

**Department of State Health Services
Texas Cancer Registry**

Handbook Quick Reference Sheet

The Sample Abstract Form can be found in Appendix F in the 2011 CRH.

Data Field 580 DATE OF FIRST CONTACT/ADMIT (YYYYMMDD) (pg 55): 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 NUMBER (pg 56): To be completed only by SCL users or facilities with a cancer registry that maintains an accession register.

Data Field 540 REPORTING FACILITY NUMBER (pg 56): 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 (pg 57): 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 (Facility or Private)

3 - Laboratory Only (Facility or Private)

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 2300 MEDICAL RECORD NUMBER (pg 59): 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 (pg 60): Divides data into analytical and non-analytical categories.

Data Field 2230 LAST NAME (pg 64): Enter the name of the patient in capital letters. Hyphens, other special characters, and spaces are allowed. **Do not leave blank.**

Data Field 2240 FIRST NAME (pg 64): Enter first name of patient in capital letters. Hyphens, other special characters, and spaces are allowed. **Do not leave blank.**

Data Field 2250 MIDDLE NAME (pg 65): Enter the middle name of the patient in capital letters. Hyphens, other special characters, and spaces are allowed. Enter middle initial if full name is unknown. Leave blank if unknown.

Data Field 2390 MAIDEN NAME (pg 65): Enter the maiden name of female patients who are or have been married. Hyphens, other special characters and spaces are allowed. Leave blank if unknown.

Data Field 2280 NAME-ALIAS (pg 65): Enter an alternative name or “AKA” used by the patient, if known. If unknown, leave blank

Data Field 2330 STREET ADDRESS (pg 66): Enter the number and street of the patient’s residence at the time the cancer is diagnosed in 25 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 web-site at <http://www.usps.com/ncsc/lookups/abbrev.html>

Data Field 2335 ADDRESS AT DX SUPPLEMENTAL (pg 68): 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 CITY (pg 69): 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 STATE (pg 69): 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 ZIP CODE (pg 72): 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 web site: <http://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: (pg 73 & 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 2320 SOCIAL SECURITY NUMBER (pg 74): 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 /or slashes are not allowed in this field.

Data Field 240 DATE OF BIRTH (YYYYMMDD) (page 74): DOB must be coded. Enter year, month and day of patient's birth. **Unknown date of birth will not be accepted**

Data Field 250 PLACE OF BIRTH (page 75 and Appendix G) Record patient’s place of birth (if available) using the SEER Geocodes in Appendix G. If the place of birth is unknown, code 999.

Data Field 160 RACE 1 (page 76): Enter the 2 digit code to identify the primary race of the patient.

Code	Race	Code	Race	Code	Race
01	White	12	Hmong	27	Samoan
02	Black	13	Kampuchean (Cambodian)	28	Tongan
03	American Indian, Aleutian, Eskimo	14	Thai	30	Melanesian, NOS
04	Chinese	15	Asian Indian or Pakistani, NOS	31	Fiji Islander
05	Japanese	16	Asian Indian	32	New Guinean
06	Filipino	17	Pakistani	96	Other Asian, Asian NOS
07	Hawaiian	20	Micronesian, NOS	97	Pacific Islander, NOS
08	Korean	21	Chamorroan	98	Other
*		22	Guamanian, NOS	99	Unknown
10	Vietnamese	25	Polynesian, NOS		
11	Laotian	26	Tahitian		

Data Field 161, 162, 163 & 164 RACE 2, RACE 3, RACE 4, & RACE 5 (page 76): 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 (page 80): 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 on the TCR website in Appendix M)

0 Non-Spanish; non Hispanic (includes Portuguese and Brazilian)	5 Other specified Spanish/Hispanic
1 Mexican (includes Chicano, NOS)	6 Spanish, NOS; Hispanic, NOS; Latino, NOS
2 Puerto Rican	7 Spanish surname only
3 Cuban	9 Unknown whether Spanish or not
4 South Central American (Except Brazil)	

Data Field 220 SEX (page 81): Enter the code to identify the gender of the patient.

1 Male	3 Other (Hermaphrodite)	9 Not stated/Unknown
2 Female	4 Trans-sexual	

Data Field 320 TEXT USUAL INDUSTRY (pg 82) Document the patient's usual industry to the extent that the information is available in the medical record.

Data Field 310 TEXT USUAL OCCUPATION (pg 83): Document the patient's usual occupation to the extent that the information is available in the medical record.

Data Field 2680 OTHER PERTINENT INFORMATION (page 84) 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.

Data Field 2470 Physician Follow Up (page 85): 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 web-site:
<http://www.docboard.org/tx/df/txsearch.htm>

Data Field 380 SEQUENCE NUMBER (pg 85): Indicates the chronological sequence of this reportable neoplasm IN THE PATIENT'S LIFETIME. Each PRIMARY tumor is assigned a different number.

Malignant Primaries

00 One malignant primary only
01 First of multiple malignant primaries
02 Second of multiple malignant primaries
03 Third of multiple malignant primaries
99 Unspecified number of malignant primaries

Benign Primaries

60 One benign primary only
61 First of multiple benign primaries
62 Second of multiple benign primaries
63 Third of multiple benign primaries
88 Unspecified number of benign primaries

Data Field 2220 OTHER PRIMARY TUMORS (SITE, MORPHOLOGY, AND DATE) (pg 87): Complete **if the patient has other reportable tumors during their lifetime.** Record the site, morphology, and date of any other primaries. **DO NOT INCLUDE SECONDARY/METASTATIC LESIONS.**

Data Field 630 PRIMARY PAYER AT DIAGNOSIS (pg 88): Record the type of insurance the patient has.

01 Not insured	62 Medicare-Administered through a managed care plan
02 Not insured, self pay	63 Medicare with private supplement
10 Insurance, NOS	64 Medicare with Medicaid eligibility
20 Private Insurance: Managed Care, HMO, PPO	65 TRICARE
21 Private Insurance: Fee-for-Service	66 Military
31 Medicaid	67 Veterans Affairs
35 Medicaid-Administered through a managed care plan	68 Indian/Public Health Services
60 Medicare without supplement, Medicare, NOS	99 Insurance status unknown
61 Medicare with supplement, NOS	

Data Field 3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, and 3164 COMORBIDITIES (pg 90): Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM or ICD-10-CM codes. All are considered secondary diagnoses. Record the codes from the discharge abstract or coding summary in the order in which they appear.

Non-NAACCR Standard Data Field 9970 SOURCE COMORBIDITIES (pg 91): Records the data source from which comorbidities/complications were collected.

0 No comorbid condition or complication identified/Not Applicable

1 Collected from facility face sheet

2 Linkage to facility/hospital discharge data set

3 Linkage to Medicare/Medicaid data set

4 Linkage with another claims data set

5 Combination of two or more sources above

9 Other source

Non-NAACCR Standard Data Field 9960 HEIGHT (pg 92): Required for breast, colorectal and CML when chemotherapy and/or other drugs were given. Record as available for all other sites/histologies. The height entered should be that listed at or around the time of diagnosis, before treatment was started. Enter the height as a 2 digit number measure in inches.

Non-NAACCR Standard Data Field 9961 WEIGHT (pg 92): Required for breast, colorectal and CML when chemotherapy and /or other drugs were give. Record as available for all other sites/histologies. The weight entered should be that listed at or around the time of diagnosis, before treatment was started. Enter the weight as a 3 digit number measured in pounds. Code a weight of less than 100 pounds with a leading 0.

Non-NAACCR Standard Data Fields 9965 (TOBACCO USE CIGARETTE), 9966 (TOBACCO USE OTHER SMOKE), 9967 (TOBACCO USE SMOKELESS), and 9968 (TOBACCO USE NOS) (pg 93-95): Record the patient's past or current use of tobacco. Record from sections such as Nursing Interview Guide, Vital Stats, or Nursing Assessment section.

0 Never used

1 Current user

2 Former user, quit within one year of the date of diagnosis

3 Former user, quit more than one year prior to the date of diagnosis

4 Former user, unknown when quit

9 Unknown/not stated/no smoking specifics provided

Data Field 390 DATE OF INITIAL DIAGNOSIS (YYYYMMDD) (pg 97): 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 2010 code 201006) 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 420, 430 MORPHOLOGY ICD-O-2: TYPE AND BEHAVIOR (pg 100): The International Classification of Diseases for Oncology, (ICD-O) 2nd Edition, is to be used for coding and reporting the morphology and behavior of tumors diagnosed before January 1, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Data Field 522 & 523 MORPHOLOGY ICD-O-3: TYPE AND BEHAVIOR (pg 100): The International Classification of Diseases for Oncology, (ICD-O) 3rd Edition is to be used for coding and reporting the morphology and behavior of tumors diagnosed on or after January 1, 2001. **Adequate documentation of tumor cell type must be provided** in the

FINAL DIAGNOSIS section 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.

Note: Refer to *Multiple Primary/Histology Rules (MP/H)*, Appendix O for cases diagnosed on or after 1/1/2007. Refer to Appendix E for hematopoietic and lymphoid malignancies diagnosed before 1/1/2010. For hematopoietic and lymphoid malignancies diagnosed on or after 1/1/2010 refer to <http://seer.cancer.gov/tools/heme/index.html>.

Data Field 400 PRIMARY SITE (pg 103): Record the specific topography code from ICD-O. **Adequate documentation must be provided** in the **FINAL DIAGNOSIS** (Data Fields 2590 and 2580) section of the reporting form to support coding.

Data Field 440 GRADE OF TUMOR (pg 110): The grade or differentiation of the tumor describes the resemblance of the tumor cells to their normal tissue counterparts. The more undifferentiated the tumor, the greater the incidence of metastases and the more rapid the clinical course. **Do not code the grade of a metastatic site.** If the grade for the primary is unknown enter "9" in this field.

- 1 Grade I Well differentiated
- 2 Grade II Moderately differentiated, moderately well differentiated, intermediate differentiation, partially well differentiated, partially differentiated, low grade NOS
- 3 Grade III Poorly differentiated, moderately undifferentiated, relatively undifferentiated, slightly undifferentiated, medium grade NOS
- 4 Grade IV Undifferentiated, anaplastic, dedifferentiated, high grade NOS
- 9 Grade or differentiation not determined, not stated, or not applicable

Codes for T-cell and B-cell designation for lymphomas and leukemia:

- 5 T-cell, T-precursor
- 6 B-cell, pre B; B-precursor
- 7 Null cell; non T-non B (for leukemia only)
- 8 Natural Killer (NK) cell
- 9 Grade or differentiation not determined, not stated or not applicable

Note: For lymphomas, do not code the descriptions "high grade", "low grade", or "intermediate grade" in this field.

Refer to Appendix A of the CRH for specific coding guidelines on grade for Prostate, Breast, Kidney, Astrocytoma, Lymphoma, Leukemia, and Sarcoma primaries.

Data Field 441 GRADE PATH VALUE (pg 114): Documents the numerator (first number) of a tumor grade reported in a 2, 3, or 4 grade system.

- 1 Recorded as Grade I or 1
- 2 Recorded as Grade II or 2
- 3 Recorded as Grade III or 3
- 4 Recorded as Grade IV or 4
- Blank No 2, 3, or 4 grade system available; Unknown

Data Field 449 GRADE PATH SYSTEM (pg 115): Documents the denominator (second number) of a tumor grade reported in a 2, 3, or 4 grade system.

- 1 Recorded as Grade I or 1
- 2 Recorded as Grade II or 2
- 3 Recorded as Grade III or 3
- 4 Recorded as Grade IV or 4
- Blank No 2, 3, or 4 grade system available; Unknown

Data Field 410 LATERALITY (pg 116): Enter the code to identify the laterality of a paired site.

- 0 Not a paired site
- 1 Right: origin of primary
- 2 Left: origin of primary
- 3 Only one side involved, right or left origin not indicated
- 4 Bilateral involvement, lateral origin unknown: stated to be single primary; includes: both ovaries involved

- simultaneously with a single histology; bilateral retinoblastoma; bilateral Wilms' tumors
- 5 Midline in a paired site
 - 9 Unknown site, paired site, lateral origin unknown; midline tumor

Data Field 2580 & 2590 FINAL DIAGNOSIS- MORPHOLOGY/BEHAVIOR, GRADE, PRIMARY SITE, AND LATERALITY DOCUMENTATION (pg 121): Record the morphology/behavior, grade, primary site, and laterality descriptions.

Data Field 1182 LYMPH-VASCULAR INVASION (pg 122): Indicates presence of absence of tumor cells in lymphatic channels.

- 0 Lymph-vascular invasion not present
- 1 Lymph-vascular invasion present
- 8 Not applicable
- 9 Unknown if lymph-vascular invasion present

Data Field 490 DIAGNOSTIC CONFIRMATION (pg 123): 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.

Microscopically Confirmed

- 1 Histology-Microscopic diagnosis based upon tissue specimens from biopsy, frozen section, surgery, autopsy, or D& C. Positive hematologic findings relative to leukemia are also included. Bone marrow specimens (including aspiration biopsies) are coded as "1".
- 2 Cytology- Cytologic diagnosis with no positive histology such as pap smears bronchial brushings, FNA and peritoneal fluid.
- 3 Positive histology PLUS positive immunophenotyping AND/OR positive genetic studies (to be used only for hematopoietic and lymphoid neoplasms)
- 4 Microscopic Confirmation, NOS -- Diagnosis stated to be microscopically confirmed but method not specified.

Not Microscopically Confirmed

- 5 Laboratory test/marker study -- Clinical diagnosis of cancer based on certain laboratory tests or marker studies.
- 6 Direct Visualization -- Visualization without microscopic confirmation, i.e., exploratory laparotomy or endoscopy.
- 7 Radiology/Imaging -- Radiology and other imaging techniques without microscopic confirmation, i.e. CAT scans and MRI.
- 8 Other (other than 5, 6 or 7) -- Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings. Physician documented the tumor in the medical record. Refer to ambiguous Terminology List on page 23.

Confirmation Unknown

- 9 Unknown -- Cases for which it is unknown whether or not microscopically confirmed. Also includes "Death Certificate Only" cases.

Data Field 760 Summary Stage 1977(pg 14): To be used with cases diagnosed/admitted prior to 2001. Summary Stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

- | | |
|-----------------------------|--|
| 0 In Situ | 4 Regional by both direct extension and regional LN involvement |
| 1 Localized | 5 Regional, NOS |
| 2 Regional direct extension | 7 Distant site(s)/node(s) involved; systemic disease |
| 3 Regional to lymph nodes | 9 Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death Certificate Only case |

Note: Do not use Code "8" for Summary Stage.

Data Field 759 SUMMARY STAGE 2000(pg 14): 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.

- | | |
|-----------|---|
| 0 In Situ | 4 Regional by both direct extension and regional LN involvement |
|-----------|---|

1	Localized	5	Regional, NOS
2	Regional direct extension	7	Distant site(s)/node(s) involved; systemic disease
3	Regional lymph nodes involved only	9	Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death Certificate Only case

Note: Do not use Code “8” for Summary Stage.

Data Field 2800 CS TUMOR SIZE (page A-30): Record for cases diagnosed on or after January 1, 2004. Record the largest dimension or diameter of the **primary tumor** before systemic therapy unless the size of the tumor is greater after neoadjuvant treatment. Always record the size in millimeters. **Documentation in the Summary Stage field is required to support coding**

Data Field 2810 CS EXTENSION (page A-38): Record for cases diagnosed on or after January 1, 2004. Code the farthest extension of the primary tumor. Do not code discontinuous metastases in this field. **Documentation in the Summary Stage field is required to support coding.**

Data Field 2820 CS /TUMOR SIZE/EXT EVAL (page A-43): Identifies how codes for CS TUMOR SIZE and CS EXTENSION were determined based on the diagnostic methods employed. **Documentation in the Summary Stage text field is required to support coding.**

Data Field 2830 CS LYMPH NODES (page A-52): Record for cases diagnosed on or after January 1, 2004. Identifies the regional lymph nodes involved with the cancer at the time of diagnoses. Record the specific regional lymph node chain farthest from the primary site that is involved by tumor either clinically or pathologically. Information can be obtained from; radiological reports, surgical reports, and pathology reports. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest involved regional lymph nodes, based on information prior to surgery. **Exception:** In the infrequent event that clinically involved lymph nodes do not respond to neoadjuvant treatment, and are, in fact, more extensively involved at surgery as determined by the pathology report, code the lymph node involvement based on pathology/operative report after surgery.

Use code 988, not applicable, for the following sites or morphologies:

Placenta

Brain and Cerebral Meninges, Other Parts of Central Nervous System

Hodgkin and Non-Hodgkin Lymphoma

Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms

Other and Ill-Defined Primary Sites, Unknown Primary Sites

Data Field 2840 CS LYMPH NODES EVAL (pg A-60): Record how the code for the item *CS Lymph Nodes* was determined, based on the diagnostic methods employed and their intent. **Documentation in the Summary Stage text field is required to support coding.**

Data Field 820 Regional Nodes Positive (page A-67): 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 (page A-71): 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

Data Field 2850 CS METS AT DIAGNOSIS (page A-74): Record for cases diagnosed on or after January 1, 2004. Identifies the distant site(s) of metastatic involvement at time of diagnosis. Assign the highest applicable code for metastasis at the time of diagnosis. This can be determined clinically or pathologically. Information can be obtained from radiological reports, surgical reports, pathology reports, or physician notes. Metastasis known to have developed after extent of disease was established should not be considered for this field. **Documentation in the Summary Stage text field is required to support coding.**

Data Field 2860 CS METS EVAL (pg A-78): Record how the code for the item *CS Mets at DX* was determined based on the diagnostic methods employed. **Documentation in the Summary Stage text field is required to support coding.**

Note: For the following Site-Specific Factors, refer to the specified site schemas in Appendix A for coding instructions.

Data Fields 2880, 2890, 2900, 2910, 2920, 2930, 2861, 2862, 2863, 2864, 2865, 2866, 2867, 2868, 2869, 2870, 2871, 2875, 2876, 2877, 2879 CS SITE-SPECIFIC FACTORS (page A-87 - A-164): Record for cases diagnosed on or after January 1, 2004.

Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival for certain primary sites.

Documentation in the Summary Stage text field is required to support coding.

Data Field 2600 SUMMARY STAGE DOCUMENTATION (page 218): 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. All combined clinical and surgical assessment within **FOUR MONTHS** of diagnosis in the absence of disease progression should be documented. 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 1292 SCOPE OF REGIONAL LYMPH NODE SURGERY (page 133): Enter the code that defines the removal of regional lymph nodes. If no cancer-directed procedure was performed code (0).

Data Field 1200 RX DATE-SURGERY (YYYYMMDD) (page 135): 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 1290 SURGICAL PROCEDURE OF PRIMARY SITE (page 137 & APPENDIX A): 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 (page 139): If no cancer directed surgery to the primary site was performed record the reason.

0 Surgery of the primary site was performed	6 Surgery recommended and unknown why not performed
1 Not part of the planned first course	7 Patient or family refused surgery
2 Not recommended due to patient risk factors	8 Surgery recommended, unknown if performed
5 Patient died prior to planned or recommended surgery	9 Unknown if surgery recommended or performed

Data Field 1294 RX SUMM-SURG.OTH REG/DIST RX CODE (page 141): Document and code the highest numbered code that describes the surgical resection of Regional/Distant Sites and Distant lymph nodes.

Data Field 1210 DATE RADIATION STARTED (YYYYMMDD) (page 143): Document and enter the date radiation began at any facility as part of the first course of treatment. Record all zeros when no radiation therapy is delivered or the cancer was diagnosed at autopsy. Record all 9's when it is unknown whether any radiation therapy was delivered.

Data Field 1211 RX DATE RADIATION FLAG (pg 144): 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 (for example, no radiation given)
15	Information is not available at this time, but it is expected that it will be available later.
(blank)	A valid date value is provided in item <i>Date Radiation Started</i> (NAACCR Item #1210).

Data Field 1570 RADIATION-REGIONAL TREATMENT MODALITY (page 145): Document and code the type of radiation therapy the patient received at any facility as part of the first course of treatment.

Data Field 1380 RX SUMM-SURG/RAD SEQUENCE (page 148): Code the sequence of radiation and surgical procedures given as part of the first course of treatment.

Data Field 1430 REASON NO RADIATION (page 150): 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 3230 DATE SYSTEMIC THERAPY STARTED (YYYYMMDD) (page 151): Document and enter the date systemic therapy began at any facility. Systemic therapy includes: chemotherapy, hormonal agents, immunotherapy, bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. Record all zeros when no systemic therapy was delivered or the cancer was diagnosed at autopsy. If no systemic therapy was given or it is unknown if systemic therapy was given, leave the field blank.

Data Field 1220 DATE CHEMOTHERAPY STARTED (YYYYMMDD) (pg 152): 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 RX DATE CHEMO FLAG (pg 153): 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)
- 15 Information is not available at this time, but it is expected that it will be available later.
- (blank) A valid date value is provided in item **DATE CHEMOTHERAPY STARTED**

Data Field 1390 CHEMOTHERAPY (page 154): 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) (pg 156): 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 (pg 157): 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)
- 15 Information is not available at this time, but it is expected that it will be available later.
- (blank) A valid date is provided in item **DATE HORMONE THERAPY STARTED**.

Data Field 1400 HORMONE THERAPY (HORMONE/STEROID THERAPY) (page 158): 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 that the patient was referred to an oncologist. Code 00 if hormone therapy was not delivered

Data Field 1240 DATE IMMUNOTHERAPY STARTED (YYYYMMDD) (pg 161): 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 RX DATE IMMUNOTHERAPY FLAG (pg 161): 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).
- 15 Information is not available at this time, but it is expected that it will be available later.
- (blank) A valid date is provided in item **DATE IMMUNOTHERAPY STARTED**.

Data Field 1410 IMMUNOTHERAPY (page 162): 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 RX SUMM-TRANSPLANT/ENDOCRINE (page 164): 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.

Data Field 1639 RX SUMM—SYSTEMIC SURG SEQ (page 167): Code the administration of systemic therapy in sequence with the first surgery performed, described in the data item **Date of First Surgical Procedure**.

Data Field 1250 DATE OTHER TREATMENT STARTED (YYYYMMDD) (page 169): 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 1420 OTHER TREATMENT (page 170): 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.

Data Field 1285 RX Summ-Treatment Status (page 173): Code whether or not first course treatment was given.

- 0 No treatment given
- 1 Treatment given
- 2 Active surveillance (watchful waiting)
- 9 Unknown if treatment was given

Data Fields 2610, 2620, 2630, 2640, 2650, 2660, 2670 TREATMENT DOCUMENTATION (page 219): 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 1750 DATE OF LAST CONTACT OR DEATH (YYYYMMDD) (page 173): 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 (page 174): Patient’s vital status as of the date recorded in the “Date of last contact/death” field.

- 0 Dead
- 1 Alive

Data Field 2090 DATE ABSTRACTED (YYYYMMDD) (page 174): Record year, month, and day reporting form is completed.

Data Field 570 ABTRACTOR INITIALS (page 174): Record the initials of the abstractor.