2021 Cancer Reporting Handbook

Rules and Guidelines for Cancer Reporting in Texas

Texas Cancer Registry

Publication No. E10-10677

Released August 2021

TEXAS Health and Human Services

Texas Department of State Health Services

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INTRODUCTION TO CANCER REPORTING

TEXAS CANCER REGISTRY

Preface

With original authorization from the *1979 Texas Cancer Control Act* and the *Texas Cancer Incidence Reporting Act,* Chapter 82, Health and Safety Code (amended April 2015), the Texas Cancer Registry (TCR) of the Texas Department of State Health Services (DSHS) collects information on each patient seeking diagnosis and/or treatment for cancer at health care facilities, clinical laboratories, as well as physician and other outpatient offices (in certain circumstances), within the State of Texas. Texas Administrative Code, Title 25, Part 1, Chapter 91, Subchapter A (amended April 2017) specifies the rules necessary to implement this act. The cancer reporting law and rules may be accessed on the TCR website at the following location: dshs.texas.gov/tcr/lawrules.aspx.

The mission of the TCR is to collect, maintain and disseminate high quality cancer data that contribute towards cancer prevention and control, research, improving diagnoses, treatment, survival, and quality of life for all cancer patients. It is estimated that there will be 127,131 new cancers and 45,858 cancer deaths in the Texas in 2020. A statewide cancer registry is the foundation for cancer prevention and control. The effectiveness of the Cancer Registry is dependent on complete, timely and accurate reporting.

The TCR is one of the largest cancer registries in the United States, and currently meets the National Program of Cancer Registries (NPCR), Centers for Disease Control and Prevention (CDC) high quality data standards, and is Gold Certified by the North American Association of Central Cancer Registries (NAACCR). In May 2021, the TCR became a Surveillance, Epidemiology, and End Results Program (SEER) Registry. Over 240,900 reports of cancer are received annually from over 550 hospitals, cancer treatment centers, ambulatory surgery centers, and pathology laboratories located throughout the state.

The Texas Cancer Registry *2021 Cancer Reporting Handbook* serves as the instruction manual to provide rules and guidelines which assure the consistent collection and coding of relevant cancer case information. This edition should be used for reportable cases diagnosed January 1, 2021 and forward. The contents of this manual are based on the guidelines and standards for cancer reporting established by the National Program of Cancer Registries (NPCR) at the Centers for Disease Control and Prevention (CDC), the North American Association of Central Cancer Registries (NAACCR), the Surveillance, Epidemiology, and End Results Program (SEER) at the National Cancer Institute (NCI), and the American College of Surgeons (ACoS).

The handbook can be accessed on the TCR website at dshs.texas.gov/tcr/training/2021-handbook.aspx.

For any problems contact the TCR. Remember to check the TCR website for training opportunities. This information can be found at dshs.texas.gov/tcr/training.aspx.

HANDBOOK SOURCES

The following sources were used in the preparation of this handbook:

- *SEER Program Coding and Staging Manual 2021* (Published September 2020). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20892. seer.cancer.gov/tools/codingmanuals/.
- *SEER Summary Stage 2018 V2.0 (September 2020)* Ruhl JL, Callaghan C, Hurlbut, A, Ries LAG, Adamo P, Dickie L, Schussler N (eds.) Summary Stage 2018: Codes and Coding Instructions, National Cancer Institute, Bethesda, MD, 2018. seer.cancer.gov/tools/ssm
- *STandards for Oncology Registry Entry (STORE 2021): Updated 2/21. Version 1.0* Commission on Cancer, American College of Surgeons, facs.org/-/media/files/quality-programs/cancer/ncdb/store_manual_2021.ashx
- *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 21* (Posted 8/14/2020; updated 8/17/20; 8/24/20; 8/31/20; 9/18/20; 10/30/20; 11/23/20). North American Association of Central Cancer Registries, Springfield, IL 62704-4194. naaccr.org/data-standards-data-dictionary/.
- *Texas Cancer Incidence Reporting Act* (Amended April 2015), Texas Health and Safety Code, Chapter 82; and Rules, Title 25 Texas Administrative Code, Chapter 91, Subchapter A. Cancer Registry (Effective April 2017). dshs.texas.gov/tcr/lawrules.aspx.
- *Solid Tumor Rules* (Published January 2019) seer.cancer.gov/tools/solidtumor/ Dickie L., Johnson, CH., Adams, S., Negoita, S. (updated December 2020). *Solid Tumor Rules*. National Cancer Institute, Rockville, MD 20850.
- *Site-Specific Data Items (SSDI) /Grade* Last updated: January 11, 2021 *Version 2.0* apps.naaccr.org/ssdi/list/2.0
- *Hematopoietic and Lymphoid Neoplasm Coding Manual* (Updated September 2020). Ruhl J, Adamo M, Dickie L., Negoita. seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf.
- *SEER*Rx Interactive Antineoplastic Drugs Database* (Web-based). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. seer.cancer.gov/seertools/seerrx/.
- *SEER Inquiry System (SINQ).* Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. seer.cancer.gov/seerinquiry/index.php.
- *Physician Data Query (PDQ).* National Cancer Institute, Bethesda, MD 20850-9765. cancer.gov/publications/pdq

Acknowledgment

We wish to acknowledge that some information presented in this handbook was taken verbatim from the SEER Program Coding and Staging Manual 2021 [Adamo M, Groves C, Dickie L, Ruhl J. (September 2020) *SEER Program Coding and Staging Manual 2021*. National Cancer Institute, Bethesda, MD 20892.] U.S. Department of Health and Human Services National Institutes of Health National Cancer Institute.

HELPFUL WEBSITES

dshs.texas.gov/tcr/

seer.cancer.gov/registrars/

cancer.gov/

ncra-usa.org/

naaccr.org/

cancer.org/

iacr.com.fr/index.php

cancerbulletin.facs.org/forums/help

facs.org/quality-programs/cancer/ncdb/call-for-data

cancerstaging.org

tools.usps.com/go/ZipLookupAction_input

zip-codes.com/zip-code/78734/zip-code-78734.asp

melissa.com/lookups/addressverify.asp

wwwn.cdc.gov/nioccs3/SingleCoding.aspx

bls.gov/soc/

nccn.org/

breastcancer.org/

nlm.nih.gov/

anatomyatlases.org/

oralcancerfoundation.org/

pathologyoutlines.com/

whonamedit.com/

docfinder.docboard.org/tx/df/txsearch.htm

txhima.org/

ACRONYMS

ACS	American Cancer Society
ACoS	American College of Surgeons
AJCC	American Joint Committee on Cancer
CDC	Centers for Disease Control and Prevention
CESB	Cancer Epidemiology and Surveillance Branch
CNS	Central Nervous System
CoC	Commission on Cancer
CRH	Cancer Reporting Handbook
CS	Collaborative Stage
DSHS	Department of State Health Services
FIPS	Federal Information Processing Standards
ICD-O-3	International Classification of Diseases for Oncology, 3rd Edition
ICD-O-2	International Classification of Diseases for Oncology, 2nd Edition
MP/H	Multiple Primary and Histology Coding Rules
NAACCR	North American Association of Central Cancer Registries
NPCR	National Program of Cancer Registries, CDC
HSR	Health Service Region
SEER	Surveillance, Epidemiology, and End Results Program, NCI
SINQ	SEER Inquiry System
SSDI	Site-Specific Data Items
STORE	**ST**andards for **O**ncology **R**egistry **E**ntry
TCR	Texas Cancer Registry
TNM	T=Tumor N=Lymph Nodes M=Metastases
WHO	World Health Organization
VSU	Vital Statistics Unit

TCR CODING AND STAGING REQUIREMENT SUMMARY

Coding Cancer Cases

For cancer coding, the correct ICD-O version must be used for all cases according to the year in which the cancer case was diagnosed. If the diagnosis year is unknown, use the year and month in which the case was accessioned. If this process is not applied the cancer case will fail required edits and will not be accepted by the TCR.

Effective for cases diagnosed January 1, 2021 forward, ICD-O-3.2 is the preferred reference for morphology codes. The Work Group strongly recommends using ICD-O-3.2 jointly with the 2021 ICD-O Histology and Behavior Code Update Tables, Solid Tumor Rules, and Hematopoietic and Lymphoid Neoplasm Database.

The 2021 ICD-O-3 Histology Behavior and Update Tables includes comprehensive tables listing all changes made after the 2018 update and is effective for cases diagnosed 1/1/2021 forward. The 2021 tables include coding instructions for cases diagnosed prior to 1/1/2021. Edits will enforce the new codes/behaviors allowed only for cases diagnosed 1/1/2021 forward. Date driven edits will also be implemented for those histology codes no longer valid.

The 2021 ICD-O-3 Update Guidelines includes comprehensive tables listing all changes to ICD-O-3 including new terminology and reportability changes effective for cases diagnosed 1/1/2021 forward. Included in these guidelines are instructions for using the tables together with ICD-O-3.2.

The guidelines also provide background on the project and issues encountered during review of the WHO 4th Edition Classifications of Tumors book series. Issues not covered in the 2021 update include reportability of histology codes with terms that include the words “high grade neoplasia” or “high grade dysplasia” or “severe dysplasia” in digestive system sites. Also, refer to the 2018 Solid Tumor Rules and the Multiple Primary and Histology rules for site specific histology rules.

The SEER Site/Histology Validation List will be updated to include the new ICD-O-3.2 histologies and behaviors and posted on the SEER website seer.cancer.gov/icd-o-3/ .

Use the 2018 Solid Tumor coding rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2018 and forward. The Solid Tumor coding rules and the 2018 General Instructions replace the 2007 Multiple Primary & Histology (MP/H) Rules for the following:

- Breast
- Colon (includes rectosigmoid and rectum for cases diagnosed 1/1/2018 forward)
- Head & Neck
- Kidney
- Lung
- Malignant CNS and Peripheral Nerves
- Non-malignant CNS
- Urinary Sites

Use the 2021 Solid Tumor Cutaneous Melanoma rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2021 forward. The Solid Tumor Cutaneous Melanoma coding rules and the 2018 General Instructions replace the 2007 Multiple Primary & Histology (MP/H) Rules beginning 1/1/2021.

Revision Status for Remaining 2007 Multiple Primary and Histology Site Rules

SEER is currently working on revisions to the Other Sites MP/H module. Release date has not yet been determined. The 2007 MP/H and 2007 General Instructions are to be used, with a few exceptions, for cases for the following site groups until instructed to do otherwise:

- Other Sites

The 2017 Multiple Primary and Histology Rules must be used for all the sites in the Other Sites except for the following sites:

- Rectosigmoid and rectum which are now included in 2018 Solid Tumor Rules under Colon
- Peripheral nerves which are now included in the 2018 Solid Tumor Rules under Malignant CNS

SEER has identified the need to separate select sites into individual modules. These site-specific rules may be individual sections within the Other Sites rules, or free-standing modules. The following sites have been determined to need additional rules: GYN, GI (excluding colorectal), Thyroid, Soft tissue/bone, and Male genital.

Staging Cancer Cases

Directly Coded SEER Summary Stage 2018 is required from all facilities for reporting year 2018 and forward. AJCC TNM data items is required only from facilities accredited by the American College of Surgeons (ACoS) and only for analytical cases. For hospitals and cancer centers that are not ACoS accredited, these data items are required for analytical cases only as available (class of case 00-22).

The TCR currently does not collect EOD 2018 for cases diagnosed in 2018 through 2021. This will be implemented for cases diagnosed January 1, 2022 and forward.

The American Joint Committee on Cancer (AJCC) is making an important change to how it updates and releases Cancer Staging content beginning in 2021. The AJCC will be shifting from a Cancer Staging Manual to a Cancer Staging System and moving away from Editions, to Versions which better align with software development and how users are increasingly consuming AJCC content. The AJCC has started rolling updates with the release of Cervix 9th version. As warranted by medical practice, additional disease sites will be updated in the future as necessary, while the other disease sites will remain unchanged, and the 8th Edition will be used. There will no longer be a single edition or version number applicable to every disease site for the diagnosis year. While references will be made to the 9th version, the registry data item will continue to reference TNM Edition Number [1060]. Additional updates to the AJCC Cancer Staging Manual are always available at cancerstaging.org and available for software developers via the AJCC API. AJCC Cancer Staging questions should be directed to the CAnswer Forum at: cancerbulletin.facs.org/forums/help

For staging cancer cases, all cases must be staged, and the corresponding stage data fields must be completed according to the correct staging guidelines for the year the cancer was diagnosed. If the diagnosis year is unknown, the correct guidelines for the year in which the case is accessioned must be used. Otherwise, the cancer case will fail required edits and will not be accepted by the TCR.

TCR CODING AND STAGING MANUALS

Table 1.1 TCR Coding and Staging Requirement Summary

Coding and Staging Schema	Diagnosis Year
International Classification of Diseases for Oncology, 2nd Edition (ICD-O-2)	1995- 2000*
International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)	2001 - 2020
International Classification of Diseases for Oncology, 3rd Edition 2nd Revision (ICD-O-3.2)	2021- forward
SEER April 1977 Summary Staging Guide	Prior to 2001
SEER Summary Staging Manual 2000 (SSSM2K)	2001 – 2003 2015 – 2017
SEER Summary Stage 2018	2018 - forward
Multiple Primary and Histology Rules	2007 - 2017
Solid Tumor Rules 2018	2018 - forward
Hematopoietic and Lymphoid Neoplasm Coding Manual	2010 – forward
Collaborative Stage Data Collection System Coding Instructions, vs. 02.05	2004 - 2015
AJCC Cancer Staging Manual, Seventh Edition	2015 - 2017
AJCC Cancer Staging Manual, Eighth Edition	2018 -forward
AJCC Cancer Staging System, Version 9	2021 - forward

*The TCR no longer requires reporting of cases diagnosed prior to 1995.

Note:

- Specific CS SSFs are required for 2017 diagnosis cases.
- SSDI's are replacing CS SSF for 2018 and forward diagnosis cases.
- Per SEER, the new coding and staging instructions/guidelines replaces the old for their respective time periods.

TCR REQUIRED SITE SPECIFIC DATA-ITEMS

Collaborative Stage Site-Specific Factors (CS SSFs) have been discontinued and Site-Specific Data Items (SSDIs) are used for collection of site-specific information for cases diagnosed on or after January

1, 2018. See the Data Standards and Data Dictionary, Version 21, Chapter VIII Required Status Table to determine which staging data items are required to be collected by the various standard setters for cases diagnosed on or after January 1, 2021.

Before using the Manual as an information resource for specific data items, it is important to review the introductory materials and general instructions carefully. Although the majority of data items that are collected as SSDIs were previously collected as SSFs, the format of the data items and allowable values have changed substantially, particularly for laboratory values.

An important new concept introduced in 2018 is the use of a **Schema ID** to define the applicable SSDIs and grade table for a particular tumor, based on primary site, histology, and in some cases, additional information. The appropriate Schema ID will be defined by registry software and will not have to be assigned by the registrar. However, a Schema ID Table defining the Schema ID number, description and associated SSDIs is provided in the SSDI Manual for reference purposes. The Schema ID Table will also be useful for registrars abstracting cases before their software is available. In addition to Schema IDs, the Schema ID Table provides the AJCC 8th Edition Chapter for which the SSDIs and grade table defined by the Schema ID apply, with a hyperlink to the page on which the description of the relevant SSDIs begins. A hyperlink at the end of the information on each SSDI can be used to return to the Schema ID Table.

For each SSDI, the SSDI Manual includes:

- NAACCR Data Item Name
- Item Length
- NAACCR Item #
- NAACCR Alternative Name
- AJCC 8th Edition Chapter(s)
- Description
    - The description is a brief summary used to define the data item in the NAACCR data dictionary.
    - The rationale describes the reason why the data item is collected, such as required for staging or recommended for registry data collection by AJCC. If the data item was collected in CSv2, the primary site and SSF# is included in the rationale.
- Definition
    - The definition provides additional background on the data item and its clinical importance. This information was previously included in the CSv2 Manual, Part I, Section II.
- Additional Information
    - This section may include source documents, other names, normal reference ranges and any other information deemed relevant for a particular SSDI. This information was previously included in the CSv2 Manual, Part I, Section II.

- Coding instructions and Codes
    - Coding instructions are provided as numbered notes. Codes are provided in a table.
    - Coding and coding instructions are usually provided in registry software.

Table 1.2 TCR Required SSDI's

NAACCR Item #	Item name	Primary site
1068	Grade Post Therapy Clin (yc)	
3816	Molecular Markers-Brain	Brain Histologies 9400/3, 9401/3, 9440/3, 9450/3, 9451/3, 9471/3, 9478/3
3817	Breslow Tumor Thickness	Melanoma of skin Previously collected in CS SSF#1
3827	Estrogen Receptor Summary	Breast Previously collected in CS SSF#1
3835	Fibrosis Score	Liver Previously collected in CS SSF#2
3855	HER2 Overall Summary	Breast Previously collected in CS SSF#15
3855	HER2 Overall Summary	Esophagus EsophagusGEJunction Stomach Previously collected in CS SSF#15
3838	Gleason Patterns Clinical	Prostate Previously collected in CS SSF#7
3839	Gleason Patterns Pathological	Prostate Previously collected in CS SSF#9
3840	Gleason Score Clinical	Prostate Previously collected in CS SSF#8
3841	Gleason Score Pathological	Prostate Previously collected in CS SSF#10
3842	Gleason Tertiary Pattern	Prostate
3845	Grade Post Therapy (yp)	
3890	Microsatellite Instability (MSI)	Colon and rectum Schema ID 0200
3915	Progesterone Receptor Summary	Breast Previously collected in CS SSF#2
3920	PSA Lab Value	Prostate Previously collected in CS SSF#1
3926	*Schema Discriminator 1	Used to assign AJCC ID

NAACCR Item #	Item name	Primary site
3927	*Schema Discriminator 2	Used to assign AJCC ID
3932	LDH Lab Value ***Note:*** LDH Pretreatment Lab Value [3932] was renamed to LDH Lab Value. The change was made to clarify that LDH may be measured before or after surgical resection.	Melanoma of skin Previously collected in CS SSF#5

*Schema Discriminator 1 - (#3926) Bile Ducts Distal/Bile Ducts Perihilar/Cystic Duct

- Esophagus GE Junction (EGJ)/Stomach
- Histology Discriminator for 9591/3
- Lacrimal Gland/Sac
- Melanoma Ciliary Body/Melanoma Iris
- Nasopharynx/Pharyngeal Tonsil C11.1 only
- Occult Head and Neck Lymph Nodes
- Plasma Cell Myeloma Terminology
- Primary Peritoneum Tumor
- Thyroid Gland/Thyroglossal Duct
- Urethra/Prostatic Urethra

*Schema Discriminator 2 - (#3927) Esophagus and Esophagogastric Junction/Histology Discriminator for 8020/3

- Undifferentiated carcinoma with squamous component
- Undifferentiated carcinoma with glandular component
- Undifferentiated carcinoma, NOS

*Schema Discriminator 2 - (#3927) Oropharyngeal p 16

- p16 expression of weak intensity or limited distribution
- p16 without an immunostain performed.

*Scheme Discriminator 2 – (#3927) Soft Tissue Sarcoma (C473, C475, C493-C495) (Schema IDs: 00410, 00421)

CDC NPCR

Beginning with cases diagnosed January 1, 2021 and forward, CDC-NPCR will adopt the new record format and data collection requirements as published in the Data Standards and Data Dictionary, Version 21. CDC NPCR will require directly assigned Summary Stage 2018 (most current version).

If voluntarily reporting EOD 18, use the most current version available on SEER*RSA, ICD-O-3 2021, and if voluntarily reporting AJCC-TNM, use the most current edition Clinical and Pathological Stage. This data item will become required for the TCR with cases diagnosed January 1, 2022 to meet SEER requirements.

Refer to the CDC-NPCR requirements listed in the Data Standards and Data Dictionary, Version 21, Chapter VIII Required Status Table. Share these requirements with your software vendors and key stakeholders. For more information, see Appendix F Comparisons of Data Sets (page 430).

Note: See TCR Coding and Staging Requirement Summary on page 6 for specific TCR requirements. Beginning with cases diagnosed January 1, 2018, TCR is requiring the TNM data items from facilities who are accredited by the American College of Surgeons (ACoS) and on analytical cases only. For hospitals and cancer centers that are not AcoS accredited, these data items are only required for analytical cases (class of case 00-22) if available.

STANDARD SETTERS STAGING REQUIREMENTS

SEER Summary Stage 2018

Summary Stage 2018 systems will continue to be used for cases diagnosed on or after January 1, 2021. A change log will be made available for the SS2018 revisions. See the Data Standards and Data Dictionary, Version 21, Chapter VIII Required Status Table to determine which staging data items are required to be collected by the various standard setters.

Directly Coded SEER Summary Stage 2018 is required for all cases diagnosed January 1, 2018 and forward from all facilities. See the SEER Summary Stage 2018 Manual for detailed coding instructions.

Summary Stage is the most basic way of categorizing how far a cancer has spread from its point of origin. Historically, Summary Stage has also been called General Stage, California Stage, historic stage, and SEER Stage.

The 2018 version of Summary Stage applies to every site and/or histology combination, including lymphomas and leukemias. Summary Stage uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease. Many central registries report their data by Summary Stage as the staging categories are broad enough to measure the success of cancer control efforts and other epidemiologic efforts.

There are six main categories in Summary Stage. In addition, the main category of Regional stage is subcategorized by the method of spread. The code structure is list in this table.

Code	Description
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

Note: For SS2018, code 5 for "Regional, NOS" can no longer be coded. Code 5 (Regional, NOS) is still applicable for SS2000.

2021 CHANGES

Changes related to cancer coding and staging include 2021 updates to:

- 2021 SEER Coding and Staging Manual
- SEER Extent of Disease (EOD) Manual
- SEER Hematopoietic Manual and Database
- SEER Solid Tumor Rules, Cutaneous Melanoma
- Grade Manual
- Site-Specific Data Items Manual
- ICD-O-3.2
- NAACCR Version 21

The following information is not inclusive of all coding changes. Refer to the manuals for more information.

NEW DATA ITEMS FOR 2021

SSDI Data Items

New SSDIs have been added to capture information related to prognosis and/or treatment planning and reflect changes in clinical guidelines. Two existing SSDIs, [3855] and [3863], will be collected for additional schemas, *Schema Discriminator 2* [3927] will be required for soft tissue sarcomas, and 5

completely new Site-Specific Data Items (SSDIs) have been created. New SSDIs and applicable Schemas are summarized below. Only *Schema Discriminator 2* [3927] for soft tissue sarcomas is required for staging. All of the new SSDI information has been incorporated into the Staging APIs. See the SSDI Manual, Version 2.0 (apps.naaccr.org/ssdi/list/).

Table 1.3 SSDI Data Items

Item #	SSDI Name	Schema
3855	HER2 Overall Summary	Esophagus Squamous (00161) Esophagus (00169) Stomach (00170)
3927*	Schema Discriminatory 2**	Soft Tissue Abdomen and Thoracic (00421) Soft Tissue Trunk and Extremities (00410) Soft Tissue Other (00450)

* These SSDIs exist in other schemas but are new to the schemas listed. The valid values and meanings in the new schemas differ from the existing definition. ** Schema Discriminator 2 [3927] is now required for C473, C475, C493-C495 with respect to Soft Tissue Abdomen and Thoracic or Soft Tissue Trunk and Extremities. These sites can be an external structure or internal viscera, and correct classification within a schema depends on this distinction. For those cases diagnosed in 2018-2020 and already collected, the value '8' should be automatically assigned to indicate the distinction was not captured and these cases will remain in Soft Tissue Abdomen and Thoracic. Registrars have the option of reviewing such cases and assigning a 1, 2, or 9 if they choose, but no standard setter is requesting or expecting this to be done. If it is done, then the schema may change, and the registrar would have to reassign the TNM and EOD fields; Summary Stage would not be affected. Cases diagnosed in 2018-2020 but collected after implementation may also be coded as '8' or may be specifically coded. Code '8' may not be used for cases diagnosed in 2021 or later. See Appendix B, section 12.1 for additional information.

Yc Data Items

The *AJCC Post Therapy Clin (yc) stage* classification has been added. The yc staging will be used for cases receiving neoadjuvant therapy with the planned surgery cancelled for various reasons. TNM data items will go into effect with cases diagnosed January 1, 2021 forward. A new grade data item, Grade Post Therapy Clin (yc), has been added to the Grade Manual (see Link to Change Log and naaccr.org/SSDI/Grade-Manual.pdf). *Grade Post Therapy Clin (yc)* is applicable for cases diagnosed January 1, 2021 forward.

- AJCC TNM Post Therapy Clin (yc) T [1062]

- AJCC TNM Post Therapy Clin (yc) T Suffix [1063]
- AJCC TNM Post Therapy Clin (yc) N [1064]
- AJCC TNM Post Therapy Clin (yc) N Suffix [1065]
- AJCC TNM Post Therapy Clin (yc) M [1066]
- AJCC TNM Post Therapy Clin (yc) Stage Group [1067] (*Not yet available in v21)
- Grade Post Therapy Clin (yc) [1068]

These data items have the same valid value lists as the corresponding *Post Therapy Path (yp)* data items for each site. The notes associated with the lookups indicate when they should be left blank.

These data items can be found in STORE v2 and are applicable for cases diagnosed January 1, 2021 forward.

Name-Birth Surname

The last name (surname) of patients at birth, regardless of gender or marital status, data item is introduced in 2021 as a gender-neutral replacement for the NAACCR data item *Name—Maiden* [2390]. Allowable values for *Name–Birth Surname* [2232] are identical to those used for *Name—Maiden*, and the NorthCon 210 Registry Plus Utility Program will move values that have been in *Name—Maiden*. Other alternate names should continue to be recorded in the data item, *Name—Alias*. The *Name-Birth Surname* 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. There are data queries and algorithms that will be affected by this change that should be identified and updated.

CHANGED DATA ITEMS

Name - Alias

The description of this data item has been updated to refer to *Name—Birth Surname* in place of *Name—Maiden*, as an alternate name that should not be entered in *Name—Alias*.

Radiation Treatment Modality

When the data item *Phase I Radiation Treatment Modality* [1506] was implemented in v18 a code indicating radiation was given but type of radiation unknown was not included. Currently patients that receive radiation, but the modality is not known are assigned a code 99. Code 99 is also used when it is unknown if radiation is given. This makes it difficult to distinguish patients that did receive radiation from those where it is unknown if radiation was given. Code 98 is added to the data item *Phase I Radiation Treatment Modality* for cases where it is known radiation was given, but modality is unknown. Code 99 is only used when it is unknown if radiation was given. The new code and changed code may be used for all cases abstracted after the v21 implementation regardless of diagnosis year.

Name Changes

LDH Pretreatment Lab Value [3932] was renamed to *LDH Lab Value*. The change was made to clarify that LDH may be measured before or after surgical resection.

In addition to these changes, which require conversion, some SSDIs had new codes added which would be available for newly collected cases but do not require changes to existing cases. Some code descriptions were modified to improve clarity. There have also been revisions to notes and additional notes for many SSDIs; due to the addition of new notes, many of the note numbers have changed. See the SSDI Manual, Version 2.0 (apps.naaccr.org/ssdi/list/) for changes to existing codes and code descriptions. New SSDIs and code changes are incorporated in the AJCC Cancer Surveillance Staging API and the SEER Staging REST API/library. Other than updating the staging API that you use, there is no need for action for these types of changes. They are documented in the change log which can be accessed on apps.naaccr.org/ssdi/list/.

Grade

In addition to the new *Grade Post Therapy Clin (yc)* [1068] data item and renaming *Grade Post Therapy* [3845] to *Grade Post Therapy Path (yp)* for clarity, changes were made to several grade fields that will require conversion.

- The Grade fields for Lacrimal Gland have had Codes A-D removed, and Code 4 has been added. Since Code 1 and Code A both meant Well Differentiated, and similarly for codes 2 and B, codes 3 and C, it was decided to streamline the available codes. Code 4 was added to capture the Undifferentiated, anaplastic cases.
- The Grade fields for Lymphoma Ocular Adnexa have been modified. Codes 5 and L have been removed, and the text of Codes 3 and 4 have been revised. Code 3 is now G3, more than 15 centroblasts per 10 HPF but with admixed centrocytes. Cases that used to have Code 4 should be changed to Code 3. Code 4 is now G4, more than 15 centroblasts per 10 HPF but without centrocytes. Cases that used to have Code 5 should be changed to Code 4. Code L, Low Grade (1 or 2) was determined to be a variation of Unknown, so cases that used to have L should be changed to Code 9.

Notes have been added to all the Grade tables in response to questions from registrars. Due to the addition of new notes, many of the note numbers have changed. These updates can be applied to cases diagnosed January 1, 2018 forward; however, registrars are not required to update previously coded grade information based on the new notes. Grade changes are incorporated in the AJCC Cancer Surveillance Staging API and the SEER Staging REST API/library. Other than updating the staging API that you use, there is no need for action for these types of changes. They are documented in the change log which can be accessed on apps.naaccr.org/ssdi/list/.

REVISED INSTRUCTIONS FOR 2021

There are revised instructions related to *Scope of Lymph Node Surgery* code 1 (Biopsy or aspiration of regional lymph node, NOS).

Do not count Scope of Lymph Node Surgery code 1 as surgery for the purpose of coding these data items:

- Date Therapy Initiated [SEER}
- Date First Course Treatment [CoC]
- Treatment Status
- Date of First Surgical Procedure
- Radiation Sequence with Surgery
- Systemic Sequence with Surgery

REPORTABILITY FOR 2021

Reportability for cases diagnosed in 2021 is based on the ICD-O-Third Edition, Second Revision Morphology (ICD-O-3.2). The following changes are also applicable for cases diagnosed in 2021.

- Early or evolving melanoma, in situ and invasive: As of 01/01/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.
- As of 01/01/2021, all GIST tumors are reportable and classified as 8936/3 in ICD-O-3.2.
- As of 01/01/2021, nearly all thymomas are reportable; the exceptions are microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0).

For 2021, major changes apply to reportability: sixteen previously non-reportable neoplasms become reportable; nine reportable pre-2021 neoplasms become non-reportable; ten histology terms have been moved to other ICD-O codes; thirteen histologies have a change in reportable terminology and twelve new terms/ICD-O codes.

While all of the standard setters approved implementation of these changes, the work group recommends you refer to the appropriate program manual for further guidance on reportable neoplasms. It is important to understand that cancer registry reportability rules based on behavior code still apply.

Note: With the exception of primary intracranial and central nervous system benign and borderline tumors, the addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable.

2018 SOLID TUMOR CODING RULES

(Formerly known as Multiple Primary and Histology Rules)

The 2018 Solid Tumor Coding Rules will be used for cases diagnosed January 1, 2018 and forward as well as the 2007 Multiple Primary and Histology Rules for Other Sites (excluding rectum and rectosigmoid, peripheral nerves) and the 2021 Solid Tumor Cutaneous Melanoma Rules. The 2018 Solid Tumor Rules must be used for all sites mentioned in the General Guidelines. The 2018 Solid Tumor Coding Rules are a comprehensive revision to the 2007 site-specific Multiple Primary and Histology Rules, which were developed to promote consistent and standardized coding for cancer

surveillance. Use the 2021 Solid Tumor Cutaneous Melanoma Rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2021 forward. Visit the SEER website to download the manual.

2021 Updates to 2018 Site-Specific Instructions

The eight site groups which were updated in 2018 will include minor updates* for 2021:

- New histologies, codes, and terms from ICD-O-3.2 and the 2021 ICD-O Update added to tables
- Corrections to histology tables
- Additional H rules to enforce correct histology coding
- Clarification of coding histology prior to neo-adjuvant therapy
- Clarification to Malignant and Benign CNS Terms & Definitions: WHO Grade II and behavior
- Additional notes and examples

*Updates will not require review of previously abstracted cases.

Cutaneous Melanoma Solid Tumor Rules

Site specific instructions for Cutaneous Melanoma have been updated for cases diagnosed January 1, 2021 forward. What to expect in the 2021 Cutaneous Melanoma rules:

- Solid Tumor Rules available in text format only
- Terms and Definitions are now included with the M-rules and H-rules
- New table for coding primary site and laterality
- Reportable and non-reportable histology tables
- Histology table updated to include WHO 4th Ed Skin Tumors, 2021 ICD-O update, and ICD-O-3.2

Site Specific Changes From 2007 MP/H Rules to 2021 Solid Tumor Cutaneous Melanoma Rules

The following information is not inclusive of all sites and does not list the Multiple Primary and Histology rules. This section summarizes the addition of the 2021 Solid Tumor Rules. Go to the **2018 Solid Tumor Rules** for full coding instructions on all sites. These changes are effective with cases diagnosed 1/1/2021 and later.

Changes from the 2007 MPH Rules

These changes are effective with cases diagnosed 1/1/2021 and later. WHO 4th Ed Classification of Skin Tumors was published in 2018.

1. 2007 Rules instruct “Code the histology from the most representative specimen.” For all sites except breast and CNS, the 2021 Rules instruct “Code the most specific histology from biopsy or resections”. When there is a discrepancy between the biopsy and resection (two distinctly different histologies), code the histology from the most representative specimen (the greater amount of tumor).” This instruction applies to the 2021 cutaneous melanoma solid tumor rules.
2. Early/evolving melanoma in situ (8720/2) and early/evolving melanoma invasive (8720/3) are reportable for cases diagnosed 1/1/2021 and later. Refer to SEER Program Coding and Staging Manual 2021 for additional information on reportable neoplasms.
3. New histology terms are included (identified by asterisks (*) in the histology table in the Terms and Definitions). No new cutaneous melanoma ICD-O histology codes have been proposed by WHO.
4. Some histologies are rare and may not be listed in the tables; refer to ICD-O and all updates. If the histology is not found in the tables or ICD-O, submit a question to Ask a SEER Registrar.
5. WHO 4th Ed Skin Tumors now classifies melanocytic tumors into two groups: A. Melanomas arising in sun-exposed skin B. Melanomas arising at sun-shielded sites or without known etiological association with UV radiation exposure.

See the 2021 Solid Tumor Cutaneous Melanoma Rules for more information and for full coding instructions for all sites above.

December 2020 Revision History for the Solid Tumor Rules

Solid Tumor Revision History

The Solid Tumor download page includes a section for revision history which includes comprehensive change logs for each update. The change logs are for reference only and should not be used in place of the solid tumor rules.

Questions regarding the Solid Tumor Rules should be directed to Ask a SEER Registrar at: seer.cancer.gov/registrars/contact.html

Changes Across All Site Modules:

- Priority Order for Using Documentation to Identify Histology: Guidance was clarified regarding coding histology when neoadjuvant therapy is given
- "Majority; major; predominantly; greater than 50%" removed from equivalent terms and definitions in all sections (module-specific histology sections take precedence)
- Bullet added to the note in all instances of the "same row rule" for site modules where histology tables contain nested subtypes/variants in column 3:
    - "A NOS histology in column 3 with an indented subtype/variant"

Urinary:

- Table 1: ICD-O Primary Site Codes
    - "Urachal remnant" added as synonym for C67.7

Colon:

- GIST reportability updated for cases diagnosed 2021+
- Colon wall illustrations added, which correspond with the anastomosis M Rules.
- Table 1: Specific Histologies, NOS/ NST, and Subtypes/Variants
- MANEC 8244 Row:
    - “Adenocarcinoma ex-goblet cell” added as a synonym
    - “Goblet cell adenocarcinoma” added to 8243 (updated terminology)
- GIST 8936 Row:
    - “GIST, NOS” and “Gastrointestinal stromal sarcoma” added as synonyms
- Multiple Primary Rules
- Note added to anastomotic site rules: "A rectal stump is an anastomotic site"
- Histology Coding Rules
- H5 Invasive mucinous adenocarcinoma rule: Sub-bullet added
    - Mucinous carcinoma must meet a percentage requirement in order to be coded. Do not use majority of tumor, predominantly, or predominant part of the tumor to code mucinous 8480.
- Rule H6 added: NEW RULE
    - Code invasive signet ring cell adenocarcinoma 8490 when the diagnosis is any of the following:
        - Exactly signet ring cell carcinoma (no modifiers)
            - Adenocarcinoma and signet ring cell carcinoma, where signet ring cell is documented to be greater than 50% of the tumor
                - Signet ring cell adenocarcinoma must meet a percentage requirement in order to be coded. Do not use majority of tumor, predominantly, or predominant part of tumor to code to signet ring cell 8490.
- Rule H7 Code adenocarcinoma NOS when the final diagnosis is…
    - Percentage requirement clarified as less than or equal to 50%

Head and Neck:

- C442 removed from H&N module. C442 with reportable histologies other than melanoma fall into “Other Sites” rules.
- Equivalent or Equal Terms:
    - "Hemangiosarcoma; angiosarcoma" added
    - “Malignant hemangioendothelioma; angiosarcoma” deleted
- Terms that are NOT Equivalent or Equal:
    - “p16 negative is not equivalent to HPV negative” added
- Table 1: Tumors of Nasal Cavity, Paranasal Sinuses and Skull base
    - Non-keratinizing squamous cell carcinoma 8072 row:
        - “Cylindrical cell carcinoma” and “Schneiderian carcinoma” moved from synonyms to subtype/variant column as histology code 8121
    - Sarcoma 8800 row:
        - “Malignant hemangioendothelioma 9130/3” added
- Table 3: Tumors of Pyriform Sinus, Hypopharynx, Larynx, Trachea, and Parapharyngeal Space
    - Squamous cell carcinoma (SCC) 8070 row:
        - “Keratinizing squamous cell carcinoma 8071” added as a subtype/variant
        - “Non-keratinizing squamous cell carcinoma 8072” added as a subtype/variant
- Table 4: Tumors of Oral Cavity and Mobile Tongue
    - Kaposi sarcoma 9140 row:
        - Deleted (Kaposi sarcoma is excluded from H&N module)
    - Squamous cell carcinoma 8070 row:
        - “Keratinizing squamous cell carcinoma 8071” added as a subtype/variant
        - “Non-keratinizing squamous cell carcinoma 8072” added as a subtype/variant
- Table 5: Tumors of the Oropharynx, Base of Tongue, Tonsils, Adenoids
    - Squamous cell carcinoma (SCC) 8070 row:
    - Note added clarifying the use of p16 IHC to code 8086
- Table 8: Tumors of Ear and External Auditory Canal
    - C442 removed from table and table name updated
    - Ceruminous adenocarcinoma 8420 row:
        - Deleted
- Table 9: Paraganglioma of Carotid Body, Larynx, Middle Ear, Vagal Nerve

- Paraganglioma codes separated into pre-2021 and 2021+

Malignant CNS

- Table 1: WHO Grades for Select CNS Neoplasms
  - Section Added: WHO Grade II CNS Tumors
  - Instructions amended to included "and WHO Grade 2 neoplasms with malignant /3 behavior"
- Table 2: Reportable Primary Sites and Histologies
  - “Conus medullaris/filum terminale” site code corrected to C720
  - “Nerves of Pelvis C475” added
- Multiple Primary Rules
  - Clarified that a subsequent glioblastoma multiforme (GBM) in residual tumor is not a new primary (must be a separate GBM)

Non-Malignant

- Introduction
  - Note 5 regarding Pilocytic astrocytoma/optic nerve glioma clarified
- Table 1: WHO Grades for Select CNS Neoplasms
  - Section Added: WHO Grade II CNS Tumors
- Table 2: Reportable Primary Sites and Histologies
  - “Conus medullaris/filum terminale” site code corrected to C720
- Table 4: Non-Reportable Neoplasms
  - Neurofibromatosis row added
- Table 5: Histologic Types of Non-Malignant Intracranial (Brain and Glands) Tumors
  - Pilocytic astrocytoma/juvenile pilocytic astrocytoma 9421/1 row
  - Posterior fossa C719, cerebrum C710 removed;
  - Optic nerve C723 added
- Table 6: Specific Histologies, NOS, and Subtypes/Variants
  - Neurocytoma 9506/1 row added
  - Pituitary adenoma 8272 row: The following terms added as synonyms:
    - Gonadotroph adenoma
    - Somatotroph adenoma

- Thyrotroph adenoma
- Null cell adenoma
- Plurihormonal and double adenomas

Breast

- Table 2: Histology Combination Codes
  - Invasive carcinoma NST/duct carcinoma and invasive lobular carcinoma 8522 row
    - Note 2 added " This is the exception to the instruction features are not coded."
    - New row added for metaplastic carcinoma AND ductal or lobular
- Table 3: Specific Histologies, NOS/ NST, and Subtypes/Variants
  - Medullary Carcinoma 8510 row:
    - "Medullary carcinoma with lymphoid stroma 8512" added as a subtype/variants
  - Metaplastic Carcinoma 8575 row:
    - Note 2 added
  - Periductal Stromal Tumor, low grade 9020 row:
    - Terminology updated to "Phyllodes tumor, malignant"
    - "Periductal stromal tumor, low grade" added as a synonym
    - "Cystosarcoma phyllodes, malignant" added as a synonym
  - Sarcoma 8800 row:
    - Histology code 9130/3 added to Malignant hemangioendothelioma
    - Note 2 added regarding Angiosarcoma subtypes
  - Ductal carcinoma 8500 row:
    - "Intraductal carcinoma 8500/2" added as a synonym
    - "Carcinoma, NOS" added as a synonym
  - Paget disease of the nipple with no underlying tumor 8540 row:
    - Behavior code removed
  - Papillary carcinoma 8503 row:
    - "Intraductal papilloma with ductal carcinoma in situ 8503/2" added as a synonym
- Multiple Primary Rules
  - New notes before Multiple Tumors MP module:
    - "ER, PR, and/or HER2 are not used to determine multiple primaries."

        - "A Subsequent tumor in the chest wall or surgical scar without evidence of residual breast tissue are regional metastasis."
- Rule M10 Abstract a single primary when multiple tumors of the same behavior are carcinoma NST/duct and lobular.
    - Same behavior requirement re-added.
- Histology Coding Rules
    - New H rule: H6 Coding pleomorphic lobular carcinoma in situ
    - New H rule: H13 Coding metaplastic carcinoma when invasive carcinoma NST is present

Lung

- Table 2: Combination/Mixed Histology Codes
    - Combined large cell neuroendocrine carcinoma 8013 row added
- Table 3: Specific Histologies, NOS, and Subtype/Variants
    - Adenocarcinoma 8140 row:
        - "Minimally invasive adenocarcinoma" added as synonym
        - "Enteric adenocarcinoma/pulmonary intestinal-type adenocarcinoma 8144": Terms swapped order
    - Large cell neuroendocrine carcinoma/combined large cell neuroendocrine carcinoma 8013/3
        - Histology removed from sarcoma row and added to its own row
- Multiple Primary Rules
    - Rule M6 Subtype/variant rule: Note 2 added that tumors may be different behaviors
    - Rule M9 Simultaneous multiple tumors in…
        - Updated notes 1 and 2 to include examples for 8000 and 8010
- Histology Coding Rules
    - Rule H3 Code the specific histology when the diagnosis is non-small cell lung carcinoma (NSCLC) consistent with (or any other ambiguous term) a specific carcinoma…
        - Rule reordered for readability (no changes to rule meaning)
    - Clarified histology coding for equal percentages of adenocarcinoma subtypes throughout histology rules and histology tables
    - Rule H10 Code mucinous adenocarcinoma (for lung only) when all tumors consist of…
        - Note 1 removed from H10 (does not apply to multiple tumors abstracted as a single primary)

2007 Multiple Primary & Histology Rules (MP/H): Other Sites

The Other Sites rules are currently being revised. Continue to apply the 2007 MP/H Other Sites Rules for cases diagnosed January 1, 2007 through December 31, 2021.

Visit the SEER website to obtain a copy of the current 2018 Solid Tumor Rules Manual.

How to Use the Multiple Primary Rules

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

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

b. When the number of tumors is unknown/not documented, use the "Unknown if Single or Multiple Tumors" module. When there is a tumor or tumors with separate microscopic foci, ignore the microscopic foci.

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

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

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

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

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

Do not use physician staging to determine multiple primaries.

How to Use the Histology Rules

- Do not use these rules to determine case reportability.
- First use the Multiple Primary Rules to determine whether this is a single primary or multiple primaries. Determine the histology for each case.

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

    a. Each section is a complete set of rules.

    b. Within each section, the rules are hierarchical. Use the first rule that applies and stop. Do not continue through the rules.

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

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

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

Code a histology when described by ambiguous terminology only when:

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

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

e. Case is accessioned (added to your database) based on a single histology described by ambiguous terminology and no other histology information is available/documented.

Note: If the histology described by ambiguous terminology does not meet one of the criteria above do not code the histology.

Ambiguous Terminology

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

Ambiguous terminology from the SEER Manual and CoC Manual is used to determine reportability, not to determine histology.

Timing Rules

Each Solid Tumor site group includes timing rules in the Multiple Primary Rules. It is important to remember that timing rules differ by site. See 2018 Solid Tumor Rules (page 17) for more information.

ICD-O-3 HISTOLOGIES

As of April 2019, the International Agency for Research on Cancer (IARC) and the WHO ICD-O committee, finalized ICD-O-3.2. ICD-O-3.2 includes changes from all twelve 4th Edition Classification of Tumor books. The Work Group recommended ICD-O-3.2 be implemented 1/1/2021 to which the standard setting agencies agreed. Beginning with cases diagnosed 1/1/2021, ICD-O-3.2 is the preferred morphology coding reference manual. The Work Group strongly recommends using ICD-O-3.2 jointly with the 2021 ICD-O Histology and Behavior Code Update Tables, 2018 Solid Tumor Rules, and Hematopoietic and Lymphoid Neoplasm Database.

The 2021 ICD-O-3 Histology and Behavior Code Update Tables includes comprehensive tables listing all changes made after the 2018 update and is effective for cases diagnosed 1/1/2021 forward. The 2021 tables include coding instructions for cases diagnosed prior to 1/1/2021. Edits will enforce the new codes/behaviors allowed only for cases diagnosed 1/1/2021 forward. Date driven edits will also be implemented for those histology codes no longer valid.

The ICD-O-3 Implementation Work Group created a guide for users which provides important information on the background and issues for this update along with how to use the tables. The 2021 ICD O 3.2 Coding Guidelines include specific tables listing histologies which have changed behavior codes. These new behavior codes resulted in a change to reportability. Along with changes to behavior codes, several histology terms that were previously non-reportable are now reportable. A table listing these terms is also included in the guidelines. The Work Group strongly recommends users read the guidelines in order to efficiently use ICD-O-3.2 and the 2021 Update tables.

SEER HEMATOPOIETIC AND LYMPHOID NEOPLASM DATABASE

The updated SEER Hematopoietic and Lymphoid Neoplasm Database will be applicable for cases diagnosed 2010 and forward. This manual and the corresponding database are to be used for coding cases diagnosed January 1, 2010 and forward. The changes made do not require registrars to recode old cases.

Important changes for 2021

Histology Changes

New histologies. These histologies can only be used for cases diagnosed 2021+:

- 9715/3: Anaplastic large cell lymphoma, ALK-negative/ Breast implant-associated anaplastic large cell lymphoma
- 9749/3: Erdheim-Chester Disease
- 9766/3: Lymphomatoid granulomatosis grade 3
- 9819/3: B-lymphoblastic leukemia/lymphoma, BCR-ALB1 like
- 9877/3: Acute myeloid leukemia with mutated NPM1
- 9878/3: Acute myeloid leukemia with biallelic mutation of CEBPA
- 9879/3: Acute myeloid leukemia with mutated RUNX1
- 9912/3: Acute myeloid leukemia with BCR-ABL1
- 9968/3: Myeloid/lymphoid neoplasm with PCM1-JAK2
- 9993/3: Myelodysplastic syndrome with ring sideroblasts and multilineage dysplasia

The following histologies are new but are /1 and not reportable. They have been included in the Hematopoietic Database for informational purposes only:

- 9591/1: Monoclonal B-cell lymphocytosis, non-CLL type
- 9673/1: In situ mantle cell neoplasia
- 9680/1: EBV-positive mucocutaneous ulcer
- 9695/1: In situ follicular neoplasia
- 9702/1: Indolent T-cell lymphoproliferative disorder of the gastrointestinal tract
- 9709/1: Primary cutaneous CD4-positive small/medium T-cell lymphoproliferative disorder (previously listed as an alternate name in 9709/3)
- 9738/1: HHV8-positive germinotropic lymphoproliferative disorder
- 9761/1: IgM monoclonal gammopathy of undetermined significance
- 9823/1: Monoclonal B-cell lymphocytosis, CLL-type

Changes in Reportability

1. The following histologies are now a /1 (instead of a /3) and are no longer reportable starting with 2021 diagnoses:
    a. 9725/3: Hydroa vacciniforme-like lymphoma (New preferred name: Hydroa vacciniforme-like lymphoproliferative disorder)

b. ***Note:*** See 9725/1 for 2021+

c. 9971/3: Post-transplant lymphoproliferative disorder (PTLD) ***Note:*** See 9971/1 for 2021+

The following histology codes and terms are obsolete and have a new code starting with 2021 diagnoses:

d. 9826/3: Burkitt Leukemia (for diagnosis 2021+, coded as 9687/3 Burkitt lymphoma with primary site C421)

e. 9991/3: Refractory neutropenia (for diagnosis 2021+, coded as 9980: Myelodysplastic syndrome with single lineage dysplasia)

f. 9992/3: Refractory thrombocytopenia (for diagnosis 2021+, coded as 9980: Myelodysplastic syndrome with single lineage dysplasia)

Change in histology 9751/3

g. Only Langerhans cell histiocytosis, disseminated is a /3 for 2021+ diagnoses. All other terminology, including Langerhans cell histiocytosis, NOS, is now a /1 (see updated alternate names list when "help me code for diagnosis" is 2021)

Coding Diagnostic Confirmation

- Code 1: Added "includes peripheral blood smear"
- Code 3: Added "includes peripheral blood smear followed by flow cytometry"
- Code 5: Added Note 2: This does not include cases where a peripheral blood smear is done (code 1) and peripheral blood smear followed by flow cytometry (code 3)

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

- Code 1: Positive histology
- 4b: White blood count (WBC)

  Note: A registrar may not abstract a hematopoietic neoplasm based on a CBC or WBC with abnormal counts alone. There must be a diagnosis of a reportable Heme neoplasm on the CBC or WBC report or a subsequent physician diagnosis based on the WBC or CBC.
- Code 3: Positive histology PLUS positive immunophenotyping or genetic testing
- Added 1c: Peripheral blood smear followed by flow cytometry (most commonly done with CLL/SLL, 9823/3)

  Note: Flow cytometry studies are normally done based on an abnormal blood smear. If unable to find documentation that a peripheral blood smear was done first, assume that it was and code 3

  Example: Peripheral blood flow cytometry report: Flow cytometry express HLA-DR, CD5, CD19, moderate CD20, CD22, bright CD45, bright CD200 and exhibit lambda immunoglobin light chain restriction by intracellular staging. These cells lack expression of CD38. Taken

together, these results demonstrate the presence of a clonal population of B-cell, immunophenotypically diagnostic of CLL/SLL

- Code 5: Positive laboratory test/marker study

  Note: Do not use this code when a peripheral blood smear is done (which qualifies for a code 1) or a peripheral blood smear followed by flow cytometry (which qualifies for a code 3). Flow cytometry studies are normally done based on an abnormal peripheral blood smear. If unable to find documentation that a peripheral blood smear was done first, assume that it was and code 3

New Section in 2021

- Appendix D (New): Introduction to Genetic Nomenclature.

COMPLIANCE

To assure timely and complete cancer case reporting in Texas, TCR monitors compliance with the Texas Cancer Incidence Reporting Act. The TCR Health Service Regions routinely monitor facility submissions of case reports. If submissions are not received complete and in a timely manner according to our current law and rules, the facility registrar/reporter will be contacted regarding the delinquent reporting status.

Further action, which may include cost recovery procedures, will be instituted if submissions continue to be delinquent. These actions are necessary to meet the state and national requirements for timely cancer data submissions.

To be compliant with the law, all records must be submitted within 6 months of initial diagnosis, or admission with active disease, or treatment for cancer at your facility. Cancer reporting rules require monthly submissions from health care facilities with an annual caseload of greater than 400 and at least quarterly submissions for health care facilities with an annual caseload of 400 or fewer. Weekly submissions from all facilities is strongly recommended.

Table 1.4 Case Submission Requirements

Caseload	Submission
>400	Monthly
Equal to or <400	≥ Quarterly

Small Cancer Caseload Facilities (125 or fewer)

TCR developed the "Small Facility Casefinding and Data Collection Program" with the goal to increase and improve the reporting and data quality of cancer cases, as required by the *Texas Cancer Incidence Reporting Act (Chapter 82, Texas Health and Safety Code)*, from Texas facilities with 120 or fewer expected cancer cases. TCR staff will conduct the casefinding and data collection activities for these

facilities. Facilities will be contacted regarding their facility's compliance and eligibility for participation in this program.

Note: Hospital Reporting instructions, as well as reporting laws and rules can be found on the TCR website: dshs.texas.gov/tcr/

Timeliness of Data Submission

Timeliness of case reporting is important; however, data quality and completeness must be assured as well. Researchers, epidemiologists, health planners, clinicians, and laypersons benefit from access to the most current information. Due to reporting requirements of CDC and TCR, all reports of cases shall be submitted to TCR within six months of initial diagnosis or admission at their facility with active disease and/or treatment of cancer. This information is in *Section 91.5(a) (When to Report*) of the Cancer Registry Rules. Refer to the TCR's Cancer Reporting Law and Rules webpage for more information regarding reporting timeliness: dshs.texas.gov/tcr/lawrules.aspx

Timely Reporting Calendar

The TCR Reporting Calendar reflects this extension and can be found online at dshs.texas.gov/tcr/reporting/hospitals.aspx.

TCR Timely Reporting Calendar

Cases admitted in:	Reported no later than:
January 2021	July 2021
February 2021	August 2021
March 2021	September 2021
April 2021	October 2021
May 2021	November 2021
June 2021	December 2021
July 2021	January 2022
August 2021	February 2022
September 2021	March 2022
October 2021	April 2022
November 2021	May 2022
December 2021	June 2022

REGIONAL CONTACTS

Table 1.5 Regional Contacts

REGISTRY OPERATIONS MANAGER **Miriam Robles, RHIT, CTR** 1100 W. 49th Street Austin, TX 78756 Phone: 512-776-3609 Cell: 512-413-4029 Email: Miriam.Robles@dshs.texas.gov	**REGISTRY OPERATIONS** **Allison Vasquez, BS, CTR** **Program Specialist (Data Acquisition)** 1100 W. 49th Street Austin, TX 78756 Phone: 512-776-2696 Email: Allison.Vasquez@dshs.texas.gov **PATHLAB/NON-HOSPITAL REPORTING** **Susan Perez, RHIT, CTR** Registry Operations Manager Phone: 512-776-3605 Email: Susan.Perez@dshs.texas.gov
HEALTH SERVICE REGIONS 2, 3, 4 **Debra Anderson, BS, CTR** Regional Program Specialist (Team Lead) Texas Department of State Health Services Texas Cancer Registry 1301 S. Bowen Rd., Ste. 200 Arlington, TX 76013 Phone: 817-264-4594 Fax: 817-264-4597 Email: Debra.Anderson@dshs.texas.gov	**HEALTH SERVICE REGIONS 1,7,9** **Jodi Vasquez, CTR, RHIT** Regional Program Specialist (Team Lead) 1100 W. 49th Street Austin, TX 78756 Phone: 512-776-3607 Fax: 512-776-7681 Email: Jodi.Vasquez@dshs.texas.gov
HEALTH SERVICE REGIONS 5, 6 **Marie Gallegos, CTR** Regional Program Specialist (Team Lead) Texas Department of State Health Services Texas Cancer Registry 5425 Polk Ave. Houston, TX 77023-1497 Phone: 713-767-3183 Fax: 713-767-3284 Email: Marie.Gallegos@dshs.texas.gov	**HEALTH SERVICE REGIONS 8, 10, 11** **Kavitha Madishetty, PhD- , CTR** Regional Program Specialist (Team Lead) 1100 W. 49th Street Austin, TX 78756 Phone: 512-776-3625 Fax: 512-776-7681 Email: Kavitha.Madishetty@dshs.texas.gov

Visit dshs.texas.gov/tcr/contact.aspx#regions to see a map of the Health Service Regions and to view the most current regional contact list.

2

STANDARDS FOR CONFIDENTIALITY, DISCLOSURE OF DATA, AND QUALITY ASSURANCE

CONFIDENTIALITY

Data obtained under the Texas Cancer Incidence Reporting Act are for the confidential use of the Texas Department of State Health Services, including persons, and public or private entities that are necessary to carry out the public health interests of the Act. The data are privileged and may not be divulged or made public in a manner that discloses the individual identity of any patient. All reporting entities that are performing in compliance with the Act are immune from civil and criminal liability for furnishing the required information.

DISCLOSURE OF DATA

All data reported to TCR are available for use in aggregate form for analysis by facility registry staff, physicians, health care workers, cancer researchers, and the public. Reports of cancer incidence are available on the TCR website under Cancer Statistics. A Web Query Tool which generates customized maps and tables of Texas cancer incidence and mortality rates is also available on the website at dshs.texas.gov/tcr/data.aspx. Public access to aggregate data is available through published reports, or through TCR, if in accordance with its data release policies and procedures.

TCR may exchange patient-specific data with the respective reporting facility, any other cancer-control agency, clinical facility, pathology laboratories, or physician's offices for the purpose of obtaining information necessary to complete the abstract or follow-up information, provided that these agencies and facilities comply with the TCR's confidentiality policies. However, no facility-specific patient information can be released unless authorized under law. TCR will not release information from one facility to a different facility under any circumstances. TCR can contact the facility where the patient was seen and obtain consent to release information other than that authorized by law under special circumstances.

To achieve complete case ascertainment, TCR may exchange patient-specific data with other state cancer registries if reciprocal data sharing agreements and confidentiality provisions are implemented.

TCR may grant researchers access to confidential information concerning individual cancer patients, provided that those researchers comply with the provisions and confidentiality policies mandated by the Texas Department of State Health Services Institutional Review Board.

QUALITY ASSURANCE

TCR implements an extensive series of quality assurance procedures that are based on the SEER Program, CDC recommendations, and NAACCR standards. These procedures, which consist of both internal and external processes, ensure the reliability, completeness, consistency, and comparability of TCR data.

INTERNAL PROCESS

Submission Review

The TCR's data upload system currently checks all submitted abstracts for errors. TCR uses CDC's Registry Plus Software Suite to upload submitted data. As abstracts are uploaded into the system, they are intensely scrutinized for:

- Possible duplicate submission of existing abstracts.
- Unacceptable codes for any field or inter-field inconsistencies.
- Invalid or unusual site/sex, age/site, age/morphology or site/morphology combinations.
- Running data submissions through NAACCR and TCR edits

Currently, TCR is not rejecting cases at upload, but this could change, and you will be notified by TCR when this change is implemented.

Note: Facilities must run their data through the appropriate NAACCR and TCR edits and make necessary corrections before submitting a file to TCR.

EXTERNAL PROCESS

Facility Training

TCR staff provides technical assistance, training, and continuing education for cancer registrars and medical records personnel on standards and procedures for reporting. Requests for training and technical assistance should be directed to the Austin Central Office Training Specialist Lead Worker. To request training submit your training needs using the online training request forms found on the Education and Training section of the TCR website: dshs.texas.gov/tcr/training.aspx. You can also contact the TCR Training Team at TCR.Training@dshs.texas.gov.

Inpatient/Outpatient Casefinding Follow-back Audit

TCR has implemented a new *Inpatient/Outpatient Casefinding and Death Clearance Follow-back Audit* process. The pilot originally consisted of inpatient/outpatient and Texas deaths which showed facility visits that did not reflect a cancer billing code. This did not yield significant missed cases for the amount of work for reporters and moving forward this process will only include inpatient and outpatient visits with cancer billing codes and Texas deaths linkage results.

This audit will ensure that complete and timely statewide cancer data is received from all Texas facilities and available for our annual Centers for Disease Control and Prevention (CDC) and North American Association of Central Cancer Registries (NAACCR) Calls for Data submissions. In addition, this data will also be available to use in cancer surveillance, program planning, and evaluation activities. The audit will be conducted on a semi-annual basis to identify potentially missed cases.

TCR will use the Texas Hospital Inpatient/Outpatient Data and Texas deaths to conduct this audit. This data will be obtained by TCR biannually. We will use this data to perform a linkage on each individual facility to identify cases that have not been reported to TCR. Once the linkage is complete, each facility will be provided with a listing of potentially missed cases for your review, abstraction, and submission. This may include multiple primaries. This process combines the Death Clearance Only Audit performed in previous years as well as Casefinding Data Quality Audits. This process will help reporters and TCR staff identify possible missed resources to identify reportable cases (pathology, cytology, ambiguous terminology etc.).

All follow-back cases will be available for facilities on one report and will contain the casefinding source, for example: DCO or Inpatient/Outpatient. This will eliminate multiple listing requests for facilities, and it will be performed annually.

Note: Small Casefinding and Data Collection (CFDC) facilities are not required to abstract missed cases. CFDC facilities must submit all medical records to TCR for review and abstraction. This process will remain the same.

Data Quality Audits

A data quality audit is a systematic method of reviewing the facility's data quality. The audit is a tool to improve a facility's data quality and is not a punitive measure. There are several triggers for these audits such as a new reporter, a pattern of edit errors, changes in national guidelines, or inconsistencies identified during one of our various internal data quality processes. TCR staff or a TCR representative will request documents from a facility's medical records and compare the abstracting and coding to the submitted abstracts. The results are shared with the facility as a learning tool. Results from a specific facility's data quality audit are not shared with other entities without the facility's approval.

Reabstracting Data Quality Audits

TCR staff, or a TCR representative, performs complete re-abstracting of a sample of reported cases without reference to the original abstract. If discrepancies are identified, they are used to assess the facility's cancer case reporting and training needs.

Ambulatory Surgery Centers Guidelines for 2021

Texas ambulatory surgery centers (ASC) that diagnose and/or treat cancer patients provide valuable treatment information, that is otherwise not available to the Texas Cancer Registry.

If an ASC is affiliated with a health care system, cancer center, and/or hospital, that healthcare system, cancer center, and/or hospital is responsible for reporting cancer case(s) on the ASC's behalf.

If an ASC is a free-standing facility, TCR will conduct a linkage with the Texas Health Care Information Council Outpatient Data to identify reportable cases that are not otherwise reported to TCR, as well as missing surgical cancer treatment information. The linkage is done to minimize any additional reporting burden on the part of the ASC and TCR. The free-standing ASC is then required to provide the requested medical records to TCR for review and possible inclusion in the registry.

Pathology Laboratory Guidelines for 2021

Pathology Laboratories, both state and national, that diagnose cancer for Texas health care providers and residents provide valuable case-finding and diagnostic information that is not otherwise available to TCR. Receiving pathology reports from pathology laboratories is a critical source of information for comprehensive population-based cancer reporting.

The preferred electronic reporting formats are versions 2.3.1 or 2.5.1 HL7 standard protocols, in accordance with the North American Association of Central Cancer Registries, Pathology Laboratory Electronic Reporting, Volume 5 central registry standards.

In order to securely transmit pathology laboratory data to TCR, there are two strongly preferred options:

1. The Texas Department of State Health Services maintains the Public Health Information Network Messaging System (PHIN MS), a secure messaging platform provided by the Centers for Disease Control and Prevention (CDC) for receiving data from pathology laboratories. Information about the PHIN MS system can be found at: cdc.gov/phin/tools/PHINms/index.html.

   Contact us for additional information on submitting data through PHIN MS.

   Pathology reporting, either in HL7 formats, or as scanned pdf documents may also be securely uploaded to TCR using Web Plus, a web-based application also provided by the CDC. With this data submission method, you must obtain a Web Plus account by completing the Online Web Plus Account Registration and submitting the Web Plus Use and Confidentiality Statement via fax at 512-776-7681, or scan and email. More information on Web Plus can be found on our website: dshs.texas.gov/tcr/webplus.aspx.

   Required information in the pathology report includes not only information about the patient's cancer, but also patient identifiers and demographics, such as name, date of birth, sex, and patient address and social security number. Other fields which are encouraged if available are race/ethnicity and primary payer. If these data items are not on the pathology report, they can be included on a separate Excel spreadsheet that can be uploaded using Web Plus. For your convenience, a template is available on the TCR website: dshs.texas.gov/tcr/CancerReporting/Pathology-Lab-Reporting.aspx

Sending paper pathology reports via mail/FedEx or fax are strongly discouraged. These reporting methods result in significantly more manual processing by TCR and are not as secure as electronically submitting reports using either PHIN MS or Web Plus.

The accountability for any HIPAA breach using mail/FedEx or fax to submit reports to TCR falls on the pathology laboratory deviating from TCR recommended method of reporting. Any laboratory sending paper records to TCR should follow HIPAA guidance for securely sending patient records through U.S. mail and needs to ensure the guidance is followed correctly.

Current guidance provided to TCR includes instructions to double envelope the pathology reports and write "CONFIDENTIAL" on the outside envelope prior to sending the paper records. Before choosing this method, consider one of the more secure electronic methods discussed previously.

Refer to Who Do I Call list for the appropriate representative to call if you have additional questions: dshs.texas.gov/tcr/contact.aspx.

3

CASEFINDING FOR COMPLETENESS OF REPORTING

The *Texas Cancer Incidence Reporting Act (Chapter 82, Health and Safety Code)* requires every health care facility, clinical laboratory, and health care practitioner center to submit cancer information for each reportable diagnosis.

Casefinding (case ascertainment) is a process used to identify all eligible cases to be reported to TCR.

Casefinding sources include disease indices, pathology and laboratory reports, patient logs, and similar resources specific to each facility.

Refer to the Casefinding sources list below for a more detailed list. Every inpatient and/or outpatient with active disease and/or receiving cancer-directed therapy must be reported to TCR regardless of the patient's state.

The requirements for reporting depend on the governing agencies of the registry. For example, hospitals participating in the Approvals Program of the Commissions on Cancer (CoC) of the American College of Surgeons follow the guidelines set forth by CoC; however, they must also adhere to the TCR reporting criteria.

Remember that cases diagnosed prior to 1995 and foreign residents are no longer required to be reported.

CASEFINDING METHODS

There are two types of casefinding methods—active and passive:

- Active casefinding—the personnel responsible for reporting obtain and review all sources for eligible cases. This method is more comprehensive and precise.
- Passive casefinding—the personnel responsible for reporting rely on others to notify the reporter of possible eligible cases. There is a greater potential for missed cases using this method.

A combination of active and passive casefinding is a more effective method and ensures fewer missed cases. It is strongly recommended that every facility have a Casefinding Policy and Procedure in place. The procedures should be evaluated from time to time and amended as facility procedures or services change.

CASEFINDING SOURCES

1. Medical Records Department
    a. Disease index
    b. Admission and discharge reports
2. Pathology Department
    a. Histology reports
    b. Cytology reports
    c. Hematology reports

   d. Autopsy reports
   e. Bone Marrow reports
3. Surgery Department
4. Outpatient Departments
5. Medical and Diagnostic Imaging
6. Radiation Oncology
7. Medical Oncology\Hematology
8. Emergency Room reports
9. Lab reports
10. Nuclear Medicine
11. Pain Clinic Logs

CASEFINDING PROCESS

Cooperation and a good working relationship between reporting personnel and other departments are essential for accurate case ascertainment. The reporter is responsible for identifying all casefinding sources under their facility licensure and arranging access to these sources. Examples include rural health clinics or surgery centers across town or off campus.

Disease indices should be obtained after medical records are completed and coded (monthly or quarterly). The indices must include both inpatient and outpatient admissions and must be based on year of admission. It must be sorted alphabetically by last name and include the following: last name, first name, medical record number, admission/discharge date, date of birth, social security number, all primary and secondary ICD-10* or ICD-10 diagnosis codes and admission type.

Electronic Disease Indices in Excel format is preferred and should include a * *Non-Reportable* column. It should be obtained after medical records are completed and coded (monthly or quarterly).

The Excel format **Non-Reportable* column should be marked if it is deemed to be a non- reportable. Refer to the NR list page. Use the codes found on page 74 Attachment B.

The ICD-10 CM parameter codes to review at 100% are found on Table 3.1 (page 43). The ICD-10 CM 5% supplemental codes table found on Table 3.2 (page 44). Review at the end of your completed submission year.

Note: The Missed Casefinding/DCO linkage project stems from the facility's Casefinding processes.

Attachment A (page 73) is an example of a disease index that can be modified for individual facilities.

The following list includes some helpful hints for the casefinding process:

- Review the disease index for reportable cancer ICD-10-CM codes to ensure the facility has reported all of its reportable cases to TCR.

- Request a TCR Facility Data Report from your regional office when needed during the reporting year. A Facility Data Report is a complete listing of cases submitted by a facility.
- Compare the patients with reportable codes on the disease index to the TCR Facility Data Report.
- Review any patient charts with reportable codes that are missing from the TCR Facility Data Report for reportability.
- Prepare an abstract for each reportable case missing from the TCR Facility Data Report.
- If a previously reported patient is found to have a subsequent primary, assign the new primary the patient's original registry number. Change the sequence number to reflect the new primary and abstract the pertinent cancer information.

Note: If a facility uses an automated casefinding method (for example: the hospital's mainframe extracts possible reportable cases and places these into cancer registry software suspense file), a manual disease index should be run at the end of the reporting year. Ensure that the ICD-10-CM codes used are the most current for the reporting year. This disease index is then checked against the cancer registry database to ensure that all cases were either reported or clearly documented as non-reportable with the reason it is not reportable.

TCR now provides an avenue for following back to each facility for potentially missed cases. It is the facility's responsibility to maintain a reportable and non-reportable list to assist in the review process of the potentially missed cases list provided annually.

COMPREHENSIVE REPORTABLE LISTS ICD-10-CM CODES

The following comprehensive lists are intended to aid appropriate staff (e.g., Information Services, Data Management) in creating the disease index (DI) with the required reportable neoplasms and ICD-10-CM codes.

Two separate DI's must be requested:

1. A DI with reportable ICD-10-CM codes - 100% review required. This DI will include the Inpatient and Outpatient admissions based on ICD-10-CM primary and secondary diagnosis codes.
2. A DI with supplementary ICD-10-CM codes - 5% review: The purpose of this review is to guarantee complete case ascertainment and improve casefinding outcomes. This can assist in determining codes requiring additional review for the facility. The 5% review of this list will be based on number of patients and not number of diagnosis codes. If a patient on this DI also appears on the DI with a reportable code, they may be crossed off this list to avoid duplicate reviews. After removing duplicate patients, review 5% of the total number of remaining patients. If cases for a particular code were identified as reportable, this information should be documented, and the following year this code should be reviewed 100%. If no reportable cases are identified after reviewing the supplementary list for a year, then it may be acceptable to omit this process for the next 2 to 3 years. However, in the event that circumstances change (for example, new coders are hired, or new codes are added to the list), then the supplementary list should be reviewed

sooner to ensure complete casefinding. Some facilities may find that it works best to review the supplementary codes every 3 or every 6 months.

All admissions (inpatient and outpatient) with the following reportable diagnosis codes must be reviewed for reportability.

Note: Some of the codes contain conditions that are not reportable. The records need to be reviewed and evaluated separately to determine whether they are reportable to TCR.

Table 3.1 Reportable ICD-10-CM Codes

ICD-10-CM Code (100% Review Required)	Description
C00.0- C43.9 C4A.0-C4A.9, C45.- C96.9	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies NEW for FY2018: C96.20 Malignant mast cell neoplasm, unspecified C96.21 Aggressive systemic mastocytosis C96.22 Mast cell sarcoma C96.29 Other malignant cell neoplasm
C44.13-C44.1392	Sebaceous cell carcinoma of skin of eyelid, including canthus ***Note:*** Effective 10/1/2018
C49.A-C49.A9	Gastrointestinal Stromal Tumors (GIST) ***Note:*** All GIST tumors are now reportable starting in 2021 (per ICD-O-3.2), including GIST, NOS
D00.00 – D03.9 D05 - D05.92 D07.0-D09.9	In-situ neoplasms ***Note:*** Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable.
D18.02	Hemangioma of any site of intracranial structures
D18.1	Lymphangioma, any site ***Note:*** Includes Lymphangiomas of Brain, Other parts of nervus system and endocrine glands, which are reportable.
D32.0-D32.9	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.0 – D33.9	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46-D46.9	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)

ICD-10-CM Code (100% Review Required)	Description
D47.02	Systemic mastocytosis ***Note:*** Effective 10/1/2017
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3)
D47.4	Osteomyelofibrosis (9961/3)
D47.Z1-D47.Z9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9931/3)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D72.110	Idiopathic hypereosinophilic syndrome [HES]
D72.111	Lymphocytic Variant Hypereosinophilic Syndrome [LHES]
D72.118	Other hypereosinophilic syndrome
D72.119	Hypereosinophilic syndrome [HES], unspecified
J84.82	Adult pulmonary Langerhans cell histiocytosis
R87.624	Cytologic evidence of malignancy on smear of vagina

^ Based on the International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2021

Source: seer.cancer.gov/tools/casefinding/icd-10-cm-casefinding-list.20201211.pdf

SUPPLEMENTARY ICD-10-CM CODES

Table 3.2 Supplementary ICD-10-CM Code List Effective 10/01/2020-9/30/2021

ICD-10-CM Code (5% Review Required)	Description
B20	Human immunodeficiency virus [HIV] disease with other diseases
B97.33, B97.34, B97.35	Human T-cell lymphotrophic virus,(type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomavirus as the cause of diseases classified elsewhere

ICD-10-CM Code (5% Review Required)	Description
D10.0 - D31.92, D34, D35.0, D35.1, D35.5_ D35.9, D36.0-D36.9	Benign neoplasms (see "must collect" list for reportable benign neoplasms) ***Note:*** Screen for incorrectly coded malignancies or reportable by agreement tumors ***Note:*** Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.
D3A.0- D3A.8 D3A.00- D3A.098	Benign carcinoid tumors
D37.0 - D41.9	Neoplasms of uncertain or unknown behavior (see "must collect" list for reportable neoplasms of uncertain or unknown behavior) ***Note:*** Screen for incorrectly coded malignancies or reportable by agreement tumors
D44.0 - D44.2, D44.6-D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands (see "must collect" list for D44.3-D44.5) ***Note:*** Screen for incorrectly coded malignancies or reportable by agreement tumors
D47.01	Cutaneous mastocytosis (9740/1) ***Note:*** Effective 10/1/2017
D47.09	Other mast cell neoplasms of uncertain behavior ***Note:*** Effective 10/1/2017
D47.2	Monoclonalgammopathy ***Note:*** Screen for incorrectly coded Waldenstrom's macroglobulinemia
D47.Z2	Castleman disease
D48.0-D48.9	Neoplasm of uncertain behavior of other and unspecified sites
D49.0 - D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)
D61.1	Drug-induced aplastic anemia (also known as “aplastic anemia due to antineoplastic chemotherapy”) ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug
D61.810	Antineoplastic chemotherapy induced pancytopenia
D61.82	Myelophthisis ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50. _)
D63.0	Anemia in neoplastic disease

ICD-10-CM Code (5% Review Required)	Description
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia ***Note:*** Screen for incorrectly coded thrombocythemia
D70.1	Agranulocytosis secondary to cancer chemotherapy
D72.1	Eosinophilia ***Note:*** Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosonophilic syndrome.")
D75.81	Myelofibrosis (note: this is not primary myelofibrosis [9961/3] ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)
D76.1-D76.3	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified ***Note:*** Review for miscodes
D89.40-D89.49	Mast cell activation syndrome and related disorders ***Note:*** Effective 10/1/2016
E08	Diabetes mellitus due to underlying condition ICD-10-CM Coding instruction note: Code first the underlying condition, such as: malignant neoplasm (C00-C96)
E31.20-E31.9	Multiple endocrine neoplasia [MEN] syndromes ICD-10-CM Coding instruction: Code also any associated malignancies and other conditions associated with the syndromes
E34.0	Carcinoid syndrome
E83.52	Hypercalcemia
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G13.0	Paraneoplastic neuromyopathy and neuropathy ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)
G32.8-G32.81	Other specified degenerative disorders of nervous system in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: cerebral degeneration (due to) neoplasm (C00-D49)
G53	Cranial nerve disorders in diseases classified elsewhere ***Note:*** Code first underlying neoplasm (C00-D49)
G55	Nerve root and plexus compressions in diseases classified elsewhere ICD-10-CM Coding instruction note: code also underlying disease, such as neoplasm (C00-D49)

ICD-10-CM Code (5% Review Required)	Description
G63	Polyneuropathy in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: neoplasm (C00-D49)
G73.1	Lambert-Eaton syndrome in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)
G89.3	Neoplasm related pain (acute)(chronic)
G99.2	Myelopathy in diseases classified elsewhere ICD-10-CM Coding instruction: Code first underlying disease, such as: neoplasm (C00-D49)
H47.42	Disorders of optic chiasm in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
H47.52-	Disorders of visual pathways in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
H47.63-	Disorders of visual cortex in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
J34.81	Nasal mucositis (ulcerative)
J91.0	Malignant pleural effusion ICD-10-CM Coding instruction: Code first underlying neoplasm
J93.12	Secondary spontaneous pneumothorax ICD-10-CM Coding instruction: Code first underlying condition, such as: Malignant neoplasm of bronchus and lung (C34._) Secondary malignant neoplasm of lung (C78.0_)
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.33	Oral mucositis (ulcerative) due to radiation
K22.711	Barrett's esophagus with high grade dysplasia
K62.7	Radiation proctitis
K62.82	Dysplasia of anus (AIN I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
M36.0	Dermato(poly)myositis in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)
M36.1	Arthropathy in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm, such as: Leukemia (C91-C95), malignant histiocytosis (C96.A), multiple myeloma (C90.0)
M84.50- M84.576	Pathologic fracture in neoplastic disease ICD-10-CM Coding instruction: Code also underlying neoplasm (C00-D49)
M90.60- M90.69	Osteitis deformans in neoplastic disease ICD-10-CM Coding instruction: Code first the neoplasm (C40._, C41._)
N42.3	Dysplasia of prostate (PIN I and PIN II)

ICD-10-CM Code (5% Review Required)	Description
N76.81	Mucositis (ulcerative) of vagina and vulva
N87._	Dysplasia of cervix uteri (CIN I and CIN II)
N89.0,N89.1, N89.3	Vaginal dysplasia (VIN I and VIN II)
N90.0,N90.1, N90.3	Vulvar dysplasia (VAIN I and VAIN II)
O01.-	Hydatidiform mole ***Note:*** Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00- C97 range
O9A.111	Malignant neoplasm complicating pregnancy, first trimester
O9A.112	Malignant neoplasm complicating pregnancy, second trimester
O9A.113	Malignant neoplasm complicating pregnancy, third trimester
O9A.119	Malignant neoplasm complicating pregnancy, unspecified trimester
O9A.12	Malignant neoplasm complicating childbirth
O9A.13	Malignant neoplasm complicating pregnancy, childbirth and the puerperium (conditions in C00-C96) ICD-10-CM Coding instruction: Use additional code to identify neoplasm
P04.11	Newborn affected by maternal antineoplastic chemotherapy ***Note:*** Effective 10/1/2018
P04.12	Newborn affected by maternal cytotoxic drugs ***Note:*** Effective 10/1/2018
Q85.0-	Neurofibromatosis (nonmalignant) (9540/1) ***Note:*** Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable
R18.0	Malignant ascites ICD-10-CM Coding instruction: Code first malignancy, such as: Malignant neoplasm of ovary (C56._), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)
R53.0	Neoplastic (malignant) related fatigue ICD-10-CM Coding instruction: Code first associated neoplasm
R59.-	Enlarged lymph nodes
R85.6-	Abnormal findings on cytological and histological examination of digestive organs. ***Note:*** See "must collect" list for R85.614
R87.61-, R87.62-	Abnormal findings on cytological/histological examination of female genital organs. ***Note:*** See "must collect" list for R87.614 and R87.624
R90.0	Intracranial space-occupying lesion found on diagnostic imaging of central nervous system
R92.-	Abnormal findings on diagnostic imaging of breast

ICD-10-CM Code (5% Review Required)	Description
R97.-	Abnormal tumor markers
T38.6-	Poisoning by antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified
T38.8-, T38.996	Poisoning by hormones and their synthetic substitutes
T45.1-	Poisoning by, adverse effect of and under dosing of antineoplastic and immunosuppressive drugs
T45.8-, T45.96	Poisoning by primary systemic and hematological agent, unspecified
T66	Unspecified effects of radiation
T80.1	Vascular complications following infusion, transfusion and therapeutic injection
T80.2-	Infections following infusion, transfusion and therapeutic injection
T80.810	Extravasation of vesicant antineoplastic chemotherapy
T80.818	Extravasation of other vesicant agent
T86.0	Complications of bone marrow transplant ICD-10-CM Coding instruction: Use addition code to identify other transplant complications, such as: malignancy associated with organ transplant (C80.2) or post-transplant lymphoproliferative disorders (PTLD) (D47.Z1)
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z12.-_	Encounter for screening for malignant neoplasms
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z15.0	Genetic susceptibility to malignant neoplasm ICD-10-CM Coding instruction: Code first, if applicable, any current malignant neoplasm (C00-C75, C81-C96); Use additional code, if applicable, for any personal history of malignant neoplasm (Z85._)
Z17.0, Z17.1	Estrogen receptor positive and negative status
Z19.1	Hormone sensitive malignancy status
Z19.2	Hormone resistant malignancy status
Z40.0_	Encounter for prophylactic surgery for risk factors related to malignant neoplasms

ICD-10-CM Code (5% Review Required)	Description
Z42.1	Encounter for breast reconstruction following mastectomy
Z48.290	Encounter for aftercare following bone marrow transplant
Z48.3	Aftercare following surgery for neoplasm ICD-10-CM Coding instruction: Use additional code to identify the neoplasm
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1-	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare
Z79.81-	Long term (current) use of agents affecting estrogen receptors and estrogen levels ICD-10-CM Coding instruction: Code first, if applicable, malignant neoplasm of breast (C50._), malignant neoplasm of prostate (C61)
Z80.-	Family history of primary malignant neoplasm
Z85._	Personal history of malignant neoplasm
Z86.0_, Z86.01_, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior
Z92.21, Z92.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z94.81, Z94.84	Bone marrow and stem cell transplant status

^Based on the International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2021

OTHER CASEFINDING PROCESSES

Other methods for identifying reportable cancer cases should be developed to assure complete case reporting. Since the patient's medical record is the primary source of information, arrangements should be made so the appropriate charts can be routed to the personnel responsible for reporting.

Pathology

The pathology department reports must be routinely checked. The best procedure is to have copies of **all** pathology reports routed to the personnel responsible for reporting. All pathology reports (both positive and negative) must be reviewed by the reporter to ensure all eligible cases are identified. The reporter

should request that all cytology, hematology, bone marrow biopsies, and autopsies be included. Both computerized and manual methods of reviewing pathology reports must include a way to track reports to ensure that every report has been included in the review. Facilities that send all pathology specimens to outside labs should keep a log of all specimens, to include date sent out, date received, and the diagnosis. The reporter should be given a copy of all reports.

Note: If a hospital sends a specimen to another hospital to be read, and the patient is never seen at the reading facility, only the hospital that performed diagnostic procedures or administered treatment for a cancer diagnosis is responsible for reporting the case. The reading facility should document this process in their policy and procedure for consistency.

Exception: To ensure complete reporting, if the specimen is sent from a physician's office to a reading facility, the reading facility would be responsible for reporting the case.

Radiation Oncology

For facilities with radiation oncology departments, a procedure must be established to identify patients receiving radiation therapy. This should include all inpatient and outpatient treatments.

Different options, such as providing copies of the treatment summary, a treatment card, or even a daily appointment book may be available to identify these cases. Many cancer patients are seen in the outpatient department, hematology clinic, laboratory, emergency room, nuclear medicine, and diagnostic radiology and oncology departments. A method to identify reportable cases from these departments must also be established.

Oncology/Hematology

Many facilities now have a designated oncology/hematology unit where patients receive chemotherapy treatments as an inpatient. In some cases, patients receive chemotherapy in an ambulatory setting, a freestanding facility, or a physician's office. The registrar/reporter must establish a policy and procedure for identifying patients who receive chemotherapy in these settings if affiliated with their facility.

Casefinding Lists

Current and previous casefinding lists are available on the SEER website: seer.cancer.gov/tools/casefinding/. Use the casefinding lists to screen prospective cases and identify cancer cases for inclusion in the registry.

A casefinding list is **not** the same as a reportable list. Casefinding lists are intended for searching a variety of sources so as not to miss any reportable cases.

GUIDELINES FOR CASE REPORTING

In some instances, it is unclear whether cancer cases seen in a clinic are reportable through an associated facility. The cases should be included in the facility's caseload when:

- The clinic is owned by the facility.

- The facility is legally responsible for the medical charts in the clinic.
- The facility receives revenue from the medical charts at the clinic.
- The clinical charts are filed in the same location as the facility charts, or
- The facility pays the physicians to work in the clinic.

Cases diagnosed and/or treated for cancer prior to admission should be reported if there is evidence of active disease, whether or not diagnostic or therapeutic procedures were performed. Stable disease indicates active disease.

Cases diagnosed at autopsy are reportable.

Patients with active cancer coming into a facility for "consultation only" should be reported.

Abstract cases with a reportable diagnosis using the medical record from the first admission (inpatient or outpatient) to your facility. Use information from subsequent admissions to supplement documentation and to include all first course treatment information. Do not submit a report for each admission; submit one report per primary tumor.

Cases in which the disease is no longer active should only be reported if the patient is still receiving cancer-directed therapy. For instance, a patient with a history of leukemia in remission, but is still receiving chemotherapy.

Example: A patient diagnosed 6 months ago with acute myelocytic leukemia is now in remission and on a maintenance dose of chemotherapy. The patient was admitted for evaluation of neutropenia following the most recent course of chemotherapy. If this is the first admission to your facility, this patient should be reported because cancer-directed treatment (chemotherapy) is being administered.

Note: Remember, physicians may refer to patients diagnosed with cancer prior to coming to a facility as having a "history of" cancer. These cases should be reviewed closely to determine if the patient has active disease and/or is receiving cancer-directed treatment. If you have any questions regarding the eligibility of a case, call your TCR health service region.

Note: Every effort should be made to identify multiple primary tumors. Refer to the *2018 Solid Tumor Rules* and to the *Hematopoietic and Lymphoid Neoplasm Coding Manual t*o prevent reporting the same primary twice for a patient, compare the patient's name and primary cancer site from the registry database to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.

Summary

If there is any indication within the medical record that the patient has evidence of disease, or is on cancer directed treatment, the case is reportable except for those morphologies listed under non-reportable neoplasms on page 62. This would include but not limited to radiology reports, pathology reports, consults, history and physicals, and clinic notes.

Note: Use the 2018 Solid Tumor coding rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2018 and forward: seer.cancer.gov/tools/solidtumor/

Examples for Determining Case Reportability

Example 1: A patient comes to a facility for a bone scan. The face sheet has been coded to prostate cancer. The bone scan is negative and there is no other information to indicate that this patient has active disease or is receiving cancer directed treatment. This case is not reportable because there is no information to indicate if this patient has active disease.

Example 2: A patient comes to the emergency room. He tells the attending physician that he had cancer years ago. There is no other information documented to indicate that he has active disease or is on cancer-directed therapy. This case is not reportable because there is no information confirming the patient has active disease.

Example 3: A patient comes into the emergency room for a broken wrist. The history/physical states that the patient is currently undergoing chemotherapy for lung cancer, but the facility does not render any treatment for the cancer; the patient is only treated for the broken wrist. This case is reportable because the patient is currently undergoing cancer directed treatment at another facility.

Example 4: A patient is admitted to a facility with a breast lump. The H&P states that the patient was diagnosed elsewhere with breast cancer seven years ago and treated with a lumpectomy. There is now recurrence of the disease and the patient was referred for a mastectomy. This case is reportable due to active disease.

Example 5: A patient comes to your facility for lab work only. The face sheet states “cancer”. The only other information available is the lab results. This case is not reportable. A physician must state the patient has active disease, recurrence, or metastatic disease.

SUSPENSE FILE

A reportable case should be abstracted after review of the patient’s complete record, not just from the unit record for the admission in question. If reportable cases are identified at the time of discharge, the complete medical record may not be available at the time the case is abstracted. A suspense file should be compiled of all cases identified as eligible or potentially eligible for abstracting. The suspense file can be something as simple as a manila folder to hold the various casefinding source documents (monthly disease index, pathology reports and outpatient log sheets and so forth) in alphabetical order and/or by date of diagnosis to assess timeliness of the abstracting process.

NON-REPORTABLE LIST

Personnel responsible for reporting should review the list of terms that indicate a diagnosis of cancer on page 34. Upon review of the disease index (DI), cases may be identified as TCR non-reportable cases. Examples of these would be basal and squamous cell carcinoma of the skin (C44.0 – C44.9) (excluding genital sites), and CIN of the cervix (D06.9). A list of these cases **must be kept each year**.

TCR will review the disease index and the non-reportable list when it conducts casefinding audits after facilities have completed reporting for a given year (see page 73). The non-reportable list will answer

any questions TCR staff may have regarding the non-reporting of these cases. The list should include patient name, date of birth, social security number, medical record number, admission date, casefinding source, and the reason the case was not reportable.

Attachment B (page 74) is a sample form that can be used as a history file of the non-reportable cases. Non-reportable cases can also be documented on the disease index. Place the notation "NR" next to the patient information and include a justification if the case is determined not reportable. Another method would be to develop an electronic spreadsheet that can be sorted alphabetically, such as Excel or Word. An alphabetical index card file can also be used.

Note: There is no non-reportable log in the Web Plus system. Reporters using Web Plus may create and use a form such as the sample Attachment B or make a not reportable notation for each case on the disease index.

The following examples are resources to determine if a case is reportable to TCR. It is critical that these scenarios be applied appropriately. If a patient has active disease and/or is on cancer directed therapy, the case must be reported, unless it is a non-reportable condition.

Non-Reportable List Examples

- The ICD-10-CM billing code indicates current disease. Reason for admission was radiology and laboratory testing. Radiology and laboratory findings do not indicate active disease. This case is not reportable since there is no indication that the patient has current disease.
- The discharge summary and face sheet states history of cancer and there is no other information within the chart to indicate active or stable disease. This case is not reportable because the patient has a history of cancer with no evidence of active disease.
- A patient is admitted for evaluation of congestive heart failure. The patient had a mastectomy for breast cancer 8 years ago and there is no evidence of recurrent or metastatic disease. This case is not reportable because there is no indication that the patient has current disease.
- A patient comes in for lab work. Face sheet states lung cancer. No other information or documentation indicating active disease is available. This case is not reportable because there is no information regarding whether the patient has current lung cancer.
- A patient comes in for a bone scan. The physician orders state prostate cancer, but the bone scan report states no evidence of disease. There is no other information in the chart. Do not report this case since there is no evidence of disease and no mention of current treatment.

Reportable List Examples

- Patient is admitted for staging procedures. Radiology reports no abnormal findings. The discharge summary states that the patient has recently been diagnosed with prostate cancer and is in the process of deciding treatment options. This case is reportable because even though the radiology report shows no abnormal findings, the discharge summary states the patient has prostate cancer.

- A patient was diagnosed with adenocarcinoma of the stomach in 1985 with no evidence of recurrent or metastatic disease. In 2021, the patient was admitted and diagnosed with small cell carcinoma of the lung. The lung cancer is reportable for 2021 because the patient has active lung cancer.
- Discharge summary diagnosis states cancer and the ICD-10-CM billing code indicates current disease. All laboratory findings are negative for active disease, but one radiology report indicates active disease compatible with malignancy. This case is reportable because according to the radiology report the patient has active disease.
- A patient is admitted to your facility with an acute cerebrovascular accident. The H&P states the patient was diagnosed with metastatic lung cancer four months prior to admission. He was treated with palliative care and referred to the Hospice program. All indications are that this patient still has active cancer. This case is reportable because apparently the patient has active disease.
- A patient was diagnosed with cervical cancer in 2000 and has had no recurrence. She is now admitted and diagnosed with a second primary in the lung. The lung case is reportable because the patient has active lung cancer.
- A patient comes to your facility for port-a-cath insertion to allow for chemotherapy for a malignancy. Documentation indicates the patient has active disease. This case is reportable because the patient has active disease and is receiving cancer directed therapy, even though the therapy may be given at a different facility.
- Patient with a recent excisional biopsy for melanoma of skin of arm is admitted to your facility for a wide excision. The pathology report shows no residual melanoma. This case is reportable because the wide excision is considered treatment for the melanoma.
- In 2021 a patient comes to your facility for a colonoscopy. The record states that the patient was diagnosed with breast cancer in 2018. She is still being treated with Tamoxifen which was part of the first course of treatment. It is unknown if the patient has evidence of disease at this time. This case is reportable because the patient is still receiving hormone treatment.

  Note: When Tamoxifen or other hormonal therapy, such as Arimidex, is used as adjuvant therapy for breast cancer it is generally prescribed for 5 years. It has been shown that when taken for 5 years it reduces the chance of the original breast cancer coming back in the same breast or metastasizing.

  - Therefore, if the patient has a history of breast cancer and is on hormonal treatment and it is known that the diagnosis was within the past 5 years, report the case.
  - It is unknown how long ago the breast cancer was diagnosed, report the case.
  - It is known that the diagnosis of breast cancer was greater than 5 years ago and there is no evidence of disease, and no evidence of other treatment being given at the time of admit, it is not necessary to report the case.
- A patient is admitted to the hospital after a heart attack. The chart states the patient has a history of prostate cancer and is on Lupron. There is no other information regarding the patient's history.

Report this case because the patient is on treatment that could be related to the history of prostate cancer.

- A patient comes to your facility for a bone scan. The physician orders state the patient was recently diagnosed with prostate cancer. Regardless of the results, report this case since the patient was stated to be recently diagnosed; the bone scan is being done for staging purposes.

HELPFUL HINTS TO CONDUCT CASEFINDING

- All possible sources of cancer cases in a facility should be reviewed to achieve complete and accurate casefinding.
- Review pathology reports monthly.
- Review disease index monthly.
- Review radiation oncology logs weekly.
- Have coders route medical charts to the registrar/reporter on all identified cancer patients.
- Review outpatient and emergency room visits for reportability. Arrangements can be made to have these routed to the registrar/reporter, or the registrar/reporter can physically review them in the department.
- Maintain a list of non-reportable cases or document non-reportable cases on the disease index.

When reporting is complete for the year, it is the facility's responsibility to maintain a reportable and non-reportable list to assist in the review process of the potentially missed cases list provided annually.

Complete cancer reporting is an important element in a cancer registry quality assurance program. TCR performs casefinding audits to determine the completeness of case ascertainment and timeliness of reporting at facilities across the state. These audits are a part of TCR's data quality procedures and are necessary to assure complete and accurate cancer information and to meet the state's federal funding obligations. The results of a casefinding audit are reported back to the facility.

Note: For more information on cancer reporting visit the Cancer Reporting webpage on the TCR website at dshs.texas.gov/tcr/reporting.aspx.

Contact your regional representative for an assessment of your casefinding procedures. This will better prepare you for an audit.

REPORTABLE NEOPLASMS

Definition of Reportable: Meets the criteria for inclusion in a registry. Refer to Appendix E1 - 2021 SEER Program Coding And Staging Manual and Appendix G of the 2021 TCR Cancer Reporting Handbook for reportable examples. The following lists are intended to assist the cancer data reporter in identifying the reportable neoplasms.

1. Malignant Histologies (In Situ and Invasive)
    a. Report all histologies with a behavior code of /2 or /3 in the ICD-O- Third Edition, Second Revision Morphology (ICD-O-3.2), except as noted in section 1.b. below.
        i. Early or evolving melanoma, in situ and invasive: As of 01/01/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.
        ii. All GIST tumors are reportable as of 01/01/2021. The behavior code is /3 in ICDO-3.2.
        iii. Nearly all thymomas are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2. The exceptions are:
            1. Microscopic thymoma or thymoma, benign (8580/0)
            2. Micronodular thymoma with lymphoid stroma (8580/1)
            3. Ectopic hamartomatous thymoma (8587/0)
        iv. Carcinoid, NOS of the appendix is reportable. As of 01/01/2015, the ICD-O-3 behavior code changed from /1 to /3.
        v. The following diagnoses are reportable (not a complete list)
            1. Lobular carcinoma in situ (LCIS) of breast
            2. Intraepithelial neoplasia, grade III

                Examples (Not a complete list. See 1.b.iii for PIN III.)

                a. Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)
                b. High grade biliary intraepithelial neoplasia (BiIN III) of the gallbladder (C239)
                c. Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
                d. Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)
                e. Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)
                f. Penile intraepithelial neoplasia, grade III (PeIN III) (C600-C609)
                g. Squamous intraepithelial neoplasia III (SIN III) excluding cervix (C53_) and skin sites coded to C44_
                h. Vaginal intraepithelial neoplasia III (VAIN III) (C529)
                i. Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)
        vi. Report Pilocytic/Juvenile astrocytomas; code the histology and behavior as 9421/3

            Exception: The behavior is non-malignant when the primary site is optic nerve (C723).

vii. Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.

viii. Mature teratoma of the testes in adults is malignant and reportable as 9080/3

ix. Urine cytology positive for malignancy is reportable for diagnoses in 2013 and forward.

1. ***Exception:*** When a subsequent biopsy of a urinary site is negative, do not report.
2. Code the primary site to C689 in the absence of any other information
3. Do not implement new/additional casefinding methods to capture these cases
4. Do not report cytology cases with ambiguous terminology.

b. Do not report (Exceptions to reporting requirements)

i. Skin primary (C440-C449) with any of the following histologies

1. Malignant neoplasm (8000-8005)
2. Epithelial carcinoma (8010-8046)
3. Papillary and squamous cell carcinoma (8050-8084)
4. Squamous intraepithelial neoplasia III (SIN III) (8077) of skin sites coded to C44_
5. Basal cell carcinoma (8090-8110)

Note: If the registry collects basal or squamous cell carcinoma of skin sites (C440-C449), sequence them in the 60-87 range and do not report to TCR.

Note: Malignant neoplasms of the skin of genital sites are reportable. These sites include: clitoris (C512), vulva (C519), vagina (C529), prepuce (C600), penis (C609), and scrotum (C632).

ii. In situ carcinoma of cervix (/2), any histology, cervical intraepithelial neoplasia (CIN III), or SIN III of the cervix (C530-C539)

Note: Collection stopped effective with cases diagnosed 01/01/1996 and later. As of the 2018 data submission, cervical in situ cancer is no longer required for any diagnosis year. Sequence all cervix in situ cases in the 60-87 range regardless of diagnosis year.

iii. Prostatic intraepithelial neoplasia (PIN III) (C619)

Note: Collection stopped effective with cases diagnosed 01/01/2001 and later.

2. **Benign/Non-Malignant Histologies**

   a. Report benign and borderline primary intracranial and central nervous system (CNS) tumors with a behavior code of /0 or /1 in ICD-O-3 (effective with cases diagnosed 01/01/2004 to 12/31/2020) or ICD-O-3.2 (effective with cases diagnosed 01/01/2021 and later). See the table below for the specific sites.

      i. Benign and borderline tumors of the cranial bones (C410) are not reportable.

      ii. Benign and borderline tumors of the peripheral nerves (C47_) are not reportable.

   b. Report Pilocytic/Juvenile astrocytomas; code the histology and behavior as 9421/3 when the primary site is C71_

      Exception: The behavior is non-malignant when the primary site is optic nerve (C723).

   c. "Neoplasm" and "tumor" are reportable terms for intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of /0 and /1

      i. "Mass" and "lesion" are not reportable terms for intracranial and CNS because they are not listed in ICD-O-3.2 with behavior codes of /0 or /1

Table 3.4 Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors

Term	Specific sites	ICD-O-3 topography code
Meninges	Cerebral meninges	C700
	Spinal meninges	C701
	Meninges, NOS	C709
Brain	Cerebrum	C710
	Frontal lobe	C711
	Temporal lobe	C712
	Parietal lobe	C713
	Occipital lobe	C714
	Ventricle NOS	C715
	Cerebellum, NOS	C716
	Brain stem	C717
	Overlapping lesion of brain	C718
	Brain, NOS	C719

Term	Specific sites	ICD-O-3 topography code
Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord	C720
	Cauda equina	C721
	Olfactory nerve	C722
	Optic nerve	C723
	Acoustic nerve	C724
	Cranial nerve, NOS	C725
	Overlapping lesion of brain and central nervous system	C728
	Nervous system, NOS	C729
Pituitary, craniopharyngeal duct and pineal gland	Pituitary gland	C751
	Craniopharyngeal duct	C752
	Pineal gland	C753

Note: Benign and borderline CNS cases diagnosed prior to 2004 are no longer required to be submitted to TCR.

Diagnosis Prior to Birth

SEER reportability requirements apply to diagnoses made in utero. Diagnoses made in utero are reportable only when the pregnancy results in a live birth. In the absence of documentation of stillbirth, abortion or fetal death, assume there was a live birth and report the case.

Disease Regression

When a reportable diagnosis is confirmed prior to birth and disease is not evident at birth due to regression, accession the case based on the pre-birth diagnosis.

Reportable Neoplasms Examples

Refer to Appendix E1 - 2021 SEER Program Coding And Staging Manual and Appendix G of the 2021 TCR Cancer Reporting Handbook for reportable examples.

Microcarcinoid tumors of the stomach and carcinoid tumors are reportable. The ICD-O-3.2 histology code is 8240/3. Microcarcinoid is a designation for neuroendocrine tumors of the stomach when they are less than 0.5 cm. in size. Neuroendocrine tumors of the stomach are designated carcinoid when they are 0.5 cm or larger. The term microcarcinoid tumor is not equivalent to carcinoid tumorlet.

Examples

- Squamous cell carcinoma of the anus, NOS. Squamous cell carcinoma of the anus (C210) is reportable. ***Note:*** Squamous cell carcinoma of the perianal skin (C445) is not reportable.

- Noninvasive low grade (micropapillary) serous carcinoma (MPSC) of the ovary. Assign code 8460/2, applying the ICD-O-3 matrix concept to this noninvasive carcinoma. Noninvasive can be used as a synonym for in situ, ICD-O-3 behavior code /2. See page 66 in ICD-O-3.
- Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high-grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high-grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive (8470/2).
- Report mature teratoma of the testis when diagnosed after puberty (malignant) and do not report when diagnosed in a child (benign). ***Note:*** Do not report Mature Teratoma of the testis when it is not known whether the patient is prepubescent or postpubescent. Pubescence can take place over a number of years; review physical history and do not rely only on age. For testis: Mature teratoma in adults is malignant (9080/3); therefore, is a reportable neoplasm.
- Hemangioma, NOS (9120/0) and cavernous hemangioma (9121/0) arising in the dura and parenchyma of the brain/CNS are reportable. ***Note:*** For cavernous sinus hemangioma, report the site as cerebral meninges C700.
- Cystic pancreatic endocrine neoplasm (CPEN) is reportable. Assign 8150/3 unless specified as a neuroendocrine tumor, Grade 1 (8240/3) or neuroendocrine tumor, Grade 2 (8249/3).
- Solid pseudopapillary neoplasm of the pancreas is reportable as 8452/3
- Rathke pouch tumor (C751, 9350/1) is a reportable neoplasm for cases diagnosed 2004 and later. Rathke cleft cyst and Rathke pouch tumor are different conditions. ***Note:*** Rathke cleft cyst is not reportable.
- "Carcinoid of the appendix found on appendectomy." Carcinoid tumor, NOS, is reportable (8240/3).
- Report liver cases with an LI-RADS category LR-4 or LR-5 based on the American College of Radiology Liver Imaging Reporting and Data System (LI-RADS) definitions. Use the date of the LR-4 (probable HCC; high probability but not 100% certainty observation is HCC) or LR-5 (definitely HCC; 100% certainty observation is HCC) scan as the date of diagnosis when it is the earliest confirmation of the malignancy. Use the date of the LR-5 or LR-5V scan as the date of diagnosis when it is the earliest confirmation of the malignancy. If there is no statement of the LI-RADS score but there is a reference that a lesion is in the Organ Procurement and Transplantation Network (OPTN) 5 category, report based on the OPTN class of 5. OPTN class 5 indicates that a nodule meets radiologic criteria for hepatocellular carcinoma.
- "Atypical fibroxanthoma (superficial malignant fibrous histiocytoma)." The case is reportable because the information in parentheses provides more detail and confirms a reportable malignancy.
- "Positive histology from needle biopsy followed by negative resection." This case is reportable based on positive needle biopsy.
- "Biopsy-proven squamous cell carcinoma of the nipple with a subsequent areolar resection showing foreign body granulomatous reaction to suture material and no evidence of residual malignancy in the nipple epidermis." This case is reportable. The fact that no residual

malignancy was found in the later specimen does not disprove the malignancy diagnosed by the biopsy.

- Final diagnosis from dermatopathologist: ulcerated histologically malignant spindle cell neoplasm, consistent with atypical fibroxanthoma.

  Note: An exhaustive immunohistochemical work-up shows no melanocytic, epithelial or vascular differentiation. Atypical fibroxanthoma is a superficial form of a malignant fibrous histiocytoma. This case is reportable. The pathologist has the final say on behavior for a particular case. In this case, the pathologist states that this tumor is malignant.
- "Aggressive adult granulosa cell tumor with one of two lymph nodes positive for malignant metastatic granulosa cell tumor." This case is reportable because malignant granulosa cell tumor is reportable. The lymph node metastases prove malignancy.
- "Ovarian mucinous borderline tumor with foci of intraepithelial carcinoma." This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).
- Dermoid cyst of the brain is reportable. This case is reportable for cases diagnosed 2014 and later, assign 9084/0.
- Tectal plate lipoma is a reportable brain tumor. It is a benign neoplasm (lipoma) of the mid brain (brain stem).

NON-REPORTABLE NEOPLASMS

Refer to Appendix E.2 SEER Program Coding and Staging Manual for non-reportable examples.

(Exclusions)

- Basal cell carcinoma (8090–8110) of the skin (C440-C449) except genital sites
- Basal and squamous cell carcinoma (8070–8110) of skin of anus (C445)
- Epithelial carcinomas (8010–8046) of the skin (C440-C449)
- Papillary and squamous cell carcinomas (8050–8084) of the skin (C440-C449) except genital sites
- Malignant neoplasms, NOS (8000–8005) of the skin (C440-C449)
- In situ neoplasms of cervix regardless of histology (behavior /2; C53_)
- SIN III of the cervix (C530-C539)
- Cervical Intraepithelial neoplasms (CIN III) (8077/2; C530-C539)
- Prostatic intraepithelial neoplasia (PIN III) (8148/2; C619)
- Borderline cystadenomas (8442, 8451, 8462, 8472, 8473) of the ovaries (C569) with behavior code 1 are not collected as of January 01, 2001.
- Cases diagnosed prior to 1995 are not reported

- Benign and borderline CNS cases diagnosed prior to 2004 are not reported
- Benign and borderline tumors of the cranial bones (C410)
- Cysts or lesions of the brain or CNS diagnosed January 01, 2004 or later which have no ICD-O-3 morphology code

  Note: Do not report even if patient is receiving treatment.
- Cholesteatoma in the cerebral meninges is not a reportable CNS case since there is no code for cholesteatoma listed in ICD-O-3.
- Carcinoid tumorlets in the lung are not reportable.
- "AIN II-III," "AIN II/III," "VAIN II-III," "VAIN II/III," "VIN II-III," "VIN II/III," etc. are not reportable (II-III or II/III is stating 2 of 3 and not 2 to 3). VAIN III, AIN III, and VIN III are reportable.
- Squamous cell carcinoma of the perianal skin (C445) is not reportable. Squamous cell carcinoma of the anus (C210) is reportable.
- Cases designated "BIRADS 4" or "BIRADS 5" without any additional information are not reportable.
- Squamous cell carcinoma of the canthus (C441) is not reportable.
- Lobular intraepithelial neoplasia grade 1 is not reportable.
- Subdural hygroma is not reportable – it is not a neoplasm. Subdural hygroma is a collection of cerebrospinal fluid in the sub-dural space. It may be related to a head injury.
- Noninvasive mucinous cystic neoplasm (MCN) of the pancreas with low or intermediate grade dysplasia is not reportable.
- For ovary: Mature teratoma is benign (9080/0); therefore, is not a reportable neoplasm.
- Intraductal papillary mucinous neoplasms with low or moderate grade dysplasia, also called IPMN adenomas, are not reportable.
- The terms "high grade dysplasia" (HGD) and "severe dysplasia" are not reportable. For the purposes of cancer registry reporting, they are not synonymous with in situ for tumors in the gastrointestinal tract (such as colon, stomach, esophagus). These cases are only reportable when the pathologist documents carcinoma in situ, or intraepithelial neoplasia grade III, or when the registry includes in their policies and procedures the pathologist's statement that HGD is equivalent to carcinoma in situ.
- Venous angiomas (9122/0) are not reportable wherever they arise. The primary site for venous hemangioma arising in the brain is blood vessel (C490). The combination of 9122/0 and C490 is not reportable. This is a venous abnormality. Previously called venous angiomas, these are currently referred to as developmental venous anomalies (DVA).
- Lymphomatoid papulosis (9718/1) is not reportable.

Examples

- Left thyroid lobectomy shows microfollicular neoplasm with evidence of minimal invasion. Micro portion of path report states "The capsular contour is focally distorted by a finger of the microfollicular nodule which appears to penetrate into the adjacent capsular and thyroid tissue." Do not report this case based on the information provided. There is no definitive statement of malignancy. Search for additional information in the record. Contact the pathologist or the treating physician.
- Sclerosing hemangioma of the lung with multiple regional lymph nodes involved with sclerosing hemangioma. This case is not reportable. The lymph node involvement is non-malignant. According to the *WHO Classification of Lung Tumours*, sclerosing hemangioma "behaves in a clinically benign fashion...Reported cases with hilar or mediastinal lymph node involvement do not have a worse prognosis."
- Low grade appendiceal mucinous neoplasm (LAMN) is not reportable. The WHO classification designates LAMN as /1 with uncertain malignant potential.
- Diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (DIPNECH) is not reportable. It is a generalized proliferation of scattered single cells, small nodules (neuroendocrine bodies), or linear proliferation of pulmonary neuroendocrine cells (PNCs), according to the WHO classification of lung tumors.
- Lentiginous melanocytic lesion is not reportable.
- Lobular intraepithelial neoplasia grade 1 and grade 2 are not reportable.
- Brain lesions associated with multiple sclerosis are not reportable. These brain lesions are not neoplastic; they are part of the disease process of multiple sclerosis.
- High grade squamous intraepithelial lesion (HGSIL or HSIL) of the vulva or vagina is not reportable. These are not the same as VIN III or VAIN III which are reportable.
- HGSIL, HSIL, carcinoma in situ (CIS), and AIN III (8077) arising in perianal skin (C445) are not reportable.

INSTRUCTIONS FOR REPORTING SOLID TUMORS

Instructions in this section apply to solid tumors. For hematopoietic and lymphoid neoplasms, see the Reportability Instructions in the *Hematopoietic and Lymphoid Neoplasm Coding Manual* and *Database*.

Documentation of Reportable Diagnoses

A reportable diagnosis made by a recognized medical practitioner may appear on a variety of medical documentation including, but not limited to

- Pathology report
- Cytology report
- Imaging report

- Discharge diagnosis
- History and physical
- Other parts of medical record
- Death certificate
- Autopsy report

Cases diagnosed clinically are reportable

In the absence of a histologic or cytologic confirmation of a reportable neoplasm, accession a case based on the clinical diagnosis (when a recognized medical practitioner says the patient has a cancer, carcinoma, malignant neoplasm, or reportable neoplasm). A clinical diagnosis may be recorded in the discharge diagnosis on the face sheet or other parts of the medical record.

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

Exceptions:

1. Patient receives treatment for cancer. Accession the case.

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

2. It has been six months or longer since the negative biopsy, and the physician continues to call this a reportable disease. Accession the case.

Intracranial or CNS Neoplasms

An intracranial or a CNS neoplasm identified only by diagnostic imaging is reportable.

- "Neoplasm" and "tumor" are reportable terms for intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of /0 and /1.
- "Mass" and "lesion" are not reportable terms for intracranial and CNS because they are not listed in ICD-O-3.2 with behavior codes of /0 or /1.

AMBIGUOUS TERMINOLOGY FOR SOLID TUMORS

In most cases, the patient's record clearly presents the diagnosis by use of specific terms which are synonymous with cancer. However, there will be times when a physician is not certain, or the documented language is not definitive. Ambiguous terminology may originate from any source document, such as pathology report, radiology report or a clinical report. The entire medical record should be reviewed before basing reportability on one of these terms. The ambiguous terms listed below are reportable when they are used with a term such as cancer, carcinoma, sarcoma, etc.

Cytology

Do not accession a case based ONLY on suspicious cytology. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. If cytology is reported using an ambiguous term, do not interpret this as a diagnosis of cancer. Report the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings or if cancer directed therapy is administered.

Accession the case when a reportable diagnosis is confirmed later. The date of diagnosis is the date of the later confirmation in this situation.

Note: "Suspicious cytology" means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable in this manual.

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

Important: Accession cases with cytology diagnoses that are positive for malignant cells. Urine cytology positive for malignancy is reportable. Code the primary site to C689 in the absence of any other information.

As of January 2013, (SEER Program Coding and Staging Manual 2021, Reportable Diagnosis List, page 7 and ix) a positive urine cytology is reportable.

- Do not report cytology cases with ambiguous terminology.
- If no information about primary site, code to C68.9.
- Do not report if subsequent biopsy of urinary site is negative.
- Do not implement new/additional casefinding methods.

Examples

- A patient with persistent hematuria has a urinalysis done in your facility and the cytology report states cells suspicious for malignancy. The patient does not return for any further work-up. Do not report this case based on the suspicious cytology alone. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended.
- A fine needle aspirate of a thyroid nodule is suspicious for follicular carcinoma. The patient has a thyroid biopsy which shows papillary follicular carcinoma. This case should be reported because the biopsy was positive for malignancy.

AMBIGUOUS TERMINOLGOY

Ambiguous Terms That Are Reportable

(used to determine reportability only)

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

Note:

- Report cases that use the words on the list or an equivalent word such as "favored" rather than "favor(s)." Do not substitute synonyms such as "supposed" for presumed or "equal" for comparable. Do not substitute "likely" for "most likely."
- There may be ambiguous terms preceded by a modifier, such as "mildly" suspicious. In general, ignore modifiers or other adjectives and accept the reportable ambiguous term.
- This list should be used only for determining case reportability. Do not use this list to determine the appropriate histology or stage. For histology always follow the *Solid Tumor Rules 2018 and the Hematopoietic and Lymphoid Neoplasm Coding Manual*.

How to Use the Ambiguous Terminology for Case Ascertainment

1. In Situ and Invasive (Behavior codes /2 and /3)
    a. If any of the reportable ambiguous terms precede a word that is synonymous with a reportable in situ or invasive tumor (e.g., cancer, carcinoma, malignant neoplasm, etc.), accession the case.

    Example: The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma. Accession the case.

    Negative Example: The final diagnosis on the outpatient report reads: Rule out pancreatic cancer. Do not accession the case.

    b. Discrepancies
        i. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.
            1. Do not accession a case when the original source document used a nonreportable ambiguous term and subsequent documents refer to history of cancer

Example: Report from the dermatologist is "possible melanoma." Patient admitted later for unrelated procedure and physician listed history of melanoma. No further information available, no evidence of treatment for melanoma. Give priority to the information from the dermatologist and do not report this case. "Possible" is not a reportable ambiguous term. The later information is less reliable in this case.

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

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

c. Do not accession a case based ONLY on suspicious cytology

Note: "Suspicious cytology" means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable on the preceding page. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended.

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

Important: Accession cases with cytology diagnoses that are positive for malignant cells.

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

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

Example 1: Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not accession the case.

Example 2: CT report states "mass in the right kidney, highly suspicious for renal cell carcinoma." CT-guided needle biopsy with final diagnosis "Neoplasm suggestive of oncocytoma. A malignant neoplasm cannot be excluded." Discharged back to the nursing home and no other information is available. Do not accession the case. The suspicious CT finding was biopsied and not proven to be malignant. "Suggestive of" is not a reportable ambiguous term.

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

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

2. Benign and borderline primary intracranial and CNS tumors
    a. Use the above "ambiguous terms that are reportable" list to identify benign and borderline primary intracranial and CNS tumors that are reportable.
    b. If any of the reportable ambiguous terms precede either the word "tumor" or the word "neoplasm", accession the case.
    c. "Neoplasm" and "tumor" are reportable terms for brain and CNS because they are listed in ICD-O-3 with behavior codes of /0 and /1.
    d. "Mass" and "lesion" are not reportable terms for brain and CNS because they are not listed in ICD-O-3 with behavior codes of /0 or /1.

    Example: The mass on the CT scan is consistent with pituitary tumor. Accession the case.

    e. Discrepancies
        i. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.
            1. Do not accession a case when subsequent documents refer to history of tumor and the original source document used a non-reportable ambiguous term.
        ii. Accept the reportable term and accession the case when there is a single report, and one section of a report uses a reportable term such as "apparently" and another section of the same report uses a term that is not on the reportable list.

    Exception: Do not accession a case based ONLY on ambiguous cytology (the reportable term is preceded by an ambiguous term such as apparently, appears, compatible with, etc.)

    Use these terms when screening diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing other than tumor markers.

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

Note: AJCC does not define ambiguous terminology and does not mandate how words should be interpreted. AJCC instructs registrars to review physician's statements, consider treatment choices, assess physical exam, medical history, symptoms, imaging, lab tests, diagnostic procedures and all other available information in order to decide cancer involvement, exercise critical thinking.

Ambiguous Terminology Lists: References of Last Resort

The references of last resort clarify the use of Ambiguous Terminology as listed in *STORE 2021* for case reportability and staging in CoC-accredited programs. When abstracting, registrars are to use the "Ambiguous Terms at Diagnosis" list with respect to case reportability, and the "Ambiguous Terms Describing Tumor Spread" list with respect to tumor spread for staging purposes. However, these lists need to be used correctly.

The first and foremost resource for the registrar for questionable cases is the physician who diagnosed and/or staged the tumor. The ideal way to approach abstracting situations when the medical record is not clear is to follow up with the physician. If the physician is not available, the medical record and any other pertinent reports (e.g., pathology, etc.) should be read closely for the required information. The purpose of the Ambiguous Terminology lists is so that in the case where wording in the patient record is ambiguous with respect to reportability or tumor spread and no further information is available from any resource, registrars will make consistent decisions. When there is a clear statement of malignancy or tumor spread (i.e., the registrar can determine malignancy or tumor spread from the resources available) they should not refer to the Ambiguous Terminology lists. Registrars should only rely on these lists when the situation is not clear, and the case cannot be discussed with the appropriate physician/pathologist.

The CoC recognizes that not every registrar has access to the physician who diagnosed and/or staged the tumor, as a result, the Ambiguous Terminology lists continue to be used in CoC-accredited programs and maintained by CoC as "references of last resort".

CASEFINDING INSTRUCTIONS FOR HEMATOPOIETIC & LYMPHOID NEOPLASMS

See the Reportability Instructions in the Hematopoietic and Lymphoid Neoplasm Coding Manual at seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf . (Reportability Instructions begin on page 26).

1. Search the Heme DB to determine case reportability.
2. Report all cases with morphology codes 9590-9993 with a /3 behavior.

   Note: Report the case and change the behavior code to a /0 or /1 in the rare instances of a benign or borderline hematopoietic neoplasm occurring in the brain and/or CNS diagnosed 1/1/2004 or later.
3. Report hematopoietic and lymphoid neoplasms with morphology codes 9590-9993 listed in ICD-O as /1 that are described as malignant by a physician. Apply the matrix rule and change behavior code to /3.

Note: Do not report in situ (/2) lymphomas.

4. Report the case when the diagnosis of a hematopoietic neoplasm is preceded by one or more of the ambiguous terms listed below:
    a. This instruction pertains to reportability and casefinding only.
    b. See the Histology Coding Instructions in the Heme Coding Manual for instructions on assigning histology with ambiguous terminology.

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

    Note: Use these terms when screening all reports other than cytology and tumor markers.
5. Report the case when the patient is treated for a reportable neoplasm.
6. Report the case when there is a clinical diagnosis (physician's statement) of reportable hematopoietic or lymphoid neoplasm.
7. Report the case when a reportable diagnosis appears in any text or report described as a Definitive Diagnostic Method in the Heme DB.

    For reportability examples, exceptions and notes See the Hematopoietic and Lymphoid Neoplasm Coding Manual "Case Reportability Instructions" section on page 25.

Determining Multiple Primaries

Solid Tumors

Apply the general and site-specific instructions for determining multiple primaries in the 2018 Solid Tumor Rules: seer.cancer.gov/tools/solidtumor/

Site-specific multiple primary rules cover the following for cases diagnosed 1/1/2018 and forward:

Primary Site	Topography Codes
Head and Neck	C000-C148, C300-C329
Colon, Rectosigmoid, Rectum	C180-C189

Primary Site	Topography Codes
Lung	C340-C349
Breast	C500-C506, C508-C509
Kidney	C649
Urinary sites	C659, C669, C670-C679, C680-C689
Non-malignant CNS	C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
Malignant CNS and Peripheral Nerves	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

Site-specific multiple primary rules cover the following for cases diagnosed 1/1/2021 and forward:

Primary Site	Topography Codes
Cutaneous Melanoma	C440-C449

The General rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site and Other sites. The head and neck, colon, rectosigmoid and rectum, breast, kidney, urinary sites, and malignant CNS and peripheral nerves rules exclude lymphoma and leukemia (M9590-M9993) and Kaposi sarcoma (M9140). All Other Sites rules exclude lymphoma and leukemia (M9590- M9993). Cutaneous Melanoma includes site C440-C449 with histology 8720-8780 and excludes melanoma of other sites.

Hematopoietic and Lymphoid Neoplasms

Updates to the *Hematopoietic and Lymphoid Neoplasm Coding Manual and Database* have been made for 2021 cases. The updates reflect changes based on updates of the WHO Classification of Tumors (Blue Books), AJCC 8th edition Staging Manual, and clarifications to current rules. Apply the Multiple Primary Rules in the Hematopoietic & Lymphoid Neoplasm Database (Heme DB).

Transplants

Transplanted organs or tissue may originate from:

- organs or tissue from the patient's own body (called autograft)
- another human donor (homograft or allograft)

Accession a new primary in the transplanted organ as you would any new primary, applying the 2018 Solid Tumor Rules. Code the primary site to the location of the transplanted organ, i.e., code the malignancy where it resides/lies.

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

ATTACHMENT A: Sample Facility Disease Index

Cancer Cases with 2019/2020 Admission Date

Mr#	Name	DOB	SSN	Sex	Pt Class/ Type	Admission Date	Discharge Date	Diagnosis/ Description
123123	Roberts, Jim	2/10/1959	455-66-9090	M	IN, MCR	05/02/19 (20)	05/03/19 (20)	C7A.010 Mal Carcinoid Tumor Duodenum
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	04/05/19 (20)	04/07/19 (20)	Z51.11 Chemo Encounter
C5412	Smith, Bob	6/29/1938	422-23-2323	M	SCD, MCR	05/11/19 (20)	05/11/19 (20)	C64.9 Mal Neo Kidney
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	09/06/19 (20)	09/14/19 (20)	C79.1 Sec Mal Neo Brain
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	10/15/19 (20)	10/22/19 (20)	C64.9 Mal Neo of Unsp Kidney
MR421	Sun, Len	11/4/1980	566-66-6666	M	IN, OTH	10/16/19 (20)	10/20/19 (20)	D63.0 Anemia in Neoplastic Disease
MR311	Timms, Emma	6/15/1959	500-00-5000	F	CLL, MCR	03/22/19 (20)	03/22/19 (20)	D24.1 Benign Neo Breast
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/19 (20)	06/02/19 (20)	C50.419 Mal Neo Breast UOQ
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/19 (20)	06/02/19 (20)	C77.3 Mal Neo Lymph-Axilla
MR311	Timms, Emma	6/15/1959	500-00-5000	F	RCR, MCR	07/13/19 (20)	07/23/19 (20)	Z51.0 Encounter for Antineoplastic Radiation Therapy
MR311	Timms, Emma	6/15/1959	500-00-5000	F	RCR, MCR	8/23/2019 (20)	11/13/19 (20)	D49.9 GIST

ATTACHMENT B: Non-Reportable List

Facility Name: _____ Facility ID#___ Reviewed by: ___ Telephone: _____

Patient Name	Med Rec #	Admit Date	Date of Birth	SSN	Casefinding Source	N/R Code

KEEP A COPY FOR YOUR RECORDS

NON-REPORTABLE (N/R) CODES:

01 – Benign

02 – Non-Reportable Skin Cancer (Site=C44.*, Morph=8000-8110)

03 – No Evidence of Disease (NED) (History of Cancer but No Evidence of Treatment Currently and No Evidence of Cancer Currently)

04 – Cancer Not Proven

05 – Duplicate Case (This Cancer has already been reported to TCR)

06 – In situ Cancer of Cervix, CIN III

07 – No Cancer Mentioned in Record

08 – Diagnosed prior to 1995

09 – Lab only

10 – Other (Include Explanation)

4

DEMOGRAPHICS AND PATIENT INFORMATION

Reporting Facility Number

(NAACCR Item #540)

Description

Identifies the facility or institution reporting the case.

Rationale

This data item is used for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Coding Instructions

1. Enter the three-digit facility number assigned by TCR. This is a 10-digit code. The three-digit facility number should be coded with 7 leading zeros.
2. If you do not know your facility number, contact your Health Service Region office or the Central Office in Austin. See page 33 for contact information.

Type of Reporting Source

(NAACCR Item #500) (SEER pages 23-25)

Description

This data item identifies the source documents that provided the most complete information when abstracting the case. This will not necessarily be the document that identified the case but the document that provided the best information.

Rationale

This field provides the source of the documents used to report the case, e.g., inpatient or outpatient charts, cases diagnosed in physician's offices, patients diagnosed at autopsy, pathology report only, or diagnosed by death certificate only.

Coding Instructions

1. Enter the code for the source of the facility and/or documents used to abstract the case.
2. When multiple source documents are used to abstract the case, use the following priority order to assign a code for Type of Reporting Source: 1, 2, 8, 4, 3, 5, 6, 7.

Table 4.1 Type of Reporting Source Codes

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 free-standing 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 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 are no source documents from codes 1, 2, 8, 4, 3, or 5.	7
7	Death Certificate Only	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 or 6.	8

Code	Label	Source Documents	Priority
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 are no source documents from codes 1 or 2.	3

Note: 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. (SEER Program Coding and Staging Manual, page 28)

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 part of a hospital or managed care system. An independent medical record containing only information from encounters with that specific facility.

Managed health plan: Any practice and/or facility where all of the diagnostic and treatment information is maintained in one unit record (all records for the patient from all departments, clinics, offices, etc. in a single file with the same medical record number). The abstractor is able to use the unit record when abstracting the case.

***Examples*:** HMOs or other health plans such as Kaiser, Veterans Administration, or military facilities.

Physician office: A physician office performs examinations and tests. Physician offices may perform limited surgical procedures.

Note: The category "physician's office" also includes facilities that are called surgery centers when surgical procedures under general anesthesia cannot be performed in these facilities.

Surgery center: Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. The patient usually does not stay overnight.

Note: 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.

Priority Order for Assigning Type of Reporting Source

Code the source that provided the best information used to abstract the case.

Example 1: A patient is admitted to your facility and expires before any treatment is rendered. An autopsy is performed, and cancer is found in the lung. Code the reporting source to 6

(autopsy only). The autopsy report is the only document used for your cancer information. The patient was not known to have cancer prior to the autopsy.

Example 2: A patient is admitted to your hospital and is diagnosed with lung cancer. Code the reporting source to 1 (Facility Inpatient/ Outpatient or Clinic). All documents in the medical record are used to gather the cancer information.

Example 3: 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.

Date of Admit/Date of First Contact

(NAACCR Item #580)

Description

The date of first admission/contact with the reporting facility for diagnosis and/or treatment of this cancer. If previously diagnosed/treated elsewhere, the date of first admission to your facility with diagnoses of active cancer.

Rationale

This data item allows the facility to document the first contact with the patient. It can be used to measure the time between admission and when the case is abstracted and the length of time between the first contact and treatment.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
2. Enter the date of the first admission to your facility for a diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.
3. Date format is YYYYMMDD

   Example: The patient is first seen at this facility on January 4, 2021 with a diagnosis of cancer. Record the date of admit: 20210104.
4. A date must be entered in this field. If the patient was never an inpatient, enter the date of the first outpatient visit e.g., biopsy, x-ray, laboratory test, or emergency room visit at your facility with active cancer.
5. For autopsy-only or death certificate-only cases, use the date of death as the date of first contact.

6. For "read only" or "pathology only" cases, enter the date the specimen was collected. These are cases where a specimen is sent to be read by the pathology department and the patient is never seen or admitted at the reporting facility. These cases are reportable if the pathology department generates revenue for the reporting facility and is not a free-standing entity. The class of case should be coded to 43 and the reporting source would be 3.

Note: *STORE 2021* instructions on page 131 differ from TCR instructions. STORE 2021 requires that for analytic cases Date of First Contact is the date the patient qualifies as an analytic case Class of Case 00-22. If the patient was admitted for non-cancer-related reasons, the Date of First Contact is the date the cancer was first suspected during the hospitalization. TCR will continue to instruct that the date be recorded as the admit date if the diagnosis is made at the reporting facility. It is understood that ACoS facilities will continue to follow the rules according to the STORE 2021 Manual.

Example 1: A patient is admitted to the hospital on January 31, 2021, with chest pains. On February 2, 2021, a CT scan shows that the patient has a lung mass consistent with malignancy. Record the date of first contact as 20210131.

Example 2: A patient has a biopsy in a staff physician's office on March 17, 2021, and the specimen is sent to the reporting facility's pathology department on that same day. The pathologist reads the specimen as malignant melanoma. The patient enters the same reporting facility on March 21, 2021, for a wide re-excision. Record the date of first contact as 20210317.

Example 3: A patient has a lymph node biopsy at a small hospital on May 15, 2021. The specimen is sent to your hospital to be evaluated in your pathology department. The pathologist reports diffuse large b- cell lymphoma. The patient never enters your hospital. Record 20210515 as the date of first contact.

Registry/Accession Number

(NAACCR Item #550) (STORE 2021 page 73)

Description

A registry or accession number is a unique number assigned to identify each patient regardless of the number of primary cancers.

Rationale

This data item serves as a reference number to protect the identity of the patient.

Coding Instructions

1. The first four digits identify the calendar year the patient was first seen at the facility with a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year's accession/registry number will start with 00001.

   Example: ---00001 would indicate the first case reported from a facility.

2. Do not assign a new registry number to a patient previously reported to TCR with a new primary cancer. Within a registry, all primaries for an individual must have the same accession number.

Note: Web Plus does not auto populate Accession Number.

Code	Definition
(fill spaces)	Nine-digit number used to identify the year in which the patient was first seen at the reporting facility for the diagnosis and/or treatment of cancer.

Medical Record Number

(NAACCR Item #2300)

Description

Records medical number used by facility to identify the patient.

Rationale

This number identifies the individual patients 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.

Coding Instructions

1. Enter the eleven digit medical record number used to identify the patient's first admission with active cancer and/or on cancer treatment. Medical record numbers with less than 11 digits and alpha characters are acceptable.
2. If a number is not available (outpatient clinic charts or ER visit reports), enter OP followed by nine 0's in this field. See Table 4.2 for other optional medical record identifiers.

Table 4.2 Optional Medical Record Identifier Codes

Code	Description
ER	Emergency Room patient without a medical record number
OP	Outpatient without a medical record number
RT	Radiation Therapy department patient without HIM number
SU	One-day surgery clinic patient without HIM number
UNK	Medical record number unknown

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

Class of Case

(NAACCR Item #610) (STORE 2021 pages 125-128)

Description

Class of case identifies the role of the reporting facility in the patient's diagnosis and treatment.

Rationale

This data item divides case records into analytic and non-analytic categories. The class of case determines which cases should be included in the analysis of the facility's cancer experience.

Note: All reporting facilities must report their non-analytic cases to TCR, regardless of their approval status with the ACoS.

1. **Analytical cases (codes 00-22):** Diagnosed at the reporting facility or in a staff physician's office and/or received any of the first course treatment at the reporting facility. Abstracting for class of case 00 through 14 is to be completed within six months of diagnosis. This allows for treatment information to be documented in the patient's medical record. Abstracting for class of case 20 through 22 is to be completed within six months of first contact with the reporting facility. These cases are analyzed because the facility was involved in the diagnostic and therapeutic decision-making.

   Note: A facility network clinic or outpatient center belonging to the facility is part of the facility.

2. **Non-analytical cases (codes 30-49 and 99):** Diagnosed and received all of the first course of treatment at another facility, or cases which were diagnosed and/or received all or part of the first course of treatment at the reporting facility prior to the registry's reference date (reference date applies to ACoS facilities, facilities striving for ACoS certification, or facilities that follow ACoS standards and do not seek certification). Abstracting for non-analytical cases should be completed within six months of first contact with reporting facility. Non-analytical cases (classes 30-49 and 99) are usually excluded from a facility's routine treatment or survival statistics.

   Note:

   - Per TCR reporting guidelines, non-analytical cases are reportable by all facilities for cases diagnosed January 1, 1995 and forward when there is documentation of active cancer or if the patient is receiving cancer directed therapy.
   - Non-analytical class of case codes 49 and 99 are to be used solely by the central registry.
   - Foreign residents are no longer required to be reported**.**

Coding Instructions

1. Code the Class of Case that most precisely describes the patient's relationship to the facility.
2. Code 00 applies only when it is known the patient went elsewhere for treatment. If that information is not available, code Class of Case 10.

3. Code 34 or 36 if the case is required by TCR but not required by CoC to be accessioned, and initial diagnosis and/or treatment was done at the reporting facility. Cases include Intraepithelial neoplasia grade III tumors (AIN III, VAIN III, VIN III) that are reportable to TCR.

   Note: TCR does not require benign or borderline cases diagnosed before 2004 OR any site other than meninges, brain, spinal cord, cranial nerves, and other parts of central nervous system, pituitary gland, craniopharyngeal duct and pineal gland diagnosed in 2004 or later. Consult Appendix G of the 2021 TCR Cancer Reporting Handbook for reportable neoplasms.

4. Use code 34 or 36 intraepithelial neoplasia grade III (8077/2 or 8148/2) of the cervix (CIN III) or prostate (PIN III).
5. A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there. Treatment provided in a staff physician's office is provided "elsewhere". That is because care given in a physician's office is not within the hospital's realm of responsibility.
6. If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not, as with any other physician.
7. "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. If these cases are abstracted, they are Class of Case 31. Monitoring of oral medication started elsewhere is coded Class of Case 31. If a patient begins first course radiation or chemotherapy infusion elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (Class of Case 21).

Table 4.3 Class of Case Definitions

Analytic Cases	
Initial Diagnosis At Reporting Facility	
Class 00*	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done ELSEWHERE. Cases include: • Patients who choose active surveillance. • Patients who choose to be treated elsewhere. • Patients referred elsewhere for treatment due to lack of special equipment; proximity of a patient's residence to the treatment center; financial, or rehabilitative considerations, etc. ***Note:*** Code 00 applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code Class of Case 10.

Class 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 done at the reporting facility, NOS. ***Note:*** ACoS facilities should include cases in which patients are diagnosed at the reporting facility prior to the registry's reference date and all or part of the first course of treatment was received at the reporting facility after the registry's reference date. ***Note:*** If there is no information regarding whether or where the patient was treated, code Class of Case 10.
Class 11	Initial diagnosis in an office of a physician with admitting privileges AND PART of first course treatment was done at the reporting facility.
Class 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.
Class 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.
Class 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, Facility Involved In First Course Of Treatment Or A Decision Not To Treat	
Class 20*	Initial diagnosis elsewhere AND ALL OR PART of first course treatment was done at the reporting facility, NOS.
Class 21*	Initial diagnosis elsewhere AND PART of first course treatment was done at the reporting facility; part or first course treatment was done elsewhere.
Class 22*	Initial diagnosis elsewhere AND ALL first course of treatment or a decision not to treat was done at the reporting facility.

NON-ANALYTIC CASES Patient appears in person at reporting facility; both initial diagnosis and treatment elsewhere. Classes of Case not required by CoC to be abstracted. May be required by Cancer Committee, state or regional registry, or other entity.	
Class 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).
Class 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/port placement). ***Note:*** In-transit care is given when a patient is temporarily away from the patient's usual practitioner for continuity of care. Monitoring an oral medication started elsewhere is coded to this class of case. If the patient begins first course therapy (radiation or chemo) elsewhere and continues at the reporting facility and the care is not in-transit, then case is analytic (Class of case 21)

Class 32*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease RECURRENCE OR PERSISTENCE (active disease).
Class 33*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease HISTORY ONLY (***disease not active***).
Class 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 done by reporting facility.
Class 35	Case diagnosed before program's Reference Date, AND initial diagnosis AND PART OR ALL of first course treatment by reporting facility.
Class 36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND part or all of first course treatment by reporting facility.
Class 37	Case diagnosed before program's Reference Date, AND initial diagnosis elsewhere AND all or part of first course treatment by facility.
Class 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	
Class 40	Diagnosis AND all first course treatment given at the same staff physician's office.
Class 41	Diagnosis and all first course treatment given in two or more different staff physician offices with admitting privileges.
Class 42	Non-staff physician or non-CoC approved 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).
Class 43*	Pathology or other lab specimens only.
Class 49*	Death certificate only. ***Note:*** Used by central registries only.
Unknown Relationship To Reporting Facility	
Class 99	Case not required by CoC to be abstracted; Of unknown relationship to facility (not for use by CoC approved cancer programs for analytic cases). ***Note:*** Used by central registries only.

*Indicates C*lass of Case* codes appropriate for abstracting cases from non-hospital sources such as physician offices, ambulatory surgery centers, freestanding pathology laboratories, radiation therapy centers. When applied to these types of facilities, the non-hospital source is the reporting facility. The codes are applied the same way as if the case were reported from a hospital.

By using *Class of Case* codes in this manner for non-hospital sources, the central cancer registry is able to retain information reflecting the facility's role in managing the cancer consistent with the way it is reported from hospitals. Using C*lass of Case* in conjunction with *Type of Reporting Source* (500) which identifies the source documents used to abstract the cancer being reported, the central cancer registry has two distinct types of information to use in making consolidation decisions.

Table 4.4 Class of Case Examples

Code	Reason
00	Leukemia was diagnosed at the facility, and all care was given in an office of a physician with practice privileges**.**
10	Reporting facility found cancer in a biopsy but was unable to discover whether the homeless patient actually received any treatment elsewhere.
11	A patient is diagnosed with melanoma in a staff physician's office. He has a wide excision at the reporting facility, and then is treated with interferon at another facility.
12	A diagnosis of prostate cancer is made in a staff physician's office. The patient receives radiation therapy at the reporting facility, and no other treatment is given.
13	A patient is diagnosed with colon cancer at the reporting facility and undergoes a hemicolectomy there. She then receives chemotherapy at an outside clinic.
14	Reporting facility admits patient with hemoptysis. Workup reveals adenocarcinoma. The patient undergoes surgery followed by radiation therapy at the reporting facility. The patient did not receive any other treatment.
20	Patient was diagnosed with primary breast cancer at another facility. The patient then comes to the reporting facility for surgery. It is unknown if she received any other treatment.
21	Patient diagnosed at another facility with breast cancer and received neo-adjuvant chemotherapy. She now presents to the reporting facility for modified radical mastectomy.
22	Patient had a biopsy at another facility and the diagnosis was breast cancer. She underwent a mastectomy at the reporting facility and did not receive any further treatment.
31	Patient receives chemotherapy while visiting relatives in the reporting facility city, then returned to the originating facility for subsequent treatments.
32	Patient was diagnosed and treated for primary bladder cancer prior to admission to reporting facility. Reporting facility admits patient for cystectomy for recurrent bladder cancer. After treatment failure, the patient was admitted to the facility for supported care.
38	Patient admitted to reporting facility with chest pain and expires. Autopsy performed at reporting facility identifies patient has pancreatic cancer.
43	A physician does a skin biopsy in his office and sends the biopsy specimen to a reading pathology/lab. The diagnosis is malignant melanoma. The pathology/lab facility is responsible for reporting the case.

Last Name

(NAACCR Item #2230) (SEER page 30)

Description

Identifies the last name of the patient. Last name may also be referred to as surname.

Rationale

This data item is used as a patient identifier.

Coding Instructions

1. Enter the last name of the patient in CAPITAL LETTERS.
2. Blank spaces, hyphens, apostrophes are allowed. Do not use other punctuation.
3. Truncate name if longer than 40 characters
4. Do not leave the data field blank. If the patient's last name is not known, enter UNKNOWN in this field. This should be done only as a last resort. Every resource should be exhausted to obtain this information.

   Note: Document in *Text Remarks - Other Pertinent Information:* Last name unknown.
5. Record the most current name and update this data item if the last name changes. Enter the previous names in the Alias data item.

Examples

- Record De Leon with a space as DE LEON.
- Record O'Hara with an apostrophe as O'HARA.
- If Janet Smith marries Fred Jones and changes her name to Smith-Jones record SMITH-JONES with the hyphen.

First Name

(NAACCR Item #2240) (SEER page 28)

Description

Identifies the first name of the patient. First name may also be referred to as given name. First name is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Rationale

This data item is used to differentiate between patients with the same last name.

Coding Instructions

1. Truncate first name if longer than 40 characters
2. Enter the first name of the patient in CAPITAL LETTERS.

3. Blank spaces, hyphens and apostrophes are allowed. Do not use other punctuation.
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.
    a. Record nicknames in the Alias data item (not included in this manual)

    Example: The patient's nickname is Bill and the first name is William. Record William in First Name.
6. If the patient's first name is unknown, enter UNKNOWN. Do not leave the field blank. This should be done only as a last resort. Every resource should be exhausted to obtain this information.

Note: Document in *Text Remarks - Other Pertinent Information:* First name unknown.

Middle Name

(NAACCR Item #2250) (SEER page 29)

Description

Identifies the middle name or middle initial of the patient.

Rationale

This data item is used to differentiate between patients with identical first and last names.

Coding Instructions

1. Enter the middle initial if the complete middle name is not provided.

   Blanks, spaces, hyphens and apostrophes are allowed. Do not use other punctuation.
2. This field may be updated if the name changes.
3. If the patient does not have a middle name or initial, or it is unknown, leave blank. Do not code UNK for unknown or NA for not applicable.

Birth Surname

(NAACCR Item #2232) (SEER page 31)

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.

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.

Alias Name

(NAACCR Item #2280)

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 not in this data item.

Rationale

A patient may use a different name or nickname. These different names are aliases. This item is useful for matching multiple records on the same patient.

Coding Instructions

1. If the patient does not use an alias leave blank. Do not record the patient's first and last name again.
2. Record the alias last name followed by a blank space and then the alias first name.
3. Mixed case, embedded spaces, hyphens and apostrophes are allowed.
4. No other special characters are allowed.

Examples

Example 1: Ralph Williams uses the name Bud Williams. Record Williams Bud in the *NAME-ALIAS* field.

Example 2: Samuel Clemens uses the name Mark Twain. Record Twain Mark in the *NAME-ALIAS* field.

Street Address

(NAACCR Item #2330) (SEER page 35)

Description

Identifies the patient's address (number and street) at the time of diagnosis.

Rationale

Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes. A patient's physical address takes precedence over a post office box. If a patient has multiple primary tumors the address may be different if diagnosed at different times. Do not update this field if the patient moves after diagnosis.

Note: ACoS facilities are required to provide information for this field regardless of class of case.

Coding Instructions

1. Enter the number and street of the patient's residence at the time the cancer is diagnosed in 60 characters or less. If the address contains more than 60 characters, omit the least important element, such as the apartment or space number.
2. Record the physical number and street address of the patient at diagnosis. If the patient also has a Post Office (PO) Box address, record the PO Box address in Address at Diagnosis-Supplemental.
3. Do not omit elements needed to locate the address in a census tract, such as house number, street, direction or quadrant, and street type (street, drive, lane, road, etc.).
4. Punctuation marks are limited to periods, slashes, hyphens in this field.
5. Only use the post office box or the rural mailing address when the physical address is not available. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Every effort should be made to obtain complete valid address information.
6. If the patient has multiple tumors, the address may be different of different primaries.
7. Do not update this item if the patient's residential address changes.
8. Abbreviate as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service (USPS). These include but are not limited to:

Table 4.5 Street Address Abbreviations

Abbrev.	Description	Abbrev.	Description	Abbrev.	Description
APT	Apartment	FL	Floor	S	South
AVE	Avenue	N	North	SE	Southeast
BLDG	Building	NE	Northeast	SQ	Square
BLVD	Boulevard	NW	Northwest	ST	Street
CIR	Circle	PLZ	Plaza	STE	Suite
CT	Court	PK	Park	SW	Southwest
DEPT	Department	PKWY	Parkway	UNIT	Unit
DR	Drive	RD	Road	W	West
E	East	RM	Room		

Example: Patient's street address is 1232 Southwest Independence Apartment 400. Record: 1232 SW Independence Apt 400

9. If the patient's address is not available in the medical record, record NO ADDRESS or UNKNOWN. Do not leave blank. These cases should be rare, and every effort should be made to obtain a valid address. The address data fields for these cases should be recorded as the city Unknown, the state as ZZ, the zip code should be 99999 and the FIPS as 999. Do not record the reporting facility's city, state, zip and FIPS.

   Note: Document in *Text Remarks - Other Pertinent Information:* Patient address is unknown. Be aware that an excessive number of unknown addresses will result in additional efforts by TCR staff to obtain a valid address which may include contacting the reporting facility or managing/following physician.

10. Use usps.com/ for help in completing address information.
11. Alternatively, you can also use melissa.com/lookups/AddressCheck.asp

Persons with More than One Residence:

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

Note: These include snowbirds who live in the south for the winter months, sunbirds who live in the north during the summer months. This also includes persons with vacation residences which they occupy for a portion of the year.

Persons with no Usual Residence, including Homeless People and Transients

1. Code the patient's residence at the time of diagnosis as unknown.

Note: Under *Text Remarks - Other Pertinent Information* document that patient is homeless. An unknown address is not the same as homeless.

Temporary Residents:

1. Code the place of usual residence rather than the temporary address for:
    a. Migrant workers
    b. Persons temporarily residing with family during cancer treatment.
    c. Military personnel on temporary duty assignment
    d. Boarding school students below the college level (code the parent's residence)
2. Code the residence where the student is living while attending college.
3. Code the address of the institution for Persons in Institutions.
    a. Persons who are incarcerated
    b. Persons who are physically or mentally handicapped or mentally ill who are residents of homes, schools, hospitals, or wards.
    c. Residents of nursing and rest homes
    d. Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

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

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

Deceased Persons

Use residency information from a death certificate-only when the residency from other sources is coded as unknown. Review each case carefully and apply the U.S. Census Bureau for determining residence. For example, the death certificate may give the person's previous home address rather than the nursing home address as the place of residence. If the person was a resident of a nursing home at diagnosis, use the nursing home address as the place of residence.

Address at Dx - Supplemental

(NAACCR Item #2335) (SEER page 36)

Description

Provides the ability to store additional address information such as the name of a place or facility (a nursing home or name of an apartment complex).

Rationale

A registry may receive the name of a facility instead of a proper street address containing the street number, name, direction, or other elements necessary to locate an address on a street file for the purpose of geocoding.

Coding Instructions

1. Record the place or facility (for example the name of a nursing home, apartment complex, prison, or group home) of the patient's usual residence when the tumor was diagnosed.
2. Do not use this data item to record the number, street, apartment, unit, suite, room, lot, space or department number of the patient's address.
3. Do not update this data item if the patient's address changes.
4. If this address space is not needed, leave blank.

City

(NAACCR Item #70) (SEER page 42)

Description

Identifies the name of the city or town in which the patient resides at the time of diagnosis. Do not update this field if the patient moves after being diagnosed.

Rationale

Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes.

Coding Instructions

1. Enter the city of residence at the time the cancer is diagnosed. If the patient resides in a rural area, record the name of the city used in the mailing address.
2. Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting.

3. If the patient has multiple primaries, the address may be different for subsequent primaries.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available, do not leave blank. The address data fields for these cases should be recorded Unknown in the street address, Unknown in the city, ZZ in the state, 99999 in the zip code and 999 in the FIPS data field. Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.

State

(NAACCR Item #80) (SEER page 43)

Description

Identifies the patient's state of residence at the time of diagnosis/admission. This field should not be updated if the patient moves after being diagnosed.

Rationale

It allows for analysis of geographic and environmental studies and inclusion in state and national cancer publications/studies.

Coding Instructions

1. Record the appropriate two-letter abbreviation for state of residence at the time of diagnosis.

   If the patient is a resident of Canada, record the appropriate two-letter abbreviation for the country of residence at time of diagnosis/admission. If the province or territory of Canada is known, record the abbreviation. See page 95 for a list of Canadian Provinces/Territories.

   If the patient is a foreign resident, other than Canada, record either XX or YY depending on the circumstance. Refer to the table below for specific instructions.

   If the patient has multiple primaries, the state of residence may be different for subsequent cases.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available, do not leave blank. The address data fields for these cases should be recorded as Unknown in the street address, Unknown in the city, ZZ in the state, 99999 in the zip code and 999 in the FIPS data field. Do not record the reporting facility's city, state, zip and FIPS.

Table 4.6 State Codes

Code	Description
TX	If the state in which the patient resides at the time of diagnosis and treatment is Texas, then use the USPS code for the state of Texas.
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)

Code	Description
CD	Resident of Canada, NOS; Use the specific abbreviation of Canadian Provinces/Territories if this information is provided.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **known.** ***Note:*** Residents of foreign countries are no longer reportable to TCR.
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **unknown.** ***Note:*** Residents of foreign countries are no longer reportable to TCR.
ZZ	Residence unknown.

Examples:

- A patient's country of residence is documented as France; record XX in the state field. ***Note:*** Residents of foreign countries are no longer reportable to TCR.
- Documentation in the patient's medical record states the patient is a resident of a foreign country and no other address documentation provided; record YY in the state field. ***Note:*** Residents of foreign countries are no longer reportable to TCR.
- The patient's medical record states the patient lives in the United States or in a territory, commonwealth, or possession of the United States and no other address documentation is provided, record US in the state field.
- If every valid attempt has been made to obtain the address and it is still unknown, record ZZ in the state field. If there is not enough information to determine patient is a foreign resident the case must be reported to TCR.

Table 4.7 Canadian Provinces/Territories

Province/Territory	
Alberta	AB
British Columbia	BC
Manitoba	MB
New Brunswick	NB
Newfoundland and Labrador	NF
Northwest Territories	NT
Nova Scotia	NS

Province/Territory	
Nunavut	NU
Ontario	ON
Prince Edward Island	PE
Quebec	QC
Saskatchewan	SK
Yukon	YT

Table 4.8 State and Territory Abbreviations

(Refer to the ZIP Code directory for further listings).

State	
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
District of Columbia	DC
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS

State	
Kentucky	KY
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC

State	
North Dakota	ND
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Table 4.9 Other US Territories

Other U.S. Territories	
American Samoa	AS
Guam	GU
Puerto Rico	PR
Virgin Islands	VI

Zip Code

(NAACCR Item #100) (SEER page 44)

Description

Identifies the postal code of the patient's address at the time of diagnosis/admission. If the patient has multiple tumors, the postal code may be different for each tumor.

Rationale

It allows for the analysis of cancer clusters, geographic or environmental studies and health services research.

Coding Instructions

1. Enter the patient's zip code at time of diagnosis/admission. Enter the nine-digit extended zip code if known. If recording the full nine-digit zip code, do not place a dash between the first five and the last four digits. The five-digit zip code is allowed if this is all the information available. Blanks follow the five-digit code if the four-digit extension is not coded.

   If the zip code is not available, refer to the *National Zip Code Directory* or to the USPS website: tools.usps.com/go/ZipLookupAction!input.action. This website is useful in obtaining missing address information in order to record a complete address.

   If the patient is a resident of a foreign country at the time of diagnosis, record 88888 for the zip code. ***Note:*** Residents of foreign countries are no longer reportable to TCR.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available, do not leave blank. The address data fields for these cases should be recorded as Unknown in the street address, Unknown in the city, ZZ in the state, 99999 in the zip code and 999 in the FIPS data field. Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.

Table 4.10 Zip Code

Code	Description
123456789	The patient's nine-digit U.S. extended postal code. Do not record dashes.
88888	Permanent address in a country other than Canada, United States, or U.S. possessions.
99999	Resident of the United States (including its possessions, etc.) or Canada and the postal code cannot be verified using the *National Zip Code Directory* or the USPS website.
99999	After every effort is made to obtain a valid address the information remains unknown.
M6G2S8	The patient's valid six character Canadian postal code left justified followed by three blanks.

Examples:

- A patient's country of residence is documented as France; record 88888 in the zip code field. ***Note:*** Residents of foreign countries are no longer reportable to TCR.
- A patient's address is in Canada and the zip code cannot be verified; record 99999 in the zip code field.
- A patient's address is not documented in the medical record and remains unknown after researching all your facility's resources; record 99999 in the zip code field. If there is not enough information to determine patient is a foreign resident the case must be reported to TCR.

FIPS County Code at Diagnosis

(NAACCR Item #90) (STORE 2021 page 82; SEER page 37)

Description

Identifies the county of the patient's residence at the time of diagnosis. If the patient has multiple tumors, the county codes may be different for each tumor.

Rationale

This data item may be used for epidemiological purposes (for example: to measure the cancer burden in a particular geographical area).

Coding Instructions

1. Enter the appropriate three-digit code for the county of residence. Use codes issued by the Federal Information Processing Standards (FIPS) publication, Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas. U.S. Census Bureau's online FIPS County Code Look-up Tool: nrcs.usda.gov/wps/portal/nrcs/detail/?cid=nrcs143_013697

   Refer to Appendix C for the list of Texas FIPS county codes.

   If the patient has multiple tumors, the FIPS county codes may be different for each tumor.

   Do not update this data item if the patient's county of residence changes after diagnosis.

   ACoS facilities following STORE guidelines must code **999** if patient is not a US resident. This case would no longer be reported to TCR.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available, do not leave blank. The address data fields for these cases should be recorded as Unknown in the street address, Unknown in the city, ZZ in the state, 99999 in the zip code and 999 in the FIPS data field. Do not record the reporting facility's city, state, zip and FIPS for unknown addresses. If there is not enough information to determine patient is a foreign resident the case must be reported to TCR.

Table 4.11 Fips County Code at Diagnosis

Code	Description	Definition
001–507	County at diagnosis	Valid Texas FIPS code
998	Outside state/country & code is unknown	Known town, city, state, or country of residence, but county code not known **AND** a resident outside the state of Texas (must meet all criteria)
999	Unknown county	The county is unknown and not documented in the patient's medical record

Address at Dx - Country

(NAACCR Item #102) (STORE 2021 page 81)

Description

Identifies the country of the patient's residence at the time of diagnosis. If the patient has multiple tumors, the country codes may be different for each tumor.

Rationale

This data item may be used for epidemiological purposes (for example: to measure the cancer burden in a particular geographical area).

Coding Instructions

1. Enter the appropriate alpha-3-digit code for the country of residence. Use codes issued by the United States Postal Service.

Table 4.12 Country Code Examples:

Code	Country
USA	United States
CAN	Canada
MEX	Mexico
SLV	El Salvador
VNM	Viet Nam

Note: For other country codes refer to the International Standards Organization (ISO) 3166-1 Country Three Character Codes: iso.org/obp/ui/#search. ***Note:*** Residents of foreign countries are no longer reportable to TCR.

Social Security Number

(NAACCR Item #2320) (SEER page 32)

Description

Identifies the patient by social security number.

Rationale

This item is used by TCR in internal processes such as linking for resolution of duplicate primaries and consolidation.

Coding Instructions

1. Every effort should be made to obtain the social security number. Research all resources from your facility for this information.
2. Enter the patient's nine-digit social security number in this field.
3. If the social security number is unavailable or unknown, enter all 9's in this field. Document in Text Remarks-Other Pertinent Information that the social security information is unavailable.
4. If only the last 4 digits are available, enter it in the following format: enter leading 7's and the last 4 digits of the SS # provided in the 9-character field:

   Example: 777771234

   Note: All efforts must be made to obtain the complete social, but if only the last four digits are provided, they now can be used in the social security number field and not just documented in the *Other Pertinent Information* text box.
5. A patient's Medicare number may not be identical to the person's social security number.
6. Do not put dashes or slashes in this field.

Note: Social security numbers are used for Medicare benefits. Suffix A on a social security number indicates the number is the patient's Medicare number. Other suffixes identify another person's Medicare number under which the patient may be entitled to receive benefits. **Take caution to enter the patient's social security number and not the spouse's or guardian's number.**

The following are not allowed:

- First 3 digits= 000, 666, or 900-999
- Fourth and fifth digits= 00
- Last four digits= 0000
- First digit 9 (except for 999999999)

Date of Birth

(NAACCR Item #240) (STORE 2021 page 85; SEER pages 59-60)

Description

Identifies the patient's month, day, and year of birth.

Rationale

This item is used by TCR to match records, and to calculate age at diagnosis.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed.

2. The patient's date of birth must be entered. Cases cannot be processed without the date of birth.
3. Date format is:
   a. YYYYMMDD - when the complete date is known and valid.

      Example: The patient's date of birth is June 28, 1983. Code the date of birth as 19830628.

   b. YYYYMM - when the year and month are known and valid, and the day is unknown.

      Example: The patient was born in November of 1981, but the day is unknown. Code 198111.

   c. YYYY when the year is known and valid, but the month and day are unknown.

      Example: The record indicates the patient was born in 1978 but no month or day is given. Code 1978.

   Note: If the complete date of birth is not available, documentation must be provided in *Other Pertinent Information.*

   Example: Medical records indicate only month and year of date of birth.
4. If only the age of the patient is known, calculate the year of birth from age and year of diagnosis and leave the day and month of birth unknown.

   Example: A 50-year-old patient diagnosed in 2010 is calculated to have been born in 1960.
5. The year of birth must be recorded. TCR will not accept unknown year of birth. Every effort must be made to obtain this information as it is critical for analysis.
6. If the patient's age is 100 years or older, check the accuracy of the date of birth and date of diagnosis, and document both in a text field.

Table 4.13 Date of Birth Code

Code	Description
YYYYMMDD	The date of birth is the year, month and day the patient was born. The first four digits are the year, the fifth and sixth digits are the month, and the seventh and eighth digits are the day.

Birthplace - State

(NAACCR Item #252) (STORE 2021 page 83; SEER page 57)

Description

Identifies the patient's state of birth. 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

Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and for epidemiological analyses.

Coding Instructions

1. Record the patient's state of birth (if available) using the US Postal Service. If the state of birth is unknown, code to **ZZ**.
2. Use the most specific code. A complete list of state and county codes may be found at seer.cancer.gov/manuals/2021/SPCSM_2021_Appendix_B.pdf

Table 4.14 Birthplace - State Examples

Code	Description
TX	If the patient is stated to have been born in Texas, then use the USPS code for the state of Texas.
US	If the patient is stated to have been born in the United States, NOS (state/commonwealth/territory/possession unknown)
CD	If the patient is stated to have been born in Canada, NOS; Use the specific abbreviation of Canadian Provinces/Territories if this information is provided.
	Born in another country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is known, refer to SEER Appendix B.
YY	Born in a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is unknown.
ZZ	Residence unknown.

Birthplace - Country

(NAACCR Item #254) (STORE 2021 page 84; SEER page 58)

Description

Identifies the patient's country of birth.

Rationale

Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and for epidemiological analyses.

Coding Instructions

1. Record the patient's country of birth (if available) using the US Postal Service. If the country of birth is unknown, code to **ZZU.**
2. Use the most specific code.

Table 4.15 Birthplace Country Examples

Code	COUNTRY
USA	United States
CAN	Canada
MEX	Mexico
SLV	El Salvador
ZZC	Central America NOS
VNM	Viet Nam
ZZU	Place of birth is unknown, no mention in patient record

Note: For other country codes refer to the SEER 2018 Manual:
seer.cancer.gov/manuals/2021/SPCSM_2021_Appendix_B.pdf

Race 1

(NAACCR Item #160) (STORE 2021 page 88-89; SEER pages 65-69)

Description

Identifies the primary race of the person.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow accurate national comparisons. Race is defined by specific physical, hereditary and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Coding Instructions

1. Record the two-digit code to identify the primary race(s) of the patient in fields race 1, race 2, race 3, race 4, and race 5. The five race fields allow for coding of multiple races consistent with the Census 2000. Refer to SEER Appendix D, Race and Nationality Descriptions from 2000 Census: seer.cancer.gov/tools/codingmanuals/
2. Race is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. If the patient has multiple tumors, all records should have the same race code.

3. 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.
   a. The patient's self-declared identification
   b. Documentation in the medical record
   c. Death Certificate
4. Assign the same race code(s) for all tumors for one patient.
5. Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2000.
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.

   Example: There is a statement that Sabrina Fitzsimmons is a Latina, but no further information is available. Code race as **01** (White).

   Note: 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. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white (01) in the next race field.
8. Codes 02-32, 96-98 take priority over code 01.
9. Code 07 takes priority over all other codes.

   Example: Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Hawaiian), Race 2 as 05 (Japanese).
10. Code only the specific race when both a specific race code and a non-specific race code apply.
    a. Codes 04-17 take priority over code 96
    b. Codes 16-17 take priority over code 15
    c. Codes 20-32 take priority over code 97
    d. Codes 02-32 and 96-97 take priority over code 98
    e. Code 98 takes priority over code 99
11. Code race as 02 (Black) when the stated race is African-American, Black, or Negro.
12. 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.
13. Assign a specific code when a specific Asian race is stated. Do not use code 96 when a specific race is known.

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

    Example 1: Race is recorded as Asian, and the place of birth is recorded as Japan. Code race as 05 (Japanese).

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

15. Do not use codes 96, 97 or 98 for "multi-racial".

16. If no race is stated in the medical record or available from other sources in your facility, review the documentation for a statement of a race category such as a patient described as a "Japanese female."

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

18. In using the patient's name to determine race:

    a. Do not code race from name alone, especially for females with no maiden name given.

    b. A Spanish name alone may not be used to determine the race code. A statement about race or place of birth must be documented.

    c. Refer to Appendix D in SEER 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. In some cases, race may be inferred from the nationality. Use Appendix D to identify nationalities from which race codes may be inferred.

    Example: Record states: "the patient was Nigerian", code race as 02 (Black) per the Appendix.

    Exception: Code *Race 1* through *Race 5* as 99 (Unknown) when patient's names is incongruous with the race inferred based on nationality. Do not code the inferred race when the patient's name in incongruent with the race inferred based on nationality.

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

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.

20. If the patient's race is determined based on the races of relatives, there is no priority to coding race, other than to code non-white first.

21. Death certificate information may be used to supplement ante mortem race information only when race is unknown in the patient record or when the death certificate information is more specific.

22. If only one race is reported for a person, *Race 2- Race 5* must be coded to 88.

23. If *Race 1* is coded to 99, unknown, *Race 2- Race 5* must also be coded 99, unknown.

24. A unique race code (other than 88 or 99) can be coded only once in *Race 1* through *Race 5*.
25. Patient photographs may be used with caution to determine race in the absence of any other information. 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 a misclassification of race.
26. If the face sheet states, "Other race" and there is not more information about race in the medical record, if no further information is found, code *Race 1* as 99, and code *Race 2-5* as 99.), and document that patient face sheet indicates "Race Other" and no further information race is available.
27. Document the specified race code in the *Text Remarks - Other Pertinent Information* field. A more specific race that is not included in the list of race codes such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

Table 4.16 Race Codes 1 - 5

Code	Description	Code	Description
01	White	17	Pakistani
02	Black	20	Micronesian, NOS
03	American Indian, Aleutian, Eskimo (includes all indigenous populations of the Western hemisphere)	21	Chamorro/Chamoru
04	Chinese	22	Guamanian, NOS
05	Japanese	25	Polynesian, NOS
06	Filipino	26	Tahitian
07	Hawaiian	27	Samoan
08	Korean	28	Tongan
10	Vietnamese	30	Melanesian, NOS
11	Laotian	31	Fiji Islander
12	Hmong	32	New Guinean
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS	98	Other
16	Asian Indian	99	Unknown
88	No additional races (Race 2-Race 5)		

- The **White** category usually includes Mexican, Puerto Rican, Cuban, Arab, and all other Caucasians including those from Europe and the Middle East.

- The **Black** category includes the designation African-American.

Table 4.17 Race Code 1 Examples

Code	Description
01	A patient was born in Mexico of Mexican parentage. A patient stated to be German-Irish. A person from Iran or Saudi Arabia. An immigrant from Sweden. A patient is described as Middle Eastern. A patient is described as Greek.
02	A black female patient. ***Note:*** A specific race code (other than blank or 99) must not occur more than once. For example, do not code Black in race 1 for one parent and Black in race 2 for the other parent.
04	A patient is of Chinese and Korean ancestry. Code 04, Chinese in Race 1. Code 08, Korean, in Race 2. Patient is stated to be Chinese and black. Code Race 1 as 04 (Chinese), code Race 2 as 02 (Black).
05	A patient has a Japanese father and a Caucasian mother. Code 05 Japanese in Race 1 and 01 White in Race 2.
07	A patient's race is a combination of Hawaiian and any other race(s). Code 07, Hawaiian, in Race 1 and Race 2–Race 5 as appropriate.
11	A patient is stated to be Asian. The place of birth is Laos. Code Race 1 as 11, Laotian, because it is more specific than 96, Asian, NOS.
25	Patient states she has a Polynesian mother and Tahitian father. Code race 1 as 25 (Polynesian), race 2 as 26 (Tahitian) and Race 3-5 as 88.
99	A patient's race is unknown. Code Race 1 as Unknown, code 99. Race 2–Race 5 must also be coded 99. If a patient has a Spanish last name and she is stated to be a native of Indiana, code to 99, Unknown, because nothing is known about her race. Exception is done when Race is noted as "other" on facesheet and there is not additional information; use code **99** for Race 1 and code 99 for Race 2-5.

Race 2, Race 3, Race 4, Race 5

(NAACCR Items #161, 162, 163, 164) (SEER pages 65-69)

Description

Identifies the patient's additional races. Race is defined by specific physical, heredity, and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow accurate national comparisons.

Coding Instructions

1. Record the two-digit code to identify a multi-racial patient.
2. Race is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. If the patient has multiple tumors, all records should have the same race code.
3. Do not use codes 96, 97 or 98 for "multi-racial".
4. All resources in the facility must be used to determine the race of the patient.
5. If more than the *Race 1* code is entered, and if any race is 99, then all race codes (*Race 1, 2, 3, 4* and *5*) must be 99. If more than the *Race 1* code is entered, and if any race codes (for *Race 2, 3, 4* and *5*) are 88 (no further race documented), then all subsequent race codes must also be 88.
6. If a person's race is a combination of Hawaiian and any other race(s), code *Race 1* as 07 Hawaiian and code the other race(s) in *Race 2*, *Race 3, Race 4*, and *Race 5* as appropriate.
7. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white (01) in the next race field.
8. Codes 02-32, 96-98 take priority over code 01.
9. Code 07 takes priority over all other codes.
10. Code only the specific race when both a specific race code and a non-specific race code apply.
    a. Codes 04-17 take priority over code 96
    b. Codes 16-17 take priority over code 15
    c. Codes 20-32 take priority over code 97
    d. Codes 02-32 and 96-97 take priority over code 98
    e. Code 98 takes priority over code 99
11. If the patient's race is determined based on the races of relatives, there is no priority to coding race, other than to code non-white first.
12. Death certificate information may be used to supplement ante mortem race information only when race is unknown in the patient record or when the death certificate information is more specific.
13. If only one race is reported for a person, *Race 2- Race 5* must be coded to 88.
14. If *Race 1* is coded to 99, unknown, *Race 2- Race 5* must also be coded 99, unknown.
15. A unique race code (other than 88 or 99) can be coded only once in *Race 1* through *Race 5*.

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. Document the specified race code in the *Text Remarks - Other Pertinent Information* field. A more specific race that is not included in the list of race codes such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

Spanish/Hispanic Origin

(NAACCR Item #190) (STORE 2021 page 90; SEER page 71-72)

Description

Identifies persons of Spanish or Hispanic origin. If a patient has multiple tumors, all records should have the same code.

Rationale

This is used to identify whether or not the person should be classified as *Hispanic* for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White) category of *race.*

Coding Instructions

1. The information is coded from the medical record or is based on Spanish/Hispanic names.
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 found on a list of Hispanic/Spanish names. Coding Spanish surname or origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
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. Use code 7 if race in the medical record is classified as White and he/she has a Spanish/Hispanic last name, or the only evidence of the patient's Hispanic origin is a surname or maiden name and there no evidence that the patient is Hispanic. Ordinarily used at the central registry level
5. Portuguese, Brazilians, and Filipinos are not presumed to be Spanish or non-Spanish.

a. Assign code 7 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.

Note: Refer to the list of Spanish/Hispanic surnames on the TCR website at: dshs.texas.gov/tcr/training/handbook/Appendix-Spanish-Hispanic-Surnames.pdf

Table 4.18 Spanish/Hispanic Origin Codes

Code	Description
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic (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 category of 1-
7	Spanish surname only. The only evidence of the person's Hispanic origin is surname or maiden name and there is no other information the person is not Hispanic. Ordinarily for central registry use only.
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not; not stated in patient record

Note: Use code 0 if patient has a Spanish/Hispanic name and there is reason to believe he/she is not Hispanic. For example, patient is Filipino, or patient is a woman with a Hispanic married name, but she is known to be non-Hispanic.

- Use codes 1–5 if specific ethnicity is known.
- Use code 6 when you know the patient is Hispanic but cannot classify him/her to codes 1–5.
- Use code 9 when Spanish/Hispanic origin is not documented or is unknown.

Examples

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

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

Sex

(NAACCR Item #220) (STORE 2021 page 91; SEER page 74)

Description

Identifies the sex of the patient.

Rationale

This data item is used to compare cancer rates and outcomes by site.

Table 4.19 Patient Sex Codes

Code	Description
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not Stated/Unknown

Definitions:

Intersex: A person born with ambiguous reproductive or sexual anatomy; chromosomal genotype and sexual phenotype other than XY male and XX female. An example is 45,X/46,XY mosaicism, also known as XO/XY mosaicism.

Transsexual: A person who was assigned to one gender at birth based in physical characteristics but who self-identifies psychologically and emotionally as the other gender.

Transgender: See Transsexual.

Transgendered person: A person who identifies with or expresses a gender identity that differs from the one which corresponds to the person's sex at birth.

Hermaphrodite: A person having both male and female reproductive organs.

Coding Instructions

1. Assign code 3 for
    a. Intersexed (person with sex chromosomes abnormalities)
    b. Hermaphrodites.

   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

Text Usual Industry

(NAACCR Item #320)

Description

Text area for information about the patient's usual industry, also known as usual kind of business/industry.

Rationale

Used to identify work-related health hazards; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

Definition

Type of business or industry where the patient worked in his or her usual occupation. Examples include manufacturing of tires, dry cleaning services, training of dogs, hospital.

Coding Instructions

1. 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.
2. 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.

   Example:

   Inadequate: "ABC, Inc."
   Adequate: "ABC, Inc., Kyle, TX"
3. 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.
4. Be descriptive and specific.

   Examples:

   Inadequate: "Automobile industry"
   Adequate: "Automobile manufacturing"

   Inadequate: "Mine"
   Adequate: "Copper mine"

   Inadequate: "Retail"
   Adequate: "Retail bookstore"
5. When recording government agencies record the level (federal, state, county, municipal) and the division.

   Example:

   Inadequate: "Census"
   Adequate: "U.S. Census Bureau"
6. If no information is available regarding patient's industry, document "Unknown" in the text field. This should be used only as a last resort.

Text Usual Occupation

(NAACCR Item #310)

Description

Text area for information about the patient's usual occupation, also known as usual type of job or work.

Rationale

Used to identify work-related health hazards; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Definition

Type of job the patient was engaged in for the longest time. It is not necessarily the highest paid job, or the job considered the most prestigious, but the one that accounted for the greatest number of working years. Examples include police officer, bank teller, or nurse.

Exception

If a patient has been a homemaker for most of her adult life, but has ever worked outside the home, report the occupation held outside the home.

Coding Instructions

1. Document the patient's usual occupation, the kind of work performed during most of the patient's working life before diagnosis of this tumor, to the extent that the information is available in the medical record. Make sure the recorded usual occupation matches the recorded industry. Do not record "retired."
2. Be descriptive, specific and complete: Record the word or words which most clearly describe the kind of work or type of duties performed by the patient.

   Examples:

   Inadequate: "Teacher"
   Adequate: "Preschool teacher," "high school teacher"

   Inadequate: "Laborer"
   Adequate: "Residential bricklayer"

   Inadequate: "worked in a warehouse," "worked in a shipping department"
   Adequate: "warehouse forklift operator"

   Inadequate: "Engineer"
   Adequate: "Chemical engineer," "Railroad engineer"

   Inadequate: "Self-employed"
   Adequate: "Self-employed auto mechanic"
3. If the patient's usual occupation is not known, record the patient's current or most recent occupation, or any available occupation. If no information is available regarding patient's occupation document "Unknown" in the text field. This should be used only as a last resort.

Commonly confused occupations

Contractor vs. skilled worker—

a. A contractor mainly obtains contracts and supervises work.

b. A “skilled worker” works with his or her own tools as a carpenter, plasterer, plumber or electrician.

Machine operator vs. machinist vs. mechanic—

a. A “machine operator” operates machines.
b. A “machinist” sets up and operates machines.
c. A “mechanic” repairs, installs, and adjusts machines.

Text Remarks - Other Pertinent Information

(NAACCR Item #2680)

Description

Text area for information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data can also be placed here. Problematic coding issues can also be discussed in this section.

Rationale

Information documenting the disease process should be entered manually from the medical record and not be generated from coded values. Such documentation should include additional staging information, additional treatment documentation, documentation of race and sex, history of disease, family history, place of birth, and comments regarding lack of information in the medical record. The name of the following (Follow Up) physicians should also be noted here. See the Text Documentation Section of 2021 TCR Cancer Reporting Handbook for detailed instructions.

Instructions

1. NAACCR-approved abbreviations should be utilized (see Appendix G).
2. Do not repeat information from other text fields.
3. Additional comments from other text fields can be continued in the Remarks field. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
4. If information is missing from the record, state that it is missing.
5. Do not include irrelevant information.
6. Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Smoking history
- Family history of cancer

- 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."

Physician Follow Up

(NAACCR Item #2470)

Description

Identifies the physician currently responsible for the patient's medical care. TCR requires the physician's state license number.

Rationale

The follow-up (or "following") physician is the first contact for obtaining information on the patient's status. This information may be used for outcome studies.

Coding Instructions

1. Record the state license number of the physician currently responsible for the patient's care. Physician license numbers for Texas can be found at the following website: tmb.state.tx.us/page/look-up-a-license.
2. Cancer reporters using third party software must check with their vendor to ensure the physician's state license number transmits to TCR.
3. This field must be populated for cases diagnosed 2006 and forward. If the information is unknown code 99999999 and document in *Text Remarks - Other Pertinent Information* that the follow up physician is unknown.

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required). TCR will continue to require this data item.

Sequence Number

(NAACCR Item #560) (STORE 2021 page 75-76)

Description

Indicates the chronological sequence of all reportable neoplasms (malignant and non-malignant) over the lifetime of the patient regardless of when or where the case was diagnosed. Each neoplasm is assigned a different number. Sequence number 00 indicates patient has only one reportable malignant neoplasm. Reportable neoplasms not included in the facility registry are also allotted a sequence number. For example, an ACoS registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the facility's reference date.

Rationale

This data item is used to distinguish among cases having the same registry numbers, to select patients with only one primary tumor for certain follow-up studies and to analyze factors involved in the development of multiple tumors.

Coding Instructions

1. Codes 00–59 and 99 indicate reportable cases of malignant or in situ behavior.
2. Code 00 if the patient has a single reportable 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 the subsequent tumors sequentially.
3. If two or more reportable primaries are diagnosed simultaneously, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
    a. Base the prognosis decision on the primary site, histology, and extent of disease for each of the primaries.
    b. If there is no difference in prognosis, the sequence numbers may be assigned in any order.
4. Codes 60–88 indicate non-malignant neoplasms (benign and borderline) that are reportable by agreement cases (e.g., those cases required by state registries). All benign or borderline neoplasms diagnosed/admitted to your facility should be sequenced according to this guideline. This includes benign and borderline CNS neoplasms.
5. Code 60 if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first primary from 60 to 61, and number subsequent non-malignant primaries sequentially (62, 63…).
6. Sequence numbers should be reassigned in the database if the facility learns later of an unaccessioned tumor that would affect the sequence.
7. The *Sequence Number* refers to the number of malignant or non-malignant primaries in the patient's lifetime.

8. *Sequence Number* should not be changed if the patient develops metastasis.

Table 4.20 Sequence Number: Malignant Neoplasms

One Primary	More Than One Primary	Sequence Unknown
00 One primary only	01 First of two or more primaries	99 Unspecified
	02 Second of two or more primaries	
	03 Third of three or more primaries	

Table 4.21 Sequence Number: Non-Malignant Neoplasms

One Primary	More Than One Primary	Sequence Unknown
60 One primary only	61 First of two or more primaries	88 Unspecified
	62 Second of two or more primaries	
	63 Third of three or more primaries	

Note: Squamous and/or basal cell carcinoma of the skin (except genital sites) **are no longer** considered when assigning the appropriate sequence number.

Examples

- A person is diagnosed with one malignant primary. Code the sequence number to 00.
- A person was diagnosed with lung cancer in 2001. A colon cancer is diagnosed in 2021. Code the sequence number of the colon cancer to 02 and change the sequence number of the lung cancer to 01.
- A person was diagnosed with breast cancer in April 2010 and metastasis to the lungs in June 2021. Since the lung is a metastatic site and not a second primary, it would not be abstracted. Code the sequence number of the breast cancer to 00.
- A person was diagnosed with signet ring cell carcinoma of the bladder in 2017. In 2021, this person developed a benign meningioma in the temporal area of the brain. Code the bladder to sequence number 00, and code the brain to sequence number 60.
- A person was diagnosed with carcinoma of the stomach in 2016, squamous cell carcinoma of the left forearm (a non-reportable neoplasm) in 2017, and non-Hodgkin's lymphoma in 2021. Code the sequence number of the stomach to 01. The sequence number of the left forearm would not be sequenced, abstracted or reported. Code the sequence number of the lymphoma to 02.
- A person was diagnosed with a benign meningioma in June 2016. MRI at your facility in 2021 shows no change. Code the sequence number to 60 for the benign meningioma.

Primary Payer At Diagnosis

(NAACCR Item #630) (STORE 22021 page 92-94; SEER pages 76-77)

Description

Identifies the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

Rationale

This item is used in financial analysis and as an indicator for quality and outcome analyses. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires the patient admission page to document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

Coding Instructions

1. Record the type of insurance reported on the patient's admission record.
2. Code the **first** insurance mentioned when multiple insurance carriers are listed in one admission record.
3. Code the type of the insurance reported **closest to the date of diagnosis** when there are multiple insurance carriers reported from 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. Consult with your facility's billing department if the primary payer information is unclear.

Note: Codes **21** and **65-68** are to be used for patients diagnosed on or after January 1, 2006.

Table 4.22 Primary Payer at Diagnosis Codes

Code	Label	Description
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 unknown or other than types listed in codes 20, 21, 31, 35, 60-68

Code	Label	Description
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 without supplement, Medicare, NOS	Federal government funded insurance for persons who are 65 years of age or older or are chronically disabled 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.
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 Medicaid administered supplement.

Code	Label	Description
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. Formally 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 Veterans Affairs facilities
68	Indian/Public Health Services	Patient who receives care at an Indian Health Services 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	It is unknown from the patient's medical record whether or not the patient is insured.

Examples

- An indigent patient is admitted with no insurance coverage. Code the *Primary Payer at Diagnosis* as 01.
- A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO. Code the *Primary Payer at Diagnosis* as 20.
- A 65-year-old male patient is admitted for treatment and the patient admission page states the patient is covered by Medicare with additional insurance coverage from a PPO. Code the *Primary Payer at Diagnosis* as 62.
- A patient has managed Medicare listed in Insurance #1 and Medicaid listed as Insurance #2. Code the *Primary Payer at Diagnosis* as 64.
- Patient comes to your facility originally diagnosed with prostate cancer in 2000. Now he has bone metastasis. Code the *Primary Payer at Diagnosis* as 99 because the information from the facility where originally diagnosed is not available.

Medicare Beneficiary Identifier

(NAACCR #2315)

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.

Coding Instructions:

1. Leave blank if not available, non-Medicare patient, not applicable, or unknown
2. The Medicare Beneficiary Identifier (MBI) is randomly generated and has 11 characters, consisting of numbers and letters, entered without dashes.
3. The MBI format and information on understanding the MBI can be found at: cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI-with-Format.pdf

5

CANCER INFORMATION

Pathology Reports

In general, SEER recommends that information from consult pathology reports be preferred over the original pathology report. This is because consults are usually requested from a more experienced or specialized pathologist/lab and are generally thought to be more accurate.

Date of Initial Diagnosis

(NAACCR Item #390) (STORE 2021 page 134-135; SEER pages 79-83)

Description

The date of initial diagnosis is the earliest date this primary reportable neoplasm is diagnosed clinically or microscopically by a recognized medical practitioner, regardless of whether the diagnosis was made at the reporting facility or elsewhere.

Rationale

The date of initial diagnosis is essential in the analysis of staging and treatment of the cancer, for epidemiology purposes, and for outcomes analysis. The timing for staging and treatment of cancer begins with the date of initial diagnosis for cancer.

Coding Instructions

1. Date format is:
   a. YYYYMMDD - when the complete date is known and valid

      Example: The patient has a CT on March 25, 2021 and the diagnosis is lung cancer. Code the diagnosis date as 20210325.

   b. YYYYMM - when year and month are known and valid, and day is unknown.

      Example: A mammogram done in January 2021 shows that the patient has a malignancy in the upper outer quadrant of the right breast, but the day is unknown. Code the diagnosis date as 202101.

   c. YYYY – when year is known/estimated; month and day cannot be estimated or are unknown. Blanks will not be accepted.
2. The initial diagnosis date may be from a clinical diagnosis, for example, when a radiologist views a chest x-ray, and the diagnosis is lung carcinoma. If later confirmed by a pathology specimen, the diagnosis date remains the date of the initial clinical diagnosis.

   Note: The Commission on Cancer does not recognize the BI-RADs schema for mammography as a case-finding source. However, if the radiologist states suspicious for malignancy (not neoplasm) in his/her impression, the case is reportable, and the date of the mammogram would be considered the date of initial diagnosis for breast cancer.

3. The date of diagnosis based on a pathology report should be the date the specimen was taken, not the date the pathology report was read or created.
4. Refer to the *List of Ambiguous Terms* language that represents a diagnosis of cancer. When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis.

   Example: Area of microcalcifications in breast suspicious for malignancy on 2/13/21. Biopsy positive for ductal carcinoma on 2/28/21. The date of diagnosis 2/13/21.
5. If a recognized medical practitioner states that, in retrospect, the patient had cancer at an earlier date, record the date of diagnosis as the earlier date. If later documentation shows the diagnosis was an earlier date, record the earlier date and document in the *Summary Stage Documentation* text field.

   Example 1: The patient has an excision of a benign fibrous histiocytoma on January 3, 2021. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The pathologist reviews the original slides and documents that the previous tumor (benign fibrous histiocytoma) was malignant. Code the diagnosis date as 20210103.

   Note: Do not back date if there is no review of previous slides with a revised physician statement of diagnosis of cancer or reportable tumor.

   Example 2: The patient had a total hysterectomy and bilateral salpingo-oophorectomy (BSO) in June 2021 with pathologic diagnosis of papillary cystadenoma of the ovaries. On December 6, 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 initial diagnosis should be coded 20211206.

   Note: Remember to check with your TCR health service regional office regarding the appropriate procedure to follow when there is updated information on an abstract already submitted to TCR. Do not resubmit the abstract. These cases will result in duplicate records and require manual resolution. TCR does not accept updated modified (M) records.
6. For autopsy- and death-certificate-only cases the date of initial diagnosis will be the date of death.
7. Use the actual date of diagnosis for an in-utero diagnosis (For cases diagnosed before January 1, 2009, assign the date of birth).

   Example: An ultrasound done on 2/2/2021 to determine expected date of birth shows an unborn baby has a brain tumor. After the baby is born on 4/12/2021, resection shows malignant teratoma. Code the date of diagnosis 20210202.
8. Use the date therapy was started as the date of diagnosis if the patient receives first course of treatment before a definitive diagnosis.
9. Positive tumor markers alone are not diagnostic of cancer. Use the date of positive clinical, positive histologic, or positive cytologic confirmation as the date of diagnosis. Positive tumor markers alone are never used for case ascertainment.

   Example: The patient has an elevated PSA, and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the

prostate. The biopsy is positive for adenocarcinoma. The date of diagnosis is the date of the biopsy (do not code the date of the PSA or the date the procedure was dictated or transcribed).

10. 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.
    - "Ambiguous" cytology means that the diagnosis is preceded by an ambiguous term such as apparently, appears, compatible with, etc.
    - Do not use ambiguous cytology alone for case ascertainment.
    - Cytology is the examination of cells rather than tissue. This would include sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluids, spinal fluid, peritoneal fluid, urinary sediment, and cervical and vaginal smears.
11. In the absence of an exact date of initial diagnosis, record the best approximation. For vague dates, estimate the date of diagnosis for month and year using all available information. An approximate date is preferable to an unknown date of diagnosis. Refer to the table and examples below. Documentation that the exact date of diagnosis is not available in the medical record must be provided in *Summary Stage Documentation* text field.
12. Code the year and month of admission when there is no basis for estimation and document "Date of DX unknown" in the *Summary Stage Documentation* text field. *This should be used only as a last resort.*

    Note: Every resource available at the reporting facility must be reviewed in order to determine the date of diagnosis.

    Example: Patient admitted to your facility on April 26, 2021 with recurrent melanoma, but the original date of diagnosis is unknown. Code the date of diagnosis as 202104. Record in the *Summary Stage Documentation* text field "Date of DX Unknown."

Table 5.1 Date of Initial Diagnosis – Date Estimates

DOCUMENTATION	DATE Code/Description
Spring	Use April (04) for the month
Summer	Use July (07) for the month
Fall/Autumn	Use October (10) for the month
Winter	Determine if this means the beginning or the end of the year. Use December (12) or January (01) for the month as determined.
Early in Year	Use January (01) for the month
Middle of Year	Use July (07) for the month
Late in Year	Use December (12) for the month

DOCUMENTATION	DATE Code/Description
Recently	Use the year and month of admission and leave the day blank. If patient was admitted during the first week of a month, use the previous month.
Several Months Ago	If the patient was not previously treated or if first course treatment started elsewhere was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown (blank).
A Couple of Years	Code to two years earlier
A Few Years	Code to three years earlier

Examples:

- A patient was admitted to your facility on March 15, 2021. The History and Physical states the patient has prostate carcinoma diagnosed about two months ago. Record the date of diagnosis as 202101.
- A patient was admitted to your facility on September 10, 2021. The History and Physical states the patient has bone and brain metastasis from malignant melanoma diagnosed in the spring. Record the date of diagnosis as 202104.
- On March 12, 2021, a mammogram reveals a mass in the upper outer quadrant of the patient's right breast. The radiologist's impression states compatible with carcinoma. On March 20, 2021, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Record the date of diagnosis as 20210312.

Note: For users of Web Plus always press the calculator icon in order to calculate age at diagnosis. If diagnosis date or date of birth are changed the calculator must be pressed to recalculate the age at diagnosis.

Morphology ICD-O-3: Type and Behavior

(NAACCR Item #522, #523) (STORE 2021 pages 139-141; SEER pages 100-103)

Description

Identifies the microscopic composition of cells and the behavior of the tumor being reported.

Rationale

The histological (morphologic) type helps to determine staging and treatment options. It also assists in determining the disease course and prognosis, and in identifying multiple primaries. The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or malignant (3).

The *2018 Solid Tumor Rules*, the *ICD-O-3.2*, the *2021 ICD-O-3 Histology and Behavior Code Update Tables*, the *Hematopoietic and Lymphoid Neoplasm Coding Manual*, and the *Hematopoietic and Lymphoid Neoplasm Database* are the standard references for histology codes for cases diagnosed 2021 and forward.

Note: Solid tumor histology can be coded only after the determination of single vs. multiple primaries has been made. Refer to Solid Tumor Rule 2018 rules to determine the number of primaries for solid tumors.

Using the Solid Tumor Manual

The Solid Tumor Manual is available online at seer.cancer.gov/tools/solidtumor/.

- Apply the general instructions and instructions for coding histologic type in the 2018 Solid Tumor Rules
- Apply the site-specific histology coding rules in the 2018 Solid Tumor rules.
- Site specific histology coding rules cover the following:

Primary Site	Topography
Head and Neck	C000-C148, C300-C329, C410, C411, C442
Colon Rectosigmoid, and 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

* Instructions for Cutaneous Melanoma for cases dx 1/1/2021 forward are in the 2021 Cutaneous Melanoma Rules.

**Other sites instructions are in the 2007 Multiple Primary Rules: seer.cancer.gov/tools/mphrules/

Note: Do not use these rules to determine case reportability, tumor grade, or behavior.

Using The ICD-O-3 Changes Effective for January 1, 2021

For 2021, major changes apply to reportability. 16 previously non-reportable neoplasms become reportable. 9 reportable pre-2021 neoplasms become non-reportable. 10 histology terms have been moved to other ICD-O codes. 13 histologies have a change in reportable terminology. 12 new terms/ICD-O codes.

The 2021 ICD-O-3 Update Guidelines includes comprehensive tables listing all changes to ICD-O-3 including new terminology and reportability changes effective for cases diagnosed 1/1/2021 forward. Included in these guidelines are instructions for using the tables together with ICD-O-3.2. The guidelines also provide background on the project and issues encountered during review of the WHO 4th Edition Classifications of Tumors book series. Issues not covered in the 2021 update include reportability of histology codes with terms that include the words "high grade neoplasia" or "high grade dysplasia" or "severe dysplasia" in digestive system sites.

The 2021 ICD-O-3 Histology Code and Behavior Update Tables include comprehensive tables listing all changes made after the 2018 update and is effective for cases diagnosed 1/1/2021 forward. The 2021 tables include coding instructions for cases diagnosed prior to 1/1/2021. Edits will enforce the new codes/behaviors allowed only for cases diagnosed 1/1/2021 forward. Date driven edits will also be implemented for those histology codes no longer valid.

2021 ICD-O-3 Histology Code and Behavior Update Tables: Specific Tables

Each table provides the list of ICD-O-3 codes which have changed behavior, reportable terminology, moved to other ICD-O codes, and are new terms and codes. The guidelines include five specific tables, on combined table in alpha order, one combined table in numerical order, and one Excel document.

- TABLE 1: BEHAVIOR Code CHANGES- NON-REPORTABLE TO REPORTABLE

  Table 1 lists 16 terms and codes that have changed behavior from non-reportable to reportable beginning with cases diagnosed on or after January 1, 2021.

- TABLE 2: BEHAVIOR Code CHANGES- REPORTABLE TO NON-REPORTABLE

  Table 2 lists nine terms and codes that have changed behavior from reportable to non-reportable beginning with cases diagnosed on or after January 1, 2021.

- TABLE 3: DELETED CODES- HISTOLOGY TERMS MOVED TO OTHER ICD-O CODES

  Table 3 lists ten terms and codes that have been deleted from one ICD-O code and moved to another code effective with cases diagnosed on or after January 1, 2021.

- TABLE 4: CHANGE IN REPORTABLE TERMINOLOGY

  Table 4 lists revised preferred terminology for 13 neoplasms in ICD-O-3.2. These neoplasms no longer require "malignant" to be included in the diagnostic term in order to report the case as malignant (/3).

- TABLE 5: NEW ICD-O CODES AND TERMINOLOGY

  Table 5 lists 12 new terms and ICD-O codes effective for cases diagnosed on or after January 1, 2021.

- TABLE 6: COMBINED 2021 ICD-0-3.2 UPDATE (NUMERICAL ORDER)

  Table 6 combines Tables 1 through 5 into a single list in numerical order by ICD-O code.

- TABLE 7: COMBINED 2021 ICD-O-3.2 UPDATE (ALPHA ORDER)

  Table 7 combines Tables 1 through 5 into a single list in alpha order by histology term

Table 6 and 7 each have five columns:

- Status: New term & code, new behavior code/term, code change, terminology change, and new term
- ICD-O-3 Morphology Code: lists code number and behavior
- Term: Histology name per WHO. Preferred terms are indicated in BOLD font.
- Reportability (Reportable Y/N): notes if the histology is reportable or non-reportable.
- Comments: Coding instructions, if applicable, are noted in this column. Instructions include coding pre-2021 cases, site specific instruction is applicable, and other useful instructions.

STATUS ABBREVIATIONS USED IN UPDATE TABLES 6 AND 7

Status	Definition
BC	Behavior code change (change in reportability)
CC	Code change: Per ICD-O-3.2, several codes have been deleted and the histologies moved to other codes
NC/T	New ICD-O code and term
PT	Preferred term
RT	Related term
Syn	Synonym

See full ICD-O-3 coding table and updates at NAACCR website**:** **naaccr.org/icdo3/**

Using The ICD-O-3 (International Classification of Diseases for Oncology, 3rd Edition) Manual

1. Record the morphology code using the Alphabetic Index (ICD-O-3 pages 105-218) and the Numerical Index (ICD-O-3 pages 69-104). Review both of these sections of the ICD-O-3 to ensure accurate coding.

   Note: For primaries diagnosed prior to January 1, 2001 use ICD-O-2.

2. Follow the coding rules outlined on pages 19-34 of ICD-O-3.
3. The term [obs] in ICD-O-3 indicates a diagnosis for which a better diagnostic term(s) is available, but which may still be used to code the cancer in certain circumstances. Obsolete terms are retained in ICD-O-3 for historical reference.
4. Adequate text documentation must be provided to support coding. Auto coding of the ICD-O-3 code description is not considered adequate text documentation.

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

For hematopoietic and lymphoid diseases code histology after the Hematopoietic and Lymphoid Neoplasm Database has been searched for reportability at seer.cancer.gov/seertools/hemelymph/.

Use the *Hematopoietic and Lymphoid Neoplasm Database (Heme DB)* at seer.cancer.gov/seertools/hemelymph/ for coding primary site, histology, grade, and to determine the number of primaries for morphology codes 9590-9993. Follow the steps in priority order for using the *Hematopoietic and Lymphoid Neoplasm Database* and Coding Manual.

For cases diagnosed prior to 2010 use the link to the table "Definitions of Single and Subsequent Primaries for Hematologic Malignancies" found in the Heme DB once you select the diagnosis year from the diagnosis year dropdown menu.

Note: If the patient has a hematopoietic or lymphoid neoplasm diagnosed prior to 2010 and a new one diagnosed January 1, 2010 or later, use the *Hematopoietic and Lymphoid Neoplasm Database and Manual*.

Behavior Codes

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 27-30 in the ICD-O-3 manual discuss behavior.

Table 5.3 Behavior Codes

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

Note: TCR does not accept cases coded with a metastatic (/6) behavior code. If the only pathology 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 basic histology. See *ICD-O-3*, page 27.

Example: A patient is diagnosed with metastatic brain tumors and a fine needle aspiration biopsy shows that the tumor is metastatic small cell carcinoma (8041/6). The pathology report indicates that the tumor originated in the lung. Code the primary site as lung and the morphology as small cell carcinoma (8041/3).

Behavior Coding Instructions

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.

- 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
- 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
- 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.
  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.

  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.

Intracranial and CNS tumors

- Intracranial and CNS tumors with behavior codes 0 (benign) and 1 (borderline malignancy) are reportable to TCR for cases diagnosed in 2004 and forward. (C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753)
- 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

- Cases reported to TCR 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.
- Code the behavior as malignant (/3) when malignant metastasis is present. Metastasis could be regional, nodal, or distant.

  Example: Adenocarcinoma in situ with lymph nodes positive for malignancy. Code the behavior as malignant (/3).

  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

- 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*, Code the behavior as malignant (/3) if any portion of the primary tumor is invasive no matter how limited, i.e., microinvasion.

Example 1: Pathology from mastectomy: Large mass composed of intraductal carcinoma with a single focus of invasion. Code the behavior as malignant (/3).Re-code the behavior as malignant (/3) when metastases are attributed to a tumor originally thought to be in situ.

Example 2: 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.

Table 5.4 Behavior Codes Examples

Code	Fifth Digit Term	Descrpiption
2	In situ and/or carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Bowen disease (not reportable for C440–C449)
		Clark's Level I for melanoma (limited to epithelium)
		Comedocarcinoma, noninfiltrating (C50_)
2	Terms synonymous with in situ	Confined to epithelium
		AIN III (C211)
		Behavior code /2
		Hutchinson's melanotic freckle, NOS (C44_)
		Intracystic, non-infiltrating (carcinoma)
		Intraductal (carcinoma)
		Intraepidermal, NOS (carcinoma)
		Intraepithelial, NOS (carcinoma)
		Involvement up to, but not including the basement membrane
		Lentigo maligna (C44_)
		LIN III (C320-C329)
		Lobular, noninfiltrating(C50_) (carcinoma)
		Noninfiltrating (carcinoma)
		Noninvasive (carcinoma only)
		No stromal invasion/involvement

Code	Fifth Digit Term	Descrpiption
		Papillary, non-infiltrating or intraductal (carcinoma)
		Precancerous melanosis (C44_) Preinvasive
		Queyrat's erythroplasia (C60_)
		SIN III
		Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)
		VAIN III (C529)
		VIN III (C51_)
3	Invasive	Invasive or microinvasive

Primary Site

(NAACCR Item #400) (STORE 2021 page 136-137; SEER pages. (88-92)

Description

Identifies the primary site of the cancer.

Rationale

The primary site helps to determine stage and treatment options and shapes disease course and prognosis.

Refer to the *Solid Tumor Rules (2018)* at seer.cancer.gov/tools/solidtumor/ / for site-specific guidelines for primary sites, including Head and Neck, Breast, Lung, Brain, and Urinary.

Refer to the *SEER Program Coding and Staging Manual Appendix C* at seer.cancer.gov/tools/codingmanuals/2021manual.html for site-specific guidelines for primary sites, including Bladder, Breast, Colon, Esophagus, Kaposi Sarcoma of All Sites, Lung, and Rectosigmoid Junction.

Refer to the *Hematopoietic and Lymphoid Neoplasm Database and Coding Manual* at seer.cancer.gov/seertools/hemelymph/ for hematopoietic and lymphoid neoplasms to determine primary site for hematopoietic and lymphoid neoplasms.

Adequate text documentation must be provided to support coding. Auto coding of the ICD-O-3 code description is not considered adequate text documentation. In general, when a primary site is preceded by carcinoma of…, or malignancy of…, code to that primary site.

Use the *ICD-O-3 (International Classification of Diseases for Oncology) Manual* for assigning topography codes for the primary site.

See the *Coding Guidelines for Topography and Morphology* in the introduction of the ICD-O-3 for additional details. Primary site codes for solid tumors may be found in the *ICD-O-3 Topography*,

Numerical List Section (*ICD-O-3*, page 45) and in the *Alphabetic Index* (*ICD-O-3*, page 105). The topography code consists of an initial character (the letter C) followed by two numeric digits, a decimal point, and one additional numeric digit. The decimal point is not entered as part of the morphology code.

Example 1: The pathology report says the primary site is the cardia of the stomach. The code (C160) is found in the *Alphabetic Index* under either "stomach" or "cardia." Enter the code as (C160); do not record the decimal point.

Note: The exact location of the primary tumor is not always stated in the pathology report or discharge diagnosis. It is necessary to review the entire medical record in order to obtain the most precise description of the primary site.

Example 2: The pathology report states right breast resection specimen. The discharge diagnosis states carcinoma in the right breast. The History and Physical states examination of the right breast reveals a mass in the upper outer quadrant. Code to the more detailed description from the History and Physical, upper outer quadrant of the right breast (C504).

Coding Instructions for Solid Tumors

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 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.

        Example 1: Final diagnosis is adenocarcinoma of the upper lobe of the right lung. Code the topography to lung, upper lobe (C341).

        Example 2: Pathology report shows adenocarcinoma arising in an ectopic patch of endometriosis on the sigmoid colon. Code primary site to sigmoid colon (C187) where the cancer originated.

        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 primary site to branchial cleft (C104).

        Example 4: The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for non- cancer reasons. She now has widespread cystadenocarcinoma in the peritoneum. Code the primary site to peritoneum,

NOS (C482). (The chart may or may not state that the patient has extra-ovarian or primary peritoneal carcinoma).

Example 5: 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 primary site to upper inner quadrant of breast (C502).

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.

   Example 1: The patient has a 5 cm tumor overlapping the base of tongue and anterior 2/3 of tongue. Code the primary site to C028 (overlapping lesion of tongue).

   Example 2: Overlapping lesion of oropharynx. Code overlapping lesion when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.

   Example 3: Overlapping lesion of bladder. Code overlapping lesion of the bladder when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.

   Note:

   - Do not use 8 when the primary site of origin is known or when more than one tumor is identified in different subsites.
   - Skin cancers overlapping site 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 C448.

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

   Example: 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).

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

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

Example 2: Patient has an infiltrating duct carcinoma 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 parenthesis, e.g., hepatoma (C220).
    a. Code the site as documented in the medical record and ignore the suggested ICD-O-3.2 code when a different primary site is specified in the medical record.

        Example 1: The pathology report says, "infiltrating duct carcinoma of the head of the pancreas." The listing in ICD-O-3 is infiltrating duct carcinoma 8500/3 (C50). Code the primary site to head of pancreas, C250, NOT to breast as suggested by the ICD-O-3.2.

        Example 2: Patient presents with headaches and seizures. CT of the brain demonstrates a meningioma in the frontal lobe. Code the Primary Site field to C70.0 [cerebral meninges], the suggested site code for most meningiomas. Meningiomas arise from the meninges, not the brain (although they can invade brain).

    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.

        Example 1: The biopsy is positive for hepatoma, but there is no information available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.2.

        Example 2: The patient has an excision of the right axillary nodes which reveals metastatic infiltrating duct carcinoma. The right breast is negative. The ICD-O-3.2 shows 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.

        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).

    Note: If at any time a specific primary site is identified, change the site code from Unknown Primary (C809) to the specified primary site. Contact the TCR regional office for the appropriate procedure if this case has already been submitted to TCR. Changing the Primary Site may be other associated fields that need to be changed appropriately.

8. See the site-specific Coding Guidelines in Appendix A of the 2021 TCR Cancer Reporting Handbook or Appendix C of the SEER Program Coding and Staging Manual for helpful primary site coding guidelines for the following sites:

a. Breast
b. Bladder
c. Colon and Rectum
d. Esophagus
e. Lung
f. Skin – Melanoma
g. Malignant Brain and CNS
h. Non Malignant Brain and CNS
i. Kaposi Sarcoma

9. See the sarcoma coding instructions on page 141.
10. Angiosarcoma
    a. Code C422 (Spleen) as the primary site for angiosarcoma of spleen with mets to bone marrow.
    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 malignant 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.

       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 of distant metastatic site and site of origin is unknown

14. In the absence of any additional information, assign the codes listed for these primary sites in the following table.

Primary Site	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 the upper lip	C000
Cutaneous leiomyosarcoma	C44_
Distal conus	C720
Edge of tongue	C021
Frontoparietal (brain)	C718
Gastric angular notch (incisura)	C163
Genu of pancreas	C250
Glossotonsillar sulcus	C109
Incisura, incisura angularis	C163
Infrahilar area of lung	C349
Interhemispheric fissure (cerebrum)	C710
Lateral tongue	C023
Leptomeninges	C709
Masticator space	C069
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 site:
    a. Consult a physician advisor to assign the site code.

b. Use Table 5.5 (page 140) when the described histologies appear only with an ill-defined site description (such as “abdominal” or “arm”). Code to the tissue in which such tumors arise rather than the ill-defined region (C76_) of the body, which contains multiple tissues.

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

   Occult Tumors of the Head and Neck

   i. 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.

   ii. 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).

   iii. Assign C760 for Occult Head and Neck primaries with positive cervical lymph nodes.

   iv. Schema Discriminator 1: Occult Head and Neck Lymph Nodes is used to discriminate between these cases and other uses of C760.

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

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

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

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

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

Table 5.5 Primary Site Codes

Histology	Description	Code To This Site
8720-8790	Melanoma	C44_, Skin
8800-8811, 8813-8830, 8840-8921, 9040-9044	Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49_, Connective, Subcutaneous and Other Soft Tissues
8990-8991	Mesenchymoma	C49_, Connective, Subcutaneous, and Other Soft Tissues

Histology	Description	Code To This Site
9120-9170	Blood vessel tumors, lymphatic vessel tumors	C49_, Connective, Subcutaneous, and Other Soft Tissues
9580-9582	Granular cell tumor and alveolar soft part sarcoma	C49_, Connective, Subcutaneous and Other Soft Tissues
9240-9252	Mesenchymal chondrosarcoma and giant cell tumors	C40_, C41_ for Bone and Cartilage C49_, Connective, Subcutaneous and Other Soft Tissues
8940-8941	Mixed tumor, salivary gland type	C07_ for Parotid Gland C08_ for Other and Unspecified Major Salivary Glands

Common Metastatic Sites

If the final diagnosis reflects carcinoma of one of the common metastatic sites listed below, carefully review documentation in the medical record to confirm the primary site.

- Bone
- CNS Sites (brain, spinal cord, meninges)
- Liver
- Lymph Nodes (excluding lymphoma)
- Pericardium (excluding mesothelioma)
- Pleura (excluding mesothelioma)
- Peritoneum
- Retroperitoneum

Sarcoma Coding Instructions

- The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system. The musculoskeletal system includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones and cartilage. The default code for sarcomas of unknown primary site is **C49.9, soft tissue, NOS,** rather than C80.9.
- 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: For carcinosarcoma of the uterine corpus, code the primary site to corpus uteri (C549).

  Example 2: For 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).
- For Bone Sarcomas (C40._, C41._) do not use C76._ codes (Other and Ill-defined Sites) such as "arm", "leg", "trunk".
- For Soft tissue sarcomas (C49._, C47._, C48._, C38.1-C38.3), do not use C76._ codes (Other and Ill-defined Sites) such as "arm", "leg", "trunk".

Kaposi Sarcoma Coding Instructions

Kaposi sarcoma is a rare condition. When not AIDS-related, it usually presents as localized disease with an easily recognized primary site. AIDS-related Kaposi sarcoma usually presents as a disseminated disease with involvement of mucosal surfaces, visceral surfaces of organs, and skin. It is important to review consecutive records carefully to determine the extent of involvement at diagnosis. Review of a single record may reveal only the site being treated during that admission.

1. Code Kaposi Sarcoma to the primary site in which it arises.
2. If the Kaposi Sarcoma is present in the skin and another site simultaneously, code to the specified skin site, (C44_).
3. If the primary site is unknown or cannot be determined, code skin, NOS (C44.9).

Melanoma Coding Instructions

Code to Skin, NOS (C44.9) if a patient is diagnosed with metastatic melanoma and the primary site is not identified.

Additional Guidelines for Coding Primary Site

- A subareolar/retroareolar carcinoma is coded to the central portion of the breast (C50.1), which indicates that the tumor arose in the breast tissue beneath the nipple, not the nipple itself.
- Mycosis Fungoides is coded to skin (C44_).
- Intestinal type adenocarcinoma (8144) is a gastric histology term and is not listed in the WHO Histological Classification of Tumors of the Colon and Rectum. This code should not be used for colon and rectum primaries.

Other Primary Site Instructions (STORE 2021 page 21-22)

Occult Cervical Lymph Node

Beginning with cases diagnosed 1/1/2018 and later, for a head and neck primary lymph node involvement with no head and neck tumor found or specified by a physician (i.e., Occult Head and Neck Lymph Node), the primary site will be coded:

- C76.0 if the neck node has not been tested or is negative for both HPV and EBV. The AJCC Chapter 6 Cervical Lymph Nodes and Unknown Primary Tumor of the Head and Neck will be used.
- C10.9 if the neck node is p16 positive indicating human papilloma virus (HPV). The AJCC Chapter 10 HPV-Mediated (p16+) Oropharyngeal Cancer will be used.
- C11.9 if the neck node is EBER positive, or both EBER and p16 positive, indicating Epstein-Barr Virus (EBV). The AJCC Chapter 9 Nasopharynx will be used.

Refer to the SSDI Manual schema discriminators for further information and follow the instructions provided within the SSDI Schema Discriminator to assign the final primary site.

Cutaneous Carcinoma of the Head and Neck

Beginning with cases diagnosed 1/1/2018 and later, for 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. These cases will be staged with AJCC Cutaneous Carcinoma of the Head and Neck. Do not use code C44.8 Overlapping lesions of the skin. Cases coded to C44.8 will represent skin lesions overlapping between head and neck sites AND/OR skin in other parts of the body. These cases will not be staged with AJCC 8th Edition.

Coding Instructions for Hematopoietic and Lymphoid Neoplasms Guidelines:

Refer to Hematopoietic and Lymphoid Neoplasms (9590-9993) **Heme DB** at seer.cancer.gov/seertools/hemelymph/

Coding tips:

1. Do not use ambiguous terms to code a specific histology.
2. Primary site C400-C419 (Bone). The following histology is always coded to primary site C400-C419: 9731/3-Solitary plasmacytoma of bone

   Note: 9731/3 for plasmacytomas of the bone. If there is an extramedullary plasmacytoma (not occurring in bone) see histology 9734/3. (See also PH3 & PH4).
3. Primary site C379 (Thymus) or C383 (Mediastinum, NOS). Assign primary site to C379 or C383 when the histology is: 9679/3-Primary mediastinal (thymic) large B-cell lymphoma.

   Note: Do not code this histology based only on mediastinal involvement. Only assign this histology code when the diagnosis is stated as "primary mediastinal" large B-cell lymphoma.

4. Primary site C421 (Bone marrow). Assign primary site C421 (Bone marrow) when the histology is:
    - 9732/3-Plasma cell myeloma
    - 9741/3-Systemic mastocytosis with an associated hematological neoplasm
    - 9742/3-Mast cell leukemia
    - 9761/3-Waldenstrom Macroglobulinemia (for cases diagnosed 1/1/2018 and forward)
    - 9800/3-Leukemia, NOS
    - 9801/3-Acute leukemia, NOS
    - 9806/3-Mixed-phenotype acute leukemia with t(9;22)(q34.1;q11.2); BCR-ABL1
    - 9807/3-Mixed-phenotype acute leukemia with t(v;11q23.3); KMT2A-rearranged
    - 9808/3- Mixed-phenotype acute leukemia, B/myeloid, not otherwise specified
    - 9809/3-Mixed-phenotype acute leukemia, T/myeloid, not otherwise specified
    - 9820/3-Lymphoid leukemia, NOS
    - 9687/3-Burkitt cell leukemia
    - 9831/3-T-cell large granular lymphocytic leukemia
    - 9832-3-Prolymphocytic leukemia, NOS
    - 9833/3-B-cell prolymphocytic leukemia
    - 9834/3-T-cell prolymphocytic leukemia
    - 9840/3-Pure erythroid leukemia
    - 9860/3-Myeloid leukemia
    - 9861/3-Acute myeloid leukemia, NOS
    - 9863/3-Chronic myeloid leukemia

Note: See the full list of codes in the Hematopoietic and Lymphoid Neoplasm Coding Manual (page 36.).

Primary site coding instructions begin on page 34 in the Hematopoietic and Lymphoid Neoplasm Coding Manual.

Grade Clinical

NAACCR Item # 3843 (STORE 2021 page 142; SEER page 104)

Description

Grade Clinical, effective 1/1/2018, records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). For some sites, grade is required to assign the clinical stage group.

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Pathological* and *Grade Post Therapy*, replaces the data item *Grade* [NAACCR Item #440] as well as site specific factors for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason].

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

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 for AJCC staging, the recommended grading system is specified in the AJCC 8th Edition Chapter. The AJCC 8th Edition Chapter-specific grading systems (codes 1-5, L,H,M,S) take priority over the generic grade definitions (codes A-E, 8, 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.

Allowable values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S

Grade Pathological

NAACCR Item # 3844 (STORE 2021 page 143; SEER page 106)

Description

Grade Pathological, effective 1/1/2018, 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.

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Clinical* and *Grade Post Therapy*, replaces the data item *Grade* [NAACCR Item #440] as well as site specific factors for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason].

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

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 for AJCC staging, the recommended grading system is specified in the AJCC 8th Edition Chapter. The AJCC 8th Edition Chapter-specific grading systems (codes 1-5, L,H,M,S) take priority over the generic grade definitions (codes A-E, 8, 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.

Hematopoietic and lymphoid neoplasms

Note: Grade is no longer applicable for cases diagnosed 2018 and forward for hematopoietic and lymphoid neoplasms.

Exception: Lymphoma Ocular Adnexa cases diagnosed in any year. Grade Clinical and Grade Pathological should default to the "not applicable" (code 8).

Grade is still required for cases diagnosed prior to 2018.

When coding grade for hematopoietic and lymphoid neoplasms remember to follow the instructions given at the current hematopoietic and lymphoid neoplasm manual:
seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Grade Post Therapy Clinical (yc)

NAACCR Item # 1068 (STORE 2021 page 202; SEER page 105)

Description

This data item, implemented in 2021, 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, 2021, and later, this data item, along with Grade Clinical, Grade Pathological, and Grade Post Therapy Path (yp), replaces all previous grade related data items, including NAACCR Data Item Grade [440] and Collaborative Stage Site-Specific Factors (SSF's) (2004-2017) for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason])

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

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 grade post therapy clin (yc) 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) 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 may apply.

Allowable values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S

Grade Post Therapy Path (yp)

NAACCR Item # 3845 (STORE 2021 page 215; SEER page 31)

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, Grade Pathological, and Grade Post Therapy Clin (yc), replaces all previous grade related data items, including NAACCR Data Item Grade (#440) and Collaborative Stage Site-Specific Factors (SSF's) (2004-2017) for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

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

Allowable values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S

Laterality

(NAACCR Item #410) (STORE 2021 page 138; SEER pages 93-95)

Description

Identifies the side of a paired organ or the side of the body where the tumor originated.

Rationale

Aids in staging and extent of disease information and may indicate the number of primaries.

Coding Instructions

1. Starting with cases diagnosed January 1, 2004 and later, laterality is coded for specified invasive, benign, and borderline primary intracranial and CNS tumors. See Paired Organ Sites Table beginning on page 150.
2. Code laterality using codes 1-9 for all sites listed in the table 5.7: Sites for Which Laterality codes must be recorded.
3. Non-paired sites are coded to 0.
4. Unknown (C809) and Ill-defined (C760–C768) sites are coded to 0.
5. Assign code 9 when the disease originated in a paired site, but the laterality is unknown AND there is no statement that only one side of the paired organ is involved.

   Example: Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer. Assign code 9.
6. Do not code metastatic sites as bilateral involvement.

   Example: Patient is diagnosed with adenocarcinoma of the left lung and the physician states patient has metastasis to the right lung. Assign laterality code 2, left origin of primary.
7. For primaries of in situ behavior, if laterality is not known, code to 3 (only one side involved, right or left origin of primary not indicated). Laterality for in situ behavior cannot be coded to 9 or 4.
8. Assign code 3 if laterality is unknown but the tumor is confined to a single side of a paired organ.

   Example: Pathology report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.
9. Code 4 is seldom used EXCEPT for the following:
   - Both ovaries involved simultaneously, single histology, or epithelial histologies (8000-8799)
   - Diffuse bilateral lung nodules
   - Bilateral retinoblastoma
   - Bilateral Wilms tumors
10. Assign code 5 for a midline tumor of a paired site. (C700, C710-C714, C722-C725, C443, C445).

Note: Midline for code 5 refers to the point where the right and left sides of paired organs come into direct contact and a tumor forms at that point such as skin of trunk (C445). Most paired sites cannot develop midline tumors. Do not assign code 5 to sites not previously listed above.

Example 1: A melanoma of the skin of back is described as midline. Record laterality as 5. Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0.

Example 2: Patient has an excision of a melanoma located just above the umbilicus (C445, laterality 5).

Example 3: Patient has a midline meningioma of the cerebral meninges (C700, laterality 5).

11. Document the laterality in the appropriate text field.

Table 5.6 Laterality Codes

Code	Description
0	Not a paired site
1	Right origin of primary
2	Left origin of primary
3	Only one side involved, right or left origin of primary not indicated
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or: • Both ovaries simultaneously involved with a single histology • Bilateral retinoblastomas • Bilateral Wilms' tumors ***Note:*** If both lungs have nodules or tumors and the lung of origin is not known, assign code 4
5	Paired site: midline tumor
9	Unknown site; paired site, lateral origin unknown

Bilateral Sites

Laterality must be recorded for the following bilateral sites. Only major headings are listed. Laterality should be recorded for all anatomic sub-sites included in *ICD-O-3* unless specifically excluded. Such exclusions are coded 0.

Code laterality using codes 1–5 or 9 for all of the sites listed in the following table:

Table 5.7 Bilateral Site Codes

Paired Organ Sites - Alphabetic Order	
Primary Site	**ICD-O-3 Code**
Acoustic nerve	C724
Adrenal gland [cortex, medulla]	C740–C749
Breast	C500–C509
Carotid body	C754
Cerebral meninges, NOS	C700
Cerebrum	C710
Conjunctiva, lacrimal gland, orbit, cornea, retina, choroid, ciliary body, iris, sclera, lens, eyeball	C690
Connective, subcutaneous and other soft tissues of lower limb & hip	C492
Connective, subcutaneous and other soft tissue of upper limb & shoulder	C491
Cranial nerve, NOS	C725
Epididymis	C630
Fallopian tube	C570
Frontal lobe	C711
Frontal sinus	C312
Kidney, NOS	C649
Long bones of upper limb, scapula and associated joints	C400
Long bones of lower limb and associated joints	C402
Lung	C341–C349
Main bronchus [excluding carina]	C340
Maxillary sinus [antrum]	C310
Middle ear [tympanic cavity]	C301
Nasal cavity [excluding nasal cartilage and nasal septum code 0]	C300
Occipital lobe	C714
Olfactory nerve	C722
Optic nerve	C723
Ovary	C569
Overlapping lesion of the eye and adnexa; Eye, NOS; Eye and lacrimal Gland	C690–C699
Parietal lobe	C713
Parotid gland	C079
Pelvic Bones and associated joints [excluding sacrum, coccyx and symphysis pubis - code 0]	C414

Paired Organ Sites - Alphabetic Order	
Primary Site	**ICD-O-3 Code**
Peripheral nerves and autonomic nervous system of lower limb and Hip	C472
Peripheral nerves and autonomic nervous system of upper limb and shoulder	C471
Pleura	C384
Renal pelvis	C659
Rib, clavicle, and associated joints [excluding sternum - code 0]	C413
Short bones of upper limb and associated joints	C401
Short bones of lower limb and associated joints	C403
Skin of external ear	C442
Skin of eyelid	C441
Skin of other and unspecified parts of face [IF midline tumor, code 5] *	C443
Skin of upper limb and shoulder	C446
Skin of lower limb and hip	C447
Skin of Scalp and Neck [IF midline tumor, code 5] *	C44.4
Skin of trunk [IF midline tumor, code 5] *	C445
Spermatic cord	C631
Sublingual gland	C081
Submandibular gland	C080
Temporal lobe	C712
Testis	C620–C629
Tonsil, NOS and Overlapping lesion of Tonsil	C098–C099
Tonsillar fossa	C090
Tonsillar pillar	C091

*Assign code 5 when the tumor originates in the midline of a site C700, C710-C714, C722-C725, C443, C445. Midline for code 5 refers to the point where the right and left sides of paired organs come into direct contact and a tumor forms at that point such as skin of trunk (C445).

Table 5.8 Bilateral Site Codes

Paired Organ Sites - Numerical Order	
ICD-O-3 Code	**Primary Site**
C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland

Paired Organ Sites - Numerical Order	
ICD-O-3 Code	**Primary Site**
C090	Tonsillar fossa
C091	Tonsillar pillar
C098	Overlapping lesion of tonsil
C099	Tonsil, NOS
C300	Nasal cavity [excluding nasal cartilage and nasal septum code 0]
C301	Middle ear [tympanic cavity]
C310	Maxillary sinus [antrum]
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 and clavicle [excluding sternum code 0]
C414	Pelvic bones [excluding sacrum, coccyx, and symphysis pubis code 0]
C441	Skin of eyelid
C442	Skin of external ear
C443	Skin of other and unspecified parts of face [IF midline tumor, code 5] *
C444	Skin of Scalp and Neck [IF midline tumor, code 5] *
C445	Skin of trunk [IF midline tumor code 5] *
C446	Skin of upper limb and shoulder
C447	Skin of lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of lower limb and hip
C500–C509	Breast
C569	Ovary
C570	Fallopian tube
C620–C629	Testis

Paired Organ Sites - Numerical Order	
ICD-O-3 Code	**Primary Site**
C630	Epididymis
C631	Spermatic cord
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter
C690–C699	Eye and Lacrimal Gland
C700	Cerebral meninges, NOS
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 [cortex, medulla]
C754	Carotid body

*Assign code 5 when the tumor originates in the midline of a site C700, C710-C714, C722-C725, C443, C445. Midline for code 5 refers to the point where the right and left sides of paired organs come into direct contact and a tumor forms at that point such as skin of trunk (C445).

Notes:

- Assign code 0 when:
- The primary site is not a paired site
- Primary site is unknown (C809), or
- 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
- A laterality code of 1–5 or 9 must be assigned for the above sites except as noted. If the site is not listed on the table, assign code 0 for laterality.
- Code the side where the primary tumor originated

- Assign code 3 if the laterality is not known but the tumor is confined to a single side of the paired organ.
- Never use code 4 for bilateral primaries for which separate abstracts are prepared, or when the side of origin is known, and the tumor has spread to the other side. Code 4 is seldom used EXCEPT for the following diseases:
- Both ovaries involved simultaneously, single histology, or epithelial histologies (8000-8799)
- Diffuse bilateral lung nodules
- Bilateral retinoblastoma
- Bilateral Wilms tumors

  Example: A left breast primary with metastasis to the right breast is coded to 2 (left). This would not be coded to 4 (bilateral).
- Assign code 5 when the tumor originates in the midline of a site C700, C710-C714, C722-C725, C443, C445

  Example 1: Patient has an excision of a melanoma located just above the umbilicus (C445, laterality code 5)

  Example 2: Patient has a midline meningioma of the cerebral meninges (C700, laterality code 5).
- Sometimes the physician may describe the site of the tumor in an organ as right or left. This is a descriptive term and does not refer to a bilateral site or organ.

  Example: Patient admitted for surgical resection of tumor in right colon. Code to 0, not a paired site. Do not code to 1. Right colon refers to the ascending colon. The colon is not a paired site.

Final Diagnosis - Morphology/Behavior, Grade, Primary Site, and Laterality Documentation

(NAACCR Items #2580 [Final Diagnosis (Primary, Laterality)], #2590 [Final Diagnosis (Morphology, Behavior, Grade)]

Text to support morphology/behavior, grade, primary site, and laterality codes **must** be provided.

Documenting Instructions

1. Record the morphology/behavior, grade, primary site, and laterality descriptions.
2. Do not use the generic ICD-10-CM code statement found on the face sheet.

   Example 1: Morphology: Moderately well differentiated mucin-producing adenocarcinoma

   Primary Site: Colon, ascending

   Example 2: Morphology: Grade 3, infiltrating ductal and lobular carcinoma

   Primary Site: Right breast, upper outer quadrant

Example 3: Morphology: Anaplastic astrocytoma
Primary Site: Brain, frontal-parietal lobe

Example 4: Morphology: Intermediate grade large cell carcinoma
Primary Site: Left lung lower lobe

Lymphovascular Invasion

(NAACCR Item #1182) (STORE 2021page 154-158; SEER page 131-133)

Description

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.

Rationale

Lymphovascular invasion is an indicator of prognosis.

Note: TCR collects this data item only for Penis (C60) and Testis (C62)**.**

Coding Instructions

1. Code from pathology report(s). Code the absence or presence of lymphovascular invasion as described in the medical record.
    a. The primary sources of information about lymphovascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician's statement, in that order.
    b. Do not code perineural invasion in this field.
    c. Information to code this field can be taken from any specimen from the primary tumor.
    d. If lymphovascular invasion is identified anywhere in the resected specimen, it should be coded as present/identified.
2. Use of codes:
    a. Use code 0 when the pathology report indicates that there is no lymphovascular invasion. This includes cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane.
    b. 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.

Note: Synonyms for lymphovascular invasion include LVI, lymphovascular invasion, vascular invasion, blood vessel invasion, and lymphatic invasion. Lymph node involvement is not the same as lymphovascular invasion.

c. Use code 9 when:
   - There is no microscopic examination of a primary tissue specimen.
   - The primary site specimen is cytology only or a fine needle aspiration.
   - The biopsy is only a very small tissue sample.
   - It is not possible to determine whether lymphovascular invasion is present.
   - The pathologist indicates the specimen is insufficient to determine lymphovascular invasion.
   - Lymphovascular invasion is not mentioned in the pathology report.

d. This field may be defaulted to a 9 or left blank for sites which do not require it to be collected. Use code 8 for Lymphoma and Hematopoietic diseases or leave it blank. Leaving the default as 9 for Lymphoma and Hematopoietic will create an edit error.

Table 5.9 Lymphovascular Invasion Codes

LVI on pathology PRIOR to neoadjuvant therapy	LVI on pathology report AFTER neoadjuvant 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

Diagnostic Confirmation

(NAACCR Item #490); (STORE 2021 pages 144-146; SEER pages 96-98)

Description

Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history. It is not limited to the confirmation at the time of initial diagnosis.

Rationale

This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed only is an indication of whether casefinding includes sources beyond pathology reports. Complete casefinding must include both clinically and pathologically confirmed cases.

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 lower code if at ANY TIME during the course of disease the patient has a diagnostic confirmation that has a higher priority. Change to a the higher-priority code even when diagnostic confirmation is based on the result of subsequent treatment. There is no time limit for this field.
3. If diagnosed elsewhere, copies of the previous pathology or radiology reports included in the medical record may be used to code this field.
4. All diagnostic reports in the medical record must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer. This review must cover the entire medical history in regards to the primary tumor. If diagnosed prior to admission to the reporting facility, review the history section of the record to identify information regarding previous diagnostic tests and treatments.
5. If the information in the medical record indicates a biopsy or resection of the tumor has been performed, assume the diagnostic confirmation is histological even if the pathology report is not available.

   Example: A patient comes in for a bone scan for staging of a known prostate cancer. It is noted in the record that the patient had a prostate biopsy two weeks prior. Use diagnostic confirmation code 1, positive histology.
6. Assign code 1 when the microscopic diagnosis is based on:
   a. Tissue specimens from fine needle aspirate, biopsy, surgery, autopsy or Dilatation & Curettage
   b. Bone marrow specimens (aspiration and biopsy)
7. 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 and vaginal smears.
   b. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.
8. Assign code 4 when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.

9. Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies with a clinical diagnosis for that specific cancer and there is no other diagnostic work up (i.e. imaging)

   Example 1: The patient has elevated alpha-fetoprotein with a clinical diagnosis of liver cancer.

   Example 2: The workup for a prostate cancer patient is limited to a highly elevated PSA and the physician diagnoses and/or treats the patient based only on that PSA.

   Note: For tests and tumor markers that may be used to help diagnose cancer, see the following fact sheets:
   - cancer.gov/cancertopics/factsheet/detection
   - cancer.gov/cancertopics/factsheet/detection/tumor-markers

10. 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).
11. 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.
12. 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 physicians' clinical diagnosis.

    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 diagnostic confirmation to 8: there is a physician's clinical diagnosis – clinical diagnosis made by the physician using the information available for the case.
13. Assign code 9 when it is unknown how the diagnosis was confirmed. Death certificate-only cases will be assigned code 9.

    Note: The diagnostic code must be changed to the lower (more specific) code if a more definitive code confirms the diagnosis during the course of the disease, regardless of time frame.

Examples

- Mammography indicates a lesion suspicious for cancer. The diagnostic confirmation code is 7. Two weeks later a biopsy confirms infiltrating ductal carcinoma. The correct diagnostic confirmation code is 1.
- MRI originally diagnosed a patient with a glioblastoma. The diagnostic confirmation code is 7. A year later a surgical biopsy is obtained. The diagnostic confirmation code would be changed to 1.
- A thoracentesis is performed for a patient who is found to have a large pleural effusion. Cytology reveals malignant cells consistent with adenocarcinoma. The diagnostic confirmation code is 2.

- CAT scan of abdomen reveals metastatic deposits in the liver and a large lesion in the ascending colon. Biopsy and later resection of the colon lesion revealed mucin-producing adenocarcinoma. The diagnostic confirmation code is 1.
- Fine needle aspiration (FNA) is positive for malignant cells. The diagnostic confirmation code is 2.

Table 5.9 Diagnostic Confirmation Codes for Solid Tumors

Code	Description	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Histological confirmation (tissue microscopically examined). In situ behavior must be microscopically confirmed.
2	Positive cytology	Cytological confirmation (no tissue microscopically examined; fluid cells microscopically examined). Includes pap smears, bronchial brushings, FNA and peritoneal fluid, cervical and vaginal smears, diagnoses based on paraffin block specimens from concentrated spinal, pleural or peritoneal fluid.
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which clinically diagnostic for that specific cancer. Positive laboratory test/marker study. ***Note:*** Includes cases with positive immunophenotyping or genetic studies and no histological confirmation.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical/endoscopic procedure only with no tissue resected for microscopic exam.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.

Code	Description	DEFINITION
MICROSCOPICALLY CONFIRMED		
8	Clinical diagnosis only (other than 5, 6, or 7)	The physician documented the tumor in the medical record. The diagnostic confirmation is coded 8 when the only confirmation of disease is a physician's clinical diagnosis.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate-only cases.

Instructions for Coding Diagnostic Confirmation of Hematopoietic or Lymphoid Tumors (9590-9993)

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

- Other than microscopic confirmation (1-4) taking priority over clinical diagnosis only (5-8), there is no priority order or hierarchy for coding the Diagnostic Confirmation for hematopoietic or lymphoid neoplasms. Most commonly the bone marrow provides several provisional diagnoses, and the specific histologic type is determined through immunophenotyping or genetic testing.
- For cases diagnosed January 1, 2010 and later see the *Hematopoietic and Lymphoid Neoplasm Database and Coding Manual* at seer.cancer.gov/tools/heme/index.html for information on the definitive diagnostic confirmation code for specific types of neoplasm.
- Use code 1 when only the tissue, bone marrow, or blood was used to diagnose the specific histology. Do not use code 1 if the provisional diagnosis was based on tissue, bone marrow, or blood and the immunophenotyping or genetic testing on that same tissue, bone marrow, or blood identified the specific disease (See code 3).
- If a neoplasm is originally confirmed by histology (code 1), and later has immunophenotyping, genetic testing or JAK2 which confirms a more specific neoplasm and there is no evidence of transformation, change the histology code to the more specific neoplasm and change the diagnostic confirmation to code 3. Do not use diagnostic confirmation code 3 for cases diagnosed prior to January 1, 2010.

Code 1: Positive histology

Code 1 includes a provisional diagnosis and/or several provisional (differential) diagnoses which may or may not be preceded by approved ambiguous terminology.

Assign code 1 for:

1. Tissue from lymph node(s), organ(s) or other tissue specimens from biopsy, frozen section, surgery or autopsy
2. Bone marrow specimens (aspiration and biopsy)
3. Peripheral blood smear
    a. Can be used as a histological diagnosis for any of the hematopoietic histologies (9590/3-9993/3)
4. Leukemia only (9800/3-9948/3): positive histology also includes
    a. Complete blood count (CBC)
    b. White blood count (WBC)
5. Neoplasm microscopically confirmed AND
    a. immunophenotyping, genetic testing, or JAK2 not done OR
    b. immunophenotyping, genetic testing, or JAK2 done but negative (non-diagnostic) for the neoplasm being abstracted.

    Example: Acute myelomonocytic leukemia (9867/3) CD10+. CD10+ is not listed under Immunophenotyping for this histology, so diagnostic confirmation should be 1.
6. IHC studies are done, but the patient has a provisional (NOS) diagnosis or one or more provisional diagnoses.
7. Historical cases not already in the database if information states that there was histologic confirmation.

    Example: Patient diagnosed in 2012 with Stage III mantle cell lymphoma, diagnosed by LN biopsy. Mantle cell lymphoma not in the database. Now presents with DLBCL in 2015.

Code 2: Positive cytology

Code 2 is rarely used for Hematopoietic and Lymphoid neoplasms.

Assign code 2 for:

1. Examination of fluid such as spinal fluid, peritoneal fluid, or pleural fluid
2. Paraffin block specimens from concentrated spinal fluid, peritoneal fluid, or pleural fluid
3. A specimen that fails to provide enough tissue to do a histologic examination - in this case, the report will be a cytology report rather than a pathology report.

Code 3: Positive histology PLUS positive immunophenotyping or genetic testing

Code 3 can be used for cases diagnosed 2010+ with histologic confirmation (see code 1) AND immunophenotyping, genetic testing, or JAK2 confirmation.

Assign code 3 for:

1. Cases with positive histology for the neoplasm being abstracted (including acceptable ambiguous terminology and provisional diagnosis) andiImmunophenotyping, genetic testing, or JAK2 is listed in the Definitive Diagnosis in the Heme DB AND the testing: (including acceptable ambiguous terminology and provisional diagnosis) AND Immunophenotyping, genetic testing, or JAK2 is listed in the Definitive Diagnosis in the Heme DB AND the testing
    a. Confirms the neoplasm, or
    b. Identifies a more specific histology (not preceded by ambiguous terminology)
    - Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when preceded by ambiguous terminology.
    - Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when the test result is preceded by "patchy weak staining."
2. NOS histology diagnosed and not a provisional diagnosis and genetics/immunophenotyping was performed.

Examples:

- Identifying a more specific histology: Bone marrow biopsy positive for acute myeloid leukemia (9861/3). Genetic testing positive for AML with inv (16) (p13.1q22) (9871/3). Code Diagnostic Confirmation code 3, positive histology and positive genetic testing, which identified a more specific histology.
- Identifying a more specific histology: Peripheral blood smear with lymphoblastic lymphoma (9671/3). Bone marrow biopsy with immunophenotyping showing CD5 negative and IgM positive, diagnosis Waldenstrom Macroglobulinemia (9761/3). Code Diagnostic Confirmation code 3, positive histology and positive immunophenotyping testing which identified a more specific histology.
- Confirming the histologic diagnosis: Bone marrow biopsy diagnosis is plasma cell dyscrasia. Peripheral blood smear is compatible with plasma cell leukemia. FISH and chromosome analysis revealed plasma cell myeloma. Both plasma cell leukemia and plasma cell myeloma are coded to the same ICD-O code, 9732/3, so there is only one disease process.
- The peripheral blood smear is histologic diagnosis for the plasma cell leukemia and FISH confirmed the diagnosis of multiple myeloma/plasma cell myeloma. Code Diagnostic Confirmation 3, positive histology and positive genetic testing.
- Histologic confirmation plus genetic and immunophenotyping confirmation: Patient diagnosed with CLL by CBC and flow cytometry that was positive for both the genetic and CD antigens (immunophenotyping) for CLL. A bone marrow biopsy not performed. Since this is leukemia, the CBC is histologic confirmation, so this patient had histologic confirmation, genetic, and immunophenotyping positive for CLL. Code Diagnostic Confirmation 3, positive histology and positive genetic testing/immunophenotyping.
- Ambiguous terminology used with immunophenotyping: Bone marrow biopsy shows B lymphoblastic leukemia. Abnormal FISH results most likely represent a hyperdiploid clone. Code the histology to 9811 (B-ALL, NOS) and assign a diagnostic confirmation code of 1.

Neither Diagnostic confirmation code 3 nor the more specific hyperdiploidy histology is coded because the associated FISH result is preceded by ambiguous terminology.

Tip: Alphabet Soup Method for Genetics Data

When determining whether to use Code 3 for Hematopoietic or Lymphoid Neoplasm, think about alphabet soup. If you see letters, numbers, and plus signs in the diagnosis, it is a Code 3. Those letters, numbers, and plus signs would not be in the diagnosis documentation unless immunophenotyping or genetic testing was done.

Examples:

- ABL-1 at 9q34
- BCR-ABL fusion protein
- Fusion of BCR at 22q11.2
- p190 kd BCR-ABL1 fusion protein
- p210 kd fusion protein
- Immunophenotyping
- CD10+
- CD19+
- TdT+

It is important to consult the Hematopoietic Database under the histology for the Definitive Diagnostic Methods. Assign Code 3 for cases with a positive histology for the neoplasm being abstracted (including acceptable ambiguous terminology and provisional diagnosis) AND immunophenotyping, genetic testing, or JAK2 is listed in the Definitive Diagnosis Methods in the Hematopoietic Database AND the testing confirms the neoplasm OR identifies a more specific histology (not proceeded by ambiguous terminology).

Code 4: Positive microscopic confirmation, method not specified.

Code 4 is rarely used for Hematopoietic and Lymphoid neoplasms.

Assign code 4 when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.

Code 5: Positive laboratory test/marker study

Assign code 5 when the diagnosis of cancer is based on laboratory tests, tumor marker studies, genetics or immunophenotyping that are clinically diagnostic for that specific cancer. Laboratory tests are listed under Definitive Diagnostic Methods in the Hematopoietic Database. Do not assign code 5 when there is histologic confirmation (See code 3).

Example: CT scan consistent with plasma cell myeloma (9732/3). Twenty-four-hour urine protein elevated with the presence of Bence-Jones kappa. Assign code 5 because the diagnosis is

based on the positive Bence-Jones and there is no histologic confirmation in this case. Bence-Jones protein is a lab test listed in the Heme DB as one of the definitive diagnostic methods for plasma cell myeloma.

Code 6: Direct visualization without microscopic confirmation

Code 6 is rarely used for Hematopoietic and Lymphoid neoplasms.

Assign code 6 when:

1. The operative report states the patient had lymphoma, but no biopsy or cytology was done.
2. The diagnosis is determined by gross autopsy findings (no tissue or cytologic confirmation)

Code 7: Radiology and other imaging techniques without microscopic confirmation

Code 7 is rarely used for Hematopoietic and Lymphoid neoplasms.

Assign code 7 when the diagnosis is confirmed by radiology or other imaging techniques only.

Example: Terminally ill patient who has a CT scan with the impression: suspicious for lymphoma. The patient refused further workup.

Code 8: Clinical diagnosis only (other than 5, 6, or 7)

Assign code 8 when:

1. While clinical diagnosis is seldom used for solid tumors, it is a valid diagnostic method for certain hematopoietic neoplasms.
2. The Heme DB will list Clinical Diagnosis as the definitive diagnostic method for certain hematopoietic neoplasms. For these neoplasms, biopsy, immunophenotyping, and genetic testing do not confirm the neoplasm.
3. The diagnosis is determined based on the physician's clinical expertise, combined with the information from the biopsy, equivocal or negative tests, and the clinical symptoms. This is called a "diagnosis of exclusion" because the physician's judgment and the work-up literally exclude all other possible diagnoses, leaving one diagnosis. Ambiguous terminology may precede the diagnosis.

Example: Bone marrow biopsy shows anemia NOS; physician notes state the patient's overall clinical presentation of hypercalcemia, fever, and anemia is consistent with Myelodysplastic Syndrome, unclassifiable (9989/3). Code Diagnostic Confirmation 8, clinical diagnosis only.

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

Assign code 9 when it is unknown if the diagnosis was confirmed microscopically:

1. For death-certificate-only (DCO) cases
2. For historical cases not already in the database when there is no information available

Example: "History of follicular lymphoma in 2010, now presents with DLBCL." Follicular lymphoma not in the database. Assign diagnostic confirmation of 9 for the follicular lymphoma.

Table 5.10 Diagnostic Confirmation Codes for Hematopoietic or Lymphoid Tumors (9590-9993)

Code	Description	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Tissue from lymph node(s), organ(s) or other tissue specimens from biopsy, frozen section, surgery or autopsy; Bone marrow specimens (aspiration and biopsy), Peripheral blood smear Can be used as a histological diagnosis for any of the hematopoietic histologies (9590/3-9993/3) Leukemia only (9800/3-9948/3): positive histology also includes Complete blood count (CBC) White blood count (WBC) Neoplasm microscopically confirmed AND immunophenotyping, genetic testing, or JAK2 not done OR immunophenotyping, genetic testing, or JAK2 done but negative (non-diagnostic) for the neoplasm being abstracted IHC studies are done, but the patient has a provisional (NOS) diagnosis or one or more provisional diagnoses. Historical cases not already in the database if information states that there was histologic confirmation ***Example:*** Patient diagnosed in 2012 with Stage III mantle cell lymphoma, diagnosed by LN biopsy. Mantle cell lymphoma not in the database. Now presents with DLBCL in 2015.

Code	Description	DEFINITION
2	Positive cytology, no positive histology	This code is rarely used for Hematopoietic and Lymphoid neoplasms. This code includes examination of fluid such as spinal fluid, peritoneal fluid, or pleural fluid. This code also includes paraffin block specimens from concentrated spinal fluid, peritoneal fluid, or pleural fluid. When a small-gauge needle (fine needle aspirations or FNA), or other method is used to obtain a specimen and there is not enough tissue to do a histologic examination the report will be a cytology report rather than a pathology report.
3	Positive histology PLUS: Positive immunophenotyping AND/OR Positive genetic studies Effective for cases diagnosed 1/1/2010 and later.	Cases with positive histology for the neoplasm being abstracted (including acceptable ambiguous terminology and provisional diagnosis) AND Immunophenotyping, genetic testing, or JAK2 is listed in the Definitive Diagnosis in the Heme DB AND the testing Confirms the neoplasm OR Identifies a more specific histology (not preceded by ambiguous terminology) ***Note:*** Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when preceded by ambiguous terminology. Do not use code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when the test result is preceded by "patchy weak staining." NOS histology diagnosed and not a provisional diagnosis and genetics/immunophenotyping was performed.

Code	Description	DEFINITION
4	Positive microscopic confirmation, method not specified	This code is rarely used for Hematopoietic Lymphoid neoplasms. The diagnosis is stated to be microscopically confirmed but the method is not specified or unknown.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker study	This code is rarely used for Hematopoietic and Lymphoid neoplasms. If there no provisional diagnosis or clinical suspicion of cancer, immunophenotyping or genetic testing would not be done. ***Example:*** CT scan consistent with multiple myeloma (9732/3). Twenty-four hour urine protein elevated with the presence of Bence-Jones kappa. Code 5 for diagnosis based on the positive Bence-Jones, which is listed as one of the diagnostic confirmation methods in the Heme DB and is also a lab test. Code 1 and 3 do not apply because there is no histologic confirmation and positive immunophenotyping and or genetic studies in this example.
6	Direct visualization without microscopic confirmation	This code is rarely used for hematopoietic and lymphoid neoplasms. The operative report may state that the patient had lymphoma, but no biopsy or cytology was done, or the diagnosis is determined by gross autopsy findings (no tissue or cytologic confirmation).
7	Radiography and other imaging techniques without microscopic confirmation	This code is rarely used for Hematopoietic and Lymphoid neoplasms. Assign code 7 when the diagnosis is confirmed by radiology or other imaging techniques only.

Code	Description	DEFINITION
8	Clinical diagnosis only (other than 5, 6, or 7)	While clinical diagnosis is seldom used for solid tumors, it is a valid diagnostic method for certain hematopoietic neoplasms. The Heme DB will list Clinical Diagnosis as the definitive diagnostic method for certain hematopoietic neoplasms. For these neoplasms, the biopsy, immunophenotyping, and genetic testing do not confirm the neoplasm. The diagnosis is determined based on the physician's clinical expertise, combined with the information from the biopsy, equivocal or negative tests, and the clinical symptoms. This is called a "diagnosis of exclusion" because the physician's judgment and the work-up literally exclude all other possible diagnoses, leaving one diagnosis. ***Example:*** Bone marrow biopsy shows anemia NOS; physician notes state the patient's overall clinical presentation of hypercalcemia, fever, and anemia is consistent with Myelodysplastic Syndrome, NOS (9989/3). Code Diagnostic Confirmation 8, clinical diagnosis only.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate-only cases.

Changing Abstract Information

There are some circumstances under which the information originally coded in the abstract should be updated.

1. To correct coding or abstracting errors when identified.
2. When better information is available at a later date.

- Earlier or more specific diagnosis date
- Better histology or grade
- More specific primary site
- Lower diagnostic confirmation code

Example 1: Patient has surgery for a benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2020. In January 2021, the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar accessions the malignant argentaffin carcinoid as a 2021 diagnosis. Two months later, the pathologist reviews the slides from the May 2020 surgery and concludes that the carcinoid diagnosed in 2020 was malignant. Change the date of diagnosis to May 2020 and histology to 8241 and the behavior code to malignant (/3).

Example 2: At the time of diagnosis, a patient is diagnosed with liver metastasis, but primary site cannot be determined, and the abstract is submitted as an unknown primary. At a later date the physician determines that the patient has a colon primary. Change the primary site from unknown to colon. Be sure to make any necessary changes in *Staging* and *Surgery Codes*. Document the new information in the appropriate text fields.

Example 3: A patient is diagnosed with lung cancer by CT exam alone. An abstract is submitted with the histology of cancer (8000/3) and diagnostic confirmation code 7. At a later admit the H&P states that the patient has squamous cell carcinoma of the lung diagnosed by fine needle aspiration. The *Histology* should be changed from cancer to squamous cell carcinoma (8070/3), and the *Diagnostic Confirmation* should be changed to 2, cytology. These findings should also be documented in the text fields.

Note: Contact the TCR health service regional office regarding the appropriate procedure to follow when there is updated information on an abstract already submitted to TCR. Do NOT resubmit the abstract. These cases will result in duplicate records and require manual resolution. TCR does not accept modified abstracts.

6

STAGING

STAGING DOCUMENATION

Explanation

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values and should not be generated electronically from coded values. Information documenting the disease process should be entered manually from the medical record. Staging should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Do not enter text in every text field when treatment is either not done, or unknown if done. Document "Not done" or "Unknown if done" in only one text field.

Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized (see Appendix E).
4. Do not repeat information from other text fields.
5. 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.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.

Summary Stage Documentation

(NAACCR Item #2600)

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 abstract 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 abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values and should not be generated electronically from coded values. Information documenting the disease process should be entered manually from the medical record. Staging should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. 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.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.

Suggestions for Text

- Date(s) of procedure(s), including clinical procedures, which provided information for assigning stage; organs involved by direct extension
- 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

Summary Stage Documentation - PE

(NAACCR Item #2520)

Suggestions 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

Summary Stage Documentation - Xray/Scan

(NAACCR #2530)

Description

Text area for manual documentation from all X-rays, scans, and/or other imaging examinations that provide information about staging.

Suggestions 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

Summary Stage Documentation - Scopes

(NAACCR Item #2540)

Description

Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

Suggestions 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

Summary Stage Documentation - Lab tests

(NAACCR Item # 2550)

Description

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

Suggestions 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)

Summary Stage Documentation - OP

(NAACCR Item # 2560)

Description

Text area for manual documentation of all surgical procedures that provide information for staging.

Suggestions for Text

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

Summary Stage Documentation - Path

(NAACCR Item # 2570)

Description

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

Suggestions 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

- 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 diagnoses considered and any ruled out or favored.

STAGE PROGNOSTIC FACTORS

Tumor Size Summary

(NAACCR Item #756) (STORE 2021 page 173-177)

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.

Table 6.1 Tumor Size Summary

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm (0.1 cm or less than 0.1 cm)
002-988	Exact size in millimeters (2 mm to 988 mm) (0.2 cm to 98.8cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given

Code	Description
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 No excisional biopsy or tumor resection done The only measurement(s) describes pieces or chips Not applicable

Coding Instructions

Note: *All measurements should be in millimeters (mm). Here is a link to one of the websites to convert cms to mms:* rapidtables.com/convert/length/cm-to-mm.htm

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 1: 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 2: Pathology report states lung carcinoma is 2.1 cm x3.2 cm x 1.4 cm. Record tumor size as 032 (32mm).

2. If neoadjuvant therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size 999.

   Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22mm).

3. If no surgical resection, then the largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment. (See the coding rules section 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 1-millimeter, round tenths of millimeters in the 1- 4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point one space to the right, converting the measurement to millimeters).

   Example 1: Breast cancer described as 6.5 millimeters in size. Round up Tumor Size as 007.

   Example 2: Cancer in polyp described as 2.3 millimeters in size. Round down Tumor Size as 002.

   Example 3: Focus of cancer described as 1.4 mm in size. Round down as 001.

Example 4: 5.2 mm breast cancer. Round down to 5 mm and code as 005.

4. Priority of imaging/radiographic techniques: Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, 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 1: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).

        Example 2: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).
8. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

    Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).
9. Record the size as stated for purely in situ lesions.
10. Disregard microscopic residual or positive surgical margins when coding tumor size. Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data field.
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.
    - Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: (histology codes 9590- 9993)
    - Kaposi Sarcoma
    - Melanoma Choroid
    - Melanoma Ciliary Body
    - Melanoma Iris
    - Unknown Primary Site
14. Document the information to support coded tumor size in the appropriate text field of the abstract.

SEER STAGING

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.

Summary Stage 2018

NAACCR Item #: 764 (SEER page 127)

The Summary Stage 2018 will apply to January 1, 2018 diagnoses and forward.

Summary Stage is the most basic way of categorizing how far a cancer has spread from its point of origin. Historically, Summary Stage has been called General Stage, California Stage, historic stage, and SEER Stage.

The 2018 Summary Stage applies to every site and/or histology combination, including lymphomas and leukemias. Summary Stage uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease. Many central registries report their data by Summary Stage as the staging categories are broad enough to measure the success of cancer control efforts and other epidemiologic efforts.

It is extremely important to thoroughly read all clinical and pathological documentation, including imaging studies, operative and pathology reports, and the clinician's narrative descriptions of tumor involvement.

There are six main categories in Summary Stage, each of which is discussed in detail. In addition, the main category of Regional stage is subcategorized by the method of spread.

Description

Summary Stage 2018 stores the directly assigned Summary Stage 2018. Effective for cases diagnosed January 1, 2018 and later. Refer to SEER*RSA for additional information.

Note: For SS2018, code 5 for "Regional, NOS" can no longer be coded. Code 5 (Regional, NOS) is still applicable for SS2000.

Refer to the Summary Stage 2018 manual for guidelines, general instructions, and site-specific instructions.

Code	Description
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 case

*Applicable for the following Summary Stage 2018 Chapters: Brain, CNS Other, Intracranial Gland.

General Coding Instructions

The 2018 Summary Stage Manual chapters consist of a one-digit hierarchical code. In the United States, these chapters will apply to January 1, 2018 diagnoses and forward. It is extremely important to thoroughly read all clinical and pathological documentation, including imaging studies, operative and pathology reports, and the clinician's narrative descriptions of tumor involvement.

1. Updates to the Summary Stage 2018 manual were based on the AJCC 8th edition. Although the two systems are similar, there are many differences between them. For example, something that is regional in AJCC (recorded in T or N) may be distant in Summary Stage. If a structure or lymph node cannot be found in localized (code 1) or regional (codes 2-4), then review distant (code 7).
2. Summary Stage chapters apply to ALL primary sites and histologies. Most chapters are based on primary site, while some are based on histology alone, or both primary site and histology.
3. Chapter-specific guidelines take precedence over general guidelines. Always read the information pertaining to a specific primary site or histology chapter.
4. For ALL primary sites and histologies, Summary Stage is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are particularly important when all malignant tissue cannot be, or was not, removed.

   a. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report.

5. Summary Stage should include all information available within four months of diagnosis in the absence of disease progression or upon completion of surgery(ies) in first course of treatment, whichever is longer.
6. Clinical information, such as description of skin involvement for breast cancer and distant lymph nodes for any site, can change the Summary Stage. Be sure to review the clinical information carefully to accurately determine the extent of disease.
   a. If the operative/pathology information disproves the clinical information, use the operative/pathology information.
7. When multiple tumors are reported as a single primary, assign the greatest Summary Stage from any tumor.
8. Information for Summary Stage from a surgical resection after neoadjuvant treatment may be used, but ONLY if the extent of disease is greater than the pre-treatment clinical findings.
9. Disease progression, including metastatic involvement, known to have developed after the initial stage workup, should be excluded when assigning Summary Stage.
10. Autopsy reports are used in Summary Stage just as are pathology reports, applying the same rules for inclusion and exclusion.
11. T, N, M information may be used to assign Summary Stage when it is the only information available.
12. Use the medical record documentation to assign Summary Stage when there is a discrepancy between the T, N, M information and the documentation in the medical record. If you have access to the physician, query to resolve the discrepancy.
    a. When there is doubt that documentation in the medical record is complete, assign Summary Stage corresponding to the physician staging.
13. It is strongly recommended that the assessment of the Summary Stage be documented, as well as the choice of the Summary Stage assignment in a related STAGE text field on the abstract.
14. Death certificate-only (DCO) cases and unknown primaries are assigned ‘9’ for Summary Stage; however, assign the appropriate Summary Stage when specific staging information is available on a DCO.

Ambiguous Terminology

Most of the time, registrars will find definitive statements of involvement; however, for those situations where involvement is described with non-definitive (ambiguous) terminology, use the guidelines below to interpret and determine the appropriate assignment of Summary Stage 2018.

Determination of the cancer stage is both a subjective and objective assessment by the physician(s) of how far the cancer has spread. When it is not possible to determine the extent of involvement because terminology is ambiguous, look at the documentation that the physician used to make informed

decisions on how the patient is being treated. For example, assign Summary Stage 2018 based on involvement when the patient was treated as though adjacent organs or nodes were involved.

Use the following lists to interpret the intent of the clinician ONLY when further documentation is not available and/or there is no specific statement of involvement in the medical record. The physician's definitions/ descriptions and choice of therapy have priority over these lists because individual clinicians may use these terms differently.

Note: Terminology in the chapter takes priority over this list. Some chapters interpret certain words as involvement, such as "encasing" the carotid artery for a head and neck or "abutment", "encases", or "encasement" for pancreas primaries.

Table 6.2 - Consider as Involvement (SEER SS 2018)

adherent	incipient invasion
apparent(ly)	induration
appears to	infringe/infringing
comparable with	into*
compatible with	intrude
consistent with	most likely
contiguous/continuous with	onto*
encroaching upon*	overstep
extension to, into, onto, out onto	presumed
features of	probable
fixation to a structure other than primary**	protruding into (unless encapsulated)
fixed to another structure**	suspected
impending perforation of	suspicious
impinging upon	to*
impose/imposing on	up to

*interpreted as involvement whether the description is clinical or operative/pathological.

**interpreted as involvement of other organ or tissue.

Table 6.3 - Do Not Consider as Involvement (SEER SS 2018)

abuts	extension to without invasion/involvement of
approaching	kiss/kissing
approximates	matted (except for lymph nodes)
attached	possible
cannot be excluded/ruled out	questionable
efface/effacing/effacement	reaching
encased/encasing	rule out
encompass(ed)	suggests
entrapped	very close to
equivocal	worrisome

Site-specific Data Items (SSDIs)

(SEER page 148-149)

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.

SEER has developed a staging tool referred to as **SEER*RSA** that provides information (primary site/histology/other factors defined) about each cancer schema. Refer to **SEER*RSA** and the **SSDI Manual** for codes and coding instructions.

Before using the Manual as an information resource for specific data items, it is important to review the introductory materials and general instructions carefully. Although the majority of data items that are collected as SSDIs were previously collected as SSFs, the format of the data items and allowable values have changed substantially, particularly for laboratory values.

For each SSDI, the SSDI Manual includes:

- NAACCR Data Item Name
- Item Length
- NAACCR Item #
- NAACCR Alternative Name
- AJCC 8th Edition Chapter(s)
- Description – a brief summary used to define the data item in the NAACCR data dictionary
- Rationale – describes the reason why the data item is collected, such as required for staging or recommended for registry data collection by AJCC. If the data item was collected in CSv2, the primary site and SSF# is included in the rationale.

- Definition – provides additional background on the data item and its clinical importance. This information was previously included in the CSv2 Manual, Part I, Section II.
- Additional Information – may include source documents, other names, normal reference ranges and any other information deemed relevant for a particular SSDI. This information was previously included in the CSv2 Manual, Part I, Section II.
- Coding instructions and codes
- Coding instructions are provided as numbered notes.
- Codes are provided in a table.
- Codes and coding instructions are usually provided in registry software.

The following tables lists the site-specific schema discriminators and site-specific data items (SSDIs) that are required by TCR for cases diagnosed 2021 and forward.

The first table lists schema discriminators with the corresponding NAACCR item number and description. The second table lists SSDIs required by TCR. For additional required data items, see NAACCR Version 21 Required Status Table and the SSDI Manual.

Table 1. Schema Discriminators

Schema Discriminator	NAACCR Item #	
Schema Discriminator 1	3926	Bile Ducts/Distal/Bile/Ducts Perihilar/Cystic Duct
Schema Discriminator 1	3926	Esophagus GEJunction (EGJ)/Stomach
Schema Discriminator 1	3926	Histology Discriminator for 9591/3
Schema Discriminator 1	3926	Lacrimal Gland/Sac
Schema Discriminator 1	3926	Melanoma Ciliary Body/Melanoma Iris
Schema Discriminator 1	3926	Nasopharynx/Pharyngeal Tonsil
Schema Discriminator 1	3926	Occult Head and Neck Lymph Nodes
Schema Discriminator 1	3926	Plasma Cell Myeloma Terminology
Schema Discriminator 1	3926	Primary Peritoneum Tumor
Schema Discriminator 1	3926	Thyroid Gland/Thyroglossal Duct
Schema Discriminator 1	3926	Urethra/Prostatic Urethra
Schema Discriminator 2	3927	Esophagus and Esophagogastric Junction/Histology Discriminator for 8020/3
Schema Discriminator 2	3927	Oropharynx (p16-)
Schema Discriminator 2	3927	HPV-Mediated (p16+)
Schema Discriminator 2	3927	Oropharynx (p16+)
Schema Discriminator 2	3927	Soft Tissue Sarcoma (C473, C475, C493-C495) (Schema IDs: 00410, 00421)

Table 2. Site-specific Data Items

NAACCR Item #	Item name	Primary site
1068	Grade Post Therapy Clin (yc)	
3816	Molecular Markers-Brain	Brain Histologies 9400/3, 9401/3, 9440/3, 9450/3, 9451/3, 9471/3, 9478/3
3817	Breslow Tumor Thickness	Melanoma of skin Previously collected in CS SSF#1
3827	Estrogen Receptor Summary	Breast Previously collected in CS SSF#1
3835	Fibrosis Score	Liver Previously collected in CS SSF#2
3855	HER2 Overall Summary	Breast Previously collected in CS SSF#15
3855	HER2 Overall Summary	Esophagus EsophagusGEJunction Stomach Previously collected in CS SSF#15
3838	Gleason Patterns Clinical	Prostate Previously collected in CS SSF#7
3839	Gleason Patterns Pathological	Prostate Previously collected in CS SSF#9
3840	Gleason Score Clinical	Prostate Previously collected in CS SSF#8
3841	Gleason Score Pathological	Prostate Previously collected in CS SSF#10
3842	Gleason Tertiary Pattern	Prostate Previously collected in CS SSF#11
3845	Grade Post Therapy (yp)	
3890	Microsatellite Instability (MSI)	Colon and Rectum Previously collected in CS SSF#7
3915	Progesterone Receptor Summary	Breast Previously collected in CS SSF#2
3920	PSA Lab Value	Prostate Previously collected in CS SSF#1
3932	LDH Lab Value	Melanoma of skin Previously collected in CS SSF#5

AJCC TNM STAGING SYSTEM

From 2004 through 2015 AJCC TNM was derived based on Collaborative Staging. Effective January 1, 2018, the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries.

AJCC TNM data items is required only from facilities accredited by the American College of Surgeons (ACoS) and only for analytical cases. For hospitals and cancer centers that are not ACoS accredited, these data items are required for analytical cases only *as available* (class of case 00-22).

The American Joint Committee on Cancer (AJCC) is making an important change to how it updates and releases Cancer Staging content beginning in 2021. The AJCC will be shifting from a Cancer Staging Manual to a Cancer Staging System and moving away from Editions, to Versions which better align with software development and how users are increasingly consuming AJCC content. The AJCC has started rolling updates with the release of Cervix 9th version. As warranted by medical practice, additional disease sites will be updated in the future as necessary, while the other disease sites will remain unchanged, and the 8th Edition will be used. There will no longer be a single edition or version number applicable to every disease site for the diagnosis year. While references will be made to the 9th version, the registry data item will continue to reference TNM Edition Number [1060]. Additional updates to the AJCC Cancer Staging Manual are always available at cancerstaging.org and available for software developers via the AJCC API.

AJCC Cancer Staging questions should be directed to the CAnswer Forum at: cancerbulletin.facs.org/forums/help

AJCC TNM is a system to describe the amount and spread of cancer in a patient's body.

- **T** describes the size of the tumor and any spread of cancer into nearby tissue.
- **N** describes spread of cancer to nearby lymph nodes.
- **M** describes metastasis (spread of cancer to other parts of the body).

This system was created and is updated by the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC). The AJCC staging system is used to describe most types of cancer.

Staging forms are available online in the AJCC Cancer Staging Form Supplement. The 104 staging forms in this supplement are numbered according to their corresponding chapters in the AJCC Cancer Staging Manual, Eighth Edition. Some chapters have multiple staging forms as they describe distinct TNM, Prognostic Factors, and AJCC Prognostic Stage Groups for unique topographical sites, histologic types or a combination of the two. These forms may provide more data elements than required for collection by standard setters such as NCI SEER, CDC NPCR, and CoC NCDB.

TNM Edition Number

(NAACCR Item #1060) (STORE 2021 page 350)

Description

A code that indicates the edition of the AJCC manual used to stage the case. This applies to the manually coded TNM values for the patient. It does not apply to the Derived AJCC T, N, M and AJCC Stage Group fields.

Rationale

TNM codes have changed over time and conversion is not always simple. Therefore, a case-specific indicator is needed to allow grouping of cases for comparison.

Code	Description
00	Not staged (cases that have AJCC staging scheme and staging was not done)
01	First Edition
02	Second Edition (published 1983)
03	Third Edition (published 1988)
04	Fourth Edition (published 1992), for use for cases diagnosed 1993-1997
05	Fifth Edition (published 1997), for use for cases diagnosed 1998-2002
06	Sixth Edition (published 2002), for use for cases diagnosed 2003-2009
07	Seventh Edition (published 2009), for use with cases diagnosed 2010+
08	Eighth Edition (published 2016), for use with cases diagnosed 2018+
88	Not applicable (cases that do not have an AJCC staging scheme)
99	Edition unknown

Coding Instruction

Code based on the edition of the AJCC manual that was used to stage the case.

AJCC TNM Clin T

(NAACCR Item #1001) (STORE 2021 page 191)

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known prior to the start of any therapy. Detailed site-specific values for the clinical T category as defined by the current AJCC edition.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018, the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The clinical T category staging data item must be recorded for *Class of Case* 10-22.
2. Code as documented by the first treating physician or managing physician per the medical record where possible; otherwise, use available information to code the clinical T.
3. If the managing physician has not recorded clinical T, registrars will assign this based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are staged according to the current AJCC edition.
5. Refer to the most recent AJCC Cancer Staging Manual, Eight Edition for detailed staging rules.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2021 manual for specifications for codes and data entry rules.

AJCC TNM Clin T Suffix

(NAACCR Item #1031) (STORE 2021 page 192)

Description

Identifies the AJCC TNM clinical T category suffix for the tumor prior to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the clinical T category suffix as documented by the first treating physician or the managing physician in the medical record.
2. If the managing physician has not recorded the suffix when applicable, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
3. If the tumor is not staged according to the AJCC manual, leave this data item blank.
4. Refer to the current AJCC Cancer Staging System for staging rules.

AJCC TNM Clin N

(NAACCR Item #1002) (STORE 2021 page 193)

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastases of the tumor known **prior** to the start of any therapy. Detailed site-specific values for the clinical tumor (N) as defined by the current AJCC edition. This field is manually coded.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. The clinical N category staging data item must be assigned for Class of Case 10-22.
3. Record clinical N category as documented by the first treating physician or the managing physician in the medical record.
4. If the managing physician has not recorded clinical N, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
5. Code 88 for clinical and pathological or post therapy T,N,M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.

6. The valid codes and labels for the AJCC Cancer Staging Manual, Eight Edition have been expanded and are now consistent for clarity.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE manual for specifications for codes and data entry rules

AJCC TNM Clin N Suffix

(NAACCR Item #1034) (STORE 2021 page 194)

Description

Identifies the AJCC TNM clinical N category suffix for the tumor prior to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. To distinguish lymph nodes identified during diagnostic evaluation by sentinel node biopsy or FNA or core needle biopsy from those identified by physical examination and imaging, the following suffixes are used in assigning the clinical N (cN) category.
2. If SLN biopsy is performed as part of the diagnostic workup, the cN category should have the sn suffix: for example, cN1(sn).
3. If an FNA or a core biopsy is performed on lymph nodes as part of the diagnostic workup, the cN category should have the f suffix: for example, cN1(f).
4. If you do not know which procedure was done, leave it blank.
5. Record the clinical N category suffix as documented by the managing physician in the medical record.
6. If the managing physician has not recorded the suffix, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
7. If the tumor is not staged according to the AJCC manual, leave this data item blank.
8. Refer to the current AJCC Cancer Staging System for staging rules.

AJCC TNM Clin M

(NAACCR Item #1003) (STORE 2021 page 195)

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known prior to the start of any therapy. Detailed site-specific values for the clinical T category suffix as defined by the current AJCC edition.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Code as documented by the first treating physician or managing physician per the medical record where possible; otherwise, use available information to code the clinical M.
3. If the managing physician has not recorded clinical M category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological or post therapy TNM as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2021 manual specifications for codes and data entry rules.

AJCC TNM Clinical Stage Group

(NAACCR Item #1004) (STORE 2021page 196)

Description

Identifies the anatomic extent of disease based on the T,N,M category data items known **prior** to the start of any therapy. Detailed site-specific values for the clinical stage group is defined by the current AJCC edition.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Record the clinical stage group as documented by the first treating physician or managing physician per the medical record where possible; otherwise, use available information to code the clinical stage group.
3. Code the value only and not the 'Stage' component (do not include the word 'Stage'); convert Roman numerals to Arabic numerals and lower case to upper case; for example, Stage IIA2 is recorded as 2A2.
4. Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for the in situ tumors that are not staged according to the current AJCC edition.
5. If stage group cannot be determined from the TNM components, then record it as unknown, code 99.
6. If pediatric staging is used and not AJCC staging, use code 88 for clinical and pathologic T, N, M, and Stage Group. If AJCC staging is used for pediatric staging, code using the appropriate AJCC values.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE 2021 manual for specifications for codes and data entry rules.

AJCC TNM Path T

(NAACCR Item #1011) (STORE 2021page 203)

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known **following** the completion of surgical therapy. Detailed site-specific values for the pathological tumor (T) as defined by the current AJCC edition. This field is manually coded.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. The pathological T category staging data item must be assigned for *Class of Case* 10-22.
3. Assign pathological T as documented by the treating physician(s) or the managing physician in the medical record.
4. Code 88 for clinical and pathological or post therapy TNM as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
5. Code the value only and not the 'T' component and convert lower case to upper case; for example, T3b is recorded as 3B.
6. The code for occult carcinoma of the lung is TX; record X.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE manual specifications for codes and data entry rules.

AJCC TNM Path T Suffix

(NAACCR Item #1032) (STORE 2021 page 204)

Description

Identifies the AJCC TMN pathological T category suffix for the tumor following the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the pathological stage T category suffix as documented by the first treating physician or the managing physician in the medical record.
2. If the managing physician has not recorded the descriptor, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
3. If the tumor is not staged according to the AJCC system, leave this data item blank.

4. Refer to the current AJCC Cancer Staging System for staging rules.

AJCC TNM Path N

(NAACCR Item #1012) (STORE 2021 page 205)

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known following the completion of surgical therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. The pathological N category staging data item must be assigned for *Class of Case* 10-22.
3. Assign pathological N category as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic N.
4. If the managing physician has not recorded pathological N category, registrar will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
5. Code 88 for clinical and pathological or post therapy TNM as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
6. Code the value only and not the 'N' component and convert lower case to upper case; for example, N2c is recorded as 2C.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE manual for specifications for codes and data entry rules.

AJCC TNM Path N Suffix

(NAACCR Item #1035) (STORE 2021 page 206)

Description

Identifies the AJCC TNM pathological N suffix for the tumor following the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. If SLN biopsy is performed in the absence of complete dissection of the nodal basin, the pN category should have the sn suffix: for example, pN0(sn).
2. If an FNA or a core biopsy is performed in the absence of a complete dissection of the nodal basin, the pN category should have the f suffix: for example, pN0(f).
3. If you do not know which procedure was done, leave it blank.
4. Record the pathological N category suffix as documented by the managing physician in the medical record.
5. If the managing physician has not recorded the suffix, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
6. If the tumor is not staged according to the AJCC System, leave this data item blank.
7. Refer to the current AJCC Cancer Staging System for staging rules.

AJCC TNM Path M

(NAACCR Item #1013) (STORE 2021 page 207)

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known following the completion of surgical therapy**.**

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. The pathological M category staging data item must be assigned for *Class of Case* 10-22.
3. Assign pathological M category as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic M.
4. If the managing physician has not recorded pathological M category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
5. Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
6. Code the value only and not the 'M' component and convert lower case to upper case; for example, M1c is recorded as 1C.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE manual for specifications for codes and data entry rules.

AJCC TNM Pathological Stage Group

(NAACCR Item #1014) (STORE 22021 page 208)

Description

Identifies the anatomic extent of disease based on the T, N, and M category data items known following the completion of surgical therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathological TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment,

evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Record the pathological stage group as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic stage group.
3. If the managing physician has not recorded the pathological stage, registrar will assign this item based on the best available information, without necessarily requiring additional contact with the physician (s).
4. If pathologic M is blank and clinical M is coded as 0, 1, 1A, 1B, or 1C, then pT, pN, and cM may be used to stage the case. If stage group cannot be determined from the TNM components, then record it as unknown. The standard setters require a non-BLANK value for the Pathologic Stage Group.
5. Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for the in situ tumors that are not staged according to the current AJCC edition.
6. If pediatric staging is used and not AJCC staging, use code 88 for clinical and pathologic T, N, M, and Stage Group. If AJCC staging is used for pediatric staging, code using the appropriate AJCC values.
7. Code the value only and not the 'Stage' component (do not include the word 'Stage'); convert Roman numerals to Arabic numerals and lower case to upper case; for example, Stage IIA2 is recorded as 2A2.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the STORE manual for specifications for codes and data entry rules.

AJCC TNM Post Therapy Clin T

(NAACCR #1062) (STORE 2021 page 197)

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post-neoadjuvant therapy surgical resection.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The post therapy clin T category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy clin T category as documented by the treating physician(s) or the managing physician in the medical record.
3. If the managing physician has not recorded post therapy clin T category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC system and for in situ tumors that are not staged according to the current AJCC system. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
5. For lung, occult carcinoma is assigned TX according to the definition in the current AJCC system.
6. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
7. Refer to the current AJCC Cancer Staging System for staging rules.
8. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: cancerstaging.org/Pages/Vendors.aspx.

AJCC TNM Post Therapy Clin T Suffix

(NAACCR #1063) (STORE 2021 page 198)

Description

Identifies the AJCC TNM post therapy clinical T category suffix for the tumor following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the post therapy clin T category suffix as documented by the first treating physician or the managing physician in the medical record.
2. If the managing physician has not recorded the post therapy clin T category suffix, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
3. If the tumor is not staged according to the AJCC system, leave this data item blank.
4. Refer to the current AJCC Cancer Staging System for staging rules.

AJCC TNM Post Therapy Clin N

(NAACCR #1064) (STORE 2021 page 199)

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of lymph node metastasis of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post-neoadjuvant therapy surgical resection.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The post therapy clin N category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy clin N category as documented by the treating physician(s) or managing physician in the medical record.

3. If the managing physician has not recorded post therapy clin N category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank. • Refer to the current AJCC Cancer Staging System for staging rules. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: cancerstaging.org/Pages/Vendors.aspx

AJCC TNM Post Therapy Clin N Suffix

(NAACCR #1065) (STORE 2021 page 200)

Description

Identifies the AJCC TNM post therapy clinical N suffix for the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. If SLN biopsy is performed in the absence of complete dissection of the nodal basin, the ypN category should have the sn suffix: for example, ypN0(sn).
2. If an FNA or a core biopsy is performed in the absence of a complete dissection of the nodal basin, the ypN category should have the f suffix: for example, ypN0(f).
3. If you do not know which procedure was done, leave it blank.

4. Record the post therapy clinical N category suffix as documented by the managing physician in the medical record.
5. If the managing physician has not recorded the suffix, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
6. If the tumor is not staged according to the AJCC System, leave this data item blank.
7. Refer to the current AJCC Cancer Staging System for staging rules.

AJCC TNM Post Therapy Clin M

(NAACCR #1066) (STORE 2021 page 201)

Description

Identifies the presence or absence of distant metastasis (M) of the tumor as known in the clinical stage before initiation of neoadjuvant therapy and records this information following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post neoadjuvant therapy surgical resection.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The post therapy clin M category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy clin M category as documented by the treating physician(s) or the managing physician in the medical record.
3. If the managing physician has not recorded post therapy clin M category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.

5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. Refer to the current AJCC Cancer Staging System for staging rules.
7. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: cancerstaging.org/Pages/Vendors.aspx

AJCC TNM Post Therapy Clinical Stage Group

(NAACCR #1067)

Description

Detailed site-specific codes for the post therapy clinical stage group as defined by AJCC.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.
Identifies the remaining anatomic extent of disease based on the T and N following the completion of neoadjuvant therapy (satisfying the definition for that disease site) before planned surgical resection or primary treatment consisting of systemic and/or radiation therapy, and the M status defined during the diagnostic workup.

Coding Instructions

1. Refer to the current AJCC Staging System for staging rules.
2. Code 88 for not applicable, no code assigned for this case in the current AJCC Staging Manual
3. Code 99 for unknown, not staged

AJCC TNM Post Therapy Path T

(NAACCR #1021) (STORE 2021 page 209)

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The post therapy path T category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy path T category as documented by the treating physician(s) or the managing physician in the medical record.
3. If the managing physician has not recorded post therapy path T category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC system and for in situ tumors that are not staged according to the current AJCC system. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
5. For lung, occult carcinoma is assigned TX according to the definition in the current AJCC system
6. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
7. Refer to the current AJCC Cancer Staging System for staging rules.
8. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: cancerstaging.org/Pages/Vendors.aspx

AJCC TNM Post Therapy Path T Suffix

(NAACCR #1033) (STORE 2021 page 210)

Description

Identifies the AJCC TNM post therapy pathological T category suffix for the tumor following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the post therapy path T category suffix as documented by the first treating physician or the managing physician in the medical record.
2. If the managing physician has not recorded the post therapy path T category suffix, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
3. If the tumor is not staged according to the AJCC System, leave this data item blank.
4. Refer to the current AJCC Cancer Staging System for staging rules.

AJCC TNM Post Therapy Path N

(NAACCR #1022) (STORE 2021 page 211)

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of lymph node metastasis of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

Coding Instructions

1. The post therapy path N category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy path N category as documented by the treating physician(s) or managing physician in the medical record.
3. If the managing physician has not recorded post therapy path N category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.

5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. Refer to the current AJCC Cancer Staging System for staging rules.
7. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: cancerstaging.org/Pages/Vendors.aspx

AJCC TNM Post Therapy Path N Suffix

(NAACCR #1036) (STORE 2021 page 212)

Description

Identifies the AJCC TNM post therapy pathological N suffix for the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. If SLN biopsy is performed in the absence of complete dissection of the nodal basin, the ypN category should have the sn suffix: for example, ypN0(sn).
2. If an FNA or a core biopsy is performed in the absence of a complete dissection of the nodal basin, the ypN category should have the f suffix: for example, ypN0(f).
3. If you do not know which procedure was done, leave it blank.
4. Record the post therapy pathological N category suffix as documented by the managing physician in the medical record.
5. If the managing physician has not recorded the suffix, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
6. If the tumor is not staged according to the AJCC System, leave this data item blank.
7. Refer to the current AJCC Cancer Staging System for staging rules

AJCC TNM Post Therapy Path M

(NAACCR #1023) (STORE 2021 page 213)

Description

Identifies the presence or absence of distant metastasis (M) of the tumor as known in the clinical stage before initiation of neoadjuvant therapy and records this information following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. The post therapy path M category staging data item must be assigned for Class of Case 10-22.
2. Assign post therapy path M category as documented by the treating physician(s) or the managing physician in the medical record.
3. If the managing physician has not recorded post therapy path M category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
4. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. Refer to the current AJCC Cancer Staging System for staging rules.
7. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: cancerstaging.org/Pages/Vendors.aspx

AJCC TNM Post Therapy Pathological Stage Group

(NAACCR #1024) (STORE 2021 page 214)

Description

Identifies the anatomic extent of disease based on the T, N, and M category data items of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the post therapy path stage group as documented by the treating physician(s) or the managing physician in the medical record.
2. If the managing physician has not recorded the post therapy path stage, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician(s).
3. Code 88 for clinical and pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition. Code 88, only if the case qualifies, for post therapy clinical or for post therapy pathological T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
4. Code 99 for clinical and pathological or post therapy clinical or post therapy pathological stage group if the TNM combination along with any required prognostic factors does not result in a valid stage group according to the current AJCC system.
5. If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
6. Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
7. Refer to the current AJCC Cancer Staging System for staging rules.
8. The valid codes and labels for the AJCC Cancer Staging System have been expanded and are now consistent for clarity. They are provided on the AJCC Web site. Refer to the most current list of valid codes and labels: cancerstaging.org/Pages/Vendors.aspx

7

TREATMENT INFORMATION

First Course of Treatment

First Course of Treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence.

"Active surveillance" is a form of planned treatment for some patients; its use is coded in *the RX Summ--Treatment Status* item.

"No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. If the patient refuses all treatment, code "patient refused" (code 7 or 87) for all treatment modalities.

Maintenance treatment given as part of the first course of planned care (for example, for leukemia) is first course treatment, and cases where patient is receiving treatment are analytic.

Definitions

- **Active Surveillance:** A treatment plan that involves closely watching a patient's condition but not giving any treatment unless there are changes in test results that show the condition is getting worse. Active surveillance may be used to avoid or delay the need for treatments such as radiation therapy or surgery, which can cause side effects or other problems. During active surveillance, certain exams and tests are done on a regular schedule. It may be used in the treatment of certain types of cancer, such as prostate cancer, urethral cancer, and intraocular (eye) melanoma. It is a type of expectant management. (Source: cancer.gov/dictionary?CdrID=616060)
- **Cancer tissue:** Proliferating malignant cells; an area of active production of malignant cells. Cancer tissue includes primary tumor and metastatic sites where cancer tissue grows. Cells in fluid such as pleural fluid or ascitic fluid are not "cancer tissue" because the cells do not grow and proliferate in the fluid.
- **Concurrent therapy**: A treatment that is given at the same time as another, such as chemotherapy and radiation therapy.
- **Disease recurrence:** For solid tumors, see the *2018 Solid tumor Rules* and for hematopoietic and lymphoid neoplasms see the *Hematopoietic and Lymphoid Neoplasm Coding Manual* and the hematopoietic database to determine disease recurrence.
- **First course of therapy:** All treatments administered to the patient after the original diagnosis of cancer in an attempt to destroy or modify the cancer tissue. See below for detailed information on timing and treatment plan documentation requirements.
- **Hospice**: A program that provides special care for people who are near the end of life and for their families, either at home, in freestanding facilities, or within hospitals. Hospice care may include treatment that destroys or modifies cancer tissue. If performed as part of the first course, treatment that destroys or modifies cancer tissue is collected when given in a hospice setting. "Hospice, NOS" is not specific enough to be included as first course treatment.

- **Neoadjuvant therapy:** Systemic therapy or radiation therapy given prior to surgery to shrink the tumor.
- **Palliative treatment:** The World Health Organization describes palliative care as treatment that improves the quality of life by preventing or relieving suffering. Palliative therapy is also part of the first course of therapy when the treatment destroys or modifies cancer tissue.

  Example: The patient was diagnosed with stage IV cancer of the prostate with painful boney metastases. The patient starts radiation treatment intended to shrink the tumor in the bone and relieve the intense pain. The radiation treatments are palliative because they relieve the bone pain; the radiation is also first course of therapy because it destroys proliferating cancer tissue.
- **Surgical Procedure:** Any surgical procedure coded in the fields Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional or Distant Sites. See Scope of Regional Lymph Node Surgery data item for exceptions.
- **Treatment:** Procedures that destroy or modify primary (primary site) or secondary (metastatic) cancer tissue.
- **Treatment failure:** The treatment modalities did not destroy or modify the cancer cells. The tumor either became larger (disease progression) or stayed the same size after treatment.
- **Watchful waiting:** Closely watching a patient's condition but not giving treatment unless symptoms appear or change. Watchful waiting is sometimes used in conditions that progress slowly. It is also used when the risks of treatment are greater than the possible benefits. During watchful waiting, patients may be given certain tests and exams. Watchful waiting is sometimes used in prostate cancer. It is a type of expectant management. (Source: cancer.gov/dictionary?CdrID=45942)

Treatment Timing

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

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

   Example 1: The first course of therapy for a breast cancer patient is surgery, chemotherapy, and radiation. The patient completes surgery and chemotherapy. Bone metastases are diagnosed before the radiation was started. The physician says that the patient will start the radiation treatment as planned. Code the radiation as first course of therapy since it was given in agreement with the treatment plan and the treatment plan was not changed as a result of disease progression.

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

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

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

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

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

Coding Instructions

For all diseases (including benign and borderline malignancy intracranial & CNS tumors) except hematopoietic and lymphoid neoplasms (seer.cancer.gov/tools/heme/index.html)

1. Code all treatment fields to 0 or 00 (Not done) when physician opts for active surveillance, deferred therapy, expectant management, or watchful waiting. When the disease progresses, or the patient becomes symptomatic, any prescribed treatment is second course.
   - Code Treatment Status (RX Summ--Treatment Status) to 2
2. Code the treatment as first course of therapy if the patient refuses treatment but changes his/her mind and the prescribed treatment is implemented less than one year from the date of diagnosis, AND there is no evidence of disease progression.
3. The first course of therapy is **no treatmen**t when the patient **refuses** treatment. Code the treatment fields to Refused.
   - Keep the refused code even if the patient later changes his/her mind and decides to have the prescribed treatment either more than one year after diagnosis or when there is evidence of disease progression before treatment is implemented.

4. Code all treatment that was started and administered, whether completed or not.

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

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

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

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

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

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

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

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

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

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

Notes:

- The first course of treatment includes all treatment planned and administered by the physician(s) from the initial diagnosis of cancer. Treatment can include multiple methods and may last a year or more. Any treatment delivered after the first course is considered subsequent treatment.
- Should there be a change of therapy due to apparent failure of the originally delivered treatment or because of the progression of the disease, the later therapy is not considered first course.

First Course Treatment for Hematopoietic and Lymphoid Neoplasms

Refer to the Hematopoietic and Lymphoid Neoplasm Coding Manual to determine the correct coding of treatment for hematopoietic diseases.

Leukemia and Lymphomas

Treatment varies by the type of hematopoietic neoplasm.

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

Starting in 2010, some neoplasms that have undergone a transformation are reported as new primaries (see rules M10-M13 for specific instructions), and treatment can affect this. For purposes of determining multiple primaries in the Hematopoietic diseases, "treatment" refers to the patient receiving at least one form of cancer-directed treatment such as surgery or systemic therapy, not passive treatment plans like supportive care or observation.

Coding Instructions

1. When there is only one neoplasm (one primary), use the documented first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is completed, no matter how long it takes to complete the plan.
2. Chronic neoplasm followed by an acute neoplasm.
    a. The presence/absence of treatment does not affect the number of primaries when a chronic neoplasm transforms to an acute neoplasm.

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

    b. First course of treatment for the chronic neoplasm may or may not be completed when the chronic neoplasm transforms to the acute neoplasm.
3. Acute neoplasm followed by a chronic neoplasm.
    a. The presence/absence of treatment does impact the determination of the number of primaries when the acute neoplasm reverts to a chronic neoplasm (see Rules M12 and M13).
    b. The planned first course of therapy may not have been completed when a biopsy/pathologic specimen shows only chronic neoplasm after an initial diagnosis of an acute neoplasm.

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

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

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

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

Other Treatment for Hematopoietic Diseases

Record all treatment as described above. The following treatments are coded as "other" in Other Treatment even though they do not "modify, control, or destroy proliferating cancer tissue."

1. Collect phlebotomy for polycythemia vera only. Phlebotomy also may be referred to as blood removal, bloodletting or venesection.
2. Do not collect blood transfusions (whole blood, plasma, etc.) as treatment. Blood transfusions are widely used to treat anemia and it is not possible to collect this procedure in a meaningful way.
3. Collect blood-thinners and/or anti-clotting agents for essential thrombocythemia (9962/3) only.

Donor Leukocyte Infusions

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

Date of Initial Treatment

(NAACCR Item #1260, 1270)

Date Therapy Initiated *(NAACCR Item #1260) (SEER page 155-157)*

Date of First Course of Treatment *(NAACCR Item #1270) (STORE 2021 page 219)*

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.

Rationale

This field is used to measure the delay between diagnosis and onset of treatment. A secondary use is as a starting point for survival statistics. This date cannot be calculated from the respective first course treatment dates if no treatment was given. Therefore, providing information about these instances is important when a physician decides not to treat a patient or the patient, patient's family or guardian declines treatment.

Date format

- YYYYMMDD when the complete date is known and valid.

  Example: A patient was found to have a large polyp during a colonoscopy on January 8, 2018. A polypectomy on that date confirmed adenocarcinoma of the descending colon. The polypectomy is considered cancer directed surgery, so code the *Date of Initial Treatment* 20180108.

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

  Example: Patient had pre-op chemo in March 2018 followed by a mastectomy. The exact chemo start date is unknown. Code the *Date of Initial Treatment* as 201803.

- YYYY when year is known and valid, and the month and day are unknown.

Coding Instructions

1. Code the start date of the first therapy. The first therapy may be recorded in the following data items:
   - Rx Summary-Scope of Reg LN Surgery (excluding code 1)
   - Surgical Procedure of Primary Site
   - Rx Summ-Surg Other Reg/Dist Rx Code

- Radiation Treatment Modality-Phase I
- Rx Summ-Chemo (Chemotherapy)
- Rx Summ-Hormone-Hormone Therapy (Hormone/Steroid Therapy)
- Rx Summ-BRM (Immunotherapy)
- Rx Summ-Hematologic Transplant/Endocrine Procedures
- Other Treatment

2. Code the date of **excisional biopsy** as the **date therapy initiated** when it is the first treatment. Code the date of a biopsy documented as incisional if further surgery reveals no residual or only microscopic residual.

   Example: Breast core needle biopsy with diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual tumor noted. Code the date of the needle biopsy as the excisional biopsy date. Code the date of the biopsy as the date of initial treatment.

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 01/10/2021, 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 therapy initiated 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:
   a. When no treatment is given during the first course
   b. When Treatment Status is coded 2, Active surveillance (watchful waiting). If you are a CoC facility, follow CoC definition of First Course of Treatment.
   c. When it is unknown whether the patient had treatment
   d. For Death certificate-only (DCO) cases when the date is unknown and cannot be estimated
   e. Autopsy only cases

Estimating Dates

- Month
- Code “spring of” to April.
- Code “summer “or “middle of the year” to July.
- Code “fall” or “autumn” as October.

- 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.
- Code "early in year" to January.
- Code "late in year" to December.
- Use whatever information is available to calculate the month.
- Code the month of admission when there is no basis for estimation.
- Leave month blank if there is no basis for approximation.
- Year
- Code "a couple of years" to two years earlier.
- Code "a few years" to three years earlier.
- Use whatever information is available to calculate the year.
- Code the year of admission when there is no basis for estimation.

Note: STORE 2021 instructions (see STORE 2021 page 219) differ from TCR instructions.

STORE 2021 instructs for Date of First Course of Treatment to record the date when the decision of active surveillance or watchful waiting is selected as the First Course of Treatment. TCR will accept STORE 2021 guidelines for this field but will continue to follow SEER guideline for this data item. Facilities following STORE 2021 guidelines will not receive an edit on this data item.

Date of Initial RX Flag

(NAACCR Item #1261) (SEER page 158)

Description

This flag explains why there is no appropriate value in the corresponding date field, Date of Initial RX-SEER (1260).

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in date field.

Coding Instructions

1. Leave this item blank if *Date of Initial Treatment* has a full or partial date recorded.
2. Assign code 10 when it is unknown whether any treatment was administered.
    - 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 of Initial Treatment cannot be determined or estimated, and the patient did receive first course treatment. Use this code only as a last resource.

Table 7.1 Date of Initial RX Flag Codes

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if therapy was administered).
11	No proper value is applicable in this context (for example, no treatment given or autopsy only).
12	A proper value is applicable but not known (for example, therapy was administered, and date is unknown).
(blank)	A valid date value is provided in item *Date of Initial Treatment* (NAACCR Item #1260).

RX Summary - Scope of Reg Ln Surgery

(NAACCR Item #1292) (STORE 2021 page 234-240; SEER pages 167-169)

Description

Indicates the removal, biopsy, or aspiration of **regional** lymph nodes at the time of surgery of the primary site or during a separate surgical procedure performed during the initial work-up of first course of therapy.

Rationale

This information is used to compare and evaluate the extent of surgical treatment.

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 regional 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 or EOD 2018.

3. Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site. The regional lymph node surgical procedure(s) may be done to diagnose cancer, stage the disease, or as a part of the initial treatment.

   Example: Patient has a sentinel node biopsy of a single lymph node. Assign code 2 (Sentinel lymph node biopsy [only]).

4. Include lymph nodes obtained or biopsied during any procedure within the first course of treatment. A separate lymph node surgery is not required.

   a. Code the removal of intra-organ lymph nodes in Scope of Regional Lymph Node Surgery.

   Example: Local excision of breast cancer. Specimen includes an intra-mammary lymph node. Assign code 4 (1 to 3 regional lymph nodes removed).

5. Add the number of all of the lymph nodes removed during each surgical procedure performed as part of the first course of treatment. The Scope of Regional Lymph Node data item is cumulative.

   Example: Patient has excision of a positive cervical node. The pathology report from a subsequent node dissection identifies three cervical nodes. Assign code 5 (4 or more regional lymph nodes removed).

   a. 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.

   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

Note: Excludes all sites and histologies that would be coded 9. (See Coding Instruction #13 below.)

b. First course of treatment was active surveillance/watchful waiting, or

c. 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.

    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).

    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, C710-C729, C751-C753, C761-C768, C770-C779, or C809
        ii. Lymphoma (excluding CLL/SLL) 00790
        iii. Lymphoma (CLL/SLL) 00795
        iv. Plasma Cell Disorders (excluding histology 9734/3) 00822

Notes:

- Table 7.2 is available in the Quick Reference.
- See Appendix A for additional instructions specific to Breast Surgical Codes (RX Summary-Scope of Reg LN Surgery).

Table 7.2 RX. Summary- Scope of Reg Ln Surgery Codes

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
		Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.	Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), an axillary lymph node dissection (ALND), or a combination of both SLNBx and ALND. 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.
0	None	No regional lymph node surgery.	

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
1	Biopsy or aspiration of regional lymph node(s), NOS	Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed, and it did not include the use of dye or tracer for a SLNBx procedure (coded 2). If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report of 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.

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
2	Sentinel lymph node biopsy (only)	• The operative report states that a SLNBx was performed. • Code 2 SLNBx when 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. • When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes are palpably abnormal and selectively removed (or harvested) as part of the SLNBx procedure by the surgeon or may be discovered by the pathologist. 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.	• 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). • 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. Code these cases as 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 [830] and Regional Lymph Nodes Positive [820].
Codes 3 – 5 are used for regional lymph node dissection/removal; there do NOT include sentinel lymph node biopsy (SLNBx).			
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure). • Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this	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).

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
4	1–3 regional lymph nodes removed	procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7). • Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only. • Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes were 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). Infrequently, a SNLBx 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.	
5	4 or more regional lymph nodes removed		

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	• SNLBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. • Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. • Infrequently, a SNLBx 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.	• SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. Generally, look for a report to the Operating Room (OR) by the pathologist on the SLNBx results prior to the regional node dissection. If the SLNBx shows positive nodes, then a dissection may be done. If the nodes are negative, it is rare that a node dissection is performed. • 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. • 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.

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
7	Sentinel node biopsy and code 3, 4, or 5 at different times	• SNLBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. • Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.	• 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. • 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.
9	Unknown or not applicable	• 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 9 in *Scope of Regional Lymph Node Surgery* to confirm the code.	

Example 1: Patient has a radical neck dissection and the number of lymph nodes removed is not stated. The appropriate code would be 3.

Example 2: The patient has modified radical mastectomy with sentinel lymph node biopsy and axillary lymph node dissection. The final diagnosis is infiltrating ductal carcinoma with 2/12 axillary lymph nodes positive. The appropriate code would be 6, sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated.

Example 3: Transverse colon: Adenocarcinoma with extension into subserosa, 3/10 pericolic lymph nodes are positive. The appropriate code would be 5, four or more regional lymph nodes removed.

Regional Lymph Nodes Positive

(NAACCR item # 820) (STORE 2021 page 169-171) (SEER page 178-180)

Description

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. Beginning with cases diagnosed on or after January 1, 2004, this item became a component of the Collaborative Staging System (CS). In 2016 use of CS was discontinued, however this data item continued to be required.

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.

Table 7.3 Regional Nodes Positive

	Codes	Description
00	All nodes examined are negative	
01-89	1-89 nodes are positive (code exact number of nodes positive	
90	90 or more nodes positive	
95	Positive aspiration or core biopsy 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	

Instructions for Coding

Note: When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual use the AJCC definition.

Regional lymph nodes only. Record information only about regional lymph nodes in this field. Involved distant lymph nodes should be coded in the M (distant metastasis) field and not counted as positive regional nodes. Include lymph nodes that are regional in the current AJCC Staging Manual or EOD 2018.

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 or EOD Regional Nodes 2018.

2. This field is based on pathological information only. This field is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.
3. True in situ cases cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). 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, if 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.

        Example 1: Lung cancer patient has a mediastinoscopy and positive core biopsy of 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.

        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. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.

        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. If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.

        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. If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority:
    a. Final diagnosis
    b. Synoptic report (also known as CAP protocol or pathology report checklist)

c. Microscopic description

d. Gross description

6. Positive Nodes in Multiple Primaries in Same Organ.

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

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

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

7. Isolated Tumor Cells (ITCs) in lymph nodes

   a. For all 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.

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

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

   Example: Lung cancer patient has aspiration of suspicious hilar mass that shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes neoadjuvant (preoperative) radiation therapy followed by lobectomy showing

6 negative hilar lymph nodes. Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected.

9. 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.

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

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

10. Use code 98 when:
    a. The assessment of lymph nodes is clinical only.
    b. No lymph nodes are removed and examined.
    c. A "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
    d. Regional Nodes Positive is coded 98, Regional Nodes Examined is usually coded 00.
11. Use code 99 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

Regional Lymph Nodes Examined

(NAACCR item # 830) (STORE 2021 page 166-168) (SEER page 181-183)

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with cases diagnosed on or after January 1, 2014, this item became a component of the Collaborative Staging System (CS). In 2016 use of CS was discontinued, however this data item continued to be required.

Rationale

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

Table 7.4 Regional Nodes Examined

Code	Description
00	No nodes were examined
01-89	1-89 nodes are examined (code exact number of nodes examined)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration OR core biopsy 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 are examined; not applicable; not stated in patient record

Instructions for coding

Note: When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual use the AJCC definition.

1. Regional lymph nodes only. Record information only about regional lymph nodes in this field. Involved distant lymph nodes should be coded in the M (distant metastasis) field and not counted as positive regional nodes.
    a. Include lymph nodes that are regional in the current AJCC Staging Manual or EOD Regional Lymph Nodes 2018.
2. This field is based on pathologic information only. This field is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.
3. Code 00 may be used in several situations:
    a. When the assessment of lymph nodes is clinical.
    b. When no lymph nodes are removed and examined.
    c. When a “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

d. If Regional Nodes Examined is coded 00, Regional Nodes Positive is coded as 98.

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

        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.

    c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.

        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. If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.

        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. If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority:
    a. Final Diagnosis
    b. Synoptic report (also known as CAP protocol or pathology report checklist)
    c. Microscopic description
    d. Gross description
6. Code 95. Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

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

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

8. Definition of "sampling" (code 96). A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy and, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.
9. Definition of "dissection" (code 97). A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, and lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed, and the number is unknown.
10. Multiple lymph node procedures. If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.
11. When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use code 98.
12. Code 99. If it is unknown whether nodes were removed or examined, code as 99.
    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

RX Date - Surgery

(NAACCR ITEM #1200) (STORE 2021 page 223; SEER page 160)

Description

The date of the first cancer-directed surgical procedure performed at any facility.

Rationale

Documents the date of the first cancer-directed surgical procedure. This date may or may not reflect the date of the most definitive surgical procedure.

This item can be used to sequence multiple treatment modalities and to evaluate the time intervals between treatments.

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 or Surgical Procedure of Other Site was recorded as part of the first course of therapy.

2. Date format is:

    a. YYYYMMDD - when the complete date is known and valid.

    Example: A patient was found to have a large polyp during a colonoscopy on January 8, 2018. A polypectomy on that date confirmed adenocarcinoma of the descending colon. The polypectomy is considered cancer directed surgery, so the date of first surgery should be coded 20180108.

    b. YYYYMM - when year and month are known and valid, and day is unknown.

    Example: Patient is seen for treatment recommendations following a mastectomy in March 2018. The exact day of surgery is unknown. Code the date of surgery as 201803.

    c. YYYY - when year is known and valid, and the month and day are unknown.

    Example: A patient had a radical prostatectomy in 2018 and is now seen with bone mets. The month and day of the surgery are unknown. Code the date of surgery as 2018.

    d. Blank - when no known date applies (no surgery was done, or it is unknown if surgery was done).

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

4. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery.

5. If surgery was done do not leave this field blank. If the date is unknown record the year of diagnosis as the surgery date and leave the month and day blank. Document in the text field that the date of surgery is unknown.

Example 1: An incisional biopsy is performed on March 3, 2020 followed by a resection on March 17, 2020. Record the date of the resection (20200317) as the date of the first surgical procedure. An incisional biopsy is a diagnostic procedure, not a cancer-directed surgery.

Example 2: February 1, 2018 a patient had a fine needle aspiration of a right breast mass, consistent with infiltrating ductal carcinoma. On February 15, 2020, the patient underwent a right modified radical mastectomy. The date of surgery would be recorded as 20200215.

Example 3: Patient had a lumpectomy as part of first course of treatment for breast cancer in 2020, but the date is unknown. On June 3, 2020 she comes to your facility to begin chemotherapy. Record the date of surgery as 2020.

RX Date Surgery Flag

(NAACCR Data Item #1201) (STORE 2021 page 224; SEER page 161)

Description

This flag explains why there is no appropriate value in the corresponding date field, *RX Date Surgery*, NAACCR Item 1200.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

1. Leave this item blank if *Surgical Procedure of Primary Site* (NAACCR Item #1200) has a full or partial date recorded.
2. Code 10 if it is unknown whether any surgery was performed.
3. Code 11 if no surgical procedure was performed.
4. Code 12 if the *Date of First Surgical Procedure* cannot be determined or estimated, but the patient did receive first course surgery. Use this code **only** as a last resort.

Table 7.5 RX Date Surgery Flag Codes

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated. (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of First Surgical Procedure* (NAACCR Item #1200).

RX Date - Most Definitive Surgical Resection of Primary Site

(NAACCR Item #3170) (STORE 2021 page 225; SEER page 162)

Description

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

treatment.

Rationale

This item is used to measure the lag time between diagnosis and the most definitive surgery of the primary site. This may or may not be the date of **RX Date - Surgery.** The most definitive surgery is the most extensive resection of the primary site done during the first course of treatment.

Coding Instructions

1. Record the date of the most invasive, extensive, or definite surgery when Surgery of Primary Site was recorded as part of the first course of therapy.
2. Transmit date data item in the year, month, day format (YYYYMMDD)

Example 1: The patient undergoes an excisional biopsy for right breast cancer on 1/2/2018, then undergoes a right modified radical mastectomy on 1/25/18. The RX Date – Surgery is 1/2/2018 since this is the date of the first surgery done as first course of treatment. 1/25/2018 is the date of the most definitive treatment, since the right modified mastectomy is more extensive than the excisional biopsy.

Example 2: The patient undergoes a colonoscopy on 2/20/18 and is found to have a suspicious polyp. A polypectomy is performed and is positive for adenocarcinoma. The patient proceeds to a segmental resection of the colon for margins done on 3/2/18. The resection shows no residual disease. The RX Date – Surgery is 2/20/18. The RX Date – MostDefSurg is 3/2/18 even though no cancer is found in the specimen.

RX Date - Mst Defn Srg Flag

(NAACCR Item #3171) (; SEER page 163)

Description

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

Rationale

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

1. Leave this item blank if *RX Date-Most Definitive Surgical Resection of Primary* Site (NAACCR Item #3170) has a full or partial date recorded.
2. Code 10 if it is unknown whether any surgery was performed.

3. Code 11 if no surgical procedure was performed.
4. Code 12 if the *RX Date-Most Definitive Surgical Resection of Primary* Site (NAACCR Item #3170) cannot be determined or estimated, but the patient did receive first course surgery. Use this code **only** as a last resort.

Table 7.6 RX Date – Mst Defn Srg Flag Codes

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated. (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date-Mst Defn Srg* (NAACCR Item #3170).

Surgical Procedure of Primary Site

(NAACCR Item #1290) (STORE 2021page 226-227; SEER pages 164-165)

Description

Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site that is performed as part of the initial diagnostic and staging work-up or first course of therapy. Code the most definitive surgical procedure of the primary site performed at any facility as part of the first course of treatment. This field is for surgery of primary site only.

Rationale

Identifies the specific cancer-directed surgery of the primary site.

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 the type of surgery the patient received as part of the first course of treatment at any facility.
2. Code 00 when:
    a. No surgery is performed on the primary site, or

b. First course of treatment was active surveillance/watchful waiting, or

c. Case was diagnosed at autopsy.

Note: Excludes all sites and histologies that would be coded as 98.

3. Use the site-specific coding scheme corresponding to the primary site or histology. Refer to the Site-specific Surgery Codes in Appendix C of the SEER Manual or Appendix A of the STORE 2021 Manual.

4. Code the most invasive, extensive, or definitive surgery if the patient has multiple surgical procedures of the primary site even if there is no tumor found in the pathologic specimen. Codes 00–80 are listed in hierarchical but not necessarily numerical order. Code the procedure listed furthest down the list within the codes 10–80.

   Example: Patient has excisional breast biopsy that is positive for carcinoma. The patient chooses to have a modified radical mastectomy. The pathologic examination of the mastectomy specimen shows no residual tumor. Code the modified radical mastectomy.

5. Excisional biopsies that remove the entire tumor and/or leave only microscopic margins are coded in this field if no further definitive surgery is done.

   a. Code an excisional biopsy, even when documented as incisional, when:

      i. All disease is removed (margins free), or

      ii. All gross disease is removed and there is only microscopic residual at the margin.

      Example: Breast core needle biopsy with diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual tumor noted. Code as excisional biopsy.

   b. Do not code an excisional biopsy when there is macroscopic residual disease.

   c. Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed, and margins are clear.

      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.

For ACoS facilities, per STORE 2021 page 226:

If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery the surgical margins are clear (i.e., no tumor remains), do not consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the Surgical Diagnostic and Staging Procedure at this Facility [740] data item and the excisional biopsy or more extensive surgery in the Surgical Procedure of the Primary Site at this Facility data item [670].

6. 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.

   Example: Left thyroidectomy for suspicious nodules. Path showed papillary carcinoma. Completion thyroidectomy was performed. Code surgery of primary site as total thyroidectomy (50)

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. Surgery to remove regional or distant tissue or organs is coded in this field only if the tissue or organs are removed in continuity with the primary site (en bloc), except where noted in Appendix A in the STORE 2021 manual. Specimens from an en bloc resection may be submitted to pathology separately.

   SEER Note: In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily as a single specimen. Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

9. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is not considered cancer-directed surgery. Brushings, washings, and aspiration of cells are not surgical procedures.
10. 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.
11. For brain tumors, gross total resection (of tumor or mass) should be coded to 20, and not 55. Code 55 would indicate total resection of a lobe of the brain.
12. Code 80 or 90 only when there is no specific information.

Note: If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item Palliative Care [3270].

13. Code 98 is used for hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease and for unknown or ill-defined sites unless the case is death certificate only. When Surgery of Primary Site is coded 98, code Reason for No Surgery of Primary Site to 1.
    a. Hematopoietic and Lymphoid Neoplasms
    b. Any case coded to primary site C420, C421, C423, or C424
    c. Cervical Lymph Nodes and Unknown Primary
    d. Unknown or ill-defined sites: C760-C768, C809 (all histologies)
        i. Excluding Spleen (C422) and C770-779 (Lymph Nodes)

14. Code 99 for death certificate-only (DCO) cases or if patient record does not state whether a surgical procedure of primary site was performed (i.e., is unknown).

Table 7.7 Surgical Procedure of Primary Site Codes

Code	Type	Description
00	None	No surgical procedure of primary site. Diagnosed at autopsy only.
10–19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to *Appendix A in the STORE 2021 manual* for correct site-specific procedure code.
20–80	Site-specific codes; resection	Refer to *Appendix A in the STORE 2021 manual* for correct site-specific procedure code.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific surgery codes; special	Special code for hematopoietic neoplasms; ill-defined sites; and unknown primaries. Refer to *Appendix A in the STORE 2021 manual* for correct site-specific procedure code.
99	Unknown	Medical record does not state whether a surgical procedure of the primary site was performed, and no information is available. Death certificate only.

Reason for No Surgery of Primary Site

(NAACCR Item #1340) (STORE 2021 page 254-255; SEER pages 186-188)

Description

Records the reason that no surgery was performed on the primary site. This field applies only to surgery of primary site. This data item records the reason that surgery of the **primary site** was not part of the first course of treatment.

Rationale

This data item provides information related to quality of care.

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 code in the range of 1-8 if 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

      Note: Surgery is not standard treatment for these cases.

   ii. There is no information in the patient's medical record about surgery, and

      - It is known that surgery is not usually performed for this type and/or stage of cancer, or
      - There is no reason to suspect that the patient would have had surgery of primary site.

        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.

      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.

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

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

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.

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.

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

4. Code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any, was provided. For death certificate-only (DCO) cases, and autopsy only cases.

Note: Table 7.8 is also available in Quick Reference, Appendix H.

Table 7.8 Reason for No Surgery Codes

Code	Description
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment.

Code	Description
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 of therapy. No reason was noted in the patient 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's 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 whether surgery of the primary site was recommended or performed. Death certificate only. Diagnosed at autopsy.

Example 1: A patient with primary tumor of the liver is not recommended for surgery due to advanced cirrhosis. The reason for no primary site surgery is 2, not recommended due to comorbid conditions.

Example 2: A patient is referred to another facility for recommended surgical resection of a non-small cell lung carcinoma. There is no further information from the facility to which the patient was referred. The reason for no surgery of primary site is 8, recommended but unknown if performed.

RX Summ - Surg Other Reg/Dist RX Code

(NAACCR Item #1294) (STORE 2021 pages 247-248; SEER page 184-185)

Description

Indicates the surgical removal of other regional site(s), distant site(s), or distant lymph node(s) beyond the primary site. Code the surgical procedure of other sites the patient received, at any facility, as part of the first course of treatment.

Rationale

Documents the extent of surgical treatment and is useful in evaluating the extent of metastatic disease.

Coding Instructions

1. Do not code tissues or organs such as an appendix that were removed incidentally, and the organ was not involved with cancer.

   Note: Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer. Examples of incidental removal of organ(s) would be removal of appendix, gallbladder, etc., during abdominal surgery.

2. Do not code removal of uninvolved contralateral breast in this data item. See Appendix C: Site Specific Surgery Codes SEER 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. Record the highest numbered code that describes the surgical resection of distant lymph nodes or regional/distant tissues or organs the patient received as part of the first course of treatment at any facility.
   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.

      Note: See also notes and codes in Appendix C, 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 (excluding cases coded to the schema Cervical Lymph Nodes and Unknown Primary 00060).
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

Table 7.9 RX Summ– Surg Other Reg/Dist RX Codes

Code	Description	Definition
0	None	No surgical procedure of non-primary site was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical procedure to other site(s), unknown if the site(s) is regional or distant.

Code	Description	Definition
2	Non-primary surgical procedure to other regional sites	Resection of regional site.
3	Non-primary surgical procedure to distant lymph node(s)	Resection of distant lymph node(s).
4	Non-primary surgical procedure to distant sites	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a non-primary site was performed. Death certificate-only (DCO) cases.

Examples

- The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon is coded to 0.
- Surgical biopsy of metastatic lesion from liver with an unknown primary is coded to 1.
- Surgical ablation of solitary liver metastasis with a hepatic flexure primary is coded to 2 (Site regional by stage).
- Excision of distant metastatic lymph nodes with a rectosigmoid primary is coded to 3.
- Removal of a solitary brain metastasis with a lung primary is coded to 4 (site distant by stage).
- Excision of a solitary liver metastasis and hilar lymph node with a rectosigmoid primary is coded to 5.

RX Text Surgery

(NAACCR Item #2610)

Description

Text area for information describing all surgical procedures performed as part of treatment.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information must be provided by all facilities.

2. Document all first course surgery regardless of where it was done, in chronological order.
3. Document type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites

Note: See the Section 8: Documentation Of Cancer Diagnosis, Extent Of Disease, And Treatment for further explanation and examples. Do not enter text in this fields when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Date Radiation Started

(NAACCR Item #1210) (STORE 2018 page 272; SEER page 189)

Description

The date the radiation therapy began at any facility as part of the first course of treatment.

Rationale

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

Coding Instructions

1. Record the date of the first/earliest radiation treatment if radiation was given and recorded as part of first course of therapy.
    a. Do not record the date of the initial radiation planning session.
2. Date format is:
    a. YYYYMMDD - when the complete date is known and valid.

    Example: A patient with breast cancer begins external beam radiation therapy on April 10, 2018. Code the date of radiation therapy as 20180410.

    b. YYYYMM - when year and month are known and valid, and day is unknown.

    Example: A patient was diagnosed with prostate cancer and underwent brachytherapy in January 2018, but the day is not known. Record date of radiation therapy as 201801.

    c. YYYY - when year is known and valid, and the month and day are unknown.

    Example: A patient is seen with brain cancer in July 2018. It is known that the patient had radiation therapy earlier in the year, but the month and day are unknown. Record the date of radiation therapy as 2018.

    d. Blank - when no known date applies (no radiation therapy was given, or it is unknown if radiation was given).

Example: A patient with a malignant brain tumor has refused all therapy including radiation therapy. Leave the date of radiation therapy blank.

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. If two or more types of radiation therapy are delivered, (for example: beam and isotopes; beam and implants) enter the date for the **first** type of radiation therapy.
5. If radiation therapy is given do not leave this field blank. If the date is not known record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the date of radiation therapy is unknown.

RX Date Radiation Flag

(NAACCR Item #1211) (SEER page 190)

Description

This flag explains why there is no appropriate value in the corresponding date field *Date Radiation Started.*

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in date field.

Coding Instructions

1. Leave this item blank if *Date Radiation Started* has a full or partial date recorded.
2. Code 10 if it is unknown whether any radiation was given.
3. Code 11 if no radiation is planned or given, or the initial diagnosis was at autopsy.
4. Code 12 if *Date Radiation Started* cannot be determined, but the patient did receive first course radiation. Use this code only as a last resource.
5. Code 15 if radiation is planned but has not yet started and the start date is not yet available.

Table 7.10 RX Date Radiation Flag Codes

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if any radiation was given).
11	No proper value is applicable in this context (for example, no radiation given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation was given but the date is unknown).

Code	Description
15	Information is not available at this time, but it is expected that it will be available later (for example, 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).
(blank)	A valid date value is provided in item *Date Radiation Started* (NAACCR Item 1210).

Radiation Treatment Modality--Phase I

(NAACCR Item #1506) (STORE 2021 pages 268-269; SEER pages 191)

NAACCR Name: Phase I Radiation Treatment Modality

NOTE: TCR only requires NAACCR item # 1506 Phase I Radiation Treatment Modality for cases diagnosed in 2018 and forward.

Description

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

Rationale

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

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.

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter 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.

- The first phase may be commonly referred to as an initial plan and subsequent phase may be referred to as a boost or code down, and would be recorded as Phase II, Phase III, etc. accordingly. TCR does not collect Phase II or III.

- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (I.e. dose given during a session), modality or treatment technique. Any one of these changes will mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.

- For purposes of this data item, photons, x-rays and gamma- rays are equivalent.

Note: Refer to the current STandards for Oncology Registry Entry (STORE) Manual and the CTR Guide to Coding Radiation Therapy Treatment in the STORE

Coding Instructions

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

Table 7.11 Radiation Treatment Modality Phase I Codes

Code	Description
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
98	Radiation therapy administered, but treatment modality is not specified or unknown
99	Unknown if radiation treatment administered

Examples

- A patient with follicular carcinoma of the thyroid is treated with post-operative injection of radioiodine (I-131) for a total dose of 150 millicuries. Record Phase I Radiation Treatment Modality as 13 (Radioisotopes, NOS).
- A woman with multiple myeloma is treated using locally opposed conformal 15Mv photons to a total dose of 2000cGy in 5 fractions. Record Phase I Radiation Treatment Modality as 13 (External beam, photons).

RX Text Radiation

(NAACCR Item #2620 and 2630)

Description

Text information regarding treatment of the tumor being reported with beam radiation and/or other radiation therapy.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support radiation treatment **must be provided by all facilities**.
2. Document all first course therapy radiation treatment regardless of where it was done, in chronological order.

Example: External beam radiation therapy completed on 6/15/18, start date not given. Estimate start date 5/2018.

Note: See the Section 8: Documentation of Cancer Diagnosis, Extent of Disease, and Treatment for further explanation and examples.

Do not enter text in this field when treatment is either not done, unknown if done. This information is conveyed by the treatment flags.

RX Summary - Surgery/Radiation Sequence

(NAACCR Item #1380) (STORE 2021 page 285-286; SEER page 195-196)

Description

This data item records the order in which surgery and radiation therapies were administered for those patients who had both surgery and radiation. For the purpose of coding the data item Radiation Sequence with Surgery, 'Surgery' is defined as a Surgical Procedure of Primary Site (codes 10-90) or Scope of Regional Lymph Node Surgery (codes 2-7) or Surgical Procedure of Other Site (codes 1-5).

Rationale

The sequence of radiation 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 timing of delivery of treatment to the patient.

Coding Instructions

1. For the purpose of coding the data item Radiation Sequence with Surgery, 'Surgery' is defined as a Surgical Procedure of Primary Site (codes 10-90) or Scope of Regional Lymph Node Surgery (codes 2-7) or Surgical Procedure of Other Site (codes 1-5). If all of these procedures are coded 0, then this item should be coded 0.

2. 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

3. Assign codes 2-9 when the 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)

    Note: Code 1 of Scope of Regional Lymph Node Surgery is defined as "aspiration or biopsy of regional node, NOS"

    Example: Preoperative radiation therapy was administered to shrink a large, bulky lesion.

Resection was performed. Postoperative radiation therapy was administered after resection.

b. Assign code 7 when there are at least two surgeries; radiation was administered between one surgical procedure and a subsequent surgical procedure.

Example 1: Patient had sentinel lymph node biopsy, followed by radiation therapy, and then surgery of primary site. Code Radiation Sequence with Surgery as 7 (surgery both before and after radiation).

Example 2: Patient had two regional lymph nodes removed, followed by radiation, and then surgery of primary site. 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.

Note: Table 7.11 is also available in the Quick Reference, Appendix H.

Table 7.11 RX Summary-Surgery/Radiation Sequence Codes

Code	Label	Description
0	No radiation therapy and/or surgical procedures	No radiation therapy given or **unknown** if radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s) or it is **unknown** whether any surgery was given.
2	Radiation therapy before surgery	Radiation therapy given before surgery to 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).
3	Radiation therapy after surgery	Radiation therapy given after surgery to 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).
4	Radiation therapy both before and after surgery	At least two courses of radiation therapy are given before and 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).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to 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).

Code	Label	Description
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to 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) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
7	Surgery both before and after radiation (for cases diagnosed 1/1/2012 and later)	Radiation was administered between two separate surgical procedures to the primary site, scope of regional lymph node surgery (excluding code 1), regional lymph nodes, surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown, but both surgery and radiation were given	Administration of radiation therapy and surgery to 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) were performed and the sequence of the treatment is not stated in the patient record.

Examples

- Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. Use code 0.
- Patient received radiation therapy prior to resection of a lung lesion. Use code 2.
- A patient underwent excisional biopsy of a right breast mass followed by radiation therapy to breast. Use code 3.
- Preoperative radiation therapy was given to a large bulky vulvar lesion, followed by a lymph node dissection. Radiation therapy was then given to treat positive lymph nodes. Use code 4.
- A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma. Use code 5.
- Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy. Use code 6.
- A primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. Use code 9.
- Patient has an unknown primary. A radical neck dissection is done followed by radiation therapy. Use code 3.

Reason For No Radiation

(NAACCR Item #1430) (STORE 2021 page 288-289) (SEER page 197)

Description

Records the reason that no regional radiation therapy was administered to the patient as part of first course of therapy.

Rationale

When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's failure to recommend that treatment, or due to the refusal of the patient, a family member, or the patient's guardian.

Coding Instructions

1. If *Regional Treatment Modality* Phase I (NAACCR Item #1506) is coded 00, then record the reason based on documentation in patient record.
2. Code 0 if the patient received regional radiation as part of first course of therapy.
3. Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include radiation therapy.

   Example: A patient with Stage I prostate cancer is offered either surgery OR brachytherapy to treat his disease. The patient elects to be surgically treated. Code *Reason for No Surgery* 1.
4. 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.
5. Code 8:
   a. if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.
   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.
6. Code 9:
   a. if the treatment plan offered multiple alternative treatment options, but it is unknown which treatment, if any, was provided.
   b. if it's a death certificate-only (DCO) case.

Table 7.12 Reason for No Radiation Codes

Code	Description
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 recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation).
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6	Radiation therapy was not administered; it was recommended by the patient's physician but was not administered as part of first course treatment. No reason was noted in patient 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 patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate cases only.

Date Chemotherapy Started

(NAACCR Item 1220) (STORE 2021 page 293; SEER page 200)

Description

The date of initiation of chemotherapy that is part of the first course of treatment.

Explanation

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 first or earliest date on which chemotherapy was administered by any facility.
    a. Code the date that the prescription or physician order was written if date administered unknown.
    b. Chemotherapy date should be the same as the Date Therapy Initiated when chemotherapy is the only treatment administered.
2. Date format is:

a. YYYYMMDD - when the complete date is known and valid.

Example: A patient with colon cancer begins 5-FU on February 5, 2021. Record the date as 20210205.

b. YYYYMM - when year and month are known and valid, and day is unknown.

Example: A patient started chemotherapy in March 2021, but the exact day is not known. Record 202103.

c. YYYY - when year is known and valid, and the month and day are unknown.

d. Blank - when no known date is applicable (no chemotherapy was given, or it is unknown if chemotherapy was given).

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. Do not leave the date blank if chemotherapy was administered. If the date is unknown code the year of diagnosis as the start date and leave the day and month blank. Document in the text field that the complete first date of chemotherapy is not known.

Example: The patient had breast cancer diagnosed in April 2021. She has completed chemotherapy and now comes to your facility for radiation therapy. Record the date of chemotherapy as 2021.

RX Date Chemo Flag

(NAACCR Item #1221) (STORE 2021 page 294; SEER page 201)

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Chemotherapy Started.*

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in date fields.

Coding Instructions

1. Leave this item blank if *Date Chemotherapy Started* has a full or partial date recorded.
2. Code 10 if it is unknown whether any chemotherapy was given.
3. Code 11 if no chemotherapy is planned or given.
4. Code 12 if the *Date Chemotherapy Started* cannot be determined or estimated, but the patient did receive first course chemotherapy. Use this code only as a last resort.
5. Code 15 if chemotherapy is planned, but not yet started.

Table 7.13 RX Date Chemo Flag Codes

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if chemotherapy was given).
11	No proper value is applicable in this context (no chemotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy was given but the date is unknown and cannot be estimated).
15	Information is not available at this time, but it is expected that it will be available later (chemotherapy is planned as part of first course treatment but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *Date Chemotherapy Started* (NAACCR Item #1220). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Chemotherapy Started* (NAACCR Item #1220) at that time.

RX Summ - Chemo (Chemotherapy)

(NAACCR Item #1390) (STORE 2021 pages 295-297; SEER pages 202-207)

Important update effective for diagnosis date January 1, 2013 and forward.

A comprehensive review of chemotherapeutic drugs currently found in the SEER *Rx -Interactive Drug Database was performed and in keeping with the U.S. Food and Drug Administration (FDA), the six (6) drugs listed in the table below have changed categories from Chemotherapy to BRM/Immunotherapy.

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

Drug name/Brand name	Previous Category	New Category	Effective Date
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno	01/01/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno	01/01/2013
Rituximab/Rituxan	Chemotherapy	BRM/Immuno	01/01/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno	01/01/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno	01/01/2013
Cetuximab/Erbitux	Chemotherapy	BRM/Immuno	01/01/2013

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.

Rationale

This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the

first course of therapy.

Coding Instructions

1. Refer to *SEER*RX* for direction on coding systemic therapy appropriately.
2. Code the chemotherapeutic agents whose actions are chemotherapeutic only; do not code the method of administration.
3. 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. Do not code as chemotherapy.

   Note: Do not assume that a chemo agent given with radiation therapy is a radiosensitizers. Seek additional information. Compare the dose given to the dose normally given for treatment.
4. 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, 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.
   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.
5. Code as treatment for both primaries when the patient receives chemotherapy for invasive carcinoma in one breast and also has in situ carcinoma in the other breast. Chemotherapy would likely affect both primaries.
6. Assign Code 00 when:
   a. The medical record documents chemotherapy was not given, was not recommended, or was not indicated.
   b. There is no information in the patient's medical record about chemotherapy, and
      i. It is known that chemotherapy is not usually performed for this type and/or stage of cancer, or
      ii. There is no reason to suspect that the patient would have had chemotherapy.
   c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include chemotherapy.
   d. Patient elects to pursue no treatment following the discussion of chemotherapy. Discussion does not equal a recommendation.

e. Watchful waiting/active surveillance is the first course of treatment (e.g., CLL).

f. Patient diagnosed at autopsy.

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

7. 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).
8. Code to 01 if chemotherapy was administered as first course treatment, but the type and number of agents is not documented in the patient record.
9. Assign Code 02 when single agent chemotherapy was administered as first course therapy.

   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.

   Note: 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).
10. Assign code 03 if multiagent chemotherapy was administered as first course therapy.

    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.
11. 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 advanced age or comorbid conditions(s) (heart disease, kidney failure, other cancer etc.).
12. Assign code 87 if the patient refused the recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended and chemotherapy is a customary option for the primary site/histology.
13. Assign code 88 when the only information available is that the patient was referred to an oncologist or there was an insertion of a port-a-cath.

    a. Review cases coded 88 periodically for later confirmation of chemotherapy. If follow-up indicates the patient was never seen by the oncologist, change the code to 00.

    b. A referral to a clinical oncologist is equivalent to a recommendation.

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.

14. Assign code 99 when there is no documentation that chemotherapy was recommended or administered. For death certificate-only (DCO) cases.

Chemotherapeutic Agents

Chemotherapy is a chemical (or group of chemicals) administered to treat cancer. Chemotherapy consists of a group of anti-cancer drugs that inhibit the reproduction of cancer cells. Chemotherapeutic agents may be administered by intravenous infusion or given orally.

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: Alkretamine, Procarbazine, Decarbazine, and Temozolomide
- Nitrosureas: Carmustine, Lomustine and Streptozocin. Nitrosoureas 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-Florouracil, 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 Tenisopide
   - 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, Danorubicin, 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, Tenisopide

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).

Molecular targeted therapy

MTT. Agents in this type of therapy are vastly different from the traditional chemotherapeutic agents. These new drugs are designed to target unique or abnormally-expressed molecules within cancer cells while sparing normal cells.

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:** 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 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.

Note: Table 7.14 is also available in the Quick Reference, Appendix H.

Table 7.14 Chemotherapy Codes

Code	Description
00	None; chemotherapy was not part of the first course of therapy.
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., comorbid conditions, advanced age.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

- A patient with primary liver cancer is known to have received chemotherapy. The type(s) of agent(s) delivered is not documented in the medical record. Record code 01 and document the information in the treatment documentation text field.
- A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the fluorouracil as a single agent and the levamisole as an immunotherapeutic agent. Record code 02 and document the information in the treatment documentation data field.
- A patient with early-stage breast cancer receives chemotherapy. The medical record indicated a combination regimen containing doxorubicin is to be administered. Record code 03 and document the information in the treatment documentation data field.

- Following surgical resection of an ovarian mass the physician recommends chemotherapy. The medical record states chemotherapy was not delivered, and the reason is not documented. Record code 86 and document that the medical record states chemo not delivered but no reason given.
- Patient has hepatocellular carcinoma. 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. A chemotherapy agent is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the diseased tissue. Record code 02 and document that chemoembolization was done.

RX Text Chemo

(NAACCR Item # 2640)

Description

Text area for documentation of information regarding chemotherapy treatment of the reported tumor.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support chemotherapy treatment information **must be provided by all facilities**.
2. Document all first course therapy chemotherapy information regardless of where it was done, in chronological order.
3. Document date, name of facility, type of chemotherapy
4. Document other treatment information, e.g., treatment cycle incomplete

Example: 3/15/17 Oncologist recommends 4 cycles adjuvant Taxol and carboplatin. PT wants treatment closer to home, referred to oncologist in his area. PT seen on 10/4/17 and physician notes patient has completed 4 cycles of Taxol and carboplatin.

Note: See Section 8: Documentation of Cancer Diagnosis, Extent of Disease, and Treatment for further explanation and examples.

Do not to enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Date Hormone Therapy Started

(NAACCR Item #1230) (STORE 2021 page 302; SEER page 208)

Description

Records the date of initiation of hormone therapy that is part of the first course of treatment.

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 first or earliest date on which hormone therapy was administered by any facility.
2. Date format is:
    a. YYYYMMDD - when the complete date is known and valid.

    Example: A patient with recently diagnosed prostate cancer begins Lupron therapy on January 21, 2018. Record the date as 20180121.

    b. YYYYMM - when year and month are known and valid, and day is unknown.

    Example: A patient with breast cancer completed chemotherapy and then began Tamoxifen in April 2018, but the exact day is not known. Record the start date as 201804.

    c. YYYY - when the year is known and valid, and the month and day are unknown.

    Example: A patient with prostate cancer started Lupron therapy earlier this year, but there is no information regarding the month and day. Record 2021 as the start date.

    d. Blank - when no known date applies (no hormone therapy was given, or it is unknown if any hormone therapy was given).
3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. If hormone therapy was administered do not leave the date blank. If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the date of hormone treatment is unknown.

RX Date - Hormone Flag

(NAACCR ITEM #1231) (STORE 2021 pages 303; SEER page 209)

Description

This flag explains why there is no appropriate value in the corresponding date field *Date Hormone Therapy Started*.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in the date field.

Coding Instructions

1. Leave this item blank if *Date Hormone Therapy Started* has a full or partial date recorded.
2. Code 10 if it is unknown whether any hormone therapy was given.
3. Code 11 if no hormone therapy is planned or given.
4. Code 12 if the *Date Hormone Therapy Started* cannot be determined or estimated, but the patient did receive first course hormone therapy. Use this code only as a last resort.
5. Code 15 if hormone therapy is planned, but not yet started.

Table 7.15 RX Date-Hormone Flag Codes

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if any hormone therapy was given).
11	No proper value is applicable in this context (no hormone therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, hormone therapy was given but the date is unknown and cannot be estimated).
15	Information is not available at this time, but it is expected that it will be available later (hormone therapy is planned as part of first course treatment but had not yet started at the time of the last follow-up).
(blank)	A valid date is provided in item *Date Hormone Therapy Started* (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Hormone Therapy Started* NAACCR Item #1230) at that time.

RX Summ - Hormone - Hormone Therapy (Hormone/Steroid Therapy)

(NAACCR Item #1400) (STORE 2021 pages 304-305; SEER pages 210-212)

Description

Records the type of hormone therapy administered as first course treatment at this and all other facilities. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale

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

Coding Instructions

1. Code the type of hormone therapy the patient received as part of the first course of treatment at any facility. Hormone therapy may involve the delivery of one or a combination of agents.
2. Refer to *SEER*Rx* for direction on coding hormone therapy appropriately.
3. Code the hormonal agent given as part of combination chemotherapy regimen, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone), or COPP (cyclophosphamide, vincristine, procarbazine, prednisone), whether it affects the cancer cells or not.

   Note: Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
4. Some types of cancers are slowed or suppressed by hormones. These cancers are treated by administering hormones and should be coded in this data field.

   Example: Endometrial cancer may be treated with progesterone. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer and should be coded.
5. 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. 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. Watchful waiting, active surveillance (e.g., prostate)

f. Patient diagnosed at autopsy.

g. Hormone treatment was given for a non-reportable condition or as chemoprevention prior to diagnosis of a reportable condition.

Example 1: Tamoxifen given for hyperplasia of breast four years prior to breast cancer diagnosis. Code 00 in Hormone therapy. Do not code tamoxifen given for hyperplasia as treatment for breast cancer.

Example 2: Patient with a genetic predisposition to breast cancer is on preventative hormone therapy. Do not code hormone therapy given before cancer is diagnosed.

6. Code to 01 for thyroid replacement therapy, which inhibits the thyroid stimulating hormone (TSH). TSH is a product of the pituitary gland that stimulates tumor growth.
7. If it is known that hormone therapy is usually delivered for this type and stage of cancer, but it was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
8. Code to 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment and hormone therapy is a customary option for the primary site/histology, or refused all treatment before any was recommended and hormone therapy is a customary option for the primary site/histology.
9. Code 88 when the only information available is that the patient was referred to an oncologist.

   Note: Review cases coded 88 periodically for later confirmation of hormone therapy. If follow-up with the oncologist indicates that the patient was never there, change code to 00.
10. Do not code as hormone replacement therapy when it is given because it is necessary to maintain normal metabolism and body function.
11. If prednisone or other hormone is delivered for other reasons, do not code as hormone therapy.

    Example 1: A patient is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy. Code to 00.

    Example 2: A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy. Code to 00.

Exception: Decadron is coded as hormonal treatment for lymphoid leukemias, lymphomas, and multiple myelomas only. It is delivered to achieve its effect on cancer tissue through change of the hormone balance.

STORE Note: If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item Palliative Care [3270].

Hormone Categories

Hormone therapy is a drug or group of drugs that is delivered to change the hormone balance. Hormone therapy may affect a long-term control of the cancer growth. It is not usually curative.

Note: Hormone therapy is administered to treat cancer tissue and is considered to achieve its effect through change of the hormone balance. Some cancers, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone-responsive. Other primaries and histologic types may be hormone-responsive, such as melanoma and hypernephroma.

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: Octreotide
- Somatostatin analog: Octreotide
- Thyroid hormones: Levothyroxine, liothyronine, Synthroid

Note: Table 7.16 is also available in the Quick Reference, Appendix H.

Table 7.16 Hormone Therapy Codes

Code	Description
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 was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration).
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 treatment. No reason was stated in 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 patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

- A patient diagnosed with metastatic prostate cancer is administered flutamide (an anti-androgenic agent) as part of the first course of therapy. Code to 01 and document the information in the Treatment Documentation data field.
- A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) as part of the first course of therapy and the refusal is documented in the medical record. Code to 87 and document the information in the Treatment Documentation data field.
- Patient with endometrial cancer is treated with progesterone. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer. Code to 01 and document the information in the Treatment Documentation data field.
- A patient with follicular or papillary cancers of the thyroid is treated with thyroid hormone to suppress/inhibits serum thyroid stimulating hormone (TSH). If a patient with papillary and/or follicular cancer of this is given TSH, code the treatment in this field. Code to 01 and document the information in the Treatment Documentation data field.
- Lupron is a hormonal treatment for prostate cancer. Code as hormonal treatment when Lupron is given for prostate cancer.
- Bromocriptine suppresses the production of prolactin, which causes growth in pituitary adenoma. Code bromocriptine as hormone treatment for pituitary adenoma.

Note: Surgical removal of organs for hormone manipulation (such as orchiectomy for prostate cancer) is not coded in this data item. Code these procedures in the data field Hematologic Transplant and Endocrine Procedures.

RX Text Hormone

(NAACCR Item #2650)

Description

Text area for information about hormonal treatment.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support hormone therapy **must be provided by all facilities**.
2. Document all first course hormone therapy regardless of where it was done.
3. Document dates, name of facility, type of hormone, type of endocrine surgery or radiation
4. Document other treatment information, e.g., treatment cycle incomplete

Example: After being diagnosed with adenocarcinoma of the prostate on 1/11/18, the patient opted for hormonal treatment and started Lupron on 2/1/18.

Note: See Section 8: Documentation of Cancer Diagnosis, Extent of Disease, and Treatment for further explanation and examples.

Do not enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Date Immunotherapy Started

(NAACCR Item #1240) (STORE 2021 page 309; SEER page 213)

Description

Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment.

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 first or earliest date on which immunotherapy or a biologic response modifier was administered by any facility. This date corresponds to administration of the agents coded in *Immunotherapy.*
2. Date format is:
    a. YYYYMMDD - when the complete date is known and valid.

    Example: A patient with multiple myeloma begins treatment with interferon on March 12, 2021. Record the date as 20210312.

    b. YYYYMM - when the month and year are known and valid and the day is unknown.

    Example: A patient with melanoma received lymphokine-activated killer cells in January 2021 the day is not known. Code 202101.

    c. YYYY - when the year is known and valid, and the month and day are unknown.

    Example: A patient diagnosed with lung cancer with malignant pleural effusion earlier in 2021 has been treated with Picibanil, but the exact date is not known. Record 2021 as the date immunotherapy started.

    d. Blank - when no known date applies (no immunotherapy was given, or it is unknown if immunotherapy was given).
3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. If immunotherapy was administered do not leave the date blank. If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the start date is unknown.

RX Date - Immunotherapy Flag

(NAACCR Item #1241) (STORE 2021 pages 310; SEER page 214)

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Immunotherapy Started.*

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in date fields.

Coding Instructions

1. Leave this item blank if *Date Immunotherapy Started* has a full or partial date recorded.
2. Code 10 if it is unknown whether any immunotherapy was given.
3. Code 11 if no immunotherapy was planned or given.
4. Code 12 if *Date Immunotherapy Started* cannot be determined or estimated, but the patient did receive first course immunotherapy or a biologic response modifier. Use this code only as a last resort.
5. Code 15 if immunotherapy is planned, but not yet started.

Table 7.17 RX Date-Immunotherapy Flag Codes

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if immunotherapy was given).
11	No proper value is applicable in this context (no immunotherapy given)
12	A proper value is applicable but not known. This event occurred, but date is unknown (that is, immunotherapy was given but the date is unknown and cannot be estimated).
15	Information is not available at this time, but it is expected that it will be available later (immunotherapy is planned as part of first course treatment, but had not yet been started at the time of the last follow-up)
(blank)	A valid date is provided in item *Date Immunotherapy Started* (NAACCR Item #1240). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Immunotherapy Started* (NAACCR Item #1240) at that time.

RX Summ - BRM (Immunotherapy)

(NAACCR Item #1410) (STORE 2021 pages 311-312; SEER pages 215-217)

Description

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.

Rationale

This data item allows for the analysis of the administration of immunotherapeutic (biological therapy, biotherapy or biological response modifier) agents as part of the first course of therapy.

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. 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. Code to 88 when the only information available is that the patient was referred to an oncologist.

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

Note: Table 7.18 is also available in the Quick Reference, Appendix H.

Table 7.18 Immunotherapy Codes

Code	Description
00	None, immunotherapy was not part of the first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only
01	Immunotherapy administered as first course of therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration).
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 treatment. No reason was stated in patient 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 patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Immunotherapy is designed to:

- Make cancer cells more recognizable and therefore more susceptible to destruction by the immune system.
- Boost the killing power of immune system cells, such as T-cells, NK-cells, and macrophages.
- Alter the growth patterns of cancer cells to promote behavior like that of healthy cells.
- Block or reverse the process that changes a normal cell or a pre-cancerous cell into a cancerous cell.
- 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.
- Prevent cancer cells from spreading to other parts of the body.

Types of Immunotherapy

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.

- **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. 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.
- **Donor Leukocyte Infusions:** A type of therapy in which lymphocytes from the blood of a donor are given to a patient who has already received a stem cell transplant from the same donor. The donor lymphocytes may kill remaining cancer cells. Donor lymphocyte infusion is used to treat chronic myelogenous leukemia (CML) that has come back and myeloma. It is being studied in the treatment of other types of cancer. The use of donor leukocyte infusions for treatment of hematopoietic neoplasms, specifically leukemias, is increasing. Abstract as immunotherapy when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion, even if it is not listed in the treatment section of the Heme DB for the specific neoplasm.

RX Text Immunotherapy

(NAACCR Item #2660)

Description

Text information describing all immunotherapy or Biological Response Modifiers given as part of first course of treatment.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information **must be provided by all facilities** if treatment was given, completed, or incomplete.
2. Document all first course immunotherapy regardless of where it was done.
3. Document date, name of facility, BRM procedures, e.g., bone marrow transplant, stem cell transplant
4. Document other treatment information, e.g., treatment cycle incomplete

Note: See Section 8: Documentation of Cancer Diagnosis, Extent of Disease, and Treatment for further explanation and examples.

Do not to enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

RX Summ – Hematologic Transplant/Endocrine Procedures

(NAACCR Item #3250) (STORE 2021pages 315-316; SEER pages 218-220)

Description

This data item records systemic therapeutic procedures administered as part of the first course of treatment. These procedures include bone marrow transplants (BMT) and stem cell harvests with rescue (stem cell transplant), endocrine surgery and/or radiation performed for hormonal effect (when cancer originates at another site), and a combination of transplants and endocrine therapy.

Rationale

This treatment involves the alteration of the immune system or changes the patient's response to tumor cells but does not involve the delivery of antineoplastic agents.

Note: Used for breast cancer, lymphoma, leukemia, aplastic anemia, myeloma, germ cell tumors, ovarian cancer, and small cell lung cancer.

Definitions

- **Bone marrow transplant (BMT)**: Procedure where bone marrow is used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.
- **BMT Allogeneic**: Receives bone marrow from a donor. This includes haploidentical (or half-matched) transplants.
- **BMT Autologous**: Uses the patient's own bone marrow. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.
- **BMT Syngeneic**: Bone marrow received from an identical twin.
- **Conditioning**: High-dose chemotherapy with or without radiation administered prior to transplant such as BMT and stem cells to kill cancer cells. This conditioning also destroys normal bone marrow cells, so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field and the radiation is coded in the Radiation field.
- **Hematopoietic Growth Factors**: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.
- **Non-Myeloablative Therapy**: Uses immunosuppressive drugs pre- and post-transplant to ablate (destroy) the bone marrow. These are **not** recorded as therapeutic agents.
- **Peripheral Blood Stem Cell Transplant (PBSCT)**: Rescue that replaces stem cells after conditioning.
- **Rescue**: Rescue is the actual BMT or stem cell transplant done after conditioning.
- **Stem Cells:** Immature cells found in bone marrow, blood stream 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.
- **Donor Leukocyte Infusions:** A type of therapy in which lymphocytes from the blood of a donor are given to a patient who has already received a stem cell transplant from the same donor. The donor lymphocytes may kill remaining cancer cells. Donor lymphocyte infusion is used to treat

chronic myelogenous leukemia (CML) that has come back and myeloma. It is being studied in the treatment of other types of cancer. The use of donor leukocyte infusions for treatment of hematopoietic neoplasms, specifically leukemias, is increasing. Abstract as immunotherapy when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion, even if it is not listed in the treatment section of the Heme DB for the specific neoplasm.

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 allogenic (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 allogenic) 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
    a. Allogenic stem cell transplant
    b. Peripheral blood stem cell transplant
    c. Umbilical cord stem cell transplant (single or double)

Note: If the patient does not have a rescue, code the stem cell harvest as 88, recommended, unknown if administered) or if harvested but unknown if infused.

6. Assign code 30 for endocrine radiation and/or surgery. Endocrine irradiation and/or endocrine surgery are procedures that suppress the naturally occurring hormonal activity of the patient and therefore alter or affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualify as endocrine surgery or endocrine radiation.

   Example 1: Bilateral orchiectomy for prostate cancer.

   Example 2: Bilateral oophorectomy for breast cancer.

   Example 3: Bilateral adrenalectomy for microadenoma.

   Example 4: Bilateral hypophysectomy for pituitary cancer

   Example 5: Bilateral radiation to ovaries for breast cancer, or to testicles for prostate cancer
7. Code 86 if the treatment plan offered multiple options which included a transplant, and the patient selected treatment that did include a transplant procedure.
8. Code to 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
9. 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.
10. Assign code 99 when there is no documentation that transplant procedure or endocrine therapy was recommended or performed. For death certificate-only (DCO) cases.

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.19 RX Summ– Hematologic Transplant/Endocrine Codes

Code	Description
00	No transplant procedure or endocrine therapy was administered as part of first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant-autologous.
12	Bone marrow transplant- allogeneic.
20	Stem cell harvest (Stem cell transplant) and infusion.
30	Endocrine surgery and/or endocrine radiation therapy as first course of therapy

Code	Description
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20) as first course of therapy.
82	Transplant procedure and/or endocrine therapy was not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of disease prior to administration).
85	Transplant procedure and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy.
86	Transplant procedure and/or endocrine surgery/radiation were 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 surgery/radiation were 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 patient record.
88	Transplant procedure and/or endocrine therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether transplant procedure or endocrine therapy was recommended or administered because it is not documented in the medical record. Death certificate only.

RX Summary Systemic/Surgery Sequence

(NAACCR Item #1639) (STORE 2021pages 317-318 SEER pages 221)

Description

This data item records the sequence of any systemic therapy and surgery given as first course of therapy for those patients who had both systemic therapy and surgery. For the purpose of coding systemic treatment sequence with surgery, 'Surgery' is defined as a Surgical Procedure of Primary Site (codes 10-90) or Scope of Regional Lymph Node Surgery (codes 2-7) or Surgical Procedure of Other Site (codes 1-5).

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 item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Systemic therapy is defined as:

- Chemotherapy
- Hormone therapy
- Biological response therapy/immunotherapy

- Bone marrow transplant
- Stem cell harvests
- Surgical and/or radiation endocrine therapy

Coding Instructions

1. Code the administration of systemic therapy in sequence with the first surgery performed, described in the item *Date of First Surgical Procedure* (NAACCR Item #1200).
2. If none of the following surgical procedures were performed: *Surgical Procedure of Primary Site* (NAACCR Item #1290) (codes 10-90), S*cope of Regional Lymph Node Surgery* (NAACCR Item #1292) (codes 2-7), S*urgical Procedure/Other Site* (NAACCR Item #1294) (codes 1-5), then this item should be coded 0.
3. If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site* (NAACCR Item #1290), S*cope of Regional Lymph Node Surgery* (NAACCR Item #1292), *Surgical Procedure/Other Site* (NAACCR Item #1294), then code this item 2–9, as appropriate.
4. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

Example: The sequence chemo, then surgery, then hormone therapy, then surgery is coded 4 for "chemo then surgery then hormone."

Note: Table 7.20 is also available in the Quick Reference, Appendix H.

Table 7.20 RX Summary Systemic/Surgery Sequence Codes

Code	Label	Description
0	No systemic therapy and/or surgical procedures; Unknown if surgery and/or systemic therapy given	No systemic therapy was given and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed. Diagnosed at autopsy. Death certificate only.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery (except code 1); surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery (except code 1); surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.

Code	Label	Description
4	Systemic therapy both before and after surgery	At least two courses of systemic therapy were given, before and after any surgical procedure of primary site; scope of regional lymph node surgery (except code 1); surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery (except code 1); surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery (except code 1); surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
7	Surgery both before and after systemic therapy (effective for cases diagnosed 1/1/2012 and later)	Systemic therapy was administered between two separate surgical procedures to the primary site; scope of regional lymph node surgery (except code 1), surgery to other regional site(s), distant site(s), or distant lymph node(s)
9	Sequence unknown	Administration of systemic therapy and surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if systemic therapy was administered and/or it is unknown if surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed.

Examples

- Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. Record code 0 and document the information in the treatment documentation data field.
- Patient with prostate cancer received hormone therapy prior to a radical prostatectomy. Record code 2 and document the information in the treatment documentation data field.
- Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen. Record code 3 and document the information in the treatment documentation data field.

- Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen. Record code 4 and document the information in the treatment documentation data field.
- Patient with intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity. Record code 5 and document the information in the treatment documentation data field.
- Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver followed by 5-FU. Record code 6 and document the information in the treatment documentation data field.
- An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown. The patient enters for radiation therapy. Record code 9 and document the information in the treatment documentation data field.

Date Other Treatment Started

(NAACCR Item #1250) (STORE 2021 page 320; SEER page 232)

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.

Rationale

Collecting dates for each treatment modality allows for 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 the *Other Treatment* was initiated.
2. Date format is:
    a. YYYYMMDD - when the complete date is known and valid.

    Example: A patient with polycythemia vera was first treated with phlebotomy on February 20, 2021. Record Date of Other Treatment as 20210220.

    b. YYYYMM - when year and month are known and valid, and day is unknown.

    Example: A patient with pancreatic cancer is enrolled in a double-blind clinical trial in May 2018, but the day is not known. Record Date of Other Treatment as 202105.

    c. YYYY - when year is known and valid, and the month and day are unknown.

Example: A patient diagnosed with essential thrombocythemia in 2021 and has since been treated with aspirin, but the exact date is unknown. Code the date as 2021.

d. Blank - when no known date applies (no other therapy was given, or it is unknown if other therapy was given).

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. If *Other Therapy* was administered do not leave the date blank. If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the date of *Other Treatment* is unknown.

RX Date - Other Treatment Flag

(NAACCR Item #1251) (SEER page 233)

Description

This flag explains why there is no appropriated value in the corresponding date field, *Date Other Treatment Started,* NAACCR Item #1250.

Explanation

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

1. Leave this item blank if *Date Other Treatment Started* (NAACCR Item #1250) has a full or partial date recorded.
2. Code 10 if it is unknown whether any other treatment was given (*Other Treatment,* NAACCR Item #1420, is 9).
3. Code 11 if no other treatment is planned or given (*Other Treatment* 0, 7 or 8).
4. Code 12 if *Date Other Treatment Started* cannot be determined or estimated, but the patient did receive first course other treatment. Use this code only as a last resort.

Table 7.21 RX Date-Other Flag Codes

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any Other Treatment was given).
11	No proper value is applicable in this context (for example, no Other Treatment given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, Other treatment was given but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (immunotherapy is planned as part of first course treatment, but had not yet been started at the time of the last follow-up)
(blank)	A valid date value is provided in item *Date Other Treatment Started* (NAACCR Item #1250).

Other Treatment

(NAACCR Item #1420) (STORE 2021 page 321-322; SEER pages 234-236)

Description

Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. This data item includes all complementary and alternative (CAM) used by the patient in conjunction with conventional therapy or in place of conventional therapy.

Rationale

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

Coding Instructions

1. Assign code 0 when:
    a. There is no information in the patient's medical record about other therapy, and
        i. It is known that other therapy is not usually performed for this type and/or stage of cancer, or
        ii. There is no reason to suspect that the patient would have had other therapy.
    b. First course of treatment was active surveillance/watchful waiting.
    c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy.
    d. Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation.
    e. Patient was diagnosed at autopsy.

2. Assign code 1 for:
    a. Hematopoietic treatments such as: phlebotomy or aspirin for polycythemia vera (9950/3) only. See SEER*Rx and Hematopoietic and Lymphoid Neoplasm Coding Manual and Database for specific guidance on coding.

       Note: Do not code blood transfusion as treatment.

       Rationale: Blood transfusions may be used for any medical condition that causes anemia. It would be virtually impossible for the registrar to differentiate between blood transfusions used for a co-morbidity (i.e., anemia) from those given as prophylactic treatment of a hematopoietic neoplasm.

    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).

       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. Photopheresis. 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 fields (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.

   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.

       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.

       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 lternative 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.

Example: Lupron given for breast cancer. Assign code 6. Lupron is not an approved hormone treatment for breast cancer and should not be coded in the hormone field.

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.

Note: Do not code ancillary drugs in this field. There is no coding scheme for ancillary drugs such as Leucovorin.

The National Cancer Institute (NCI), Office of Cancer Complementary and Alternative Medicine (OCCAM) defines Complementary and Alternative Medicine (CAM) as any medical system, practice, or product that is not thought of as "western medicine" or standard medical care.

- Complementary medicine means it is used along with standard medicine, also called conventional medicine.
- Alternative medicine is used in place of standard treatments.

CAM treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation.

The OCCAM was established to coordinate and enhance activities of the NCI in complementary and alternative medicine research as it relates to the prevention, diagnosis, and treatment of cancer, cancer-related symptoms and side effects of conventional cancer treatment.

See complete information on types of complementary and alternative medicine specific to cancer at cancer.gov/about-cancer/treatment/cam. For additional information on cancer and other diseases, visit nccih.nih.gov/health/integrative-health.

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.

Note: Table 7.22 is also available in the Quick Reference, Appendix H.

Table 7.22 Other Treatment Codes

Code	Type	Description
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases. *See **Examples**

Code	Type	Description
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by non-medical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Recommended; unknown if done	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment.

Examples

- A patient with polycythemia vera is treated with phlebotomies. Use code 1 for polycythemia vera ONLY according to the *Hematopoietic and Lymphoid Neoplasm Coding Manual* page 22 for cases diagnosed January 2010 and later. Phlebotomy may be called blood removal, bloodletting, or venesection.
- A patient with pancreatic cancer is enrolled in a double-blind clinical trial. The treatment agents are unknown. Use code 3.
- A patient was treated for melanoma with PUVA (psoralen and long-wave ultraviolet radiation). Code this treatment as *Other Treatment,* code 1.

RX Text Other

(NAACCR Item #2670)

Description

Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment 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 as first course of treatment.

Rationale

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information MUST BE PROVIDED BY ALL FACILITES.
2. Document all first course other treatment regardless of where it was done, in chronological order.
3. Document date, name of facility, and type of treatment
4. Document other treatment information, e.g., treatment cycle incomplete.

Note: See Section 8: Documentation of Cancer Diagnosis, Extent of Disease, and Treatment for further explanation and examples.

Do not enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

RX Summ - Treatment Status

(NAACCR Item #1285) (STORE 2021 page 220-221; SEER page 159)

Description

This data item summarizes whether the patient received any treatment, or the tumor was under active surveillance.

Rationale

This item documents active surveillance (watchful waiting) and eliminates searching each treatment modality to determine whether treatment was given. It is used in conjunction with *Date of First Course of Treatment* to document whether treatment was or was not given, it is unknown if treatment was given, or treatment was given on an unknown date.

Coding Instructions

1. This item may be left blank for cases diagnosed prior to 2010.
2. Treatment given after a period of active surveillance is considered subsequent treatment and it is not coded in this item.
3. Use code 0 when treatment is refused, or the physician decides not to treat for any reason such as the presence of comorbidities.
    a. Scope of Regional Lymph Node Surgery may be coded 0, 1-7, or 9
4. Assign code 1 when the patient receives treatment collected in any of the following fields:

a. Surgery of Primary Site
b. Surgical Procedure of Other Site
c. Radiation
d. Chemotherapy
e. Hormone therapy
f. Immunotherapy
g. Hematologic transplant and endocrine procedures
h. Other Therapy

5. Assign code 2 when there is documentation that the patient is being monitored using active surveillance/watchful waiting/deferred therapy or other similar options.
6. Assign code 9 for death certificate-only (DCO) cases.

Table 7.23 RX Summ - Treatment Status Codes

Code	Description
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

Examples

- An elderly patient with pancreatic cancer requested no treatment. Use code 0.
- Patient is expected to receive radiation, but it has not occurred yet (*Reason for No Radiation* [NAACCR Item #1430] = 8). Use code 0 for this field.
- Treatment plan for a lymphoma patient is active surveillance. Use code 2.

Date of Last Contact or Death

(NAACCR Item #1750) (STORE 2021 page 335; SEER page 239-241)

Description

The date of last contact with the patient or the date the patient expired.

Rationale

This information is used for follow-up and patient outcome studies.

Coding Instructions

1. Record the date the patient was last seen at your facility, date of last contact, or date of death.
2. Date format is YYYYMMDD.
3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the *Text Remarks-Other Pertinent Information* text area, document that the patient is deceased, and the date of death is not available.

Vital Status

(NAACCR Item #1760) (STORE 2021 page 336) (SEER page 243)

Description

Records the vital status of the patient as of the *Date of Last Contact or Death* known to the reporting facility through all available resources. If the patient has multiple tumors, vital status should be the same for all tumors.

Rationale

This information is used for outcome studies.

Coding Instructions

1. Code the patient's vital status as of the date recorded in the *date of last contact or death* field. Use the most current and accurate information available.
2. If a patient has multiple primaries **simultaneously**, all records should have the same vital status.
3. Assign code 0 for
    a. Deceased patients
    b. Death certificate-only (DCO) cases
    c. Autopsy only cases

Table 7.24 Vital Status Codes

Code	Description
0	Dead
1	Alive

Place of Death - State

(NAACCR Item #1942)

Description

State where the patient died and where certificate of death is filed.

Rationale

When a hospital reports a place of death, the information can help in death certificate matching.

Coding Instructions

1. See Appendix B of the SEER Program Code Manual 2021 for the alphabetic code list by Country/State or alphabetic list by Code.
2. Leave blank if patient alive.

Place of Death - Country

(NAACCR Item #1944)

Description

Code for the country in which the patient died and where certificate of death is filed.

Explanation

When a hospital 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.

Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes. Leave blank if patient alive.

Coding Instructions

See Appendix B of the SEER Program Code Manual 2021 for the alphabetic code list by Country/State or alphabetic list by Code. 2.

Leave blank if patient alive.

Table 7.25 Place of Death Sample Codes

Code	Description
USA	United States
ZZN	North America NOS
ZZC	Central America NOS
ZZX	Non-US NOS
ZZU	Unknown

Date Abstracted

(NAACCR Item #2090)

Description

Record the date the registrar determined the tumor report was complete (all first course therapy administered, or treatment plan coded and documented) and the case has passed edits.

Rationale

This field is used for TCR data quality and timeliness evaluation.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
2. Record the year, month, and day (YYYYMMDD) the form was completed.

Abstractor Initials

(NAACCR Item #570) (STORE 2018 page 401)

Description

Records the initials or assigned code of the individual abstracting the case.

Rationale

This data item is used for providing feedback for quality control.

Coding Instruction

Record the initials of the person abstracting the case.

8

DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

TEXT DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

(NAACCR Text Item #s 2220, 2520, 2530, 2540, 2550, 2560, 2570, 2590, 2580, 2600, 2610, 2620, 2640, 2650, 2660, 2670, 2680)

Text documentation to support cancer diagnosis, stage, and treatment codes **must be provided by all facilities**.

Text documentation is an important element of a complete abstract. It is critical for quality assurance and special studies.

Text is used to support coded values and to provide supplemental information not transmitted within coded values. Complete text documentation facilitates consolidation of information from multiple reporting sources.

The text field must contain a description that has been entered by the abstractor. Cancer Registry software generating text automatically from coded data cannot be utilized to support coded values. Information documenting the disease and treatment must be entered manually from the medical record. **TNM staging is not an acceptable substitute for stage documentation**.

Text documentation should explain where the cancer started, where it went (lymph nodes, other organs) and how it got there (direct extension, metastasis, implants). Clinical and pathological findings should be documented.

Document all types of the **first course** of definitive treatment administered, regardless of where the treatment was received, in chronological order. Documentation is necessary to verify all coded fields regarding types and timing of treatment.

Unknown is used when there is insufficient information to determine stage or extent of disease. If the primary site is unknown (C809) then the Summary Stage must be unknown. Document where the cancer was found if the primary site is unidentified.

NO treatment: Do not enter text in the treatment text fields when treatment is either not done or it's unknown if it was done. This information is conveyed by the treatment flags. Do not use words such as "none" or "unknown" or N/A. If a port is placed for chemotherapy, record this information but do not code that chemotherapy was given unless it is known that it was.

Always use text to document certain basic information:

1. The date of the examination or procedure (***Example:*** 6/15/2021); keep dates in chronological order.
2. The name of the examination or procedure (***Example:*** excisional biopsy).
3. The results of the examination or procedure-any pertinent positive or negative information (Examples: negative margins, chest X-ray negative, liver biopsy positive for metastasis).
4. The diagnostic impression, final diagnosis, or final conclusion if one is given (***Example:*** Ductal carcinoma of left breast).

5. The planned treatment, whether or not it is known if treatment was given (***Example:*** chemotherapy planned after left modified mastectomy).
6. The date and type of treatment given, even if it was done at another institution (***Example:*** 6/15/2021 5FU administered at ABC hospital).
7. Specific subsite of primary site (***Example:*** upper outer quadrant of left breast).
8. Specific number, chain of lymph nodes examined and results (***Example:*** 3/16+ left axillary lymph nodes).
9. Specific information about metastatic spread of disease to lymph nodes and/or other organs and tissues (***Example:*** metastasis to 15 supraclavicular lymph nodes; brain metastasis).
10. Documentation is used to verify all coded fields regarding the patient, disease, extent of disease and spread of disease. Text should be documented in the appropriate text fields.
11. Demographic information such as age at diagnosis, race and sex of the patient should also be recorded in text fields (***Example:*** 76-year-old Caucasian male).

Call your Health Service Region contact for technical assistance if additional direction is needed to determine the appropriate information to document. TCR staff may request copies of the necessary reports with your data submission in order to assist you.

Types of Reports to Review

- **Medical imaging** can provide key information for evaluating clinical extent of disease. For example, a CT of the lung can show the size and location of the tumor within the lung. It can demonstrate the presence of pleural effusion, or extension of the tumor to other tissues such as ribs, chest wall or pleura. Bone scans and MRI or CT of the brain are often used to evaluate for metastatic sites. History and Physical reports sometimes give the results from outside imaging studies. Documentation of all positive and negative findings from imaging exams should be recorded in the Summary Stage Documentation field.
- **Physical exam** or **History and Physical (H&P)** can provide the size for palpable masses and information regarding palpable lymph nodes. For example, during a digital rectal exam (DRE) the prostate is palpated. The physician will note findings such as nodularity, induration, fixation of seminal vesicles, enlargement, firmness, etc. All positive and negative findings pertinent to the patient's cancer are an important aspect of Staging and must be noted in the Summary Stage Documentation field to support coding. Patient demographics can also be found in the H&P. Record age, race and sex when available. This information is useful in record consolidation.
- **Pathology reports provide** key information including cell type, grade, size and location of tumor, number of lesions or foci, depth of invasion, spread of tumor to other organs, and lymph node involvement. Record each of these items in the Summary Stage Documentation. Be sure to record the furthest extension that the pathologist mentions, for example: confined to mucosa; into subserosa; through full thickness of abdomen wall, etc.
- **Operative reports** will often contain the surgeon's observations regarding involvement or lack of involvement of lymph nodes or other organs. The operative report will also contain detailed

information of the exact type of surgery performed, tissue or organ(s) excised, and tissue or organ(s) left intact. Record these findings in the Summary Stage Documentation.

- **Discharge summaries, clinical notes, or progress reports** are good sources for treatment information. Review all available reports and document all planned treatment, as well as the date and modalities of known treatment in the Treatment Documentation. Give specific information when available such as type and number of courses of chemotherapy. If no treatment is planned or the patient refuses recommended treatment, include this information in the text field.
- **Lab results** are used to code many of the Site-Specific Data Items (SSDI's). Source documents for many of the SSDI's can be found in Appendix A, General Coding Information.

Text Field Examples

Table 8.3 lists suggestions for the type of text to include for each text field.

- The pertinent information in the following examples is in **bold lettering** for easier identification of required text.
- Do not enter text in treatment fields, including "unknown" or "n/a", when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Table 8.3 Text Field Examples

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Other Pertinent Information #2680	• Age, sex and race of patient • Spanish/Hispanic Origin • Place of birth • Country of Birth • Insurance/primary payer information • Name of Follow Up Physician • Family and personal history of cancer • Comorbidities • Smoking history • Unknown demographic information (unknown SS#, unknown address at diagnosis) • Overflow or problematic coding issues	Date of Initial Diagnosis #390 Sex #220 Race 1-5 #160-164 Spanish/Hispanic Origin #190 Place of Birth #250 Country of Birth Primary Payer at Dx #630 Physician Follow Up #2470 Sequence Number #560
Summary Stage Documentation #2600	• Date(s) of procedure(s) including biopsies and clinical procedures that provide staging information such as x-rays • Organs involved by direct extension • Size of tumor • Status of margins • Number and sites of positive lymph nodes • Metastatic sites • Physician's specialty (Surgeon, Oncologist, etc.) • Physician's comments	Date of Initial Diagnosis #390 Diagnostic Confirmation #490 Primary site #400 Morphology/Behavior # 522, 523 Regional Nodes Positive #820 Regional Nodes Examined #830 Laterality #410

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Summary Stage Documentation –PE #2520	• Date of physical exam • History relating to cancer diagnosis • Primary site • Histology (if dx prior to this admission) • Tumor location • Tumor size • Impression pertaining to cancer diagnosis • Positive and negative clinical findings • Palpable lymph nodes • Treatment plan	Date of First Contact #580 Date of Diagnosis #390 Race 1-5 #160-164 Span/Hispanic Origin #190 Sex #220 Primary Site #400 Laterality #410 Histology ICD-O-3 #522 Sequence # Hospital #560 SEER Summary Stage 2018 #764
Summary Stage Documentation-Xray/Scan #2530	• Date and type of X-ray or Scan • Primary site • Histology (if given) • Tumor location • Tumor size • Lymph nodes • Record positive and negative findings • Distant disease or mets	Date of Diagnosis #390 Primary Site #400 Laterality #410 Histology ICD-O-3 #522 SEER Summary Stage 2018 #764
Summary Stage Documentation-Scopes #2540	• Dates of endoscopic exams • Primary site • Histology • Tumor location • Tumor size • Site and type of endoscopic biopsy • Positive and negative clinical findings	Date of Diagnosis #390 Diagnostic Confirmation #490 Primary Site #400 Laterality #410 Histology ICD-O-3 #522 SEER Summary Stage 2018 #764 RX Date-Surgery #1300

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Summary Stage Documentation-Lab Tests #2550	• Type of lab test/tissue specimen • Both positive and negative findings • Tumor markers, special studies etc. Including: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu, Human Chorionic Gonadotropin (hCG) • Date of lab tests	Primary Site #400 Grade Clin #3843 and Grade Path #3844 Diagnostic Confirmation #490 Date of Diagnosis #390 SSDIs #3803-3933
Summary Stage Documentation-Op #2560	• Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived • Number of lymph nodes removed • Size of tumor removed • Documentation of residual tumor • Evidence of invasion of surrounding areas	Date of Diagnosis #390 Diagnostic Confirmation #490 Primary Site #400 SSDIs #3803-3933 SEER Summary Stage 2018 #764

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Summary Stage Documentation Path #2570	• Dates of procedures • Anatomic source of specimen • Type of tissue specimen • Tumor type and grade (include all modifying adjectives: predominantly, with features of etc.) • Gross tumor size • Extent of tumor spread • Involvement of resection margin • Number of lymph nodes involved and examined • Both positive and negative findings • Record any additional comments from the pathologist, including differential diagnosis considered and any ruled out or favored	Date of Diagnosis #390 Primary Site #400 Laterality #410 Histologic Type ICD-O-3 #522 Grade Clin #3843 and Grade Path #3844 SSDIs #3803-3933 Diagnostic Confirmation #490 RX Summ-Surg Prim Site #670 RX Sum-Scope Reg LN Sur #1392 RX Summ-Surg Oth Reg/Dis # 1394 SEER Summary Stage 2018 #764 Regional Nodes Positive #820 Regional Nodes Examined #830 RX Date-Surgery #1300 Reason for No Surgery #1340 RX Summ-Surg/Rad Seq #1380 RX Summ-Systemic/Sur Seq #1639
Final Diagnosis (Primary, Laterality) #2580	• Location of primary site of tumor • Information on laterality of tumor	Primary site #400 Laterality #410
Final Diagnosis (Morphology, Behavior, Grade) #2590	• Histologic Type/Behavior • Grade of tumor	Morphology/Behavior #522, #523 Clin Grade #3843 and Path Grade #3844

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Rx Text Surgery #2610	• Date of each surgical 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.	DX confirmation #490 RX Date Surgery #1300 Surgery Rx Code #1390 RX Summ Scope of Reg LN Surgery #1392 RX Summ-Surg Other/Dist RX Code #1394 Reason for No Surgery #1340 RX-Summ-Radiation # 1360
Rx Text-Radiation #2620	• Date radiation treatment began and ended • Where treatment was given, e.g., at this facility, at another facility • Type(s) of radiation • Planned doses • Other treatment information (discontinued after 2 treatments.)	Date Radiation Started #1310 Phase I Radiation Treatment Modality Code #1506 RX Summ-Surg/Rad Sequence #1380
Rx Text-Chemo #2640	• Date when chemotherapy began and ended • Where chemotherapy was given, e.g., at this facility, at another facility • Type of chemotherapy (name of agent(s) and doses planned/received • Other treatment information (treatment cycle incomplete.)	Chemotherapy Code #1390 RX Date-Systemic #3230 Systemic/Surgery Sequence #1639 RX Date Chemo #1220

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Rx Text-Hormone #2650	• Date treatment was started • Where treatment was given, e.g., at this facility, at another facility • Type of hormone or antihormone • Type of endocrine surgery or radiation • Other treatment Information, e.g. Treatment cycle incomplete.	Hormone Code #1400 RX Date-Systemic #3230 Systemic/Surgery Sequence #1639
Rx Text-BRM Immunotherapy #2660	• Date treatment began • Where treatment was given e.g. at this facility, at another facility • BRM procedures, e.g. bone marrow transplant, stem cell transplant • Type of immunotherapy given • Type of BRM agent, e.g. Interferon, BCG • Other treatment information e.g. treatment cycle incomplete.	Immunotherapy Code #1340
Rx Text-Other #2670	• Date treatment was started • Where treatment was given, e.g., at this facility, at another facility • Type of other treatment • Other treatment information (incomplete)	Date of Initial Treatment #1360 RX Summ-Other #1420 RX Date-Other #1350

Examples

Case #1 Lung

- Imaging Reports
    - 2/18/21 VA Clinic: CT Chest: Findings: Supraclavicular, axillary, and mediastinal structures unremarkable. No mediastinal or hilar adenopathy. There is a 2.8 x 2.4 x 4.8cm mass in the right lower lobe. The margins are well defined with minimal peripheral ground-glass opacity, probably some degree of obstructive pneumonitis. The remainder of the lungs is clear.
    - Impression: Lobulated soft tissue mass in the right lower lobe consistent with neoplasm. No evidence of adenopathy, mediastinal or hilar spread.
    - 2/28/21 CT Brain Your Hospital: Impression: No evident disease process.
- Pathology Reports
    - 2/28/21 Your Hospital: Final Diagnosis: Fine Needle Aspirate, right lower lobe lung: positive for malignant cells
    - 3/1/21 Your Hospital: Final Diagnosis: Superior segment right lower lobe, resection: moderately differentiated squamous cell carcinoma, maximum tumor diameter 5.0cm, 2nd nodule in right lower lobe measures 0.5cm, resection margin free of tumor, peribronchial lymph node negative for tumor, right lower paratracheal lymph node negative for tumor, right pretracheal lymph node negative for tumor.
- Clinic Reports
    - 3/15/21: Oncologist recommended 4 cycles of adjuvant Taxol and carboplatin. The patient would rather receive treatment closer to home and has been referred to an oncologist in that area.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

2/18/21 (VA Clinic) CT Chest: 4.8cm mass in RLL c/w neoplasm, supraclavicular, axillary, and mediastinal structures unremarkable, no mediastinal or hilar lymphadenopathy, probably some obstructive pneumonitis, remainder of lungs clear

2/28/21 Fine Needle Aspirate RLL lung: positive for malignant cells

2/28/21 Ct Brain: No evident dz process

3/1/21 RLL Resection: MD Squamous cell car, 2 nodules 5cm and 0.5cm, margin free, 0/3 peribronchial, paratracheal and pretracheal lns

Treatment Documentation (2610, 2620, 2640, 2650, 2660, 2670)

3/1/21 RLL lobectomy with mediastinal ln dissection

3/15/21 Oncologist recommends 4 cycles adjuvant Taxol and carboplatin. PT wants treatment closer to home, referred to oncologist in his area, unknown if chemo done.

Case #2 Lung

- Imaging Reports
    - 6/25/21 River Ranch Radiology CT Chest: I see no pneumothorax or pleural effusion. There is an 11.7 x 8.5cm soft tissue mass in the right apex. There is associated marked mediastinal lymphadenopathy with enlarged nodes in the anterior mediastinum, enlarged nodes lying lateral to the main pulmonary artery, and enlarged nodes in the pretracheal and precarinal region. There are enlarged nodes around the right hilum. The left lung appears normal.
    - Conclusion: Right upper lobe mass with associated marked mediastinal lymphadenopathy. The findings are highly suspicious for a primary carcinoma of the lung.
    - 7/1/21 Oncology Associates Bone scan: Non-specific increased uptake at L3 and L5, no obvious metastasis.
    - 7/1/21 Oncology Associates MRI brain: Diffuse cerebral atrophy
- Bronchoscopy Report
    - 6/26/21 Bronchoscopy: The vocal cords were visualized and appeared to move normally. The bronchoscope was passed to the trachea, which was widely patent. No endobronchial lesions were noted. There was a small amount of bleeding from the right upper orifice. No lesions were noted at the right lower lobe or right middle lobe. Endobronchial biopsy was performed times six at the right upper lobe. Bleeding was minimal.
- Pathology Report
    - 6/26/21 Right upper lobe mass biopsy Final Diagnosis: non-small cell carcinoma
- Clinical Reports
    - 7/5/21 Oncology Clinic Consultation: This patient has at least Stage 3b disease. This condition can best be treated with a combination of chemotherapy and radiation therapy concurrently. We want to start treatment as soon as possible.
    - 7/15/21 Discharge Summary: The patient has been treated with VP-16 times three days along with daily radiation therapy for a diagnosis of non-small cell carcinoma. He was hospitalized because of shortness of breath and iron deficiency anemia. At this time his condition has stabilized.

Summary Stage Documentation ((2520, 2530, 2540, 2550, 2560, 2570, 2600)

6/25/21 (RRR) CT chest: no pneumothorax or pleural effusion, 11.7cm mass in rt apex, highly suspicious for lung carcinoma, marked mediastinal lymphadenopathy, enlarged nodes in anterior mediastinum, enlarged nodes lateral to main pulmonary artery, in pretracheal and precarinal region and in rt hilum, lft lung appears normal

6/26/21 Bronchoscopy: vocal cords appear to move normally, no endobronchial, rll or rml lesions

6/26/21 RUL mass bx: Non-small cell carcinoma

7/1/21 Bone Scan: no mets

7/1/21 MRI brain: diffuse cerebral atrophy

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

7/5/21 concurrent chemo/radiation therapy recommended

7/15/21 Discharge Summary: PT has been treated with VP-16 x 3 days along with daily radiation therapy

Case #3 Breast

- Imaging Reports
    - 1/2/21 Mammogram: Left breast: No dominant masses, or suspicious calcifications, or architectural disturbances are present. In the right breast there is a 3.5 x 4.6cm irregular spiculated mass in the lower-outer quadrant.
    - Impression: Large mass in the lower-outer quadrant of the right breast, biopsy is recommended.
    - 1/13/21 CT Chest: COPD with mild parenchymal scarring. No evidence of cardiomegaly. There is bone destruction of posterior ribs/spine. CT Abdomen and Pelvis no abnormal findings.
    - Impression: Bone destruction of posterior ribs/spine, probably mets from known breast cancer.
- Pathology Reports
    - 1/10/21 Core biopsy right breast lower outer quadrant: Final Diagnosis: Infiltrating ductal carcinoma, poorly differentiated, ER and PR positive, HER2 ICH 0, negative.
- Clinical Reports
    - 1/15/21 Surgery consult: Patient noted a mass in the lower-outer quadrant of her right breast. There is marked lymphadenopathy in the right axilla. The left breast is within normal limits.

- HEENT: Clear conjunctivae, pupils equal, round and reactive to light. Nasal passages clear without drainage.
- Neck: Supple, full range of motion. No thyromegaly, trachea is midline.
- Lungs: No wheezing or crackles. There are no bronchial breath sounds or pleural rub.
- Abdomen: Soft, non-tender, non-distended without hepatosplenomegaly or masses. Normal bowel sounds.
- Patient will be referred to Radiation Oncology for consideration of radiation therapy to known bony mets.
- 2/1/21 Oncology note: Patient has decided to try alternative therapy and has declined radiation therapy and chemotherapy.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

1/2/21 Mammogram: Lt breast no masses, Rt breast 4.6cm mass in LOQ, biopsy recommended.

1/10/21 Bx rt breast LOQ Infil ductal car, PD, ER and PR positive, HER2 IHC 0-Negative

1/13/21 CT Chest: Bone destruction posterior ribs/spine, probably mets from breast ca, CT Abdomen/Pelvis: no abnormal findings

1/15/21 Surg consult: marked lymphadenopathy in rt axilla

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

1/15/21 Surg Consult: Patient referred to radiation oncology for consideration of radiation therapy to bony mets.

2/1/21 Oncology note: Pt has decided to try alternative therapy, declined radiation therapy and chemotherapy.

Case #4 Breast

- Imaging Reports
  - 6/1/21 Mammogram: In the right breast there is a 1.2 x 1.5cm mass in the upper-outer quadrant. There is no evidence of axillary lymphadenopathy. The left breast appears normal.
  - 6/14/21 Chest Xray: Within normal limits
  - 6/14/21 Bone Scan: Impression: No evidence of skeletal disease. Thoracic and lumbar spine negative for metastases.
- Pathology Reports
  - 6/8/21 Right breast fine needle aspiration cytology: Adenocarcinoma

- 6/15/21 Right breast modified radical mastectomy: Final Diagnosis: Infiltrating ductal carcinoma, tubular type, 1.4cm, margins clear, Bloom Richardson score 3, no dermal or lymphatic invasion, no evidence of tumor in 32 regional lymph nodes, Estrogen and Progesterone Receptors negative, HER2 IHC 3+, positive.

- Clinical Reports
  - 6/1/21 History and Physical: Family physician noted 2cm mass in right breast on physical exam. No pain or tenderness; no nipple discharge; no skin changes. Slight nipple retraction. Freely movable mass. Left breast: no masses palpated. No enlarged lymph nodes.
  - 10/13/21 Oncology Clinic Follow-up ***Note:*** Patient started 3 cycles of adjuvant Adriamycin and Cytoxan on 7/20/21, recently completed and now has begun Tamoxifen.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

6/1/21 Mammogram: 1.5cm mass rt breast UOQ, no lymphadenopathy, lt breast appears normal

6/1/21 H&P 2cm mass in right breast, no masses palpated in lt breast, no enlarged lymph nodes

6/14/21 CXR: WNL; Bone Scan: no evident mets

6/8/21 Rt Breast fine needle aspiration = adenoca

6/15/21 Rt breast mastectomy: infiltrating duct carcinoma, tubular type, 1.4cm, margin clear, Bloom Richardson score 3, 0/32 LNS positive, ER/PR negative, HER2 IHC 3+ positive.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

6/15/21 Rt breast modified radical mastectomy

10/13/21 Oncology note: pt had 3 cycles Adriamycin and Cytoxan begun on 7/20/17, recently completed and has begun Tamoxifen.

Case #5 Colon/Rectum

- Imaging Reports
  - 4/20/21 CT Abdomen and Pelvis
    - Two areas of circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the right lower quadrant/right pelvic region with multiple low-density lesions being noted in the liver. Although these could represent incidental benign hepatic cysts, metastatic liver disease cannot be excluded at this time as colonic carcinoma is one of the causes of cystic liver metastasis. It should be noted although there are shotty lymph nodes present, there is no definite lymphadenopathy demonstrated.

        - History of uterine cancer in 2003 with evidence of prior hysterectomy. This is not usually a cause of cystic liver metastasis.
        - Otherwise, unremarkable CT scan of the abdomen and pelvis with other incidental findings as noted above.
    - 4/25/21 Whole Body PET Scan
        - Conclusion: Radionuclide uptake in the left abdomen, representing a nonspecific finding.
        - No focal areas of increased uptake are seen in the liver to suggest hepatic metastasis.
- Pathology Reports
    - 4/15/2021 Final Diagnosis: Colon biopsy at 135cm moderately differentiated adenocarcinoma, mucin producing signet ring cell, high grade.
    - 5/1/2021 Final Diagnosis right hemicolectomy
        - High-grade mucin-producing signet ring cell carcinoma, 4 cm in size and located in colon near ileocolic junction, tumor invades pericolonic adipose tissue, (PT3)
        - No evidence of lymph node metastasis among seven lymph nodes. (PNO)
        - Excision margin is negative.
        - KRAS mutated
        - Normal heterozygous state (Normal LOH)
- Operative Report
    - Date of Procedure: 5/1/21
    - Preoperative Diagnosis: Right colon cancer
    - Postoperative Diagnosis: Right colon cancer, with adhesive bowel disease.
    - Procedures Performed: Exploratory laparotomy, lysis of adhesions, right hemicolectomy.
    - Findings: On exploration of the abdomen, the liver was palpated found to be unremarkable. There were no lesions in the colon other than in the right colon. In the small bowel, there were adhesions, especially in the terminal ileum, adherent to the cecum.
- Oncology Consult: 5/15/21
    - History Of Present Illness: Patient is a 56-year-old female who had a diagnosis of endometrial cancer, status post-surgery followed by radiation therapy fifteen years ago. A few weeks ago, the patient had a routine colonoscopic examination and the patient was found to have lesions in the right side of the colon. The patient underwent surgery on May 1, 2021.

- Assessment: The patient has a new diagnosis of high-grade mucin producing signet ring cell adenocarcinoma of colon. This is about 4 cm in size with pericolonic tissue invasion. Based on these reports and findings, the patient may benefit from adjuvant chemotherapy.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

4/15/21 Colon biopsy at 135cm: Moderately differentiated adenoca, mucin producing signet ring cell, high grade.

4/20/21 Ct Abdomen and Pelvis: 2 areas circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the rt lower quadrant/rt pelvic region. Multiple liver lesions could represent benign hepatic cysts, mets liver dz cannot be excluded; snotty lymph nodes present, no definitive lymphadenopathy, otherwise unremarkable CT abdomen and pelvis; pt has a history of uterine cancer in 2003 with evidence of hysterectomy

4/25/21 Whole body PET scan: no focal areas of increased uptake in liver to suggest hepatic mets

5/1/21 Operative report: Liver palpated, found to be unremarkable, no lesion in colon other than rt colon

5/1/21 Right hemicolectomy: High-grade mucin producing signet ring cell carcinoma, 4cm, located near ileocolic junction, invades pericolonic adipose tissue, 0/7LNS positive, excision margin is negative; MSI-stable, KRAS mutated, normal LOH

5/15/21 Oncology consult: The patient may benefit from adjuvant chemotherapy; unknown if chemotherapy given.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/1/21 Right Hemicolectomy

Case #6 Melanoma

- Imaging Reports
  - 5/10/21 CT Chest: Impression: Probably malignant involvement of left axillary lymph nodes. Several lymph nodes seen in supraclavicular region too small to characterize. The remainder of the exam is normal.
- Pathology Reports
  - 5/3/21 Final Diagnosis: Shave biopsy skin of left forearm, Malignant melanoma
  - 5/11/21 Final Diagnosis: Wide excision of skin of left forearm, Malignant melanoma, nodular type, Clark's Level III, Breslow's depth 1.0mm, papillary dermis invaded, no ulceration present no mitosis present. Margins of resection free, but within less than 2mm. LDH Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay

- Oncology Report
    - 6/15/21 The patient was started on an interferon regimen today.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

5/3/21 Shave bx skin of lt forearm: Malignant melanoma

5/10/21 CT chest: Probably malignant involvement of lt axillary lymph nodes, remainder of exam normal

5/11/21 Wide exc skin of lt forearm: Malignant melanoma, nodular type, Clark's Level 3, Breslow's depth 1.0mm, papillary dermis invaded, no ulceration, no mitosis, margin free but within less than 2mm, LDH Range 1: Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/11/21 Wide excision of skin of lt forearm

6/15/21 started interferon regimen

Case #7 Melanoma

- Imaging Reports
    - 11/18/21 Chest Xray: Within normal limits
    - 11/24/21 CT Chest, Abdomen and Pelvis: Impression: Nonspecific soft tissue nodule in the right upper lobe. This is nonspecific but would be consistent with benign parenchymal scar or granuloma. The remainder of the lungs is clear.
    - There is no evidence of metastatic disease in the chest, abdomen or pelvis.
- Pathology Reports
    - Outside Facility:
        - 11/13/21 Final Diagnosis: Excision of lesion on right side of neck, 1.5 x .0.8 x 0.5 cm specimen contains a pigmented, 0.4 x 0.3cm area consistent with malignant melanoma in situ, extending to margins of excision.
    - Your Facility:
        - 11/25/21 Final Diagnosis: Wide re-excision skin of right neck, Inflammation and organizing granulation tissue, negative for any residual melanoma, margins of resection negative.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

11/18/21 CXR: Within normal limits

11/24/21 CT Chest/abdomen/pelvis: No evidence of mets in chest, abdomen or pelvis

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

11/13/21 Exc of lesion rt side of neck: 0.4x0.3cm malignant melanoma in situ, Ext to margin

11/25/21 Wide re-excision of skin rt neck, negative for residual melanoma, margins negative

Case #8 Lymphoma

- Imaging Reports
    - 2/2/21 CT Chest Impression: Extensive right and left hilar lymphadenopathy, enlarged lymph nodes in the mediastinum.
    - 2/2/21 CT Abdomen Impression: Splenomegaly, otherwise within normal limits.
    - 2/4/21 PET scan: Intense focus of tracer uptake seen in peri-portal region consistent with lymphoma.
- Pathology Reports
    - 2/3/21 Biopsy of left axillary lymph nodes, Follicular Lymphoma, Gr 1
    - H&P
    - 2/2/21 Patient presents with bilateral cervical and axillary lymphadenopathy, night sweats, and fevers for last couple of months.
- Oncology Consult
    - 2/13/21 The patient was started on combination chemotherapy including Rituxan on February 5 and has done well with the exception of nausea. We will start him on a trial of antiemetics.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

2/2/21 H&P Pt has bilateral cervical and axillary lymphadenopathy, hx of night sweats, fevers

2/2/21 CT Chest: rt and lt hilar lymphadenopathy, enlarged lymph nodes in the mediastinum

2/2/21 CT Abdomen: Splenomegaly, otherwise within normal limits

2/3/21 Biopsy lt axillary lns: Follicular Lymphoma, Gr 1

2/4/21 PET scan: focus of tracer uptake in peri-portal region consistent with lymphoma

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

2/5/21 Combination chemotherapy including Rituxan, other types of chemo not mentioned

Case #9 Prostate

- Imaging Reports
  - 4/14/21 CT Abdomen/Pelvis Impression:
  - Tiny cyst in the liver.
  - No lymphadenopathy in abdomen or pelvis
  - 4/14/21 Bone scan Impression: Evidence of previous fracture in right 13th rib, otherwise negative bone scan
- Pathology Reports
  - 4/1/21 Final Diagnosis: Prostate core needle biopsy, adenocarcinoma present in 8 of 13 cores, Gleason Score 3+3=6
- Clinical Reports
  - 3/27/21 Surgical consult: Patient is seen in consultation because PSA elevated at 6. DRE shows slightly enlarged prostate with no nodularity or induration. The abdomen and pelvis are examined and show no palpable abnormalities.
  - 7/1/21 Patient was counseled regarding various treatment options including radiation therapy, surgery and hormonal treatment. He decided to proceed with external beam radiation therapy, and this was completed on 6/15/18.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

3/27/21 PE: DRE shows slightly enlarged prostate with no nodularity or induration, abdomen and pelvis with no palpable abnormalities, PSA 6

4/1/21 Prostate core needle biopsy: adenocarcinoma in 8/13 cores, Gleason Score 3+3=6

4/14/21 CT Abdomen/Pelvis: no lymphadenopathy in abdomen or pelvis

4/14/21 Bone scan: negative

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

External beam radiation therapy completed on 6/15/21, start date not given; estimate start date 5/2021

A

APPENDIX A: CODING GUIDELINES AND RECORDING INSTRUCTIONS

Appendix A consists of Coding Guidelines and Instructions for recording information such as Site-Specific coding, lab tests, tumor markers, and other reports for Site Specific Data Items (SSDI's) The information comes from SEER, STORE 2021, NAACCR Required Status Table in the Data dictionary and other sources.

- The site-specific surgery codes are from The American College of Surgeons Commission on Cancer Standards for Oncology Registry Entry (STORE 2021).
- The Site-Specific Surgery Codes can be found in Appendix C of the SEER Manual

This appendix combines the coding guidelines and instructions for recording information per site-specific sites such as the breast, bladder, colon and rectosigmoid, esophagus, lung and Malignant and benign brain and CNS tumors. It includes links to instruction manuals (SEER Program Coding and Staging Manual and 2018 Solid Tumor Rules), SSDI manual, grade manual, and surgery codes. You will also have access to links for SSDI schema per site. This appendix should not replace the 2021 manuals and resources for cases diagnosed in 2021 and forward.

SEER Program Coding and Staging Manual Includes data item descriptions, codes, and coding instructions for cases diagnosed 01/01/2018 and forward. Provides detailed instructions and examples to promote consistent abstracting and coding.

2018 Solid Tumor Rules

2007 MPH Rules, the 2018 Solid Tumor Rules, and the 2021 Cutaneous Melanoma Rules are used based on date of diagnosis.

- Tumors diagnosed 01/01/2007 through 12/31/2017: Use 2007 MPH Rules
- Tumors diagnosed 01/01/2018 and later: Use 2018 Solid Tumor Rules (with exceptions)
- ***Exception:*** Cutaneous Melanoma diagnosed 1/1/2021 and forward: Use 2021 Cutaneous Melanoma Rules
- The original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2018 or later in the same primary site: Use the 2018 Solid Tumor Rules
- A melanoma diagnosed before 1/1/2021 and a subsequent melanoma diagnosed 1/1/2021 or later: Use the 2021 Cutaneous Melanoma Rules

  Notes:

  - The 2007 Multiple Primary & Histology rules and the 2007 General Instructions are to be used for cases diagnosed 01/01/2007 to 12/31/2017 for Cutaneous Melanoma, Other Sites.
  - Rectosigmoid and Rectum are included in the 2018 Colon rules.
  - Peripheral nerves are included in the 2018 Colon rules.

Refer to the 2018 Solid Tumor Rules for determining the site, number of primaries, and histology.

2021 ICD-O Histology and Behavior Code Update Tables and the ICD-O-3.2 are used to determine the histology if the information cannot be found in the Solid Tumor Rules.

When a histology code cannot be identified using the above recommendations, submit a question to Ask

a SEER Registrar.

Grade Manual is the primary resource for documentation and coding instructions for Grade for cases diagnosed on or after 01/01/2018.

2018 Summary Staging Manual provides instructions for categorizing how far a cancer has spread from its point of origin using a combination of precise clinical and pathological documentation of the extent of the disease. This staging system applies to all primary sites and histologies.

AJCC 8th Edition Cancer Staging Manual provides instructions on the TNM staging rules for applicable sites. Refer to the Quick 1-page resource on the general rules and rationale.

Site-Specific Data Item (SSDI) Manual is the primary resource for documentation and coding instructions for site-specific data items introduced in 2018. An important new concept introduced in 2018 is the use of a Schema ID to define the applicable SSDIs and grade table for a particular tumor, based on primary site, histology, and in some cases, additional information. The appropriate Schema ID will be defined by registry software and will not have to be assigned by the registrar. However, a Schema ID Table defining the Schema ID number, description and associated SSDIs is provided in the SSDI Manual (page 31) for reference purposes.

In addition to Schema IDs, the Schema ID Table provides the AJCC 8th Edition Chapter for which the SSDIs and grade table defined by the Schema ID apply (page 28).

SSDI/Grade Schema List by site can be found on the NAACCR website.

SITE-SPECIFIC CODING GUIDELINES

Breast

seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Breast_2021.pdf

Site codes

The Site Code Table contains terms used in mammograms, clinical diagnosis, and less frequently the operative and pathology reports to describe the location of the tumor. Find the term in Column 1 and use the site code in Column 2.

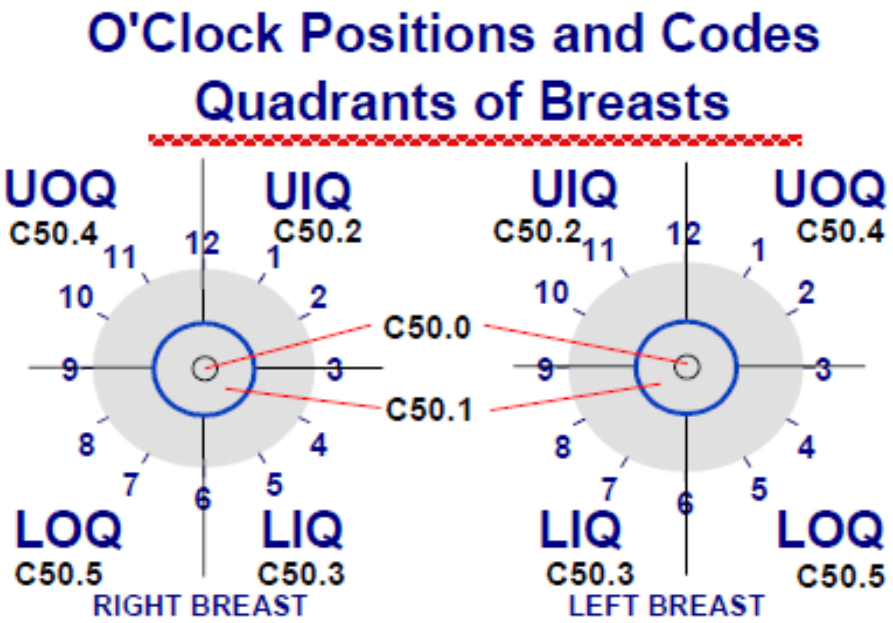
Refer to the SEER Program Coding and Staging Manual and COC STORE Manual for a priority list for using documents such as mammograms, operative reports, and pathology reports to determine the tumor location.

Terms and Descriptive Language	Site Term and Code
Areolar Nipple Paget disease without underlying tumor Note: Paget with underlying tumor is coded to the quadrant of breast in which the underlying tumor is located	Nipple **C500**

Terms and Descriptive Language	Site Term and Code
Above nipple Area extending 1 cm around areolar complex Behind the nipple Below the nipple Beneath the nipple Central portion of breast Cephalad to nipple Infra-areolar Lower central Next to areola NOS Next to nipple Retroareolar Subareolar Under the nipple Underneath the nipple	Central portion of breast **C501**
Superior inner Superior medial Upper inner quadrant (UIQ) Upper media	Upper inner quadrant of breast **C502**
Inferior inner Inferior medial Lower inner quadrant (LIQ) Lower medial	Lower inner quadrant of breast **C503**
Superior lateral Superior outer Upper lateral Upper outer quadrant (UOQ)	Upper outer quadrant of breast **C504**
Inferior lateral Inferior outer Lower lateral Lower outer quadrant (LOQ)	Lower outer quadrant of breast **C505**
Axillary tail of breast Tail of breast NOS Tail of Spence	Axillary tail of breast **C506**

Terms and Descriptive Language	Site Term and Code
12:00 o'clock 3:00 o'clock 6:00 o'clock 9:00 o'clock Inferior breast NOS Inner breast NOS Lateral breast NOS Lower breast NOS Medial breast NOS Midline breast NOS Outer breast NOS Overlapping lesion of breast Superior breast NOS Upper breast NOS	Overlapping lesion of breast **C508** ***Note:*** This is a single tumor which overlaps quadrants/subsite.
¾ or more of breast involved with tumor Diffuse (tumor size 998) Entire breast Inflammatory without palpable mass Multiple tumors in different subsites (quadrants) within the same breast	Breast NOS **C509** ***Note:*** Used for: • Non-contiguous multiple tumors in different quadrants/subsites of same breast OR • Unknown/unable to identify in which quadrant/subsite the tumor is located ***Example:*** Outpatient biopsy with no quadrant identified. Patient lost to follow-up. • Inflammatory carcinoma; diffuse tumor

Additional Subsite Descriptors
The position of the tumor in the breast may be described as the positions on a clock



Code the primary site to C508 when:

- There is a single tumor in two or more subsites and the subsite in which the tumor originated is unknown OR
- There is a single tumor located in the 1,3,6, or 9 o'clock position on the breast.

Code the primary site to C509 when

- There are two non-contiguous tumors in different quadrants/subsites of the same breast OR
- Unknown/unable to identify in which quadrant/subsite the tumor is located OR
- Inflammatory carcinoma; diffuse tumor

Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with; (duct and lobular is equivalent to duct with lobular)

  Note: "And" and "with" are used as synonyms when describing multiple histologies within a single tumor.
- Behavior code /2; DCIS; intraductal; noninfiltrating; noninvasive; carcinoma in situ
- Carcinoma; adenocarcinoma
- De novo; new tumor; frank (obsolete term)

- Duct; ductal; NST (no special type); carcinoma NST; mammary carcinoma
- Mammary; breast
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Topography; site code
- Tumor; mass; tumor mass; lesion; neoplasm
    - The terms tumor, mass, tumor mass, lesion, and neoplasm are not used in a standard manner in clinical diagnoses, scans, or consults. Disregard the terms unless there is a physician's statement that the term is malignant/cancer.
    - These terms are used ONLY to determine multiple primaries.
    - Do not use these terms for casefinding or determining reportability.
- Type; subtype; variant

Ambiguous Terminology

Code the histology when described by ambiguous terminology only when:

- There is a NOS histology and a more specific (subtype/variant) described by ambiguous terminology and the more specific histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)

  Example: The pathology diagnosis is carcinoma NST consistent with pleomorphic carcinoma. The oncology consult says the patient has pleomorphic carcinoma of the right breast. This is clinical confirmation of the diagnosis, code pleomorphic carcinoma. The case meets the criteria in bullet 1.

- There is a NOS histology and a more specific (subtype/variant) described by ambiguous terminology and the Patient is receiving treatment based on the specific histology described by an ambiguous term.

  Example: The pathology diagnosis is sarcoma consistent with liposarcoma. The treatment plan says the patient will receive the following treatment for liposarcoma of the breast. Treatment plan confirms liposarcoma; code liposarcoma. The case meets the criteria in bullet 2.

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

  Example: Outpatient biopsy says probably apocrine carcinoma. The case is accessioned (entered into the database) as required by both SEER and COC. No further information is available. Code the histology apocrine carcinoma. The case meets the criteria in bullet 3.

List of Ambiguous Terminology

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

Note: If the histology described by ambiguous terminology does not meet any of the criteria in bullets 1, 2, or 3, do not code the histology.

Priority Order for Using Documentation to Identify Histology

Use documentation in the following priority order to identify the **histology type(s):**

1. Tissue or pathology report from primary site (in priority order)
    a. Addendum(s) and/or comment(s)
    b. Final diagnosis / synoptic report as required by CAP
    c. CAP protocol

    Notes:

    - Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
    - The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority. The final diagnosis is often the synoptic CAP report.
    - The CAP protocol is a checklist which:
        - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care.

- Allows physicians to check multiple histologies

2. Cytology (nipple discharge or fine needle aspirate (FNA) of primary site)
3. Tissue/pathology from a metastatic site
    a. Code the behavior /3.
    b. The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan.
4. Radiography: The following list is not in priority order because they are not a reliable method for identifying specific histology(ies). They are, however, valuable in diagnosing a malignancy.
    a. Mammography
    b. Ultrasound
    c. CT
    d. MRI
5. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
    a. Treatment Plan
    b. Documentation from Tumor Board
    c. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
    d. Physician's reference to type of cancer (histology) in the medical record

    Notes:

    - Code the specific histology when documented.
    - Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

When a histology term is not found in Table 3 (2018 STR Breast), refer to ICD-0 and any errata or updates. If not found, then consult Ask a SEER Registrar: seer.cancer.gov/registrars/contact.html

The following data items are used to collect ER and PR information:

- Estrogen Receptor Summary [NAACCR Data Item #3827]
- Progesterone Receptor Summary [NAACCR Data Item #3915]

Do not use results from the following tests to record ER or PR results

- Oncotype Dx
- MammaPrint
- EndoPredict
- PAM 50 (Prosigna)

- Any other test that records HER2

See page 200 of SSDI Manual: apps.naaccr.org/ssdi/list/2.0.

Site-Specific Data Items (SSDI)/Clinical Grade and Pathological Grade

apps.naaccr.org/ssdi/schema/breast/2.0?breadcrumbs=(~schema_list~)

Primary Site	Histology
C500-C506, C508-C509	8000-8700, 8982-8983, 9700-9701
C501-C506, C508-C509	8720-8790

Name	Default Value	Used for Staging	NAACCR Item	Required By
ER Summary	9	Yes	NAACCR #3827	All
PR Summary	9	Yes	NAACCR #3915	All
HER2 Overall Summary	9	Yes	NAACCR #3855	All
Grade Clinical	9	Yes	NAACCR #3843	All
Grade Pathological	9	Yes	NAACCR #3844	All

Grade ID 12-Clinical Grade and Pathological Grade Instructions (see pages 71 and 73)

Grade Coding Instructions and Tables

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00480	Breast	48.1	Breast: DCIS and Paget
00480	Breast	48.2	Breast: Invasive Breast Cancers

Surgery Codes

C50.0–C50.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9993)

For the surgery codes for the breast visit seer.cancer.gov/manuals/2021/appendixc.html

Additional Resources

- 2018 Solid Tumor Rules for breast: seer.cancer.gov/tools/solidtumor/
- SSDI Manual for coding breast: apps.naaccr.org/ssdi/list/2.0

Bladder

seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Bladder_2021.pdf

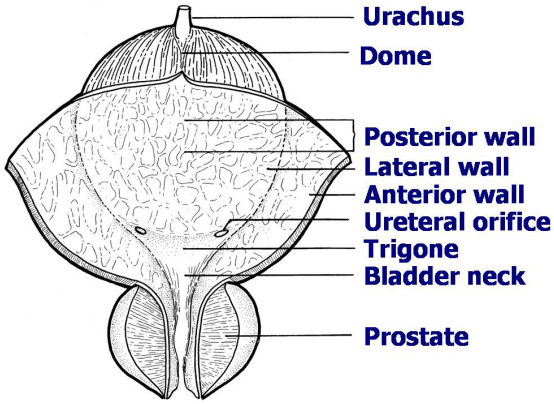
Site codes

Use the following table to determine the correct site code.

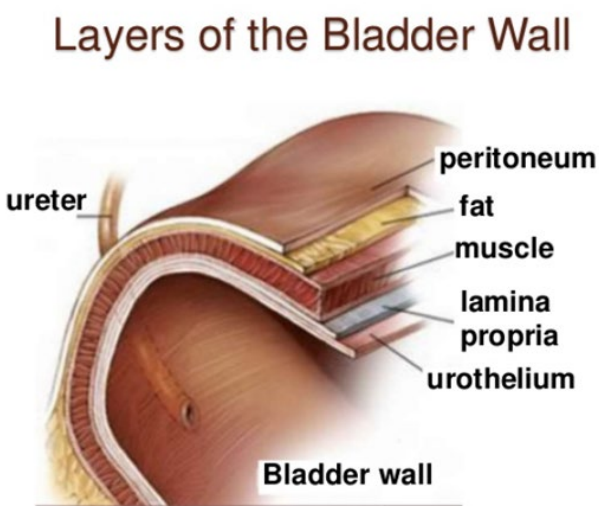
Column 1 contains the site term and ICD-O code.

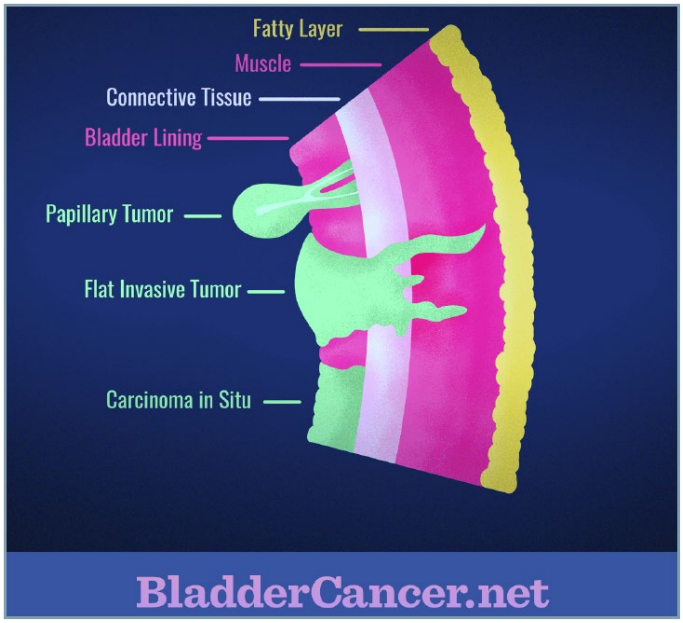
Column 2 contains synonyms for the site code and term in column 1.

Site Term and code	Synonyms
Bladder, anterior wall **C673**	-
Bladder, dome **C671**	Roof Vault Vertex
Bladder, lateral wall **C672**	Lateral to ureteral orifice Left wall Right wall Sidewall
Bladder neck **C675**	nternal urethral orifice Vesical nec
Bladder NOS **C679**	Lateral posterior wall **(no hyphen)**
Bladder, posterior wall **C674**	-
Bladder, trigone **C670**	Base of bladder Below interureteric crest Below interureteric field Below interureteric ridge Floor of bladder
Bladder, urachus **C677**	Mid umbilical ligament Urachal remnant
Overlapping lesion of urinary organs **C688**	-
Paraurethral gland **C681**	-
Renal pelvis **C659**	Pelvis of kidney Pelviureteric junction Renal calyces Renal calyx
Ureter **C669**	-
Urethra **C680**	Cowper gland Prostatic utricle Urethral gland
Urinary system NOS **C689**	-



Source: TNM Atlas, 3rd edition, 2nd revision





Priority for Coding Primary Site

The following list is in priority order:

1. Code overlapping lesion of urinary bladder **C678** when:
    a. A single tumor of any histology overlaps subsites of the bladder
    b. A single tumor or discontinuous tumors which are:
        i. **Urothelial carcinoma in situ 8120/2 AND**
        ii. Involves only bladder and one or both ureters (no other urinary sites involved)

Note: Overlapping non-invasive tumors of the bladder and ureter almost always originate in the bladder. They extend/overlap into the ureter by spreading along the mucosa. It is important to code these primaries to bladder C678, NOT to overlapping lesion of urinary organs C688.

2. Code bladder NOS **C679** when there are **multiple non-contiguous tumors** within the **bladder AND** the subsite/origin is unknown/not documented.
3. Code overlapping lesion of urinary organs **C688** when a single tumor overlaps two urinary sites, and the origin is unknown/not documented.

   Note: See the following examples of contiguous urinary sites where overlapping tumor could occur:

   c. Renal pelvis and ureter
   d. Bladder and urethra
   e. Bladder and ureter (for all histologies other than in situ urothelial cell)
4. Code Urinary System NOS C689 when there are multiple non-contiguous tumors in multiple organs within the urinary system.

   Note: The physician subject matter experts (SME) discussed the issue of coding primary site for multifocal/multicentric urinary tract carcinoma. Although the SMEs understood and acknowledged the importance of coding a specific primary site, there is no literature or criteria for determining the organ of origin for multiple tumors involving multiple urinary sites.

Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with

  Note: "And" and "with" are used as synonyms when **describing multiple histologies** within a **single tumor**. Urothelial carcinoma **and** small cell neuroendocrine carcinoma is **equivalent** to urothelial carcinoma **with** small cell neuroendocrine carcinoma.
- Carcinoma; adenocarcinoma
- Flat transitional cell carcinoma; flat urothelial carcinoma; urothelial carcinoma in situ; noninvasive flat carcinoma; in situ transitional cell carcinoma
- Multifocal; multicentric
- Noninvasive may describe either in situ papillary carcinoma or flat urothelial cell carcinoma
- Papillary transitional cell carcinoma; papillary urothelial carcinoma
- Simultaneous; synchronous; existing at the same time; concurrent; prior to first course treatment
- Topography; site code
- Tumor; mass; tumor mass; lesion; neoplasm

- The terms tumor, mass, tumor mass, lesion, and neoplasm are **not** used in a standard manner in clinical diagnoses, scans, or consults. Disregard the terms unless there is a physician's statement that the term is malignant/cancer.
- These terms are used **only** to determine multiple primaries.
- Do not use these terms for casefinding or for determining reportability.
- Type; subtype; variant
- Urothelial carcinoma; transitional cell carcinoma
- Urothelium; epithelium; transitional epithelium

Terms That Are Not Equivalent

- Phenotype is not equivalent to subtype/type/variant.
- Noninvasive; papillary urothelial carcinoma; flat urothelial carcinoma

  Note: Noninvasive is not equivalent to either papillary urothelial or flat urothelial carcinoma. Both Ta and Tis tumors are technically noninvasive. Code the histology specified by the pathologist.

Over 90% of bladder cancers are urothelial (transitional) cell carcinomas, derived from the uroepithelium. Other types include squamous cell carcinoma (about 2% to 7%) and adenocarcinoma (about 2%). Adenocarcinomas may be of urachal origin or nonurachal origin, with the nonurachal type generally thought to arise from metaplasia of chronically irritated transitional epithelium. Small cell carcinoma, and rarely sarcoma, can also occur. Childhood rhabdomyosarcoma, a type of sarcoma, can form in muscle tissue of the bladder.

For all sites except breast and CNS, 2018 Rules instruct "Code the most specific histology from biopsy or resection. When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor)."

Priority Order for Using Documentation to Identify Histology

1. Code the histology diagnosed prior to neoadjuvant treatment.
    a. Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
    b. Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
2. Code the histology using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable for staging.

The priority list is used for single primaries (including multiple tumors abstracted as a single primary)

Use documentation in the following priority order to identify the histology type(s):

Code the most specific pathology/tissue from either resection or biopsy.

- The term “most specific” usually refers to a subtype/variant.
- The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
- When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

1. Tissue or pathology report from primary site (in priority order)
    a. Addendum(s) and/or comment(s)
    b. Final diagnosis / synoptic report as required by CAP.
    c. CAP protocol
    - Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
    - The pathologist’s diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority. The final diagnosis is often the synoptic CAP report.
    - The CAP protocol is a checklist which:
        - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care.
        - Allows physicians to check multiple histologies
2. Cytology (usually urine)
3. Tissue/pathology from a metastatic site
    - Code the behavior /3.
    - The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan and only physician documentation.
4. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
    a. Treatment Plan
    b. Documentation from Tumor Board
    c. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
    d. Physician’s reference to type of cancer (histology) in the medical record
    - Code the specific histology when documented.
    - Code the histology to 8000 (cancer/malignant neoplasm NOS) or as stated by the physician when nothing more specific is documented.

5. Scans: CT, MRI. There is no priority order because scans are not a very reliable method for identifying specific histology(ies) for these sites.

Coding Rules

1. Code the most specific histology or subtype/variant, regardless of whether it is described as:
    a. The majority or predominant part of tumor
    b. The minority of tumor
    c. A component
    - The terms above must describe a carcinoma or sarcoma.
    - When the most specific histology is described as differentiation or features, see #2.
2. Code the histology described as differentiation or features/features of ONLY when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
    - Do not code differentiation or features when there is no specific ICD-O code.
3. Code the specific histology described by ambiguous terminology (list follows) ONLY when:
    - There is a NOS histology and a more specific (subtype/variant) described by ambiguous terminology and the specific histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.)

      Example: The pathology diagnosis is sarcoma NOS consistent with leiomyosarcoma. The oncology consult says the patient has leiomyosarcoma of the bladder. This is clinical confirmation of the diagnosis, code leiomyosarcoma. The case meets the criteria in the first bullet .
    - There is a NOS histology and a more specific (subtype/variant) described by ambiguous terminology and the Patient is receiving treatment based on the specific histology described by an ambiguous term.
    - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented.

List of Ambiguous Terminology

- Apparently
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing

- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

Note: **If the histology described by ambiguous terminology does not meet any of the criteria in bullets 1, 2, or 3, DO NOT Code the histology.**

Do not code histology when described as:

- Architecture
- Configuration
- Foci; focus; focal
- Pattern

Bladder Wall Pathology

The bladder wall is composed of three layers. There may be "sub layers" within the major layers of the bladder.

Bladder Layer	Sub Layer	Synonyms	Staging	Description
Mucosa		Epithelium, Transitional epithelium, urothelium, mucosal surface, transitional mucosa	No blood vessels, in situ/noninvasive	First layer on inside of bladder; Lines bladder, ureters, and urethra
	Basement membrane		No invasion of basement membrane is in situ Invasion/penetration of basement membrane is invasive	Single layer of cells that lies beneath the mucosal layer separating the epithelial layer from the lamina propria

Bladder Layer	Sub Layer	Synonyms	Staging	Description
	Submucosa	Submucous coat, lamina propria, areolar connective tissue		Areloar connective tissue interlaced with the muscular coat. Contains blood vessels, nerves, and in some regions, glands
Lamina propria		Submucosa, Suburothelia connective tissue, subepithelial tissue, stoma, muscularis mucosa, transitional epithelium	Invasive	
Muscle	Bladder Wall	Muscularis, Muscularis propria, muscularis externa, smooth muscle	Invasive	

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

Grade Coding Instructions and Table

Primary Site	Histology
C670-C679	8000-8700, 8720-8790, 9700-9701

Site- Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

Name	Default Value	Used for Staging	NAACCR Item	Required By
Grade Clinical Grade Pathological	9	No	NAACCR #3843 NAACCR #3844	CCCR/Canada COC NPCR SEER

Grade ID 19-Clinical and Pathological Grade Instructions (see page 96 and 97)

Grade Coding Instructions and Tables

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00610	Kidney Renal Pelvis	61.1	Renal Pelvis and Ureter: Urothelial Carcinomas
00610	Kidney Renal Pelvis	61.2	Renal Pelvis and Ureter: Squamous Cell Carcinoma and Adenocarcinoma

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00620	Bladder	62.1	Urinary Bladder: Urothelial Carcinomas
00620	Bladder	62.2	Urinary Bladder: Squamous Cell Carcinoma and Adenocarcinoma

Surgery Codes

Bladder C670–C679

(Except for M9732, 9741-9742, 9761-9809, 9820, 9826, 9831-9834, 9840-9920, 9931-9993)

For the surgery codes for the bladder, visit

seer.cancer.gov/manuals/2021/AppendixC/Surgery_Codes_Bladder_2021.pdf

Additional resources

- SEER Program Coding and Staging Guidelines for the bladder:
  seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Bladder_2021.pdf
- 2018 Solid Tumor Rules for the bladder:
  seer.cancer.gov/tools/solidtumor/

Colon and Rectum

Colon: seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Colon_2021.pdf

Rectum: seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Rectosigmoid_2021.pdf

Site Codes

Site Term and Code	Parts of the Colon and Rectum
C180	Cecum 6x9 cm pouch covered with peritoneum
C181	Appendix A vermiform diverticulum located in the lower cecum
C182	Ascending colon, Right colon 20-25 cm long, located behind the peritoneum
C183	Hepatic flexure Lies under right lobe of liver
C184	Transverse colon Lies anterior in abdomen, attached to gastrocolic ligament

C185	Splenic flexure Near tail of pancreas and spleen
C186	Descending colon, left colon 10-15 cm long, located behind the peritoneum
C187	Sigmoid colon, Pelvic Loop extending distally from border of left posterior major psoas muscle
C188	Rectosigmoid segment Between 10 and 15 cm from anal verge
C189	Colon, NOS
C199	Rectosigmoid, Colon & Sigmoid
C209	Rectum 12 cm long; upper third covered by peritoneum; no peritoneum on lower third which is also called the rectal ampulla. About 10 cm of the rectum lies below the lower edge of the peritoneum (below the peritoneal reflection), outside the peritoneal cavity
C211	Anal canal Most distal 4-5 cm to anal verge

Primary Site

Code the subsite with the most tumor when the tumor overlaps two subsites of the colon and the point of origin cannot be determined.

Code C188 when both subsites of the colon are equally involved.

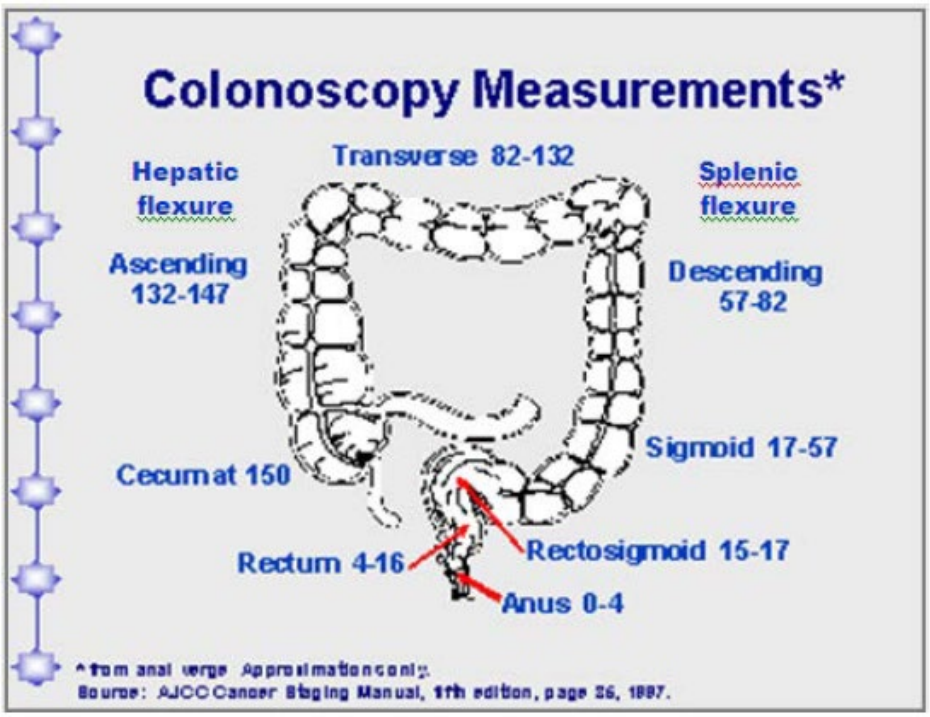
A tumor is classified as rectosigmoid when differentiation between rectum and sigmoid is not possible.

A tumor is classified as rectal if:

- lower margin lies less than 16 cm from the anal verge or
- any part of the tumor is located at least partly within the supply of the superior rectal artery.

Terminology

- Anal verge: The lower (distal) end of the anal canal, junction between the skin of the anal canal and the perianal skin.
- Anorectal ring: Top (proximal end) of the anal canal.
- Dentate line: An anatomic landmark located between the anal verge and the anorectal ring indicating where the rectum changes to the anal canal. Also called the pectinate line.
- Tenia coli: (Plural: teniae coli). Any one of three longitudinal bands of smooth muscle in the colon. They extend from the cecum to the sigmoid colon. Each band is approximately 8 mm wide throughout most of the colon. The widths of the teniae increase in the sigmoid colon and eventually fuse into a covering of longitudinal muscle in the rectum.



Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with

  Note: "And" and "with" are used as synonyms when describing multiple histologies within a single tumor.
- Carcinoid; NET; neuroendocrine tumor
- Carcinoma; carcinoma NOS; adenocarcinoma; adenocarcinoma NOS; intestinal type adenocarcinoma 8140
- De novo; frank adenocarcinoma (obsolete)
- Familial polyposis; familial adenomatous polyposis (FAP) 8220
- Intramucosal; lateral extension within the mucosal layer of the GI tract
- Invasion through colon wall; extension through colon wall; transmural

  Note: The term "transmural" is used to describe extension through all layers of the wall, but not past the wall OR extension through the serosa into the mesentery. Read the pathology report carefully.
- Mucinous; mucoid; mucous; colloid
- Neuroendocrine carcinoma; NEC
- Polyp; adenoma; polyp NOS; adenomatous polyp

    - The term “polyp” means projecting from a surface.
    - There are many kinds of polyps. Most common are adenomas, which are part of the adenoma-cancer sequence.
    - Other types of polyps include hyperplastic, juvenile, Peutz-Jeghers and serrated adenoma/polyp.
- Serosa; visceral peritoneum
- Simultaneous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- Tumor; mass; tumor mass; lesion; neoplasm
- The terms tumor, mass, tumor mass, lesion, and neoplasm are not used in a standard manner in clinical diagnoses, scans, or consults. Disregard the terms unless there is a physician’s statement that the term is malignant/cancer.
- These terms are used only to determine multiple primaries.
- Do not use these terms for casefinding or determining reportability.
- Type; subtype; variant

Terms That Are Not Equivalent Or Equal

- Component is not equivalent to subtype/variant

  Note: Component is only coded when the pathologist specifies the component as a second carcinoma.
- “Exophytic” and “polypoid” are not synonymous with either an adenoma or an adenomatous polyp. The terms “exophytic” and “polypoid” refer to anything projecting from the bowel mucosa into the lumen. The lesion may be benign, malignant, or inflammatory.
- Phenotype is not equivalent to subtype/type/variant.
- Polypoid adenocarcinoma is not equivalent to adenocarcinoma in a polyp.

Priority Order for Using Documentation to Identify Histology

- Code the histology diagnosed prior to neoadjuvant treatment.
    - Histology changes may occur following immunotherapy, chemotherapy, target therapy, and radiation therapy.
    - Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
- Code the histology using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable to staging.

- The priority list is used for single primaries (including multiple tumors abstracted as a single primary).

- Code the most specific pathology/tissue from either resection or biopsy.
  - The term “most specific” usually refers to a subtype/variant.
  - The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
  - When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

This is a hierarchical list of source documentation.

Code the most specific pathology/tissue from either resection or biopsy.

- The term “most specific” usually refers to a subtype/variant.
- The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
- When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

1. Tissue or pathology report from primary site (in priority order)
   a. Addendum(s) and/or comment(s)
   b. Final diagnosis / synoptic report as required by CAP.
   c. CAP protocol

   Note:

   - Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
   - The pathologist’s diagnosis from the pathology report is always reliable, so the final diagnosis is the secod priority.
   - The CAP protocol is a checklist which:
     - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care.
     - Allows physicians to check multiple histologies
2. Tissue/pathology from a metastatic site

   Note:

   - Code the behavior /3.

- The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan.

3. Scan: The following list is in priority order.
    a. CT
    b. PET
    c. MRI
4. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
    a. Treatment plan
    b. Documentation from Tumor Board
    c. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
    d. Physician's reference to type of cancer (histology) in the medical record

    Note:

    - Code the specific histology when documented.
    - Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.
5. Cytology (seldom used for colon, rectosigmoid and rectum)

Polyps are now disregarded when coding histology. For example, adenocarcinoma in an adenomatous polyp is coded as adenocarcinoma 8140. For the purposes of determining multiple primaries, tumors coded as adenocarcinoma in a polyp for pre-2018 cases should be treated as adenocarcinoma 8140.

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

staging.seer.cancer.gov/eod_public/schema/2.0/colon_rectum/?breadcrumbs=(~schema_list~)

Colon and Rectum

Primary Site	Histology
C180, C182-C189, C199, C209	8000-8149, 8154, 8157, 8160-8231, 8243-8248, 8250-8682, 8690-8700, 8720-8790, 9700-9701

SSDI Data Items

Name	Default Value	Used for Staging	NAACCR Item	Required By
Grade Clinical Grade Pathological	9 9	No No	NAACCR #3843 NAACCR #3844	CCCR/Canada COC NPCR SEER

Grade ID 02-Clinical Grade and Pathological Grade Instructions

Grade Coding Instructions and Tables

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00200	Colon and Rectum	20	Colon and Rectum

Surgery Codes

(Except for M9732, 9741-9742, 9761-9809, 9820, 9826, 9831-9834, 9840-9920, 9931-9993)

- Colon C180–C189: seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Colon_2021.pdf
- Rectosigmoid C199: seer.cancer.gov/manuals/2021/AppendixC/Surgery_Codes_Rectosigmoid_2021.pdf
- Rectum C209: seer.cancer.gov/manuals/2021/AppendixC/Surgery_Codes_Rectum_2021.pdf

Additional resources

- SEER Program Coding and Staging guidelines for the colon: seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Colon_2021.pdf
- 2018 Solid Tumor Rules for Colon: seer.cancer.gov/tools/solidtumor/Colon_STM.pdf

Esophagus

seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Esophagus_2021.pdf

Site codes

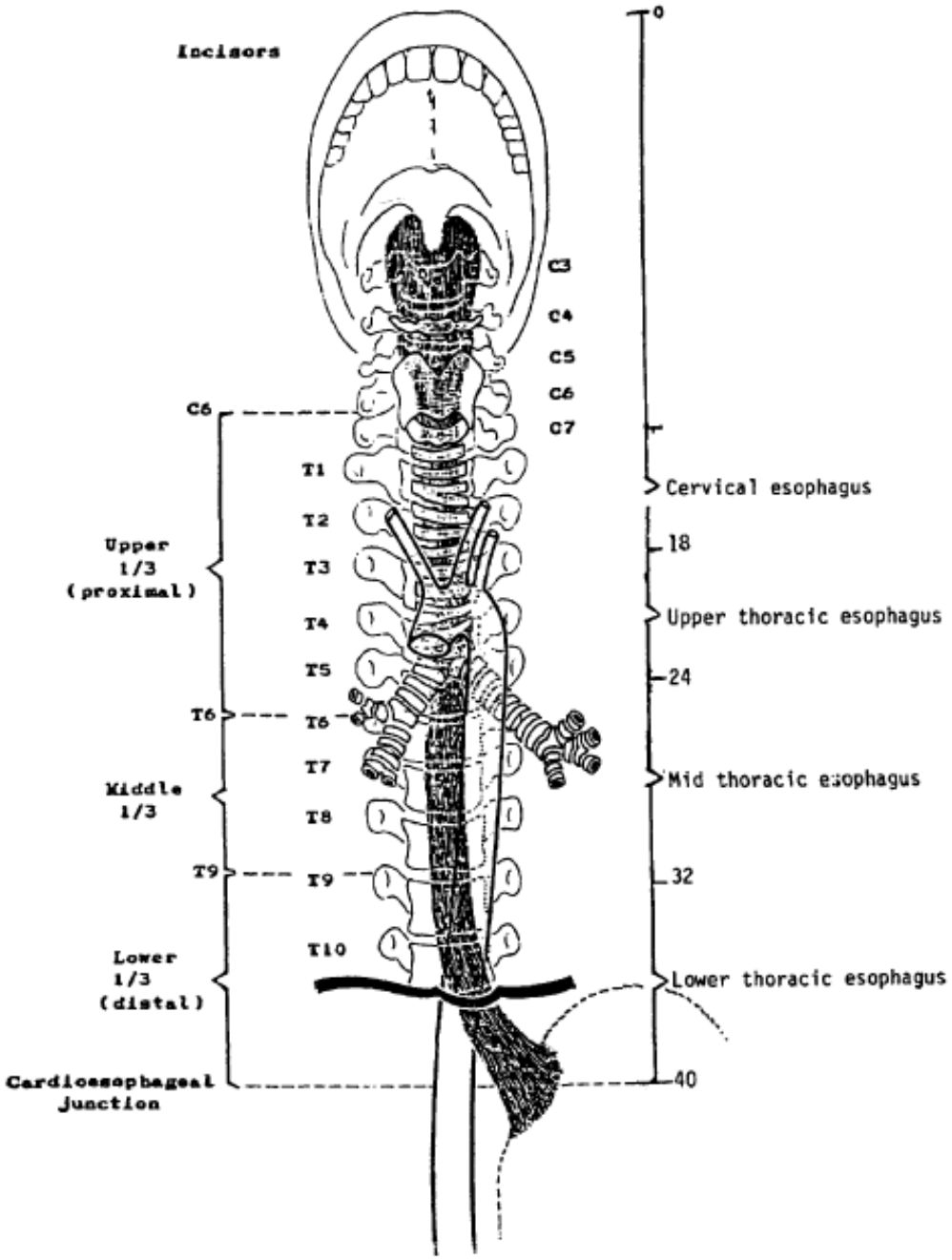
Code	Site
C15	Esophagus
C15.0	Cervical esophagus
C15.1	Thoracic esophagus
C15.2	Abdominal esophagus
C15.3	Upper third of esophagus
	Proximal third of esophagus

C15.4	Middle third of esophagus
C15.5	Lower third of esophagus
	Distal third of esophagus
C15.8	Overlapping lesion of esophagus
C15.9	Esophagus, NOS

There are two systems that divide the esophagus into three subsites. The first system divides the esophagus into the upper third, middle third, and lower third. The second system describes the subsites as the cervical esophagus, upper thoracic esophagus, mid thoracic esophagus, and lower thoracic (abdominal) esophagus. The subsites for these two different systems are not identical.

Assign the ICD-O-3 topography code that describes the primary site documented in the medical record. See the following image for an illustration of both systems.

Measurements of the Esophagus (From the Incisors to the Stomach)



Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

apps.naaccr.org/ssdi/schema/esophagus_gejunction/2.0?breadcrumbs=(~schema_list~)

Esophagus (Including GE Junction) (Excluding Squamous)

Primary Site	Histology	Schema Discriminator 1	Schema Discriminator 2
C150-C155, C158-C159	8000-8015, 8021-8046, 8060, 8071-8073, 8075-8076, 8078-8082, 8084-8552, 8561-8700, 8720-8790, 9700-9701		
C160	8000-8015, 8021-8046, 8060, 8071-8073, 8075-8076, 8078-8082, 8084-8149, 8154, 8157, 8160-8231, 8243-8248, 8250-8552, 8561-8682, 8690-8700, 8720-8790, 9700-9701	2	
C150-C155, C158-C159	8020		2
C160	8020	2	2

Name	Default Value	Used for Staging	NAACCR Item	Required By
Schema Discriminator 1	*<BLANK>*	Yes	NAACCR #3926	All
Schema Discriminator 2	*<BLANK>*	Yes	NAACCR #3927	All
Grade Clinical	9	No	NAACCR #3843	CCCR/Canada COC NPCR SEER
Grade Pathological	9	Yes	NAACCR #3844	

Esophagus (Including GE Junction) Squamous

apps.naaccr.org/ssdi/schema/esophagus_including_ge_junction_squamous/2.0?breadcrumbs=(~schema_list~)

Primary Site	Histology	Schema Discriminator 1	Schema Discriminator 2
C150-C155, C158-C159	8050-8054, 8070, 8074, 8077, 8083, 8560		
C160	8050-8054, 8070, 8074, 8077, 8083, 8560	2	
C150-C155, C158-C159	8020		1, 9
C160	8020	2	1, 9

Name	Default Value	Used for Staging	NAACCR Item	Required By
Schema Discriminator 1	<*BLANK*>	Yes	NAACCR #3926	All

Grade ID 03-Clinical Grade and Pathological Grade Instructions

Grade Coding Instructions and Tables

	Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00161	Esophagus (including GE junction) Squamous	16.1	Esophagus and Esophagogastric Junction: Squamous Cell Carcinoma	
00169	Esophagus (including GE junction) (excluding Squamous)	16.9	Esophagus and Esophagogastric Junction: Adenocarcinoma	

Surgery Codes

Esophagus C150–C159

(Except for M9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9993)

Surgery codes of the esophagus:

seer.cancer.gov/manuals/2021/AppendixC/Surgery_Codes_Esophagus_2021.pdf

Additional Resources

- 2018 Solid Tumor Rules of the esophagus: seer.cancer.gov/tools/solidtumor/Other_sites_STM.pdf
- SSDI Manual for coding the esophagus: naaccr.org/wp-content/uploads/2021/01/SSDI-Manual_v-2.0.pdf?v=1610725077

Lung

seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Lung_2021.pdf

Cancers from many primary sites metastasize to the lung. It is important to rule out metastases from another organ/site before abstracting a lung primary.

Site Codes

Use this table to determine the correct site code. Do not use for other fields such as laterality.

- Column 1 contains the terminology used by physicians or on scans to describe lung "masses" (not lymph nodes).
- Column 2 indicates whether the term is used only for the right lung, or only for the left lung, or if it is used for both the right or left lung.
- Column 3 contains the ICD-O term and site code.

Terminology	Laterality	Site Term and Code
Bronchus intermedius Carina Hilus of lung Perihilar	Bilateral	Mainstem bronchus C340 Note: Bronchus intermedius is the portion of the right mainstem bronchus between the upper lobar bronchus and the origin of the middle and lower lobar bronchi
Lingula of lung	Left	Upper lobe **C341**
Apex Apex of lung Lung apex Pancoast tumor Superior lobar bronchus Upper lobe bronchi	Bilateral	Upper lobe **C341**
Middle lobe Middle lobe bronchi	Right	Middle lobe **C342**
Base of lung Lower lobar bronchus Lower lobe Lower lobe bronchi Lower lobe segmental bronch	Bilateral	Lower lobe **C343**
Overlapping lesion of lung	Bilateral	Overlapping lesion of lung **C348** ***Note:*** One lesion/tumor which overlaps two or more lobes

Terminology	Laterality	Site Term and Code
Bronchus NOS Bronchogenic Extending up to the hilum Extending down to the hilar region Lung NOS Pulmonary NOS Suprahilar NOS	Bilateral	Lung NOS C349 ***Note:*** Includes • Multiple tumors in different lobes of ipsilateral lung, or • Multiple tumors in ipsilateral lung; unknown if same lobe or different lobe, or • Tumor in bronchus, unknown if mainstem or lobar bronchus, or • Tumor present, unknown which lobe
Lobar bronchi NOS Lobar bronchus NOS	Bilateral	Code the lobe in which the lobar bronchus tumor is present **C34__** ***Note:*** When **lobe** of origin is **not documented/unknown,** code to lung NOS **C349**

Coding Rules

1. The mainstem bronchus starts at the trachea and extends only a few centimeters into the lung where it connects with the secondary bronchus and divides into secondary bronchi.
    a. Each lobe of the lung has secondary bronchi
        i. The right lung has 3 secondary bronchi, one in each of the three lobes: upper; middle, and lower.
        ii. The left lung has 2 secondary bronchi, one in each of the two lobes: upper and lower.
    b. Code to mainstem bronchus C340 when it is specifically stated in the operative report and/or documented by a physician.
    c. When only called bronchus, code to the lobe in which the bronchial tumor is located
2. Refer to the SEER Program Coding and Staging Manual (page 88) for a priority list for using documents such as radiographic reports, operative reports, and pathology reports to determine the tumor location.

Equivalent or Equal Terms

These terms can be used interchangeably:

- Adenocarcinoma, carcinoma

- And; with

  Note: "And" and "with" are used as synonyms when describing multiple histologies within a single tumor.
- Non-small cell carcinoma 8046; a broad category which includes all histologies in Table 3 (see page 3 STR) except for small cell carcinoma/neuroendocrine tumors (NET Tumors) 8041 and all subtypes
- Simultaneous; existing at the same time; concurrent; prior to first course treatment
- Site; topography
- Squamous cell carcinoma, SCC, epidermoid carcinoma
- Tumor, mass, tumor mass, lesion, neoplasm, nodule
- The terms tumor, mass, tumor mass, lesion, neoplasm and nodule are not used in a standard manner in clinical diagnoses, scans, or consults. Disregard the terms unless there is a physician's statement that the term is malignant/cancer.
- These terms are used ONLY to determine multiple primaries.
- Do not use these terms for casefinding or determining reportability.
    - Type; subtype; variant

Terms That Are Not Equivalent Or Equal

This is a list of terms that are not equivalent. There are no casefinding implications.

- Bilateral is NOT equivalent to either single primary or multiple primaries. See Multiple Primary rules for instructions.
- Bronchus is not always equivalent to mainstem bronchus. The mainstem bronchus only extends a few centimeters into the lung.
    - Code to mainstem bronchus C340 when it is specifically stated in the operative report and/or documented by a physician.
    - When only called bronchus, code to the lobe in which the bronchial tumor is located.
- Component is not equivalent to subtype/variant.

  Note: Component is only coded when the pathologist specifies the component as a second carcinoma.
- Mucinous; colloid (for lung only)

  Note: The new codes for mucinous adenocarcinoma were implemented so mucinous carcinoma and colloid carcinoma could be analyzed separately.
- Mucin-producing/mucin-secreting carcinoma 8481 is not equivalent to mucinous carcinoma 8253 (new code for lung primaries only)

- Mucin-producing/secreting tumors produce mucin, but not enough to be classified as mucinous carcinoma.
    - The terms mucin-producing and mucin-secreting are still reportable. This bullet simply states they are not equivalent or equal to mucinous carcinoma.
- Multilocular is not equivalent to multinodular (see glossary for further information. The electronic glossary will be available in 2019)
- Phenotype is not equivalent to subtype/type/variant.

For all sites except breast and CNS, 2018 Rules instruct "Code the most specific histology from biopsy or resection. When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor)."

Priority Order for Using Documents to Identify Histology

- Code the histology diagnosed prior to neoadjuvant treatment.
    - Histology changes do occur following immunotherapy, chemotherapy, targeted therapy, and radiation therapy.
    - Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
- Code the histology using the following priority list and the Histology Rules. Do not change histology in order to stage.

The priority list is used for single primaries (including multiple tumors abstracted as a single primary)

Code the most specific histology from either resection or biopsy.

- The term "most specific" usually refers to a subtype/variant.
- The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
- When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

1. Tissue or pathology report from primary site (in priority order)
    a. Addendum(s) and/or comment(s)
    b. Final diagnosis/synoptic report as required by CAP
    c. CAP protocol
    - Addendums and comments on the pathology report are given a high priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.

- The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority.
- The CAP protocol is a checklist which:
    - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care.
    - Allows physicians to check multiple histologies

2. Cytology (Fine needle biopsy, pleural fluid) from primary site
3. Tissue/pathology from a metastatic site
    a. Code the behavior /3.
    b. The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan.
4. Scan: The following list is in priority order.
    a. CT
    b. PET
    c. MRI
    d. Chest X-ray
5. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
    a. Treatment Plan
    b. Documentation from Tumor Board
    c. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
    d. Physician's reference to type of cancer (histology) in the medical record
    - Code the specific histology when documented.
    - Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

Coding Instructions

- The priority is to code the most specific histology. Do not use breast histology coding rules for this site.
- Only use this section for one or more histologies within a single tumor.
- Do not use this section in place of the Histology Rules.

1. Code the most specific histology or subtype/variant, regardless of whether it is described as:
    a. The majority or predominant part of tumor

b. The minority of tumor
c. A component

Example 1: Diagnosis for a single tumor is adenocarcinoma 8140 with the majority or predominant part of tumor being acinar adenocarcinoma 8551. Code the subtype/variant: acinar adenocarcinoma 8551.

Example 2: Diagnosis for a single tumor is squamous cell carcinoma 8070 with minority of tumor being keratinizing squamous cell carcinoma 8071. Code the subtype/variant: keratinizing squamous cell carcinoma 8071.

Example 3: Diagnosis for a single tumor is sarcoma NOS 8800/3 with a component of leiomyosarcoma 8890/3. Code the subtype/variant: leiomyosarcoma 8890/3.

Note*:* The terms above (A, B, C) must describe a carcinoma or sarcoma in order to code a histology described by those terms.

Example: When the diagnosis is adenocarcinoma with a component of medullary carcinoma, code medullary carcinoma 8510.

Negative Example: When the diagnosis is simply adenocarcinoma with a medullary component, code adenocarcinoma NOS 8140. Do not assume this is a medullary carcinoma. This could be medullary differentiation or features.

Note: When the most specific histology is described as differentiation or features, see #2.

2. Code the histology described as differentiation or features/features of only when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".

   Note: Do not code differentiation or features when there is no specific ICD-O code.

3. Code the specific histology described by ambiguous terminology (list follows) only when a or b is true:

   a. The only diagnosis available is one histology term described by ambiguous terminology
      - CoC and SEER require reporting of cases diagnosed only by ambiguous terminology
      - Case is accessioned (added to your database) based on ambiguous terminology and no other histology information is available/documented

   b. There is a NOS histology and a more specific (subtype/variant) described by ambiguous terminology
      - Specific histology is clinically confirmed by a physician (attending, pathologist, oncologist, etc.), or
      - Patient is receiving treatment based on the specific histology described by ambiguous term

   Example 1: The pathology diagnosis is NSCLC consistent with adenocarcinoma. The oncology consult says the patient has adenocarcinoma of the right lung. This

is clinical confirmation of the diagnosis, code adenocarcinoma. The case meets the criteria in the first bullet .

Example 2: The pathology diagnosis is NSCLC consistent with squamous cell carcinoma. The treatment plan says the patient will receive treatment for squamous cell carcinoma. Treatment plan confirms squamous cell carcinoma; code squamous cell carcinoma. The case meets the criteria in the second bullet.

If the specific histology does not meet the criteria in #3B, then code the NOS histology.

List of Ambiguous Terminology

- Apparently
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing
- Most Likely
- Presumed
- Probable
- Suspected
- Suspicious (for)
- Typical (of)

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

Site-Specific Data Items (SSDI)/Grade

apps.naaccr.org/ssdi/schema/lung/2.0?breadcrumbs=(~schema_list~)

Primary Site	Histology
C340-C343, C348-C349	8000-8700, 8720-8790, 8972, 8980, 9700-9701

SSDI Data Items

Name	Default Value	Used for Staging	NAACCR Item	Required By
Grade Clinical	9	No	NAACCR #3843	CCCR/Canada COC NPCR SEER
Grade Pathological	9	No	NAACCR #3844	

Grade ID 02-Clinical and Pathological Grade Instructions

Grade Coding Instructions and Tables

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00360	Lung	36	Lung

Surgery Codes

Lung C340–C349

(Except for M9732, 9741-9742, 9761-9809, 9820, 9826, 9831-9834, 9840-9920, 9931-9993)

Surgery codes for the lung:

seer.cancer.gov/manuals/2021/AppendixC/Surgery_Codes_Lung_2021.pdf

Additional resources

- SEER Program Coding and Staging guidelines for the lung: seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Lung_2021.pdf
- 2018 Solid Tumor Rules for the lung: seer.cancer.gov/tools/solidtumor/Lung_STM.pdf

Skin

seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Melanoma_2021.pdf

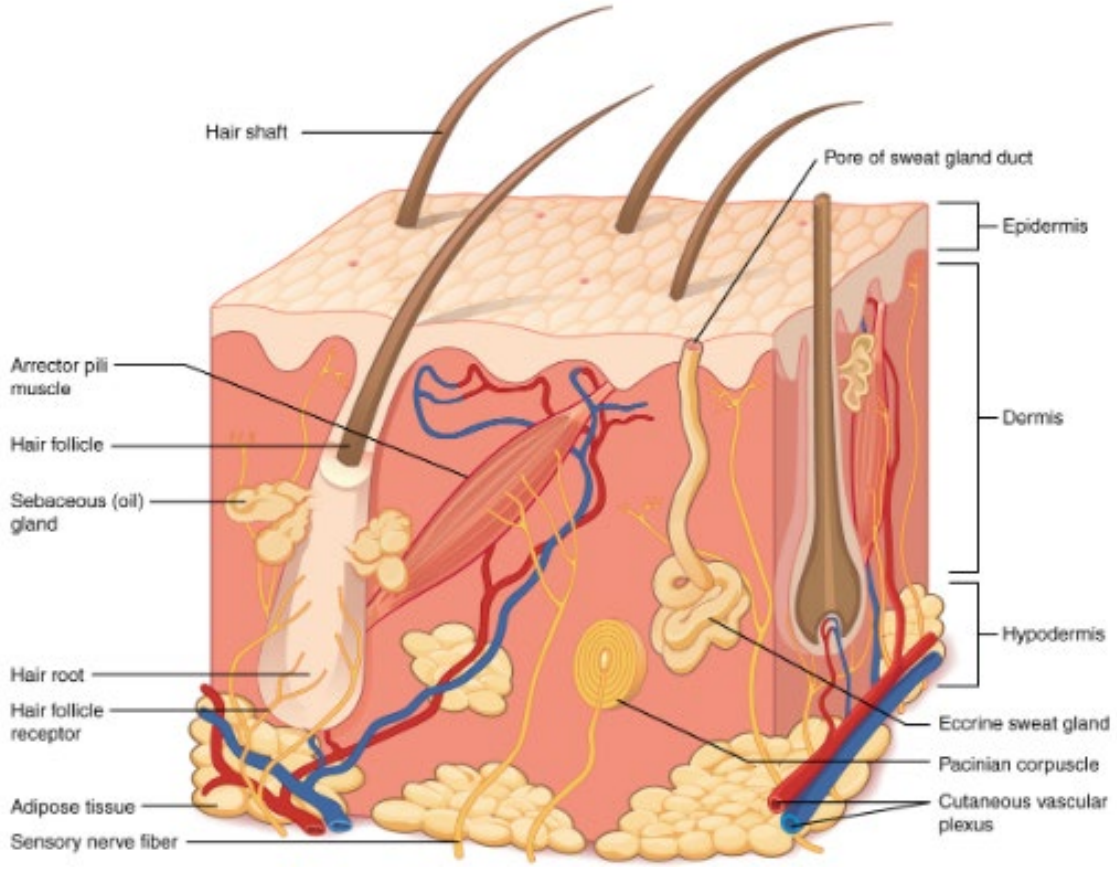
Melanoma C440-C449 with Histology 8720-8780

As of cases diagnosed January 1, 2021, early or evolving melanoma of any type is reportable. This includes both invasive and in situ melanomas; early or evolving are reportable.

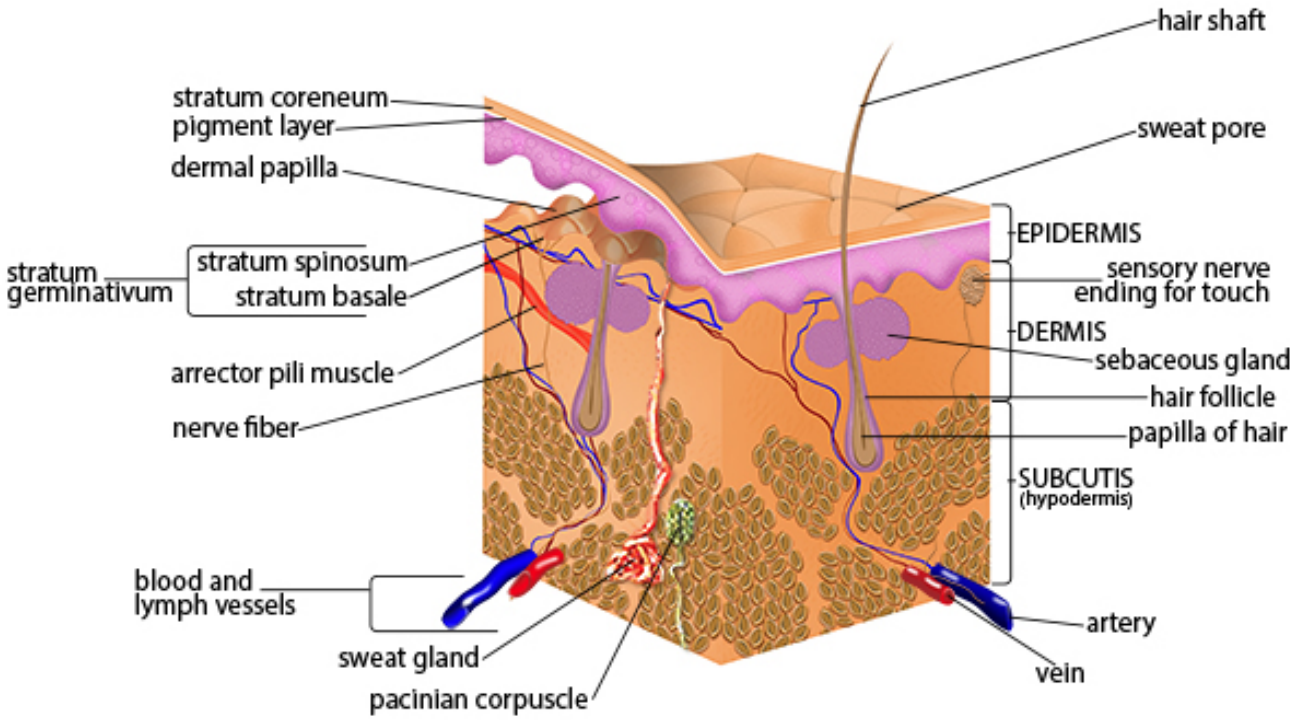
Site codes

Site code	Term
C44.0	Skin of lip, NOS
C44.1	Eyelid
C44.2	External ear
C44.3	Skin of other and unspecified parts of face

Site code	Term
C44.4	Skin of scalp and neck
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C44.8	Overlapping lesion of skin
C44.9	Skin, NOS
C51.0	Labium majus
C51.1	Labium minus
C51.2	Clitoris
C51.8	Overlapping lesion of vulva
C51.9	Vulva, NOS
C60.0	Prepuce
C60.1	Glans penis
C60.2	Body of penis
C60.8	Overlapping lesion of penis
C60.9	Penis, NOS
C63.2	Scrotum, NOS



Source: opentextbc.ca/anatomyandphysiology/chapter/5-1-layers-of-the-skin/



Source: training.seer.cancer.gov/melanoma/anatomy/

Melanomas are divided into 5 main types, depending on their location, shape and whether they grow outward or downward into the dermis:

- Acral melanoma occurs on the palms of the hand, soles of the feet, or nail beds.
- Desmoplastic melanoma: is a rare malignant melanoma marked by non-pigmented lesions on sun-exposed areas of the body.
- Lentigo maligna: usually occur on the faces of elderly people.
- Superficial spreading or flat melanoma grows outwards at first to form an irregular pattern on the skin with an uneven color.
- Nodular melanomas: are lumpy and often blue-black in color and may grow faster and spread downwards.

These types account for the majority of melanomas occurring in the US population. For a more complete listing of histologic types of melanoma, see the AJCC Cancer Staging Manual, 6th Ed.

Melanoma can also start in the mucous membranes of the mouth, anus and vagina, in the eye or other places in the body where melanocytes are found. This scheme is used only for melanomas that occur on

the skin.

Equivalent or Equal Terms

- And; with

  Note: "And" and "with" are used as synonyms when describing multiple histologies within a single tumor.
- Giant pigmented nevus; giant congenital nevus
- Mixed epithelioid and spindle cell melanoma (8770); Epithelioid melanoma and spindle cell melanoma
- Melanoma in situ, superficial spreading type; low-cumulative sun damage (CSD) melanoma in situ
- Mole; Nevus
- Simultaneous; existing at the same time; concurrent
- Site; topography
- Superficial spreading melanoma; low-cumulative sun damage (CSD) melanoma
- Tumor; mass; tumor mass; lesion; neoplasm
  - The terms tumor, mass, tumor mass, lesion, and neoplasm are not used in a standard manner in clinical diagnoses scans, or consults. Disregard the terms unless there is a physician's statement that the term is malignant/cancer.
  - These terms are used ONLY to determine multiple primaries.
  - Do not use these terms for casefinding or determining reportability.
- Type, subtype, variant

Terms that are not Equivalent or Equal

- Component is not equivalent to subtype/type/variant.
  - Component is only coded when the pathologist specifies the component as a second melanoma
- Phenotype is not equivalent to subtype/type/variant.

Synonyms for In Situ

- Behavior code 2
- Clark level 1 (limited to the epithelium)
- Hutchinson freckle (See synonyms for Hutchinson freckle)
- Intraepidermal, NOS

- Intraepithelial, NOS
- Lentigo maligna
- Noninvasive
- Precancerous melanosis (C44_)
- Stage 0
- Tis

Synonyms for Hutchinson freckle

- Circumscribed precancerous melanosis
- Intraepidermal malignant melanoma
- Lentigo maligna
- Precancerous melanosis of Dubreuilh

Priority Order for Using Documentation to Identify Histology

- Code the histology diagnosed prior to neoadjuvant treatment.
    - Histology changes may occur following immunotherapy, chemotherapy, targeted therapy, and radiation therapy.
    - Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
- Code the histology using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable to staging.

The priority list is used for single primaries (including multiple tumors abstracted as a single primary).

This is a hierarchical list of source documentation.

- Code the most specific pathology/tissue from either resection or biopsy.
    - The term “most specific” usually refers to a subtype/variant.
    - The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
    - When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

1. Tissue or pathology report from primary site (in priority order)
    a. Addendum(s) and/or comment(s)
    b. Final diagnosis / synoptic report as required by CAP

c. CAP protocol

- Addendums and comments on the pathology report are given the highest priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
- The pathologist's diagnosis from the pathology report is always reliable, so the final diagnosis is the second priority.
- The CAP protocol is a checklist which:
    - Provides guidelines for collecting the essential data elements for complete reporting of malignant tumors and optimal patient care
    - Allows physicians to check multiple histologies

2. Tissue/pathology from a metastatic site
    - Code the behavior /3.
    - The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan.
3. Scans: MRI, CT, PET. There is no priority order because scans are not a reliable method for identifying specific histology(ies).
4. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
    a. Treatment plan
    b. Documentation from Tumor Board
    c. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
    d. Physician's reference to type of cancer (histology) in the medical record
    - Code the specific histology when documented.
    - Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

apps.naaccr.org/ssdi/schema/melanoma_skin/2.0?breadcrumbs=(~schema_list~)

Melanoma Skin

Primary Site	Histology
C000-C002, C006, C440-C449, C500, C510-C512, C518-C519, C600-C602, C608-C609, C632	8720-8790

SSDI Data Items

Name	Default Value	Used for Staging	NAACCR Item	Required By
Grade Clinical	9	No	NAACCR #3843	CCCR/Canada COC NPCR SEER
Grade Pathological	9	No	NAACCR #3844	
Breslow Thickness	XX.8	Yes	NAACCR #3817	All

Grade ID 98-Clinical and Pathological Grade Instructions

Grade Coding Instructions and Tables

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00460	Merkel Cell Carcinoma	46	Merkel Cell Carcinoma
00470	Melanoma of the Skin	47	Melanoma of the Skin

Surgery Codes

Skin C440–C449

(Except for M9732, 9741-9742, 9761-9809, 9820, 9826, 9831-9834, 9840-9920, 9931-9993)

Surgery codes for melanoma of the skin:

seer.cancer.gov/manuals/2021/AppendixC/Surgery_Codes_Skin_2021.pdf

Additional resources

- SEER Program Coding and Staging guidelines for cutaneous melanoma: https://seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Melanoma_2021.pdf
- 2018 Solid Tumor Rules for cutaneous melanoma: seer.cancer.gov/tools/solidtumor/Melanoma_STM.pdf

Brain and Central Nervous System

seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Brain_2021.pdf

Site codes

Site Group	Reportable Subsite Terms and Code
Brain	Brain NOS **C719** Brain stem **C717** Cerebellum NOS **C716** Cerebrum **C710** Frontal lobe **C711** Occipital lobe **C714** Overlapping lesion of brain **C718** Parietal lobe **C713** Temporal lobe **C712** Ventricle NOS **C715**
Cranial Nerves	Abducent (cranial nerve VI) **C725** Accessory (cranial nerve XI) **C725** Acoustic (cranial nerve VIII) **C724** Cranial nerve NOS **C725** Facial (cranial nerve VII) C**725** Glossopharyngeal (cranial nerve IX) **C725** Hypoglossal (cranial nerve XII) **C725** Oculomotor (cranial nerve III) **C725** Olfactory (cranial nerve I) **C722** Optic (cranial nerve II) **C723** Trigeminal (cranial nerve V) **C725** Trochlear (cranial nerve IV) **C725** Vagus (cranial nerve X) **C725**
Ill-Defined Sites Central Nervous System	Nervous system NOS **C729** Overlapping lesion of brain and central nervous system **C728**
Intracranial Duct and Glands	Craniopharyngeal duct **C752** Pineal gland **C753** Pituitary gland **C751**
Meninges	Cerebral meninges **C700** Meninges NOS **C709** Spinal meninges **C701**

Site Group	Reportable Subsite Terms and Code
Peripheral Nerve and Autonomic Nervous System	Abdomen **C474** Autonomic nervous system NOS **C479** Head, face and neck **C470** Lower limb and hip **C472** Overlapping lesion of peripheral nerves and autonomic nervous system **C478** Thorax **C473** Pelvis **C475** Trunk NOS **C476** Upper limbs and shoulder **C471** Spinal Nerve NOS **C479**
Spinal Sites	Cauda equina/conus medullaris/filum terminale **C721** Meninges NOS **C709** Spinal cord **C720** Spinal meninges **C701**

Note: Behavior determines which set of CNS rules should be used: malignant or non-malignant.

Priority Order for Using Documentation to Assign Behavior

1. Pathology: Tissue from resection
    a. Use the pathologist's description of malignant/invasive behavior
    b. Cases are reportable as malignant when pathology states a WHO Grade 3 or 4
    c. WHO Grade 2 may be either non-malignant or malignant. Use the pathologist's description of behavior (priority #1).
    d. Never change behavior described by pathologist
2. Pathology: Tissue from biopsy
3. Cytology (usually cerebrospinal fluid)
4. Physician's documentation (no pathology report) in the following priority order:
    a. Tumor Board
    b. Documentation of original pathologic diagnosis and behavior
    c. Documentation of behavior, no mention of original diagnosis
5. Scan, use behavior information from radiography in the following priority order:
    a. MRI
    b. CT
    c. PET
    d. Angiogram
6. When instructions 1-5 do not apply, use Table 1 (page 7) to determine behavior.

Priorities for Coding Primary Site

- Always check the operative report(s) which will have information on whether the surgery or biopsy was intracranial (inside the cranium/skull) or intraspinal (within the dura/meninges covering the spinal cord).
- Code the specific primary site. Use an NOS site code only when a specific site is not known.

Use the list in hierarchical order:

1. Resection
    a. Operative report(s)
    b. Pathology report(s)
2. Biopsy
    a. Operative report(s)
    b. Pathology report(s)
3. Resection and/or biopsy performed, but operative report(s) and pathology are not available (minimal information)
    a. Tumor Board
    b. Code from physician's documentation of original diagnosis from operative or pathology report OR
    c. Physician's documentation of primary site in the medical record
4. For cases diagnosed by imaging (no pathology/resection or biopsy) use information from scans in the following priority order:
    a. MRI
    b. CT
    c. PET
    d. Angiogram
5. See page 14 of STR Table 2: Reportable Primary Sites to confirm the primary site is reportable.
6. When the primary site is cranial nerve OR peripheral nerve, see page 20 of STR Table 4: Coding Primary Site for Malignant Tumors of Cranial and Peripheral Nerves to determine whether the portion of the nerve is cranial or peripheral (different site codes).

Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with

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

- Cerebrospinal fluid; CSF
- Dura; meninges
- Extradural; not within the meninges; within the cranium; within the skull but not within the cerebral meninges
- Extramedullary; outside medulla oblongata C700
- Infratentorial; below the tentorium cerebelli; either cerebellum or brainstem
- Intracranial; within the skull, within the cranium
- Intradural; between layers of the cerebral meninges; C700
- Intradural-extramedullary; within the spinal canal but outside of the nerves
- Intraspinal; occurring within the spinal column especially the vertebral canal; spinal nerve roots
- Site; topography
- Supratentorial; above the tentorium cerebelli; cerebrum
    - Cerebrum contains frontal lobe, parietal lobe, occipital lobe, and temporal lobe
- Tentorium cerebelli; cerebellar tentorium
- Tumor; mass; lesion; neoplasm when
    - These terms are used ONLY to determine multiple primaries
    - Do not use these terms for casefinding or determining reportability
- Type; subtype; variant
- WHO Grade 3 and WHO Grade 4; malignant; invasive; /3

Terms that are Not Equivalent or Equal

This is a term that is **not equivalent**. There are no casefinding implications.

- Component is not equivalent to subtype/type/variant
- Component is only coded when the pathologist specifies the component as a second carcinoma.

Priority Order for Using Documentation to Identify Histology

- Code the histology diagnosed prior to neoadjuvant treatment.
- Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
- Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
- Code the histology using the following priority list and the Histology Rules. Do not change histology in order to make the case applicable to staging.

The priority list is used for single primaries (including multiple tumors abstracted as a single primary) This is a hierarchical list of source documentation.

1. Pathology/tissue from resection of primary tumor
    a. Biomarkers
        - Biomarkers are emerging as an important part of cancer diagnosis and treatment. Some biomarkers are used to determine treatment rather than histologic type. The efficacy of identification of histologic type using biomarkers differs from primary site to primary site. When a histologic type is identified using a biomarker, code the identified histology. Biomarkers do not identify all histologic types.
        - Biomarkers are not listed because they change rapidly.
    b. The addendum and/or comments
    c. Final diagnosis
    d. CAP protocol/summary
2. Pathology/tissue from biopsy of primary tumor
    a. Biomarkers
        - Biomarkers are emerging as an important part of cancer diagnosis and treatment. Some biomarkers are used to determine treatment rather than histologic type. The efficacy of identification of histologic type using biomarkers differs from primary site to primary site. When a histologic type is identified using a biomarker, code the identified histology. Biomarkers do not identify all histologic types.
        - Biomarkers are not listed because they change rapidly
    b. The addendum and/or comments
    c. Final diagnosis
    d. CAP protocol/summary
        - Addendums and comments are given the highest priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
        - The pathologist's diagnosis is always the most reliable, so the final diagnosis is the second priority.
        - Do not use the microscopic or gross section of the pathology report for coding.
        - The CAP protocol is a checklist which:
            - Provides guidelines for collecting the essential data elements for complete reporting of tumors and optimal patient care.
            - Allows physicians to check multiple histologies
3. Cytology (most frequently cerebrospinal fluid)

4. Tissue/pathology from a metastatic site
    - Code the behavior /3
    - The tissue from a metastatic site often shows variations from the primary tumor. When it is the only tissue available, it is more accurate than a scan.
5. Scan: The following list is in priority order.
    a. MRI
    b. CT
    c. PET
    d. Angiogram
6. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
    a. Treatment plan
    b. Documentation from Tumor Board
    c. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
    d. Physician's reference to type of cancer (histology) in the medical record

- Code the specific histology when documented.
- Code the histology to malignant neoplasm NOS 8000 or as stated by the physician when nothing more specific is documented

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

https://apps.naaccr.org/ssdi/schema/brain/2.0?breadcrumbs=(~schema_list~)

Primary Site	Histology	Behavior
C700, C710-C719	8000-8700, 8720-8790, 8802, 8810, 8815, 8850, 8890, 8900, 9064, 9070-9071, 9080, 9084-9085, 9100-9105, 9120, 9133, 9140, 9180, 9220, 9362, 9364, 9380-9540, 9680, 9699, 9700-9715, 9751-9759	Any Value
C700, C710-C719	8710-8714, 8800-8801, 8803-8806, 8811-8814, 8816-8818, 8820-8842, 8851-8881, 8891-8898, 8901-9063, 9065, 9072-9073, 9081-9083, 9086-9091, 9110, 9121-9132, 9135-9138, 9141-9175, 9181-9213, 9221-9361, 9363, 9365-9373, 9541-9582	0, 1
C700, C710-C719	9590-9679, 9687-9698, 9716-9742, 9749, 9761-9993	0, 1

Site-Specific Data Items (SSDI)/Grade

apps.naaccr.org/ssdi/schema/brain/2.0?breadcrumbs=(~schema_list~)

Name	Default Value	Used for Staging	NAACCR Item	Required By
Grade Clinical	9	No	NAACCR #3843	CCCR/Canada COC NPCR SEER
Grade Pathological	9	No	NAACCR #3844	
Brain Molecular Markers	88	No	NAACCR #3816	NPCR SEER

Grade ID 24-Clinical and Pathological Grade Instructions

Grade Coding Instructions and Tables

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00721	Brain	72	Brain and Spinal Cord
00722	CNS Other	72	Brain and Spinal Cord
00723	Intracranial Gland	72	Brain and Spinal Cord

Surgery Codes

Brain [and other parts of central nervous system] Meninges C700-C709, Brain C710–C719, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C720-C729

(Except for M9732, 9741-9742, 9761-9809, 9820, 9826, 9831-9834, 9840-9920, 9931-9993)

Surgery Codes for the Brain, Meninges, Spinal Cord, Cranial Nerves and Other Parts of the CNS:

seer.cancer.gov/manuals/2021/AppendixC/Surgery_Codes_Brain_2021.pdf

Additional Resources

- 2018 Solid Tumor Rules for Brain/CNS: seer.cancer.gov/tools/solidtumor/Malignant_CNS_STM.pdf
- SSDI Manual for coding Brain/CNS: naaccr.org/wp-content/uploads/2021/01/SSDI-Manual_v-2.0.pdf?v=1610725077

Non-Malignant Brain and Central Nervous System

seer.cancer.gov/manuals/2021/AppendixC/Coding_Guidelines_Brain_2021.pdf

Site codes

Site Group	Reportable Subsite Terms and Code
Brain	Brain NOS C719 Brain stem C717 Cerebellum NOS C716 Cerebrum C710 Frontal lobe C711 Occipital lobe C714 Overlapping lesion of brain and central nervous system C718 Parietal lobe C713 Temporal lobe C712 Ventricle NOS C715
Cranial Nerves	Abducent (cranial nerve VI) C725 Accessory (cranial nerve XI) C725 Acoustic (cranial nerve VIII) C724 Cranial nerve NOS C725 Facial (cranial nerve VII) C725 Glossopharyngeal (cranial nerve IX) C725 Hypoglossal (cranial nerve XII) C725 Oculomotor (cranial nerve III) C725 Olfactory (cranial nerve I C722) Optic (cranial nerve II) C723 Trigeminal (cranial nerve V) C725 Trochlear (cranial nerve IV) C725 Vagus (cranial nerve X) C725
Ill-Defined Sites Central Nervous System	Nervous system NOS C729 Overlapping lesion of brain and central nervous system C728
Intracranial Duct and Glands	Craniopharyngeal duct C752 Pineal gland C753 Pituitary gland C751
Meninges	Cerebral meninges C700 Meninges NOS C709 Spinal meninges C701
Spinal Sites	Cauda equina/conus medullaris/filum terminale C721 Meninges NOS C709 Spinal cord C720 Spinal meninges C701

Priority Order for Using Documentation to Assign Behavior

1. Pathology: Tissue from resection in the following priority order:
    a. Use the pathologist's description of behavior

        i. Never change behavior described by pathologist
    b. Cases are reportable as non-malignant when pathology states a WHO Grade 1
    c. WHO Grade 2 may be either non-malignant or malignant. Use the pathologist's description of behavior (priority #1a)
2. Pathology: Tissue from biopsy
3. Cytology (usually cerebrospinal fluid)
4. Physician's documentation (no pathology report) in the following priority order:
    a. Tumor Board
    b. Documentation of original diagnosis/tumor behavior
    c. Documentation of behavior, no mention of original diagnosis
5. Scans: Use behavior information from imaging in the following priority order:
    a. MRI
    b. CT
    c. PET
    d. Angiogram
6. When above instructions do not apply, use Table 1 (see page 7 of STR) to determine behavior.

Equivalent or Equal Terms

These terms can be used interchangeably:

- And; with

  Note: "And" and "with" are used as synonyms when describing multiple histologies within a single tumor.
- Atypical; uncertain behavior /1
- Cerebrospinal fluid; CSF
- Dermoid; dermoid cyst
- Dura; meninges
- Extradural; not within the meninges; within the cranium; within the skull but not within the cerebral meninges
- Extramedullary; outside medulla oblongata C700
- Intracranial; within the skull, within the cranium
- Intradural; between layers of the cerebral meninges; C700
- Intradural-extramedullary; within the spinal canal but outside of the nerves

- Intraspinal; occurring within the spinal column especially the vertebral canal
- Non-malignant is synonymous with:
    - /0 Benign
    - /1 Uncertain whether benign or malignant; borderline malignancy; low malignant potential; uncertain malignant potential
    - WHO Grade 1
- Site; topography
- Subarachnoid space; between the arachnoid mater and the pia mater of spinal meninges
- Type; subtype; variant
- Tumor; mass; tumor mass; lesion; neoplasm
    - The terms tumor, mass, tumor mass, lesion, and neoplasm are not used in a standard manner in clinical diagnoses, scans, or consults. Disregard the terms unless there is a physician's statement that the term is a non-malignant tumor/neoplasm
    - These terms are used only for determining multiple primaries
    - Do not use these terms for casefinding or determining reportability

Terms that are Not Equivalent or Equal

This is a term that is **not equivalent**. There are no casefinding implications.

- Phenotype is not equivalent to subtype/type/variant
- WHO Grade is not equivalent to tumor grade
- Component is not equivalent to subtype/variant

  Note: Component is only coded when the pathologist specifies the component as a second carcinoma

Priorities for Coding Primary Site

- Always check the operative report(s) which will have information on whether the surgery or biopsy was intracranial (inside the cranium/skull) or intraspinal (within the dura/meninges covering the spinal cord)
- Code the specific primary site. Use an NOS site code only when a specific site is not known.
- See Table 2: Reportable Primary Sites (2018 STR Non-Malignant CNS) to confirm the primary site is reportable
- When the primary site is cranial nerve OR cranial nerve meninges, see Table 3: Reportability of Non-Malignant Cranial Nerve (CN) Tumors to confirm the site of the tumor is intracranial (reportable) or extracranial (not reportable)

- See Table 4: Non-Reportable Neoplasms (2018 STR Non-malignant CNS) for site/histology combinations and histologies that are not reportable.
- When the primary site is brain or intracranial glands, see Table 5: Histologic Types of Non-Malignant Intracranial (Brain and Gland) Tumors (2018 STR Non-malignant CNS) to confirm site/histology combinations.

Use the list below in hierarchical order:

1. Resection
    a. Operative report(s)
    b. Pathology report(s)
2. Biopsy
    a. Operative report(s)
    b. Pathology report(s)
3. Resection and/or biopsy performed, but operative report(s) and pathology are not available (minimal information):
    a. Tumor Board
    b. Code from physician's documentation of original diagnosis from operative or pathology report OR
    c. Physician's documentation of primary site in the medical record
4. For cases diagnosed by imaging (no pathology/resection or biopsy) use information from scans in the following priority order:
    a. MRI
    b. CT
    c. PET
    d. Angiogram

Priority Order for Using Documentation to Identify Histology

- Code the histology diagnosed prior to neoadjuvant treatment.
- Histology changes do occur following immunotherapy, chemotherapy and radiation therapy.
- Neoadjuvant treatment is any tumor-related treatment given prior to surgical removal of the malignancy.
- Code the histology assigned by the physician. Do not change histology in order to make the case applicable to staging.

The priority list is used for single primaries (including multiple tumors abstracted as a single primary).

This is a hierarchical list of source documentation:

- Pathology/tissue from resection
    a. The addendum and/or comments
    b. Final diagnosis/synoptic report as required by CAP
    c. CAP protocol
    d. Biomarkers
        - Biomarkers do not identify all histologic types.
        - Biomarkers are not listed because they change rapidly.
- Pathology/tissue from biopsy
    a. The addendum and/or comments
    b. Final diagnosis/synoptic report are required by CAP
    c. CAP protocol
    d. Biomarkers
        - Biomarkers do not identify all histologic types.
        - Biomarkers are not listed because they change rapidly.
    - Addendums and comments are given the highest priority because they often contain information about molecular testing, genetic testing, and/or special stains which give a more specific diagnosis.
    - The pathologist's diagnosis is always the most reliable, so the final diagnosis is the second priority.
    - Do not use the microscopic or gross section of the pathology report for coding.
    - The CAP protocol is a checklist which:
        - Provides guidelines for collecting the essential data elements for complete reporting of tumors and optimal patient care.
        - Allows physicians to check multiple histologies
    - The CAP summary must be documented in one locate on. It is usually found in:
        - Pathology final diagnosi, or
        - An addendum to the path report
- Cytology (most frequently spinal fluid)
- Radiography: The following list is in priority order.
    a. MRI
    b. CT
    c. PET

d. Angiogram

- Clinical Diagnosis: Code the histology documented by the physician when none of the above are available. Priority for using documentation:
  a. Treatment plan
  b. Documentation from Tumor Board
  c. References to pathology diagnosis
  d. Physician's reference to type of cancer (histology) in the medical record
  - Code the specific histology when documented.

Site-Specific Data Items (SSDI) and Clinical Grade and Pathological Grade

apps.naaccr.org/ssdi/schema/brain/2.0?breadcrumbs=(~schema_list~)

Primary Site	Histology	Behavior
C700, C710-C719	8000-8700, 8720-8790, 8802, 8810, 8815, 8850, 8890, 8900, 9064, 9070-9071, 9080, 9084-9085, 9100-9105, 9120, 9133, 9140, 9180, 9220, 9362, 9364, 9380-9540, 9680, 9699, 9700-9714, 9751-9759	***<Any value>***
C700, C710-C719	8710-8714, 8800-8801, 8803-8806, 8811-8814, 8820-8842, 8851-8881, 8891-8898, 8901-9063, 9065, 9072-9073, 9081-9083, 9086-9091, 9110, 9121-9132, 9135-9137, 9141-9175, 9181-9210, 9221-9361, 9363, 9365-9373, 9541-9582	0, 1
C700, C710-C719	9590-9679, 9687-9698, 9716-9742, 9761-9993	0, 1

Name	Default Value	Used for Staging	NAACCR Item	Required By
Grade Clinical	9	No	NAACCR #3843	CCCR/Canada COC NPCR SEER
Grade Pathological	9	No	NAACCR #3844	
Brain Molecular Markers	88	No	NAACCR #3816	NPCR SEER

Grade ID 24-Clinical and Pathological Grade Instructions

naaccr.org/wp-content/uploads/2021/01/Grade-Manual_v-2.01.pdf?v=1610721103

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00721	Brain	72	Brain and Spinal Cord

Schema ID#	Schema ID Name	AJCC ID	AJCC Chapter
00722	CNS Other	72	Brain and Spinal Cord
00723	Intracranial Gland	72	Brain and Spinal Cord

Surgery Codes

Brain [and other parts of central nervous system] Meninges C700-C709, Brain C710–C719, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C720-C729

(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9993)

Brain, CNS, Meninges, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System:

seer.cancer.gov/manuals/2021/AppendixC/Surgery_Codes_Brain_2021.pdf

Additional Resources

- 2018 Solid Tumor Rules for Non-Malignant Brain/CNS: seer.cancer.gov/tools/solidtumor/Non_Malignant_CNS_STM.pdf
- SSDI Manual for coding Brain/CNS: naaccr.org/wp-content/uploads/2021/01/SSDI-Manual_v-2.0.pdf?v=1610725077

B

APPENDIX B:
REPORTING LAW AND RULES

THE LAW

HEALTH AND SAFETY Code

TITLE 2. HEALTH

SUBTITLE D. PREVENTION, CONTROL, AND REPORTS OF DISEASES

CHAPTER 82. CANCER REGISTRY

Sec. 82.001. SHORT TITLE. This chapter may be cited as the Texas Cancer Incidence Reporting Act.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 33, eff. Sept. 1, 1991.

Sec. 82.002. DEFINITIONS. In this chapter:

(1) "Cancer" includes:

(A) a large group of diseases characterized by uncontrolled growth and spread of abnormal cells;

(B) any condition of tumors having the properties of anaplasia, invasion, and metastasis;

(C) a cellular tumor the natural course of which is fatal, including malignant and benign tumors of the central nervous system; and

(D) malignant neoplasm, other than nonmelanoma skin cancers such as basal and squamous cell carcinomas.

(2) "Clinical laboratory" means an accredited facility in which:

(A) tests are performed identifying findings of anatomical changes; and

(B) specimens are interpreted, and pathological diagnoses are made.

(3) "Health care facility " means:

(A) a general or special hospital as defined by Chapter 241 (Texas Hospital Licensing Law);

(B) an ambulatory surgical center licensed under Chapter 243;

(C) an institution licensed under Chapter 242; or

(D) any other facility, including an outpatient clinic, that provides diagnosis or treatment services to patients with cancer.

(4) "Health care practitioner" means:

(A) a physician as defined by Section 151.002, Occupations Code; or

(B) a person who practices dentistry as described by Section 251.003, Occupations Code.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 1, eff. Sept. 1, 2001.

Sec. 82.003. APPLICABILITY OF CHAPTER. This chapter applies to records of cases of cancer, diagnosed on or after January 1, 1979, and to records of all ongoing cancer cases diagnosed before January 1, 1979.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 2, eff. Sept. 1, 2001.

Sec. 82.004. REGISTRY REQUIRED. The department shall maintain a cancer registry for the state.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0252, eff. April 2, 2015.

Sec. 82.005. CONTENT OF REGISTRY. (a) The cancer registry must be a central data bank of accurate, precise, and current information that medical authorities agree serves as an invaluable tool in the early recognition, prevention, cure, and control of cancer.

(b) The cancer registry must include:

(1) a record of the cases of cancer that occur in the state; and

(2) information concerning cancer cases as the executive commissioner considers necessary and appropriate for the recognition, prevention, cure, or control of cancer.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 3, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0253, eff. April 2, 2015.

Sec. 82.006. EXECUTIVE COMMISSIONER AND DEPARTMENT POWERS. (a) To implement this chapter, the executive commissioner may adopt rules that the executive commissioner considers necessary.

(b) To implement this chapter, the department may:

(1) execute contracts considered necessary;

(2) receive the data from medical records of cases of cancer that are in the custody or under the control of clinical laboratories, health care facilities, and health care practitioners to record and analyze the data directly related to those diseases;

(3) compile and publish statistical and other studies derived from the patient data obtained under this chapter to provide, in an accessible form, information that is useful to physicians, other medical personnel, and the general public;

(4) comply with requirements as necessary to obtain federal funds in the maximum amounts and most advantageous proportions possible;

(5) receive and use gifts made for the purpose of this chapter; and

(6) limit cancer reporting activities under this chapter to specified geographic areas of the state to ensure optimal use of funds available for obtaining the data.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 4, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0254, eff. April 2, 2015.

Sec. 82.007. REPORTS. (a) The department shall publish an annual report to the legislature of the information obtained under this chapter.

(b) The department, in cooperation with other cancer reporting organizations and research institutions, may publish reports the department determines are necessary or desirable to carry out the purpose of this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 34, eff. Sept. 1, 1991.

Sec. 82.008. DATA FROM MEDICAL RECORDS. (a) To ensure an accurate and continuing source of data concerning cancer, each health care facility, clinical laboratory, and health care practitioner shall furnish to the department, on request, data the executive commissioner considers necessary and appropriate that is derived from each medical record pertaining to a case of cancer that is in the custody or under the control of the health care facility, clinical laboratory, or health care practitioner. The department may not request data that is more than three years old unless the department is investigating a possible cancer cluster. At the request and with the authorization of the applicable health care facility, clinical laboratory, or health care practitioner, data may be furnished to the department through a health information exchange as defined by Section 182.151.

(b) A health care facility, clinical laboratory, or health care practitioner shall furnish the data requested under Subsection (a) in a reasonable format prescribed by department rule and within six months of the patient's admission, diagnosis, or treatment for cancer unless a different period is prescribed by the United States Department of Health and Human Services.

(c) The data required to be furnished under this section must include patient identification and diagnosis.

(d) The department may access medical records that would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified patient from the following sources:

(1) a health care facility or clinical laboratory providing screening, diagnostic, or therapeutic services to a patient with respect to cancer; or

(2) a health care practitioner diagnosing or providing treatment to a patient with cancer, except as described by Subsection (g).

(e) The executive commissioner shall adopt procedures that ensure adequate notice is given to the health care facility, clinical laboratory, or health care practitioner before the department accesses data under Subsection (d).

(f) A health care facility, clinical laboratory, or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for the costs of accessing and reporting the data. The costs reimbursed under this subsection must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of data under Subsection (d), and may include salary and travel expenses. The department may assess a late fee on an account that is 60 days or more overdue. The late fee may not exceed one and one-half percent of the total amount due on the late account for each month or portion of a month the account is not paid in full. A health care facility, clinical laboratory, or health care practitioner may request that the department conduct a hearing to determine whether reimbursement to the department under this subsection is appropriate.

(g) The department may not require a health care practitioner to furnish data or provide access to records if:

(1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and

(2) the facility reported the same data the practitioner would be required to report.

(h) The data required to be furnished under this section may be shared with cancer registries of health care facilities subject to the confidentiality provisions in Section 82.009.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 35, eff. Sept. 1, 1991; Acts 1997, 75th Leg., ch. 343, Sec. 1, eff. May 27, 1997; Acts 1999, 76th Leg., ch. 1411, Sec. 23.01, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 589, Sec. 5, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0255, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1085 (H.B. 2641), Sec. 5, eff. September 1, 2015.

Sec. 82.009. CONFIDENTIALITY. (a) Reports, records, and information obtained under this chapter are confidential and are not subject to disclosure under Chapter 552, Government Code, are not subject to subpoena, and may not otherwise be released or made public except as provided by this section or Section 82.008(h). The reports, records, and information obtained under this chapter are for

the confidential use of the department and the persons or public or private entities that the department determines are necessary to carry out the intent of this chapter.

(b) Medical or epidemiological information may be released:

(1) for statistical purposes in a manner that prevents identification of individuals, health care facilities, clinical laboratories, or health care practitioners;

(2) with the consent of each person identified in the information; or

(3) to promote cancer research, including release of information to other cancer registries and appropriate state and federal agencies, under rules adopted by the executive commissioner to ensure confidentiality as required by state and federal laws.

(c) A state employee may not testify in a civil, criminal, special, or other proceeding as to the existence or contents of records, reports, or information concerning an individual whose medical records have been used in submitting data required under this chapter unless the individual consents in advance.

(d) Data furnished to a cancer registry or a cancer researcher under Subsection (b) or Section 82.008(h) is for the confidential use of the cancer registry or the cancer researcher, as applicable, and is subject to Subsection (a).

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(90), eff. Sept. 1, 1995; Acts 1997, 75th Leg., ch. 343, Sec. 2, eff. May 27, 1997; Acts 1999, 76th Leg., ch. 1411, Sec. 23.02, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 589, Sec. 6, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0256, eff. April 2, 2015.

Sec. 82.010. IMMUNITY FROM LIABILITY. The following persons subject to this chapter that act in compliance with this chapter are not civilly or criminally liable for furnishing the information required under this chapter:

(1) a health care facility or clinical laboratory;

(2) an administrator, officer, or employee of a health care facility or clinical laboratory;

(3) a health care practitioner or employee of a health care practitioner; and

(4) an employee of the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 7, eff. Sept. 1, 2001.

Sec. 82.011. EXAMINATION AND SUPERVISION NOT REQUIRED. This chapter does not require an individual to submit to any medical examination or supervision or to examination or supervision by the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0257, eff. April 2, 2015.

THE RULES

Texas Administrative Code

Title 25. Health Services

Part 1. Department of State Health Services

Chapter 91. Cancer

Subchapter A. Cancer Registry

Effective Date: April 2, 2017

§91.1. Purpose.

This subchapter implements the Texas Cancer Incidence Reporting Act, Health and Safety Code, Chapter 82. This legislation concerns the reporting of cases of cancer for the recognition, prevention, cure or control of those diseases, and to facilitate participation in the national program of cancer registries established by 42 United States Code, §§280e - 280e-4. Nothing in this subchapter shall preempt the authority of facilities or individuals providing diagnostic or treatment services to patients with cancer to maintain their own cancer registries.

§91.2. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--The Texas Cancer Incidence Reporting Act, Texas Health and Safety Code, Chapter 82.

(2) Cancer--Includes a large group of diseases characterized by uncontrolled growth and spread of abnormal cells; any condition of tumors having the properties of anaplasia, invasion, and metastasis; a cellular tumor the natural course of which is fatal, including intracranial and central nervous system malignant, borderline, and benign tumors as required by the national program of cancer registries; and malignant neoplasm, other than non-melanoma skin cancers such as basal and squamous cell carcinomas.

(3) Cancer Reporting Handbook--The Texas Cancer Registry's manual for reporting entities that documents reporting procedures and format.

(4) Clinical laboratory--An accredited facility in which tests are performed identifying findings of anatomical changes; specimens are interpreted, and pathological diagnoses are made.

(5) Confidential cancer data--Information that includes items that may identify an individual, and is subject to Health and Safety Code, §82.009.

(6) Department--Department of State Health Services.

(7) Health care facility--A general or special hospital as defined by the Health and Safety Code, Chapter 241; an ambulatory surgical center licensed under the Health and Safety Code, Chapter 243; an institution licensed under the Health and Safety Code, Chapter 242; or any other facility, including an outpatient clinic, that provides diagnostic or treatment services to patients with cancer.

(8) Health care practitioner--A physician as defined by Occupations Code, §151.002 or a person who practices dentistry as described by the Occupations Code, §251.003.

(9) Quality assurance--Operational procedures by which the accuracy, completeness, and timeliness of the information reported to the department can be determined and verified.

(10) Report--Information provided to the department that notifies the appropriate authority of the occupancy of a specific cancer in a person, including all information required to be provided to the department.

(11) Reporting Entity--A reporting entity may include a health care facility, clinical laboratory, health care practitioner, or a health information exchange as defined by Health and Safety Code, §182.151.

(12) Research--A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

(13) Statistical cancer data--Aggregate presentation of individual records on cancer cases excluding patient identifying information.

(14) Texas Cancer Registry--The cancer incidence reporting system administered by the Department of State Health Services.

§91.3. Who Reports and Access to Records.

(a) Each health care facility, clinical laboratory or health care practitioner shall report to the department, by methods specified in §§91.4 - 91.7 of this title (relating to Cancer Registry), required data from each medical record pertaining to a case of cancer in its custody or under its control except for cases to which subsection (d) of this section would apply.

(b) A health care facility or clinical laboratory providing screening, diagnostic or therapeutic services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient.

(c) A health care practitioner providing diagnostic or treatment services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient except for cases to which subsection (d) of this section would apply.

(d) The department may not require a health care practitioner to furnish data or provide access to records if:

(1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and

(2) the facility reported the same data the practitioner would be required to report.

(e) Health care facilities, clinical laboratories, and health care practitioners are subject to federal law known as the Health Insurance Portability and Accountability Act of 1996 found at Title 42 United States Code §1320d et seq.; the federal privacy rules adopted in Title 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164; and applicable state medical records privacy laws. Because state law requires reporting of cancer data, persons subject to this chapter are permitted to provide the data to the department without patient consent or authorization under 45 C.F.R. §164.512(a) relating to uses and disclosures required by law and §164.512(b)(1) relating to disclosures for public health activities. Both of these exceptions to patient consent or authorization are recognized in the state law.

§91.4. What to Report.

(a) Reportable conditions.

(1) The cases of cancer to be reported to the Texas Cancer Registry are as follows:

(A) all neoplasms with a behavior code of two or three in the most current edition of the International Classification on Diseases for Oncology (ICD-O) of the World Health Organization with the exception of those designated by the Texas Cancer Registry as non-reportable in the Cancer Reporting Handbook; and

(B) all benign and borderline intracranial and central nervous system neoplasms as required by the national program of cancer registries.

(2) Codes and taxa of the most current edition of the International Classification of Diseases, Clinical Modification of the World Health Organization which correspond to the Texas Cancer Registry's reportable list are specified in the Cancer Reporting Handbook.

(b) Reportable information.

(1) Except as provided in paragraph (2) of this subsection and health care practitioners in §91.5(c) of this title (relating to When to Report), those data required to be reported for each cancer case shall include:

(A) name, address, zip code, and county of residence;

(B) social security number, date of birth, gender, race and ethnicity, marital status, birthplace, and primary payer at time of diagnosis, to the extent such information is available from the medical record;

(C) information on industrial and occupational history, smoking status, height and weight to the extent such information is available from the medical record;

(D) diagnostic information including the cancer site and laterality, cell type, tumor behavior, markers, grade and size, stage of disease, date of diagnosis, diagnostic confirmation method, sequence number, and other primary tumors;

(E) first course of cancer-related treatment, including dates and types of procedures;

(F) text information to support cancer diagnosis, stage and treatment codes;

(G) health care facility or practitioner related information including reporting institution number, casefinding source, type of reporting source, medical record number, registry number, tumor record number, class of case, date of first contact, date of last contact, vital status, facility referred from, facility referred to, managing physician, follow-up physician, date abstracted, abstractor, and electronic record version; and

(H) clinical laboratory related information including laboratory name and address, pathology case number, pathology report date, pathologist, and referring physician name and address.

(2) The department or its authorized representative may exempt a reporting entity from providing specific reportable data items delineated in paragraph (1) of this subsection to the extent that those data to be exempted are not collected by the reporting entity.

(3) Except as provided in §91.6(b) of this title (relating to How to Report), each report shall:

(A) be electronically readable and contain all data items required in paragraph (1) of this subsection;

(B) be fully coded and in a format prescribed by the Texas Cancer Registry;

(C) meet all quality assurance standards utilized by the Texas Cancer Registry;

(D) in the case of individuals who have more than one form of cancer, be submitted separately for each primary cancer diagnosed;

(E) be submitted to the Texas Cancer Registry electronically; and

(F) be transmitted by secure means at all times to protect the confidentiality of the data.

§91.5. When to Report.

(a) All reports shall be submitted to the department within six months of the patient's admission, initial diagnosis, or treatment for cancer.

(b) Data shall be submitted no less than quarterly by health care facilities with annual caseloads of 400 or less. Monthly submissions are required for all other health care facilities.

(c) Data shall be submitted no less than quarterly by health care practitioners initially diagnosing a patient with cancer and performing the in-house pathological tests for that patient. Otherwise, data shall be submitted within 2 months of the request to a health care practitioner by the department or its authorized representative for a report or subset of a report on a patient diagnosed or treated elsewhere and for whom the same cancer data has not been reported.

(d) Data shall be submitted no less than quarterly by clinical laboratories.

§91.6. How to Report.

(a) Reports of cancer from health care facilities, clinical laboratories and health care practitioners shall be submitted to the Texas Cancer Registry electronically using a secure electronic process as defined by the department. At the request and with the authorization of the applicable health care facility, clinical laboratory, or health care practitioner, data may be furnished to the Texas Cancer Registry through a health information exchange.

(b) The Texas Cancer Registry may accept the submission of paper copies of medical records from a health care facility, pathology reports from a clinical laboratory and reports or subsets of reports from a health care practitioner under the following conditions.

(1) The department, or its authorized representative, shall determine that such paper submissions are more expedient than electronic reporting.

(2) The acceptance of paper submissions from a health care facility, clinical laboratory or health care practitioner shall be approved by the department or its authorized representative.

(3) The department, or its authorized representative, may approve acceptance of paper submissions from defined groups or types of health care facilities, clinical laboratories or health care practitioners.

(4) All records and reports provided to the Texas Cancer Registry pursuant to this subsection must be transmitted by secure means at all times to protect the confidentiality of the data.

§91.7. Where to Report.

Data reports should be submitted to the Texas Cancer Registry as specified in the Cancer Reporting Handbook.

§91.8. Compliance.

(a) Each health care facility, clinical laboratory, or health care practitioner that reports to the department, by methods specified in §§91.4 - 91.7 of this title (relating to Cancer Registry), is considered compliant.

(b) A person will be notified in writing if the person has not reported in compliance with this chapter within 30 days following the end of the required monthly or quarterly reporting timeframe and will be given an opportunity to take corrective action within 60 days from the date of the notification letter. A second notification letter will be sent 30 days after the date of the original notification letter if no corrective action has been taken.

(c) If a person is non-compliant and takes no corrective action within 60 days of the original notification letter, the department or its authorized representative may access the information from the health care facility, clinical laboratory or health care practitioner as provided in §91.3 of this title (relating to Who Reports, Access to Records) and report it in the appropriate format.

(1) The health care facility, clinical laboratory or health care practitioner shall be notified at least two weeks in advance before a scheduled arrival for collection of the information.

(2) A health care facility, clinical laboratory or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for its cost to access and report the information. The costs must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of the data and may include salary and travel expenses. It is presumed that a health care facility, clinical laboratory or health care practitioner acted knowingly or in bad faith if it failed to take corrective action within 60 days of the date of the original notification letter.

(3) A health care facility, clinical laboratory or health care practitioner may request the department to conduct a hearing under the department's fair hearing rules to determine whether reimbursement to the department is appropriate.

(d) Any health care facility, clinical laboratory or health care practitioner which is required to reimburse the department or its authorized representative for the cost to access and report the information pursuant to subsection (c)(2) of this section shall provide payment to the department or its authorized representative within 60 days of the day this payment is demanded. In the event any health care facility, clinical laboratory or health care practitioner fails to make payment to the department or its authorized representative within 60 days of the day the payment is demanded, the department or its authorized representative may, at its discretion, assess a late fee not to exceed 1-1/2 % per month of the outstanding balance.

§91.9. Confidentiality and Disclosure.

(a) Pursuant to the Act, Chapter 82, §82.009, all data obtained is for the confidential use of the department and the persons or entities, public or private, that the department determines are necessary to carry out the intent of the Act.

(b) Limited release of the data is allowed by the Act, §82.008(h) and §82.009(b).

(c) Any requests for confidential or statistical cancer data shall be made in accordance with §91.11 or §91.12 of this title (relating to Cancer Registry).

(d) The Texas Cancer Registry is subject to state law that requires compliance with portions of the federal law and regulations cited in §91.3(e) of this title (relating to Who Reports, Access to Records). The department is authorized to use and disclose, for purposes described in the Act, cancer data without patient consent or authorization under 45 C.F.R §164.512(a) relating to uses and disclosures required by law, §164.512(b)(1) and (2) relating to uses and disclosures for public health activities, and §164.512(i) relating to uses and disclosures for research purposes.

§91.10. Quality Assurance.

The department shall cooperate and consult with persons required to comply with this chapter so that such persons may provide timely, complete, and accurate data. The department will provide:

(1) reporting training, technical assistance, on-site case-finding studies, and reabstracting studies;

(2) quality assessment reports to ascertain that the computerized data utilized for statistical information and data compilation is accurate; and

(3) educational information on cancer morbidity and mortality statistics available from the Texas Cancer Registry and the department.

§91.11. Requests for Statistical Cancer Data.

(a) Statistical cancer data previously analyzed are available upon written or oral request to the Texas Cancer Registry. All other requests for statistical cancer data shall be in writing and directed to: Texas Cancer Registry, Mail Code 1928, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347 or CancerData@dshs.state.tx.us.

(b) To ensure that the proper data are provided, the request shall include, but not be limited to, the following information:

(1) name, address, and telephone number of the person requesting the information;

(2) type of data needed and for what years (e.g. lung cancer incidence rates, Brewster County, 1998 - 2002); and

(3) name and address of person(s) to whom data and billings are to be submitted (if applicable).

§91.12. Requests and Release of Confidential Cancer Data.

(a) Data requests for research.

(1) Requests for confidential cancer data shall be in writing and directed to: Texas Cancer Registry, Mail Code 1928, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347 or CancerData@dshs.state.tx.us.

(2) Written requests for confidential cancer data shall meet the submission requirements of the department's Institutional Review Board (IRB) before release.

(3) The Texas Cancer Registry may release confidential cancer data to state, federal, local, and other public agencies and organizations if approved by the IRB.

(4) The Texas Cancer Registry may release confidential cancer data to private agencies, organizations, and associations if approved by the IRB.

(5) The Texas Cancer Registry may release confidential cancer data to any other individual or entities for reasons deemed necessary by the department to carry out the intent of the Act if approved by the IRB.

(b) Data requests for non-research purposes.

(1) The Texas Cancer Registry may provide reports containing confidential cancer data back to the respective reporting entity from records previously submitted to the Texas Cancer Registry from each respective reporting entity for the purposes of case management and administrative studies. These reports will not be released to any other entity.

(2) The Texas Cancer Registry may release confidential cancer data to other areas of the department, provided that the disclosure is required or authorized by law. All communications of this nature shall be clearly labeled "Confidential" and will follow established departmental internal protocols and procedures.

(3) The Texas Cancer Registry may release confidential cancer data to state, federal, local, and other public agencies and organizations in accordance with subsection (a) of this section.

(4) The Texas Cancer Registry may release confidential cancer data to any other individual or entities for reasons deemed necessary to carry out the intent of the Act and in accordance with subsection (a) of this section.

(5) An individual who submits a valid authorization for release of an individual cancer record shall have access to review or obtain copies of the information described in the authorization for release.

- Texas Cancer Incidence Reporting Act and Reporting Rules also available on the web at dshs.texas.gov/tcr/lawrules.aspx.
- The Texas Cancer Registry Rule can be found at the Texas Administrative Code webpage texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=91&rl=4.

C

APPENDIX C:
FIPS COUNTY CODES

Texas County	FIPS Code
Anderson	001
Andrews	003
Angelina	005
Aransas	007
Archer	009
Armstrong	011
Atascosa	013
Austin	015
Bailey	017
Bandera	019
Bastrop	021
Baylor	023
Bee	025
Bell	027
Bexar	029
Blanco	031
Borden	033
Bosque	035
Bowie	037
Brazoria	039
Brazos	041
Brewster	043
Briscoe	045
Brooks	047
Brown	049
Burleson	051
Burnet	053
Caldwell	055
Calhoun	057
Callahan	059
Cameron	061
Camp	063
Carson	065

Texas County	FIPS Code
Cass	067
Castro	069
Chambers	071
Cherokee	073
Childress	075
Clay	077
Cochran	079
Coke	081
Coleman	083
Collin	085
Collingsworth	087
Colorado	089
Comal	091
Comanche	093
Concho	095
Cooke	097
Coryell	099
Cottle	101
Crane	103
Crockett	105
Crosby	107
Culberson	109
Dallam	111
Dallas	113
Dawson	115
Deaf Smith	117
Delta	119
Denton	121
DeWitt	123
Dickens	125
Dimmit	127
Donley	129
Duval	131

Texas County	FIPS Code
Eastland	133
Ector	135
Edwards	137
Ellis	139
El Paso	141
Erath	143
Falls	145
Fannin	147
Fayette	149
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Gaines	165
Galveston	167
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Gregg	183
Grimes	185
Guadalupe	187
Hale	189
Hall	191
Hamilton	193
Hansford	195
Hardeman	197

Texas County	FIPS Code
Hardin	199
Harris	201
Harrison	203
Hartley	205
Haskell	207
Hays	209
Hemphill	211
Henderson	213
Hidalgo	215
Hill	217
Hockley	219
Hood	221
Hopkins	223
Houston	225
Howard	227
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Hunt	231
Hutchinson	233
Irion	235
Jack	237
Jackson	239
Jasper	241
Jeff Davis	243
Jefferson	245
Jim Hogg	247
Jim Wells	249
Johnson	251
Jones	253
Karnes	255
Kaufman	257
Kendall	259
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Texas County	FIPS Code
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Kimble	267
King	269
Kinney	271
Kleberg	273
Knox	275
Lamar	277
Lamb	279
Lampasas	281
La Salle	283
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Lee	287
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Lipscomb	295
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Madison	313
Marion	315
Martin	317
Mason	319
Matagorda	321
Maverick	323
Medina	325
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Texas County	FIPS Code
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Mills	333
Mitchell	335
Montague	337
Montgomery	339
Moore	341
Morris	343
Motley	345
Nacogdoches	347
Navarro	349
Newton	351
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Potter	375
Presidio	377
Rains	379
Randall	381
Reagan	383
Real	385
Red River	387
Reeves	389
Refugio	391
Roberts	393
Robertson	395

Texas County	FIPS Code
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Runnels	399
Rusk	401
Sabine	403
San Augustine	405
San Jacinto	407
San Patricio	409
San Saba	411
Schleicher	413
Scurry	415
Shackelford	417
Shelby	419
Sherman	421
Smith	423
Somervell	425
Starr	427
Stephens	429
Sterling	431
Stonewall	433
Sutton	435

Texas County	FIPS Code
Swisher	437
Tarrant	439
Taylor	441
Terrell	443
Terry	445
Throckmorton	447
Titus	449
Tom Green	451
Travis	453
Trinity	455
Tyler	457
Upshur	459
Upton	461
Uvalde	463
Val Verde	465
Van Zandt	467
Victoria	469
Walker	471
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Texas County	FIPS Code
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Webb	479
Wharton	481
Wheeler	483
Wichita	485
Wilbarger	487
Willacy	489
Williamson	491
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D

APPENDIX D: CONFIDENTIAL CANCER REPORTING FORM

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Reporting Source *		64
Date of Admit/First Contact *		67
Registry Number *		68
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Class of Case		69
PATIENT INFORMATION/DEMOGRAPHICS		
Patient Last Name		74
Patient First Name		74
Patient Middle Name		75
Birth Surname		75
Name-Alias		76
Patient Street Address *		77
Addr at DX-Supplemental		79

Patient City		80
Patient State		80
Patient Zip Code		83
FIPS County Code at DX		84
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Patient SSN		85
Patient Date of Birth *		86
BPState		87
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Patient Sex		96
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Diagnostic Confirmation		142
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Summary Stage Documentation – PE		150
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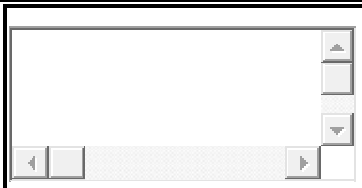		
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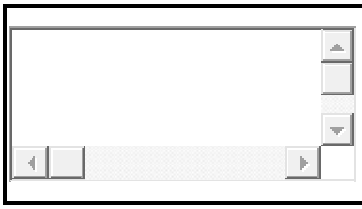		
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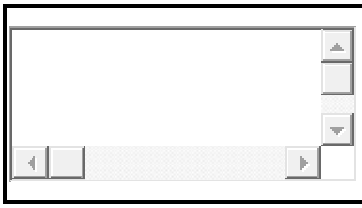
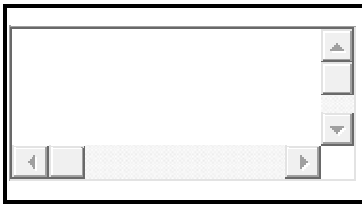
		
Summary Stage Documentation – OP		152
		
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AJCCTNMClinN		
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AJCCTNMPathT		
AJCCTNMPathN		
AJCCTNMPathM		
AJCCTNMPathStgGrp		
AJCCID		
SchemaID		
SchemaDisc1		
SchemaDisc 2		
SSDI		
BrainMolMarkers		
BreslowThickness		
LDHLabValue		
ERSummay		
PRSummary		
HER2OverallSumm		

FibrosisScore		
PSAValue		
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Grade of Tumor		
CS Site-Specific Factor 1		
CS Site-Specific Factor 2		
CS Site-Specific Factor 3		
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CS Site-Specific Factor 25		
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DerivedSS2000		Derived
SEER Sum Stage 1977		

SEER Sum Stage 2000		
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AJCCNClin		
AJCCMClin		
TNMClinDesc		
AJCCClinGrp		
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Chemo Date Started Flag		208
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Hormone Date Started		215
Hormone Date Started Flag		216
RX Summ-Hormone *		217
RX Text-Hormone		220
Immunotherapy Date Started		221
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E

APPENDIX E: COMMON ACCEPTABLE ABBREVIATIONS

Common Acceptable Abbreviations

(In order of Abbreviation)

In writing this text, registrars rely on abbreviations, especially in response to time and record space constraints. Abbreviations can generate confusion, however, as they may vary among different institutions and different specialties. Because abbreviations should be understood by any reader, only those that are clear and precise should be used. The NAACCR Recommended Abbreviations Lists, below, were compiled for cancer abstractors and the agencies to which they submit their data.

datadictionary.naaccr.org/default.aspx?c=17&Version=21

When abbreviating words in an address, refer to the Address Abbreviations section of the National Zip Code and Post Office Directory, published by the U.S. Postal Service. For short names of antineoplastic drugs, consult SEER*RX Interactive Antineoplastic Drugs Database: seer.cancer.gov/seertools/seerrx/.

Abbreviation/Symbol	Term
^	Above or elevated
&	And
≈	Approximately
@	At
=	Equals
>	Greater than, more, or more than
<	Less or less than
-	Negative or minus
#	Number or pound(s)
+	Plus or positive
X	Times
A FIB	Atrial fibrillation
A FLUTTER	Atrial flutter
A&P	Auscultation & percussion
A/P	Abdomen/Pelvis
AA	African American
AB	Antibody
ABD	Abdomen (abdominal)
ABG	Arterial blood gases
ABN	Abnormal
ABNL	Abnormal
ABS	Absent/Absence

Abbreviation/Symbol	Term
ABST	Abstract/Abstracted
ABX	Antibiotics
AC	Adrenal cortex
ACBE	Air contrast barium enema
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
A-COLON	Ascending Colon
ACTH	Adrenocorticotrophic hormone
ADENOCA	Adenocarcinoma
ADENOP	Adenopathy
ADH	Antidiuretic hormone
ADJ	Adjacent
ADL	Activities of daily living
ADM	Admission/Admit
ADR	Adverse drug reaction
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Antigen
AGL	Acute granulocytic leukemia
AI	Aromatase inhibitor
AI	Atrial stenosis/insufficiency/incompetence
AIDS	Acquired Immune Deficiency Syndrome
AIHA	Autoimmune hemolytic anemia
AIN III or AIN 3	Anal intraepithelial neoplasia, grade III
AK(A)	Above knee (amputation)
AKA	Also known as
ALB	Albumin
ALK PHOS	Alkaline phosphatase
ALL	Acute lymphocytic leukemia
ALND	Axillary Lymph node dissection
ALS	Amyotrophic lateral sclerosis
AM	Before noon
AMA	Against medical advice
AMB	Ambulatory
AMI	Acute myocardial infarction

Abbreviation/Symbol	Term
AML	Acute myelogenous leukemia
AMP	Amputation
AMT	Amount
ANAP	Anaplastic
ANGIO	Angiography/Angiogram
ANS	Autonomic nervous system
ANT	Anterior
AODM	Adult-onset Diabetes Mellitus
AP	Abdominal perineal
A-P	Anteroposterior
APC	Atrial premature complexes
APP	Appendix
APPL'Y	Apparently
ARC	AIDS-related condition (complex)
ARD	AIDS-related disease
ARDS	Acute Respiratory Distress (Disease) Syndrome
ARF	Acute renal failure
ARRHY	Arrhythmia
ART	Artery (ial)
AS	Arteriosclerosis/Arteriosclerotic
ASA	Aspirin, Acetylsalicylic acid
ASAP	As soon as possible
ASCVD	Arteriosclerotic cardiovascular disease
ASHD	Arteriosclerotic heart disease
ASP	Aspiration
ASPVD	Arteriosclerotic Peripheral Vascular Disease
ASSOC	Associated
A-STEN	Aortic stenosis
ATN	Acute tubular necrosis
ATP	Adenosine triphosphate
ATR	Achilles tendon reflex
AUT	Autopsy
AV	Arteriovenous
AVG	Average
AVM	Arteriovenous malformation

Abbreviation/Symbol	Term
AX	Axilla(ry)
AXLND	Axillary Lymph node dissection
B/F	Black female
B/L	Bilateral
B/M	Black male
BA	Barium
BAD	Bipolar affective disorder
BCC	Basal cell carcinoma
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema
BF	Black female
BID	Twice a day (daily)
BIL	Bilateral
BK(A)	Below knee (amputation)
B/L	Bilateral
BM	Black Male
BM	Bone marrow
BM	Bowel movement
BMBX	Bone marrow biopsy
BMI	Body mass index
BMT	Bone marrow transplant
BOT	Base of tongue
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BR	Bloom-Richardson
BRACHY	Brachytherapy
BRBPR	Bright red blood per rectum
BRCA 1 and BRCA 2	Breast cancer susceptibility gene
BRM	Biological response modifier
BRO	Brother
BSA	Body surface area
BSC	Bone scan
BSO	Bilateral salpingo-oophorectomy
BT	Bladder tumor or Brain tumor

Abbreviation/Symbol	Term
BUN	Blood urea nitrogen
BUS	Bartholin's, Urethral & Skene's
BV	Blood volume
BX	Biopsy
C/A/P	Chest, abdomen, pelvis
C/O	Complaint (-ning) of
C/W	Consistent with
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CA 125	Cancer antigen 125
CA 19-9	Carbohydrate antigen 19-9
CA++	Calcification(s)
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CALC(S)	Calcification(s)
CAP(S)	Capsule(s)
CBC	Complete blood count
CC	Chief complaint or Cubic centimeter
CCU	Coronary care unit
CEA	Carcinoembryonic antigen
CF	Cystic fibrosis
CFN	Centimeters from nipple
CGA	Serum chromogranin A
CGL	Chronic granulocytic leukemia
CGY	Centigray
CHD	Congenital heart disease
CHEMO	Chemotherapy
CHF	Congestive heart failure
CHG	Change
CHR	Chronic
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIN III or CIN 3	Cervical intraepithelial neoplasia, grade III
CIS	Carcinomain situ

Abbreviation/Symbol	Term
CISH	Chromogenic in situ hybridization
CLL	Chronic lymphocytic leukemia
CLR	Clear
CM	Centimeter
CML	Chronic myeloid (myelocytic) leukemia
CNS	Central nervous system
CO60	Cobalt 60
COLD	Chronic obstructive lung disease
CONT	Continue/continuous
CONTRA	Contralateral
COPD	Chronic obstructive pulmonary disease
CRF	Chronic renal failure
CRM	Circumferential resection margin
CS	Collaborative stage
CSF	Cerebrospinal fluid
C-SF	Colony stimulating factor
C-SPINE	Cervical spine
CT	CAT/CT scan/Computerized axial tomography
CTC	Circulating tumor cells
CUC	Chronic ulcerative colitis
CVA	Cerebrovascular accident
CVD	Cardiovascular disease
CXR	Chest X-ray
CYSTO	Cystoscopy
CYTO	Cytology
D&C	Dilatation and curettage
D/C	Discharge
D/T	Due to
DC	Discontinue(d)
DCIS	Ductal carcinoma in situ
D-COLON	Descending colon
DDX	Differential diagnosis
DECR	Decrease(d)
DERM	Dermatology
DES	Diethylstilbestrol

Abbreviation/Symbol	Term
DIAM	Diameter
DIC	Disseminated intravascular coagulopathy
DIFF	Differentiated/differential
DISCH	Discharge
DJD	Degenerative joint disease
DK	Don't/Doesn't know
DM	Diabetes mellitus
DNA	Deoxyribonucleic acid
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of death
DOE	Dyspnea on exertion
DRE	Digital rectal examination
DTC	Disseminated tumor cells
DTR	Deep tendon reflex
DVT	Deep vein thrombosis
DX	Diagnosis
DZ	Disease
E.G.	For example
E/O	Evidence of
EBRT	External beam radiotherapy
ECG/EKG	Electrocardiogram
ED	Emergency department
EEG	Electroencephalogram
EENT	Eye, ear, nose, throat
EGD	Esophagogastro-duodenoscopy
EGFR	Epidermal growth factor receptor
ELEV	Elevated
EMG	Electromyogram
ENL	Enlarged
ENLGD	Enlarged
ENT	Ears, nose, and throat
ER	Emergency room
ER(A)	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography

Abbreviation/Symbol	Term
ESRD	End stage renal disease
ETOH	Alcohol
EUA	Exam under anesthesia
EV	Electron volt
EVAL	Evaluation
EXAM	Examination
EXC(D)	Excision/excised
EXP	Expired
EXP LAP	Exploratory laparotomy
EXPL	Exploratory
EXPL LAP	Exploratory laparotomy
EXT	Extend/extension
FAP	Familial adeomatous polyposis
FCOT	First course of treatment
FHX	Family History
FISH	Fluorescence in situ hybridization
FL	Fluid
FLIPI	Follicular lymphoma international prognostic index
FLOW CYTO	Flow cytometry
FLURO	Fluoroscopy
FNA	Fine needle aspiration
FNAB	Fine needle aspiration biopsy
FOM	Floor of mouth
FREQ	Frequent/Frequency
FS	Frozen section
FTSG	Full thickness skin graft
FU	Follow-up
FUO	Fever of unknown origin
FX	Fracture
FX(S)	Fractions(s)
GB	Gallbladder
GE	Gastroesophageal
GEN	General/Generalized
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal

Abbreviation/Symbol	Term
GIST	Gastrointestinal stromal tumors
GR	Grade
GU	Genitourinary
GY	Gray
GYN	Gynecology
H&E	Hematoxylin and Eosin
H&P	History and physical
H/H	Hemoglobin and hematrocrit
H/O	History of
HAV	Hepatitis A (virus)
HBV	Hepatitis B (virus)
HCG	Human chorionic gonadotropin
HCT	Hematocrit
HCV	Hepatitis C (virus)
HCVD	Hypertensive cardiovascular disease
HDR	High dose rate
HDV	Hepatitis D (virus)
HEM/ONC	Hematology/Oncology (ist)
HEP A	Hepatitis A (virus)
HEP B	Hepatitis B (virus)
HEP C	Hepatitis C (virus)
HEP D	Hepatitis D (virus)
HER2	Human epidermal growth factor receptor 2
HF	Hispanic female
HGB	Hemoglobin
HGSIL	High grade squamous intraepithelial lesion
HIV	Human Immunodeficiency Virus
HM	Hispanic male
HORM	Hormone
HOSP	Hospital
HPI	History of present illness
HPV	Human Papilloma Virus
HR(S)	Hour/Hours
HRT	Hormone replacement therapy
HSM	Hepatosplenomegaly

Abbreviation/Symbol	Term
HTLV	Human T-Lymphotrophic Virus, (Type III)
HTN	Hypertension
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I&D	Incision & drainage
I-131	Iodine 131
IBD	Inflammatory bowel disease
ICB	Intracavitary brachytherapy
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IDC	Infiltrating/invasive ductal carcinoma
IDDM	Insulin-dependent diabetes mellitus
IG	Immunoglobulin
IHC	Immunohistochemical
IHSS	Idiopathic hypertrophic subaortic stenosis
ILD	Interstitial lung disease
IM	Intramuscular
IMP	Impression
IMRT	Intensity modulated radiation therapy
INCL	Includes/Including
INCR	Increase(d)
INF	Inferior
INFIL	Infiltrating
INFILT	Infiltrating
INPT	Inpatient
INT	Internal
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement/involving
IP	Inpatient
IPI	International prognostic index (for lymphoma)
IPPB	Intermittent positive pressure breathing
IPS	International prognostic score
IPSI	Ipsilateral

Abbreviation/Symbol	Term
IRREG	Irregular
IT	Intrathecal
ITC	Isolated tumor cells
ITP	Idiopathic thrombocytopenia
IV	Intravenous
IVC	Inferior vena cava
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
JAK2	Janus kinase 2
JRA	Juvenile rheumatic arthritis
JVD	Jugular venous distention
KG	Kilogram
KS	Kaposi sarcoma
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L1-L5	Lumbar vertebra
LAB	Laboratory
LAD	Lymphadenopathy
LAN	Lymphadenopathy
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LB(S)	Pound(s)
LBBB	Left bundle branch block
LCIS	Lobular carcinoma in situ
LCM	Left costal margin
LDH	Lactic dehydrogenase
LDR	Low dose rate
LE	Lower extremity
LFT	Liver function test
LIN	Laryngeal intraepithelial neoplasia
LINAC	Linear accelerator
LIQ	Lower inner quadrant
LLE	Left lower extremity
LLL	Left lower lobe

Abbreviation/Symbol	Term
LLQ	Left lower quadrant
LMP	Last menstrual period
LN(S)	Lymph node(s)
LND	Lymph node dissection
LOQ	Lower outer quadrant
LPN	Licensed practical nurse
LRG	Large
LS	Lumbosacral
LSO	Left salpingo-oophorectomy
L-SPINE	Lumbar spine
LS SCAN	Liver/spleen scan
LT	Left
LUE	Left upper extremity
LUL	Left upper lobe
LUOQ	Left upper outer quadrant
LUQ	Left upper quadrant
LVI	Lymph/vascular invasion / Lymphovascular invasion
M/DIFF	Moderately differentiated
MAL	Malignant
MALIG	Malignant
MAMMO	Mammogram
MAND	Mandible/mandibular
MAT	Multifocal atrial tachycardia
MAX	Maximum
MC	Medical center
MC(H)	Millicurie (hours)
MCG	Microgram
MCID	Mixed combined immunodeficiency
M-CSF	Macrophage colony-stimulating factor
MCN	Mucinous cystic neoplasm
MCTD	Mixed connective tissue disease
MD	Moderately differentiated
MDS	Myelodysplastic syndrome
MED	Medication
MED ONC	Medical oncology (ist)

Abbreviation/Symbol	Term
METS	Metastatic/Metastasis
MEV	Million electron volts
MG	Myasthenia gravis
MG(H)	Milligram (hours)
MGF	Maternal grandfather
MGM	Maternal grandmother
MGUS	Monoclonal gammaopathy of uncertain significance
MI	Myocardial infarction
MIBB	Minimally invasive breast biopsy
MICRO	Microscopic
MIN	Minimum
MIN	Minute
MIS	Melanoma in situ
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MMG	Mammogram
MO(S)	Months
MOD	Moderate(ly)
MOD DIFF	Moderately differentiated
MPVC	Multifocal premature ventricular contraction
MRCP	Magnetic resonance cholangiopancreatography
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MRSA	Methicillin Resistant Staphylococcus Aureus
MS	Multiple sclerosis
MSB	Main stem bronchus
MSI	Microsatellite instability
MULT	Multiple
MV	Megavolt
MVP	Mitral valve prolapse
N&V	Nausea and vomiting
N/A	Not applicable
N/V	Nausea and vomiting
NA	Not applicable

Abbreviation/Symbol	Term
NE	No evidence
NEC	Not elsewhere classified
NED	No evidence of disease
NEG	Negative
NEOPL	Neoplasm
NET	Neuroendocrine tumor
NEURO	Neurology
NH	Nursing home
NHL	Non-Hodgkin lymphoma
NIDDM	Non insulin dependent diabetes mellitus
NL	Normal
NML	Normal
NORM	Normal
NOS	Not otherwise specified
NR	Not recorded
NR	Not reportable
NSCCA	Non small cell carcinoma
NSCLC	Non small cell lung carcinoma
NSF	No significant findings
NVD	Neck vein distention
OB	Obstetrics
OBS	Organic brain syndrome
OBST	Obstructed (-ing, -ion)
ONC	Oncology (ist)
OP	Outpatient
OP RPT	Operative report
OR	Operating room
ORTHO	Orthopedics
OTO	Otology
OUTPT	Outpatient
OZ	Ounce
P/DIFF	Poorly differentiated
P32	Phosphorus 32
PAC	Premature atrial contraction
PALP	Palpated (-able)

Abbreviation/Symbol	Term
PAP	Papanicolaou smear
PAP	Papillary
PATH	Pathology
PBSCT	Peripheral blood stem cell transplant
PCP	Primary care physician
PCV	Polycythemia vera
PD	Poorly differentiated
PE	Physical examination
PEDS	Pediatrics
PERC	Percutaneous
PET	Positron emission tomography
PGF	Paternal grandfather
PGM	Paternal grandmother
PID	Pelvic inflammatory disease
PIN III or PIN 3	Prostatic intraepithelial neoplasia, grade III
PLT	Platelets
PMH	Past/personal (medical) history
PMP	Primary medical physician
PNS	Peripheral nervous sytem
POOR DIFF	Poorly differentiated
POS	Positive
POSS	Possible
POST	Posterior
POST OP	Postoperative(-ly)
PPD	Packs per day
PR	Per rectum
PR(A)	Progesterone receptor (assay)
PRE OP	Preoperative(-ly)
PREV	Previous
PROB	Probable (-ly)
PROCTO	Proctoscopy
PS	Performance status
PSA	Prostatic specific antigen
PT	Patient
PT	Physiotherapy/Physical therapy

Abbreviation/Symbol	Term
PTA	Prior to admission
PTC	Percutaneous transhepatic cholecystogram
PTCC	Papillary transitional cell carcinoma
PUD	Peptic ulcer disease
PULM	Pulmonary
PVD	Peripheral vascular disease
P VERA	Polycythemia vera
PY	Pack years
Q	Every
QD	Every day
QUAD	Quadrant
R/O	Rule out
RA	Rheumatoid arthritis
RAD	Radiation absorbed dose
RAD ONC	Radiation Oncology
RAEB	Refractory anemia with excess blasts
RAI	Radioactive iodine
RAIU	Radioactive iodine uptake
RAL	Robotic assisted laparoscopy
RARP	Robotic assisted radical prostatectomy
RBBB	Right bundle branch block
RBC	Red blood cells (count)
RCC	Renal cell carcinoma
RCM	Right costal margin
RCS	Reticulum cell sarcoma
RE	Regarding
REC	Recommend
REC'D	Received
REFRACT ANEM	Refractory anemia
REG	Regional
REG	Regular
RESEC	Resection (ed)
RHD	Rheumatic heart disease
RIA	Radioimmunoassay
RIQ	Right inner quadrant

Abbreviation/Symbol	Term
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
RMC	Regional medical center
RML	Right middle lobe
ROF	Review of outside films
RONC	Radiation Oncology
ROQ	Right outer quadrant
ROS	Review of outside slides
RRP	Radical retropubic prostatectomy
RSO	Right salpingo-oophorectomy
RSR	Regular sinus rhythm
RT	Radiation therapy
RT	Right
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
RX	Prescription
RXT	Radiation therapy
S/P	Status post
S1-S5	Sacral vertebra
SATIS	Satisfactory
SB	Small bowel
SCC	Squamous cell carcinoma
SCF	Supraclavicular fossa
SCID	Severe combined immunodeficiency syndrome
S-COLON	Sigmoid colon
SCT	Stem cell transplant
SCV	Supraclavicular
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum glutamic pyruvic transaminase
SH	Social history
SHX	Social history
SIADH	Syndrome of inappropriate ADH
SIG COLON	Sigmoid colon

Abbreviation/Symbol	Term
SIN III or SIN 3	Squamous intraepithelial neoplasia
SLE	Systemic lupus erythematosus
SLL	Small lymphocytic lymphoma
SLN	Sentinel lymph node
SLNBX	Sentinel lymph node biopsy
SM	Small
SmCC	Small cell carcinoma
SO	Salpingo-oophorectomy
SOB	Short(ness) of breath
SPEC	Specimen
SPEP	Serum protein electrophoresis
SQ	Squamous
SS	Summary stage
S-SPINE	Sacral spine
SSS	Sick sinus syndrome
STSG	Split thickness skin graft
SQCC	Squamous cell carcinoma
SUBCU	Subcutaneous
SUBQ	Subcutaneous
SUGG	Suggestive
SURG	Surgery/Surgical
SUSP	Suspicious/suspected
SVC	Superior vena cava
SX	Symptoms
T1-T12	Thoracic vertebra
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy- bilateral salpingo-oophorectomy
TB	Tuberculosis
TB	Tumor board
TCC	Transitional cell carcinoma
T-COLON	Transverse colon
TIA	Transient ischemic attack
TNM	Tumor, node, metastatis
TOB	Tobacco
TRANS-COLON	Transverse colon

Abbreviation/Symbol	Term
TRUS	Transrectal ultrasound
TS	Tumor size
T-SPINE	Thoracic spine
TTP	Thromboticthrombocytopenia purpura
TUR	Transurethral resection
TURB	Transurethral resection bladder
TURP	Transurethral resection prostate
TVC	True vocal cord
TVH	Total vaginal hysterectomy
TX	Treatment
UE	Upper extremity
UGI	Upper gastrointestinal (series)
UIQ	Upper inner quadrant
UNDIFF	Undifferentiated
UNK	Unknown
UOQ	Upper outer quadrant
URI	Upper respiratory infection
US	Ultrasound
UTI	Urinary tract infection
VAG	Vagina/Vaginal
VAG HYST	Vaginal hysterectomy
VAIN III or VAIN 3	Vaginal intraepithelial neoplasia (grade III)
VIN III or VIN 3	Vulvar intraepithelial neoplasia (grade III)
VGP	Vertical growth phase
VGR	Vertical growth rate
VS	Vital signs
W/	With
W/DIFF	Well differentiated
W/F	White female
W/M	White male
W/O	Without
W/U	Work-up
WBC	White blood cells (count)
WD	Well differentiated
WELL DIFF	Well differentiated

Abbreviation/Symbol	Term
WF	White female
WK(S)	Week(s)
WL	Weight loss
WM	White male
WNL	Within normal limits
WPW	Wolff-Parkinson-White syndrome
WT	Weight
XR	Xray
XRT	External radiation therapy
Y/O	Year old
YO	Year old
YR(S)	Year(s)

Symbols

@ At

/ Comparison

< Decrease, Less than

= Equals

> Increase, More than

- Negative

Number*

+ Positive

Pounds**

x Times

*If it appears before a numeral.

**If it appears after a numeral.

F

APPENDIX F:
COMPARISON OF DATA SETS

Definitions

- **Required Data Set (R):** Commission-approved programs must record the required data set items using the codes and definitions specified in the STORE manual.
- **Supplementary Data Set (S):** The supplementary data set contains additional data items that are important for the efficient operation of a cancer registry.
- **Surveillance, Epidemiology, and End Results Program (SEER):** Required data elements for a central registry affiliated with the National Cancer Institute's SEER Program.
- **National Program of Cancer Registries (NPCR):** Refers to requirements and recommendations of the NPCR regarding data items that should be collected or computed by NPCR state registries.
- **Commission on Cancer (CoC):** Refers to requirements and recommendations of the Commission on Cancer of ACoS.
- **Texas Cancer Registry (TCR):** Refers to the requirements and recommendations of the Texas Cancer Registry.
- **Exchange Elements for Hospital to Central and Central to Central:** Items required for facilities reporting to central registries (labeled Hosp>Central), and items that central registries should use when sending cases to other central registries (labeled Central>Central).

Codes for Recommendations

(If left blank, the data field is not currently collected by TCR and other entities.)

• No recommendations

C Collect

D Derived

D* Derived, when available

D+ Derived; central registries may collect either SEER Summary Stage 2000 or Collaborative Stage

DH Historically derived and currently transmitted

DH* Historically derived and currently transmitted when available

R Required

R# Required; central registries may code available data using either SEER or CoC data items and associated rules

R#* Required, when available; central registries may code available data using SEER or CoC data items and associated rules

R$ Requirements differ by year

R* Required, when available

R^ Required, these text requirements may be met with one or several text block fields

R+ Required, central registries may collect either SEER Summary Stage 2000 or Collaborative Stage

RC Collected by SEER from CoC-accredited hospitals

RH Historically collected and currently transmitted

RH* Historically collected and currently transmitted when available

RN Collect according to NPCR stage transition schedule

RS Required, site specific

RS# Required, site specific; central registries may code available data using either SEER or CoC data items and associated rules

RS* Required, site specific; when available

Ret. Retired

Rev. Revised

S Supplementary/recommended

T Data is vital to complete exchange record

T* Transmit data if available for any case in exchange record

TH Only certain historical cases may require these fields

TH* Only certain historical cases may require these fields; transmit data if available for any case in exchange record

√ Populated by TCR

Table F.1 is derived from Chapter VIII: Required Status Table of the NAACCR *Standards for* Cancer Registries Volume II: Data Standards and Data Dictionary.

Table F.1 Comparison of Data Sets

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central >	
	10	Record Type	√	R	•	R	•	R			NAACCR
	20	Patient ID Number	√	R	•	•	R	R			Reporting Registry
	21	Patient System ID-Hosp	•	•	•	•	•	•			NAACCR
	30	Registry Type	•	•	•	•	•	•			NAACCR
Ret.	35	FIN Coding System									Retired

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Ret.	37	Reserved 00									
	40	Registry ID	R	R	•	•	R	R			NAACCR
	45	NPI--Registry ID	•	•	•	•	R*	•			CMS
	50	NAACCR Record Version	R	R	•	R	R	R			NAACCR
	60	Tumor Record Number	•	•	•	•	S	S			NAACCR
	70	Addr at DX--City	R	R	R	R	R	•			CoC
	80	Addr at DX--State	R	R	R	R	R	R			CoC
	81	State at DX Geocode 1970/80/90	D	D	•	•	R	R			NAACCR
	82	State at DX Geocode 2000	D	D	•	•	R	R			NAACCR
	83	State at DX Geocode 2010	D	D	•	•	R*	R*			NAACCR
	84	State at DX Geocode 2020	D	D	•	•	•	•			NAACCR
	89	County at DX Analysis	D	D	•	•	R	R			NAACCR
	90	County at DX Reported	R	R	R	R	R	R			FIPS/SEER
	94	County at DX Geocode 1970/80/90	D	D	•	•	D	R			NAACCR
	95	County at DX Geocode2000	D	D	•	•	D	R			NAACCR
	96	County at DX Geocode2010	D	D	•	•	D	R			NAACCR
Rev.	97	County at DX Geocode2020	D	D	•	•	•	•			NAACCR
	100	Addr at DX--Postal Code	R	R	R	R	R	•			CoC
	102	Addr at DX--Country	•	•	R	R	R	•			NAACCR
	110	Census Tract 1970/80/90	DH*	RH*	•	•	RH	RH			SEER

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	120	Census Cod Sys 1970/80/90	DH*	RH*	•	•	RH	RH			SEER
	125	Census Tract 2020	D	D	•	•	R*	R*			NAACCR
	130	Census Tract 2000	RH	RH	•	•	RH	RH			NAACCR
	135	Census Tract 2010	R	R	•	•	R	R			NAACCR
Ret.	145	Census Tr Poverty Indictr	R	R	•	•	D	R			NAACCR
	150	Marital Status at DX	•	•	•	•	R	R			SEER
	160	Race 1	R	R	R	R	R	R			SEER/CoC
Rev.	161	Race 2	R	R	R	R	R	R			SEER/CoC
Rev.	162	Race 3	R	R	R	R	R	R			SEER/CoC
Rev.	163	Race 4	R	R	R	R	R	R			SEER/CoC
Rev.	164	Race 5	R	R	R	R	R	R			SEER/CoC
Rev.	170	Race Coding Sys--Current	•	•	R	R	•	•			NAACCR
Rev.	180	Race Coding Sys--Original	•	•	R	R	•	•			NAACCR
Rev.	190	Spanish/Hispanic Origin	R	R	R	R	R	R			SEER/CoC
	191	NHIA Derived Hisp Origin	D	D	•	•	D	R			NAACCR
	192	IHS Link	√	R*	•	•	•	R			NPCR
Rev.	193	Race--NAPIIA(derived API)	D	R	•	•	D	R			NAACCR
	200	Computed Ethnicity	R	R	•	•	D	R			SEER
	210	Computed Ethnicity Source	R	R	•	•	R	R			SEER
	220	Sex	R	R	R	R	R	R			SEER/CoC
	230	Age at Diagnosis	√	R	R	R	R	R			SEER/CoC
	240	Date of Birth	R	R	R	R	R	R			SEER/CoC
Rev.	241	Date of Birth Flag	D	R	R	R	R	R			NAACCR
	250	Birthplace	RH*	RH*	•	•	•	•			SEER/CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	252	Birthplace--State	R*	R*	R	R	R	R			NAACCR
	254	Birthplace--Country	R*	R*	R	R	R	R			NAACCR
Ret.	260	Religion									
	270	Census Occ Code 1970-2000	√	R*	•	•	•	•			Census/NPCR
	272	Census Ind Code 2010 CDC	R*	R*	•	•	•	•			Census/NPCR
	280	Census Ind Code 1970-2000	√	R*	•	•	•	•			Census/NPCR
	282	Census Occ Code 2010 CDC	R*	R*	•	•	•	•			Census/NPCR
	290	Occupation Source	√	R*	•	•	•	•			NPCR
	300	Industry Source	√	R*	•	•	•	•			NPCR
	310	Text--Usual Occupation	R	R*	•	•	•	•			NPCR
	320	Text--Usual Industry	R	R*	•	•	•	•			NPCR
	330	Census Occ/Ind Sys 70-00	√	R*	•	•	•	•			NPCR
	339	RUCA 2000		D	•	•	D	R			NAACCR
Ret.	340	Tobacco History									
	341	RUCA 2010		D	•	•	D	R			NAACCR
	345	URIC 2000		D	•	•	D	R			NAACCR
	346	URIC 2010		D	•	•	D	R			NAACCR
	351	GeoLocationID - 1970/80/90		D	•	•	R	R			NAACCR
	352	GeoLocationID - 2000		D	•	•	R	R			NAACCR
	353	GeoLocationID - 2010		D	•	•	R	R			NAACCR
	354	GeoLocationID - 2020		D	•	•	•	•			NAACCR
	361	Census Block Group 2020		•	•	•	•	•			Census
	362	Census Block Group 2000	D	•	•	•	S	•			Census

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	363	Census Block Group 2010	•	•	•	•	R	•			Census
	364	Census Tr Cert 1970/80/90	D	RH*	•	•	RH	RH			SEER
	365	Census Tr Certainty 2000	D	RH	•	•	RH	RH			NAACCR
	366	GIS Coordinate Quality	R*	R*	•	•	S	•			NAACCR
	367	Census Tr Certainty 2010	D	R	•	•	R	R			NAACCR
	368	Census Block Grp 1970/80/90	•	•	•	•	S	•			Census
	369	Census Tract Certainty 2020	D	D	•	•	•	•			NAACCR
Ret.	370	Reserved 01									
	380	Sequence Number--Central	R	R	•	•	R	R			SEER
	390	Date of Diagnosis	R	R	R	R	R	R			SEER/CoC
	391	Date of Diagnosis Flag	D	R	•	•	R	R			NAACCR
	400	Primary Site	R	R	R	R	R	R			SEER/CoC
	410	Laterality	R	R	R	R	R	R			SEER/CoC
	419	Morph--Type&Behav ICD-O-2	•	•	•	•	•	•			
	420	Histology (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH			SEER/CoC
	430	Behavior (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH			SEER/CoC
	439	Date of Mult Tumors Flag	•	•	RH	RH	RH	RH			NAACCR
	440	Grade	RH	RH	RH	RH	RH	RH			SEER/CoC
Rev.	441	Grade Path Value		RH*	RH	RH	RH	RH			AJCC
	442	Ambiguous Terminology DX	•	•	RH	RH	RH	RH			SEER
	443	Date Conclusive DX	•	•	RH	RH	RH	RH			SEER

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	444	Mult Tum Rpt as One Prim	•	•	RH	RH	RH	RH			SEER
	445	Date of Mult Tumors	•	•	RH	RH	RH	RH			SEER
	446	Multiplicity Counter	•	•	RH	RH	RH	RH			SEER
	448	Date Conclusive DX Flag	•	•	RH	RH	RH	RH			NAACCR
Rev.	449	Grade Path System		RH*	RH	RH	RH	RH			AJCC
Rev.	450	Site Coding Sys--Current	R	R	R	R	•	•			NAACCR
Rev.	460	Site Coding Sys--Original	•	•	R	R	•	•			NAACCR
Rev.	470	Morph Coding Sys--Current	R	R	R	R	•	•			NAACCR
Rev.	480	Morph Coding Sys--Originl	•	•	R	R	•	•			NAACCR
	490	Diagnostic Confirmation	R	R	R	R	R	R			SEER/CoC
	500	Type of Reporting Source	R	R	•	•	R	R			SEER
	501	Casefinding Source	R*	R*	•	•	•	•			NAACCR
	521	Morph--Type&Behav ICD-O-3	•	•	•	•	•	•			
	522	Histologic Type ICD-O-3	R	R	R	R	R	R			SEER/CoC
	523	Behavior Code ICD-O-3	R	R	R	R	R	R			SEER/CoC
Ret.	530	Reserved 02									
	540	Reporting Facility	R	R	R	R	R	•			CoC
	545	NPI--Reporting Facility	D	R*	R	R	R*	•			CMS
	550	Accession Number--Hosp	R	•	R	R	R	•			CoC
	560	Sequence Number--Hospital		•	R	R	R	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	570	Abstracted By	R	•	R	R	R	•			CoC
	580	Date of 1st Contact	R	R	R	R	•	•			CoC
	581	Date of 1st Contact Flag	R	R	R	R	•	•			NAACCR
	590	Date of Inpt Adm	•	•	•	•	•	•			NAACCR
	591	Date of Inpt Adm Flag	•	•	•	•	•	•			NAACCR
	600	Date of Inpt Disch	•	•	•	•	•	•			NAACCR
	601	Date of Inpt Disch Flag	•	•	•	•	•	•			NAACCR
	605	Inpatient Status	•	•	•	•	•	•			NAACCR
	610	Class of Case	R	R	R	R	RC	•			CoC
	630	Primary Payer at DX	R*	R*	R	R	R	R			CoC
	668	RX Hosp--Surg App 2010	•	•	R	R	•	•			CoC
	670	RX Hosp--Surg Prim Site	•	•	R	R	R	•			CoC
	672	RX Hosp--Scope Reg LN Sur	•	•	R	R	R	•			CoC
	674	RX Hosp--Surg Oth Reg/Dis	•	•	R	R	R	•			CoC
	676	RX Hosp--Reg LN Removed	•	•	RH	RH	•				CoC
Ret.	680	Reserved 03									
	682	Date Regional Lymph Node Dissection	•	•	R	R	RC				NAACCR
Rev.	683	Date Regional Lymph Node Dissection Flag	•	•	•	•	RC				NAACCR
	690	RX Hosp--Radiation	•	•	•	•	RH				SEER
	700	RX Hosp--Chemo	•	•	R	R	R				CoC
	710	RX Hosp--Hormone	•	•	R	R	R				CoC
	720	RX Hosp--BRM	•	•	R	R	R				CoC
	730	RX Hosp--Other	•	•	R	R	R				CoC
	740	RX Hosp--DX/Stg Proc	•	•	R	R	•				CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	746	RX Hosp--Surg Site 98-02	•	•	RH	RH	RH				CoC
	747	RX Hosp--Scope Reg 98-02	•	•	RH	RH	RH				CoC
	748	RX Hosp--Surg Oth 98-02	•	•	RH	RH	RH				CoC
Ret.	750	Reserved 04	•								
	752	Tumor Size Clinical	•	•	•	•	R				SEER
	754	Tumor Size Pathologic	•	•	•	•	R	R			SEER
	756	Tumor Size Summary	R	R	R	R	S	S			NPCR/CoC
	759	SEER Summary Stage 2000	RH	R	RH	RH	RH	RH			SEER
	760	SEER Summary Stage 1977	RH	RH	RH	RH	•	S			SEER
	762	Derived Summary Stage 2018	•	RN	•	•	D	R			SEER
Rev.	764	Summary Stage 2018	R	R	R	R	R*	R*			SEER
	772	EOD Primary Tumor	•	•	•	•	R	R			SEER
	774	EOD Regional Nodes	•	•	•	•	R	R			SEER
	776	EOD Mets	•	•	•	•	R	R			SEER
	779	Extent of Disease 10-Dig		RN	•	•	•	•			
	780	EOD--Tumor Size	RH	RN	RH	RH	RH	RH			SEER/CoC
	785	Derived EOD 2018 T	•	•	•	•	D	R			SEER
	790	EOD--Extension	•	•	•	•	RH	RH			SEER
	795	Derived EOD 2018 M	•	•	•	•	D	R			SEER
Rev.	800	EOD--Extension Prost Path	•	•	•	•	RH	RH			SEER
	810	EOD--Lymph Node Involv	•	•	•	•	RH	RH			SEER
	815	Derived EOD 2018 N	•	•	•	•	D	R			SEER
	818	Derived EOD 2018 Stage Group	•	•	•	•	D	R			SEER

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	820	Regional Nodes Positive	R	R	R	R	R	R			SEER/CoC
	830	Regional Nodes Examined	R	R	R	R	R	R			SEER/CoC
	832	Date of Sentinel Lymph Node Biopsy	•	•	RS	RS	R*	R*			CoC
Rev.	833	Date Sentinel Lymph Node Biopsy Flag	•	•	RS	RS	R*	R*			CoC
	834	Sentinel Lymph Nodes Examined	•	•	RS	RS	R*	R*			CoC
	835	Sentinel Lymph Nodes Positive	•	•	RS	RS	R*	R*			CoC
	840	EOD--Old 13 Digit	•	•	•	•	RH	RH			SEER
	850	EOD--Old 2 Digit	•	•	•	•	RH	RH			SEER
	860	EOD--Old 4 Digit	•	•	•	•	RH	RH			SEER
	870	Coding System for EOD	•	•	•	•	RH	RH			SEER
Rev.	880	TNM Path T	RH	RH	RH	RH	RH	RH			AJCC
Rev.	890	TNM Path N	RH	RH	RH	RH	RH	RH			AJCC
Rev.	900	TNM Path M	RH	RH	RH	RH	RH	RH			AJCC
Rev.	910	TNM Path Stage Group	RH	RH	RH	RH	RH*	RH*			AJCC
Rev.	920	TNM Path Descriptor	RH	RH	RH	RH	RH	RH			CoC
	930	TNM Path Staged By	•	•	RH	RH	RH	RH			CoC
Rev.	940	TNM Clin T	RH	RH	RH	RH	RH	RH			AJCC
Rev.	950	TNM Clin N	RH	RH	RH	RH	RH	RH			AJCC
Rev.	960	TNM Clin M	RH	RH	RH	RH	RH	RH			AJCC
Rev.	970	TNM Clin Stage Group	RH	RH	RH	RH	RH*	RH*			AJCC
Rev.	980	TNM Clin Descriptor	RH	RH	RH	RH	RH	RH			CoC
	990	TNM Clin Staged By	•	•	•	RH	RH	RH			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	995	AJCC ID	D	D	D	R	R*	R*			NAACCR
	1001	AJCC TNM Clin T	•	•	R	R	R*	R*			AJCC
	1002	AJCC TNM Clin N	•	•	R	R	R*	R*			AJCC
	1003	AJCC TNM Clin M	•	•	R	R	R*	R*			AJCC
	1004	AJCC TNM Clin Stage Group	•	•	R	R	R*	R*			AJCC
	1011	AJCC TNM Path T	•	•		R	R*	R*			AJCC
	1012	AJCC TNM Path N	•	•	•	•	R*	R*			AJCC
	1013	AJCC TNM Path M	•	•	R	R	R*	R*			AJCC
	1014	AJCC TNM Path Stage Group	•	•	R	R	R*	R*			AJCC
Rev.	1021	AJCC TNM Post Therapy T	•	•	R	R	R*	R*			AJCC
Rev.	1022	AJCC TNM Post Therapy N	•	•	R	R	R*	R*			AJCC
Rev.	1023	AJCC TNM Post Therapy M	•	•	R	R	R*	R*			AJCC
Rev.	1024	AJCC TNM Post Therapy Stage Group	•	•	R	R	R*	R*			AJCC
Ret.	1030	TNM Other Stage Group									Retired
	1031	AJCC TNM Clin T Suffix	•	•	•	•	R*	R*			AJCC
	1032	AJCC TNM Path T Suffix	•	•	•	•	R*	R*			AJCC
Rev.	1033	AJCC TNM Post Therapy T Suffix	•	•	•	•	R*	R*			AJCC
	1034	AJCC TNM Clin N Suffix	•	•	•	•	R*	R*			AJCC
	1035	AJCC TNM Path N Suffix	•	•	•	•	R*	R*			AJCC
Rev.	1036	AJCC TNM Post Therapy N Suffix	•	•	•	•	R*	R*			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Rev.	1060	TNM Edition Number	RH	RH	RH	RH	RH	RH			CoC
New	1062	AJCC TNM Post Therapy Clin (yc) T	•	•	R	R	RC	RC			AJCC
New	1063	AJCC TNM Post Therapy Clin (yc) T Suffix	•	•	R	R	RC	RC			AJCC
New	1064	AJCC TNM Post Therapy Clin (yc) N	•	•	R	R	RC	RC			AJCC
New	1065	AJCC TNM Post Therapy Clin (yc) N Suffix	•	•	R	R	RC	RC			AJCC
New	1066	AJCC TNM Post Therapy Clin (yc) M	•	•	R	R	RC	RC			AJCC
New	1067	AJCC TNM Post Therapy Stage Group	•	•	•	•	•	•			AJCC
New	1068	Grade Post Therapy Clin (yc)	R*	R*	R	R	RS	RS			NAACCR
	1112	Mets at DX-Bone	•	•	R	R	R	R			SEER
	1113	Mets at DX-Brain	•	•	R	R	R	R			SEER
	1114	Mets at Dx-Distant LN	•	•	R	R	R	R			SEER
	1115	Mets at DX-Liver	•	•	R	R	R	R			SEER
	1116	Mets at DX-Lung	•	•	R	R	R	R			SEER
	1117	Mets at DX-Other	•	•	R	R	R	R			SEER
	1120	Pediatric Stage	•	•	•	•	•	•			CoC
	1130	Pediatric Staging System	•	•	•	•	•	•			CoC
	1140	Pediatric Staged By	•	•	•	•	•	•			CoC
	1150	Tumor Marker 1	•	•	RH	RH	RH	RH			SEER
	1160	Tumor Marker 2	•	•	RH	RH	RH	RH			SEER
	1170	Tumor Marker 3	•	•	RH	RH	RH	RH			SEER
	1180	Reserved 05	•								

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Ret.	1182	Lymphovascular Invasion	R	R*	R	R	RS	RS			AJCC
Ret.	1190	Reserved 06									
	1200	RX Date Surgery	R	R	R	R	RC	RC			CoC
	1201	RX Date Surgery Flag	R	R	R	R	RC	RC			NAACCR
	1210	RX Date Radiation	R	R	R	R	RC	RC			CoC
	1211	RX Date Radiation Flag	R	R	R	R	RC	RC			NAACCR
	1220	RX Date Chemo	R	R	R	R	RC	RC			CoC
Rev.	1221	RX Date Chemo Flag	R	R	R	R	RC	RC			NAACCR
	1230	RX Date Hormone	R	R	R	R	RC	RC			CoC
	1231	RX Date Hormone Flag	R	R	R	R	RC	RC			NAACCR
	1240	RX Date BRM	R	R	R	R	RC	RC			CoC
	1241	RX Date BRM Flag	R	R	R	R	RC	RC			NAACCR
	1250	RX Date Other	R	R	R	R	RC	RC			CoC
Rev.	1251	RX Date Other Flag	R	R	R	R	RC	RC			NAACCR
	1260	Date Initial RX SEER	R	R#	•	•	R	R			SEER
	1261	Date Initial RX SEER Flag	D	R#	•	•	R	R			NAACCR
	1270	Date 1st Crs RX CoC	R#	R#	R	R	•	•			CoC
Rev.	1271	Date 1st Crs RX CoC Flag	R#	R#	R	R	•	•			NAACCR
	1280	RX Date DX/Stg Proc	•	•	R	R	•	•			CoC
	1281	RX Date DX/Stg Proc Flag	•	•	R	R	•	•			NAACCR
	1285	RX Summ--Treatment Status	R#	R#	R	R	R	R			SEER/CoC
	1290	RX Summ--Surg Prim Site	R	R	R	R	R	R			SEER/CoC
	1292	RX Summ--Scope Reg LN Sur	R	R	R	R	R	R			SEER/CoC
	1294	RX Summ--Surg Oth Reg/Dis	R	R	R	R	R	R			SEER/CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	1296	RX Summ--Reg LN Examined	•	•	RH	RH	RH	RH			SEER/CoC
Ret.	1300	Reserved 07									
	1310	RX Summ--Surgical Approch		•	RH	RH	•	•			CoC
	1320	RX Summ--Surgical Margins	•	•	R	R	R*	R*			CoC
Rev.	1330	RX Summ--Reconstruct 1st	•	•	RH	RH	RH	RH			SEER
	1340	Reason for No Surgery	R	R	R	R	R	R			SEER/CoC
	1350	RX Summ--DX/Stg Proc	•	•	R	R	•	•			CoC
	1360	RX Summ--Radiation	RH	RH	•	•	RH	RH			SEER
	1370	RX Summ--Rad to CNS	•	•	•	•	RH	RH			SEER/CoC
	1380	RX Summ--Surg/Rad Seq	R	R	R	R	R	R			SEER/CoC
	1390	RX Summ--Chemo	R	R	R	R	R	R			SEER/CoC
	1400	RX Summ--Hormone	R	R	R	R	R	R			SEER/CoC
	1410	RX Summ--BRM	R	R	R	R	R	R			SEER/CoC
	1420	RX Summ--Other	R	R	R	R	R	R			SEER/CoC
	1430	Reason for No Radiation	R	R	R	R	•	•			CoC
	1460	RX Coding System--Current	R	R	R	R	•	RH			NAACCR
	1501	Phase I Dose per Fraction	•	•	R	R	R*	R*			CoC
	1502	Phase I Radiation External Beam Planning Tech	•	•	R	R	R*	R*			CoC
	1503	Phase I Number of Fractions	•	•	R	R*	R*				CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	1504	Phase I Radiation Primary Treatment Volume	•	•	R	R*	R*				CoC
	1505	Phase I Radiation to Draining Lymph Nodes	•	•	R	R*	R*				CoC
	1506	Phase I Radiation Treatment Modality	R	R	R	R	R	R			CoC
	1507	Phase I Total Dose	•	•	R	R	R*	R*			CoC
	1510	Rad--Regional Dose: cGy	•	•	RH	RH	•	•			CoC
	1511	Phase II Dose per Fraction	•	•	R	R	R*	R*			CoC
	1512	Phase II Radiation External Beam Planning Tech	•	•	R	R	R*	R*			CoC
	1513	Phase II Number of Fractions	•	•	R	R	R*	R*			CoC
	1514	Phase II Radiation Primary Treatment Volume	•	•	R	R	R*	R*			CoC
	1515	Phase II Radiation to Draining Lymph Nodes	•	•	R	R	R*	R*			CoC
	1516	Phase II Radiation Treatment Modality	•	•	R	R	R	R			CoC
	1517	Phase II Total Dose	•	•	R	R	R*	R*			CoC
	1520	Rad--No of Treatment Vol	•	•	RH	RH	•	•			CoC
	1521	Phase III Dose per Fraction	•	•	R	R	R*	R*			CoC
	1522	Phase III Radiation External Beam Planning Tech	•	•	R	R	R*	R*			CoC
	1523	Phase III Number of Fractions	•	•	R	R	R*	R*			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	1524	Phase III Radiation Primary Treatment Volume	•	•	R	R	R*	R*			CoC
	1525	Phase III Radiation to Draining Lymph Nodes	•	•	R	R	R*	R*			CoC
	1526	Phase III Radiation Treatment Modality	•	•	R	R	R	R			CoC
	1527	Phase III Total Dose	•	•	R	R	R*	R*			CoC
	1531	Radiation Treatment Discontinued Early	•	•	R	R	R*	R*			CoC
	1532	Number of Phases of Rad Treatment to this Volume	•	•	R	R	R*	R*			CoC
	1533	Total Dose	•	•	R	R	R*	R*			CoC
	1540	Rad--Treatment Volume	•	•	RH	RH	•	•			CoC
	1550	Rad--Location of RX	•	•	RH	RH	•	•			CoC
	1570	Rad--Regional RX Modality	RH	RH	RH	RH	RH	•			CoC
New	1632	Neoadjuvant Therapy	•	•	•	•	R	R			SEER
New	1633	Neoadjuvant Therapy-Clinical Response	•	•	•	•	R	R			SEER
New	1634	Neoadjuvant Therapy-Treatment Effect	•	•	•	•	R	R			SEER
	1639	RX Summ--Systemic/Sur Seq	R	R	R	R	R	R			CoC
	1640	RX Summ--Surgery Type	•	•	•	•	RH	RH			SEER
Ret.	1646	RX Summ--Surg Site 98-02	•	•	RH	RH	RH	RH			SEER/CoC
	1647	RX Summ--Scope Reg 98-02	•	•	RH	RH	RH	RH			SEER/CoC
	1648	RX Summ--Surg Oth 98-02	•	•	RH	RH	RH	RH			SEER/CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Ret.	1650	Reserved 08	•								
	1660	Subsq RX 2nd Course Date	•	•	•	•	•	•			CoC
	1661	Subsq RX 2ndCrs Date Flag	•	•	•	•	•	•			NAACCR
	1670	Subsq RX 2nd Course Codes	•	•	•	•	•	•			
	1671	Subsq RX 2nd Course Surg	•	•	•	•	•	•			CoC
	1672	Subsq RX 2nd Course Rad	•	•	•	•	•	•			CoC
	1673	Subsq RX 2nd Course Chemo	•	•	•	•	•	•			CoC
	1674	Subsq RX 2nd Course Horm	•	•	•	•	•	•			CoC
	1675	Subsq RX 2nd Course BRM	•	•	•	•	•	•			CoC
	1676	Subsq RX 2nd Course Oth	•	•	•	•	•	•			CoC
	1677	Subsq RX 2nd--Scope LN SU	•	•	•	•	•	•			CoC
	1678	Subsq RX 2nd--Surg Oth	•	•	•	•	•	•			CoC
	1679	Subsq RX 2nd--Reg LN Rem	•	•	•	•	•	•			CoC
	1680	Subsq RX 3rd Course Date	•	•	•	•	•	•			CoC
	1681	Subsq RX 3rdCrs Date Flag	•	•	•	•	•	•			NAACCR
	1690	Subsq RX 3rd Course Codes	•	•	•	•	•	•			
	1691	Subsq RX 3rd Course Surg	•	•	•	•	•	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	1692	Subsq RX 3rd Course Rad	•	•	•	•	•	•			CoC
	1693	Subsq RX 3rd Course Chemo	•	•	•	•	•	•			CoC
	1694	Subsq RX 3rd Course Horm	•	•	•	•	•	•			CoC
	1695	Subsq RX 3rd Course BRM	•	•	•	•	•	•			CoC
	1696	Subsq RX 3rd Course Oth	•	•	•	•	•	•			CoC
	1697	Subsq RX 3rd--Scope LN Su	•	•	•	•	•	•			CoC
	1698	Subsq RX 3rd--Surg Oth	•	•	•	•	•	•			CoC
	1699	Subsq RX 3rd--Reg LN Rem	•	•	•	•	•	•			CoC
	1700	Subsq RX 4th Course Date	•	•	•	•	•	•			CoC
	1701	Subsq RX 4thCrs Date Flag	•	•	•	•	•	•			NAACCR
	1710	Subsq RX 4th Course Codes	•	•	•	•	•	•			
	1711	Subsq RX 4th Course Surg	•	•	•	•	•	•			CoC
	1712	Subsq RX 4th Course Rad	•	•	•	•	•	•			CoC
	1713	Subsq RX 4th Course Chemo	•	•	•	•	•	•			CoC
	1714	Subsq RX 4th Course Horm	•	•	•	•	•	•			CoC
	1715	Subsq RX 4th Course BRM	•	•	•	•	•	•			CoC
	1716	Subsq RX 4th Course Oth	•	•	•	•	•	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	1717	Subsq RX 4th--Scope LN Su	•	•	•	•	•	•			CoC
	1718	Subsq RX 4th--Surg Oth	•	•	•	•	•	•			CoC
	1719	Subsq RX 4th--Reg LN Rem	•	•	•	•	•	•			CoC
Ret.	1740	Reserved 09									
	1741	Subsq RX--Reconstruct Del	•	•	•	•	•	•			CoC
	1750	Date of Last Contact	R	R	R	R	R	R			SEER/CoC
Rev.	1751	Date of Last Contact Flag	D	R	R	R	R	R			NAACCR
	1760	Vital Status	R	R	R	R	R	R			SEER/CoC
	1762	Vital Status Recode	D	D	•	•	D	R			NAACCR
	1770	Cancer Status	•	•	R	R	•	•			CoC
	1772	Date of Last Cancer (tumor) Status	•	•	R	R	•	•			CoC
Rev.	1773	Date of Last Cancer (tumor) Status Flag			R	R	•	•			CoC
Rev.	1775	Record Number Recode	•	•	•	•	D	R			NAACCR
	1780	Quality of Survival	•	•	•	•	•	•			CoC
Rev.	1782	Surv-Date Active Followup	•	•	•	•	D	R			NAACCR
Rev.	1783	Surv-Flag Active Followup	•	•	•	•	D	R			NAACCR
Rev.	1784	Surv-Mos Active Followup	•	•	•	•	D	R			NAACCR
	1785	Surv-Date Presumed Alive	•	D	•	•	D	R			NAACCR
	1786	Surv-Flag Presumed Alive	•	D	•	•	D	R			NAACCR
	1787	Surv-Mos Presumed Alive	•	D	•	•	D	R			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	1788	Surv-Date DX Recode	•	D	•	•	D	R			NAACCR
	1790	Follow-Up Source	R*	R*	R	•	•	•			CoC
	1791	Follow-up Source Central	D	R	•	•	•	•			NAACCR
	1800	Next Follow-Up Source	•	•	R	•	•	•			CoC
	1810	Addr Current--City	•	•	R	•	R	•			CoC
	1820	Addr Current--State	•	•	R	•	R	•			CoC
	1830	Addr Current--Postal Code	•	•	R	•	R	•			CoC
	1832	Addr Current--Country	•	•	R	•	R	•			NAACCR
	1835	Reserved 10									
	1840	County--Current	•	•	•	•	•	•			NAACCR
	1842	Follow-Up Contact--City	•	•	•	•	•	•			SEER
	1844	Follow-Up Contact--State	•	•	•	•	•	•			SEER
	1846	Follow-Up Contact--Postal	•	•	•	•	•	•			SEER
	1847	FollowUp Contact--Country	•	•	•	•	•	•			NAACCR
	1850	Unusual Follow-Up Method	•	•	•	•	•	•			NAACCR
	1860	Recurrence Date--1st	•	•	R	R	RC	•			CoC
Rev.	1861	Recurrence Date--1st Flag	•	•	R	R	RC	•			NAACCR
	1880	Recurrence Type--1st	•	•	R	R	RC	•			CoC
Ret.	1900	Reserved 11									
	1910	Cause of Death	√	R	•	•	R	R			SEER
	1914	SEER Cause Specific COD	•	D	•	•	D	R			SEER
	1915	SEER Other COD	•	D	•	•	D	R			SEER
	1920	ICD Revision Number	√	R	•	•	R	R			SEER

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	1930	Autopsy	•	•	•	•	•	•			NAACCR
	1940	Place of Death		RH	•	•	•	•			NPCR
	1942	Place of Death--State	R	R	•	•	R*	R*			NAACCR
	1944	Place of Death--Country	R*	R*	•	•	R*	R*			NAACCR
	1960	Site (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1970	Morph (73-91) ICD-O-1	•	•	•	•	•	•			
	1971	Histology (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1972	Behavior (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1973	Grade (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
Rev.	1980	ICD-O-2 Conversion Flag	•	•	RH	RH	R	R			SEER
	1981	Over-ride SS/NodesPos	•	•	•	•	R	R			NAACCR
	1982	Over-ride SS/TNM-N	•	•	•	•	R	R			NAACCR
	1983	Over-ride SS/TNM-M	•	•	•	•	R	R			NAACCR
Rev.	1985	Over-ride Acsn/Class/Seq	•	•	R	R	•	•			CoC
Rev.	1986	Over-ride HospSeq/DxConf	•	•	R	R	•	•			CoC
Rev.	1987	Over-ride CoC-Site/Type	•	•	R	R	•	•			CoC
Rev.	1988	Over-ride HospSeq/Site	•	•	R	R	•	•			CoC
Rev.	1989	Over-ride Site/TNM-StgGrp	R	R	R	R	•	•			CoC
Rev.	1990	Over-ride Age/Site/Morph	D	R	R	R	R	R			SEER
Rev.	1992	Over-ride TNM Stage	•	RN	•	•	•	•			NAACCR
Rev.	1993	Over-ride TNM Tis	•	RN	•	•	•	•			NAACCR
	1994	Over-ride TNM 3	•	RN	•	•	•	•			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	2000	Over-ride SeqNo/DxConf	D	R	•	•	R	R			SEER
	2010	Over-ride Site/Lat/SeqNo	D	R	•	•	R	R			SEER
Rev.	2020	Over-ride Surg/DxConf	D	R	R	R	R	R			SEER
Rev.	2030	Over-ride Site/Type	D	R	R	R	R	R			SEER
Rev.	2040	Over-ride Histology	D	R	R	R	R	R			SEER
	2050	Over-ride Report Source	D	R	•	•	R	R			SEER
	2060	Over-ride Ill-define Site	D	R	•	•	R	R			SEER
Rev.	2070	Over-ride Leuk, Lymphoma	D	R	R	R	R	R			SEER
Rev.	2071	Over-ride Site/Behavior	D	R	R	R	R	R			SEER
	2072	Over-ride Site/EOD/DX Dt	D	•	•	•	R	R			SEER
	2073	Over-ride Site/Lat/EOD	D	•	•	•	R	R			SEER
Rev.	2074	Over-ride Site/Lat/Morph	D	R	R	R	R	R			SEER
	2078	Over-ride Name/Sex	•	R	•	•	R	R			NAACCR
Ret.	2080	Reserved 13									
	2081	CRC CHECKSUM	•	•	•	•	S	S			NAACCR
	2085	Date Case Initiated	•	•	•	•	•	•			NAACCR
	2090	Date Case Completed	•	•	•	•	•	•			NAACCR
	2092	Date Case Completed--CoC	•	•	D	D	•	•			CoC
	2100	Date Case Last Changed	√	•	D	D	•	•			NAACCR
	2110	Date Case Report Exported	√	R	•	•	•	•			NPCR
	2111	Date Case Report Received	√	R	•	•	•	•			NPCR
	2112	Date Case Report Loaded	√	R	•	•	•	•			NPCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	2113	Date Tumor Record Availbl	R	R	•	•	•	•			NPCR
Rev.	2116	ICD-O-3 Conversion Flag	D	R	•	•	R	R			SEER/CoC
New	2117	Schema ID Version Current	D	D	D	D	D	D			SEER
New	2118	Schema ID Version Original	D	D	D	D	D	D			SEER
	2120	SEER Coding Sys--Current	•	•	•	•	•	R			NAACCR
	2130	SEER Coding Sys--Original	•	•	•	•	•	R			NAACCR
Rev.	2140	CoC Coding Sys--Current	•	•	R	R	•	•			CoC
	2150	CoC Coding Sys--Original	•	•	R	R	•	•			CoC
	2152	CoC Accredited Flag	D	R	•	•	R*	R*			NPCR
Rev.	2155	RQRS NCDB Submission Flag	•	•	R	R	•	•			CoC
New	2156	AJCC API Version Current	•	•	D	D	D*	D*			AJCC
New	2157	AJCC API Version Original	•	•	D	D	D*	D*			AJCC
New	2158	AJCC Cancer Surveillance API Version Current	D	D	D	D	D*	D*			AJCC
New	2159	AJCC Cancer Surveillance API Version Original	D	D	D	D	D*	D*			AJCC
Ret.	2161	Reserved 18									
Ret.	2162	Reserved 19									
Ret.	2163	Reserved 20									
	2170	Vendor Name	√	•	R	R	•	•			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Rev.	2180	SEER Type of Follow-Up	•	•	•	•	R	R			SEER
	2190	SEER Record Number	•	•	•	•	•	R			SEER
	2200	Diagnostic Proc 73-87	•	•	•	•	RH	RH			SEER
Ret.	2210	Reserved 14	•								
	2220	State/Requestor Items	•	•	•	•	•	•			Varies
Rev.	2230	Name--Last	R	R	R	•	R	•			CoC
New	2232	Name-Birth Surname	R	R	•	•	R	R			NAACCR
Rev.	2240	Name--First	R	R	R	•	R	•			CoC
Rev.	2250	Name--Middle	R	R	R	•	R	•			CoC
	2260	Name--Prefix	•	•	•	•	•	•			NAACCR
	2270	Name--Suffix	•	•	•	•	R	•			NAACCR
	2280	Name--Alias	R	R	•	•	R	•			NAACCR
	2290	Name--Spouse/Parent	•	•	•	•	•	•			NAACCR
Rev.	2300	Medical Record Number	R	R	R	•	R	•			CoC
	2310	Military Record No Suffix	•	•	•	•	•	•			CoC
Rev.	2315	Medicare Beneficiary Identifier									NAACCR
Rev.	2320	Social Security Number	R	R	R	•	R	•			CoC
Rev.	2330	Addr at DX--No & Street	R	R	R	•	R	•			CoC
Rev.	2335	Addr at DX--Supplementl	R	R	R*	•	R	•			CoC
Rev.	2350	Addr Current--No & Street	•	•	R	•	R	•			CoC
	2352	Latitude	D	R*	•	•	S	•			NAACCR
	2354	Longitude	D	R*	•	•	S	•			NAACCR
Rev.	2355	Addr Current--Supplementl	•	•	R*	•	R*	•			CoC
Rev.	2360	Telephone	•	•	R	•	R	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	2380	DC State File Number	R	R	•	•	R*	•			State
	2392	Follow-Up Contact--No&St	•	•	•	•	•	•			SEER
	2393	Follow-Up Contact--Suppl	•	•	•	•	•	•			SEER
	2394	Follow-Up Contact--Name	•	•	•	•	•	•			SEER
Ret.	2400	Reserved 15									
	2410	Institution Referred From	•	•	•	•	•	•			CoC
	2415	NPI--Inst Referred From	•	•	R	•	•	•			CMS
	2420	Institution Referred To	•	•	•	•	•	•			CoC
	2425	NPI--Inst Referred To	•	•	R	•	•	•			CMS
	2440	Following Registry	•	•	•	•	RH	•			CoC
	2445	NPI--Following Registry	•	•	•	•	RH*	•			CMS
Ret.	2450	Reserved 16									
	2460	Physician--Managing	•	•	•	•	•	•			NAACCR
Rev.	2465	NPI--Physician--Managing	•	•	R	•	•	•			CMS
	2470	Physician--Follow-Up	R	•	•	•	R	•			CoC
Rev.	2475	NPI--Physician--Follow-Up	•	•	R	•	R*	•			CMS
	2480	Physician--Primary Surg	•	•	•	•	•	•			CoC
	2485	NPI--Physician--Primary Surg	•	•	R	R	•	•			CMS
	2490	Physician 3		•	•	•	•	•			CoC
	2495	NPI--Physician 3	•	•	R	R	•	•			CMS
	2500	Physician 4	•	•	•	•	•	•			CoC
	2505	NPI--Physician 4	•	•	R	R	•	•			CMS
	2508	EHR Reporting	•	•	•	•	•	•			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Ret.	2510	Reserved 12	•								
	2520	Text--DX Proc--PE	R^	R^	•	•	R	•			NPCR
	2530	Text--DX Proc--X-ray/Scan	R^	R^	•	•	R	•			NPCR
	2540	Text--DX Proc--Scopes	R^	R^	•	•	R	•			NPCR
	2550	Text--DX Proc--Lab Tests	R^	R^	•	•	R	•			NPCR
	2560	Text--DX Proc--Op	R^	R^	•	•	R	•			NPCR
	2570	Text--DX Proc--Path	R^	R^	•	•	R	•			NPCR
	2580	Text--Primary Site Title	R	R^	•	•	R	•			NPCR
	2590	Text--Histology Title	R	R^	•	•	R	•			NPCR
	2600	Text--Staging	R	R^	•	•	R	•			NPCR
	2610	RX Text--Surgery	R	R^	•	•	R	•			NPCR
	2620	RX Text Radiation (Beam)	R	R^	•	•	R	•			NPCR
	2630	RX Text Radiation Other	R	R^	•	•	R	•			NPCR
	2640	RX Text Chemo	R	R^	•	•	R	•			NPCR
	2650	RX Text Hormone	R	R^	•	•	R	•			NPCR
	2660	RX Text--BRM	R	R^	•	•	R	•			NPCR
	2670	RX Text--Other	R	R^	•	•	R	•			NPCR
	2680	Text--Remarks	•	•	•	•	R	•			NPCR
	2690	Text--Place of Diagnosis	•	•	•	•	•	•			NPCR
Ret.	2700	Reserved 17									
Ret.	2730	CS PreRx Tumor Size									
Ret.	2735	CS PreRx Extension									
Ret.	2740	CS PreRx Tum Sz/Ext Eval									
Ret.	2750	CS PreRx Lymph Nodes									

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Ret.	2755	CS PreRx Reg Nodes Eval									
Ret.	2760	CS PreRx Mets at DX									
Ret.	2765	CS PreRx Mets Eval									
Ret.	2770	CS PostRx Tumor Size									
Ret.	2775	CS PostRx Extension									
Ret.	2780	CS PostRx Lymph Nodes									
Ret.	2785	CS PostRx Mets at DX									
	2800	CS Tumor Size	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2810	CS Extension	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2820	CS Tumor Size/Ext Eval	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2830	CS Lymph Nodes	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2840	CS Lymph Nodes Eval	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2850	CS Mets at DX	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2851	CS Mets at Dx-Bone	•	•	RH	RH	RH	RH			AJCC
	2852	CS Mets at Dx-Brain	•	•	RH	RH	RH	RH			AJCC
	2853	CS Mets at Dx-Liver	•	•	RH	RH	RH	RH			AJCC
	2854	CS Mets at Dx-Lung	•	•	RH	RH	RH	RH			AJCC
	2860	CS Mets Eval	RH*	RH*	RH	RH	RH*	RH*			AJCC
	2861	CS Site-Specific Factor 7	RH*	RH*	RH	RH	RH	RH			AJCC
	2862	CS Site-Specific Factor 8	RS*	RS*	RH	RH	RH	RH			AJCC
	2863	CS Site-Specific Factor 9	RS*	RS* RH*	RH	RH	RH	RH			AJCC
	2864	CS Site-Specific Factor10	RS*	RS* RH*	RH	RH	RH	RH			AJCC
	2865	CS Site-Specific Factor11	RS*	RS* RH*	RH	RH	RH	RH			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	2866	CS Site-Specific Factor12	RH*	RH*	RH	RH	RH	RH			AJCC
	2867	CS Site-Specific Factor13	RS*	RS* RH*	RH	RH	RH	RH			AJCC
	2868	CS Site-Specific Factor14	RS*	RS* RH*	RH	RH	RH	RH			AJCC
	2869	CS Site-Specific Factor15	RS*	RS* RH*	RH	RH	RH	RH			AJCC
	2870	CS Site-Specific Factor16	RS*	RS* RH*	RH	RH	RH	RH			AJCC
	2871	CS Site-Specific Factor17	RH*	RH*	RH	RH	RH	RH			AJCC
	2872	CS Site-Specific Factor18	•	•	RH	RH	RH	RH			AJCC
	2873	CS Site-Specific Factor19	•	•	RH	RH	RH	RH			AJCC
	2874	CS Site-Specific Factor20	•	•	RH	RH	RH	RH			AJCC
	2875	CS Site-Specific Factor21	•	•	RH	RH	RH	RH			AJCC
	2876	CS Site-Specific Factor22	•	•	RH	RH	RH	RH			AJCC
	2877	CS Site-Specific Factor23	•	•	RS	RS	RH	RH			AJCC
	2878	CS Site-Specific Factor24	•	•	RH	RH	RH	RH			AJCC
	2879	CS Site-Specific Factor25	RS*	RS* RH*	RH	RH	RH	RH			AJCC
	2880	CS Site-Specific Factor 1	RS*	RS* RH*	RH	RH	RH	RH			AJCC
	2890	CS Site-Specific Factor 2	RS*	RS* RH*	RH	RH	RH	RH			AJCC
	2900	CS Site-Specific Factor 3	RH*	RH*	RH	RH	RH	RH			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	2910	CS Site-Specific Factor 4	RH*	RH*	RH	RH	RH	RH			AJCC
	2920	CS Site-Specific Factor 5	RS*	RS* RH*	RH	RH	RH	RH			AJCC
	2930	CS Site-Specific Factor 6	RS*	RS* RH*	RH	RH	RH	RH			AJCC
	2935	CS Version Input Original	D	R*	RH	RH	RH*	RH*			AJCC
	2936	CS Version Derived	RH*	RH*	DH	DH	D*	DH*			AJCC
	2937	CS Version Input Current	D	R* RH	RH	RH	RH*	RH*			AJCC
	2940	Derived AJCC-6 T	•	•	DH	DH	DH	RH			AJCC
	2950	Derived AJCC-6 T Descript	•	•	DH	DH	DH	RH			AJCC
	2960	Derived AJCC-6 N	•	•	DH	DH	DH	RH			AJCC
	2970	Derived AJCC-6 N Descript	•	•	DH	DH	DH	RH			AJCC
	2980	Derived AJCC-6 M	•	•	DH	DH	DH	RH			AJCC
	2990	Derived AJCC-6 M Descript	•	•	DH	DH	DH	RH			AJCC
	3000	Derived AJCC-6 Stage Grp	•	•	DH	DH	DH	RH			AJCC
	3010	Derived SS1977	D	•	DH	DH	D*	S			AJCC
	3020	Derived SS2000	D+	RH*	DH	DH	D+	R+			AJCC
	3030	Derived AJCC--Flag		•	DH	DH	DH	RH			AJCC
	3040	Derived SS1977--Flag	^	•	DH	DH	D*	S			AJCC
	3050	Derived SS2000--Flag	^	RH*	DH	DH	D*	S			AJCC
	3100	Archive FIN	•	•	R	R	•	•			CoC
	3105	NPI--Archive FIN	•	•	R	R	•	•			CMS
	3110	Comorbid/Complication 1	•	•	RH	RH	•	•			CoC
	3120	Comorbid/Complication 2	•	•	RH	RH	•	•			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	3130	Comorbid/Complication 3	•	•	RH	RH	•	•			CoC
	3140	Comorbid/Complication 4	•	•	RH	RH	•	•			CoC
	3150	Comorbid/Complication 5	•	•	RH	RH	•	•			CoC
	3160	Comorbid/Complication 6	•	•	RH	RH	•	•			CoC
	3161	Comorbid/Complication 7	•	•	RH	RH	•	•			CoC
	3162	Comorbid/Complication 8	•	•	RH	RH	•	•			CoC
	3163	Comorbid/Complication 9	•	•	RH	RH	•	•			CoC
	3164	Comorbid/Complication 10	•	•	RH	RH	•	•			CoC
	3165	ICD Revision Comorbid	•	•	•	•	•	•			CoC
	3170	RX Date Mst Defn Srg	R	R	R	R	R*	R*			CoC
Rev.	3171	RX Date Mst Defn Srg Flag	R	R	R	R	R*	R*			NAACCR
	3180	RX Date Surg Disch	•	•	R	R	•	•			CoC
Rev.	3181	RX Date Surg Disch Flag	•	•	R	R	•	•			NAACCR
	3190	Readm Same Hosp 30 Days	•	•	R	R	•	•			CoC
	3200	Rad--Boost RX Modality	•	•	•	•	•	•			CoC
	3210	Rad--Boost Dose cGy	•	•	•	•	•	•			CoC
	3220	RX Date Rad Ended	•	•	R	R	•	•			CoC
Rev.	3221	RX Date Rad Ended Flag	•	•	R	R	•	•			NAACCR
	3230	RX Date Systemic	•	•	R	R	RC	RC			CoC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Rev.	3231	RX Date Systemic Flag	•	•	R	R	RC	RC			NAACCR
	3250	RX Summ--Transplnt/Endocr	R	R	R	R	R	R			CoC
	3270	RX Summ--Palliative Proc	•	•	R	R	•	•			CoC
	3280	RX Hosp--Palliative Proc	•	•	R	R	•	•			CoC
	3300	RuralUrban Continuum 1993	D	D	•	•	•	•			NAACCR
	3310	RuralUrban Continuum 2003	D	D	•	•	•	•			NAACCR
	3312	RuralUrban Continuum 2013	D	D	•	•	D	R			NAACCR
	3400	Derived AJCC-7 T	RH*	RH*	DH	DH	DH	RH			AJCC
	3402	Derived AJCC-7 T Descript	RH*	RH*	DH	DH	DH	RH			AJCC
	3410	Derived AJCC-7 N	RH*	RH*	DH	DH	DH	RH			AJCC
	3412	Derived AJCC-7 N Descript	RH*	RH*	DH	DH	DH	RH			AJCC
	3420	Derived AJCC-7 M	RH*	RH*	DH	DH	DH	RH			AJCC
	3422	Derived AJCC-7 M Descript	RH*	RH*	DH	DH	DH	RH			AJCC
	3430	Derived AJCC-7 Stage Grp	RH*	RH*	DH	DH	DH	RH			AJCC
	3440	Derived PreRx-7 T	•	•	•	•	•	•			AJCC
	3442	Derived PreRx-7 T Descrip	•	•	•	•	•	•			AJCC
	3450	Derived PreRx-7 N	•	•	•	•	•	•			AJCC
	3452	Derived PreRx-7 N Descrip	•	•	•	•	•	•			AJCC
	3460	Derived PreRx-7 M	•	•	•	•	•	•			AJCC
	3462	Derived PreRx-7 M Descrip	•	•	•	•	•	•			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	3470	Derived PreRx-7 Stage Grp	•	•	•	•	•	•			AJCC
	3480	Derived PostRx-7 T	•	•	•	•	•	•			AJCC
	3482	Derived PostRx-7 N	•	•	•	•	•	•			AJCC
	3490	Derived PostRx-7 M	•	•	•	•	•	•			AJCC
	3492	Derived PostRx-7 Stge Grp	•	•	•	•	•	•			AJCC
	3600	Derived Neoadjuv Rx Flag	•	•	•	•	•	•			AJCC
	3605	Derived SEER Path Stg Grp	•	•	•	•	DH	RH			SEER
	3610	Derived SEER Clin Stg Grp	•	•	•	•	DH	RH			SEER
	3614	Derived SEER Cmb Stg Grp	•	•	•	•	DH	RH			SEER
	3616	Derived SEER Combined T	•	•	•	•	DH	RH			SEER
	3618	Derived SEER Combined N	•	•	•	•	DH	RH			SEER
	3620	Derived SEER Combined M	•	•	•	•	DH	RH			SEER
	3622	Derived SEER Cmb T Src	•	•	•	•	DH	RH			SEER
	3624	Derived SEER Cmb N Src	•	•	•	•	DH	RH			SEER
	3626	Derived SEER Cmb M Src	•	•	•	•	DH	RH			SEER
	3645	NPCR Derived AJCC 8 TNM Clin Stg Grp	•	•	•	•	•	•			NPCR
	3646	NPCR Derived AJCC 8 TNM Path Stg Grp	•	•	•	•	•	•			NPCR
	3647	NPCR Derived AJCC 8 TNM Post Therapy Stg Grp	•	•	•	•	•	•			NPCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Rev.	3650	NPCR Derived Clin Stg Grp	RH	RH	•	•	•	•			NPCR
Rev.	3655	NPCR Derived Path Stg Grp	RH	RH	•	•	•	•			NPCR
	3700	SEER Site-Specific Fact 1	•	•	•	•	R	R			SEER
	3702	SEER Site-Specific Fact 2	•	•	•	•	•	•			SEER
	3704	SEER Site-Specific Fact 3	•	•	•	•	•	•			SEER
	3706	SEER Site-Specific Fact 4	•	•	•	•	•	•			SEER
	3708	SEER Site-Specific Fact 5	•	•	•	•	•	•			SEER
	3710	SEER Site-Specific Fact 6	•	•	•	•	•	•			SEER
	3720	NPCR Specific Field	R	R	•	•	•	•			NPCR
	3750	Over-ride CS 1	•	•	RH	RH	•	•			AJCC
	3751	Over-ride CS 2	•	•	RH	RH	•	•			AJCC
	3752	Over-ride CS 3	•	•	RH	RH	•	•			AJCC
	3753	Over-ride CS 4	•	•	RH	RH	•	•			AJCC
	3754	Over-ride CS 5	•	•	RH	RH	•	•			AJCC
	3755	Over-ride CS 6	•	•	RH	RH	•	•			AJCC
	3756	Over-ride CS 7	•	•	RH	RH	•	•			AJCC
	3757	Over-ride CS 8	•	•	RH	RH	•	•			AJCC
	3758	Over-ride CS 9	•	•	RH	RH	•	•			AJCC
	3759	Over-ride CS 10	•	•	RH	RH	•	•			AJCC
	3760	Over-ride CS 11	•	•	RH	RH	•	•			AJCC
	3761	Over-ride CS 12	•	•	RH	RH	•	•			AJCC
	3762	Over-ride CS 13	•	•	RH	RH	•	•			AJCC
	3763	Over-ride CS 14	•	•	RH	RH	•	•			AJCC
	3764	Over-ride CS 15	•	•	RH	RH	•	•			AJCC

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	3765	Over-ride CS 16	•	•	RH	RH	•	•			AJCC
	3766	Over-ride CS 17	•	•	RH	RH	•	•			AJCC
	3767	Over-ride CS 18	•	•	RH	RH	•	•			AJCC
	3768	Over-ride CS 19	•	•	RH	RH	•	•			AJCC
Rev.	3769	Over-ride CS 20	RH	RH	RH	RH	RH	RH			AJCC/NPCR
	3780	Secondary Diagnosis 1	•	•	RH	RH	•	•			CoC
	3782	Secondary Diagnosis 2	•	•	RH	RH	•	•			CoC
	3784	Secondary Diagnosis 3	•	•	RH	RH	•	•			CoC
	3786	Secondary Diagnosis 4	•	•	RH	RH	•	•			CoC
	3788	Secondary Diagnosis 5	•	•	RH	RH	•	•			CoC
	3790	Secondary Diagnosis 6	•	•	RH	RH	•	•			CoC
	3792	Secondary Diagnosis 7	•	•	RH	RH	•	•			CoC
	3794	Secondary Diagnosis 8	•	•	RH	RH	•	•			CoC
	3796	Secondary Diagnosis 9	•	•	RH	RH	•	•			CoC
	3798	Secondary Diagnosis 10	•	•	RH	RH	•	•			CoC
	3800	Schema ID	D	D	D	D	D	R			NAACCR
	3801	Chromosome 1p: Loss of Heterozygosity (LOH)	•	•	RS	RS	RS	RS			NAACCR
	3802	Chromosome 19q: Loss of Heterozygosity (LOH)	•	•	RS	RS	RS	RS			NAACCR
	3803	Adenoid Cystic Basaloid Pattern	•	•	RS	RS	RS	RS			NAACCR
Rev.	3804	Adenopathy	•	•	RS	RS	RS	RS			NAACCR
	3805	AFP Post-Orchiectomy Lab Value	•	•	RS	RS	RC	RC			NAACCR
	3806	AFP Post-Orchiectomy Range	•	•	RS	RS	RC	RC			NAACCR
	3807	AFP Pre-Orchiectomy Lab Value	•	•	RS	RS	RC	RC			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	3808	AFP Pre-Orchiectomy Range	•	•	RS	RS	RC	RC			NAACCR
Rev.	3809	AFP Pretreatment Interpretation	•	•	RS	RS	RC	RC			NAACCR
	3810	AFP Pretreatment Lab Value	•	•	RS	RS	RC	RC			NAACCR
Rev.	3811	Anemia	•	•	RS	RS	RS	RS			NAACCR
Rev.	3812	B symptoms	•	•	RS	RS	RS	RS			NAACCR
	3813	Bilirubin Pretreatment Total Lab Value	•	•	RS	RS	RC	RC			NAACCR
	3814	Bilirubin Pretreatment Unit of Measure	•	•	RS	RS	RC	RC			NAACCR
	3815	Bone Invasion	•	•	RS	RS	RS	RS			NAACCR
	3816	Brain Molecular Markers	R	R	•	•	RS	RS			NAACCR
Rev.	3817	Breslow Tumor Thickness	R	R	RS	RS	RS	RS			NAACCR
Rev.	3818	CA-125 Pretreatment Interpretation	•	•	RS	RS	RS	RS			NAACCR
Rev.	3819	CEA Pretreatment Interpretation	•	•	RS	RS	RS	RS			NAACCR
	3820	CEA Pretreatment Lab Value	•	•	RS	RS	RS	RS			NAACCR
	3821	Chromosome 3 Status	•	•	RS	RS	RC	RC			NAACCR
	3822	Chromosome 8q Status	•	•	RS	RS	RC	RC			NAACCR
Rev.	3823	Circumferential Resection Margin (CRM)	•	•	RS	RS	RS	RS			NAACCR
	3824	Creatinine Pretreatment Lab Value	•	•	RS	RS	RC	RC			NAACCR
	3825	Creatinine Pretreatment Unit of Measure	•	•	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	3826	Estrogen Receptor Percent Positive or Range	•	•	•	•	RC	RC			NAACCR
Rev.	3827	Estrogen Receptor Summary	R	R	RS	RS	RS	RS			NAACCR
	3828	Estrogen Receptor Total Allred Score	•	•	RS	RS	RC	RC			NAACCR
Rev.	3829	Esophagus and EGJ Tumor Epicenter	•	•	RS	RS	RS	RS			NAACCR
	3830	Extranodal Extension Clin (non-Head and Neck)	•	•	RS	RS	RC	RC			NAACCR
	3831	Extranodal Extension Head and Neck Clinical	•	•	RS	RS	RC	RC			NAACCR
Rev.	3832	Extranodal Extension Head and Neck Pathological	•	•	RS	RS	RS	RS			NAACCR
	3833	Extranodal Extension Path (non-Head and Neck)	•	•	RS	RS	RC	RC			NAACCR
	3834	Extravascular Matrix Patterns	•	•	RS	RS	RC	RC			NAACCR
	3835	Fibrosis Score	R	R	RS	RS	RC	RC			NAACCR
	3836	FIGO Stage	•	•	RS	RS	RS	RS			NAACCR
Rev.	3837	Gestational Trophoblastic Prognostic Scoring Index	•	•	RS	RS	RS	RS			NAACCR
Rev.	3838	Gleason Patterns Clinical	•	•	RS	RS	RS	RS			NAACCR
Rev.	3839	Gleason Patterns Pathological	•	•	RS	RS	RS	RS			NAACCR
Rev.	3840	Gleason Score Clinical	•	•	RS	RS	RC	RC			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Rev.	3841	Gleason Score Pathological	•	•	RS	RS	RC	RC			NAACCR
Rev.	3842	Gleason Tertiary Pattern	•	•	RS	RS	RC	RC			NAACCR
	3843	Grade Clinical	R	R	R	R	R	R			NAACCR
Rev.	3844	Grade Pathological	RN	RN	R	R	R	R			NAACCR
Rev.	3845	Grade Post Therapy	RN	• RN	R	R	RS	RS			NAACCR
	3846	hCG Post-Orchiectomy Lab Value	•	•	RS	RS	RC	RC			NAACCR
	3847	hCG Post-Orchiectomy Range	•	•	RS	RS	RS	RS			NAACCR
	3848	hCG Pre-Orchiectomy Lab Value	•	•	RS	RS	RC	RC			NAACCR
	3849	hCG Pre-Orchiectomy Range	•	•	RS	RS	RS	RS			NAACCR
Rev.	3850	HER2 IHC Summary	•	•	RS	RS	RS*	RS*			NAACCR
Rev.	3851	HER2 ISH Dual Probe Copy Number	•	•	RS	RS	RS*	RS*			NAACCR
Rev.	3852	HER2 ISH Dual Probe Ratio	•	•	RS	RS	RS*	RS*			NAACCR
Rev.	3853	HER2 ISH Single Probe Copy Number	•	•	RS	RS	RS*	RS*			NAACCR
Rev.	3854	HER2 ISH Summary	•	•	RS	RS	RS*	RS*			NAACCR
Rev.	3855	HER2 Overall Summary	R	R	RS	RS	RS	RS			NAACCR
Rev.	3856	Heritable Trait	•	•	RS	RS	RS	RS			NAACCR
Rev.	3857	High Risk Cytogenetics	•	•	RS	RS	RS	RS			NAACCR
	3858	High Risk Histologic Features	•	•	RS	RS	RS	RS			NAACCR
Rev.	3859	HIV Status	•	•	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	3860	International Normalized Ratio Prothrombin Time	•	•	RS	RS	RC	RC			NAACCR
	3861	Ipsilateral Adrenal Gland Involvement	•	•	RS	RS	RS	RS			NAACCR
	3862	JAK2	•	•	RS	RS	RS	RS			NAACCR
	3863	Ki-67	•	•	RS	RS	RC	RC			NAACCR
	3864	Invasion Beyond Capsule	•	•	RS	RS	RS	RS			NAACCR
Rev.	3865	KIT Gene Immunohistochemistry	•	•	RS	RS	RC	RC			NAACCR
	3866	KRAS	•	•	RS	RS	RS	RS			NAACCR
	3867	LDH Post-Orchiectomy Range	•	•	RS	RS	RS	RS			NAACCR
	3868	LDH Pre-Orchiectomy Range	•	•	RS	RS	RS	RS			NAACCR
Rev.	3869	LDH Pretreatment Level	•	•	RS	RS	RS	RS			NAACCR
	3870	LDH Upper Limits of Normal	•	•	RS	RS	RC	RC			NAACCR
	3871	LN Assessment Method Femoral-Inguinal	•	•	RS	RS	RC	RC			NAACCR
	3872	LN Assessment Method Para-Aortic	•	•	RS	RS	RC	RC			NAACCR
	3873	LN Assessment Method Pelvic	•	•	RS	RS	RC	RC			NAACCR
	3874	LN Distant Assessment Method	•	•	RS	RS	RC	RC			NAACCR
	3875	LN Distant: Mediastinal, Scalene	•	•	RS	RS	RC	RC			NAACCR
	3876	LN Head and Neck Levels I-III	•	•	RS	RS	RS	RS			NAACCR
	3877	LN Head and Neck Levels IV-V	•	•	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	3878	LN Head and Neck Levels VI-VII	•	•	RS	RS	RS	RS			NAACCR
	3879	LN Head and Neck Other	•	•	RS	RS	RS	RS			NAACCR
	3880	LN Isolated Tumor Cells (ITC)	•	•	RS	RS	RS	RS			NAACCR
	3881	LN Laterality	•	•	RS	RS	RS	RS			NAACCR
	3882	LN Positive Axillary Level I-II	•	•	RS	RS	RS	RS			NAACCR
Rev.	3883	LN Size	•	•	RS	RS	RS	RS			NAACCR
	3884	LN Status Femoral-Inguinal, Para-Aortic, Pelvic	•	•	RS	RS	RS	RS			NAACCR
Rev.	3885	Lymphocytosis	•	•	RS	RS	RS	RS			NAACCR
	3886	Major Vein Involvement	•	•	RS	RS	RS	RS			NAACCR
	3887	Measured Basal Diameter	•	•	RS	RS	RS	RS			NAACCR
	3888	Measured Thickness	•	•	RS	RS	RS	RS			NAACCR
	3889	Methylation of O6-Methylguanine-Methyltransferase	•	•	RS	RS	RS	RS			NAACCR
Rev.	3890	Microsatellite Instability (MSI)	RS*	RS*	RS	RS	RS	RS			NAACCR
	3891	Microvascular Density	•	•	RS	RS	RC	RC			NAACCR
	3892	Mitotic Count Uveal Melanoma	•	•	RS	RS	RC	RC			NAACCR
Rev.	3893	Mitotic Rate Melanoma	•	•	RS	RS	RS	RS			NAACCR
	3894	Multigene Signature Method	•	•	RS	RS	RS	RS			NAACCR
	3895	Multigene Signature Results	•	RN	RS	RS	RS	RS			NAACCR
	3896	NCCN International Prognostic Index (IPI)	•	•	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Rev.	3897	Number of Cores Examined	•	•	RS	RS	RS	RS			NAACCR
Rev.	3898	Number of Cores Positive	•	•	RS	RS	RS	RS			NAACCR
	3899	Number of Examined Para-Aortic Nodes	•	•	RS	RS	RC	RC			NAACCR
	3900	Number of Examined Pelvic Nodes	•	•	RS	RS	RC	RC			NAACCR
	3901	Number of Positive Para-Aortic Nodes	•	•	RS	RS	RC	RC			NAACCR
	3902	Number of Positive Pelvic Nodes	•	•	RS	RS	RC	RC			NAACCR
	3903	Oncotype Dx Recurrence Score-DCIS	•	•	RS	RS	RC	RC			NAACCR
Rev.	3904	Oncotype Dx Recurrence Score-Invasive	RN	RN •	RS	RS	RS	RS			NAACCR
	3905	Oncotype Dx Risk Level-DCIS	•	•	RS	RS	RC	RC			NAACCR
	3906	Oncotype Dx Risk Level-Invasive	•	•	RS	RS	RC	RC			NAACCR
Rev.	3907	Organomegaly	•	•	RS	RS	RS	RS			NAACCR
Rev.	3908	Percent Necrosis Post Neoadjuvant	•	•	RS	RS	RC	RC			NAACCR
	3909	Perineural Invasion	•	•	RS	RS	RS	RS			NAACCR
Rev.	3910	Peripheral Blood Involvement	•	•	RS	RS	RS	RS			NAACCR
	3911	Peritoneal Cytology	R	•	RS	RS	RS	RS			NAACCR
	3913	Pleural Effusion	•	•	RS	RS	RS	RS			NAACCR
	3914	Progesterone Receptor Percent Positive or Range	•	•	RS	RS	RC	RC			NAACCR
Rev.	3915	Progesterone Receptor Summary	R	R	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	3916	Progesterone Receptor Total Allred Score	•	•	RS	RS	RC	RC			NAACCR
	3917	Primary Sclerosing Cholangitis	•	•	RS	RS	RC	RC			NAACCR
	3918	Profound Immune Suppression	•	•	RS	RS	RS	RS			NAACCR
Rev.	3919	Prostate Pathological Extension	•	•	RS	RS	RS	RS			NAACCR
Rev.	3920	PSA (Prostatic Specific Antigen) Lab Value	R	R	RS	RS	RS	RS			NAACCR
	3921	Residual Tumor Volume Post Cytoreduction	•	•	RS	RS	RS	RS			NAACCR
	3922	Response to Neoadjuvant Therapy	•	•	RS	RS	RC	RC			NAACCR
Rev.	3923	S Category Clinical	•	•	RS	RS	RS	RS			NAACCR
Rev.	3924	S Category Pathological	•	•	RS	RS	RS	RS			NAACCR
	3925	Sarcomatoid Features	•	•	RS	RS	RS	RS			NAACCR
Rev.	3926	Schema Discriminator 1	R	R	RS	RS	RS	RS			NAACCR
Rev.	3927	Schema Discriminator 2	•	•	RS	RS	RS	RS			NAACCR
Rev.	3928	Schema Discriminator 3	•	•	RS	RS	RS	RS			NAACCR
	3929	Separate Tumor Nodules	•	•	RS	RS	RS	RS			NAACCR
Rev.	3930	Serum Albumin Pretreatment Level	•	•	RS	RS	RS	RS			NAACCR
Rev.	3931	Serum Beta-2 Microglobulin Pretreatment Level	•	•	RS	RS	RS	RS			NAACCR
Rev.	3932	LDH Pretreatment Lab Value	R	R	RS	RS	RS	RS			NAACCR
Rev.	3933	Thrombocytopenia	•	•	RS	RS	RS	RS			NAACCR
	3934	Tumor Deposits	•	•	RS	RS	RS	RS			NAACCR
	3935	Tumor Growth Pattern	•	•	RS	RS	RS	RS			NAACCR

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
Rev.	3936	Ulceration	•	•	RS	RS	RS	RS			NAACCR
	3937	Visceral and Parietal Pleural Invasion	•	•	RS	RS	RS	RS			NAACCR
New	3938	ALK Rearrangement	•	•	RS	RS	R	R			NAACCR
New	3939	EGFR Mutational Analysis	•	•	RS	RS	R	R			NAACCR
New	3940	BRAF Mutational Analysis	•	•	RS	RS	R	R			NAACCR
New	3941	NRAS Mutational Analysis	•	•	RS	RS	R	R			NAACCR
New	3942	CA 19-9 PreTX Lab Value	•	•	RS	RS	R	R			NAACCR
New	3943	NCDB—SARSCoV2--Test	•	•	R*	R*	R*	R*			NAACCR
New	3944	NCDB—SARSCoV2--Pos	•	•	R*	R*	R*	R*			NAACCR
New	3945	NCDB—SARSCoV2—Pos Date	•	•	R*	R*	R*	R*			NAACCR
New	3946	NCDB—COVID19—Tx Impact	•	•	R*	R*	R*	R*			NAACCR
	7010	Path Reporting Fac ID 1	•	•	•	•	•	•			HL7
	7011	Path Reporting Fac ID 2	•	•	•	•	•	•			HL7
	7012	Path Reporting Fac ID 3	•	•	•	•	•	•			HL7
	7013	Path Reporting Fac ID 4	•	•	•	•	•	•			HL7
	7014	Path Reporting Fac ID 5	•	•	•	•	•	•			HL7
	7090	Path Report Number 1	•	•	•	•	•	•			HL7
	7091	Path Report Number 2	•	•	•	•	•	•			HL7
	7092	Path Report Number 3	•	•	•	•	•	•			HL7
	7093	Path Report Number 4	•	•	•	•	•	•			HL7
	7094	Path Report Number 5	•	•	•	•	•	•			HL7
	7100	Path Order Phys Lic No 1	•	•	•	•	•	•			HL7

Note	Item #	Item Name	TCR	NPCR	CoC		SEER		Exchange Elements		Source Of Standard
					Collect	Transmit	Collect	Transmit	Hosp > Central	Central > Central	
	7101	Path Order Phys Lic No 2	•	•	•	•	•	•			HL7
	7102	Path Order Phys Lic No 3	•	•	•	•	•	•			HL7
	7103	Path Order Phys Lic No 4	•	•	•	•	•	•			HL7
	7104	Path Order Phys Lic No 5	•	•	•	•	•	•			HL7
	7190	Path Ordering Fac No 1	•	•	•	•	•	•			HL7
	7191	Path Ordering Fac No 2	•	•	•	•	•	•			HL7
	7192	Path Ordering Fac No 3	•	•	•	•	•	•			HL7
	7193	Path Ordering Fac No 4	•	•	•	•	•	•			HL7
	7194	Path Ordering Fac No 5	•	•	•	•	•	•			HL7
	7320	Path Date Spec Collect 1	•	•	•	•	•	•			HL7
	7321	Path Date Spec Collect 2	•	•	•	•	•	•			HL7
	7322	Path Date Spec Collect 3	•	•	•	•	•	•			HL7
	7323	Path Date Spec Collect 4	•	•	•	•	•	•			HL7
	7324	Path Date Spec Collect 5	•	•	•	•	•	•			HL7
	7480	Path Report Type 1	•	•	•	•	•	•			HL7
	7481	Path Report Type 2	•	•	•	•	•	•			HL7
	7482	Path Report Type 3	•	•	•	•	•	•			HL7
	7483	Path Report Type 4	•	•	•	•	•	•			HL7
	7484	Path Report Type 5	•	•	•	•	•	•			HL7

G

APPENDIX G:
REPORTABLE LIST

This list provides documentation of all conditions TCR considers reportable for cases **diagnosed 1/1/2021 and forward**.

The 2021 ICD-O-3.2 Coding Table Excel includes the comprehensive list of ICD-O-3.2 codes effective for cases diagnosed 1/1/2021 forward.

For coding instructions refer to the 2021 ICD-O-3 Implementation Guidelines.

See the coding tables in .pdf and Excel format for 2021 ICD-O-3.2 New Codes, Behaviors, and Terms-Updated 10/01/2020.

For this list:

- New terms and synonyms for existing ICD-O codes were added.
- Terms **bolded** indicate new terms in ICD-O-3 effective for January 1, 2021.
- Terms followed by asterisks (**) indicate that the terms are reportable for benign and borderline behaviors (0 and 1) only when the primary site is listed in the table Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors on page 59 in the Casefinding Section of the Cancer Reporting Handbook 2021. If the behavior is malignant (2 or 3) the terms are reportable for any site.

Reportable List

- **ACTH-producing tumor**
- **Acute myeloid leukemia with mutated NPM1**
- **Acute myeloid leukemia with biallelic mutation of CEBPA**
- **Acute myeloid leukemia with mutated RUNX1**
- **Acute myeloid leukemia with BCR-ABL1 Adamantinoma (long bones, malignant, tibial only)**
- Adenoacanthoma
- Adenocarcinofibroma
- Adenocarcinoma
- Adenocarcinoma, pancreatobilliary-type
- Adenofibroma (malignant endometrioid only)
- Adenoma**
- Adenoma (carcinoid bronchial and cylindroid bronchial and islet cell)
- **Adenoma, Beta cell**
- Adenomyoepithelioma with carcinoma
- Adenosarcoma
- **Adrenal medullary paraganglioma (C74.1)**

- **Aggressive digital papillary adenoma (C44._)**
- AIN III (anal intraepithelial neoplasia, grade III)
- ALK positive large B-cell lymphoma
- Ameloblastoma (malignant only)
- **Anaplastic large cell lymphoma, ALK-negative/ Breast implant-associated anaplastic large cell lymphoma**
- Anaplastic oligodendroglioma, IDH-mutant and 1p/19q-codeleted
- Anaplastic pleomorphic xanthroastrocytoma
- Androblastoma (malignant only)
- Anemia, refractory
- Angioendotheliomatosis
- Angiolipoma**
- Angiomyosarcoma
- Angiosarcoma
- **Aortic body tumor (C75.5)**
- **Aortic body paraganglioma (C75.5)**
- **Aorticopulmonary paraganglioma (C75.5)**
- Argentaffinoma (malignant only)
- Arrhenoblastoma (malignant only)
- Astroblastoma
- Astrocytoma**
- Astroglioma
- B lymphoblastic leukemia/lymphoma
- **B-lymphocytic leukemia/lymphoma, BCR-ABL1-like**
- **Beta cell adenoma (C25.4)**
- Biliary intraepithelial neoplasia (BiIN III) (c23.9)
- Blastoma
- **Breast implant-associated anaplastic large cell lymphoma**
- **Bronchus associated lymphoid tissue lymphoma**
- Cancer
- Carcinoid, malignant (stromal, argentaffin tumor NOS, enterochromaffin-like cell NOS, and tubular)

- **Carcinoid, NOS (C18.1)**
- Carcinofibroma
- Carcinoma
- Carcinomatosis
- Carcinosarcoma
- **Carotid body paranganglioma (C75.4)**
- **Carotid body tumor (C75.4)**
- CASTLE (Carcinoma showing thymus-like element)
- **Chemodectoma**
- Chloroma
- Cholangiocarcinoma
- Chondroblastoma
- Chondrosarcoma
- Chordoma
- Choriocarcinoma
- Chorioepithelioma
- Chorionepithelioma
- **Chromaffin paraganglioma (C74.1)**
- **Chromaffin tumor**
- Chronic lymphoproliferative disorder of NK-cells
- Class IV cytology
- Class V cytology
- CNS Embryonal tumor with rhabdoid features
- Combined large cell neuroendocrine carcinoma
- Comedocarcinoma
- **Composite paraganglioma (C74.1)**
- CPNET (central primitive neuroectodermal, NOS)
- Craniopharyngioma**
- Cylindroma (exclude eccrine dermal, and skin)
- Cyst (dermoid with malignant transformation only or dermoid with secondary tumor)
- Cystadenocarcinofibroma

- Cystadenocarcinoma
- Cystadenofibroma (malignant endometrioid only)
- Cystic pancreatic endocrine neoplasm (CPEN)
- Cystosarcoma phyllodes (malignant only)
- **Cytopenia, refractory of childhood**
- Cytopenia, refractory with multilineage dysplasia
- Dermatofibrosarcoma, protuberans, fibrosarcomatous
- **Dermatofibrosarcoma, sarcomatous**
- Differentiated penile intraepithelial neoplasia
- Differentiated-type vulvar intraepithelial neoplasia
- Diffuse leptomeningeal glioneuronal tumor**
- Diktyoma (exclude benign)
- DIN III (ductal intraepithelial neoplasia, grade III)
- Disease (include only):
    - alpha heavy chain
    - Bowen
    - Chronic myeloproliferative
    - Di Guglielmo
    - Franklin
    - Gamma heavy chain
    - Heavy chain NOS
    - Hodgkin
    - immunoproliferative [NOS and small
    - intestinal only]
    - Letterer-Siwe
    - Mast cell, systemic tissue
    - Mu heavy chain
    - Myeloproliferative, chronic, NOS
    - Paget [exclude of bone]
    - Sezary
- Disorder, myeloproliferative, chronic

- Disorder, primary cutaneous CD30+ T-cell lymphoproliferative
- Dysgerminoma
- Ectomesenchymoma
- **Embryoma**
- Embryonal tumor with multilayered rosettes C19MC-altered
- Embryonal tumor with multilayered rosettes, NOS
- Embryonal tumor with rhabdoid features
- **Endocrine tumor, functioning, NOS**
- **Endometriod intraepithelial neoplasia (C54.1)**
- Endometriosis, stromal
- Ependymoblastoma
- Ependymoma**
- Epithelioid malignant peripheral nerve sheath tumor
- Epithelioma (NOS, basal cell, malignant, and squamous cell only)
- **Erdheim-Chester Disease**
- Erythremia (acute and chronic only)
- Erythroleukemia
- Erythroplasia, Queyrat
- Esthesioneuroblastoma
- Esthesioneurocytoma
- Esthesioneuroepithelioma
- **Extra-adrenal paraganglioma, NOS**
- Fibroblastic reticular cell tumor
- Fibrochondrosarcoma
- Fibrodentinosarcoma
- Fibroepithelioma, of Pinkus type or NOS
- Fibrolipoma**
- Fibroliposarcoma
- Fibroma, NOS**
- Fibromyxosarcoma
- Fibro-odontosarcoma

- Fibrosarcoma
- Fibrosarcomatous dermatofibrosarcoma protuberans
- Fibroxanthoma (malignant only)
- Gangliocytoma**
- Ganglioglioma**
- Ganglioneuroblastoma
- Ganglioneuroma**
- Gastrinoma
- Gemistocytoma
- Germ cell tumors with associated hematological malignancy
- Germinoma
- GIST-Gastrointestinal stromal tumor (malignant)
- **Gastrointesitnal autonomic nerve tumor (GANT)**
- **Gastrointestinal pacemaker cell tumor**
- **Gastrointestinal stomal tumor (GIST)**
- Glioblastoma
- Gliofibroma**
- Glioma**
- Gliomatosis cerebri
- Gliosarcoma
- Glomangiosarcoma
- **Glomus jugulare tumor, NOS (C75.5)**
- Glucagonoma
- Granuloma (Hodgkin only)
- **Granulosa cell tumor, adult type (C56.9)**
- Hemangioblastoma**
- Hemangioendothelioma**
- Hemangioma**
- Hemangiopericytoma**
- Hemangiosarcoma
- Hepatoblastoma

- Hepatocarcinoma
- Hepatocholangiocarcinoma
- Hepatoma (exclude benign)
- Hidradenocarcinoma
- Hidradenoma (malignant only)
- Histiocytoma (malignant fibrous only)
- Histiocytosis (malignant, and acute progressive X only)
- Histiocytosis, Langerhans cell, disseminated or generalized
- Hutchinson melanotic freckle (melanoma in situ only)
- HypernephromaImmunocytoma
- **Insulinoma, NOS (C25.4)**
- **Intrapulmonary thymoma (C34._)**
- Intravascular large B-cell lymphoma
- **Islet cell adenoma (C25.4)**
- **Islet cell adenomatosis (C25.4)**
- **Islet cell tumor, NOS (C25.4)**
- **Jugular paraganglioma (C75.5)**
- **Jugulotympanic paraganglioma (C75.5)**
- **Keratoacanthoma**
- Langerhans cell histiocytosis, multifocal**
- Langerhans cell histiocytosis, unifocal**
- Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
- Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
- **Laryngeal paraganglioma**
- LCIS, NOS (lobular carcinoma in situ)
- Leiomyoma (NOS)**
- Leiomyomatosis (NOS)**
- Leiomyosarcoma
- Lentigo maligna
- Leukemia
- LIN III

- Linitis plastica
- Lipoma (atypical or NOS)**
- Liposarcoma (exclude well differentiated liposarcoma, superficial)
- LN2 (of breast also called lobular neoplasia, grade 2 only)
- Lobular carcinoma in situ (LCIS) (C50._)
- Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) (C50._)
- Lymphangioendothelioma (malignant only)
- Lymphangioma **
- Lymphangiosarcoma
- Lymphoblastoma
- Lymphoepithelioma
- Lymphoma
- **Lymphomatoid granulomatosis grade 3**
- Lymphosarcoma
- Macroglobulinemia, Waldenstrom
- Malignancy
- Malignant
- Malignant Poorly Differentiated neuroendocrine tumors
- Mastocytoma (malignant only)
- Mastocytosis (malignant only)
- Medulloblastoma
- Medulloepithelioma
- Medullomyoblastoma
- Melanocytoma, meningeal
- **Melanoma, early/evolving invasive**
- Melanoma (exclude juvenile)
- Melanocytoma, meningial**
- Melanocytosis, diffuse**
- Melanomatosis, meningeal
- Melanosis (precancerous only)
- Meningioma**

- Meningiomatosis**
- Mesenchymoma (malignant only)
- Mesonephroma (exclude benign)
- Mesothelioma (exclude benign and cystic)
- Metaplasia, agnogenic myeloid
- **Metaplastic thymoma (C37.9)**
- Microglioma
- Micropapillary carcinoma, NOS
- **Middle ear paraganglioma (C30.1, C755.5)**
- Midline carcinoma of children and young adults with NUT rearrangement
- Mixed acinar ductal carcinoma
- Mixed phenotype acute leukemia
- MPNST, NOS (malignant peripheral nerve sheath tumor)
- **Multinodular and vascolating neuronal tumor (MVNT)(C71.2)**
- Mycosis Fungoides
- Myeloid and lymphoid neoplasms
- Myelodysplastic/Myeloproliferative neoplasm
- Myelofibrosis (acute, chronic idiopathic, with myeloid metaplasia or as a result of myeloproliferative disease only)
- Myeloma
- Myelomatosis
- Myelosclerosis (megakaryocytic, acute, malignant or with myeloid metaplasia)
- Myelosis
- Myoblastoma (malignant granular cell only)
- Myoepithelioma (malignant only)
- Myosarcoma
- Myosis, stromal NOS or endolymphatic stromal
- Myxoliposarcoma
- Myxosarcoma
- Neoplasia, ductal intraepithelial, grade 3 (of breast, also called DIN III)
- Neoplasia, intratubular germ cell
- Neoplasia, lobular, grade 2 of breast only (also called LN2)

- Neoplasia, squamous intraepithelial, grade 3 (of anus, vulva and vagina only- also called, AIN III, VIN III and VAIN III)
- Neoplasm (malignant only)
- Neoplasm**
- Nephroblastoma
- Nephroma (exclude mesoblastic)
- **Nesidioblastoma (C25.4)**
- Neurilemmoma**
- Neurilemmosarcoma
- Neuroblastoma
- Neurocytoma**, olfactory
- Neuroendocrine tumor, well differentiated
- Neuroepithelioma
- Neurofibroma**
- Neurofibromatosis (NOS)**
- Neurofibrosarcoma
- Neuroma (NOS)**
- Neurosarcoma
- Neurothekeoma**
- Nevus (malignant blue only)
- Non-invasive EFVPTC
- Non-invasive mucinous cystic neoplasm (MCN) of the páncreas with high-grade displasia
- **Nonchromaffin paraganglioma, NOS**
- NUT carcinoma
- Odontosarcoma
- Oligoastrocytoma, mixed
- Oligoastrocytoma, Anaplastic
- Oligodendroblastoma
- Oligodendroglioma
- Orchioblastoma
- Osteochondrosarcoma
- Osteoclastoma (malignant only)

- Osteofibrosarcoma
- Osteosarcoma
- **Pancreatic endocrine tumor, NOS (C25.4)**
- Pancreatic intraepitelial neoplasia (PanIN III) (C25._)
- Pancreatoblastoma
- Pancreatobilliary-type carcinoma
- Panmyelosis, acute only
- Papillary tumor of the pineal region
- Papilloma**
- Paraganglioma
- Paragranuloma, Hodgkin
- PEComa, malignant
- Penile intraepithelial neoplasia, grade III (PeIN III) (C60._)
- Perineural MPNST
- Perineurioma**
- **Pheochromoblastoma (C74.1)**
- Pheochromocytoma
- **Pheochromocytoma, NOS (C74.1)**
- Pilocytic/Juvenile astrocytomas (code the histology and behavior as 9421/3
  Exception: behavior is non-malignant when primary site is optic nerve (C72.3)
- Pilomatrixoma (malignant only)
- Pilomyxoid astrocytoma
- Pinealoma (NOS)**
- Pineoblastoma
- Pineocytoma**
- **Pituicytoma****
- Pituitary Adenoma
- Plasmacytoma
- Plasmablastic lymphoma
- PNET (primitive neuroectodermal tumor)
- Pneumoblastoma

- Polycythemia (proliferative, rubra vera, or vera)
- Polyembryoma
- Polymorphic PTLD
- Polyposis (malignant lymphomatous only)
- Porocarcinoma
- Poroma, eccrine (malignant only)
- PPNET (peripheral primitive neuroectodermal tumor)
- Preleukemia
- Primary cutaneous follicle centre lymphoma
- Primary cutaneous gamma-delta T-cell lymphoma
- Prolactinoma**
- Pseudomyxoma peritonei
- Queyrat erythroplasia
- Rathke Pouch Tumor
- Refractory neutropenia
- Refractory thrombocytopenia
- Reticuloendotheliosis
- Reticulosarcoma
- Reticulosis (histiocytic medullary, malignant, pagetoid, and polymorphic only)
- Retinoblastoma
- Rhabdomyoma (NOS)**
- Rhabdomyosarcoma
- Rhabdosarcoma
- Sarcoma (exclude well differentiated liposarcoma, superficial)
- Sarcomatosis (meningeal only)
- Schwannoma**
- **Sclerosing thymoma (C34._)**
- Secondary Neuroendocrine tumors
- Seminoma
- Serrated adenocarcinoma
- SETTLE (spindle epithelial tumor with thymus-like element)

- **Solid pseudopapillary neoplasm of the pancreas**
- Somatostatinoma
- Spermatocytoma
- Spiradenoma (malignant only)
- Spongioblastoma
- Spongioneuroblastoma
- **Squamous intraepithelial neoplasia, grade II (excludes cervix and skin sites coded to C44._)**
- Stromatosis, endometrial
- Struma (malignant ovarii and Wuchernde Langhans only)
- Subependymoma**
- Subependymoma-ependymoma, mixed
- Sympathicoblastoma
- Syndrome
    - 5q deletion with Myelodysplastic (5q-) syndrome
    - Hypereosinophilic
    - Myelodysplastic
        - NOS
        - with 5q deletion syndrome
        - **with multilineage dysplasia**
        - **with isolated del (5q)**
        - **with ring sideroblasts and multilineage dysplasia**
        - **with ring sideroblasts and single lineage dysplasia**
        - **with single lineage dysplasia**
        - therapy-related, NOS
        - therapy-related, alkylating agent related
        - therapy-related, epidopophyllotoxin related
    - Preleukemic
    - Sezary
- Synovioma (NOS and malignant only)
- Syringoma chondroid, (malignant only)
- Systemic EBV positive T-cell Lymphoproliferative disease of childhood

- T-cell/histiocyte rich large B-cell lymphoma
- T-cell large granular lymphocytic leukemia
- T lymphoblastic leukemia/lymphoma
- Teratoblastoma, malignant
- Teratocarcinoma
- Teratoma**
- **Teratoma, immature (except for lung, thyroid, and thymus)**
- Teratoma, mature (C62._) code the histology and behavior as 9080/3
- Thecoma (malignant only)
- Thrombocythemia (essential, essential hemorrhagic, idiopathic, or idiopathic hemorrhagic)
- Thymoma, NOS (C37.9)
    - **Type A thymoma including atypical variant (C37.9)**
    - **Type AB thymoma (C37.9)**
    - **Type B1 thymoma (C37.9)**
    - **Type B2 thymoma (C37.9)**
    - **Type B3 thymoma (C37.9)**
    - **Thymoma, atypical (C37.9)**
    - **Thymoma, epithelial (C37.9)**
- Tumor (include only):
    - **ACTH-producing**
    - adenocarcinoid
    - adrenal cortical (malignant only)
    - alpha cell (malignant only)
    - Aortic body
    - Askin
    - beta cell (malignant only)
    - Brenner (malignant only)
    - Burkitt
    - carcinoid, NOS (except of appendix)
    - carcinoid (malignant only)
    - **Carotid body**

- cells**
- **Chromaffin**
- desmoplastic small round cell
- dysembryoplastic neuroepithelial**
- embolus
- **endocrine, functioning, NOS**
- endodermal sinus
- **endolymphatic sac**
- epithelial**
- Ewing
- fibrous, solitary**
- follicular dendritic cell
- fusiform cell type (malignant only)
- G cell (malignant only)
- gastrin cell (malignant only)
- gastrointestinal stromal (malignant only)
- germ cell
- giant cell (malignant only)
- glomus (malignant only)
- **Glomus jugulare tumor, NOS (C75.5)**
- granular cell**
- granulosa cell (malignant or sarcomatoid or **adult type**)
- Grawitz
- interstitial cell (malignant only)
- intravascular bronchial alveolar
- **islet**
- Klatskin
- Krukenberg
- Leydig cell (malignant only)
- malignant (any type)
- mast cell (malignant only)

- Merkel cell
- mesenchymal (malignant only)
- mesodermal, mixed
- metastatic
- mixed pineal
- mixed salivary gland type (malignant only)
- mucinous, of low malignant potential
- mucocarcinoid
- Mullerian mixed
- neuroectodermal (exclude melanotic)
- **neuroendocrine, (grade 2, grade 3)**
- nonencapsulating sclerosing
- odontogenic (malignant only)
- olfactory, neurogenic
- Pancoast
- **Pancreatic endocrine, nonfunctioning**
- **Pancreatic endocrine, NOS**
- **Pancreatic neuroendocrine, nonfunctioning**
- Papillary glioneuronal tumor
- papillary mucinous, of low malignant potential
- papillary serous, of low malignant potential
- **Parathyroid**
- peripheral neuroectodermal or peripheral primitive neuroectodermal, NOS
- peripheral nerve sheath (malignant only)
- phyllodes (malignant only)
- pineal parenchymal of intermediate differentiation
- Pinkus
- plasma cell
- polyvesicular vitelline
- primitive neuroectodermal
- rhabdoid, NOS

- rhabdoid/teratoid, atypical,
- round cell, desmoplastic, small
- Rosette-forming glioneuronal tumor
- Schminke
- Secondary
- serous, NOS, of low malignant potential serous, papillary, of low malignant potential
- Sellar region granular cell tumor
- Sertoli-Leydig cell (poorly differentiated, with heterologous elements, sarcomatoid (malignant only)
- sinus, endodermal
- small cell type (malignant only)
- smooth muscle (NOS)**
- soft tissue**
- spindle cell type (malignant only)
- spindle epithelial with thymus-like element or thymus-like differentiation
- steroid cell (malignant only)
- sweat gland (malignant only)
- teratoid/rhabdoid, atypical
- transitional pineal
- Triton, malignant
- trophoblastic, epithelioid
- vitelline, polyvesicular
- Wilms
- yolk sac or yolk sac, hepatoid

- **Type A thymoma including atypical variant (C37.9)**
- **Type AB thymoma (C37.9)**
- **Type B1 thymoma (C37.9)**
- **Type B2 thymoma (C37.9)**
- **Type B3 thymoma (C37.9)**
- **Thymoma, atypical (C37.9)**
- **Thymoma, epithelial (C37.9)**
- Ulcer, rodent

- Urachal carcinoma
- Urine cytology (positive for malignancy)

  Exception: when subsequent biopsy of urinary site if negative
- **Vagal paraganglioma**
- VAIN III (vaginal intraepithelial neoplasia, grade 3)
- VIN III (vulvar intraepithelial neoplasia, grade 3)
- VipomaXanthoastrocytoma, pleomorphic

H

APPENDIX H:
QUICK REFERENCE

Data Fields Quick Reference

The Sample Abstract Form can be found in Appendix D in the 2018-2019 CRH.

Data Field 540: Reporting Facility Number

See page 76

Enter 3-digit code assigned by TCR. If you do not know your facility number, contact your regional office or call 1-800-252-8059.

Data Field 500: Reporting Source

See page 76

Enter code for the source documents and/or facility used to abstract the case.

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

5 - Nursing/Convalescent Home, Hospice

6 - Autopsy Only

7 - Death certificate only

8 – Other hospital outpatient units/surgery centers

Note: *Assign codes in priority order: 1, 2, 8, 4, 3, 5, 6 and 7 (if more than one source is used)*

Data Field 580: Date Of Admit/First Contact/Admit (YYYYMMDD)

See page 79

Enter year, month and day of the patient's first admission to your facility for diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.

Data Field 550: Registry Accession Number

See page 80

The first four digits identify the calendar year the patient was first seen at the facility with a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year's accession/registry number will start with **00001**.

Data Field 2300: MEDICAL RECORD NUMBER

See page 81

Enter the medical record number (MRN) used for the patient's first admission with a DX of cancer. MRN's less than 11 digits and alpha characters are acceptable. If the MRN is not available (for example, outpatient clinic charts) enter "OP" in this field.

Special Codes:

RT: Radiation Therapy department patient without a medical record number

SU: One-day surgery clinic patient without a medical record number

UNK: Medical Record Number Unknown

Data Field 610: Class Of Case

See page 82

Divides data into analytical and non-analytical categories.

Data Field 2230: Last Name

See page 86

Enter the name of the patient in CAPITAL LETTERS. Hyphens, apostrophes, and spaces are allowed. **Do not leave blank.**

Data Field 2240: First Name

See page 87

Enter first name of patient in CAPITAL LETTERS. Hyphens, apostrophes, and spaces are allowed. **Do not leave blank.**

Data Field 2250: Middle Name

See page 88

Enter the middle name of the patient in CAPITAL LETTERS. Blanks, hyphens, spaces, and apostrophes are allowed. Enter middle initial if full name is unknown. Leave blank if unknown.

Data Field 2232: Birth Surname

See page 88

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].

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.

Data Field 2280: Name-Alias

See page 89

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 not in this data item.

A patient may use a different name or nickname. These different names are aliases. This item is useful for matching multiple records on the same patient.

Data Field 2330: Street Address

See page 90

Enter the number and street of the patient's residence at the time the cancer is diagnosed in 60 characters or less. If address is not known, enter "NO ADDRESS" or "UNKNOWN". Do not leave blank.

Punctuation marks are not allowed in this field. Abbreviate, as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service or on the website at usps.com/.

Data Field 2335: Address at DX Supplemental

See page 93

If the name of a facility is provided instead of an address enter the facility name here. If this space is not needed **leave it blank**.

Data Field 70: Patient City

See page 93

Enter the city of residence at the time the cancer is diagnosed. If no address is known, record "Unknown". **Do not leave blank.**

Data Field 80: Patient State

See page 94

Enter the two-letter abbreviation for state of residence at time of diagnosis. Record US for resident of United States, NOS. If resident of foreign country, other than Mexico (MX) or Canada (CD), record either XX if the country is known or YY if the country is unknown. If no address is known, enter "ZZ".

Data Field 100: Patient Zip Code

See page 96

Enter patient's zip code at time of diagnosis. If known, enter nine digit extended zip code. If unavailable, refer to National Zip Code Directory or the USPS website: zip4.usps.com/zip4/welcome.jsp. If resident of foreign country, code all "8's." If address is not available enter "99999".

Data Field 90: FIPS County Code

See page 98 & APPENDIX C

Enter the three-digit Federal Information Processing Standards code found in Appendix C. Code “998" for out-of-state or foreign residents. If address is not available enter “999”.

Data Field 102: Address at DX-Country

See page 99

Enter the appropriate alpha-3-digit code for the country of residence. Use codes issued by the United States Postal Service. Use USA for United States.

Data Field 2320: Patient SSN

See page 99

Every resource should be exhausted to obtain social security number. If not available, code all "9's” **as a last resort only**. Take caution to enter the patient's number and not the spouse's number. Dashes and slashes are not allowed in this field.

Data Field 240: Patient Date Of Birth (YYYYMMDD)

See page 100

DOB must be coded. Enter year, month and day of patient's birth. Unknown date of birth will not be accepted.

Data Field 252: Place Of Birth-State

See page 101

Record the patient’s state of birth (if available) using the US Postal Service. If the state of birth is unknown, code to ZZ.

Data Field 254: Place Of Birth-Country

See page 102

Record the patient’s country of birth (if available) using the US Postal Service. If the country of birth is unknown, code to ZZU.

Data Field 160: Race Codes 1 – 5

See page 103

Enter the 2-digit code to identify the primary race of the patient.

Code	Description	Code	Description
01	White	17	Pakistani
02	Black	20	Micronesian, NOS
03	American Indian, Aleutian, Eskimo (includes all indigenous populations of the Western hemisphere)	21	Chamorro/Chamoru
04	Chinese	22	Guamanian, NOS
05	Japanese	25	Polynesian, NOS
06	Filipino	26	Tahitian
07	Hawaiian	27	Samoan
08	Korean	28	Tongan
10	Vietnamese	30	Melanesian, NOS
11	Laotian	31	Fiji Islander
12	Hmong	32	New Guinean
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS	98	Other
16	Asian Indian	99	Unknown
88	No additional races (races 2-5)		

Data Field 161, 162, 163 & 164: Race 2, Race 3, Race 4, & Race 5

See page 107

If the patient is multi-racial, code all the races using items (RACE 2) through (RACE 5) Use code “88" for no further race documented.

Data Field 190: Spanish/Hispanic Origin

See page 109

This code identifies persons of Spanish or Hispanic origin. The information may be coded from the medical record or may be based on Spanish/Hispanic names. Persons of Spanish or Hispanic origin may be of any race. A list of Spanish/Hispanic surnames is available on the TCR website online appendices: dshs.texas.gov/tcr/training/handbook/Appendix-Spanish-Hispanic-Surnames.pdf

Code	Description
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS)
2	Puerto Rican

Code	Description
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic (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 category of 1–5.
7	Spanish surname only. The only evidence of the person's Hispanic origin is surname or maiden name and there is no other information the person is not Hispanic. Ordinarily for central registry use only.
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not; not stated in patient record

Data Field 220: Patient Sex Codes

See page 111

Enter the code to identify the gender of the patient.

Code	Description
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not Stated/Unknown

Data Field 320: Text Usual Industry

See page 112

Document the patient's usual industry to the extent that the information is available in the medical record.

Data Field 310: Text Usual Occupation

See page 113

Document the patient's usual occupation to the extent that the information is available in the medical record.

Data Field 2680: Other Pertinent Information

See page 115

Document other pertinent information for which adequate or appropriate space has not been provided on the reporting form. Such information may include additional staging or treatment information, history of disease or comments regarding lack of documentation in the medical record. Document the name of the facility that referred the patient or the name of the facility that the patient was referred to in this field. Document age and race of the patient in this field.

Suggestions for text:

- Smoking history
- Family history of cancer
- 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."

Data Field 2470: Physician Follow Up

See page 116

Record the state license number of the physician currently responsible for following the patient. Physician license numbers for Texas can be found at the following website: tmb.state.tx.us/page/look-up-a-license.

Data Field 560: Sequence Number

See page 117

Indicates the chronological sequence of this reportable neoplasm IN THE PATIENT'S LIFETIME. Each PRIMARY tumor is assigned a different number.

Sequence Number: Malignant Neoplasms

One Primary	More Than One Primary	Sequence Unknown
00 One primary only	01 First of two or more primaries	99 Unspecified
	02 Second of two or more primaries	
	03 Third of three or more primaries	

Sequence Number: Non-Malignant Neoplasms

One Primary	More Than One Primary	Sequence Unknown
60 One primary only	61 First of two or more primaries	88 Unspecified
	62 Second of two or more primaries	
	63 Third of three or more primaries	

Data Field 630: Primary Payer At Dx

See page 119

Record patient's insurance.

Code	Description
01	Not insured
02	Not insured, self-pay
10	Insurance, NOS
20	Private Insurance: Managed Care, HMO, or PPO
21	Private Insurance: Fee-for-Service
31	Medicaid
35	Medicaid-Administered through a Managed Care plan
60	Medicare without supplement, Medicare, NOS
61	Medicare with supplement, NOS
62	Medicare-Administered through a Managed Care plan
63	Medicare with private supplement
64	Medicare with Medicaid eligibility
65	TRICARE
66	Military
67	Veterans Affairs
68	Indian/Public Health Services
99	Insurance status unknown

Data Field 2315: Medicare Beneficiary Identifier

Page 122

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.

Data Field 39: Date Of Initial Diagnosis (YYYYMMDD)

See page 124

Enter the date of initial diagnosis of this cancer by a recognized medical practitioner **by any method** (for example, a positive finding from a radiology report); regardless of whether the diagnosis was made at this facility or elsewhere. The date of diagnosis for "Death Certificate Only" or "Autopsy Only" is the date of death. For vague dates, estimate month and year. For cases with unknown date of diagnosis code month and year of date of first contact (for June 2018 code 201806) and document "Date of dx unknown" in *Other Pertinent Information* Text Field. This should be used as a last resort after exhausting all available resources. Every effort must be made to obtain date of diagnosis.

Data Field 522 & 523: Morphology ICD-O-3: Type and Behavior

See page 127

The *2018 Solid Tumor Rules*, the *ICD-O-3.2*, the *2021 ICD-O-3 Histology and Behavior Code Update Tables*, the *Hematopoietic and Lymphoid Neoplasm Coding Manual*, and the *Hematopoietic and Lymphoid Neoplasm Database* are the standard references for histology codes for cases diagnosed 2021 and forward. **Adequate documentation of tumor cell type must be provided** in the Final Diagnosis section (Data Fields 2590 and 2580) of the reporting form to support coding. Use all pathology reports available; generally, tissue from a resection or excision is most representative of the tumor's histology.

Data Field 400: Primary Site

See page 134

Record the specific topography code from ICD-O-3. **Adequate documentation must be provided** in the Final Diagnosis section (Data Fields 2590 and 2580) of the reporting form to support coding.

Data Field 3843: Grade Clinical

See pages 145

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, 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]).

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

Codes (Refer to the most recent version of the SSDI Manual for additional site-specific instructions.)

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank. Leave blank for cases diagnosed prior to 2018.

Data Field 3844: Grade Pathological

See page 145

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.

For cases diagnosed January 1, 2018 and later, this data item, along with Grade Clinical and Grade Post Therapy, replaces the data item Grade [NAACCR Item #440] as well as site specific. 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.

For cases diagnosed January 1, 2018 and later, this data item, along with Grade Clinical and Grade Post Therapy, replaces the data item Grade [NAACCR Item #440] as well as site specific instructions.

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.

Codes (Refer to the most recent version of the SSDI Manual for additional site-specific instructions.)

Each Site-Specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank. Leave blank for cases diagnosed prior to 2018.

Data Field 1068: Grade Post Therapy Clinical (yc)

See page 146

This data item, implemented in 2021, 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, 2021, and later, this data item, along with Grade Clinical, Grade Pathological, and Grade Post Therapy Path (yp), replaces all previous grade related data items, including NAACCR Data Item Grade [440] and Collaborative Stage Site-Specific Factors (SSF's) (2004-2017) for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason])

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

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 grade post therapy clin (yc) 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) 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 may apply.

Allowable values: 1-5, 8, 9, A, B, C, D, E, L, H, M, S

Data Field 3845: Grade Post Therapy Path (yp)

Page 147

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, Grade Pathological, and Grade Post Therapy Clin (yc), replaces all previous grade related data items, including NAACCR Data Item Grade (#440) and Collaborative Stage Site-Specific Factors (SSF's) (2004-2017) for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Refer to the most recent version of the Grade Coding Instructions and Tables for additional site-specific instructions.

Data Field 410: Laterality

See page 147

Enter the code to identify the laterality of a paired site.

Code	Description
0	Not a paired site
1	Right origin of primary
2	Left origin of primary
3	Only one side involved, right or left origin of primary not indicated
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or: Both ovaries simultaneously involved with a single histology, Bilateral retinoblastomas, and Bilateral Wilms' tumors. ***Note:*** If both lungs have nodules or tumors and the lung of origin is not known, assign code 4
5	Paired site: midline tumor
9	Unknown site; paired site, lateral origin unknown

Data Field 2580 & 2590: Final Diagnosis- Morphology/Behavior, Grade, Primary Site, and Laterality Documentation

See page 154

Record the morphology/behavior, grade, primary site, and laterality descriptions.

Data Field 1182: Lymphovascular Invasion

See page 155

Indicates presence or absence of tumor cells in lymphatic channels.

Code	Description
0	Lymphovascular invasion not present (absent)/Not identified
1	Lymphovascular invasion present/Identified
8	Not applicable
9	Unknown if lymphovascular invasion present Indeterminate

Data Field 490: Diagnostic Confirmation

See page 156

The best method of confirmation throughout the entire course of the disease. All diagnostic reports in the medical record must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer. Different coding instructions are given for solid tumors (page 136) and hematopoietic and lymphoid neoplasms (page 139).

Table H.1 DIAGNOSTIC CONFIRMATION FOR SOLID TUMORS

Code	Description	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Histological confirmation (tissue microscopically examined). In situ behavior must be microscopically confirmed.
2	Positive cytology	Cytological confirmation (no tissue microscopically examined; fluid cells microscopically examined). Includes pap smears, bronchial brushings, FNA and peritoneal fluid, cervical and vaginal smears, diagnoses based on paraffin block specimens from concentrated spinal, pleural or peritoneal fluid.
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker	A clinical diagnosis of cancer is based on laboratory

Code	Description	DEFINITION
	study	tests/marker studies that are clinically diagnostic for cancer but there is no histologic confirmation. This includes alpha-fetoprotein for liver cancer. Elevated PSA is non-diagnostic of cancer. However, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, code to 5. (STORE 2021 Manual).
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical/endoscopic procedure only with no tissue resected for microscopic exam.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only (other than 5, 6, or 7)	The physician documented the tumor in the medical record. ***Note:*** Refer to the *Ambiguous Terminology List* in the MP/H Rules for cases diagnosed on or after 1/1/2007.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate-only cases.

Table H.2 DIAGNOSTIC CONFIRMATION FOR HEMATOPOIETIC OR LYMPHOID TUMORS (9590-9993)

Code	Description	DEFINITION
MICROSCOPICALLY CONFIRMED		
	Positive histology	Tissue from lymph node(s), organ(s) or other tissue specimens from biopsy, frozen section, surgery or autopsy; Bone marrow specimens (aspiration and biopsy); Peripheral blood smear can be used as histological diagnoses for all hematopoietic histologies (9590/3-9993/3) For **leukemia** only (9800/3-9948/3), positive histology also includes • Complete blood count (CBC) • White blood count (WBC) Neoplasm microscopically confirmed **AND** • Immunophenotyping, genetic testing or JAK2 **not** done **OR** • Immunophenotyping, genetic testing or JAK2 done but **negative** (non-diagnostic) for the neoplasm being abstracted **OR** • Immunophenotyping, genetic testing or JAK2 done but **not**

Code	Description	DEFINITION
		listed in the Definitive Diagnostic Methods in the Heme DB ○ In situations like this, the immunophenotyping, genetic testing, or JAK2 may have been done to **rule out** other neoplasms that are clonally similar to the neoplasm being abstracted. Usually, the provisional diagnosis will include two or more neoplasms ***Example:*** Bone marrow positive for myeloproliferative neoplasm, probable essential thrombocythemia. JAK2 done and is negative. The JAK2 did not confirm the essential thrombocythemia. Code the myeloproliferative neoplasm (9975/3) with diagnostic confirmation code 1 (positive bone marrow biopsy only). ***Example:*** Acute Myeolomonocytic Leukemia (9867/3) CD 10 (+). CD 10 (+) is not listed under Immunophenotyping for this histology, diagnostic confirmation should be 1 Use for historical cases not already in the database if information states that there was histologic confirmation.
2	Positive cytology, no positive histology	This code is rarely used for Hematopoietic and Lymphoid neoplasms. This code includes examination of fluid such as spinal fluid, peritoneal fluid, or pleural fluid. This code also includes paraffin block specimens from concentrated spinal fluid, peritoneal fluid, or pleural fluid. When a small-gauge needle (fine needle aspirations or FNA), or other method is used to obtain a specimen and there is not enough tissue to do a histologic examination the report will be a cytology report rather than a pathology report.

Code	Description	DEFINITION
3	Positive histology PLUS: • Positive immunophenotyping AND/OR • Positive genetic studies (**Effective for cases diagnosed 1/1/2010 and later**)	This code can only be used when there is histologic confirmation (including ambiguous terminology and provisional diagnosis) (Code 1) **and** • Immunophenotyping, genetic testing, or JAK2 is listed in the **Definitive Diagnostic Methods** in the Heme DB **AND** a) Immunophenotyping, genetic testing, or JAK2 is **positive** for the neoplasm being abstracted ***(confirms disease)*** **OR** b) Immunophenotyping, genetic testing, or JAK2 identified a ***more specific histology*** (not preceded by ambiguous terminology) ***Note: Do not use*** code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when preceding by ambiguous terminology. ***Example (identifying a more specific histology:*** Bone Marrow biopsy (+) for Acute Myeloid Leukemia (9861/3). Genetic testing (+) for AML with inv (16) (p13.1q22) (9871/3) code diagnostic confirmation code 3, positive histology and positive genetic testing.
4	Positive microscopic confirmation, method not specified	This code is rarely used for Hematopoietic Lymphoid neoplasms The diagnosis is stated to be microscopically confirmed but the method is not specified or unknown.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker study	This code is rarely used for Hematopoietic and Lymphoid neoplasms. If there no provisional diagnosis or clinical suspicion of cancer, immunophenotyping or genetic testing would not be done. ***Example:*** CT scan consistent with multiple myeloma (9732/3). Twenty-four-hour urine protein elevated with the presence of Bence-Jones kappa. Code 5 for diagnosis based on the positive Bence-Jones, which is listed as one of the diagnostic confirmation methods in the Heme DB and is also a lab test. Code 1 and 3 do not apply because there is no histologic confirmation and positive immunophenotyping and or genetic studies in this example.
6	Direct visualization without microscopic confirmation	This code is rarely used for hematopoietic and lymphoid neoplasms. The operative report may state that the patient had lymphoma, but no biopsy or cytology was done, or the the diagnosis is determined by gross autopsy findings (no tissue or cytologic confirmation).

Code	Description	DEFINITION
7	Radiography and other imaging techniques without microscopic confirmation	This code is rarely used for Hematopoietic and Lymphoid neoplasms. Assign code 7 when the diagnosis is confirmed by radiology or other imaging techniques only.
8	Clinical diagnosis only (other than 5, 6, or 7)	While clinical diagnosis is seldom used for solid tumors, it is a valid diagnostic method for certain hematopoietic neoplasms. The Heme DB will list Clinical Diagnosis as the definitive diagnostic method for certain hematopoietic neoplasms. For these neoplasms, the biopsy, immunophenotyping, and genetic testing do not confirm the neoplasm. The diagnosis is determined based on the physician's clinical expertise, combined with the information from the biopsy, equivocal or negative tests, and the clinical symptoms. This is called a "diagnosis of exclusion" because the physician's judgment and the work-up literally exclude all other possible diagnoses, leaving one diagnosis. ***Example:*** Bone marrow biopsy shows anemia NOS; physician notes state the patient's overall clinical presentation of hypercalcemia, fever, and anemia is consistent with Myelodysplastic Syndrome, NOS (9989/3). Code Diagnostic Confirmation 8, clinical diagnosis only.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate-only cases.

Data Fields 2520, 2530, 2540, 2550, 2560, 2570: Documentation of Cancer Diagnosis, Extent of Disease, and Treatment

See page 173

Text information to support cancer diagnosis, stage, and treatment codes **must be provided by all facilities**. Document all types of the **first course** of definitive treatment administered, regardless of where the treatment was received, in chronological order.

Data Field 756: Tumor Size Summary

See page 176

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen. 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.

Tumor size code 999 is used when size is unknown or not applicable. Sites/morphologies where tumor size is not applicable:

- Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms (histology codes 9590-9993)
- Kaposi Sarcoma
- Melanoma Choroid
- Melanoma Ciliary Body
- Melanoma Iris
- Unknown Primary

Note: Do not use Code "8" for Summary Stage.

Data Field 2600: Summary Stage Documentation

See page 171

Text field for documentation of extent of disease to support coding. Include findings from radiology and pathology reports and descriptions of observations from history and physical and operative reports. Include dates and types of procedures and exams. Document information such as lymph node involvement, extent of invasion, extension to adjacent organs, and metastatic spread of disease. Both positive and negative findings that are pertinent to describing the spread of the tumor from the primary site should be recorded. Stage documentation should include all information available through completion of surgery(ies) in the first course of treatment or within **4 months** of diagnosis in the absence of disease progression, whichever is longer. These findings may be obtained from diagnostic reports of radiology, endoscopy, surgery, and laboratory tests prior to treatment. Document both the date and the source of the staging information.

Data Field 764: Summary Stage 2018

See page 180

To be used with cases diagnosed/admitted January 1, 2001 and after. Summary Stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

Code	Description
0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
7	Distant
8	Not applicable
9	Unstaged

Note: Do not use Code "8" for Summary Stage.

Data Fields SSDI's

See page 184

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. SEER has developed a staging tool referred to as **SEER*RSA** that provides information (primary site/histology/other factors defined) about each cancer schema. See tables lists of the site-specific schema discriminators and SSDIs that are new and are required for collection in 2021, page 186.

Page 186 - The **first table lists** schema discriminators with the corresponding NAACCR item number and description. The **second table** lists SSDIs required for staging. For additional required data items, see **NAACCR Version 21 Required Status Table** and the **SSDI Manual**. Refer to **SEER*RSA** and the SSDI manual for codes and coding instructions.

Data Field 1060: TNM Edition Number

See page 188

A code that indicates the edition of the AJCC manual used to stage the case. This applies to the manually coded TNM values for the patient. It does not apply to the Derived AJCC T, N, M and AJCC Stage Group fields.

TNM codes have changed over time and conversion is not always simple. Therefore, a case-specific indicator is needed to allow grouping of cases for comparison.

Data Field 1001: TNM Clinical T

See page 188

Detailed site-specific codes for the clinical tumor (T) as defined by the current AJCC edition.

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1031: AJCC TNM Clin T Suffix

See page 189

Description

Identifies the AJCC TNM clinical T category suffix for the tumor prior to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Data Field 1002: TNM Clinical N

See page 190

Detailed site-specific codes for the clinical nodes (N) as defined by the current AJCC edition.

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1034: AJCC TNM Clin N Suffix

See page 191

Identifies the AJCC TNM clinical N category suffix for the tumor prior to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1003: TNM Clinical M

See page 192

Detailed site-specific codes for the clinical metastases (M) as defined by the current AJCC edition.

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1004: TNM Clinical Stage Group

See page 192

Detailed site-specific codes for the clinical stage group as defined by the current AJCC edition.

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1011: TNM Pathologic T

See page 193

Detailed site-specific codes for the pathologic tumor (T) as defined by the current AJCC edition.

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1032: AJCC TNM Path T Suffix

See page 194

Identifies the AJCC TMN pathological T category suffix for the tumor following the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1012: TNM Pathologic N

See page 195

Detailed site-specific codes for the pathologic nodes (N) as defined by the current AJCC edition.

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules. **Documentation in the Summary Stage Text field is required to support coding.**

Data Field 1035: AJCC TNM Path N Suffix

See page 196

Identifies the AJCC TNM pathological N suffix for the tumor following the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1013: TNM Pathologic M

See page 196

Detailed site-specific codes for the clinical path (M) as defined by the current AJCC edition.

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules

Data Field 1014: TNM Pathologic Stage Group

See page 197

Detailed site-specific codes for the pathologic stage group as defined by the current AJCC edition.

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the AJCC Cancer Staging Manual)

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
Blank	Information not available to code this item.

Note: See the AJCC Cancer Staging Manual, 8th edition for site-specific categories for the TNM elements and stage groups. See the CURRENT *STORE* manual for specifications for codes and data entry rules.

Data Field 1062: AJCC TNM Post Therapy Clin T

See page 198

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post-neoadjuvant therapy surgical resection.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1063: AJCC TNM Post Therapy Clin T Suffix

See page 199

Identifies the AJCC TNM post therapy clinical T category suffix for the tumor following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1064: AJCC TNM Post Therapy Clin N

See page 200

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of lymph node metastasis of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post-neoadjuvant therapy surgical resection.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1065: AJCC TNM Post Therapy Clin N Suffix

See page 201

Identifies the AJCC TNM post therapy clinical N suffix for the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1066: AJCC TNM Post Therapy Clin M

See page 202

Identifies the presence or absence of distant metastasis (M) of the tumor as known in the clinical stage before initiation of neoadjuvant therapy and records this information following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and before planned post neoadjuvant therapy surgical resection.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries when the planned post neoadjuvant therapy surgery has been canceled. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1067: AJCC TNM Post Therapy Clinical Stage Group

See page 203

Detailed site-specific codes for the post therapy clinical stage group as defined by AJCC.

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze

outcome, to design follow-up strategies, and to assess early detection results.
Identifies the remaining anatomic extent of disease based on the T and N following the completion of neoadjuvant therapy (satisfying the definition for that disease site) before planned surgical resection or primary treatment consisting of systemic and/or radiation therapy, and the M status defined during the diagnostic workup

Data Field 1021: AJCC TNM Post Therapy Path T

See page 203

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1033: AJCC TNM Post Therapy Path T Suffix

See page 204

Identifies the AJCC TNM post therapy pathological T category suffix for the tumor following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1022: AJCC TNM Post Therapy Path N

See page 205

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of lymph node metastasis of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

Data Field 1036: AJCC TNM Post Therapy Path N Suffix

See page 206

Identifies the AJCC TNM post therapy pathological N suffix for the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post

neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1023: AJCC TNM Post Therapy Path M

See page 207

Identifies the presence or absence of distant metastasis (M) of the tumor as known in the clinical stage before initiation of neoadjuvant therapy and records this information following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires use of the current AJCC Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1024: AJCC TNM Post Therapy Pathological Stage Group

See page 208

Identifies the anatomic extent of disease based on the T, N, and M category data items of the tumor known following the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The CoC requires that AJCC TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Data Field 1260: Date of Initial Treatment (YYYYMMDD)

See page 2016

Enter the date the first course of treatment (surgery, radiation, systemic or other) started at any facility.

Note: This field will no longer be derived.

Data Field 1261: Date of Initial RX Flag

See page 218

This flag explains why there is no appropriate value in the corresponding date field.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if therapy was administered).
11	No proper value is applicable in this context (no treatment given or autopsy only).
12	A proper value is applicable but not known.
(blank)	A valid date value is provided in item Date of Initial Treatment (NAACCR Item #1260).

Data Field 1292: Scope of Reg LN Surgery

See page 219

Enter the code that defines the removal of regional lymph nodes. If no cancer-directed procedure was performed code (0).

Data Field 820: Regional Lymph Nodes Positive

See page 229

Record the total number of regional lymph nodes pathologically examined and found to be positive. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

Use code 99 for sites or morphologies for which information about the field is unknown or not applicable:

Examples:

- Brain
- Intracranial Gland
- Reticuloendotheliosis
- Placenta
- Leukemia, Lymphoma
- Myeloma and Plasma Cell Disorder
- Other and Ill-Defined Primaries, Unknown Primaries

Data Field 830: Regional Lymph Nodes Examined

See page 232

Record the total number of regional lymph nodes removed. The number of regional lymph nodes removed is cumulative from all procedures that removed lymph nodes through the completion of

surgeries in the first course of treatment. If no regional lymph nodes are identified in the pathology report, code 00.

Use code 99 for sites or morphologies for which information about the field is unknown or not applicable:

Examples:

- Brain
- Intracranial Gland
- Reticuloendotheliosis
- Placenta
- Leukemia, Lymphoma
- Myeloma and Plasma Cell Disorder
- Other and Ill-Defined Primaries, Unknown Primaries

Documentation in the Summary Stage text field is required to support coding.

Data Field 1200: RX Date-Surgery (YYYYMMDD)

See page 235

Document and enter the date of the **first** definitive cancer-directed surgery performed at any facility. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery. If surgery was done but the date is unknown record the year and month of diagnosis and leave the day blank.

Data Field 1201: RX Date Surgery Flag

See page 237

This flag explains why there is no appropriate value in the corresponding date field.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item Date of First Surgical Procedure (NAACCR Item #1200).

Data Field 3170: RX Date Most Definitive Surgery (YYYYMMDD)

See page 237

Document and enter the date of the most definitive surgery of the primary site performed at any facility as part of first course treatment.

Data Field 3171: RX Date Mst Defn Srg Flag

See page 238

This flag explains why there is no appropriate value in the corresponding date field.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item Date of First Surgical Procedure (NAACCR Item #3170).

Data Field 1290 Surgery RX Code

See page 239

Document and code the most definitive first course cancer-directed surgery at any facility. Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is not considered cancer-directed surgery. Brushings, washings and aspiration of cells are not surgical procedures.

Data Field 1340: Reason for no Surgery

See page 242

If no cancer directed surgery to the primary site was performed record the reason.

Code	Description
0	Surgery of the primary site was performed
1	Not part of the planned first course
2	Not recommended due to patient risk factors
5	Patient died prior to planned or recommended surgery
6	Surgery recommended and unknown why not performed
7	Patient or family refused surgery

8	Surgery recommended, unknown if performed
9	Unknown if surgery recommended or performed

Data Field 1294: RX Summ-Surg.Oth Reg/Dist RX Code

See page 245

Document and code the highest numbered code that describes the surgical resection of Regional/Distant Sites and Distant lymph nodes.

Data Fields 2610, 2630, 2640, 2650, 2660, 2670: Treatment Documentation

See page 247

Text field used to support codes in the treatment fields. Document all planned treatment even if it is unknown if treatment was given. List dates and types of all treatment given, even if it was done at another facility.

Data Field 1210: Date Radiation Started (YYYYMMDD)

See page 248

Document and enter the date radiation began at any facility as part of the first course of treatment.

Data Field 1211: Date Radiation Flag

See page 249

This flag explains why there is no appropriate value in the corresponding date field.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if radiation given).
11	No proper value is applicable in this context (no radiation given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (radiation therapy is planned as part of first course of therapy but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item Date Radiation Started (NAACCR Item #1210).

Data Field 1506: Phase I Radiation Treatment Modality

See page 250

Phase I Radiation Treatment Modality

STORE 2021 pages 285-286

Radiation Treatment Modality--Phase I is new for 2018. This data item identifies the radiation modality administered during the first phase of radiation treatment delivered during the first course of treatment. **TCR only requires NAACCR item # 1506 Phase I Radiation Treatment Modality for cases diagnosed in 2018.**

Identifies the radiation modality administered during first phase of radiation treatment delivered during the first course treatment. This data item is required for CoC-accredited facilities as of 1/1/2018 and it is required by TCR.

Code	Description
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
98	Radiation therapy administered, but treatment modality is not specified or unknown
99	Unknown if radiation treatment administered

*For more detailed coding instructions See STORE 2021 Manual beginning on page 304

Data Field 1380: RX Summ-Surg/Rad Seq

See page 253

Code the sequence of radiation and surgical procedures given as part of the first course of treatment.

Code	Description
0	No radiation therapy and/or surgical procedures

2	Radiation therapy before surgery
3	Radiation therapy after surgery
4	Radiation therapy both before and after surgery
5	Intraoperative radiation therapy
6	Intraoperative radiation therapy with other therapy administered before or after surgery
7	Surgery both before and after radiation
9	Sequence unknown, but both surgery and radiation were given

Data Field 1430: Reason No Radiation

See page 256

Code the reason no regional radiation therapy was administered to the patient.

Code	Description
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors.
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6	Radiation therapy was not administered; it was recommended by the patient's physician but was not administered as part of first course treatment. No reason was noted in patient 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 patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate and autopsy cases only.

Data Field 1220: Chemotherapy Date Started (YYYYMMDD)

See page 257

Record the first or earliest date of chemotherapy. If no chemotherapy was given or it is unknown if chemotherapy was given, leave the field blank.

Data Field 1221: Chemotherapy Date Started Flag

See page 258

This flag explains why there is no appropriate value in the corresponding date field.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if chemotherapy was given).
11	No proper value is applicable in this context (no chemotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (chemotherapy is planned as part of first course treatment but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item Date Chemotherapy Started (NAACCR Item #1220). Case was diagnosed between 2003 and 2009 and the facility did not record Date Chemotherapy Started (NAACCR Item #1220) at that time.

Data Field 1390: Chemotherapy Code

See page 259

Document and code the type of chemotherapy the patient received as part of the first course of treatment at any facility. Chemotherapy may involve the delivery of one or a combination of chemotherapeutic agents. Code 88 if the only information available is that the patient was referred to an oncologist. Code 00 if chemotherapy was not delivered.

Data Field 1230: Date Hormone Therapy Started (YYYYMMDD)

See page 267

Record the first or earliest date on which hormone therapy was given as part of first course of treatment. If no hormone therapy was given or it is unknown if hormone therapy was given, leave this field blank.

Data Field 1231: RX Date Hormone Flag

See page 268

This flag explains why there is no appropriate value in the corresponding date field.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if any hormone therapy was given).
11	No proper value is applicable in the context (no hormone therapy given).

Code	Description
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (hormone therapy is planned as part of first course treatment but had not yet started at the time of the last follow-up).
15	Information is not available at this time, but it is expected that it will be available later (hormone therapy is planned as part of first course treatment but had not yet started at the last follow-up).
(blank)	A valid date is provided in item Date Hormone Therapy Started (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record Date Hormone Therapy Started (NAACCR Item #1230) at that time.

Data Field 1400 RX Summ-Hormone

See page 269

Document and code the type of hormone therapy the patient received as part of the first course of treatment at any facility. Hormonal therapy may involve the delivery of one or a combination of agents. Code 88 when the only information available is the patient was referred to an oncologist. Code 00 if hormone therapy was not delivered.

Table RX Date-Hormone Flag Codes

Code	Description
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 was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration).
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 treatment. No reason was stated in 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 patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Data Field 1240: Immunotherapy Date Started (YYYYMMDD)

See page 273

Record the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of therapy. If no immunotherapy was given or it is unknown if immunotherapy was given, leave this field blank.

Data Field 1241: Immunotherapy Date Started Flag

See page 274

This flag explains why there is no appropriate value in the corresponding date field.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if immunotherapy was given).
11	No proper value is applicable in this context (no immunotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (immunotherapy is planned as part of first course treatment but had not yet started at the time of the last follow-up).
15	Information is not available at this time, but it is expected that it will be available later (immunotherapy is planned as part of first course treatment but had not yet been started at the time of the last follow-up).
(blank)	A valid date is provided in item Date Immunotherapy Started (NAACCR Item #1240). Case was diagnosed between 2003 and 2009 and the facility did not record Date Immunotherapy started (NAACCR Item #1240) at that time.

Data Field 1410: Immunotherapy Code

See page 275

Document and code the type of Immunotherapy the patient received as part of the first course of treatment at any facility. Code to 88 when the only information is that the patient was referred to an oncologist. Code 00 if Immunotherapy was not delivered.

Data Field 3250: Transplant/Endocrine Code

See page 279

Code the type of hematologic transplant and/or endocrine procedures the patient received as part of the first course of treatment at any facility. Code 88 if the only information is that the patient was referred to a specialist for hematologic transplant or endocrine procedures. Code 00 if a transplant or endocrine procedure was not done.

RX Summ– Transplant/Endocrine Codes

Code	Description
00	No transplant procedure or endocrine therapy was administered as part of first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant autologous.
12	Bone marrow transplant- allogeneic.
20	Stem cell harvest (Stem cell transplant) and infusion.
30	Endocrine surgery and/or endocrine radiation therapy as first course of therapy
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20) as first course of therapy.
82	Transplant procedure and/or endocrine therapy was not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of disease prior to administration).
85	Transplant procedure and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy.
86	Transplant procedure and/or endocrine surgery/radiation were 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 surgery/radiation were 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 patient record.
88	Transplant procedure and/or endocrine therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether transplant procedure or endocrine therapy was recommended or administered because it is not documented in the medical record. Death certificate only.

Data Field 1639: RX Summ—Systemic Surg Seq

See page 283

Code the administration of systemic therapy in sequence with the first surgery performed, described in the data item **Date of First Surgical Procedure.**

Code	Description
0	No systemic therapy and/or surgical procedures
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy

6	Intraoperative systemic therapy with other therapy administered before or after surgery
7	Surgery both before and after systemic therapy
9	Sequence unknown

Data Field 1250: Date Other Treatment Started (YYYYMMDD)

See page 286

Enter the date other treatment is delivered that is not included in surgery, radiation therapy, and systemic treatment. If no other treatment was given or it is unknown if other treatment was given, leave the field blank.

Data Field: 1251 RX Date Other Flag

See page 287

This flag explains why there is no appropriate value in the corresponding date field.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if any Other Treatment was given).
11	No proper value is applicable in this context (no other treatment given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (other treatment was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (radiation therapy is planned as part of first course of therapy but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item Date Other Treatment Started (NAACCR Item #1250).

Data Field 1420: Other Treatment Code

See page 288

Document and code the type of "other treatment" the patient received as part of the first course of treatment at any facility. "Other treatment" is designed to modify or control the cancer cells, but is not included in surgery, radiation, or systemic therapy.

Code	TYPE	Description
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases. *See **Examples**

Code	TYPE	Description
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by non-medical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Recommended; unknown if done	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment.

Data Field 1285: RX Summ-Treatment Status

See page 293

Code whether or not first course treatment was given.

Code	Description
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

Data Field 1750: Date of Last Contact or Death (YYYYMMDD)

See page 294

Enter the date the patient was last seen at your facility, date of last contact, or date of death. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the *Other Pertinent Information* text area, document the patient is deceased and the date of death is not available.

Data Field 1760: Vital Status

See page 295

Patient's vital status as of the date recorded in the "Date of last contact/death" field.

Code	Description
0	Dead
1	Alive

Data Field 1942: Place of Death - State

See page 296

See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes: seer.cancer.gov/tools/codingmanuals/index.html

Data Field 1944: Place of Death-Country

See page 296

Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes.

Code	Description
USA	United States
ZZN	North America NOS
ZZC	Central America NOS
ZZX	Non-US NOS
ZZU	Unknown

Data Field 2090: Date Abstracted (YYYYMMDD)

See page 297

Record year, month, and day reporting form is completed.

Data Field 570: Abstractor Initials

See page 297

Record the initials of the abstractor.

CASEFINDING QUICK REFERENCE

Casefinding and Reportable List

1. Every inpatient and outpatient case with active disease and/or receiving cancer-directed therapy **must** be reported to the Department of State Health Services, Texas Cancer Registry (TCR) regardless of the state or country of residence.
2. Cases of cancer to be reported to TCR include:
    a. All neoplasms with a behavior code of two or three in the International Classification of Diseases for Oncology (ICD-O) 3rd edition (with certain exceptions); and
    b. All benign and borderline neoplasms of the central nervous system with a morphology term and code listed in ICD-O-3 (includes brain and other CNS neoplasms)

    Note: Benign and borderline CNS cases diagnosed prior to 2004 are no longer required to be submitted to TCR.
3. Obtain disease indices including both inpatient and outpatient admissions after medical records are completed and coded (monthly or quarterly).
4. Check the indices against a list of cases previously reported to TCR to identify new cases.
5. Complete an abstract for patients found on the disease index with a reportable diagnosis not previously submitted to TCR. Patients who have been previously reported to TCR need to be checked for possible multiple primaries. Refer to the *2018 Solid Tumor* Rules and to *the Hematopoietic and Lymphoid Neoplasm Coding Manual* for assistance.
6. To prevent reporting a primary for a patient twice, compare the patient's name and primary cancer site from your registry database (accession list) to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.
7. Other department logs/records (radiation therapy logs, emergency department logs, oncology unit records, surgery logs, etc.) are to be reviewed in the same method as the disease index to ensure all reportable cases are submitted to TCR.
8. Pathology reports, including all histology, cytology, hematology and autopsy reports, should be reviewed to identify all reportable neoplasms. These should also be reviewed against a list of records submitted to TCR.

The following lists are intended to aid the appropriate personnel in creating a disease index with the required reportable neoplasms and ICD-10-CM codes. **A DI with the reportable ICD-10-CM codes will require a 100% review.**

REPORTABLE ICD-10-CM CODES

Table H.3 Reportable ICD-10-CM Codes

ICD-10-CM Code (100% Review Required)	Description
C00.0- C43.9 C4A.0-C4A.9, C45.- C96.9	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies NEW for FY2018: C96.20 Malignant mast cell neoplasm, unspecified C96.21 Aggressive systemic mastocytosis C96.22 Mast cell sarcoma C96.29 Other malignant cell neoplasm
C44.13-C44.1392	Sebaceous cell carcinoma of skin of eyelid, including canthus ***Note:*** Effective 10/1/2018
C49.A-C49.A9	Gastrointestinal Stromal Tumors (GIST) ***Note:*** All GIST tumors are now reportable starting in 2021 (per ICD-O-3.2), including GIST, NOS
D00.00 – D03.9 D05 - D05.92 D07.0-D09.9	In-situ neoplasms (***Note:*** *Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*).
D18.02	Hemangioma of any site of intracranial structures
D18.1	Lymphangioma, any site (***Note:*** *Includes Lymphangiomas of Brain, Other parts of nervus system and endocrine glands, which are reportable*)
D32.0-D32.9	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.0 – D33.9	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46-D46.9	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.02	Systemic mastocytosis ***Note:*** Effective 10/1/2017
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3)

ICD-10-CM Code (100% Review Required)	Description
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3)
D47.4	Osteomyelofibrosis (9961/3)
D47.Z1-D47.Z9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9931/3)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D72.110	Idiopathic hypereosinophilic syndrome [HES]
D72.111	Lymphocytic Variant Hypereosinophilic Syndrome [LHES]
D72.118	Other hypereosinophilic syndrome
D72.119	Hypereosinophilic syndrome [HES], unspecified
J84.82	Adult pulmonary Langerhans cell histiocytosis
R87.624	Cytologic evidence of malignancy on smear of vagina

^ *Based on the International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2021*

Source: *seer.cancer.gov/tools/casefinding/icd-10-cm-casefinding-list.20201211.pdf*

Table H.4 Supplementary ICD-10-CM Code List Effective 10/01/2020-9/30/2021

ICD-10-CM Code (5% Review Required)	Description
B20	Human immunodeficiency virus [HIV] disease with other diseases
B97.33, B97.34, B97.35	Human T-cell lymphotrophic virus,(type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomavirus as the cause of diseases classified elsewhere
D10.0 - D31.92, D34, D35.0, D35.1, D35.5_ D35.9, D36.0-D36.9	Benign neoplasms (see "must collect" list for reportable benign neoplasms) **Note:** Screen for incorrectly coded malignancies or reportable by agreement tumors **Note:** Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.
D3A.0-D3A.8 D3A.00-D3A.098	Benign carcinoid tumors

ICD-10-CM Code (5% Review Required)	Description
D37.0 - D41.9	Neoplasms of uncertain or unknown behavior (see "must collect" list for reportable neoplasms of uncertain or unknown behavior) **Note:** Screen for incorrectly coded malignancies or reportable by agreement tumors
D44.0 - D44.2, D44.6-D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands (see "must collect" list for D44.3-D44.5) **Note:** Screen for incorrectly coded malignancies or reportable by agreement tumors
D47.01	Cutaneous mastocytosis (9740/1) **Note:** Effective 10/1/2017
D47.09	Other mast cell neoplasms of uncertain behavior **Note:** Effective 10/1/2017
D47.2	Monoclonalgammopathy **Note:** Screen for incorrectly coded Waldenstrom's macroglobulinemia
D47.Z2	Castleman disease
D48.0-D48.9	Neoplasm of uncertain behavior of other and unspecified sites
D49.0 - D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)
D61.1	Drug-induced aplastic anemia (also known as “aplastic anemia due to antineoplastic chemotherapy”) ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug
D61.810	Antineoplastic chemotherapy induced pancytopenia
D61.82	Myelophthisis ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50. _)
D63.0	Anemia in neoplastic disease
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia **Note:** Screen for incorrectly coded thrombocythemia
D70.1	Agranulocytosis secondary to cancer chemotherapy
D72.1	Eosinophilia (**Note:** Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosonophilic syndrome.")
D75.81	Myelofibrosis (note: this is not primary myelofibrosis [9961/3] ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)

ICD-10-CM Code (5% Review Required)	Description
D76.1-D76.3	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified **Note:** Review for miscodes
D89.40-D89.49	Mast cell activation syndrome and related disorders **Note:** Effective 10/1/2016
E08	Diabetes mellitus due to underlying condition ICD-10-CM Coding instruction note: Code first the underlying condition, such as: malignant neoplasm (C00-C96)
E31.20-E31.9	Multiple endocrine neoplasia [MEN] syndromes ICD-10-CM Coding instruction: Code also any associated malignancies and other conditions associated with the syndromes
E34.0	Carcinoid syndrome
E83.52	Hypercalcemia
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G13.0	Paraneoplastic neuromyopathy and neuropathy ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)
G32.8-G32.81	Other specified degenerative disorders of nervous system in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: cerebral degeneration (due to) neoplasm (C00-D49)
G53	Cranial nerve disorders in diseases classified elsewhere **Note:** Code first underlying neoplasm (C00-D49)
G55	Nerve root and plexus compressions in diseases classified elsewhere ICD-10-CM Coding instruction note: code also underlying disease, such as neoplasm (C00-D49)
G63	Polyneuropathy in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: neoplasm (C00-D49)

ICD-10-CM Code (5% Review Required)	Description
G73.1	Lambert-Eaton syndrome in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)
G89.3	Neoplasm related pain (acute)(chronic)
G99.2	Myelopathy in diseases classified elsewhere ICD-10-CM Coding instruction: Code first underlying disease, such as: neoplasm (C00-D49)
H47.42	Disorders of optic chiasm in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
H47.52-	Disorders of visual pathways in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
H47.63-	Disorders of visual cortex in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
J34.81	Nasal mucositis (ulcerative)
J91.0	Malignant pleural effusion ICD-10-CM Coding instruction: Code first underlying neoplasm
J93.12	Secondary spontaneous pneumothorax ICD-10-CM Coding instruction: Code first underlying condition, such as: Malignant neoplasm of bronchus and lung (C34._) Secondary malignant neoplasm of lung (C78.0_)
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.33	Oral mucositis (ulcerative) due to radiation
K22.711	Barrett's esophagus with high grade dysplasia
K62.7	Radiation proctitis
K62.82	Dysplasia of anus (AIN I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
M36.0	Dermato(poly)myositis in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)
M36.1	Arthropathy in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm, such as:Leukemia (C91-C95), malignant histiocytosis (C96.A), multiple myeloma (C90.0)

ICD-10-CM Code (5% Review Required)	Description
M84.50-M84.576	Pathologic fracture in neoplastic disease ICD-10-CM Coding instruction: Code also underlying neoplasm (C00-D49)
M90.60-M90.69	Osteitis deformans in neoplastic disease ICD-10-CM Coding instruction: Code first the neoplasm (C40._, C41._)
N42.3	Dysplasia of prostate (PIN I and PIN II)
N76.81	Mucositis (ulcerative) of vagina and vulva
N87._	Dysplasia of cervix uteri (CIN I and CIN II)
N89.0,N89.1, N89.3	Vaginal dysplasia (VIN I and VIN II)
N90.0,N90.1, N90.3	Vulvar dysplasia (VAIN I and VAIN II)
O01.-	Hydatidiform mole **Note:** Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00- C97 range
O9A.111	Malignant neoplasm complicating pregnancy, first trimester
O9A.112	Malignant neoplasm complicating pregnancy, second trimester
O9A.113	Malignant neoplasm complicating pregnancy, third trimester
O9A.119	Malignant neoplasm complicating pregnancy, unspecified trimester
O9A.12	Malignant neoplasm complicating childbirth
O9A.13	Malignant neoplasm complicating pregnancy, childbirth and the puerperium (conditions in C00-C96) ICD-10-CM Coding instruction: Use additional code to identify neoplasm
P04.11	Newborn affected by maternal antineoplastic chemotherapy **Note:** Effective 10/1/2018
P04.12	Newborn affected by maternal cytotoxic drugs **Note:** Effective 10/1/2018
Q85.0-	Neurofibromatosis (nonmalignant) (9540/1) **Note:** Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable
R18.0	Malignant ascites ICD-10-CM Coding instruction: Code first malignancy, such as: Malignant neoplasm of ovary (C56._), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)

ICD-10-CM Code (5% Review Required)	Description
R53.0	Neoplastic (malignant) related fatigue ICD-10-CM Coding instruction: Code first associated neoplasm
R59.-	Enlarged lymph nodes
R85.6-	Abnormal findings on cytological and histological examination of digestive organs. **Note:** see "must collect" list for R85.614
R87.61-, R87.62-	Abnormal findings on cytological/histological examination of female genital organs. **Note:** see "must collect" list for R87.614 and R87.624
R90.0	Intracranial space-occupying lesion found on diagnostic imaging of central nervous system
R92.-	Abnormal findings on diagnostic imaging of breast
R97.-	Abnormal tumor markers
T38.6-	Poisoning by antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified
T38.8-, T38.996	Poisoning by hormones and their synthetic substitutes
T45.1-	Poisoning by, adverse effect of and under dosing of antineoplastic and immunosuppressive drugs
T45.8-, T45.96	Poisoning by primary systemic and hematological agent, unspecified
T66	Unspecified effects of radiation
T80.1	Vascular complications following infusion, transfusion and therapeutic injection
T80.2-	Infections following infusion, transfusion and therapeutic injection
T80.810	Extravasation of vesicant antineoplastic chemotherapy
T80.818	Extravasation of other vesicant agent
T86.0	Complications of bone marrow transplant ICD-10-CM Coding instruction: Use addition code to identify other transplant complications, such as: malignancy associated with organ transplant (C80.2) or post-transplant lymphoproliferative disorders (PTLD) (D47.Z1)
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out

ICD-10-CM Code (5% Review Required)	Description
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z12.-_	Encounter for screening for malignant neoplasms
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z15.0	Genetic susceptibility to malignant neoplasm ICD-10-CM Coding instruction: Code first, if applicable, any current malignant neoplasm (C00-C75, C81-C96); Use additional code, if applicable, for any personal history of malignant neoplasm (Z85._)
Z17.0, Z17.1	Estrogen receptor positive and negative status
Z19.1	Hormone sensitive malignancy status
Z19.2	Hormone resistant malignancy status
Z40.0_	Encounter for prophylactic surgery for risk factors related to malignant neoplasms
Z42.1	Encounter for breast reconstruction following mastectomy
Z48.290	Encounter for aftercare following bone marrow transplant
Z48.3	Aftercare following surgery for neoplasm ICD-10-CM Coding instruction: Use additional code to identify the neoplasm
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1-	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare
Z79.81-	Long term (current) use of agents affecting estrogen receptors and estrogen levels ICD-10-CM Coding instruction: Code first, if applicable, malignant neoplasm of breast (C50._), malignant neoplasm of prostate (C61)
Z80.-	Family history of primary malignant neoplasm
Z85._	Personal history of malignant neoplasm
Z86.0_, Z86.01_, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior
Z92.21, Z92.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z94.81, Z94.84	Bone marrow and stem cell transplant status

^ *Based on the International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2021*

Table H.5 The following are exclusions and do not need to be reported to TCR:

ICD-O-3 Morphology Codes	Diagnosis/Terminology
8000–8005	Neoplasms, malignant, NOS of the skin
8010/2	Carcinoma in-situ of cervix (CIN) beginning with 1996 cases
8010–8046	Epithelial carcinomas of the skin
8050–8084	Papillary and squamous cell carcinomas of the skin except genital sites
8077/2	Squamous Intraepithelial Neoplasia, grade III of cervix beginning with 1996 cases; CIN
8090–8110	Basal cell carcinomas of the skin except genital sites
8148/2	Prostatic Intraepithelial Neoplasia (PIN)

Ambiguous Terminology

The following terms are diagnostic of cancer: Apparent(ly), Appears, Comparable with, Compatible with, Consistent with, Favor(s), Malignant appearing, Most likely, Neoplasm (beginning with 2004 diagnosis and only for C700-C729, C751-C753), Presumed, Probable, Suspect(ed), Suspicious(for), Tumor (beginning with 2004 diagnosis and only for C700-C729, C751-C753), Typical (of).

Note: Do not substitute synonyms such as “supposed” for presumed, or “equal” for comparable. Do not substitute “likely” for most likely.

Exception: If cytology is reported as “suspicious” do not interpret this as a diagnosis of cancer. Report the case only if there is either a positive biopsy, a physician’s clinical diagnosis of cancer supporting the cytology findings, or cancer directed therapy is administered.

Note: This list should be used only for determining case reportability. Do not use this list to determine the appropriate histology or stage.

Cases to Report Only If Cancer-Directed Therapy Is Planned or Given

- Cases diagnosed and/or treated for cancer prior to admission should be reported if there is evidence of active disease, whether or not diagnostic or therapeutic procedures were performed.
- Cases diagnosed at autopsy, with no suspicion prior to death that the cancer existed, should be reported.
- Abstract cases using the medical record from the first admission (inpatient or outpatient) to your facility with a reportable diagnosis. Use information from subsequent admissions to include all first course treatment information and to supplement documentation.
- Do not report cases diagnosed prior to 1995.
- Do not complete a report for each admission; submit one report per primary tumor.

Example 1: A patient is diagnosed with prostate cancer and has several admissions for treatment of the prostate cancer. Only one abstract should be completed.

Example 2: A patient is diagnosed with two separate primary tumors, such as adenocarcinoma of the prostate and squamous cell carcinoma of the lung. Complete one abstract for the prostate primary and another for the lung.

Helpful Hints

- Report all cases of *active* cancer regardless of state of residence.
- Report all inpatients and outpatients.
- To ensure case ascertainment, review the disease indexes, pathology, cytology, hematology, and autopsy reports.
- Do not complete an abstract for each admission.
- Do not report basal or squamous cell carcinomas of the skin, except skin of genital sites.
- Do not report carcinoma in situ of cervix (any histology).
- Do not report intraepithelial neoplasia of the prostate (PIN III).
- Report all benign and borderline tumors of the central nervous system.
- Cases in which the disease is no longer active (such as leukemia in remission) should only be reported if the patient is still receiving cancer-directed therapy.
- A negative pathology report normally takes precedence over a positive clinical diagnosis.
- However, if the physician treats the patient for cancer in spite of a negative biopsy, accession the case.
- It has been six months or longer since the negative biopsy, and the physician continues to call this a reportable disease. Accession the case.
- Physicians may refer to patients diagnosed with cancer prior to coming to a facility as having a "history of" cancer. These cases should be reviewed closely to determine if the patient has active disease and/or is receiving cancer-directed treatment.
- Accession cases with cytology diagnoses that are positive for malignant cells. Urine cytology positive for malignancy is reportable. Code the primary site to C689 in the absence of any other information.
- Do not accession a case based ONLY on suspicious cytology. Report the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings or if cancer directed therapy is administered.
- If you have any questions regarding the eligibility of a case, call your TCR health service region.

TREATMENT STANDARD TABLES

Table H.6 Scope of Regional Lymph Node Surgery Codes

Code	Description
0	None
1	Biopsy or aspiration of regional lymph nodes, NOS
2	Sentinel lymph node biopsy (only)
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS
4	1–3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

Note: For specific instructions on coding this data field see page 219 of this manual or go to facs.org/cancer/ncdb/scope-regional-lymph-node-surgery.pdf

Table H.7 Surgery Codes

Code	Description
00	None
10-19	Site-specific codes; tumor destruction
20-80	Site-specific codes; resection
90	Surgery, NOS
98	Site-specific surgery codes; special
99	Unknown

Table H.8 Phase I Radiation Treatment Modality Codes

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

Code	Description
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-232
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
98	Radiation therapy administered, but treatment modality is not specified or unknown
99	Unknown if radiation treatment administered

Note: For specific instructions on coding this data field see page 251 of this manual.

Table H.9 Chemotherapy Codes

Code	Description
00	None; chemotherapy was not part of the first course of therapy
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., comorbid conditions, advanced age.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Chemotherapy was not delivered. 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 patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: For specific instructions on coding this data field see page 259 of this manual.

Table H.10 Hormone Therapy Codes

Code	Description
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 was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration).
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 treatment. No reason was stated in 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 patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: For specific instructions on coding this data field see page 269 of this manual.

Table H.11 Immunotherapy Codes

Code	Description
00	None, immunotherapy was not part of the first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only
01	Immunotherapy administered as first course of therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration).
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 treatment. No reason was stated in patient 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 patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.

Code	Description
99	It is unknown whether immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: For specific instructions on coding this data field see page 275 of this manual.

Table H.12 Hematologic Transplant and Endocrine Procedures

Code	Description
00	No transplant procedure or endocrine therapy was administered as part of the first course of therapy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant-autologous.
12	Bone marrow transplant-allogeneic.
20	Stem cell harvest and infusion
30	Endocrine surgery and/or endocrine radiation therapy
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20).
82	Hematologic transplant and/or endocrine surgery/radiation were not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hematologic transplant and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician but was not administered as part of the first course therapy. No reason was stated in patient's record.
87	Hematologic transplant and/or endocrine surgery/radiation were 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 patient record.
88	Hematologic transplant and/or endocrine surgery/radiation were recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation were recommended or administered because it is not documented in the medical record. Death certificate only.

Note: For specific instructions on coding this data field see page 279 of this manual.

Table H.13 Other Treatment Codes

Code	Description
0	None
1	Other
2	Other-Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended; unknown if administered
9	Unknown

Note: For specific instructions on coding this data field see page 288 of this manual.

Table H.14 Regional Nodes Positive Standard Table

Code	Description
00	All nodes examined are negative
01-89	1–89 nodes are positive (Code exact number of nodes positive)
90	90 or more nodes are positive
95	Positive aspiration or core biopsy 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.

Note: For specific instructions on coding this data field see page 229 of this manual.

Table H.15 Regional Nodes Examined Standard Table

Code	Description
00	No nodes were examined
01-89	1–89 nodes were examined. (Code the exact number of regional lymph nodes examined.)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration or core biopsy 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.

Code	Description
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown.
99	It is unknown whether nodes were examined; not applicable or negative, not stated in record

Note: For specific instructions on coding this data field see page 232 of this manual.

DATA ITEMS CURRENTLY OR PREVIOUSLY COLLECTED

The Texas Cancer Registry adheres to reporting requirements mandated by the National Program of Cancer Registries. Additional data items are required to meet requests from our data users.

Table H.16 Data Items Currently or Previously Collected

Data Item	NAACCR Item Number	Collection Dates
Date of Admission/First Contact	580	1995 - present
Date of Admission/First Contact Flag *	581	2010 – present
Registry/Accession Number	550	1995 - present
Reporting Facility	540	1995 - present
NPI Reporting Facility (Derived)	545	2009 - present
Types of Reporting Source	500	1995 - present
Medical Record #	2300	1995 - present
Class of Case	610	1998 - present
Last Name	2230	1995 - present
First Name	2240	1995 - present
Middle Name	2250	1995 - present
Maiden Name	2390	1995 - 2020
Birth Surname	2232	2021
Alias	2280	1995 - 2002 2006 - present
Street Address	2330	1995 - present
Address at Dx Supplemental	2335	2006 - present
City	70	1995 - present
State	80	1995 - present
Zip Code	100	1995 - present
FIPS County Code at DX	90	1995 - present
Address at Dx-Country	102	2013 - present
Social Security Number	2320	1995 - present
Date of Birth	240	1995 - present
Date of Birth Flag *	241	2010 - present
Place of Birth	250	1998 - 2013
Birthplace-State	252	2013 - present
Birthplace-Country	254	2013 -present

Data Item	NAACCR Item Number	Collection Dates
Race 1	160	1995 - present
Race 2	161	2001 - present
Race 3	162	2001 - present
Race 4	163	2001 - present
Race 5	164	2001 - present
Spanish/Hispanic Origin	190	1995 - present
Sex	220	1995 - present
Text Usual Occupation	310	2010 - present
Text Usual Industry	320	2010 - present
Other Pertinent Information	2680	1995 - present
Physician Managing	2460	2006 - 2010
Physician Follow Up	2470	2006 - present
Facility Referred From	2410	2001 - 2010
Facility Referred To	2420	2001 - 2010
Sequence Number Hospital	560	1995 - present
Sequence Number Central	380	1995 - present
Other Primary Tumors	2200	1995 - 2020
Primary Payer at DX	630	2007 - present
Comorbidity/Secondary Diagnosis #1	3110	2011 - 2017
Comorbidity/Secondary Diagnosis #2	3120	2011 - 2017
Comorbidity/Secondary Diagnosis #3	3130	2011 - 2017
Comorbidity/Secondary Diagnosis #4	3140	2011 - 2017
Comorbidity/Secondary Diagnosis #5	3150	2011 - 2017
Comorbidity/Secondary Diagnosis #6	3160	2011 - 2017
Comorbidity/Secondary Diagnosis #7	3161	2011 - 2017
Comorbidity/Secondary Diagnosis #8	3162	2011 - 2017
Comorbidity/Secondary Diagnosis #9	3163	2011 - 2017
Comorbidity/Secondary Diagnosis #10	3164	2011 - 2017
Source Comorbidity/Secondary Diagnosis	Non-NAACCR 9970	2011 - 2017
Date of Initial Diagnosis	390	1995 - present
Date of Diagnosis Flag	391	2010 - present
ICD-O-2 Morph Prior to 2001	420	1995 - 2001

Data Item	NAACCR Item Number	Collection Dates
Behavior prior to 2001	430	1995 - 2001
ICD-O-3 2001 and forward	522	2001 - present
Behavior 2001 and forward	523	2001 - present
Primary Site	400	1995 - present
Grade of Tumor	440	1995 - 2017
Grade Path Value	441	2011 - 2013
Grade Path System	449	2011 - 2013
Grade Clinical	3843	2018 – present
Grade Pathological	3844	2018 - present
Grade Post Therapy Clinical (yc)	1068	2021
Grade Post Therapy Path (yp)	3845	2021
Laterality	410	1995 - present
Final DX Morph/Beh/Grade	2590	1995 - present
Final DX Primary Site and Laterality	2580	1995 - present
Lymph - Vascular Invasion	1182	2011 - present
Diagnostic Confirmation	490	1995 - present
Tumor Size Summary	756	2016 - present
Tumor Size Prior to 2004	780	1998 – 2003
Summary Stage 1977 for appropriate years	760	1995 - 2000
Summary Stage 2000 for appropriate years	759	2001 – 2004, 2014-present
CS Tumor Size 2004 and forward	2800	2004 - 2015
CS Extension	2810	2004 - 2015
CS Tumor Size/EXT Eval	2820	2008 - 2015
CS Lymph Nodes	2830	2004 - 2015
CS Lymph Nodes Eval	2840	2011 - 2015
Regional Nodes Positive	820	1998 - present
Regional Nodes Examined	830	1998 - present
CS Mets at DX	2850	2004 - 2015
CS Mets Eval	2860	2011 - 2015
CS Site Specific Factor 1 NPCR required only	2880	2004 - 2017
CS Site Specific Factor 2 NPCR required only	2890	2010 - 2017
CS Site Specific Factor 3 NPCR required only	2900	2004 - 2015
CS Site Specific Factor 4 NPCR required only	2910	2011 - 2015

Data Item	NAACCR Item Number	Collection Dates
CS Site Specific Factor 5 NPCR required only	2920	2011 - 2017
CS Site Specific Factor 6 NPCR required only	2930	2011 - 2017
CS Site Specific Factor 7 NPCR required only	2861	2011 - 2015
CS Site Specific Factor 8 NPCR required only	2862	2010 - 2017
CS Site Specific Factor 9 NPCR required only	2863	2010 - 2017
CS Site Specific Factor 10 NPCR required only	2864	2010 - 2017
CS Site Specific Factor 11 NPCR required only	2865	2010 - 2017
CS Site Specific Factor 12 NPCR required only	2866	2010 - 2015
CS Site Specific Factor 13 NPCR required only	2867	2010 - 2017
CS Site Specific Factor 14 NPCR required only	2868	2010 - 2017
CS Site Specific Factor 15 NPCR required only	2869	2011 - 2017
CS Site Specific Factor 16 NPCR required only	2870	2011 - 2017
CS Site Specific Factor 17 NPCR required only	2871	2011 - 2015
CS Site Specific Factor 25 NPCR required only	2879	2010 - 2017
Brain Molecular Markers	3816	2018 – present
Breslow Tumor Thickness	3817	2018 – present
Estrogen Receptor Summary	3827	2018 – present
Fibrosis Score	3835	2018 – present
HER2 Overall Summary	3855	2018 – present
LDH Lab Value	3932	2018 – present
Gleason Patterns Clinical	3838	2021
Gleason Patterns Pathological	3839	2021
Gleason Score Clinical	3840	2021
Gleason Score Pathological	3841	2021
Gleason Tertiary Pattern	3842	2021
Microsatellite Instability (MSI)	3890	2021
Progesterone Receptor Summary	3915	2018 – present
PSA (Prostatic Specific Antigen) Lab Value	3920	2018 – present
Schema Discriminator 1	3926	2018 - present
Schema Discriminator 2	3927	2018 - present
Summary Stage Documentation	2600	1995 - present
TNM Clinical T	940	2015 – 2017
AJCC TNM Clin T	1001	2018 - present

Data Item	NAACCR Item Number	Collection Dates
AJCC TNM Clin T Suffix	1031	2021
TNM Clinical N	950	2015 – 2017
AJCC TNM Clin N	1002	2018 – present
AJCC TNM Clin N Suffix	1034	2021
TNM Clinical M	960	2015 – 2017
AJCC TNM Clin M	1003	2018- present
TNM Clinical Stage (Prefix/Suffix) Descriptor	980	2015 - 2017
TNM Clinical Stage Group	970	2015 - 2017
AJCC TNM Clin Stage Group	1004	2018 – present
TNM Pathologic T	880	2015 – 2017
AJCC TNM Path T	1011	2018 – present
AJCC TNM Path T Suffix	1032	2021
TNM Pathologic N	890	2015 - 2017
AJCC TNM Path N	1012	2018- present
AJCC TNM Path N Suffix	1035	2021
TNM Pathologic M	900	2015 - 2017
AJCC TNM Path M	1013	2018 – present
TNM Pathologic Stage (Prefix/Suffix) Descriptor	920	2015 – 2017
TNM Pathologic Stage Group	910	2015 - 2017
AJCC TNM Path Stage Group	1014	2018- present
AJCC TNM Post Therapy Clin (yc) T	1062	2021
AJCC TNM Post Therapy Clin (yc) T Suffix	1063	2021
AJCC TNM Post Therapy Clin (yc) N	1064	2021
AJCC TNM Post Therapy Clin (yc) N Suffix	1065	2021
AJCC TNM Post Therapy Clin (yc) M	1066	2021
AJCC TNM Post Therapy Clin (yc) Stage Group	1067	2021
AJCC TNM Post Therapy Path (yc) T	1021	2021
AJCC TNM Post Therapy Path (yc) T Suffix	1033	2021
AJCC TNM Post Therapy Path (yc) N	1022	2021
AJCC TNM Post Therapy Path (yc) N Suffix	1036	2021
AJCC TNM Post Therapy Path (yc) M	1023	2021
AJCC TNM Post Therapy Path Stage Group	1024	2021
RX Summary - Reg LN Examined	1296	2001 - 2005

Data Item	NAACCR Item Number	Collection Dates
RX Summary - Scope of Reg LN Surgery	1292	2001 - present
Date of Initial Treatment	1260	2010 - present
Date of Initial Treatment Flag	1261	2010 - present
RX Date Surgery	1200	1995 - present
RX Date Surgery Flag	1201	2010 - present
Surgery RX Code	1290	1995 - present
RX Date Mst Defn Srg	3170	2015 - present
RX Date Mst Defn Srg Flag	3171	2015 - present
Reason for No Surgery	1340	1998 - 2002 2006 - present
RX Summary - Surgery Other/Dist RX Code	1294	1998 - present
RX Text Surgery	2610	2004 - present
Date Radiation Started	1210	1995 - present
RX Date Radiation Flag	1211	2010 - present
RX Summary - Radiation	1360	1998 - 2002 2012 - 2017
Radiation Regional RX Modality Code	1570	2003 - 2017
Phase I Radiation Treatment Modality	1506	2018 – present
Reason for no Radiation	1430	1998 - 2002 2011 - present
RX Text - Radiation	2620, 2630	2004 - present
RX Summary - Surgery/Radiation Sequence	1380	2004 - present
RX Date - Systemic	3230	2004 - 2010
Date Chemotherapy Started	1220	2010 - present
RX Date Chemotherapy Flag	1221	2010 - present
Chemotherapy Code	1390	1995 - present
Reason for no Chemotherapy	1440	1998 - 2002
RX Text - Chemotherapy	2640	2004 - present
Date Hormone Therapy Started	1230	2010 - present
RX Date Hormone Flag	1231	2010 - present
Hormone Code	1400	1995 - present
Reason for no Hormone	1450	1998 - 2002
RX Text - Hormone	2650	2004 - present
Date Immunotherapy Started	1240	2010 - present

Data Item	NAACCR Item Number	Collection Dates
RX Date Immunotherapy Flag	1241	2010 - present
Immunotherapy Code	1410	1995 - present
RX Summary Transplant/Endocrine	3250	2003 - present
RX Text - Immunotherapy	2660	2004 - present
RX Summary - Systemic/Surgery Sequence	1639	2006 - present
Date other Treatment Started	1250	1995 - present
RX Date Other Flag	1251	2010 - present
Other Treatment Code	1420	1995 - present
RX Text - Other	2670	2004 - present
RX - Summary Treatment Status	1285	2010 - present
Date of Last Contact or Death	1750	1995 - present
Date of Last Contact Flag	1751	2010 - present
Vital Status	1760	1998 - present
Place of Death-State	1942	2013 - present
Place of Death-Country	1944	2013 - present
Follow Up Source (Derived)	1790	2009 - present
Date Abstracted	2090	1995 - present
Abstractor Initials	570	1995 - present
NAACCR Record Version	50	2003 - present
AJCC Edition Number	1060	2015 - present
Height	Non - NAACCR 9960	2011 - 2020
Weight	Non - NAACCR 9961	2011 - 2020
Tobacco Use	Non - NAACCR 9965 - 9968	2011- 2020
CoC Accredited Flag	2152	2018

TCR does not allow blanks for the following items:

*Date of Admission/First Contact, NAACCR #580

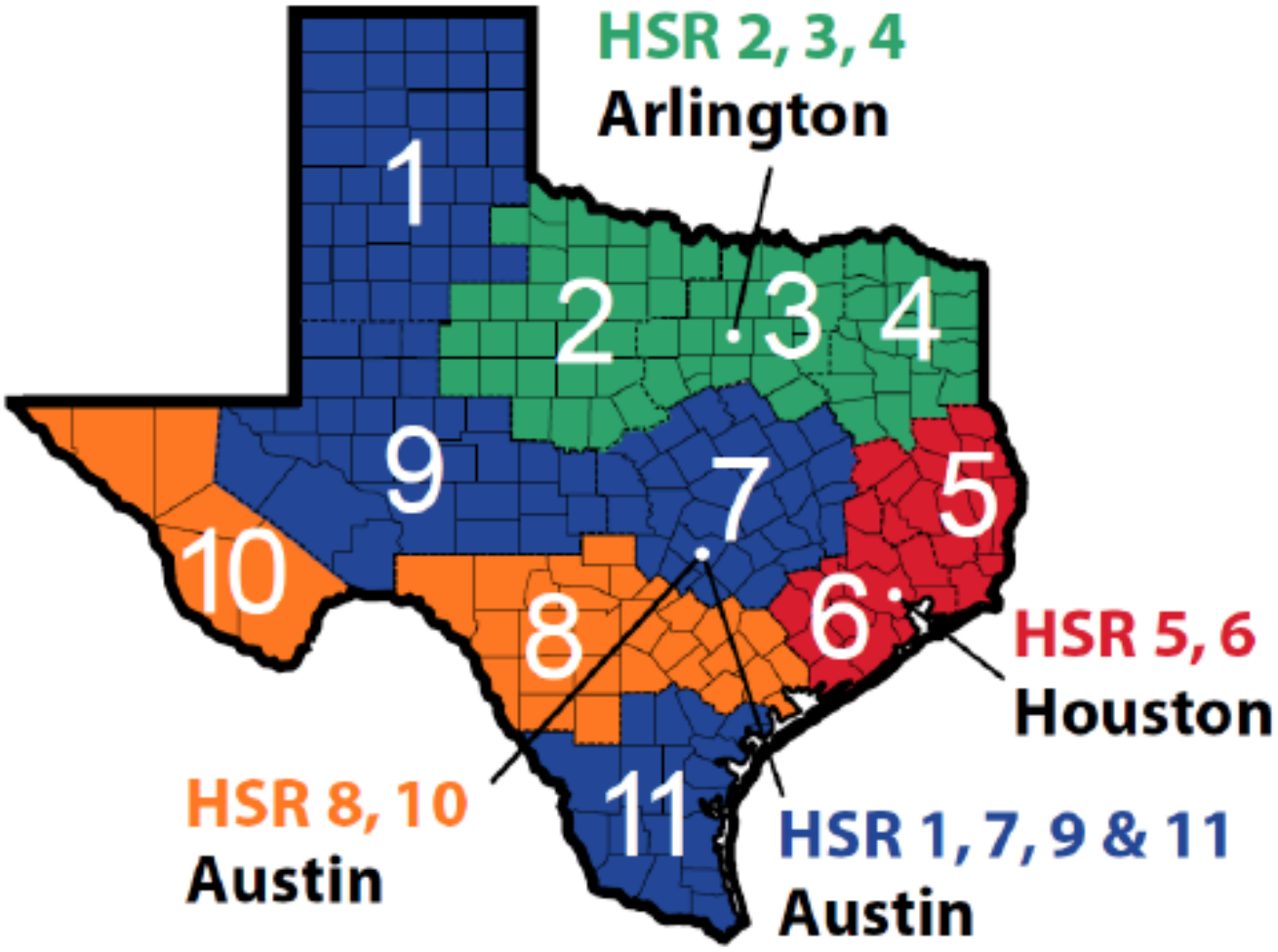
*Date of Date of Birth, NAACCR #240

I

APPENDIX I:
HEALTH SERVICES REGIONS

Health Service Region Map

dshs.texas.gov/tcr/training/handbook/Appendix-Health-Service-Regions.pdf



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APPENDIX J:
SPANISH/HISPANIC SURNAMES

Available on the TCR website at
dshs.texas.gov/tcr/training/handbook/Appendix-Spanish-Hispanic-Surnames.pdf

2021 Cancer Reporting Handbook

Texas Cancer Registry

Publication No. E10-10677

Released August 2021