate Only
8	Other hospital outpatient units/surgery centers

Definitions

Comprehensive, unified medical record

- A hospital or managed health care system that maintains a single record for each patient. That record includes all encounters in affiliated locations.

Stand-alone medical record

- An independent facility; a facility that is not a part of a hospital or managed care system.
- An independent medical record containing only information from encounters with that specific facility or practice.

Managed health plan

- Any practice and/or facility where all of the diagnostic and treatment information is maintained in one unit record.
- The abstractor is able to use the unit record when abstracting the case.
- Examples of such facilities: HMOs or other health plan such as Kaiser, Veterans Administration, or military facilities.

Physician office

- A physician office performs examinations and tests. Physician offices may perform limited surgical procedures.
- ***Note:*** The category “physician’s office” also includes facilities that are called surgery centers when surgical procedures under general anesthesia cannot be performed in these facilities.

Unit record

- All records for the patient from all departments, clinics, offices, etc. in a single file with the same medical record number.

Coding Instructions

Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This is a change to reflect the addition of codes 2 and 8 and to prioritize laboratory reports over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

This data item is intended to indicate the completeness of information available to the abstractor. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients, which is why 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.

Priority Order for Assigning Type of Reporting Source

1. Code the source that provided the best information used to abstract the case.
    a. ***Example:*** The only patient record available for a physician office biopsy is the pathology report identified from a freestanding laboratory. Assign code 3 [Laboratory Only (hospital-affiliated or independent)]. Reporting source should reflect the lab where this case was identified. The MD office added nothing to the case, not even a confirmation of malignancy.
2. When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source: Codes: 1, 2, 8, 4, 3, 5, 6, 7.
    a. ***Note:*** Beginning with cases diagnosed 01/01/2006, the definitions for this data item have been expanded. Codes 2 and 8 were added to identify outpatient sources that were previously grouped under code 1. Laboratory reports now have priority over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.
3. SEER recommends that you do **not** make changes to this data item for historic cases in the central cancer registry database; i.e., cases diagnosed prior to January 1, 2006. Conversion of the old codes would be problematic and would require extensive and time-consuming review of original source documents.

Code	Label	Source Documents	Priority
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records	Hospital inpatient Offices/facilities with a comprehensive, unified record HMO physician office or group HMO-affiliated freestanding laboratory, surgery, radiation or oncology clinic Includes outpatient services of HMOs and large multi-specialty physician group practices with unified records.	1
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)	Facilities with a stand-alone medical record Radiation treatment centers Medical oncology centers (hospital affiliated or independent) There were no source documents from code 1.	2
3	Laboratory Only (hospital-affiliated or independent)	Laboratory with a stand-alone medical record There were no source documents from codes 1, 2, 8, or 4.	5
4	Physician's Office Private Medical Practitioner (LMD)	Physician's office that is NOT an HMO or large multi-specialty physician group practice There were no source documents from codes 1, 2, or 8.	4
5	Nursing/Convalescent Home/Hospice	Nursing or convalescent home or a hospice There were no source documents from codes 1, 2, 8, 4, or 3.	6

6	Autopsy Only	Autopsy The cancer was first diagnosed on autopsy. There were no source documents from codes 1, 2, 8, 4, 3, or 5.	7
7	Death Certificate Only	Death certificate Death certificate is the only source of information; follow-back activities did not identify source documents from codes 1, 2, 8, 4, 3, 5 or 6. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1, 2, 8, 4, 3, 5, or 6.	8
8	Other hospital outpatient units/surgery centers	Other hospital outpatient units/surgery centers Includes, but not limited to, outpatient surgery and nuclear medicine services. There were no source documents from codes 1 or 2.	3

VENDOR NAME

Item #	Length
2170	10

Alternate Name:	
XML NAACCR ID:	vendorName
PARENT XML ELEMENT:	Tumor

Description

System-generated. Name of the computer services vendor who programmed the system submitting the data. Abbreviate as necessary and keep a consistent name throughout all submissions. Include software version number where available. 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

Item #	Length
1760	1

Alternate Name:	
XML NAACCR ID:	vitalStatus
PARENT XML ELEMENT:	Patient

Description

Vital status of the patient as of the date entered in Date of Last Contact [1750]. If the patient has multiple tumors, vital status should be the same for all tumors.

Codes

0	Dead
1	Alive