CANCER REPORTING IN CALIFORNIA SYSTEM STANDARDS

ABSTRACTING AND CODING PROCEDURES FOR HOSPITALS

California Cancer Reporting System Standards

Volume One

Tenth Edition, October 2010
Revised, April 2011

PREPARED BY
California Cancer Registry
Data Standards and Quality Control Unit

STATE OF CALIFORNIA
Department of Public Health

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PREFACE TO THE TENTH EDITION

The staff of the Data Standards and Quality Control (DSQC) Unit of the California Cancer Registry presents the tenth edition, of Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, Volume I, dated October 2010. The CCR provides Volume I in two formats. One version is in HTML and is interactive and fully searchable. The other version is a printable, PDF version for downloading. Changes to this document are identified through the use of ***italicized, bolded, maroon-colored font.***

The vast changes for 2010 include the implementation of the Collaborative Stage Data System, version 2 (CSv2) with many new or revised data items, the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual, the addition of date flag fields, new data items, Grade Path Value and Grade Path System and the revision of the data item, Class of Case, just to name a few.

All of the 2010 changes are requirements from national standard setting agencies. None of the changes were initiated by California Cancer Registry; however, the CCR DxRx Path data items have been replaced in 2010 with the national data items, Path Reporting Fac ID 1-5, Path Report Number 1-5, Path Date Specimen Collect 1-5, Path Report Type 1-5. Data in the DxRx fields have been converted to the new data items.

The 2010 data changes work effort has been a huge undertaking. Fortunately, we were able to hire Lois Inferrera, RHIA, CTR as the new Quality Control Specialist II to fill the data standards position, primarily responsible for updating Volume I. Lois took on the challenge, not only incorporating the new data items for 2010, but she has also made many changes to streamline Volume I, making it more user-friendly. The abbreviations list in Appendix M has been substantially increased to provide users a more robust and relevant list. The Spanish Surname List (Appendix O), has been revised to make it easier and faster to perform search functions.

Instructions on current abstracting and coding rules are listed first in each section. Instructions on historical rules follow and are often provided via links in the HTML version.

A document titled Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, California Cancer Reporting System Standards, Volume I, Changes and Clarifications – 10th Edition, September 2010, provides a detailed summary of the changes in Volume I. This document is posted to the CCR web site.

I want to acknowledge Lois Inferrera, as the lead for the revision of Volume I for 2010, Dennis O'Neal, Alan Houser, MA, MPH, and Cathy Schindler for their technical expertise and editorial assistance. Thanks also to the following DSQC Quality Control Staff, for their review, suggestions and assistance in revising this document: Katheryne Vance, BA, CTR, Taina Valone, RHIA, CTR, Kyle Ziegler, CTR, Cheryl Moody, BS, CTR.

For reporting facilities in California, please send corrections, comments, and suggestions regarding this document to your regional registry. They will

send/forward this information to our unit. If individuals or facilities that are not part of the California reporting system need copies, they may download Volume I from the California Cancer Registry web site.

The changes for 2010 are not simple and will require a learning curve for everyone. The CCR DSQC Unit will continue to provide abstracting and coding clarifications through this process to assist registrars. We are all in this together!

As always, I want to thank you for the contribution and dedication you make to the California Cancer Registry and its mission - searching for the causes and cures of cancer.

Winny Roshala, B.A., CTR
Data Standards and Quality Control
Unit Chief

Part I. Introduction

I.1 Reporting Cancer Statistics

The systematic gathering of information about the incidence of cancer in designated populations is an indispensable tool in the struggle to contain the disease. With access to reliable statistics on the occurrence of different types of cancer, the people affected, the treatment provided, and other epidemiological factors, researchers and public health officials are better able to identify problems and evaluate remedies. Findings from such studies include possible environmental influences on the development of neoplasms, the susceptibility of certain ethnic and social groups to particular neoplasms, the need for oncology services in various locales, and the appropriateness of diagnostic and therapeutic procedures.

I.1.1 Role of the Cancer Registry

Many California hospitals have had their own cancer registries since the 1950's in accordance with guidelines established by the American College of Surgeons (ACoS) and its requirements for accreditation of oncology services. The main purpose of a hospital registry is to provide physicians with the data needed to maintain quality of care through peer review and to compare performance with recognized standards. However, a more comprehensive level of reporting is required by state law and that level is supported by the California Cancer Registry and its statewide database system, Eureka DMS.

I.1.2 The California Cancer Registry

Information from hospital registries and other sources is gathered by the California Cancer Registry (CCR) primarily for use in epidemiological research and for monitoring the occurrence of cancer in the state. A unit in the Chronic Disease Surveillance and Research Branch of the California Department of Public Health, the CCR was established in 1947 as a pilot study to determine the feasibility of basing a central registry on data reported by hospitals. The study was successful and the registry gradually expanded its coverage from nine hospitals to thirty six, most of which were located in the San Francisco Bay area and Los Angeles County. As a result, valuable statistics were developed about the survival of cancer patients. But since the data did not apply to a defined segment of the population, it was not possible to calculate the incidence of cancer. A section covering the population of Alameda County was therefore added to the registry in 1960. When the National Cancer Institute (NCI) undertook its Third National Cancer Survey in 1969, the population-based registration was extended to the entire San Francisco Oakland Standard Metropolitan Statistical Area (SF-O SMSA) consisting of Alameda, Contra

Costa, Marin, San Francisco, and San Mateo counties. Support for the SF-O SMSA registration was subsequently provided by the NCI's Surveillance, Epidemiology and End Results (SEER) Program. Established in 1973, SEER is among the largest population-based registries in the Western world, covering approximately 36 million people in eleven designated regions of the United States.

Expansion of the registration to the SF-O SMSA produced a number of important benefits. It strengthened the DHS's ability to estimate the incidence of cancer in California, ascertain risk factors in the occurrence of the disease, study variations in risks among different ethnic groups and social classes, identify changes in the incidence of various forms of cancer in subgroups of the population, and study long-term changes in the interrelationship of incidence, early diagnosis, treatment, length of survival, and mortality for a greater understanding of cancer. In addition, it greatly increased the number of cases available to researchers for epidemiological studies of human cancer and its relationship to the environment, genetics, cancer in different species, and other fields. Because of these benefits, the CCR's coverage was extended to the State's entire population, which now totals over 37 million people.

I.1.3 State Cancer Reporting Requirements

Provisions of the California Health and Safety Code enacted in 1985 (Sections 103875 and 103885) mandate the establishment of a statewide system of cancer reporting. The purpose of the system is to *conduct a Program of epidemiological assessments of the incidence of cancer*, with a view to identifying cancer hazards to the public health and their remedies. Under the code, *any hospital or other facility providing therapy to cancer patients within an area designated as a cancer reporting area shall report each case of cancer to the department or the authorized representative of the department.*

January 1, 2001 Forward

Beginning January 1, 2001, diagnoses of borderline and benign primary intracranial and central nervous system (CNS) tumors are also reportable, as well as borderline ovarian cancer and Newly Reportable Hematopoietic Diseases (NRHD) (see Section II.I.8).

It is the reporting facility's responsibility to inform patients that their cancer diagnosis has been reported to the California Cancer Registry as required by regulations that govern the cancer reporting law. A Patient Information Sheet has been developed by the California Department of Public Health, which may be used to inform patients. Please refer to Appendix J. A reporting facility may modify this information sheet, if they so choose.

I.1.4 Confidentiality

The California Health and Safety Code stipulates that the identity of patients whose cases are reported to the CCR must be held in the strictest confidence. Information that could be used to identify a patient may not be released to or discussed with anyone other than authorized personnel at the reporting hospital or other reporting source***s***, unless prior informed consent is received from the patient. Section 100330 of the code states:

> All records of interviews, written reports and statements procured by the state Department of Public Health or by any other person, agency or organization acting jointly with the state department, in connection with special morbidity and mortality studies shall be confidential insofar as the identity of the individual patient is concerned and shall be used solely for the purposes of the study. The furnishing of such information to the state or its authorized representative, or to any other cooperating individual, agency or organization in any such special study, shall not subject any person, hospital, sanitarium, rest home, nursing home, or other organization furnishing such information to any action for damages.

The CCR also has a policy of maintaining the confidentiality of any information that could be used to identify the caseload of a specific facility or physician.

Under certain circumstances confidential information may be released for research purposes without the patient's consent. Legal provisions for these exceptions to the rules of confidentiality are contained in the Information Practices Act, Civil Code 1798.24. (See Appendix J for a sample Patient Information Sheet for use in notifying patients that cancer is reportable.)

For more information regarding the CCR's confidentiality policy, please see the CCR web site.

I.1.5 Casefinding

The foundation of the State's cancer reporting system is the hospital, and a key to successful registration is a casefinding system within the hospital for identifying patients with reportable cancers. Although exact procedures might vary from hospital to hospital, they ordinarily involve careful monitoring of the records kept by the services and departments that usually deal with cancer cases.

I.1.5.1 Sources

The principal sources for a hospital's identification of cancer patients are:

- Pathology reports, including histology, cytology, hematology, bone marrow, and autopsy findings. Since pathologic studies are made for most patients suspected of having cancer, the majority of reportable cases can be found by reviewing or obtaining copies of reports with positive or indicative diagnoses.
- Daily discharges
- Disease indexes (See Appendix K for applicable ICD-9-CM codes used in medical records departments.)
- Outpatient records
- Surgery reports
- Radiation therapy logs
- Nuclear medicine logs
- Radiology logs, including logs of scans

I.1.5.2 Follow-Up

To meet the requirements of the State's cancer reporting system, it is necessary to periodically determine the vital status and condition of registered patients. One method of obtaining this information is through the casefinding process. Reporting facilities must have a systematic method of identifying patients who are re-admitted to the hospital or who are treated on an outpatient basis, whether for the reported cancer or for another condition. This information can be used to update the reported patient's vital status and condition.

See Part VII for additional information.

I.1.6 Reporting

The reporting facility must report every case of cancer first seen as an inpatient or outpatient, either with evidence of cancer or for cancer-directed treatment, on or after the date that mandatory reporting was declared for the region (the region's reference date). ***Refer to the Regional Registry Reference Date Guide for the specific date when mandatory reporting began in each region.***

There are two methods of reporting cancer cases to the CCR.

- ***A full abstract is required for any case diagnosed and/or treated at the reporting facility (analytic cases) and for most nonanalytic cases. For the list of required data items included in a full abstract, see Appendix U.***
- ***A CMR or other approved notification mechanism is used to identify cancer cases with limited information. These cases are diagnosed and treated elsewhere, however they must be submitted to the regional registry/CCR for incidence reporting. The CCR/Region may***

request the reporting facility to submit an abstract for incidence reporting if the case submitted via CMR is not found in the CCR database.

Refer to the Required Method of Reporting Guide for the CCR's reporting requirements.

I.1.6.1 Definition of Cancer

Cancer is defined by the Health and Safety Code for registry purposes, as "all malignant neoplasms, regardless of the tissue of origin, including malignant lymphoma, Hodgkin Disease, and leukemia, but excluding basal cell and squamous cell carcinoma of the skin."

January 1, 2001 and Forward

Effective with cases diagnosed January 1, 2001, benign and uncertain behavior intracranial and central nervous system (CNS) tumors became reportable along with newly reportable histologies published in ICD-O-3. Although borderline ovarian tumors changed behavior in ICD-O-3 from /3 (malignant) to /1 (borderline), the CCR will continue to require reporting them. They are to be coded with a behavior code of /1. The CCR establishes an official list of reportable neoplasms annually. A tumor must be reported if it is diagnosed as cancer by any physician (including a pathologist or radiologist), surgeon, or dentist.

January 1, 1996 and Forward

Effective with cases diagnosed January 1, 1996, carcinoma in situ (including squamous cell and adenocarcinoma) of the cervix and CIN III (cervical intraepithelial neoplasia, grade III) are no longer reportable to the CCR.

I.1.6.2 Abstracting Cancer Data

Information about cancer cases is reported to the CCR in the form of abstracts, which summarize pertinent information about individual cases. (Refer to Appendix U -- Data Items and Their Required Status). If in doubt about how certain fields should be completed, the regional registry should be contacted.

Whatever reporting software is used, rules for entering data must be followed precisely. The text summaries required for the sections on diagnostic procedures and treatment should be as concise as possible. Every required data item must be completed, and the entries must be accurate, concise, and clear.

I.1.6.3 Coding

Much of the information is entered in codes consisting of numbers or characters. Codes ***must*** be supported by text documentation on the abstract.

I.1.6.4 Entering Dates

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, dates transmitted between facility registries and central registries changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format.

Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. In traditional form, some dates also permit 88888888 or 00000000 for special meaning.

Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. An allowable date must contain the year.

Consult your software vendor for specific data entry instructions.

Description	Traditional Date	Interoperable Date	Date Flag
Full date known	MMDDCCYY	CCYYMMDD	Blank
Month and year known	MM99CCYY	CCYYMMbb	Blank
Year only known	9999CCYY	CCYYbbbb	Blank
Unknown date	99999999	bbbbbbbb	10, 11, 12, or 15*

b= blank * Allowable date flag values

I.1.6.5 Date Format and Date Flag Guide

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, dates transmitted between facility registries and central registries changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format.

Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. In traditional form, some dates also permit 88888888 or 00000000 for special meaning.

Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. An allowable date must contain the year.

Consult your software vendor for specific data entry instructions.

Description	Traditional Date	Interoperable Date	Date Flag
Full date known	MMDDCCYY	CCYYMMDD	Blank
Month and year known	MM99CCYY	CCYYMMbb	Blank
Year only known	9999CCYY	CCYYbbbb	Blank
Unknown date	99999999	bbbbbbbb	10, 11, 12, or 15*

b= blank *Allowable date flag values

Refer to the Date Flag Guide for the allowable values for each date flag field.

I.1.6.6 Coding Resources

A registry must have certain reference works for coding, in addition to this manual.	
Data Collection of Primary Central Nervous System Tumors	http://www.cdc.gov/cancer/npcr/pdf/btr/braintumorguide.pdf
Collaborative Staging Data Collection System Coding Instructions	Collaborative Stage Work Group of the American Joint Committee on Cancer. *Collaborative Stage Data Collection System Coding Instructions*, ***version 02.00.00***. Incorporates updates through April 2010.

	http://cancerstaging.org/cstage/manuals/index.html
Collaborative Staging Manual and Coding Instructions	Collaborative Staging Task Force of the American Joint Committee on Cancer. Version 01.04 Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004, NIH Publication Number 04-5496. http://cancerstaging.org/cstage/manuals/archives.html
Hematopoietic Database (Hematopoietic DB)	SEER (Surveillance, Epidemiology, and End Results Program). [www.seer.cancer.gov] Hematopoietic and Lymphoid Database, Version 1.6 released 04/12/2010 National Cancer Institute, DCCPS, Surveillance Research Program. http://seer.cancer.gov/tools/heme/index.html
2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual	Johnson CH, Adamo M, Peace S (eds.), 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual National Cancer Institute, Bethesda, MD 20892-8316 http://seer.cancer.gov/tools/heme/index.html
International Classification of Diseases for Oncology (ICD-O)	Fritz, A., Percy, C. et al, eds. 3rd ed. Geneva; World Health Organization, 2000.
International Classification of Diseases for Oncology (ICD-O)	Percy, C., VanHolten, V., and Muir, C., eds. 2d ed. Geneva: World Health Organization, 1990.
2007 Multiple Primary and Histology Coding Rules Manual	SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: National Institutes of Health, National Cancer Institute, January 01, 2007. http://seer.cancer.gov/tools/mphrules/download.html
SEER Extent of Disease—1988 Codes and Coding Instructions	SEER (Surveillance, Epidemiology, and End Results Program). 3rd ed. [Bethesda]: National Institutes of Health, National Cancer Institute, 1998. NIH Pub. No. 98-1999.
Summary Staging Guide for the Cancer Surveillance, Epidemiology and End Results Reporting (SEER) Program	SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, NIH, April 1977, reprinted July 1986.

SEER*Rx ***Version 1.4.1.*** The Cancer Registrar's Interactive Antineoplastic Drug Database	SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, 2007 (applicable for cases diagnosed January 1, 2005 forward). http://seer.cancer.gov/tools/seerrx/index.html
Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs	SEER (Surveillance, Epidemiology, and End Results Program). 3d ed. [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, 1994 (applicable for cases diagnosed prior to January 1, 2005).
AJCC Cancer Staging Manual	***AJCC (American Joint Committee on Cancer). 7th ed. New York: Springer-Verlag, 2010.***
Manual for Staging of Cancer	AJCC (American Joint Committee on Cancer). 6th ed. New York: Springer-Verlag, 2002.
CNExT User Manual/ ***Online Help System***	C/NET Solutions. [Berkeley]: Public Health Institute, CNExT Project.
Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data Standards (FORDS)	ACoS (American College of Surgeons Commission on Cancer). Chicago: American College of Surgeons Commission on Cancer, January 2003, revised 2007and ***2010.***
Helpful references, although not necessary for abstracting and coding, include the following:	
California Cancer Registry Inquiry System	California Cancer Registry, California Public Health Institute https://dsqc.ccr.ca.gov/logon.aspx
SEER Inquiry System (SINQ): Resolved Questions	SEER (Surveillance, Epidemiology, and End Results Program) http://seer.cancer.gov/seerinquiry/index.php
CAnswer Forum	***Commission on Cancer, American College of Surgeons*** http://cancerbulletin.facs.org/forums/content.php
SEER Program: Comparative Staging Guide for Cancer	SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: National Institutes of Health, National Cancer Institute, 1993. NIH Pub. No. 93-3640.
SEER Program Coding and Staging Manual 2010	***Adamo MB, Johnson CH, Ruhl JL, Dickie LA, (eds). 2010 SEER Program Coding and Staging Manual. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD.*** ***http://seer.cancer.gov/tools/codingmanuals***

WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues	***Edited by H. Swerdlow, E. Campo, et al.4th ed. IARC, Lyon 2008***
SEER Program: Self-Instructional Manual for Cancer Registrars Shambaugh, E., ed-in-chief. [Bethesda]: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, various years. http://seer.cancer.gov/training/manuals *Book One-Objectives and Functions of a Tumor Registry* 2d ed, 1980. [New edition is in preparation.] *Book Two-Cancer Characteristics and Selection of Cases* 3d ed, 1992. NIH Pub. No. 92-993 *Book Three-Tumor Registrar Vocabulary: The Composition of Medical Terms* 2d ed, 1993. NIH Pub. No. 93-1078. *Book Four-Human Anatomy as Related to Tumor Formation* 2d ed, 1993. NIH Pub. No. 93-2161. *Book Five-Abstracting a Medical Record: Patient Identification, History, and* Examinations, 2d ed, 1993. NIH Pub. No. 93-1263 *Book Seven-Statistics and Epidemiology for Tumor Registrars*, 1994	
International Classification of Diseases for Oncology (ICD-O)	World Health Organization. Geneva: World Health Organization, 1976.
International Classification of Diseases for Oncology(ICD-O)	Percy, C., and VanHolten, V. Field Trial Edition. Geneva: World Health Organization, 1988.
U.S. Postal Service National Zip Code & Post Office Directory.	http://www.usps.com/

I.1.6.7 CCR Reportability Guide

Please refer to the Reportability Guide for information on specific histologies and sites for tumors that are reportable or not reportable to the CCR.

I.1.7 Reporting by Non-Hospital Treatment Centers

Not all abstracting requirements apply to free-standing radiation therapy centers and other cancer treatment centers that are not part of hospitals and do not have inpatient facilities. Usually, patients seen at these facilities have been hospitalized elsewhere previously, and the treatment center is not the primary source for detailed information about their diagnostic work-ups. However, case reports from such facilities afford a quality check on the hospitals' reports and, even more important, provide data that complete the information about the patient's first course of treatment. Without these reports, statewide data on patterns of care would not be accurate or clinically useful.

When submitting abstracts, treatment centers must provide complete patient identification and treatment information, but they are not required to fill in text fields for diagnostic procedures that were performed elsewhere (see Section IV.1). Recording stage is also important. When planning treatment, the radiation therapist often performs the most thorough assessment of stage available for the case.

The treatment center's abstract must be prepared in the same electronic format used by other facilities, although many of the data fields may be left blank or coded as unknown. Required data are listed in Appendix U.

I.1.8 Abstracting Requirements for Non-analytic Cases

A population-based registry like California's must record all cases, regardless of place of diagnosis or class of case, even though the American College of Surgeons (ACoS) does not require hospitals to abstract non-analytic cases.

Therefore, the CCR requires that non-analytic cases be abstracted and submitted. For definitions of non-analytic and analytic cases and class of case, see Section III.3.5.

I.1.8.1 Autopsy Only Cases

Abstracting requirements for Autopsy Only (Class ***38***) cases are the same as those for analytic cases.

I.1.8.2 Cases Diagnosed and Treated Elsewhere

Reporting requirements for cases diagnosed and treated elsewhere are less stringent than those for other cases. The reporting hospital's medical record often does not contain the required data, or contains only secondhand data. Report any information included in the medical record, but it is not necessary to obtain missing information, although a hospital may choose to do so. Text information about diagnostic procedures limited to a brief statement of the patient's history and the reason for the present admission must be included. Enter the statement in the Physical Exam text area.

Even though information for many required data fields might not be available, all of the fields must be completed. If necessary, enter the codes for UNKNOWN or NONE.

I.2 CNExT

This section was software specific and deleted in 2008.

Part II. Reportable Neoplasms

The essential criteria for a reportable tumor is a diagnosis of cancer by a physician, surgeon, or dentist, even if it is not pathologically confirmed.

II.1 Determining Reportability

Every reporting facility must report all cases, inpatient or outpatient, admitted on or after the regional registry's reference date with a neoplasm classified in the morphology section of ICD-O-3 (International Classification of Diseases for Oncology, Third Edition, 2000) as malignant or in situ, including those discovered at an autopsy. The only exceptions are certain carcinomas of the skin. See Section II.1.4. Neoplasms described by terms synonymous with in situ are reportable. See Section V.5.8.1 for a list of these terms. Effective with cases diagnosed January 1, 2001, benign and uncertain behavior intracranial and central nervous system (CNS) tumors become reportable along with newly reportable histologies published in ICD-O-3. Although borderline ovarian tumors changed behavior in ICD-O-3 from /3 (malignant) to /1 (borderline), the CCR will continue to require reporting them. Other benign neoplasms are not reportable. For a list of reportable and non-reportable neoplasms, refer to the morphology section of ICD-O-3.

II.1.1 Criterion for Reportability of Benign/Borderline Brain and CNS Tumors

In determining whether a tumor is reportable, the basic criterion is a diagnosis of cancer by a physician, surgeon, or dentist, even if it is not pathologically confirmed. For vague and ambiguous diagnostic terms, see Section II.1.6. A positive pathology report takes precedence over any other report or statement in a patient's chart. In case of doubt about the reportability of a tumor, contact the hospital's regional registry for advice.

For benign and borderline brain and CNS tumors, there must be a corresponding ICD-0-3 histology code for any CNS
tumor-related diagnosis.

- The terms "tumor" and "neoplasm" are diagnostic and reportable for non-malignant brain and CNS primaries.
- The terms "mass" and "lesion" are not reportable for non-malignant brain and CNS primaries, but may be used for initial casefinding purposes.
- The terms "hypodense mass" or "cystic neoplasm" are not reportable even for CNS tumors.

See Section II.1.9.1 Reportability - Benign/Borderline Brain and CNS Tumors.

II.1.2 Identifying the Primary Neoplasm

Accurate identification of a patient's primary neoplasm is essential for determination of the extent to which the disease has progressed. It is also imperative for successful use of the data by research scientists and public health officials.

A primary neoplasm is the original lesion, as compared to a tumor that has developed as a result of metastasis or extension. A patient might have many lesions that developed from one tumor or different tumors that developed independently.

II.1.2.1 Metastasis

Metastasis is the dissemination of tumor cells from the primary site to a remote part of the body. It is important to distinguish metastatic lesions from new primaries. A metastatic lesion is not a primary tumor. Pathologic reports are usually the best source. The term "secondary" is sometimes used for a metastatic lesion. Since the lymphatic system is one of the main routes of metastasis, frequent reference will be found in examinations of the lymph nodes. Occurrence of a lesion in a lymph node ordinarily indicates metastasis.

II.1.2.2 Abstracting Each Primary

A separate abstract must be prepared for each primary reportable neoplasm present at the time of admission unless it was previously reported. This would ordinarily exclude a tumor identified only by its history.

For definitions and rules, see Section II.1.3 and Section V.1.

January 1, 2007 and Forward

Beginning with cases diagnosed January 1, 2007 forward, the 2007 Multiple Primary and Histology Rules must be used to determine histologic type. Do not apply these rules to cases diagnosed prior to January 1, 2007. Refer to the Multiple Primary and Histology Coding Rules Manual for details and instructions.

January 1, 2005 through December 31, 2006

For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

II.1.2.1 Metastasis

Metastasis is the dissemination of tumor cells from the primary site to a remote part of the body. It is important to distinguish metastatic lesions from new primaries. A metastatic lesion is not a primary tumor. Pathologic reports are usually the best source. The term "secondary" is sometimes used for a metastatic lesion. Since the lymphatic system is one of the main routes of metastasis, frequent reference will be found in examinations of the lymph nodes. Occurrence of a lesion in a lymph node ordinarily indicates metastasis.

II.1.2.2 Abstracting Each Primary

A separate abstract must be prepared for each primary reportable neoplasm present at the time of admission unless it was previously reported. This would ordinarily exclude a tumor identified only by its history.

For definitions and rules, see Section II.1.3 and Section V.1.

II.1.3 Single and Multiple Primaries

The CCR has adopted the SEER policy for reporting whether lesions are single or multiple primaries. The policy states:

> The determination of how many primary cancers a patient has is, of course, a medical decision, but operational rules are needed in order to ensure consistency of reporting by all participants. Basic factors include the site of origin, the date of diagnosis, the histologic type, the behavior of the neoplasm (i.e., in situ vs. malignant), and laterality. In some neoplasms, one must be careful since different histologic terms are used to describe progressive stages or phases of the same disease process.

Therefore, for purposes of statewide reporting, the following operational rules take precedence over the physician's determination of the number of primaries. Refer to Section V.1.2 for the rules for determining site.

January 1, 2007 and Forward

Beginning with cases and tumors diagnosed January 1, 2007 forward, the CCR requires the use of the 2007 Multiple Primary and Histology Coding Rules Manual. The 2007 Multiple Primary and Histology rules replace all previous multiple primary rules except those for hematopoietic neoplasms.

The rules are effective for cases diagnosed on or after January 1, 2007. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.

If there is a previously diagnosed cancer primary before January 1, 2007, do not change the previous primary based on the new rules. Use the new rules for any new tumor diagnosed after January 1, 2007, to determine if it is an additional primary. Refer to the SEER Multiple Primary and Histology Coding Rules Manual for specific instructions.

Note: Use the 2007 Multiple Primary and Histology rules to determine the number of primaries to be abstracted. Do not use the Multiple Primary and Histology Rules to determine reportability, stage or to assign grade.

January 1, 2005 through December 31, 2006

For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

Prior to January 1, 2005

For cases diagnosed prior to January 1, 2005, refer to Section II.1.3.1.

II.1.3.1 Single Primaries

January 1, 2007 and Forward

For cases and tumors diagnosed January 1, 2007 forward, apply the SEER Multiple Primary and Histology Coding Rules.

January 1, 2005 through December 31, 2006

For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

Prior to January 1, 2005

For cases diagnosed prior to January 1, 2005, the following are to be considered single primaries:

- A single lesion of one histologic type, even if the lesion crosses site boundaries (for definitions of site boundaries and histologic types. See Sections V.1 and V.3 respectively.
- A single lesion with multiple histologic types. See Section V.3.3.3 for coding instructions.
- A new cancer with the same histology as an earlier one, if diagnosed in the same site within two months.
- Multiple lesions of the same histologic type, if diagnosed in the same site within two months. Furthermore, if one lesion has a behavior code of in situ and another a malignant behavior code, they are to be reported as a single primary whose behavior is malignant. (For definition of behavior codes, see Section V.3.4.
- Two lesions occurring within two months of each other in a single site are considered a single primary if one is reported as (adeno)carcinoma, NOS, and the other is a more specific type of (adeno)carcinoma. For coding instructions, see Section V.3.3.3.2.

II.1.3.2 Multiple Primaries
January 1, 2007 Forward

For cases and tumors diagnosed January 1, 2007 forward, apply the 2007 Multiple Primary and Histology Coding Rules Manual.

January 1, 2005 through December 31, 2006

For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

Prior to January 1, 2005

For cases diagnosed prior to January 1, 2005, the following are to be considered separate primaries:

- A new cancer with the same histology and behavior as an earlier one, if diagnosed in the same site after two months, unless stated to be recurrent or metastatic.

  Exception #1: For bladder cancers with site codes C67.0-C67.9 and morphology codes 8120 8130 and adenocarcinomas of the prostate (C61.9), a single report of the first invasive lesion only is required.

  Exception #2: If there is an in situ followed by an invasive cancer in the same site more than two months apart, report as two primaries even if noted to be a recurrence. The invasive case must be diagnosed 1/1/95 or later. Effective with cases diagnosed January 1, 1998, and later, this also applies to bladder and prostate sites. For these two sites, the first invasive case must be diagnosed 1/1/98 and later. The purpose of this guideline is to ensure that a case is counted as an incidence case, *i.e.*, invasive, when data are analyzed by the regional and central registry.
- Multiple lesions of different histologic types in the same site, whether occurring simultaneously or at different times. (Note: Different histologic terms are sometimes used to describe progressive stages or phases of the same disease process.)
- Multiple lesions of different histologic types in different sites.

See also:

- Section II.1.3.3 Paired Sites
- Section II.1.3.4 Breast Ductal and Lobular Carcinomas
- Section II.1.3.6 Lymphatic and Hematopoietic Diseases - Subsequent Diagnoses
- Section II.1.3.7 Other Single and Multiple Primaries

II.1.3.3 Paired Sites
January 1, 2007 Forward

For cases diagnosed January 1, 2007 forward, apply the 2007 Multiple Primary and Histology Coding Rules Manual for determining how many primaries are involved in paired sites.

See Section V.2 Laterality

II.1.3.4 Breast Ductal and Lobular Carcinomas
January 1, 2007 Forward

For cases diagnosed January 1, 2007 forward, apply the Multiple Primary and Histology Coding Rules for determining how many primaries are involved in breast tumors with ductal and lobular carcinoma. See 2007 Multiple Primary and Histology Coding Rules Manual.

II.1.3.5 Intraductal Carcinoma and Paget Disease
January 1, 2007 Forward

For cases and tumors diagnosed January 1, 2007 forward, refer to the 2007 Multiple Primary and Histology Coding Rules Manual to determine how to code breast tumors with intraductal carcinoma and Paget Disease.

Prior to January 1, 2007

For cases diagnosed prior to January 1, 2007, enter code 8543/3 for a combination of intraductal carcinoma (8500/2) and Paget Disease (8540/3).

II.1.3.6 Lymphatic and Hematopoietic Diseases - Subsequent Diagnoses
For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, please refer to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic Database.

II.1.3.7 Single and Multiple Primaries, Kaposi's Sarcoma
Kaposi's Sarcoma (9140/3) is to be reported only once.

II.1.4 Skin Carcinomas

Basal and squamous cell carcinomas of the skin are not reportable. Specifically, do not report the following histologies occurring in the skin (site codes C44.0-C44.9):

- 8000-8005 Neoplasms, malignant, NOS, of the skin
- 8010-8046 Epithelial carcinomas of the skin
- 8050-8084 Papillary and squamous cell carcinomas of the skin
- 8090-8110 Basal cell carcinomas of the skin

II.1.4.1 Skin Carcinoma Exceptions

Genitalia	Report all carcinomas of the external genital organs, including the vulva, scrotum, and penis (ICD-O-3 site codes C51.9, C63.2, and C60.9).
AC0S Requirements	Hospitals may include other sites to comply with the requirements of the American College of Surgeons or the facility's cancer committee. However, these should not be reported to the registry.

II.1.4.2 Reportable Skin Tumors

All other malignant tumors of the skin, such as adnexal carcinomas (e.g., carcinomas of the sweat gland, sebaceous gland, ceruminous gland, and hair follicle), adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumor must be reported regardless of site. Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in the skin.

II.1.5 Cervix

Carcinoma in situ (including squamous cell and adenocarcinoma) of the cervix and cervical intraepithelial neoplasia, grade III (CIN III) are not reportable effective with cases diagnosed January 1, 1996 and later. See Section I.1.6.1.

II.1.6 Ambiguous Diagnostic Terms

Vague or ambiguous terms are sometimes used by physicians to describe a tumor when its behavior is uncertain. This occurs primarily when there is no histologic diagnosis. Reporting requirements depend on the term used.

II.1.6.1 Reportable Terms

Apparently (malignant)

Appears to*

Comparable with*

Compatible with (a malignancy)*

Consistent with (a malignancy)

Favor (a malignancy)

Malignant appearing*

Most likely (malignant)

Presumed (malignant)

Probable (malignancy)

Suspect or suspected (malignancy)

Suspicious (of malignancy)

Typical (of/for malignancy)

*Effective with cases diagnosed January 1, 1998 and later.

II.1.6.2 Non-Reportable Terms *

Do not report the tumor if the only term used is:

Approaching (malignancy)

Cannot be ruled out

Equivocal (for malignancy)

Possible (malignancy)

Potentially malignant

Questionable (malignancy)

Rule out (malignancy)

Suggests (malignancy)

Very close to (malignancy)

Worrisome (for malignancy)

* Without additional information

Note: If cytology is reported as "suspicious," do not interpret this as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

If a phrase such as "strongly suggestive" or "highly worrisome" is used, disregard the modifier ("-ly") and refer to the guidelines above regarding the primary term.

II.1.6.3 Negative Biopsies

A cytologically confirmed case with a negative biopsy must be evaluated carefully. If the biopsy rules out the presence of cancer, do not report the case. But if a negative biopsy does not rule out the presence of cancer, the case is considered to be cytologically confirmed and is reportable.

See Section IV.2 Diagnostic Confirmation.

II.1.7 Pathology Only, Tumor Board Only, and Consultation Only Cases

Abstract reporting by facilities is not mandatory for malignancies diagnosed by the pathology department on the basis of slides or specimens submitted from outside the hospital, cases seen only by the hospital's tumor board, and cases seen for consultation only. However, the facility must notify the regional registry about these types of cases in order to verify that all cancers in the population have been recorded. Regional registries establish alternative reporting mechanisms for use when an abstract is not prepared -- for example, submission of a copy of the pathology report or the DHS's "Confidential Morbidity Report" (CMR form). In the interest of ensuring complete information about the incidence of cancer, the CCR requests hospitals to report a first diagnosis even if the patient is not seen at the hospital (for example, a biopsy performed in a doctor's office). But a confirmation diagnosis -- that is, review of a diagnosis already made at another hospital -- need not be reported.

It is sometimes difficult to identify a consultation only case, especially at a large teaching hospital. As a guideline, the CCR recommends determination of who is ultimately responsible for treatment decisions and follow-up of the patient.

If the reporting hospital is responsible, an abstract should be submitted.

If the reporting hospital is confirming a diagnosis made elsewhere, rendering a second opinion, or recommending treatment to be delivered and managed elsewhere, an abstract is not required, although the regional registry ***must*** be notified of the case using one or both of the following methods:

- Submit the patient's pathology report
- Submit a completed Confidential Morbidity Report (CMR) form

When in doubt about whether or not to submit a report, either consult the regional registry or report the case using a CMR form.

II.1.8 Newly Reportable Hematopoietic Diseases (NRHD)

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, please refer to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic Database.

II.1.9 Benign/Borderline Intracranial and CNS Tumors

The CCR requires reporting of all intracranial and CNS benign and borderline tumors and has since 1/1/2001. However, the National Benign Brain Tumor Cancer Registries Amendment Act, signed into law in October 2002, which created Public law 107-260, required the collection of benign and borderline intracranial and CNS tumors beginning with cases diagnosed 1/1/2004 forward.

The CCR requires that follow-up be performed on these cases. Due to this national implementation, several elements of reporting these entities have changed.

Refer to topics Section II.1.9.1 through Section II.1.9.8 for specifics.

II.1.9.1 Reportability - Benign/Borderline Brain and CNS Tumors

With the national implementation, any tumor diagnosed on January 1, 2004 or later with a behavior code of 0 or 1 will be collected for the following site codes based on ICD-O-3:

- Meninges (C70.0 - C70.9)
- Brain (C71.0 - C71.9)
- Spinal Cord, Cranial Nerves, and Other Parts of Central Nervous System (C72.0 - C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

Note: Benign Schwannomas (9560/0) of the cranial nerves only are reportable to the CCR. Benign Schwannomas occurring in the spinal cord, peripheral nerves or peripheral nerve root are not reportable to the CCR.

The histology codes (also based on ICD-O-3) have been expanded and are listed in Appendix V for ICD-O-3 Primary Brain and CNS Site/Histology Listing.

Juvenile astrocytomas/pilocytic astrocytomas should continue to be reported as 9421/3. Only benign brain tumor cases with a diagnosis year of 2001 forward are required to be reported to the CCR. Do not report benign brain tumor cases with an unknown year of diagnosis, unless you know that the year of diagnosis is 2001 forward. Apply the rules under Section III.3.3.2 - Vague Dates to determine a date of diagnosis if it is known that the benign brain case was diagnosed after 2001.

Reportable Terminology

In order to be reportable, there must be a corresponding ICD-0-3 histology code for any CNS tumor related diagnosis.

- The terms "tumor" and "neoplasm" are diagnostic and reportable for non-malignant brain and CNS primaries.
- The terms "mass" and "lesion" are not reportable for non-malignant brain and CNS primaries, but may be used for initial casefinding purposes.

- The terms "hypodense mass" or "cystic neoplasm" are not reportable even for CNS tumors.

II.1.9.2 Determining Multiple Primaries For Brain and CNS Tumors

This page contains a discussion of determining the number of primaries. You can review this page in sequence or you can click one of the following links and jump directly to Site, Histology, Timing, or Laterality.

- Site(s)
- Histologies
- Timing
- Laterality

Site

Non-malignant CNS tumors are different primaries at the subsite level.

Examples

Meningioma of cervical spine dura (C70.1) and separate meningioma overlying the occipital lobe (C70.0, cerebral meninges). Count and abstract as 2 separate primary tumors.

The exception is when one of the primaries has an NOS site code (C__.9), and the other primary is a specific subsite within the same rubic. Meninges, NOS (C70.9) with spinal meninges (C70.1) or cerebral meninges (C70.0). Count as a single primary and code to the specific subsite.

Histology

Refer to the Histology Groups Table below, using the rules in priority order:

Histologic Group	ICD-O-3 Histology Code
Choroid plexus neoplasms	9390/0, 9390/1
Ependymomas	9383, 9394, 9444
Neuronal and neuronal-glial neoplasms	9384, 9412, 9413, 9442, 9505/1, 9506
Neurofibromas	9540/0, 9540/1, 9541, 9550, 9560/0
Neurinomatosis	9560/1
Neurothekeoma	9562

Neuroma	9570
Perineuroma, NOS	9571/0

1. If all histologies are in the same histologic grouping or row in the table, then the histology is the same. Histologies that are in the same groupings are a progression, differentiation or subtype of a single histologic category.

Example

A subependymal giant cell astrocytoma (9384/1) of the cerebrum (C71.0) and a gliofibroma (9442/1) of the Island of Reil (C71.0), count as a single primary.*

2. If the first 3 digits are the same as the first 3 digits of any histology in a grouping or row in the table above, then the histology is the same.

Example

A ganglioglioma (9505/1) of the cerebellum (C71.6) and a neurocytoma (9506/1) of the cerebellopontine angle (C71.6), count as a single primary.*

*NOTE: If one histology is an NOS and the other is more specific, code the specific histology. If both histologies are NOS or both are specific, code the histology that was diagnosed first.

3. If the first 3 digits are the same but one or both histology codes are not found on the table above, then the histology is considered the same.

Example

Clear cell meningioma (9538/1) of the cerebral meninges and a separate transitional meningioma (9537/0) in another part of the same hemisphere, count as a single primary.

4. If the histologies are listed in different groupings in the table, they are different histologies.
5. If the first three digits of the histology code are different, and one or both histologies is not listed in the table above, the histology types are different. Report as 2 primaries.

Timing

If a non-malignant tumor of the same histology and same site as an earlier one is subsequently diagnosed at any time, it is considered to be the same primary.

Laterality

- Beginning with malignant and benign/borderline CNS tumors diagnosed January 1, 2004 forward, the following sites require a laterality code of 1- ***5*** , or 9:

    - C70.0 Cerebral meninges, NOS
    - C71.0 Cerebrum
    - C71.1 Frontal lobe
    - C71.2 Temporal lobe
    - C71.3 Parietal lobe
    - C71.4 Occipital lobe
    - C72.2 Olfactory nerve
- C72.3 Optic nerve
- C72.4 Acoustic nerve
- C72.5 Cranial nerve

Laterality is used to determine if multiple non-malignant CNS tumors are counted as multiple primary tumors.

- If same site and same histology and laterality is same side, one side unknown or not applicable, then code single primary
- If same site and same histology and laterality is both sides, then code separate primaries

Counting Non-Malignant Primaries

B = Benign/borderline tumor

M = Malignant tumor

Counting Malignant Primaries

Same Histology *unless stated to be metastatic or recurrent

Tumor		Timing months	Same Site			Different Site		
1st	2nd		Same side	Other side	Unkn side	Same side	Other side	Unkn side
M	M	< 2	1	1	1	2*	2*	2*
M	M	2 +	2*	2*	2*	2*	2*	2*
M	B	NA	2	2	2	2	2	2

Same Histology

Tumor 1st	Tumor 2nd	Timing (months)	Same Site: Same side	Same Site: Other side	Same Site: Unkn side	Different Site: Same side	Different Site: Other side	Different Site: Unkn side
B	B	NA	1	2	1	2	2	2
B	M	< 2	2	2	2	2	2	2
B	M	2 +	2	2	2	2	2	2

Different Histology

Tumor 1st	Tumor 2nd	Timing (months)	Same Site: Same side	Same Site: Other side	Same Site: Unkn side	Different Site: Same side	Different Site: Other side	Different Site: Unkn side
B	B	NA	2	2	2	2	2	2
B	M	< 2	2	2	2	2	2	2
B	M	2 +	2	2	2	2	2	2

Different Histology **unless one histology is a specific subtype of the other

Tumor 1st	Tumor 2nd	Timing months	Same Site: Same side	Same Site: Other side	Same Site: Unkn side	Different Site: Same side	Different Site: Other side	Different Site: Unkn side
M	M	< 2	2**	2**	2**	2	2	2
M	M	2 +	2	2	2	2	2	2
M	B	NA	2	2	2	2	2	2

B = Benign/borderline tumor

M = Malignant tumor

II.1.9.3 Date of Diagnosis For Benign/Borderline Brain and CNS Tumors

As the CCR began reporting benign brain and CNS tumors prior to national reporting implementation, there are two sets of rules for establishing the Date of Diagnosis for benign and malignant brain tumors.

January 1, 2004 and Forward

For cases diagnosed January 1, 2004 forward, record the date a recognized medical practitioner states the patient has a reportable tumor, whether that diagnosis was made clinically or pathologically. If a clinical diagnosis, do not change the date of diagnosis/when there is a subsequent tissue diagnosis.

Example

A CT scan done 4/1/04 states brain tumor. The patient has surgery on 4/5/04 and a biopsy reveals an astrocytoma. The date of diagnosis is 4/1/04.

January 1, 2001 to December 31, 2003

For cases diagnosed January 1, 2001 to December 31, 2003, use the most definitive source of diagnostic confirmation as the date of diagnosis.

Example

A CT scan done 2/1/03 states brain tumor. The patient has surgery on 2/5/03 and a biopsy reveals an astrocytoma. The date of diagnosis is 2/5/03.

II.1.9.4 Sequence Number For Benign/Borderline Brain and CNS Tumors January 1, 2001 and Forward

A primary non-malignant tumor of any of the sites specified on or after January 1, 2001 is reportable.

The sequence number for the tumor is in the range 60-87.

The sequencing of non-malignant tumors does not effect the sequencing of malignant tumors and vice versa.

A malignancy (sequence 00) will remain 00 if followed by a non-malignant tumor (sequence 60-87).

Example

First tumor, benign meningioma, sequence 60.

Second tumor, astrocytoma, sequence 00.

II.1.9.5 Malignant Transformation - Benign/Borderline Brain and CNS Tumors

If a benign or borderline tumor transforms into a malignancy, abstract the malignancy as a new primary. If there is a change in WHO grade from a WHO I to a higher WHO grade, abstract as a new primary malignancy. If a malignant CNS tumor transforms into a higher grade tumor, do not change histology or grade and do not abstract as a new primary. This determination is made by the pathologist based on review of slides.

Example

Non-malignant WHO grade I to malignant WHO grade III.

Complete two abstracts, one for the non-malignant tumor and one for the malignant tumor.

Situation	Create new abstract?
Benign /0 to borderline /1	No*
Benign /0 to malignant /3	Yes
Borderline /1 to malignant /3	Yes
Malignant /3 to malignant /3	No*
WHO Grade I to Grade II, III, or IV	Yes
WHO Grade II to III or IV	No*
WHO Grade III to IV	No*

* Abstract as one primary using original histology and note progression in remarks.

II.1.9.6 Tumor Grade - Benign/Borderline Brain and CNS Tumors

Always assign "tumor" grade 9 for non-malignant brain and CNS tumors.

Do not code WHO grade in the 6th digit histology data field.

II.1.9.7 WHO Grade - Benign/Borderline Brain and CNS Tumors

Code the WHO grade classification as documented in the medical record in Collaborative Staging Site Specific Factor 1, for Brain and other Central Nervous System sites.

- WHO grade I generally describes non-malignant or benign tumors; however, non-malignant tumors should not be coded as Grade I unless WHO grade is specifically stated in the source document.
- WHO grade II generally describes a malignant tumor but it can describe a non-malignant tumor depending on histologic type.
- WHO grade III and IV describe malignant tumors.

For certain types of CNS tumors, no WHO grade is assigned.

References:

Collaborative Stage Data Collection System Coding Instructions

Data Collection of Primary Central Nervous System Tumors

II.1.9.8 CS Staging - Benign/Borderline Brain and CNS Tumors

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, refer to Collaborative Stage Data Collection System Coding Instructions.

January 1, 2004 and Forward

For intracranial and CNS benign and borderline tumor cases diagnosed January 1, 2004 and prior to January 1, 2010, apply Collaborative Staging and Coding Manual.

January 1, 2001 to December 31, 2003

For intracranial and CNS benign and borderline tumor cases diagnosed from January 1, 2001 to December 31, 2003, the CCR does not require that these cases be staged. The CCR recommends that these cases be coded as EOD 99 (Unknown). If your registry uses SEER Summary Stage, it is recommended that these cases be coded to 9.

II.1.10 Borderline Ovarian Tumors

Due to ongoing studies, the CCR is continuing to require that borderline ovarian tumors be reported for cases diagnosed January 1, 2010 and forward.

Recording Collaborative Staging data items will be simplified using the coding guidelines provided below that were developed with the assistance of the CCR's Cancer Epidemiology and Research Unit and regional registries.

In addition, active follow-up will no longer be required for cases diagnosed January 1, 2001 and forward. Follow-up will be obtained through passive

follow-up linkages performed at the CCR. Reporting facilities may elect to continue conducting active follow-up on these cases. These cases will only be visually edited for failed electronic edits.

2010 Coding Guidelines

CSv2 Suggested Codes*

CS Extension	999
CS Tumor Size /Extension Eval	9
CS Lymph Nodes	999
CS Lymph Nodes Eval	9
Regional Lymph Nodes Positive	99
Regional Lymph Nodes Examined	99
CS Mets	99
CS Mets at DX - Bone	***9***
CS Mets at DX - Brain	***9***
CS Mets at DX - Liver	***9***
CS Mets at DX - Lung	***9***
CS Mets Eval	9

CS Tumor Size: Continue to code tumor size as directed in the Collaborative Stage (CS) Data Collection System

SSF 1-SSF 5: 999

SSF 6 - SSF 25: 988

Class of Case: 34, 36 (using the 2010 revised codes)

* Registrars may choose to include a value other than the suggested codes in any of the fields.

Although borderline ovarian tumors changed behavior in ICD-O-3 from /3 (malignant) to /1 (borderline), the CCR will continue to require reporting them. They are to be coded with a behavior code of /1.

As listed in Appendix 6 of the ICD-O-3 Code Manual, reportable borderline ovarian tumors include the following terms and morphology codes:

Serous cystadenoma, borderline malignancy	8442/1
Serous tumor, NOS, of low malignant potential	8442/1
Papillary cystadenoma, borderline malignancy	8451/1
Serous papillary cystic tumor of borderline malignancy	8462/1
Papillary serous cystadenoma, borderline malignancy	8462/1
Papillary serous tumor of low malignant potential	8462/1
Atypical proliferative papillary serous tumor	8462/1
Serous surface papillary tumor of borderline malignancy	***8463/1***
Mucinous cystic tumor of borderline malignancy	8472/1
Mucinous cystadenoma, borderline malignancy	8472/1
Pseudomucinous cystadenoma, borderline malignancy	8472/1
Mucinous tumor, NOS, of low malignant potential	8472/1
Papillary mucinous cystadenoma, borderline malignancy	8473/1
Papillary pseudomucinous cystadenoma, borderline malignancy	8473/1
Papillary mucinous tumor of low malignant potential	8473/1

January 1, 2008 and Forward
Beginning with the implementation of Collaborative Staging, Version 01.04.00, and for borderline ovarian cases diagnosed on or after January 1, 2008, code CS Extension to 99.

January 1, 2004 and Forward
Apply the Collaborative Staging ovary scheme for cases diagnosed on or after January 1, 2004. Do not use Collaborative Staging Extension code 00 (in situ) for borderline ovarian tumors. Follow-up is required for these cases.

Prior to January 1, 2004
For cases diagnosed prior to January 1, 2004, these cases are to be staged according to the ovary scheme in the EOD Manual.

II.2 Abstracting: Preliminary Procedures

Each patient in a hospital's cancer registry is identified by a permanent nine-digit accession number and each of the patient's primary tumors is identified by a different two-digit sequence number. The accession number remains the same in every abstract prepared by the hospital for the patient, but the sequence number is different.

The first four digits of the accession number usually represents the year first seen for the patient. See Section II.2.1. The last five digits usually represent the approximate chronological order of the abstracts prepared for that year.

Each abstract must contain an accession number and each patient can only have one accession number. Check to see if the patient already has an accession number, then use that number when it is available. Assign an accession number only when the patient did not have one assigned previously.

II.2.1 Year First Seen

Certain abstracting software applications, request Year First Seen.

Enter the four digit year during which the patient was first seen at the reporting hospital for diagnosis or treatment of the neoplasm reported in this abstract. For patients seen at the end of the year, use the year of diagnosis as the year first seen for this primary.

Example

A patient is admitted to the reporting hospital in December 1992 and is diagnosed in January 1993.

Assign 1993 as the year first seen for this primary.

II.2.2 CNExT Generated Accession Numbers

This section was software specific and deleted in 2008.

II.2.3 Accession Number

This data item identifies the patient and the tumor. Each patient entered in a hospital registry is assigned a unique accession number, and each primary diagnosed for that patient is assigned a sequence number. The first four digits of the accession number usually represents the year first seen for the patient. See Section II.2.1. The last five digits usually represents the approximate chronological order of the abstracts prepared for that year.

The accession number never changes. Accession numbers are never reassigned, even if a patient is removed from the registry.

Examples

If the patient was admitted or the tumor was diagnosed on February 11, 2005, the first four digits are 2005. If the abstract for the reported tumor was the 285th prepared for 2005, the accession number is 200500285.

Two abstracts are being prepared for a patient with one primary tumor diagnosed in 2004 and another in 2006. The first four digits of the accession number are 2004 and the next five represent the abstract's place in the chronological order of cases reported for 2004. The same accession number must be used for the second and subsequent abstracts. (However, the year first seen for the first tumor is 2004 and for the second it is 2006.)

II.2.4 Sequence Number

Sequence refers to the chronological position of a patient's primary tumor among all the reportable tumors occurring during the patient's lifetime, whether they exist at the same or at different times and whether or not they are entered in the reporting hospital's registry. If two or more reportable neoplasms are diagnosed at the same time, the lowest sequence number is assigned to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Sequence Codes for Tumors with Invasive and In Situ Behavior:

00	ONE PRIMARY MALIGNANCY
01	FIRST OF TWO OR MORE PRIMARIES
02	SECOND OF TWO OR MORE PRIMARIES
59	FIFTY-NINTH OR HIGHER OF FIFTY-NINE OR MORE PRIMARIES
99	UNSPECIFIED IN SITU/ INVASIVE SEQUENCE NUMBER OR UNKNOWN

Sequence Codes for Benign and Uncertain Behavior CNS Tumors, Borderline Ovarian Tumors and Cases Reportable by Agreement:

60	ONE BENIGN OR BORDERLINE TUMOR REPORTABLE BY AGREEMENT
61	FIRST OF TWO OR MORE BENIGN OR BORDERLINE TUMORS
62	SECOND OF TWO OR MORE BENIGN OR BORDERLINE TUMORS
87	TWENTY-SEVENTH OF TWENTY-SEVEN OR MORE TUMORS
88	UNSPECIFIED BENIGN, BORDERLINE, TUMOR OF UNCERTAIN BEHAVIOR

	AND REPORTABLE BY AGREEMENT SEQUENCE NUMBER

Effective with cases diagnosed 1/1/2003 forward, use numeric sequence codes in the range of 00-35 to indicate reportable neoplasms of malignant or in situ behavior. Cases of juvenile astrocytomas, diagnosed prior to 1/1/2001, but entered after 1/1/2003 also use a sequence code in the 00-35 range

Effective with cases diagnosed 1/1/2003 forward, reportable borderline ovarian tumors, benign and uncertain behavior CNS tumors and cases that are reportable by agreement must be sequenced using numeric codes (60-87).

NOTE: Alphabetic sequence codes are no longer allowed.

II.2.4.1 Simultaneous Diagnosis

When two or more of the patient's tumors were diagnosed simultaneously, assign the lowest sequence number to the one with the worst prognosis. To determine worst prognosis you can review the following topics (or entire topic area).

See Section V.5, Stage at Diagnosis

See Section V.3.5, Grade and Differentiation.

If these sections do not reveal the worst prognosis, assign sequence numbers in the order in which the abstracts are prepared.

Example

A patient's medical record shows a history of three primary malignant (reportable) tumors in the past and two simultaneously diagnosed recent malignant tumors, one of which is the subject of this report, for a total of five malignancies. The stage of the tumor being reported is regional, whereas the stage of the second of the multiple tumors is localized, a better prognosis. Assign sequence number 04 to the tumor being reported. The number for the second multiple primary is 05.

II.2.4.2 Updating

If more tumors are diagnosed before the report is submitted, the sequence number must be updated if it was originally coded as 00 or 60, designating a single tumor.

II.2.5 Other Tumors

In the Remarks area, record the primary sites, histologies, and diagnosis dates of other reportable tumors that the patient had before the diagnosis of the tumor being reported.

Part III. Identification

III.1 Registry Information

Registry information fields may be used by reporting facilities or regional registries for local purposes.

III.1.1 Abstractor

Enter the abstractor's initials, beginning in the left most space. If there are fewer than three initials, leave the trailing spaces blank. Abstractor initials should clearly reflect the identity of the person abstracting the case.

January 1, 2007 and Forward
Beginning in January 2007, each reporting facility must submit a list of names and initials of all abstractors in their facility, including temporary staff. Changes to this list must be submitted to the region as abstractors no longer create abstracts at the facility or when new abstractors are added.

III.1.2 Suspense Flag

This section was software specific and deleted in 2008.

III.1.3 Year First Seen, Accession Number, and Sequence Number

This section was software specific and deleted in 2008.

III.1.4 Reporting Facility

Enter the reporting facility's CCR assigned ***reporting facility*** code or the facility's name.

Reporting facilities in alphabetic order.

Reporting facilities in code order.

III.1.5 CNExT Automatic Entries

This section was software specific and deleted in 2008.

III.1.6 ACoS Approved Flag

Enter the status of the hospital's ACoS cancer program approval. The following codes are to be used:

1	CANCER PROGRAM APPROVED
2	CANCER PROGRAM NOT APPROVED

NOTE: Code 1 is also to be used for hospitals who have three-year approval with a contingency or one-year approval.

III.2 Patient Information

III.2.1 Name

The CCR relies on patient identification information for matching data in the abstract with data about the patient from other sources. It is imperative, therefore, that reporting facilities use the same rules for entering names, dates, and other information. The CCR requires the following information and formatting for patient name.

Guidelines for Entering Patient Name:

- Enter the patient's last name, first name, middle name, maiden name, and any known alias.
- Begin at the far left of each field.
- Do not enter punctuation marks or spaces (except hyphens when part of last names, maiden names, and aliases).
- Use uppercase letters only.
- Do not enter the gender or marital status-Mr., Mrs., Miss, Ms.-or similar forms of address in other languages before the name. For religious order names, see Section III.2.1.7.
- Spell out abbreviated names (e.g., Robt. = Robert). However, if a name includes the word Saint (e.g., Saint James), abbreviate Saint and connect it to the rest of the name as one word ("STJAMES"), then enter "SAINTJAMES," without a space, under Alias Last Name. See Section III.2.1.5.
- If the patient is a child under age 18 living with its parent(s) or guardian(s), record the name(s) of the parent(s) or guardian(s) in the Remarks area.

III.2.1.1 Last Name

Note the following guidelines for entering the patient's last name:

- Enter the patient's entire last name.
- Include the hyphen in a hyphenated name, but do not enter any other non-alphabetic characters.
- If the last name contains more than ***40*** characters, enter only the first ***40***.
- If the patient has no last name or the name cannot be determined, enter NLN.
- If a patient's last name has changed, enter the current last name in the Last Name field and move the original name to the Alias field.

III.2.1.2 First Name

For the first name enter no more than the first ***40*** characters.

If a woman uses her husband's full name (e.g., Mrs. John Smith), try to learn her first name.

If the patient has no first name or the name cannot be determined, enter NFN.

If the patient's first name is not a common male or female name or it is ambiguous with regard to gender, include a statement in the Remarks field confirming the patient's gender.

III.2.1.3 Middle Name

Enter the middle name, up to ***40*** characters, or middle initial. Leave the space blank if there is no middle name or initial or if it is not known.

III.2.1.4 Maiden Name

Enter a woman's maiden name, if known, even if it has been entered in the Last Name field.

- Include the hyphen in a hyphenated name, but do not enter any other non-alphabetic characters.
- If the name is longer than ***40*** characters, enter only the first ***40***.
- Leave the field blank if maiden name is not applicable or it is not known.

III.2.1.5 Alias Last Name

Enter up to ***40*** characters in the Alias Last Name field.

- An alias (also known as, or AKA) surname used by the patient.
- The spelled out version of a name containing the word Saint. Do not leave a blank space between the words.
- Certain religious order names. See Section III.2.1.7.
- The first part of a Chinese name that might appear as a last name on another report. (For example, Sun Yat sen might appear elsewhere as Sun, Yat sen or Yat sen Sun).
- Include the hyphen in a hyphenated name, but do not enter any other non-alphabetic characters.
- Leave the field blank if there is no alias last name.
- Do not enter a maiden name in the Alias Last Name field, but use the Maiden Name field. See Section III.2.1.4.

III.2.1.6 Alias First Name

In the Alias First Name Field enter up to ***40*** characters. Including:

- An alias (also known as, or AKA) first name used by the patient.
- The hyphen in a hyphenated name, but do not enter any other non-alphabetic characters.
- Leave the field blank if there is no alias first name.

III.2.1.7 Religious Names

Do not enter religious designations like Sister, Brother, or Father unless the patient's secular name is unknown. However, when the secular name is known, enter the last name of the religious name under Alias Last Name. When the religious name only is known, enter the last name under Last Name, the designation under First Name, and the religious first name under Middle Name.

Examples

1. Religious name: Sister Mary Anthony
   Secular name: Jane Smith
   Report as: (last name) Smith
   (first name) Jane
   (alias) Anthony

Religious name: Sister Mary Anthony
Secular name: Smith (first name unknown)
Report as: (last name) Smith
(first name) Sister
(alias) Anthony

Religious name: Sister Mary Anthony
Secular name: unknown
Report as: (last name) Anthony
(first name) Sister
(middle name) Mary

III.2.1.8 Name Suffix

A name suffix is a title that would follow the name in a letter. It is frequently a generation identifier. It helps to distinguish between patients with the same name.

- Do not use punctuation.
- Leave blank if the patient does not have a name suffix.

Use this field to name suffixes such as as Jr, Sr, III, IV.

Do not use this field to record suffices such as MD, PhD, as these suffixes will be stripped off at the central registry.

III.2.1.9 Mother's First Name

Enter the patient's mother's first name in this field. This is to be entered for all patients, not just children. It is ***40*** characters in length. If this name is not available, this field may be left blank.

III.2.2 Medical Record Number

Enter the medical record number assigned to the patient at the reporting hospital. For hospitals using a serial numbering system, enter the latest number assigned at the time of abstracting. (This will not be updated.)

If a patient has not been assigned a medical record number at the time the abstract is prepared, certain other identifying numbers may be entered. For example:

- Some hospitals enter the log number assigned by the radiation therapy department, preceded by the letters RT, for patients who do not have a medical record number but are receiving radiation therapy.
- For outpatients who are not admitted and not seen in the radiation therapy department, the assigned number can be preceded with the letters OP.
- If a number is not assigned, enter a code meaningful to the hospital. This field should not be left blank.
- Medical Records numbers ***can be alphanumeric and*** should be left justified.
- Do not use punctuation or leave a blank space. Enter leading zeroes that are part of the number.

III.2.3 Social Security Number

A patient's social security number is very important for identification of multiple reports of the same cancer so that they are not counted as separate cases.

Two fields are provided: a nine-character field for the number and a two-character field for a suffix. If the suffix is only one character, leave a trailing blank space in the Suffix field. The medical record might contain the patient's actual social security number, or a Medicare claim number with a suffix indicating the patient's relationship to the wage earner or primary beneficiary/claimant, or both. (The suffix A, for example, indicates that the patient is the wage earner or primary beneficiary/claimant and the social security number is the patient's.) Make every effort to ascertain the patient's own number. Enter it and its suffix in the fields provided.

Partial social security numbers should be entered as 999999999. Document the partial number in the Remarks text field.

If the patient's own number cannot be determined, enter whatever number (including its suffix) is available from the medical record. Do not combine the suffix from one number with a different number. When not entering a suffix, leave the two character field blank. If the social security number is not known, enter 9's. (Military hospitals use the sponsor's social security number plus a numeric prefix as the clinic number or medical record number. Disregard such a number when entering the social security number and suffix, but enter it in the Medical Record Number field when appropriate. See Section III.2.2 for instructions.

The following values are not allowed:

- First three digits cannot be 000 or 666
- Fourth and fifth digits cannot be 00
- Last four digits cannot be 0000
- First digit cannot be 8 or 9 (except for 999999999)

Examples

1. Social security number from face sheet: 111-22-3333

Medicare claim number: 123-45-6789B

Enter 111-22-3333.

2. Social security number from face sheet: 222-33-4444D5

No other numbers recorded in chart.

Enter 222-33-4444D5.

3. Social security number from face sheet: not recorded

Clinic record number at Air Force hospital: 30-333-44-5555

Enter 999-99-9999.

III.2.4 Phone Number (Patient)

This field is to be used for entering the patient's current telephone number including the area code.

Enter all 0's, if there is no phone.

Leave blank, if the phone number is unknown.

Update this field with the most current telephone number, when follow-up indicates that the telephone number has been changed.

III.2.5 Address at Diagnosis

For all population-based registries, it is essential to have accurate statistics on the occurrence of types of cancer in defined geographical areas. The main purpose of the address field, therefore, is to identify the patient's residence at the time the cancer was first diagnosed, not the patient's current address.

Every effort should be made to determine the correct address.

Rules for determining residency are based on those used by the U.S. Department of Commerce for the 1990 Census of Population.

It is important to follow the rules exactly, because the central registry uses automated data processing methods that reject non-standard entries. The data are used for grouping cases by geographic area.

III.2.5.1 Rules for Recording Address

Following are the rules for recording the address:

Enter the address of the patient's *Usual Residence* on the date of the initial diagnosis. See Section III.3.3 for definition of date of diagnosis.

- *Usual Residence* is where the patient lives and sleeps most of the time and is not necessarily the same as the legal or voting residence.
- Do not record a temporary address, such as a friend's or relative's.
- If both a street address and a P.O. Box are given, use the street address.
- For military personnel and their families living on base, the address is that of the base. For personnel living off base, use the residence address. For details about military personnel assigned to ships and about crews of merchant vessels, see Appendix E.
- For institutionalized patients, including those who are incarcerated or in nursing, convalescent, or rest homes, the address is that of the institution.
- Use the current address of a college student. But for children in boarding schools below the college level enter the parents' address.
- If the case is nonanalytic (see Section III.3.5 for criteria), use the address at admission unless there is a documented reason to suspect that the patient resided elsewhere at the time of diagnosis. If there is such an indication, record what is known of the address at diagnosis.

- If the patient is homeless or transient with no usual residence, enter the street, city and zip code as unknown but code county of residence to the county where the hospital is located and code the state to California.
- Persons with more than one residence (snowbirds) are considered residents of the place they designate as their residence at the time of diagnosis if their usual residence cannot be determined.

III.2.5.2 Number and Street at DX

When entering number and street at diagnosis, note the following requirements:

- Use up to ***60*** characters for the street address.
- Only letters, numbers, spaces, and the number symbol (#), slash (/), hyphen (-), comma (,), and period (.) may be entered.
- House numbers must precede the street name.
- Insert a single space between each component in the street address (e.g., "NEW MONTGOMERY STREET").
- Direction (e.g., North, West) and street types (e.g., Avenue, Road) may be abbreviated (e.g., N MAIN ST). However, do not abbreviate a direction that is the name of a street (e.g., 123 NORTH ST).
- Use intersection addresses (e.g., "FOURTH AND MAIN"), post office box numbers, and building names (e.g., "HOTEL NEW HAMPSHIRE") only if an exact address is not available in the medical record, business office, or elsewhere.
- Place a unit designation directly after the house number (e.g., "139A MAIN ST") or after the street name (e.g., "106 CHURCH STREET 1ST FLOOR," "36 EASTERN CIRCLE APT A").
- If the address contains more than ***60*** characters, omit the least important elements, such as the apartment or space number. Do not omit elements needed to locate the address in a census tract, such as house number, street, direction or quadrant, and street type.
- Abbreviate as needed, using the standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service. If the address cannot be determined, enter the word "UNKNOWN."
- The field, Patient Address at Diagnosis Supplemental, provides the ability to record additional address information such as the name of a place or facility (i.e., a nursing home or name of an apartment complex) at the time of diagnosis. Use up to ***60*** characters for this field. If the patient has multiple

tumors, the address may be different for subsequent primaries. Do not update this data item if the patient's address changes.

III.2.5.3 City at Dx

Enter a maximum of ***50*** characters and spaces. Keep spaces in names consisting of more than one word, but do not use punctuation (e.g., "LOS ANGELES," "SAN FRANCISCO," "ST PAUL").

If a patient's usual place of residence at the time of diagnosis was in a foreign country, enter the name of the city in the foreign country.

Enter the word "UNKNOWN" if the city where the patient lived can not be determined.

III.2.5.4 Data Entry, State

For states in the U.S. and provinces in Canada, enter the standard two letter Postal Service abbreviation.

California is CA.

For other states, U.S. Territories and Canadian provinces, see Appendix B.

III.2.5.5 Data Entry, ZIP

Enter the five-digit or nine-digit U.S. postal zip code or the proper postal code for any other country. When entering only five digits, leave the last spaces blank.

Enter 8's in the entire field, if the patient resided outside the U.S. or Canada at time of diagnosis and the zip code is unknown.

To obtain an unknown zip code, consult the U.S. Postal Service National Zip Code and Post Office Directory, published by the U.S. Postal Service, or phone the local post office.

If the code cannot be determined and it is a U.S. or Canadian resident, enter 9's in the entire field.

III.2.5.6 County at DX

For California residents, enter the code for the county of residence at the time of diagnosis. Some abstracting software will automatically enter the code if the county name is entered. Consult maps or reference works as needed to determine the correct county. If your software vendor provides FIPS codes for this data field, see Appendix L.1 and L.2 for code conversions.

Required California county codes, in alphabetical order, are listed in Appendix L.1.

Required California county codes, in numerical order, are listed in Appendix L.2.

Enter code 220 for Canada, NOS, or the specific code for the known Canadian province.

Canadian province codes are listed in Appendix C.

For non-United States or Canadian residents, use the country of residence.

Country codes, in alphabetical order, are listed in Appendix D.1.

Country codes, in numerical order, are listed in Appendix D.2.

III.2.5.7 City at DX, USPS - Obsolete in 2010

This data item became obsolete in 2010 because City at DX has been expanded to 50 characters.

III.2.6 Marital Status

Incidence of cancer and sites of cancer have shown correlations to marital status. These patterns are also different among races. Thus this data item is very important to researchers.

Use the following codes to report the patient's marital status at the time of first diagnosis.

1	SINGLE (never married, including only marriage annulled)
2	MARRIED (including common law)
3	SEPARATED
4	DIVORCED
5	WIDOWED
9	UNKNOWN

III.2.7 Sex

Enter one of the following codes for the patient's sex:

1	MALE
2	FEMALE
3	HERMAPHRODITE/INTERSEXED (persons with sex chromosome abnormalities)
4	TRANSSEXUAL/TRANSGENDERED (persons who desire or plan to undergo or have undergone sex change surgery)
9	UNKNOWN

If the patient's first name is not a common male or female name or it is ambiguous with regard to gender, include a statement in the Remarks field confirming the patient's gender.

III.2.8 Religion

Enter the code for the patient's religion or creed.

Use code 99 if the religion is not stated.

01	NONE
02	AGNOSTIC
03	ATHEIST
04	NONE, AGNOSTIC, ATHEIST (OLD)
05	CATHOLIC; ROMAN CATHOLIC
06	CHRISTIAN, NOS; PROTESTANT, NOS
PROTESTANT DENOMINATIONS:	
07	AFRICAN METHODIST EPISCOPAL (AME)
08	ANGLICAN; CHURCH OF ENGLAND
09	BAPTIST
10	COMMUNITY
11	CONGREGATIONAL
12	EPISCOPALIAN
13	LUTHERAN
14	METHODIST
15	PRESBYTERIAN
16	UNITARIAN

17	PROTESTANT DENOMINATION, OTHER
18	CHRISTIAN REFORMED
19	DISCIPLES OF CHRIST
20	DUTCH REFORMED
21	FIRST CHRISTIAN
22	INTERDENOMINATIONAL
23	MORAVIAN
24	NON-DENOMINATIONAL
25	SEAMAN'S CHURCH
26	TRINITY
27	UNIVERSAL
28	PROTESTANT, OTHER
ORTHODOX:	
29	ARMENIAN ORTHODOX
30	COPTIC
31	GREEK ORTHODOX
32	RUSSIAN ORTHODOX
33	SERBIAN ORTHODOX
34	LEBANESE MARONITE; MARONITE; ORTHODOX, CHRISTIAN, OTHER; ORTHODOX, CHRISTIAN, NOS
CHRISTIAN SECTS:	
35	JEHOVAH'S WITNESSES
36	CHRISTIAN SCIENCE
37	MORMON; LATTER DAY SAINTS
38	SEVENTH-DAY ADVENTIST
39	FRIENDS; QUAKER
CHRISTIAN SECTS-OTHER:	
40	AMISH
41	MENNONITES
42	APOSTOLIC
43	ARMENIAN APOSTOLIC
44	ASSEMBLIES OF GOD

45	BRETHREN; BROTHERS
46	CHRISTIAN APOSTOLIC
47	CHURCH OF ARMEDIAN
48	CHURCH OF CHRIST
49	CHURCH OF GOD
50	CHURCH OF MESSIANITY
51	CHURCH OF THE DIVINE
52	CHURCH OF THE OPEN DOOR
53	CONGREGATIONAL HOLY; HOLY CONGREGATIONAL
54	COVENANT
55	DIVINE SCIENCE
56	EVANGELICAL
57	FUNDAMENTAL
58	FOURSQUARE
59	FULL GOSPEL
60	HOLINESS
61	HOLY INNOCENTS
62	NAZARENE
63	NEW APOSTOLIC
64	PENTECOSTAL
65	RELIGIOUS SCIENCE
66	SALVATION ARMY
67	SCIENCE OF MIND
68	UNITY
69	CHRISTIAN SECTS, OTHER
70	JEWISH
71	JEWISH ORTHODOX; ORTHODOX JEWISH
WESTERN OTHER:	
72	BAHA'I
73	CRICKORIAN; ETHICAL CULTURE; GREGORIAN; LAWSONIAN; MASON; METAPHYSICS; OCCULT; PEACE OF MIND; PEOPLE'S; SELF-REALIZATION; SOCIETY OF LIFE; SPIRITUALIST; THEOSOPHY; TRUTH SEAKER

74	MOLIKAN; MOLOKAN
75	WESTERN RELIGION OR CREED, OTHER; WESTERN RELIGION OR CREED, NOS
76	KO
EASTERN RELIGIONS:	
77	BUDDHIST; ZEN; ZEN BUDDHISM
78	DROUZE
79	CONFUCIANISM; TOAISM
80	JAIN
81	NATION OF ISLAM
82	MOSLEM; MUSLIM; MOHAMMEDAN
83	HINDU
84	ISLAM
85	PARSEE; ZOROASTRIAN
86	SHINTO
87	SIKH
88	VEDANTA
89	ORIENTAL PHILOSOPHY; EASTERN RELIGION, OTHER; EASTERN RELIGION, NOS
90	AMERICAN INDIAN RELIGIONS; NATIVE AMERICAN TRADITIONAL RELIGIONS
91	HAITIAN/AFRICAN/BRAZILIAN RELIGIONS, OTHER; SANTORIA; VOODOO
92	SHAMANISM
93	OTHER TRADITIONAL OR NATIVE RELIGION
94	SCIENTOLOGY
98	OTHER
99	UNSPECIFIED; UNKNOWN

Note: Effective with cases diagnosed January 1, 1998, new codes and definitions were added for religion. Religion codes prior to 1998 were converted. The new codes and definitions are to be used for all cases.

III.2.9 Race and Ethnicity

Race and ethnicity are two of the most important data items to epidemiologists who investigate cancer. Differences in incidence rates among ethnic groups generate hypotheses for research. The National Cancer institute has recognized the need to

better explain the cancer burden in racial/ethnic minorities and is concerned with research on the full diversity of the U.S. population. The CCR recognizes the importance of these data items and relies on quality data to assist researchers in identifying and reducing disparities due to race and ethnicity.

The CCR requires that race code documentation must be supported by text documentation for those cases where there is conflicting information. Outlined below are examples of when text documentation would be required. A text statement indicating patient's race, i.e., "Pt is Japanese", is required for conflicting types of cases. Such remarks must be entered in either the physical exam or remarks text fields.

NOTE: These examples are not intended to demonstrate all possible scenarios.

Scenarios Demonstrating Conflicting Race Information:

A	Name:	June Hashimoto		B	Name:	Bob Nguyen
	Race:	White			Race:	White
	Birthplace:	Unknown			Birthplace:	Mexico
	Marital Status:	Single				
C	Name:	Robert Jackson		D	Name:	Moon Smith
	Race:	Mexican			Race:	Japanese
	Birthplace:	California			Birthplace:	California
					Marital Status:	Married
E	Name:	Maria Tran		F	Name:	Carlos Johnson
	Race:	White			Race:	Black
	Birthplace:	Spain			Ethnicity:	Hispanic
	Marital Status:	Separated			Marital Status:	California
G	Name:	Arlene Thompson				
	Race:	Filipino				
	Birthplace:	California				
	Marital Status:	Divorced				

Cases with conflicting information that lack supporting text documentation will be returned as queries and counted as discrepancies.

While race code documentation is only required when there is conflicting information, CCR recognizes the importance of race code documentation and strongly recommends that registrars document race in the physical exam or remarks fields. Remember to search beyond the face-sheet for the most definitive race and/or ethnicity information.

Race and ethnicity are defined by specific physical, heredity and cultural traditions, not by birthplace or place of residence. Beginning with cases diagnosed January 1, 2000, four race fields were added to the data set in addition to the existing race field. These fields were added so that patients who belong to more than one racial category can be coded with multiple races, consistent with the 2000 Census. The codes for all five fields are identical with the exception of Code 88 - No further race documented. Code 88 is not to be used for coding the first race field.

Code 99 is to be used for coding the second through fifth race field if the first race field is unknown. If information about the patient's race or races is not given on the face-sheet of the medical record, the physical examination, history, or other sections may provide race information.

January 1, 2004 and Forward

Effective with cases diagnosed January 1, 2004 forward, apply the following SEER race coding guideline:

Race (and ethnicity) are defined by specific physical, heredity and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship. 'Origin' is defined by the Census Bureau as the heritage, nationality group, lineage, or in some cases, the country of birth of the person or the person's parents or ancestors before their arrival in the United States.

1. All resources in the facility, including the medical record, face-sheet, physician and nursing notes, photographs, and any other sources, must be used to determine race. If a facility does not print race in the medical record but does maintain it in electronic form, the electronic data must also be reviewed.
2. Record the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. The five race fields allow for the coding of multiple races consistent with the Census 2000. Rules 2 - 8 further specify how to code Race 1, Race 2, Race 3, Race 4 and Race 5. See the editing guidelines that follow for further instructions. If a person's race is a combination of white and any other race(s), code to the appropriate other race(s) first and code white in the next race field.
   a. 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 races in Race 2, Race 3, Race 4, and Race 5 as appropriate.

Example:

Patient is described as Japanese and Hawaiian. Code Race 1 as 07 Hawaiian, Race 2 as 05 Japanese, and Race 3 through Race 5 as 88.

b. If the person is not Hawaiian, code Race 1 to the first stated non-white race (using race codes 02 - 98).

Example:

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

Note: In the following scenarios, only the race code referred to in the example is coded. For cases diagnosed after January 1, 2000, all race fields must be coded.

3. The fields Place of Birth, Race, Marital Status, Name, Maiden Name, and Hispanic Origin are inter-related. Use the following guidelines in order:

a. Code the patient's stated race, if possible. Refer to Appendix W, "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" for guidance.

Examples:

Patient is stated to be Japanese. Code as 05 Japanese.

Patient is stated to be German-Irish. Code as 01 White.

Patient is described as Arabian. Code as 01 White.

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

Examples:

The person's race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 Japanese because it is more specific than 96 Asian, NOS.

The person describes himself as an Asian-American born in Laos. Code race as 11 Laotian because it is more specific than 96 Asian, NOS.

b. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to list the non-white race(s) first.

Example:

The patient is described as Asian-American with Korean parents. Code race as 08 Korean because it is more specific than 96 Asian-American.

c. If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of a race category.

Examples:

Patient described as a black female. Code as 02 Black.

Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code as 02 Black.

Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as 25 Polynesian, Race 2 as 26 Tahitian and Race 3 through Race 5 as 88.

d. If 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. Refer to Appendix W "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" to identify nationalities from which race codes may be inferred.

Examples:

Record states: "This native of Portugal." Code race as 01 White per the Appendix W.

Record states: "This patient was Nigerian." Code race as 02 Black per the Appendix W.

Exception: If the patient's name is incongruous with the inferred race, code Race 1 through Race 5 as 99, Unknown.

Examples:

Patient's name is Siddhartha Rao and birthplace is listed as England. Code Race 1 through Race 5 as 99 Unknown.

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

e. Use of patient name in determining race

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

ii. In general, a name may be an indicator of a racial group, but should not be taken as the only indicator of race.

iii. A patient name may be used to identify a more specific race code.

Examples:

Race reported as Asian, name is Hatsu Mashimoto. Code race as 05 Japanese.

Birthplace is reported as Guatemala and name is Jose Chuicol [name is Mayan]. Code race as 03 Native American.

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

Example:

Alice Gomez is a native of Indiana (implied birthplace: United States).

Code Race 1 through Race 5 as 99 Unknown, because we know nothing about her race.

4. 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 through Race 5.

Example:

Miss Sabrina Fitzsimmons is a native of Brazil.

Code race as 01 White per Appendix W.

Note: Race and ethnicity are coded independently.

5. When the race is recorded as African-American, code race as 02.

6. Code 03 should be used for any person stated to be Native American or [western hemisphere] Indian, whether from North, Central, South, or Latin America.

7. Death certificate information may be used to supplement antemortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.

Examples:

In the cancer record Race 1 through Race 5 are coded as 99 Unknown.

The death certificate states race as black.

Change cancer record for Race 1 to 02 Black and Race 2 through Race 5 to 88.

Race 1 is coded in the cancer record as 96 Asian.

Death certificate gives birthplace as China.

Change Race 1 in the cancer record to 04 Chinese and code Race 2 through Race 5 as 88.

8. Code as white (01) when the race is described as white (01) but the place of birth is Hawaii.

For cases diagnosed prior to January 1, 2000, only the first race field is to be completed and patients of mixed parentage are to be classified according to the race or ethnicity of the mother. For cases diagnosed January 1, 2000 and later, this no longer applies. Enter each race given. For cases diagnosed prior to January 1, 2004, no "primary" race is designated, and multiple races may be listed in any order, consistent with the 2000 Census. When any of the race fields are coded as Other Asian - Code 96, Pacific Islander, NOS - Code 97, or Other - Code 98" and a more specific race is given which is not included in the list of race codes, this more specific race must be entered in the Remarks field. (When a patient is described as Asian or Oriental and the birthplace is recorded as a specific Asian country, use the birthplace if possible to assign a more specific code.) If there is no information on race in the medical record, a statement documenting that there is no information must be entered in the Remarks Field.

III.2.9.1 Codes For Race Field

Enter the most appropriate code for a patient's race(s) or ethnicity:

01	WHITE
02	BLACK
03	AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
04	CHINESE
05	JAPANESE
06	FILIPINO

07	HAWAIIAN
08	KOREAN
09	***Formerly Asian Indian or Pakistani, retired effective 1/1/10. See replacement codes 15-17.***
10	VIETNAMESE
11	LAOTIAN
12	HMONG
13	KAMPUCHEAN (CAMBODIAN)
14	THAI
15	***Asian Indian or Pakistani, NOS***
16	***Asian Indian***
17	***Pakistani***
20	MICRONESIAN, NOS
21	CHAMORRO
22	GUAMANIAN, NOS
25	POLYNESIAN, NOS
26	TAHITIAN
27	SAMOAN
28	TONGAN
30	MELANESIAN, NOS
31	FIJI ISLANDER
32	NEW GUINEAN
88	NO FURTHER RACE DOCUMENTED (Do not use for coding the first race field)
90	OTHER SOUTH ASIAN*, INCLUDING BANGLADESHI, BHUTANESE, NEPALESE, SIKKIMESE, SRI LANKAN (CEYLONESE)
96	OTHER ASIAN, INCLUDING BURMESE, INDONESIAN, ASIAN, NOS AND ORIENTAL, NOS
97	PACIFIC ISLANDER, NOS
98	OTHER
99	UNKNOWN

Following are some of the ethnic groups included in the White category:

Example

A person of Chinese ancestry born in Thailand and living in Hawaii at the time of diagnosis is to be reported as Chinese (code 04) instead of Thai (code 14) or Hawaiian (code 07).

For cases diagnosed January 1, 2010 and forward use codes 15 Asian Indian or Pakistani, NOS, code 16 Asian Indian, and code 17 Pakistani. Code 09 Asian Indian, Pakastani was retired.

Note: Per 2004 SEER guidelines, races previously coded to 09 – Asian Indian were to be coded to 96 - Other Asian. For consistency in these codes over time, the CCR created a new code, code 90 for Other South Asian that includes Bangladeshi, Bhutanese, Nepalese, Sikkimese, Sri Lankan (Ceylonese). Cases are converted from 90 to 96 for Calls for Data.

Afghan

Albanian

Algerian

Arabian

Armenian

Australian

Austrian

Bulgarian

Caucasian

Central American*

Cuban**

Cypriot

Czechoslovakian

Dominican**

Eqyptian

Greek

Gypsy

Hungarian

Iranian

Iraqi

Israeli

Italian

Jordanian

Latino

Lebanese

Mexican*

Moroccan

Palestinian

Polish

Portuguese

Puerto Rican**

Rumanian

Russian

Saudi Arabian

Slavic

Slovene

South American*

Spanish

Syrian

Tunisian

Turkish

Yugoslavian

* Unless specified as Indian (code 03).

** Unless specified as Black (code 02).

III.2.9.2 Spanish/Hispanic Origin

The Spanish/Hispanic Origin field is for identifying patients of Spanish or Hispanic origin or descent. The field corresponds to a question asked in the U.S. census. Included are people whose native tongue is Spanish, who are nationals of a Spanish speaking Latin American country or Spain, and/or who identify with Spanish or Hispanic culture (such as Chicanos living in the American Southwest). Coding is independent of the Race field, since persons of Hispanic origin might be described as white, black, or some other race in the medical record. Spanish origin is not the same as birth in a Spanish language country. Birthplace might provide guidance in determining the correct code, but do not rely on it exclusively. Information about

birthplace is entered separately. See Section III.2.12. In the Spanish/Hispanic Origin field, enter one of the following codes:

0	NON-SPANISH, NON-HISPANIC
1	MEXICAN (including Chicano, NOS)
2	PUERTO RICAN
3	CUBAN
4	SOUTH OR CENTRAL AMERICAN (except Brazilian)
5	OTHER SPECIFIED SPANISH ORIGIN (includes European; excludes DOMINICAN REPUBLIC for cases diagnosed January 1, 2005 forward)
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 (only evidence of person's Hispanic origin is surname or maiden name, and there is no contrary evidence that the person is not Hispanic.)**
8	DOMINICAN REPUBLIC (for cases diagnosed on or after January 1, 2005)
9	UNKNOWN WHETHER SPANISH OR NOT

For cases diagnosed 2010 and forward, per SEER guidelines, do not presume that Portuguese, Brazilians and Filipinos are to be Spanish or non-Spanish. Assign code 7 if the name is on the Spanish Surname list. Use code 0 if not found on the Spanish Surname list. See Appendix O for the Spanish Surname list.

The primary source for coding is an ethnic identifier stated in the medical record.

If the record describes the patient as Mexican, Puerto Rican, or another specific ethnicity or origin included in codes 1 to 5 or 8, enter the appropriate code whether or not the patient's surname or maiden name is Spanish.

If the patient has a Spanish surname, but the record contains information that he or she is not of Hispanic origin, use code 0, Non-Spanish. (American Indians frequently have Spanish surnames but are not considered to be of Spanish origin in the sense meant here.)

If the record does not state an origin that can be assigned to codes 1-5 or 8 and there is evidence other than surname that the person is Hispanic, use code 6, Spanish, NOS.

If the record does not state an origin that can be assigned to codes 0-6, base the code on the patient's name, and use code 7, Spanish Surname Only.

Use code 7, Spanish Surname Only, for a woman with a Spanish maiden name or a male patient with a Spanish Surname.

If a woman's maiden name is not Spanish, use code 0, Non-Spanish, Non-Hispanic.

But if her maiden name is not known or not applicable and she has a Spanish Surname, use code 7.

If race is not known (Race code 99), use code 9, Unknown Whether Spanish or Not, unless the patient's last name appears on the Spanish surname list, then use code 7, Spanish surname only.

Code 7, Spanish Surname Only (or code 6, Spanish, NOS, if diagnosed prior to January 1, 1994) may be used for patients whose name appears on the official list of Spanish Surnames, but code 9 is the preferred code.

Examples:

A woman whose married surname is Gonzales but who is stated to be of Japanese origin should be coded 0.

A patient who is stated to be South American but does not have a Spanish surname should be coded 4, South or Central American.

A woman is identified as white in the medical record. Her married name is Anderson, and her maiden name is Chavez. Enter code 7, Spanish, Surname Only.

Note: The CCR has adopted the official list of Spanish Surnames from the 1980 U.S. Census, and this list should be used to assign code 7. See Appendix O.

III.2.10 Date of Birth

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Consult with your software vendor for specific data entry instructions.

III.2.10.1 Date of Birth Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

12	***Date of Birth cannot be determined***
Blank	***Full or partial date recorded***

III.2.11 Age at Diagnosis

Age at First Diagnosis is a required field. Usually, the Age at First Diagnosis is calculated and generated by the abstracting software. If the Age at First Diagnosis is calculated and generated by the abstracting software, calculate the age and enter it into this field.

III.2.12 Birthplace

Enter the name of the state, territory, or country where the patient was born.

III.2.13 Occupation and Industry

Because the identification of occupational cancer is an important aspect of cancer research, every effort should be made to record the occupation and the industry in which the patient works or worked, regardless of whether the patient was employed at the time of admission. Ideally, the information should pertain to the longest held job (other than housework performed in the patient's home).

Review all admissions in the patient's medical record, including those before the diagnosis of cancer, and record the best information available. It is not necessary to request parts of the medical record predating diagnosis solely to determine occupation and industry, but review all admissions in the parts pulled for abstracting.

Good sources of information include admission and discharge summaries, face sheets, history and physical examination reports, oncology consultation reports, and health and social history questionnaires the patient has completed. The CCR will code the occupation and industry using the United States Bureau of the Census occupation and industry classifications.

III.2.13.1 Occupation

Enter any available information about the kind of work performed (e.g., television repairman, chemistry teacher, bookkeeper, construction worker), up to ***100*** characters associated with the longest held occupation.

- Avoid the use of abbreviations where possible.

- If an occupation is recorded in the chart without mention of its being the longest held, indicate this with an asterisk next to the entry (e.g., insurance salesman*).
- If the patient is not employed, try to determine the longest held occupation.
- Do not enter a term such as "homemaker," "student," "retired," "unemployed," or "disabled" unless no other information can be obtained.
- If no information is available, enter "NR" (not recorded). Do not leave this field blank.

III.2.13.2 Industry

Enter any available information about the industry associated with the longest held occupation (e.g., automotive repair, junior high school, trucking, house construction), up to ***100*** characters.

If the chart identifies the employer's name but does not describe the industry, enter the employer's name (and city if available). If only an abbreviation is given for the industry or employer (e.g., PERS, USD, or FDIC), record it even if its meaning is not known. However, avoid the use of abbreviations where possible.

If no information is available, enter "NR" (not recorded). Do not leave this field blank.

III.2.13.3 Children

If the patient is a child, enter "Child" in the Occupation field, beginning in the leftmost space.

Also record any information available about the occupations of the parents and the industries in which they are employed.

Record the occupation and industry of both parents if the information is in the medical record. If there is not enough room, however, give priority to the father's occupation and industry. Precede information about a parent with "FA" (father) or "MO" (mother).

Examples:

1. Patient is 10 years old. Father is a field engineer with an oil company. Mother is an artist (NOS). Complete the Occupational and Industry fields as follows:

   Occupation: Child—FA: field engineer MO: artist

   Industry: FA: oil industry

2. Patient is 14 years old. Father's occupation is not recorded. Mother is a biology professor at a university. Complete the Occupational and

Industry fields as follows:

Occupation: Child—MO: biology professor

Industry: MO: University

III.2.14 Patient, No Research Contact Flag

This flag is to be set to code 1, 2, or 3 if there is documentation on the medical record or if the cancer registry has been contacted by the patient or the patient's physician saying that they do not want to be included in research studies. Cases coded to 4 are out of state cases and ***VA cases*** should not be contacted for research studies. Code 4 is generated by the CCR.

If there is no information with regard to the patient's not wanting inclusion in one or more research studies, this flag should remain set to 0.

Code 0 - There is no information with regard to the patient's not wanting inclusion in one or more research studies.

Code 1 - Hospital First Notified - would be entered.

Codes 2 and 3 are for regional and central registry use.

Code 4 - Out of State Case, ***VA case,*** Not for Research - is generated by the CCR.

> The purpose of this code is to notify CCR and its regional registries that a case has been shared from another state and that this case cannot be given to researchers without approval of that state registry. It is not to be set for patients not wanting to be contacted during routine annual follow-up. Please use the Follow-up Switch for this purpose. This is a required data item and cannot be blank.

The codes are:

0	NO FLAG
1	HOSPITAL FIRST NOTIFIED
2	REGION FIRST NOTIFIED
3	CCR FIRST NOTIFIED
4	OUT OF STATE CASE, ***VA CASE,*** NOT FOR RESEARCH

III.3 Case Identification

While some of the data reported on the Case Identification screens are only for identification and document control, the Date of Diagnosis serves as the basis for computing incidence, survival, and other statistics. Accurate recording of the date of the first diagnosis of a reportable neoplasm is especially important.

III.3.1 Date of First Contact

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

For Inpatients, enter the first date of admission as an inpatient for the reportable neoplasm, or the ***actual*** date when ***the*** diagnosis of a reportable neoplasm was made during a hospitalization.

For Outpatients, enter the date first diagnosed, treated, or seen as an outpatient for the reportable neoplasm.

Consult with your software vendor for specific data entry instructions.

III.3.1.1 Date of First Contact Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

12	***Date of first contact cannot be determined***
Blank	***Full or partial date recorded***

III.3.2 Dates of Inpatient Admission and Inpatient Discharge

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Enter the dates of the dates of "Inpatient Admission and Inpatient Discharge" to the reporting facility for the most definitive surgery.

If the patient does not have surgery, use the inpatient admission and discharge dates for any other cancer-directed therapy.

If the patient has not had cancer-directed therapy, use the dates of inpatient admission and discharge for diagnostic evaluation.

Consult with your software vendor for specific data entry instructions.

III.3.2.1 Date of Inpatient Admission Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

10	***No information, unknown if an inpatient***
11	***Patient was never an inpatient***
12	***Patient was inpatient but the date is unknown***
Blank	***Full or partial date recorded***

III.3.2.2 Date of Inpatient Discharge Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

10	***No information, unknown if an inpatient***
11	***Patient was never an inpatient***

12	***Patient was inpatient but the date is unknown***
Blank	***Full or partial date recorded***

III.3.3 Date of Diagnosis

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Enter the date a physician, surgeon, or dentist first stated that the patient has cancer, whether or not the diagnosis was ever confirmed microscopically. The rule applies even if the cancer was confirmed at a later date and whether or not the diagnosis was made at the reporting hospital or before admission.
However, if upon clinical and/or pathological review of a previous condition it is determined that the patient had the tumor at an earlier date, enter that date (that is, backdate the diagnosis). For cases diagnosed at autopsy, enter the date of death. If diagnosis date is not known, see Section III.3.3.3.

Beginning in 2009, diagnosis and treatment dates for a fetus prior to birth are to be assigned the actual date of the event. In the past, those dates were set by rule to the date the baby was born.

Consult with your software vendor for specific data entry instructions.

III.3.3.1 Coding Dates

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Consult with your software vendor for specific data entry instructions.

III.3.3.2 Vague Dates

Following are coding procedures for vague dates ***relating to diagnosis or an admission:***

- ***Use whatever information is available to calculate the year.***
- ***Code the year of admission when there is no basis for estimation.***
- ***Use the date treatment was started if the patient receives a first course of treatment before a definitive diagnosis.***

RECENTLY	Enter the month and year of admission, and unknown ("99") for the day. If patient was admitted during the first week of a month, enter the previous month.
COUPLE OF YEARS AGO	Two years ago
FEW YEARS AGO	Three years ago
SEVERAL MONTHS AGO	If the patient was not previously treated or if a course of treatment started elsewhere was continued at the reporting hospital, assume the case was first diagnosed three months before admission with the day unknown.
SPRING	Enter as April.
SUMMER	Enter as July.
FALL	Enter as October.
WINTER	Enter as January.
MIDDLE OF YEAR	Enter as July.

III.3.3.3 Approximation

If possible, enter an approximate date when the exact date cannot be determined. It is preferable to use an approximate year rather than enter "unknown."

The date of first cancer directed therapy may be used as the date of diagnosis, if the therapy was initiated before definitive confirmation of the diagnosis.

III.3.3.4 Date of Diagnosis Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

12	***Date of Diagnosis cannot be determined***
Blank	***Full or partial date recorded***

III.3.4 Place of Diagnosis

If the case was not first diagnosed at the reporting hospital, enter whatever is known about the place of diagnosis:

ANOTHER HOSPITAL	Enter the hospital's name, the city, and the state.
PHYSICIAN ONLY	Enter physician's name and address. If the physician is on the reporting hospital's medical staff, also enter "Staff Physician."
HOSPITAL AND PHYSICIAN UNKNOWN	Enter name of city, state, or country where diagnosis was first made.
NO INFORMATION AVAILABLE	Enter "unknown."

III.3.5 Class of Case

Class of Case is divided into two basic categories. Analytic cases (codes 00-22) are grouped according to the location of diagnosis and first course of treatment. Analytic cases are required to be abstracted by the CCR, as well as by accredited CoC facilities. These cases are included in treatment and survival analyses.

Nonanalytic cases include codes 30-49 and 99. The CCR requires that specific nonanalytic cases be abstracted by the reporting facility. See Section I.1.6 for specific CCR reportability requirements. The facility's Cancer Committee may also direct reporting of nonanalytic cases. Nonanalytic cases are not required to be abstracted by the CoC and are not included in treatment and survival analyses.

CODES	DEFINITION
ANALYTIC CLASSES OF CASE	
INITIAL DIAGNOSIS AT REPORTING FACILITY	
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere *Note: Beginning in 2010, Class of Case 00 includes cases diagnosed by the facility that are treated in physician offices, as well as, cases when it is known that the patient went elsewhere for treatment. Facility Referred To must be documented.*
10	Initial diagnosis at the reporting facility or in a staff physician's* office AND all or part of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Initial diagnosis in a staff physician's* office AND part of first course treatment was done at the reporting facility
12	Initial diagnosis in a staff physician's* office AND all first course treatment or a decision not to treat was done at the reporting facility
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility
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 THERAPY		
20		Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21		Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility
22		Initial diagnosis elsewhere AND all first course of treatment or a decision not to treat was done at the reporting facility
NON-ANALYTIC CLASSES OF CASE		
PATIENT APPEARS IN PERSON AT REPORTING FACILITY; BOTH INITIAL DIAGNOSIS AND TREATMENT ELSEWHERE		
30		Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup
31		Initial diagnosis and all first course treatment provided elsewhere AND reporting facility provided in-transit care
32		Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence *Example: A patient with active disease admitted for other medical condition*
33		Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only *Note: Not required to be reported to the CCR.*
34		Type of cases not required by CoC to be accessioned AND initial diagnosis AND all or part of first course treatment by reporting facility *Cases required to be reported and followed by the CCR in this category include:* • *Benign and borderline intracranial/CNS tumors diagnosed 1/1/2001 - 12/31/2003 only Note: For cases diagnosed on or after 1/1/04 when these diagnoses became nationally reportable, use Class of Case codes 00-22.* • *Intraepithelial neoplasia grade III tumors as follows:* o *Anus (AIN III) cases, diagnosed 1/1/2001 forward* o *Vagina (VAIN III) cases, diagnosed 1/1/1992 forward* o *Vulva (VIN III) cases, diagnosed 1/1/1992 forward* • *Borderline ovarian tumors (see Section II.I.10 for specific histology codes), diagnosed 1/1/2001 forward Note: Effective 1/1/2010, active follow-up is no longer required for borderline ovarian cases diagnosed 1/1/2001 forward.*
35		Cases diagnosed before program's Reference Date AND initial diagnosis

		AND all or part of first course treatment by reporting facility
36		Type of cases not required by CoC to be accessioned AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility *Cases required to be reported and followed by the CCR in this category include:* • *Benign and borderline intracranial/CNS tumors diagnosed 1/1/2001 - 12/31/2003 only Note: For cases diagnosed on or after 1/1/04 when these diagnoses became nationally reportable, use Class of Case codes 00-22.* • *Intraepithelial neoplasia grade III tumors as follows:* o *Anus (AIN III) cases, diagnosed 1/1/2001 forward* o *Vagina (VAIN III) cases, diagnosed 1/1/1992 forward* o *Vulva (VIN III) cases, diagnosed 1/1/1992 forward* • *Borderline ovarian tumors (see Section II.I.10 for specific histology codes), diagnosed 1/1/2001 forward Note: Effective 1/1/2010, active follow-up is no longer required for borderline ovarian cases diagnosed 1/1/2001 forward.*
37		Cases diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
38		Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death
PATIENT DOES NOT APPEAR IN PERSON AT REPORTING FACILITY		
40		Diagnosis AND all first course treatment given at the same staff physician's* office
41		Diagnosis AND all first course treatment given in two or more different staff physician* offices
42		Nonstaff physician, clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43		Pathology or other lab specimens only
49		Death certificate only
UNKNOWN RELATIONSHIP TO REPORTING FACILITY		
99		Nonanalytic case of unknown relationship to facility

** A staff physician is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there.*

III.3.6 Type of Reporting Source

A one-digit code represents the source of information about the patient's neoplasm. Codes are arranged in the order of the precedence of the sources, with a hospital record first. Code this field in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. The codes are:

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, hospital or private (e.g., pathology specimen only)
4	PRIVATE MEDICAL PRACTITIONER
5	NURSING HOME, CONVALESCENT HOSPITAL, OR HOSPICE
6	AUTOPSY ONLY (neoplasm discovered and diagnosed for the first time as a result of an autopsy—see Section III.3.5)
7	DEATH CERTIFICATE ONLY
8	OTHER HOSPITAL OUTPATIENT UNITS/SURGERY CENTERS

Note: For Class ***40 and 41*** cases, enter code 1 for reporting source and code 2 for type of admission.

III.3.7 Type of Admission

Enter one of the following codes representing the type(s) of admission at the reporting hospital during the four months after the patient was seen there for the first time.

1	INPATIENT ONLY
2	OUTPATIENT ONLY
3*	TUMOR BOARD ONLY
4*	PATHOLOGY SPECIMEN ONLY
5	INPATIENT AND OUTPATIENT
6	INPATIENT AND TUMOR BOARD
7	OUTPATIENT AND TUMOR BOARD
8	INPATIENT, OUTPATIENT, AND TUMOR BOARD
9	UNKNOWN (may appear in archival files but is not entered by hospitals)

*See Section I.1.6 Reporting, Required Method of Reporting Guide

III.3.8 Casefinding Source

Determine where the case was first identified, and enter the appropriate code. However, if a hospital and a non-hospital source identified the case independently of each other, enter the code for the non-hospital source (i.e., codes 30-95 have priority over codes 10-29).

If the case was first identified at a cancer reporting facility (codes 10-29), code the earliest source of identifying information.

Case first identified at cancer reporting facility:

10 REPORTING HOSPITAL, NOS

20 PATHOLOGY DEPARTMENT REVIEW (surgical pathology reports, autopsies, or cytology reports)

21 DAILY DISCHARGE REVIEW (daily screening of charts of discharged patients in the medical records department)

22 DISEASE INDEX REVIEW (review of disease index in the medical records department)

23 RADIATION THERAPY DEPARTMENT/CENTER

24 LABORATORY REPORTS (other than pathology reports, code 20)

25 OUTPATIENT CHEMOTHERAPY

26 DIAGNOSTIC IMAGING/RADIOLOGY (other than radiation therapy, code 23; includes nuclear medicine)

27 TUMOR BOARD

28 HOSPITAL REHABILITATION SERVICE OR CLINIC

29 OTHER HOSPITAL SOURCE (including clinic, NOS or outpatient department, NOS)

Case first identified by source other than a cancer reporting facility:

30 PHYSICIAN INITIATED CASE (e.g., CMR)

40 CONSULTATION ONLY OR PATHOLOGY ONLY REPORT (not abstracted by reporting hospital)

50 PRIVATE PATHOLOGY LABORATORY REPORT

60 NURSING HOME INITIATED CASE

70 CORONER'S OFFICE RECORDS REVIEW

75 MANAGED CARE ORGANIZATION (MCO) OR INSURANCE RECORDS

80 DEATH CERTIFICATE FOLLOW BACK (case identified through death clearance)

85 OUT-OF-STATE CASE SHARING

90 OTHER NON REPORTING HOSPITAL SOURCE

95 QUALITY CONTROL REVIEW (case initially identified through quality control activities of a regional registry or the CCR)

99 UNKNOWN

If a death certificate, private pathology laboratory report, consultation only report from a hospital, or other report was used to identify a case that was then abstracted from a different source, enter the code for the source that first identified the case, not the source from which it was abstracted. If the regional registry or CCR identifies a case and asks a reporting facility to abstract it, enter the code specified by the regional registry or CCR.

III.3.9 Payment Source (Primary and Secondary) and Payment Source Text

These data items have been added for hospital-based registrars to collect payment information on their cancer patients at the time of diagnosis. It consists of three fields, one for recording the primary source of payment, one for recording the secondary source of payment, and a 40-character alphanumeric field for collecting the specific name of the payment source, i.e., Foundation Health Plan, Blue Shield, etc.

The primary payment source and text fields are required and may not be left blank. ***Record the primary payer from the information available at diagnosis. When the primary payer at diagnosis is unknown, record the information available during the initial treatment period.***

Enter the secondary payment source if it is available in the medical record.

The CCR has adopted the codes and definitions used by the American College of Surgeons. The codes are the same for both fields and are as follows:

01 NOT INSURED

02 NOT INSURED, SELF PAY

10 INSURANCE, NOS

20 MANAGED CARE

21 PRIVATE INSURANCE: FEE-FOR SERVICE

28 HMO

29 PPO

31 MEDICAID

35 MEDICAID ADMINISTERED THROUGH A MANAGED CARE PLAN

60 MEDICARE/MEDICARE, NOS

61 MEDICARE WITH SUPPLEMENT, NOS

62 MEDICARE - ADMINISTERED THROUGH A MANAGED CARE PLAN

63 MEDICARE WITH PRIVATE SUPPLEMENT

64 MEDICARE WITH MEDICAID ELIGIBILITY

65 TRICARE

66 MILITARY

67 VETERANS AFFAIRS

68 INDIAN/PUBLIC HEALTH SERVICES

89 COUNTY FUNDED, NOS

99 INSURANCE STATUS UNKNOWN

NOTE: For further information regarding these codes, please refer to the table in the FORDS Manual under Primary Payer at Diagnosis.

NOTE: Codes 28-HMO, 29-PPO and 89-County Funded, NOS are California specific codes. Effective with 2004 cases, codes 28-HMO and 29-PPO are converted to code 20-Managed Care, for submission to standard setting agencies. Effective with 2006 cases, code 89-County Funded, NOS, is converted to code 31-Medicaid for submission to standard setting agencies.

III.3.10 Reporting Facility Referred From

If the diagnosis was made before admission (diagnosed PTA), ***enter the CCR assigned reporting facility code for the other facility*** at which the patient was previously seen for the disease.

Reporting facilities in alphabetic order.

Reporting facilities in code order.

III.3.11 Reporting Facility Referred To

If the patient is seen at another hospital or other facility for specialized cancer treatment or any other cancer-related reason after admission to the reporting hospital, enter the facility's name or ***CCR assigned reporting facility code.***

Reporting facilities in alphabetic order.

Reporting facilities in code order.

III.3.12 Physicians

Each hospital must maintain its own roster of physicians and their code or NPI numbers. The non-NPI numbers codes are based on the physicians' California license numbers.

As physicians who treat cancer patients join the hospital staff, they must be added to the roster with their license or NPI numbers. If the license number is unavailable, assign a temporary number, beginning it with the letter X to differentiate it from regular codes. When the license number becomes available, update the files as soon as possible.

III.3.12.1 Physician License Numbers

State physician's license numbers are nine characters.

For license numbers less than eight characters, insert zero(s) after the first alpha character. For handling a nine-character number, enter the alpha character and drop the first zero.

For dentists, the same instructions apply.

For osteopaths, ***add*** a leading O (alpha character) and then enter the entire eight-character code . For handling a nine-character number, drop the zero after O2.

Examples:

Physician - A23456 would be entered A0023456

Dentist - D00056789 would be entered D0056789

Osteopath - O20A4422 would be entered O20A4422 or for nine digit O20A44222 would be entered O2A44222

NOTE: It is important to note that the first character of the osteopath license is an alpha character and the third character is a zero.

You may enter out-of-state license numbers. The first character must be an X. If this number is less than seven characters, insert zeroes between the X and the license number.

III.3.12.2 Entering Physician NPI Codes January 1, 2007 Forward

Beginning with cases diagnosed January 1, 2007, if available, enter the physician NPI code, in the respective field. See Appendix X for further details.

The ***managing*** physician field may not be blank.

- If there is no ***managing*** physician, or the ***managing*** physician cannot be determined, the code for "unknown physician" or "license number not assigned" (99999999) must be entered.
- If the ***managing*** physician is the same as another physician, (i.e., the medical oncologist) the license number must be entered in both places.

Use the following codes for Surgeon, Radiation Oncologist, and Medical Oncologist:

Surgeon

00000000 No surgery and no surgical consultation performed
88888888 Non - surgeon performed procedure
99999999 Physician is unknown or an identification number is not assigned.

Radiation Oncologist

00000000 No radiation therapy or radiation therapy consult performed

99999999 Physician is unknown or an identification number is not assigned.

Medical Oncologist

00000000 No chemotherapy or chemotherapy consult was performed

99999999 Physician is unknown or an identification number is not assigned.

Additional Physicians are designated by their role in the case, i.e. referring, consulting, and other.

For instructions regarding Follow-Up Physician, see Section VII.2.10.

III.3.13 Comorbidity/Complications

Enter the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of the cancer. These factors may affect treatment decisions and influence outcomes.

Although data collection for these fields is not required by the CCR, Comorbidity/Complications 1-10 will be collected from CoC facilities. Comorbidity/Complications fields 7-10 were added in 2006. Refer to the FORDS Manual Revised for 2010 for instructions.

III.3.14 ICD Revision, Comorbidities and Complications

This item indicates the coding system from which the *Comorbidities and Complications* (secondary diagnoses) codes are provided. *ICD Revision Comorbidities and Complications* is to be recorded for patients diagnosed on or after January 1, 2006. This data item is not required by the CCR, but it is required for ACoS approved facilities. The CCR will collect this data item from ACoS approved facilities only.

ICD Revision Comorbidity and Complications codes are as follows:

0 No secondary diagnosis reported

1 ICD - 10

9 ICD - 9

BlankComorbidities and Complications not collected

III.3.15 Discovered By Screening

This field has been added for the purpose of tracking which cancer cases were first diagnosed via screening programs. If this information is not available, the field may be left blank.

This item is an existing optional data item as part of the Department of Defense Data Set and will be collected and transmitted from facilities completing the Department of Defense Data Set.

This item is not required by the CCR.

Codes:

0 No (discovered by some other method such as symptomatic patient)

1 Routine screening exam (e.g. routine screening mammogram in asymptomatic patient)

2 Hospital screening program (targeted to a particular cancer)

3 State-sponsored screening program

4 Nationally-sponsored screening program

5 Other type of screening (e.g., American Cancer Society screening project)

9 Unknown if via screening (default)

Part IV. Diagnostic Procedures

IV.1 Diagnostic Procedures Performed

The purpose of the information is to provide as complete a description as possible of a patient's tumor and the extent to which it has spread.

Report the results of physical examinations and diagnostic procedures for all analytic cases and for autopsy only (class ***38***) cases.

Reporting diagnostic procedures is optional for non-analytic cases, however record a brief statement of the patient's history and the reason for the present admission in the Physical Exam text area.

IV.1.1 General Instructions

Following installation of CSv2 software, text fields have been expanded to 1000 characters, however, only pertinent text should be entered. Text must support coded data items and must be entered in a clear and concise manner.

In the text fields for recording the results of diagnostic examinations, enter all pertinent findings, negative as well as positive, in chronological order. Enter the date first, then the name of each procedure, then the results and other pertinent information. Do not record details unrelated to cancer. Use standard medical abbreviations when possible to save space.

See Appendix M.1 for common acceptable abbreviations in alphabetical order.

See Appendix M.2 for common acceptable abbreviations in numerical order.

Enter text for both site and histology in the fields designated.

IV.1.1.1 Location

When recording location as the results of diagnostic examinations, record where the tumor is located in the primary site, such as the lobe, quadrant, etc.

IV.1.1.2 Tumor Size

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, refer to Collaborative Stage Data Collection System Coding Instructions.

January 1, 2004 and Forward

For cases diagnosed January 1, 2004 and forward, apply the Collaborative Staging rules for documenting tumor size.

IV.1.1.3 Extension

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, refer to Collaborative Stage Data Collection System Coding Instructions.

January 1, 2008 and Forward

For cases diagnosed January 1, 2008 forward, apply the Collaborative Staging rules and guidelines for documenting tumor extension.

IV.1.1.4 Lymph Nodes

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, refer to the Collaborative Stage Data Collection System Coding Instructions for rules and guidelines for documenting lymph node involvement.

January 1, 2008 and Forward

For cases diagnosed January 1, 2008 forward, apply the Collaborative Staging rules and guidelines for documenting lymph node involvement.

IV.1.2 Physical Examination

Record the dates of the patient's physical examinations and all findings about the presence or absence of neoplasm, particularly the location of the primary tumor, its size, the extent to which it has spread, and involvement of lymph nodes.

IV.1.3 X-Ray/Scans

When recording X-Rays or Scans, enter dates and pertinent positive and negative results of X-rays, computerized axial tomography (CT- or CAT-scans), magnetic resonance imaging (MRI), echosonography, and other imaging.

If a metastatic series is reported, record the results of each study in the series. Enter a description of the primary tumor, including size, location, and whether or not multi-focal.

Enter "none" if no X-rays or scans were performed.

IV.1.4 Scopes

Record dates and positive and negative findings of laryngoscopies, sigmoidoscopies, mediastinoscopies, and other endoscopic procedures.

Include mention of biopsies, washings, and other procedures performed during the examinations, but enter their results in the Pathology section.

Record size of an observed lesion, if given.

Enter "none" if no endoscopic examination was performed.

IV.1.5 Laboratory Tests

Laboratory tests and tumor markers recorded in CSv2 site specific factor fields must be documented in the laboratory text field by using the actual name of the test. Do not use "SSF 1-25" to identify the test. Documentation includes date, test type, value, and interpretation (elevated, borderline or normal).

Enter dates, names, and results of laboratory tests or procedures used in establishing the diagnoses of neoplasms or metastases, such as serum protein electrophoresis for multiple myeloma or Waldenstrom's macroglobulinemia, serum alpha fetoprotein (AFP) for liver cancer, and other tumor marker studies.

Record T-and B-cell marker studies on leukemias and lymphomas, but enter hematology reports for leukemia and myeloma under Pathology.

In leukemia cases where both bone marrow and chromosomes are analyzed, the bone marrow results take precedence in coding histologic type, unless more specific information is given in the cytogenetic report. See Section IV.2.

Subcategories of acute myeloid leukemia are described according to cytogenetic abnormalities. If these abnormalities are included in a laboratory report, they take precedence in coding histologic type.

The chromosome study or cytogentic and molecular biological data results can be recorded here. Enter "none" if no pertinent laboratory tests were performed.

Document the date, test type, value and interpretation (elevated, borderline or normal) of any pertinent tumor markers or lab tests in the lab text field.

IV.1.6 Operative Findings

Record dates, names, and relevant findings of diagnostic surgical procedures, such as biopsies, dilation and curettage (D & C), and laparotomy.

For definitive surgery entered under treatment, record pertinent findings. See Sections VI.2.1 through VI.2.9.

Record tumor size, if given, and any statements about observed nodes, even if they are not involved.

IV.1.7 Pathology

In the pathology text area, enter the source of the specimen(s), size of the largest tumor, and other details needed per the following list:

- Describe the location of the primary site or sub-site and laterality of the primary tumor. See Section V.1 and Section V.2.
- Record the histologic diagnosis and identify the appropriate ICD-O-3 code. See Section V.3.2 and Section V.3.3.
- Describe multiple tumors and multiple sites of origin.
- Document the extent of disease and stage at diagnosis. See Section V.4.1 and Section V.4.2.
- Describe the number of lymph nodes examined and the number positive for cancer.
- Determine the method of diagnosis or confirmation.
- Identify all specimens examined microscopically.

Record all tumor related gross (non-microscopic) and microscopic cytologic and histologic finding whether positive or negative, and include differentiation. If additional space is needed, continue the pathology text in the Staging Text field.

For details about microscopic diagnoses, see Section IV.2.

For grade and differentiation, see Section V.3.5.

If there is a pathology report, all the Path Report fields must be completed. If the medical record only includes "hearsay" information or the physician only refers to a report finding, but there is no report in the medical record, do not complete the Path Report fields, but include the information in the text field.

Enter the facility ID number, dates, report types, and pathology numbers. See Path Report Facility (1-5) Section IV.4.1, Path Report Numbers (1-5) Section IV.4.2, Path Date Specimen Collected (1-5) Section IV.4.3, and Path Report Type (1-5) Section IV.4.4.

IV.1.7.1 Pathology Report Number - Biopsy/FNA - Obsolete in 2008

This data item became obsolete with the implementation of DXRX Report Number, January 1, 2008.

IV.1.7.2 Pathology Report Number - Surgery - Obsolete in 2008

This data item became obsolete with the implementation of DXRX Report Number, January 1, 2008.

IV.2 Diagnostic Confirmation

A gauge of the reliability of histologic and other data is the method of confirming that the patient has cancer.

Coding for the confirmation field is in the order of the conclusiveness of the method with the lowest number taking precedence over other codes. The most conclusive method, microscopic analysis of tissue, is therefore coded as 1, while microscopic analysis of cells, the next most conclusive method, is coded as 2.

Medical records must be studied to determine what methods were used to confirm the diagnosis of cancer. The most conclusive method should be coded in the confirmation field. As the confirmation field covers the patient's entire medical history in regard to the primary tumor, follow-up data might change the coding. The codes, in the order of their conclusiveness, are:

Microscopic Confirmation

1 POSITIVE HISTOLOGY

Use for microscopic confirmation based on biopsy, including punch biopsy, needle biopsy, bone marrow aspiration, curettage, and conization.

Code 1 also includes microscopic examination of frozen section specimens and surgically removed tumor tissue, whether taken from the primary or a metastatic site. In addition, positive hematologic findings regarding leukemia and NRHD are coded 1. Cancers first diagnosed as a result of an autopsy or previously suspected and confirmed in an autopsy are coded 1 if microscopic examination is performed on the autopsy specimens.

2 POSITIVE CYTOLOGY, NO POSITIVE HISTOLOGY

Cytologic diagnoses based on microscopic examination of cells, rather than tissue.

Do not use code 2 if cancer is ruled out by a histologic examination.

Included are sputum, cervical, and vaginal smears; fine needle aspiration from breast or other organs; bronchial brushings and washings; tracheal washings; prostatic secretions; gastric, spinal, or peritoneal fluid; and urinary sediment.

Also include diagnoses based on paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

3 POSITIVE HISTOLOGY PLUS

Positive immunophenotyping AND/OR positive genetic studies

Note: Code 3 was adopted for use effective with 2010 diagnoses. Use only for hematopoietic and lymphoid neoplasms 9590/3-9992/3.

4 POSITIVE MICROSCOPIC CONFIRMATION, METHOD NOT SPECIFIED

Cases with a history of microscopic confirmation, but no information about whether based on examination of tissue or cells.

No Microscopic Confirmation

5 POSITIVE LABORATORY TEST OR MARKER STUDY

Clinical diagnosis of cancer based on certain laboratory tests or marker studies that are clinically diagnostic for cancer.

Examples are the presence of alpha fetoprotein (AFP) for liver cancer and an abnormal electrophoretic spike for multiple myeloma or Waldenstrom's macroglobulinemia.

Although an elevated PSA is nondiagnostic of cancer, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.

6 DIRECT VISUALIZATION WITHOUT MICROSCOPIC CONFIRMATION

Includes diagnoses by visualization and/or palpation during surgical or endoscopic exploration, or by gross autopsy.

Do not use code 6 if visualization or palpation during surgery or endoscopy is confirmed by a positive histology or cytology report.

7 RADIOGRAPHY WITHOUT MICROSCOPIC CONFIRMATION

Includes all diagnostic radiology, scans, ultrasound, and other imaging technologies not confirmed by a positive histologic or cytologic report or by direct visualization.

8 CLINICAL DIAGNOSIS ONLY (Other than 5, 6, or 7)

Cases diagnosed by clinical methods other than direct visualization and/or palpation during surgery, endoscopy, or gross autopsy, if not confirmed microscopically.

9 UNKNOWN WHETHER OR NOT MICROSCOPICALLY CONFIRMED

(Death Certificate Only cases are included in code 9.)

IV.3 DXRX Report Identifier Data Items-Obsolete in 2010

Refer to IV.4.1 Path Report Facility (1-5), IV.4.2 Path Report Numbers (1-5), IV.4.3 Path Date Specimen Collected (1-5), and IV.4.4 Path Report Type (1-5).

See Section IV.4.1

See Section IV.4.2

See Section IV.4.3

See Section IV.4.4

IV.3.1 DXRX Report Facility ID (1-5) - Obsolete in 2010

This data item became obsolete with the implementation of Path Reporting Facility ID 1-5 Section IV.4.1, January 1, 2010.

IV.3.2 DXRX Report Number (1-5) - Obsolete in 2010

This data item became obsolete with the implementation of Path Report Numbers 1-5 Section IV.4.2, January 1, 2010.

IV.3.3 DXRX Report Date (1-5) - Obsolete in 2010

This data item became obsolete with the implementation of Path Date Spec Collect 1-5 Section IV.4.3, January 1, 2010.

IV.3.4 DXRX Report Type (1-5) - Obsolete in 2010

This data item became obsolete with the implementation of Path Report Type 1-5 Section IV.4.4, January 1, 2010.

IV.3.5 Text - Staging

This text field can be used to document additional staging and diagnostic workup information. Text information that supports the ***Path Report*** data items (1-5) should be listed here, identifying each report by using the R1- R5 designation. Each path report must be identified in the text field as R1 - R5 with R1 referencing ***Path*** Report 1, R2 referencing Report 2, etc.

As a reminder, record the text for each pathology report type (see the ***Path*** Report Type listing, IV.4.4 Path Report Type 1-5) in the Path Text field. If additional space is necessary, continue the text documentation in the Text - Staging field. ***Path*** Reports other than each ***Path*** report must be identified in the text field as R1 - R5 with R1 referencing ***Path*** Report 1, R2 referencing Report 2, etc.

This text field was available in the past, but not transmitted to the CCR.

IV.4.1 Path Reporting Facility (1-5) (NEW)

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item identifies the pathology facility that produced the report. Enter the reporting facility's CCR assigned reporting facility code. This data item replaces CCR data item, DXRX Report Facility ID, and is a required.

Reporting facilities in alphabetic order.

Reporting facilities in code order.

IV.4.2 Path Report Numbers (1-5) (New)

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is a unique sequential number assigned by a laboratory to the corresponding pathology report for the case. This data item replaces CCR data item, DXRX Report Number, and is required.

IV.4.3 Path Date Specimen Collected (1-5) (New)

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item collects the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed. This data item replaces CCR data item, DXRX Report Date, and is required.

Enter the date and, if available, the time the specimen was collected.

IV.4.4 Path Report Type (1-5) (New)

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item describes the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry. This data item accommodates information for only one path report. If additional path reports were prepared, enter the path report type(s) in Path Report Type 2 through Path Report Type 5. This data item is required by the CCR.

Consult your software vendor for specific data entry instructions.

01	***Pathology***
02	***Cytology***
03	***Gyn Cytology***
04	***Bone Marrow (biopsy/aspirate)***
05	***Autopsy***
06	***Clinical Laboratory Blood Work, NOS***
07	***Tumor Marker (p53, CD's Ki, CEA, HER2/neu, etc.)***

08	***Cytogenetics***
09	***Immunohistochemical Stains***
10	***Molecular Studies***
11	***Flow Cytometry, Immunophenotype***
98	***Other***
99	***Unknown***

Part V. Tumor Data

V.1 Primary Site

It is essential to identify the original (primary) site of a tumor rather than a metastatic (secondary) site.

- Identify the primary site by careful scrutiny of all reports in the patient's medical record.
- Where information in the record is conflicting, statements in the pathology report generally take precedence over other statements.
- If the record does not provide a clear answer, ask the patient's physician.
- If the only information available is the secondary site, then it should be reported in accordance with the instructions in Section V.1.3.

V.1.1 ICD-O Coding

The Primary Site field codes are found in the topography section of ICD-O*.

In the ICD-O index, the site is indicated by a three-digit number preceded by a "C".

In the topography section, the first two digits stand for the part of the body and the third digit for a specific area in the part. Listings are arranged in the numerical order of the three digits. When entering the code, omit the period following the second digit.

Examples

(1) All entries under lung have the first three characters C34, followed by a final digit indicating the subsite:
C34 BRONCHUS AND LUNG
C34.0 Main bronchus
Carina
Hilus of lung
C34.1 Upper lobe, lung
Lingula of lung
Upper lobe, bronchus
C34.2 Middle lobe, lung
Middle lobe, bronchus
C34.3 Lower lobe, lung
Lower lobe, bronchus
C34.8 Overlapping lesion of lung or bronchus
C34.9 Lung, NOS (not otherwise specified)
Bronchus, NOS
Bronchiole
Bronchogenic
Pulmonary, NOS

A computerized axial tomographic (CT or CAT) scan of a patient's chest revealed a large malignancy in the upper lobe of the left lung. The correct ICD-O-2 code is therefore C34.1, which should be entered C341.

(2) The site cardia of the stomach (the part of the stomach at the opening of the esophagus) is listed in the ICD-O-2 index under "cardia" or "stomach, cardia" as T-C16.0, which should be entered C160.

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.

Examples

The patient has a 5 cm tumor that involves the dorsal surface and anterior 2/3 of the tongue.

Code the primary site to C028 (overlapping lesion of tongue).
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, unless the subsite is defined in one of the site groups listed in the SEER Site Grouping Table. Refer to the SEER Site Grouping Table in the section entitled "How to Determine Same vs Different Primary Site" to determine the primary site code for specified site groups.

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).

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

For Primary Site coding rules:

See Section V.1.2 Identification of Separate Sites

See Section V.1.3 Indefinite and Metastatic Sites

See Section V.1.4 Special Conditions

See Section V.1.5 Site-Specific Morphology

See Section V.1.6 Uncertain Diagnoses

V.1.2 Identification of Separate Sites

For Cases Diagnosed January 1, 2007 and Forward

Beginning with cases diagnosed January 1, 2007 forward, the 2007 Multiple Primary and Histology Rules must be used to determine the number of primaries. Do not apply these rules to cases diagnosed prior to January 1, 2007. Refer to the 2007 Multiple Primary and Histology Coding Rules Manual for details and instructions.

When determining multiple primaries for solid malignant tumors, do not use a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary. Use the multiple primary rules as written unless a pathologist compares (slide review) the present tumor to the "original" tumor and states that this tumor is a recurrence of a cancer from the previous primary.

This does not apply to metastatic tumors.

In applying MP/H rules, tumor recurrences only relate to the organ of origin. Metastatic tumors in regional and distant site are not considered tumor recurrences when applying the MP/H rules.

See Section VII.2.12

V.1.3 Indefinite and Metastatic Sites

Assign codes from the following categories only when the primary site cannot be identified exactly:

NOS

Use NOS (not otherwise specified) subcategory when a subsite or tissue of an organ is not specifically listed in ICD-O-3. Do not use NOS if a more descriptive term is available.

Codes C76.0 - C76.8

Use these codes for diagnoses referring to regions and ill defined sites of the body, such as "head", "thorax", "abdomen", "pelvis", "upper limb," and "lower limb". These sites typically contain several types of tissue (e.g., bone, skin, soft tissue), which might not be specified on the diagnostic statement. If the tissue in which the tumor originated can be identified, use a more specific site code.

Code C80.9

Use this code when the primary site is not known and the only information available is the metastatic, or secondary site.

V.1.4 Special Conditions

For leukemia and lymphoma cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, please refer to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.

Special rules apply to the following tumors:

Subareolar/Retroareolar Tumor

Code as the central portion of the breast (C50.1), which indicates that the tumor arose in the breast tissue beneath the nipple, but not in the nipple itself.

Ductal And Lobular Breast Lesions

See Section II.1.3.4 for a discussion of certain mixed ductal and lobular lesions of the female breast. If these lesions occur in different quadrants of the same breast, the site code is C50.9.

Melanoma

If the primary site is unknown, assume the primary site is the skin and enter C44.9.

Unless it is stated to be a recurrent or metastatic melanoma, record each melanoma as a separate primary when any of the following apply:

- The occurrences are more than two months apart
- The fourth character of the ICD-O topography code for skin (C44._) is different
- The first three digits of the ICD-O-3 morphology code are different
- An in situ melanoma is followed by an invasive melanoma
- The occurrences are within the same sub-site code, but different lateralities or different trunk sides, such as chest and back

Neuroblastoma

Code neuroblastomas of ill defined sites for the most likely site in each case. (Adrenal medulla is a common site.) If the location of the primary tumor is unknown, code as connective, subcutaneous, and other soft tissue, NOS (C49.9).

Kaposi's Sarcoma

Code the primary site as the site in which the tumor arises. If Kaposi's sarcoma arises in the skin and another site simultaneously, or if no primary site is stated, code the primary site as skin (C44._).

Familial Polyposis

When multiple carcinomas arising in familial polyposis involve multiple segments of the colon or the colon and rectum, code the primary site as colon, NOS (C18.9).

Colon

If there is no other information given regarding subsite except for the measurement given in the colonoscope, the measurement may be used to assign subsite. If the colonoscope measurement is used to assign a specific subsite, the CCR's standard reference is the colon diagram in the *AJCC Cancer Staging Manual, 5th Edition*, page 85. A copy of this diagram is also available in DSQC Memo 2000-04, page 2. (Note, select DSQC Memo 2000-04 from the 2004 folder that will be visible in the Historical DSQC Memo interactive book.)

If there is conflicting information in the medical record with regard to subsite and there is no surgical resection, code the subsite as stated by the physician. If there is a surgical resection, code the subsite as stated in the operative report, or a combination of the operative report and the pathology report.

V.1.5 Site-Specific Morphology

Certain types of neoplasms arise only or usually in certain organs, such as hepatoma (the liver), nephroblastoma (the kidney), retinoblastoma (the retina).

If the diagnosis in the medical record refers only to the histologic type, look it up in the ICD-O-3 index. In instances of site-specific morphology, the index refers to a topographic code. Enter that code if no site is specified in the diagnosis, or if only the metastatic site is given.

Example:

The code C22.0 (liver) is given after listings in the ICD-O-3 index for hepatoma, NOS; hepatoma, benign; hepatoma, embryonal; and hepatoma, malignant.

If the site designated by a physician is different from the site referred to in the ICD-O-3 index, report the site specified by the physician.

V.1.6 Uncertain Diagnoses

Vague or ambiguous terms are sometimes used by physicians when indicating the primary site of a tumor. Interpretation of terms in this context is like their interpretation in a diagnosis of cancer itself. See Section II.1.6.1.

Interpret the following terms as indication of the primary site:

Apparently (malignant)

Appears to

Comparable with

Compatible with (a malignancy)

Consistent with (a malignancy)

Favor (a malignancy)

Malignant appearing

Most likely (malignant)

Presumed (malignant)

Probable (malignancy)

Suspect or suspected (malignancy)

Suspicious (of malignancy)

Typical (of/for malignancy)

Do not interpret the following terms as indication of the primary site:

Approaching (malignancy)

Cannot be ruled out

Equivocal (for malignancy)

Possible (malignancy)

Potentially malignant

Questionable (malignancy)

Rule out (malignancy)

Suggests (malignancy)

Very close to (malignancy)

Worrisome (for malignancy)

V.1.7 Multiple Primaries Related Data Items

For cases diagnosed January 1, 2007 and forward, apply the 2007 Multiple Primary and Histology Coding Rules to code the following fields:

- Ambiguous Terminology
- Date of Conclusive Diagnosis
- Multiplicity Counter
- Date of Multiple Tumors
- Multiple Tumor Reported as a Single Primary

Leave these fields blank for cases diagnosed prior to January 1, 2007.

See Section V.1.7.1 Ambiguous Terminology Diagnosis

See Section V.1.7.2 Date of Conclusive Diagnosis

See Section V.1.7.3 Multiplicity Counter

See Section V.1.7.4 Date of Multiple Tumors

V.1.7.1 Ambiguous Terminology Diagnosis January 1, 2007 Forward

Beginning with cases diagnosed January 1, 2007 and forward, this data item identifies all cases, including DCO and autopsy only cases which are reportable based only on ambiguous terminology. Ambiguous terms that are considered reportable include the following:

Apparent(ly)

Appears (effective with cases diagnosed 1/1/1998 and later)

Comparable with (effective with cases diagnosed 1/1/1998 and later)

Compatible with (effective with cases diagnosed 1/1/1998 and later)

Consistent with

Favor(s)

Malignant appearing (effective with cases diagnosed 1/1/1998 and later)

Most likely

Presumed

Probable

Suspect(ed)

Suspicious (for)

Typical (of)

Definitions

Ambiguous terminology - Terms that have been mandated as reportable when used in a diagnosis. For more details, see Section II.1.6.

Examples:
Clinical: a physician's statement that the patient most likely has lung cancer.
Laboratory tests: A CBC suspicious for leukemia.
Pathology: A prostate biopsy compatible with adenocarcinoma.

Conclusive terminology - A clear and definite statement of cancer. The statement may be from a physician (clinical diagnosis); or may be from a laboratory test, autopsy, cytologic findings, and/or pathology.
Ambiguous Terminology Diagnosis Codes:

Code	Description	Timeframe
0	**Conclusive term.** There was a conclusive diagnosis within 60 days of the original diagnosis. Case was accessioned based on conclusive terminology. Includes all diagnostic methods such as clinical diagnosis, cytology, pathology, etc.	Within 60 days of the date of initial diagnosis.
1	**Ambiguous term only.** The case was accessioned based only on ambiguous terminology. There was no conclusive terminology during the first 60 days following the initial diagnosis. Includes all diagnostic methods except cytology.Note: Cytology is excluded because registrars are not required to collect cases with ambiguous terms describing a cytology diagnosis.	Not Applicable
2	**Ambiguous term followed by conclusive term.** The case was originally assigned a code 1 (was accessioned based only on ambiguous terminology). More than 60 days after the initial diagnosis the information is being updated to show that a conclusive diagnosis was made by any diagnostic method including clinical diagnosis, cytology, pathology, autopsy, etc.	60 days or more after the date of diagnosis
9	**Unknown term**. There is no information about ambiguous terminology.	Not Applicable

1. Use Code 0 when a case is accessioned based on conclusive terminology. The diagnosis includes clear and definite terminology describing the malignancy within 60 days of the original diagnosis.

Note: Usually the patient undergoes a diagnostic work-up because there is a suspicion of cancer (ambiguous terminology). For example, a mammogram may show calcifications suspicious for intraductal carcinoma; the date of the

mammogram is the date of initial diagnosis. When there is a clear and definite diagnosis within 60 days of that mammogram (date of initial diagnosis) such as the pathology from an excisional biopsy showing intraductal carcinoma, assign a code 0.

2. Use Code 1 when a case is accessioned based on ambiguous terminology and there is no clear and definite terminology used to describe the malignancy within 60 days of the date of initial diagnosis. The diagnosis may be from a pathology report, a radiology report, an imaging report, or on the medical record.
3. Use Code 2 when a case is accessioned based on ambiguous terminology followed by clear and definite terminology more than 60 days after the initial diagnosis.

4. Follow-back to a physician or subsequent readmission (following the initial 60 days period) may eventually confirm cancer (conclusive cancer term more than 60 days after ambiguous term). Assign Code 2.

5. Leave this data item blank for cases diagnosed prior to 01/01/2007.

Cases accessioned based on ambiguous terminology (Code 1) should be excluded from case selection in research studies. Direct patient contact is not recommended. See 2007 Multiple Primary and Histology Coding Rules.

V.1.7.2 Date of Conclusive Diagnosis

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Enter the date a definite statement of malignancy is made following an initial diagnosis based on ambiguous terminology only. The date of conclusive diagnosis must be greater than 60 days following the initial (ambiguous terminology only) diagnosis.

Note: If the date of conclusive diagnosis is made after 60 days, change the code for the data item “Ambiguous Terminology” from 1 to 2 and enter the date that the malignancy was described clearly and definitely in Date of Conclusive Terminology.

Consult with your software vendor for specific data entry instructions.

See 2007 Multiple Primary and Histology Coding Rules Manual.

V.1.7.2.1 Date of Conclusive Diagnosis Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

10	***Unknown if based on ambiguous terminology***
11	***Date cannot be determined, diagnosed originally or within 60 days using unambiguous terminology***
12	***Date cannot be determined, diagnosed using ambiguous terminology, conclusively diagnosed > 60 days later***
15	***Diagnosed using ambiguous terminology, no conclusive diagnosis followed***
Blank	***Full or partial date recorded***

V.1.7.3 Multiplicity Counter

Code the number of tumors being abstracted as a single primary at the time of diagnosis or the number of reportable tumors that occur within one year of the original diagnosis reported as a single primary using the 2007 SEER Multiple Primary and Histology Coding Rules. Do not count metastasis. When there is a tumor or tumors with separate single or multiple foci, ignore/do not count the foci.

Change code from 01 to 02 when a second tumor is determined to be the same primary as the first tumor within one year of the initial date of diagnosis. Leave this field blank for cases diagnosed prior to January 1, 2007.

Use code 01 when:

- There is a single tumor in the primary site being abstracted.
- There is a single tumor with separate foci of tumor.
- It is unknown if there is a single tumor or multiple tumors and the multiple primary rules instructs you to default to a single tumor.

Use code 88 for:

- Leukemia
- Lymphoma
- Immunoproliferative disease
- Unknown primary

Use code 99 when:

- The original pathology report is not available and the documentation does not specify whether there was a single or multiple tumors in the primary site.
- The tumor is described as multifocal or multicentric and the number of tumors is not mentioned.
- The tumor is described as diffuse ***or disseminated.***
- The operative or pathology report describes multiple tumors but does not give an exact number.

Multiplicity Counter Codes:

01 ONE TUMOR ONLY

02 TWO TUMORS PRESENT

03 THREE TUMORS PRESENT

"

"

88 INFORMATION ON MULTIPLE TUMOR NOT COLLECTED/NOT APPLICABLE FOR THIS SITE

99 MULTIPLE TUMORS PRESENT, UNKNOWN HOW MANY, ***DIFFUSE, DISSEMINATED***

See 2007Multiple Primary and Histology Coding Rules Manual.

V.1.7.4 Date of Multiple Tumors

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Enter the date the patient is diagnosed with multiple tumors reported as a single primary using the 2007 SEER Multiple Primary and Histology Coding Rules.

Enter the Date of Diagnosis as the Date of Multiple Tumors when multiple reportable tumors are abstracted and reported as a single primary at the time of the initial diagnosis.

Change the code from zeros (00000000) to the date that the second tumor was diagnosed when the second tumor is determined to be the same primary as the first tumor and both are abstracted as a single primary.

Multiple tumors must have the same histology as the original tumor and must be located in the same organ or primary site as the original tumor, using the primary site and histology coding rules.

The Date of Multiple Tumors must occur within one year following the initial/first diagnosis of the reported tumor.

Consult with your software vendor for specific data entry instructions.

See 2007 Multiple Primary and Histology Coding Rules Manual.

V.1.7.4.1 Date of Multiple Tumors Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

11	***Multiple tumors not collected for this site/histology***
12	***Date cannot be determined, but known to be multiple tumors***
15	***Single tumor***
Blank	***Full or partial date recorded***

V.1.7.5 Type of Multiple Tumors Reported as a Single Primary

Code the type of multiple tumors that are abstracted as a single primary using the 2007 Multiple Primary and Histology Coding Rules Manual.

Multiple tumors found in the same organ or in a single primary site may occur at the time of initial diagnosis or within one year of the initial diagnosis. Ignore metastatic tumors for this data item.

January 1, 2007 and Forward

For cases diagnosed on or after January 1, 2007, change this code from 00 to another code when subsequent tumor(s) are determined to be the same primary as the first tumor and are abstracted as a single primary, within one year of the initial diagnosis.

V.2 Laterality

Because topographic codes do not distinguish between the right and left side of a paired site - such as the lung - the location (laterality) of a primary tumor must be recorded. The main purpose is to identify the origin of the tumor.

See Section V.2.1 Coding (Laterality)

See Section V.2.2 Principal Paired Sites

See Section V.2.3 Site Coding Restriction

V.2.1 Coding (Laterality)

Code numbers for recording laterality are:

0 NOT A PAIRED SITE

1 RIGHT SIDE ORIGIN OF PRIMARY

2 LEFT SIDE ORIGIN OF PRIMARY

3 ONE SIDE ONLY INVOLVED, BUT RIGHT OR LEFT SIDE ORIGIN NOT SPECIFIED

4 BOTH SIDES INVOLVED, BUT ORIGIN UNKNOWN (including bilateral ovarian primaries of the same histologic type, diagnosed within two months of each other; bilateral retinoblastomas; and bilateral Wilms' tumors)

5 PAIRED SITE, MIDLINE TUMOR

9 PAIRED SITE, BUT NO INFORMATION AVAILABLE CONCERNING LATERALITY

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.

Example:

A left ovarian primary with metastases to the right ovary is code 2, rather than code 4.

For malignant and benign/borderline brain and CNS tumors, effective with cases diagnosed January 1, 2004 forward, the following sites require a laterality code using codes 1- ***5*** or 9:

C70.0 Cerebral meninges, NOS

C71.0 Cerebrum

C71.1 Frontal lobe

C71.2 Temporal lobe

C71.3 Parietal lobe

C71.4 Occipital lobe

C72.2 Olfactory nerve

C72.3 Optic nerve

C72.4 Acoustic nerve

C72.5 Cranial nerve, NOS

All other CNS/brain subsites of C70, C71, and C72 are coded Laterality = 0 (not a paired organ) regardless of the date of diagnosis. All pituitary and pineal gland and craniopharyngeal duct tumors (C75.1-3) are coded Laterality = 0 (not a paired site).

All primary brain and CNS tumors diagnosed prior to January 1, 2004, are coded Laterality = 0 (not a paired site).

V.2.2 Principal Paired Sites

Laterality codes of 1, 2, 3, 4, ***5*** or 9 must be entered for certain parts of the body. The requirement includes any subsite, except those specifically noted. Enter those exclusions as 0 (not a paired site).

ICD-O-3 codes and sites for which laterality codes must be entered are:

C07.9 Parotid gland

C08.0 Submandibular gland

C08.1 Sublingual gland

C09.0 Tonsillar fossa

C09.1 Tonsillar pillar

C09.8 Overlapping lesion of tonsil

C09.9 Tonsil, NOS

C30.0 Nasal cavity-*excluding nasal cartilage, nasal septum*

C30.1 Middle ear

C31.0 Maxillary sinus

C31.2 Frontal sinus

C34.0 Main bronchus–*excluding carina*

C34.1-C34.9 Lung

C38.4 Pleura, NOS

C40.0 Upper limb long bones, scapula

C40.1 Upper limb short bones

C40.2 Lower limb long bones

C40.3 Lower limb short bones

C41.3 Rib, clavicle—*excluding sternum*

C41.4 Pelvic bones—*excluding sacrum, coccyx, symphysis pubis*

C44.1 Eyelid skin

C44.2 External ear skin

C44.3 Skin of other and unspecified parts of face

C44.5 Trunk skin

C44.6 Upper limb and shoulder skin

C44.7 Lower limb and hip skin

C47.1 Peripheral nerves and autonomic nervous system of upper limb and shoulder

C47.2 Peripheral nerves and autonomic nervous system of lower limb and hip

C49.1 Connective, subcutaneous, and other soft tissues of upper limb and shoulder

C49.2 Connective, subcutaneous, and other soft tissues of lower limb and hip

C50.0-C50.9 Breast

C56.9 Ovary

C57.0 Fallopian tube

C62.0 C62.9 Testis

C63.0 Epididymis

C63.1 Spermatic cord

C64.9 Kidney, NOS

C65.9 Renal pelvis

C66.9 Ureter

C69.0-C69.9 Eye and adnexa

C70.0 Cerebral meninges, NOS (excluding diagnoses prior to 2004)

C71.0 Cerebrum (excluding diagnoses prior to 2004)

C71.1 Frontal lobe (excluding diagnoses prior to 2004)

C71.2 Temporal lobe (excluding diagnoses prior to 2004)

C71.3 Parietal lobe (excluding diagnoses prior to 2004)

C71.4 Occipital lobe (excluding diagnoses prior to 2004)

C72.2 Olfactory nerve (excluding diagnoses prior to 2004)

C72.3 Optic nerve (excluding diagnoses prior to 2004)

C72.4 Acoustic nerve (excluding diagnoses prior to 2004)

C72.5 Cranial nerve, NOS (excluding diagnoses prior to 2004)

C74.0-C74.9 Adrenal gland

C75.4 Carotid body

V.2.3 Site Coding Restrictions

From January 1/1/2004 and Forward

From January 1, 2004 and forward, the Laterality field must only be coded for sites listed in Volume I, Section V.2.2 including benign and malignant CNS tumors. All other non-paired sites, including unknown primaries, must be coded to 0.

Prior to January 1, 2004

Prior to 1/1/200 , completion of this field was optional for sites not listed in Section V.2.2.

V.3 Histology, Behavior, and Differentiation

The five digit histology field consists of two parts:

1. The morphology, or cell type, of the primary tumor (first four digits).
2. The tumor's behavior - that is, the degree of malignancy or how the tumor can be expected to eventually behave.

A separate one digit differentiation code represents the grade, or degree of differentiation, of neoplastic tissue-that is, the extent to which cells have the specialized characteristics of a particular tissue or organ.

In general, the less differentiated the cells, the more aggressive the tumor.

V.3.1 ICD-O

January 1, 2001 and Forward (ICD-O-3)

The CCR has adopted the ICD-O-3 (*International Classification of Diseases for Oncology*, Third Edition, 2000) Morphology section as its official morphology code system for all cases diagnosed January 1, 2001 forward.

Prior to January 1, 2001 (ICD-O-2)

Cases diagnosed prior to January 1, 2001, must be coded using the *International Classification of Diseases for Oncology*, Second Edition, 1990 (ICD-O-2).

Note: Although ICD-O-3 is referenced in coding site and histology throughout this document, unless otherwise noted, these statements apply to ICD-O-2 coding also.

V.3.2 ICD-O Coding

Coding for the histologic type and behavior consists of the five digits in the morphology section of ICD-O. In the ICD-O index the codes are preceded by the letter "M". The first three digits of the ICD-O code represent the histologic type. The fourth digit represents a subtype.

Example

Synovial-Like Neoplasms has the general code 904_. Listed under synovial-like neoplasms are:

9040/3 Synovial sarcoma, NOS

9041/3 Synovial sarcoma, spindle cell

9042/3 Synovial sarcoma, epithelioid cell

9043/3 Synovial sarcoma, biphasic

9044/3 Clear cell sarcoma, except of kidney

Morphology listings in ICD-O also include as the fifth digit the usual behavior code. For circumstances in which other behavior codes are to be entered, see Section V.3.4. For differentiation codes, see Section V.3.5. When entering the ICD-O code, drop the slash following the fourth digit.

ICD-O-3 contains new morphology terms and synonyms, terms that changed morphology code from ICD-O-2, terms that changed from tumor-like lesions to neoplasms, and terms that changed behavior code. ICD-O-3 also deleted and/or replaced terms.

V.3.3 Histologic Type

Histology is the study of the minute structure of cells, tissues, and organs in relation to their functions. It is primarily through histological analysis that neoplasms are identified. Determination of the correct histology code can be one of the most difficult aspects of abstracting. Training and experience are essential for development of the ability to assign the correct code. The rules are taken from the SEER Program. They provide guidance, but no set of rules can cover all situations.

January 1, 2007 and Forward

Beginning with cases diagnosed January 1, 2007, the 2007 Multiple Primary and Histology Rules Manual must be used to determine histologic type. Refer to the 2007 Multiple Primary and Histology Coding Rules Manual for details and instructions.

Prior to January 1, 2007

For cases diagnosed January 1, 2005 through December 31, 2006, apply the Multiple Primary and Histology Rules Manual as written in the SEER Program Coding and Staging Manual, 2004.

Ask the regional registry for advice when the rules do not seem to apply to a case or when their application results in a code that seems incorrect. In addition, it is always appropriate to ask for advice about coding from a pathologist or clinician familiar with the case. Document in a text field, every source of information used.

V.3.3.1 Sources for Determining Histology

For hematopoietic and lymphoid cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, please refer to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.

January 1, 2007 and Forward

For cases or tumors diagnosed after January 1, 2007, refer to the 2007 Multiple Primary and Histology Coding Rules Manual to determine histology.

V.3.3.2 Basic Rule

For hematopoietic and lymphoid cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, please refer to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.

January 1, 2007 and Forward

Before attempting to code histology, determine whether the case involves a single primary or multiple primaries.

For cases diagnosed January 1, 2007 and forward, refer to the 2007 Multiple Primary and Histology Coding Rules Manual.

See Section II.1.3.

V.3.3.3 Variations in Terminology

For hematopoietic and lymphoid cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, please refer to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.

January 1, 2007 and Forward

For cases diagnosed January 1, 2007 and forward, refer to the 2007 Multiple Primary and Histology Coding Rules Manual.

V.3.3.4 Unspecified Malignancies

Enter the code for neoplasm (8000) for unspecific terms such as "malignant tumor," "malignant neoplasm", and "cancer". Do not use the code for a clinically malignant tumor that has not been microscopically confirmed (9990).

Use code 8001 (malignant cells, NOS), if a diagnosis is based only on a cytology report stating "malignant cells".

See also Section IV.2.

V.3.3.5 Metastatic Site

January 1, 2007 and Forward

Beginning with cases diagnosed January 1, 2007 and forward, the 2007 Multiple Primary and Histology Coding Rules Manual must be used to determine histologic type. Do not apply these rules to cases diagnosed prior to January 1, 2007. Refer to the historic coding instructions.

V.3.3.6 Leukemia and Lymphoma Codes

For hematopoietic and lymphoid cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, please refer to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.

V.3.3.7 Special Cases - Obsolete

January 1, 2007 and Forward

Beginning with cases diagnosed January 1, 2007 and forward, the must be used Multiple Primary and Histology Coding Rules Manual to determine histologic type.

Refer to the 2007 Multiple Primary and Histology Rules Manual for details and instructions.

V.3.4 Behavior

To code behavior, use the best information in the pathology report, regardless of whether it appears in the microscopic description, final diagnosis, or comments. If an AJCC staging form provides the best information, use it if the form is signed by a physician. ICD-O-3 assigns a behavior code as the fifth digit of the histology number following the slash. For example, in the number 8012/3 for large cell carcinoma, the 3 is the behavior code.

Codes are listed below:

/0* BENIGN

/1* UNCERTAIN WHETHER BENIGN OR MALIGNANT

BORDERLINE MALIGNANCY (except cystadenomas in the range 844-849)

LOW MALIGNANT POTENTIAL

/2 CARCINOMA IN SITU

Intraepithelial

Non-infiltrating

Non-invasive

/3 MALIGNANT, PRIMARY SITE

/6** MALIGNANT, METASTATIC SITE

MALIGNANT, SECONDARY SITE

/9** MALIGNANT, UNCERTAIN WHETHER PRIMARY OR METASTATIC SITE

* Not reportable to the California Cancer Registry, except for brain and CNS tumors, beginning with cases diagnosed January 1, 2001.

** Reportable behavior, but enter code 3.

V.3.4.1 ICD-O / Pathology Conflicts

If there is a conflict between the behavior code specified by ICD-O for a histologic subtype and the behavior described by a pathologist in the final diagnosis, the pathologic diagnosis generally prevails. ICD-O codes only indicate the usual behavior.

V.3.4.2 In Situ Coding

The term "in situ" means a tumor that meets all microscopic criteria for malignancy, except invasion of basement membrane. For further discussion of "in situ", see Section V.5.8.

"In situ" behavior can be determined only by pathologic examination and not by clinical evidence alone. If a tumor is classifiable as "in situ" according to the time period rules for stage at diagnosis see Section V.5, code the tumor as "in situ". In other words, a behavior code of 2, "in situ", corresponds to a stage code of 0, "in situ" and vice versa. Computer and visual edits will verify that the codes in these two fields correspond. Do not interpret terms like "approaching in situ" or "very close to in situ" as "in situ".

Reportable terms indicating "in situ"behavior include:

AIN III (anal intraepithelial neoplasia, Grade II-III or III)**

Bowen's Disease

DCIS (ductal carcinoma in situ)

DIN 3 (ductal intraepithelial neoplasia 3)**

Clark's level 1 for melanoma (limited to epithelium)

Confined to epithelium

Hutchinson's melanotic freckle

Intracystic, non-infiltrating

Intraductal

Intraepidermal

Intraepithelial

Intrasquamous

Involvement up to but not including the basement membrane

LCIS (lobular carcinoma in situ)

Lentigo maligna

LIN (laryngeal intraepithelial neoplasia)**

Lobular neoplasia, Grade III

No stromal invasion

Non-infiltrating

Non-invasive

PanIN-III (pancreatic intraepithelial neoplasia III)***

Precancerous melanosis

Preinvasive

Queyrat's erythroplasia

Stage 0

VAIN III (vaginal intraepithelial neoplasia, Grade II-III or III)*

VIN III (vulvar intraepithelial neoplasia, Grade II-III or III)*

* Effective with cases diagnosed 1/1/1992 and later
** Effective with cases diagnosed 1/1/2001 and later
***Cases diagnosed January 2004 and later.

All other terms have been reportable since the region's reference date.

Not Reportable (Reminder)

As a reminder, carcinoma "in situ" (including squamous cell and adenocarcinoma) of the cervix and Cervical Intaepithelial Neoplasia, CIN III, are not reportable effective with cases diagnosed January 1, 1996 and later. Prostatic Intraepithelial Neoplasia (PIN III), morphology code 8148/2 is also not reportable to the CCR.

V.3.4.3 Microinvasion

Code a pathologic diagnosis of "microinvasive"--meaning the earliest stage of invasion--as malignant, not "in situ".

For the diagnosis of microinvasive squamous cell carcinoma, a common form of cervical cancer, use the morphology code provided by ICD-O-3, 8076/3.

V.3.5 Grade and Differentiation

Code the grade, or degree of differentiation, as stated in the final pathologic diagnosis.

Do not code as "not stated" if there is a relevant statement in the microscopic description. If there is a difference in grade between two pathologic specimens, code a known grade over an unknown grade. ***Exception: For noninvasive bladder tumor, assign code 9 (unknown) to the Grade field. This applies to only histology codes 8120/2 (Transitional cell (urothelial) carcinoma in situ and 8130/2 (Papillary transitional cell (papillary urothelial) noninvasive carcinoma). See DSQC Memo #2010-01.***

A grade stated in a histopathology report takes precedence over one stated in a cytology report.

Information on an AJCC staging form may be used if the form is signed by a physician.

If a needle biopsy or excisional biopsy of a primary site has a differentiation given and the excision or resection does not, code the information from the needle/incisional biopsy. If there is no grade provided for the primary site, code as 9, even if a grade is given for a metastatic site.

Do not use FIGO grade to code differentiation. FIGO grade is something completely different from FIGO stage. If the only grade provided is a FIGO grade, code grade to 9, unknown.

When a patient receives neoadjuvant therapy, code the grade from the pathology report prior to neoadjuvant therapy. Code 9 (grade unknown) when the pathology is after neoadjuvant therapy or it is unknown whether the pathology is before or after neoadjuvant therapy.

The codes are:

1	Grade I grade i grade 1 Well differentiated Differentiated, NOS
2	Grade II grade ii grade 2 Moderately differentiated Moderately well differentiated Partially well differentiated Partially differentiated Intermediate differentiation Low grade, NOS
3	Grade III grade iii grade 3 Poorly differentiated

	Moderately undifferentiated Relatively undifferentiated Slightly differentiated Dedifferentiated Medium grade, NOS
4	Grade IV grade iv grade 4 Undifferentiated Anaplastic High grade, NOS
5**	T-Cell T-Precursor
6**	B-Cell Pre B B-Precursor
7**	Null Cell Non-T–Non-B
8**	NK (Natural Killer Cell)
9	Grade or Differentiation Not Determined or Not Stated

**Apply to leukemias and lymphomas only. See Section V.3.5.7.

See Section II.1.9.7 WHO Grade

See Section V.3.5.6 Gleason's Score

See Section V.3.5.7 Lymphomas and Leukemias

See Section V3.5.8 Bloom-Richardson Grade for Breast Cancer

See Section V.3.5.9 Grading Astrocytomas

V.3.5.1 Mixed Differentiation

If a diagnosis indicates different degrees of differentiation in the same neoplasm, enter the code with the highest number, even if it does not represent the majority of the neoplasm. This could include different degrees of differentiation between the biopsy and resection specimens.

Example:

The final diagnosis states predominantly grade II, focally grade III.

Code as grade III.

V.3.5.2 Microscopic Description

If the final pathologic diagnosis states one degree of differentiation, while the microscopic description states another, enter the code for the final diagnosis.

Examples:

The microscopic description states moderately differentiated squamous cell carcinoma with poorly differentiated areas. The final diagnosis states moderately differentiated squamous cell carcinoma. Enter code 2 (8070/32).

But if the final pathologic diagnosis does not state the degree of differentiation, code the grade stated in the microscopic description.

The microscopic description states moderately differentiated squamous cell carcinoma with poorly differentiated areas.

The final diagnosis states squamous cell carcinoma. Enter code 3 (8070/33).

V.3.5.3 Variation in Terms for Degree of Differentiation

Use the higher grade when different terms are used for the degree of differentiation as follows:

Term	Grade	Code
Low grade	I-II	2
Medium grade; intermediate grade	II-III	3
High grade	III-IV	4
Partially well differentiated	I-II	2
Moderately undifferentiated	III	3
Relatively undifferentiated	III	3

Occasionally a grade is written as "2/3" or "2/4" meaning this is grade 2 of a 3-grade system or grade 2 of a 4-grade system, respectively.

To code in a three grade system, refer to the following codes:

Histologic Grade	Nuclear Grade	Description	Code
1/3, or I/III	1/2, 1/3	Low Grade	2
2/3, or II/III	2/3	Medium Grade	3
3/3, or III/III	2/2, 3/3	High Grade	4

To code in a two-grade system, refer to the following codes:

Histologic Grade	Description	Code
1/2, or I/II	Low Grade	2
2/2, or II/II	High Grade	4

See Section V.3.5.11 Grade Path Value

See Section V.3.5.12 Grade Path System

V.3.5.4 In Situ

Medical reports ordinarily do not contain statements about differentiation of in situ lesions. But if a statement is made, enter the code indicated.

V.3.5.5 Brain Tumors

Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) can sometimes establish the grade of a brain tumor.

If there is no tissue diagnosis, but grade or differentiation is stated in a MRI or PET report, base the grade code on the report.

However, if there is a tissue diagnosis, do not base the grade code on any other source.

V.3.5.6 Gleason's Score

A special descriptive method, Gleason's Score, is used for prostate cancer. It is obtained by adding two separate numbers to produce a score in the range of 2 to 10. First, a number is assigned to the predominant (primary) pattern (i.e., the pattern that comprises more than half the tumor). Then a number is assigned to the lesser (secondary) pattern, and the two numbers are added to obtain Gleason's Score.

If only one number is stated, and it is 5 or less, assume that it represents the primary pattern. If the number is higher than 5, assume that it is the score. If there are two numbers, add them to obtain the score.

Sometimes, the number 10 is written after Gleason's Score to show the relationship between the actual score and the highest possible score (e.g., Gleason's 3/10 indicates a score of 3).

If a number is not identified as Gleason's, assume that a different grading system was used and code appropriately.

When both grade and Gleason's Score are provided in the same specimen, code the grade. When they are in different specimens, code to the highest grade.

If only Gleason's Score (2-10) is available, convert it to grade according to the following table:

Gleason's Score	Grade	Code
2, 3, 4	I	1
5, 6	II	2
7*, 8, 9, 10	III	3

**** The grade and code for Gleason's Score 7 were revised in 2003. See historic coding instructions for specific information.***

Note: This grading system is coded in a site-specific factor for the applicable CS schema.

V.3.5.7 Lymphomas and Leukemias

For hematopoietic and lymphoid cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, please refer to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic Database.

Note: This grading system is coded in a site-specific factor for the applicable CS schema.

V.3.5.8 Bloom-Richardson Grade for Breast Cancer

Beginning with breast cancer cases diagnosed January 1, 1996, the Bloom-Richardson grading system should be used, if available.

Synonyms include: Modified Bloom-Richardson, Scarff-Bloom-Richardson, Nottingham, SBR Grading, BR Grading, Elston-Ellis modification of Bloom-Richardson grading system. This grading scheme is based on three morphologic features as follows:

- Degree of tumor tubule formation
- Tumor mitotic activity
- Nuclear pleomorphism of tumor cells (nuclear grade)

Seven possible scores are condensed into three Bloom-Richardson grades. The three grades then translate into well-differentiated (BR low grade), moderately differentiated (BR intermediate grade) and poorly differentiated (BR high grade).

Tumor tubule formation	Score
>75% of tumor cells arranged in tubules	1
>10% and <75%	2
<10%	3
Number of mitoses (low power scanning (X100), find most mitotically tumor area, proceed to high power (x400)	
<10 mitoses in 10 high-power fields	1
>10 and <20 mitoses	2
>20 mitoses per 10 high power fields	3
Nuclear pleomorphism (nuclear grade)	
Cell nuclei are uniform in size and shape, relatively small, have dispersed chromatin patterns, and are without prominent nucleoli	1
Cell nuclei are somewhat pleomorphic, have nucleoli, and are intermediate size	2
Cell nuclei are relatively large, have prominent nucleoli or multiple nucleoli, coarse chromatin patterns, and vary in size and shape	3

To obtain the final Bloom-Richardson (Nottingham) score, add score from tubule formation plus number of mitoses score, plus score from nuclear pleomorphism. The combined score converts to the following BR grade:

Bloom-Richardson (Nottingham) combined scores	**Differentiation / BR Grade**	**ICD-O-3 6th digit**
3, 4, 5	Well-differentiated (BR low grade)	1
6, 7	Moderately differentiated (BR intermediate grade)	2
8, 9	Poorly differentiated (BR high grade)	3

There are coding rules and conventions to be used to code breast cancer cases. Use grade or differentiation information from the breast histology in the following priority order:

- Bloom-Richardson (Nottingham) scores 3-9 converted to grade (see conversion table below)
- Bloom-Richardson grade (low, intermediate, high)
- Nuclear grade only
- Terminology (well diff, mod diff…)
- Histologic grade (grade I, grade ii…)

Caution : In this grading system, the terms low, intermediate, and high are codes 1, 2, and 3 respectively. This is an exception to the usual rule for all other grading systems which code "low", "intermediate", and "high" as 2, 3, and 4 respectively. In the Bloom-Richardson system, if grades 1, 2, and 3 are specified, these should be coded 1, 2, and 3 respectively.

Bloom-Richardson (Nottingham) Scores	**Bloom-Richardson Grade**	**Nuclear Grade**	**Terminology**	**Histologic Grade**	**Code**
3- 5 points	Low Grade	1/3, 1/2	Well Differentiated	(BR low grade)	1

6, 7 points	Intermediate Grade	2/3	Moderately differentiated	(BR intermediate grade)	2
8, 9 points	High Grade	2/2, 3/3	Poorly Differentiated	(BR high grade)	3

Note: This grading system is coded in a site-specific factor for the applicable CS schema.

V.3.5.9 Grading Astrocytomas

ICD-O-3 rules are to be used for grading astrocytomas. The World Health Organization coding of aggressiveness is reserved for assignment of grade for staging. If there is no information on grade, code as follows:

Term	ICD-O-3 6th digit
Anaplastic astrocytoma	4
Astrocytoma (low grade)	2
Glioblastoma multiforme	9
Pilocytic astrocytoma	9
Astrocytoma Grade 1	1
Astrocytoma Grade 2	2
Astrocytoma Grade 3	3
Astrocytoma Grade 4	4

Note: This grading system is coded in a site-specific factor for the applicable CS schema.

V.3.5.10 Fuhrman's Grade for Renal Cell Carcinoma January 1, 2004 and Forward

Effective with cases diagnosed January 1, 2004, the priority order for coding grade for renal cell carcinoma (site code C64.9) is as follows:

1. Fuhrman's grade
2. Nuclear grade

3. Terminology (well diff, moderately diff…)
4. Histologic grade (grade I, grade II…)

Fuhrman's grade is based on 3 parameters:

- Nuclear diameter: in microns
- Nuclear outline: regular or irregular
- Nucleoli (visibility): present or not and at what power (low or high power)

Fuhrman's grade (I-IV) is the sum of the points for all 3 parameters.

These prioritization rules do not apply to Wilm's tumor (morphology code 8960).

Note: This grading system is coded in a site-specific factor for the applicable CS schema.

V.3.5.11 Grade Path System (New)

For cases January 1, 2010 and forward or following installation of CSv2 software, this data item records whether a two, three or four grade system was used in the pathology report to describe the grade. This item is used in conjunction with Grade Path Value. This data item is required by the CCR.

- ***Code this item from the same tissue as that used to code Grade/Differentiation. This item records how the original grade of the tumor was described.***
- ***Code the value corresponding to the number of grades used in the grading system reported in the pathology report.***

Leave the item blank if:

- ***Case is diagnosed prior to 2010.***
- ***No pathological grade is available.***
- ***Only a verbal description of grade is reported (for example, moderately differentiated).***
- ***Another grading system is used in the pathology report. For example, <u>do not report</u> grading systems such as Bloom-Richardson for breast primaries, Fuhrman for kidney, Gleason for prostate, or WHO grade.***

Those grading systems are coded in a site-specific factor for the applicable CS schema.

- *Case is a lymphoma or hematopoietic malignancy (9590-9992).*

Note: This item and Grade Path Value should both be coded or both should be blank. If both are coded, Grade/Differentiation must not be 9.

Code	Definition
Blank	No 2, 3, or 4 grade system available. Unknown.
2	A 2-grade grading system was used (2, II or ii)
3	A 3-grade grading system was used (3, III or iii)
4	A 4-grade grading system was used (4, IV or iv)

See Section V.3.5.8 Bloom-Richardson Grade for Breast Cancer.
See Section V.3.5.10 Fuhrman's Grade for Renal Cell Carcinoma.
See Section V.3.5.6 Gleason's Score.
See Section V.3.5.7 Lymphoma and Leukemia grades.
See Section V.3.5.9 Grading Astrocytomas.

V.3.5.12 Grade Path Value (New)

For cases January 1, 2010 and forward or following installation of CSv2 software, this data item records the numeric grade reported in the pathology report. This item supplements but does not replace Grade/Differentiation. This data item is required by the CCR.

- *Code this item from the same tissue as that used to code Grade/Differentiation. This item records how the original grade of the tumor was described.*
- *Code the value of the numeric grade from the pathology report if the Grade Path system was 2-4. Code the histologic grade in priority over a nuclear or architectural grade.*
- *Do not convert the terms well, moderately, or poorly differentiated, low/high, or anaplastic into codes in this field. Leave blank if that is all that is available.*

Leave the item blank if:

- *Case is diagnosed prior to 2010.*

- ***Numeric grade is given, but the grading system is not stated (for example, Grade 1, with no information about the grade system).***
- ***Another grading system is used in the pathology report. For example, do not report grading systems such as Bloom-Richardson for breast primaries, Fuhrman for kidney, Gleason for prostate, or WHO grade. Those grading systems are coded in a site-specific factor for the applicable CS schema.***
- ***Case is a lymphoma or hematopoietic malignancy (9590-9992).***

Note: This item and Grade Path System should both be coded or both should be blank. If both are coded, Grade/Differentiation must not be 9. Grade Path Value can never be larger than Grade Path System.

Code	Definition
Blank	No 2, 3, or 4 grade system available. Unknown.
1	Recorded as Grade I, i or 1 of a 2-4 grade system
2	Recorded as Grade II, ii or 2 of a 2-4 grade system
3	Recorded as Grade III, iii or 3 of a 3-4 grade system
4	Recorded as Grade IV, iv of a 4 grade system

See Section V.3.5.8 Bloom-Richardson Grade for Breast Cancer.
See Section V.3.5.10 Fuhrman's Grade for Renal Cell Carcinoma.
See Section V.3.5.6 Gleason's Score.
See Section V.3.5.7 Lymphoma and Leukemia grades.
See Section V.3.5.9 Grading Astrocytomas.

V.3.6 Edits of Primary Site/Histology Codes

Certain combinations of histology and primary site codes indicate errors in coding. The CCR data management system (Eureka) edit data and reject false combinations. False combinations (edit errors) must be corrected before the data management system can store the data and make it available for research.

Disallowed combinations are of two types:

- Those involving the first four digits of the histology field (morphology code).
- Those involving the behavior code (fifth digit of the histology field).

V.3.6.1 Morphology/Site Codes

Some combinations of morphology and site codes are rejected because another site code more accurately reflects the tissue of origin. For example, a liposarcoma (8850/3) arising in the abdominal wall should be coded as site C49.4, soft tissues of abdomen, instead of C76.2, abdomen, NOS. Contact the regional or central registry for coding assistance, if required. Following are combinations of morphology and site codes that are rejected:

Morphology/Site Code

1. 8090-8096, Basal cell carcinomas, with

    C00._ Lip

    C19.9 Rectosigmoid

    C20.9-C21.8 Rectum and anus

2. 8720-8790, Melanoma, with

    C48.0 C48.8 Retroperitoneum/ peritoneum

    C38.1 C38.8 Pleura and Mediastinum

    C40.0-C41.9 Bone

    C76._ Other and ill-defined sites

3. 8010-8671 Epithelial & with

    C38.1-C38.8 Pleura and Mediastinum

    specialized gonadal

    C40.0-C41.9* Bone tumors

    C47.0-C47.9 Peripheral Nerves

    C49.0-C49.9 Soft Tissues

    C70.0-C72.9 Brain and Other Nervous System

4. 8940–8941, Mixed tumors, with

    C38.1 C38.8 Pleura and Mediastinum

    C40.0-C41.9* Bone

    C47.0-C47.9 Peripheral Nerves

    C49.0-C49.9 Soft tissues

    C70.0-C71.9 Brain

    C72._ Other nervous system

    C76._ Other and ill defined sites

    *Site C40.0-C41.9 (bone) with histology 8070 (squamous cell carcinoma) is possible.

5. 9250 9340, Bone tumors, with

C30.0-C31.9 Nasal cavity, sinuses

6. 8800-8811, 8813-8831, 8840-8920, 8990-8991, 9040-9044, 9120-9170, 9240-9251, 9540-9560, 9580-9581, Sarcomas and other soft-tissue tumors, with

76._ Other and ill defined sites

7. 9500 Neuroblastoma, NOS with C64.9 Kidney, NOS

V.3.6.2 Behavior/Site Codes

Do not code in situ behavior with a primary site that is unknown or ill defined. Therefore, if the behavior code is 2 (in situ), the following primary site codes are rejected as errors:

C26.9 Gastrointestinal tract, NOS

Alimentary tract, NOS

Digestive organs, NOS

C39.9 Ill defined sites within respiratory system

Respiratory tract, NOS

C55.9 Uterus, NOS

Uterine, NOS

C57.9 Female genital tract, NOS

Female genital organs, NOS

Female genitourinary tract, NOS

Urethrovaginal septum

Vesicocervical tissue

Vesicovaginal septum

C63.9 Male genital organs, NOS

Male genital tract, NOS

Male genitourinary tract, NOS

C68.9 Urinary system, NOS

C72.9 Nervous system, NOS

Central nervous system

Epidural

Extradural

Parasellar

C75.9 Endocrine gland, NOS

C76._ Other and ill-defined sites

C80.9 Unknown primary site

V.4 Coding Systems

V.4.1 Extent of Disease

Extent of Disease (EOD) coding applies to cases diagnosed prior to January 1, 2004. EOD staging was replaced by Collaborative Staging for cases diagnosed January 1, 2004 and forward.

V.4.2 Collaborative Stage Data Collection System

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, CS Site-Specific Factor items (7-25) have been added to code additional site-specific information needed to derive TNM or AJCC stage, or to code prognostic factors that have an effect on stage or survival. This data item belongs to the Collaborative Stage (CS) Data Collection System. The Collaborative Stage Data Collection System is based on the AJCC Cancer Staging Manual, 6th and 7th editions.

The Collaborative Stage Data Collection System provides a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation for T, N, M, and stage.

To code, see the most current version of the Collaborative Stage Data Collection System Manual and Coding Instructions for rules, site-specific codes, and coding structures.

Additional educational information is available in Part 1- Section 2: Lab Tests, Tumor Markers and Site-Specific Factor Notes.

For CS SSF data items not required by the CCR, enter code 988. For CS SSF data items required by the CCR with an unknown value, enter code 999.

Refer to Volume 1, Appendix Y, for the list of CS Site-Specific Factors required by the CCR by schema.

The following CSv2 data items are required effective with cases diagnosed January 1, 2010 and forward:

- CS Extension
- CS Lymph Nodes
- Regional Nodes Positive
- Regional Nodes Examined
- CS Mets at Diagnosis
- ***CS Mets at DX Bone***
- ***CS Mets at DX Brain***
- ***CS Mets at DX Liver***
- ***CS Mets at DX Lung***
- CS Site Specific Factor 1
- CS Site Specific Factor 2
- CS Site Specific Factor 3
- CS Site Specific Factor 4
- CS Site Specific Factor 5
- CS Site Specific Factor 6
- ***CS Site Specific Factor 7***
- ***CS Site Specific Factor 8***
- ***CS Site Specific Factor 9***
- ***CS Site Specific Factor 10***
- ***CS Site Specific Factor 11***
- ***CS Site Specific Factor 12***
- ***CS Site Specific Factor 13***
- ***CS Site Specific Factor 14***
- ***CS Site Specific Factor 15***
- ***CS Site Specific Factor 16***
- ***CS Site Specific Factor 17***
- ***CS Site Specific Factor 18***
- ***CS Site Specific Factor 19***
- ***CS Site Specific Factor 20***

- ***CS Site Specific Factor 21***
- ***CS Site Specific Factor 22***
- ***CS Site Specific Factor 23***
- ***CS Site Specific Factor 24***
- ***CS Site Specific Factor 25***
- CS Tumor Size/Extension Evaluation
- CS Lymph Node Evaluation
- CS Metastasis Evaluation
- ***CS Version Input Current***
- Derived AJCC***-7*** T Descriptor
- ***Derived AJCC-7 T***
- Derived AJCC***-7*** N Descriptor
- ***Derived AJCC-7 N***
- Derived AJCC***-7*** M Descriptor
- ***Derived AJCC-7 M***
- ***Derived AJCC-7 Stage Group***

January 1, 2008 and Forward

Although Collaborative Staging has been required by the CCR since 2004, effective with cases diagnosed January 1, 2008 and forward, SEER (and thus the CCR) expanded the requirement to also include the CS Evaluation fields. Thus the following CS fields are required effective with cases diagnosed January 1, 2008 and forward:

- CS Extension
- CS Lymph Nodes
- Regional Nodes Positive*
- Regional Nodes Examined
- CS Mets at Diagnosis
- CS Site Specific Factor 1
- CS Site Specific Factor 2
- CS Site Specific Factor 3
- CS Site Specific Factor 4
- CS Site Specific Factor 5
- CS Site Specific Factor 6
- CS Tumor Size/Extension Evaluation

- CS Lymph Node Evaluation
- CS Metastasis Evaluation
- Derived AJCC T Descriptor
- Derived AJCC N Descriptor
- Derived AJCC M Descriptor

V.4.2.1 CS Mets at DX – Bone (New)

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, CS Mets at DX - Bone identifies the presence of discontinuous or distant metastatic involvement of bone at time of diagnosis. This includes only bone, not bone marrow. This data item is required by the CCR.

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

Codes:

0	***No distant (discontinuous) metastases identified either clinically or pathologically, negative findings on imaging reports, or metastases other than bone identified***
1	***Distant (discontinuous) metastases identified clinically or pathologically. Primary site is bone and there are metastases in different bone or bones.***
8	***CS Mets at DX is coded as 98 (not applicable for site). Not applicable sites include hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms, Hodgkin and non-Hodgkin lymphoma, Kaposi sarcoma, other and ill-defined primary sites, unknown primary site.***
9	***CS Mets at Dx is coded to 99. There are known distant metastases but it is not known whether the distant metastases include bone.***

For additional coding instructions refer to Collaborative Stage Data Collection System Manual and Coding Instructions.

V.4.2.2 CS Mets at DX – Brain (New)

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, CS Mets at DX - Brain identifies the presence of discontinuous or distant involvement of brain at time of diagnosis. This includes only the brain, not spinal cord or other parts of the central nervous system. This data item is required by the CCR.

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

Codes:

0	***No distant (discontinuous) metastases identified either clinically or pathologically, negative findings on imaging reports, or metastases other than brain identified***
1	***Distant (discontinuous) metastases identified clinically or pathologically. Primary site is brain and there are metastases within the brain.***
8	***CS Mets at DX is coded as 98 (not applicable for site). Not applicable sites include hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms, Hodgkin and non-Hodgkin lymphoma, Kaposi sarcoma, other and ill-defined primary sites, unknown primary site.***
9	***CS Mets at Dx is coded to 99. There are known distant metastases but it is not known whether the distant metastases include brain.***

For additional coding instructions refer to Collaborative Stage Data Collection System Manual and Coding Instructions.

V.4.2.3 CS Mets at DX – Liver (New)

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, CS Mets at DX identifies the presence of discontinuous or distant metastatic involvement of the liver at time of diagnosis and involvement may be single or multiple. This data item is required by the CCR.

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

Codes:

0	***No distant (discontinuous) metastases identified either clinically or pathologically, negative findings on imaging reports, or metastases other than liver identified***
1	***Distant (discontinuous) metastases identified clinically or pathologically. Primary site is liver and there are metastases within the liver.***
8	***CS Mets at DX is coded as 98 (not applicable for site). Not applicable sites include hematopoietic, reticuloendothelial, immunoproliferative***

	and myeloproliferative neoplasms, Hodgkin and non-Hodgkin lymphoma, Kaposi sarcoma, other and ill-defined primary sites, unknown primary site.
9	***CS Mets at Dx is coded to 99. There are known distant metastases but it is not known whether the distant metastases include liver.***

For additional coding instructions refer to Collaborative Stage Data Collection System Manual and Coding Instructions.

V.4.2.4 CS Mets at DX – Lung (New)

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, CS Mets at DX identifies the presence of discontinuous or distant metastatic involvement of the lung at time of diagnosis. This includes only the lung, not pleura or pleural fluid. This data item is required by the CCR.

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

Codes:

0	***No distant (discontinuous) metastases identified either clinically or pathologically, negative findings on imaging reports, or metastases other than lung identified***
1	***Distant (discontinuous) metastases identified clinically or pathologically. Primary site is lung and there are metastases within the lung.***
8	***CS Mets at DX is coded as 98 (not applicable for site). Not applicable sites include hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms, Hodgkin and non-Hodgkin lymphoma, Kaposi sarcoma, other and ill-defined primary sites, unknown primary site.***
9	***CS Mets at Dx is coded to 99. There are known distant metastases but it is not known whether the distant metastases include lung.***

For additional coding instructions refer to Collaborative Stage Data Collection System Manual and Coding Instructions.

V.5 Stage at Diagnosis

Stage at Diagnosis is a grouping of cases into broad categories, for example, localized, regional, and distant. This is different than Extent of Disease which is a detailed description of the spread of the disease from the site of origin.

January 1, 2004 and Forward

Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, Stage Group, Summary Stage 1977, and Summary Stage 2000.

Prior to January 1, 2004

For cases seen prior to January 1, 2004, apply the following guidelines:

In the Stage at Diagnosis field, enter the code that represents the farthest tumor involvement as indicated by all the evidence obtained from diagnostic and therapeutic procedures performed during the first course of treatment or within four months after the date of diagnosis, whichever is earlier. (See Section VI.1 for definitions of first course of treatment and definitive treatment.) Coding must be supported by textual information entered under Diagnostic Procedures (see Section IV.1).

Stage at Diagnosis is not required beginning with cases diagnosed January 1, 1994. Hospitals wishing to do so may continue its use.

Prior to January 1, 1994

Cases diagnosed prior to January 1, 1994 must continue to be staged using SEER Summary Staging Guide 1977. this document is available from SEER.

Rules for Summary State 1978 and SEER Summary Stage 2000

Although Summary Stage is not required by the CCR, it is required by NAACCR and NPCR. The rules for using SEER Summary Stage 1977 and SEER Summary Stage 2000 are as follows:

Cancer cases diagnosed before January 1, 2001 should be assigned a summary stage according to SEER Summary Stage Guide 1977.

Cases diagnosed on or after January 1, 2001 should be assigned a stage according to SEER Summary Stage 2000.

V.5.1 Codes

Always base coding on the site-specific schemes presented in the *Summary Staging Guide for the Cancer Surveillance, Epidemiology and End Results Reporting (SEER)*

Program, which is available as a separate publication or as Book 6 of the *Self Instructional Manual for Tumor Registrars.* See Section I.1.6.5.

Instructions in Section V.5.8, Section V.5.9, Section V.5.10, and Section V.5.11 are provided for guidance only. The codes are:

0	IN SITU
1	LOCALIZED
2	REGIONAL, DIRECT EXTENSION ONLY
3	REGIONAL, LYMPH NODES ONLY
4	REGIONAL, DIRECT EXTENSION AND LYMPH NODES
5	REGIONAL, NOS
7	DISTANT METASTASES OR SYSTEMIC DISEASE (REMOTE)
9	UNSTAGEABLE (stage cannot be determined from available information)
Blank	NOT DONE

V.5.2 Staging Definitions

Terms commonly used to describe stage include:

Invasion

Local spread of a neoplasm by infiltration into or destruction of adjacent tissue.

Microinvasive

The earliest invasive stage. Applied to cervical cancer, describes a small cancer that has invaded the stroma to a limited extent. The FIGO stage is IA. See Section V.3.4.3 and Section V.5.9.4.

Direct Extension

A continuous infiltration or growth from the primary site into other tissue or organs (compare to metastasis).

Metastasis

Dissemination of tumor cells in a discontinuous fashion from the primary site to other parts of the body—for example, by way of the circulatory system or a lymphatic system.

Regional

Organs or tissues related to a site by physical proximity. Also applies to the first chain of lymph nodes draining the area of the site.

V.5.3 Ambiguous Terms

Physicians sometimes use ambiguous terms to indicate the involvement of tissue or an organ by a tumor. Refer to the Collaborative Stage Data Collection System Coding Instructions, for a list of ambiguous terms.

See Section V.1.7.1 Ambiguous Terminology Diagnosis

V.5.4 Staging - Time Period

Report the stage of each case at the time of diagnosis. Consider all diagnostic and therapeutic information obtained during the first course of treatment or within four months after the date of diagnosis, whichever is earlier. This time limitation ensures that the stage recorded is based on the same information that was used to plan the patient's treatment. Exclude progression of the disease since the time of the original diagnosis. See Section VI.1.1 for the analogous rule concerning first course of treatment.

Example

A patient with lung cancer is staged "regional lymph nodes" by the physician on the basis of positive mediastinal lymph nodes and radiation therapy is instituted. Four weeks into the treatment course the patient develops neurological symptoms, and further work–up reveals previously unsuspected brain metastases. The treatment plan is changed to take this new manifestation into account. Since the disease has progressed since the time of original diagnosis, the stage would not be changed to distant

V.5.5 Autopsy Reports

Include pertinent findings from autopsy reports if the patient dies within four months of the diagnosis of the cancer. However, as with other types of information, exclude data about progression of the disease since the time of the original diagnosis.

V.5.6 Staging by Physician

When a physician has assigned a stage using the TNM, FIGO, Dukes', or any other system, use the information as a guide for coding stage, especially when information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread. For a discussion of TNM, see Section V.7. However, take certain precautions:

- Physicians might use different versions of a staging system at the same time, and a specific designation of stage might have different meanings. To determine the corresponding summary stage code, it is essential to know exactly which version a physician is using.

- Some staging systems (FIGO for example) use clinical information only, whereas CCR's Stage at Diagnosis includes all information, clinical, surgical, and pathological, that falls into the time period. Use the physician's clinical stage if no pathological information is available.

V.5.7 Contradictory Reports

Sometimes the stage is stated incorrectly in the medical record due to a typographical, transcription, or similar error. If the stage recorded in one report is clearly contradicted in another, query the physician or the registry's medical consultant. Do not code stage based on information that appears to be inaccurate.

V.5.8 Summary Stage - In Situ (Code 0)

A diagnosis of in situ, which must be based on microscopic examination of tissue or cells, means that a tumor has all the characteristics of malignancy except invasion, that is, the basement membrane has not been penetrated. A tumor that displays any degree of invasion is not classified as in situ.

For example, even if a report states *carcinoma in situ of the cervix showing microinvasion of one area*, the tumor is not in situ and code 0 is incorrect. However, a primary tumor might involve more than one site (for example, cervix and vagina, labial mucosa and gingiva) and still be in situ, as long as it does not show any invasion.

V.5.8.1 Terms Indicating In Situ

Certain terms indicate an in situ stage. Also see Section V.3.4.2.

AIN (anal intraepithelial neoplasia Grade II-III)**

Bowen's Disease

DCIS (ductal carcinoma in situ)

DIN 3 (ductal intraepithelial neoplasia 3)**

CIN III (cervical intraepithelial neoplasia, grade III)*

Clark's level 1 for melanoma (limited to epithelium)

Confined to epithelium

Hutchinson's melanotic freckle, nos

Intracystic, non infiltrating

Intraductal

Intraepidermal

Intraepithelial

Intrasquamous

Involvement up to but not including the basement membrane

LCIS (lobular carcinoma in situ)

Lentigo maligna

LIN (laryngeal intraepithelial neoplasia)**

Lobular neoplasia, Grade III

No stromal invasion

Non infiltrating

Non invasive

PanIN-III (pancreatic intraepithelial neoplasia III)***

Precancerous melanosis

Preinvasive

Queyrat's erythroplasia

Stage 0

Vaginal intraepithelial neoplasia, Grade III (VAIN III)*

Vulvar intraepithelial neoplasia, Grade III (VIN III)*

* Cases diagnosed January 1992 and later.

** Cases diagnosed January 2001 and later.

***Cases diagnosed January 2004 and later.

V.5.8.2 In Situ Stage - Behavior Code

If a tumor is staged in situ, the behavior code is 2. See Section V.3.4.

V.5.9 Summary Stage - Localized (Code 1)

Localized denotes a tumor that is invasive, but is still confined entirely to the organ of origin. For most sites, the tumor might be widely invasive or have spread within the organ, as long as it does not extend beyond the outer limits of the organ of origin and there is no evidence of metastasis to other parts of the body.

V.5.9.1 Staging Rules for Inaccessible Sites

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, refer to Collaborative Staging Data Collection System Coding Instructions manual for coding instructions.

V.5.9.2 Staging - Vessel and Lymphatic Involvement

Invasion of blood vessels, lymphatics, and nerves within the primary site is a localized stage, unless there is evidence of invasion outside the site.

V.5.9.3 Staging - Multicentric Tumors

Tumors with more than one focus, or starting point, are considered to be localized unless extension beyond the primary site has occurred. But a tumor that has developed a "satellite" nodule, that is, a lesion secondary to the primary one, might not be localized. Refer to the Collaborative Stage Data Collection System Coding Instructions for rules about satellite lesions.

V.5.9.4 Staging - Microinvasive

Microinvasive, a term used by pathologists to describe the earliest invasive stage, has a precise meaning for cancer of certain sites. Microinvasive cancers are staged as localized, code 1. (Microinvasive squamous cell carcinoma is a common form of cervical cancer, for which ICD-O provides a specific morphology code—8076/3.)

V.5.10 Summary Stage - Regional (Codes 2, 3, 4, 5)

A tumor at the Regional stage has grown beyond the limits of the organ of origin into adjacent organs or tissues by direct extension and/or to regional lymph nodes by metastasis. Neoplasms appearing to be in the regional stage must be evaluated very carefully to make sure they have not spread any farther.

Example

A malignant tumor of the stomach or of the gallbladder often passes through the wall of the primary organ into surrounding tissue.

Before coding as regional, make certain that radiological or scan examinations do not reveal metastasis to a lung or bone and that findings during surgery do not include metastasis to the liver or serosal surfaces that are not regional.

Also check progress notes and the discharge summary for any mention of metastasis.

V.5.10.1 Summary Stage - Regional, Direct Extension Only (Code 2)

At times a cancer spreads to surrounding organs or tissue with no involvement of regional lymph nodes. Before assigning code 2 to such a case, make sure that tissue adjacent to the original organ is actually involved. The terms "penetrating" and "extension" are sometimes used to describe spreading within an organ, such as the large intestine or bladder, in which case the stage might still be localized (code

1). The Summary Staging Guide lists organs and structures considered to be regional for each site. Also see Section V.5.3 for interpretation of ambiguous terms.

V.5.10.2 Summary Stage - Regional, Lymph Nodes Only (Code 3)

If a cancer continues to grow after the onset of local invasion, the regional lymph nodes draining the area usually become involved at some point. Enter code 3 if nodal involvement is indicated but there is no other evidence of extension beyond the organ of origin. Words like "local" and "metastasis" appearing in medical records sometimes cause confusion in coding this stage. Failure to recognize the names of regional lymph nodes might lead to incorrect staging. The Summary Staging Guide and the American Joint Committee on Cancer's Manual for Staging of Cancer (see Section I.1.6.5) contain helpful information about the names of nodes.

Examples

Diagnoses such as "carcinoma of the stomach with involvement of the local lymph nodes" should, lacking further evidence, be considered regional and staged as code 3.

Statements like "carcinoma of the breast with auxiliary lymph node metastasis" and "carcinoma of the stomach with metastasis to perigastric nodes" indicate metastasis to regional nodes and should be staged as code 3.

V.5.10.3 Bilateral Lymph Node Involvement

Bilateral lymph node metastases are considered regional for primaries on the midline of the body (for example, on the tongue, esophagus, or uterus), and should be coded as 3. But bilateral regional node involvement of primaries that are not on the midline (like the breast) indicates that the cancer has spread to remote tissue (code 7).

V.5.10.4 Summary Stage - Regional, Direct Extension and Lymph Nodes (Code 4)

Enter code 4 when a tumor has metastasized to regional lymph nodes and also has spread to regional tissue via direct extension, but there is no evidence of metastasis to a distant site or distant lymph nodes.

V.5.10.5 Summary Stage - Regional, NOS (Code 5)

If available information only states that a cancer has spread regionally, stage as code 5. Also use code 5 for a nodal lymphoma described as regional which is sometimes stated in the record as Stage II. See Section V.5.6 and Section V.7.5).

V.5.11 Summary Stage - Distant (Code 7)

Enter code 7 for any tumor that extends beyond the primary site by:

- Direct extension beyond adjacent organs or tissues specified as regional in the Summary Staging Guide.
- Metastasis to distant lymph nodes.
- Development of discontinuous secondary or metastatic tumors. (These often develop in the liver or lungs, because all venous blood flows through these organs and the veins are invaded more easily than the thicker walled arteries.)

Code 7 also includes contralateral or bilateral lymph node metastases, if the primary site is not located along the midline of the body (for example, in the breast, lung, bronchus, ovary, testis, or kidney). Also included in code 7 are systemic diseases such as leukemia and multiple myeloma.

V.5.12 Summary Stage - Unstageable (Code 9)

If information in medical records is insufficient to assign a stage, enter code 9. Code 9 is required when the primary tumor site is not known. For non-analytic cases, code 9 is appropriate unless the stage at the time of the initial diagnosis is known.

V.5.13 Special Rules for Lymph Nodes

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 Software, refer to Collaborative Stage Data Collection System Coding Instructions manual for coding instructions.

Refer to the instructions below for counting regional lymph nodes for a core needle biopsy or aspiration followed by a dissection.

- ***Add 1 to the number of regional lymph nodes positive and examined when the core biospy or aspiration is positive for metastases, the lymph node dissection does not include the area where the core biopsy or aspiration was done and that lymph node was a regional lymph node for the primary site.***
- ***Add 1 only to the number of regional lymph nodes examined when the core biopsy or aspiration is negative for metastases and that lymph node was a regional lymph node for the primary site. Note: You would not add 1 to regional lymph nodes positive because the biopsy or aspiration was negative for metastases.***

- ***Do not add to the regional lymph nodes examined or positive when the area biopsied or aspirated is included in the dissection.***

V.5.14 Lymph-Vascular Invasion (New)

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, lymph-vascular invasion identifies the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels with the primary tumor as noted microscopically by the pathologist. Lymph-vascular invasion is an indicator of prognosis. The CCR requires that this data item be collected for primary sites penis and testis only.

This item may be left blank for cases diagnosed before 2010.

The primary source of this information is the College of American Pathologists (CAP) synoptic report or checklist. If that is not available, code from the pathology report or a physician's statement, in that order of priority.

Codes:

0	***Pathology report indicates no lymph-vascular invasion***
1	***Lymph-vascular invasion is identified anywhere in a primary specimen***
8	***No pathologic examination of primary site tissue performed***
9	***Primary tissue was sent to pathology, but the report cannot be found or surgery was at a different facility and the information was not provided to the reporting facility***
9	***Pathology report indicates that the presence of lymph-vascular invasion could not be determined***

V.6 Tumor Markers

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, Tumor Markers 1-3 and Tumor Marker California 1 (HER2/neu) are collected as site-specific factors. Refer to Collaborative Stage Data Collection System Coding Instructions - Site Specific Factor Fields (Part 1, Section 2).

V.6.1 Tumor Marker 1

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is collected as a site-specific factor. Refer to Collaborative

Stage Data Collection System Coding Instructions - Site Specific Factor Fields (Part 1, Section 2).

V.6.2 Tumor Marker 2

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is collected as a site-specific factor. Refer to Collaborative Stage Data Collection System Coding Instructions - Site Specific Factor Fields (Part 1, Section 2).

V.6.3 Tumor Marker 3

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is collected as a site-specific factor. Refer to Collaborative Stage Data Collection System Coding Instructions - Site Specific Factor Fields (Part 1, Section 2).

V.6.4 Tumor Marker California-1

This data item has been replaced by CS breast schema site-specific factors 8-14.

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, Tumor Marker California 1 (HER2/neu) is collected as a site-specific factor. Refer to Collaborative Stage Data Collection System Coding Instructions - Site Specific Factor Fields (Part 1, Section 2).

V.7 AJCC Staging and Other ACoS Items

January 1, 2008 and Forward

Effective with cases diagnosed January 1, 2008 forward, physician-assigned pathologic AJCC staging will no longer be required to be collected by ACoS approved facilities.

V.7.1 The TNM System

January 1, 2004 and Forward

Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, and Stage Group.

As the AJCC *Manual for Staging of Cancer* explains, the TNM system "is based on the premise that cancers of similar histology or site of origin share similar patterns of growth and extension. The size of the untreated cancer or tumor (T) increases progressively and at some point in time regional lymph node involvement (N) and finally, distant metastases (M) occur."

Because classifications are different for each primary site, and coding for extension depends on precise anatomical identification, the AJCC manual must be referred to for data entry unless the coding is provided by physicians in the medical records. But fundamentally the system consists of assigning appropriate numbers or letters to the three fields:

- T (primary tumor)
- N (nodal involvement)
- M (distant metastasis)

For those sites not included in the AJCC Manual for Staging of Cancer, the Summary Staging Guide for Surveillance Epidemology and End Results Group (SEER) is to be used. For a list of these sites, please refer to *AJCC Manual for Staging of Cancer, Sixth Edition*.

V.7.2 TNM Data Entry

In entering data, do not include the letters T, N, or M, even though they are part of the code.

V.7.3 TNM Stage Basis

This data item identifies the nature of the information on which AJCC staging is based. The *AJCC Cancer Staging Manual* provides specific recommendations about which information should be used for each type of staging at each primary site.

The codes are as follows:

S*	Surgical evaluative
R	Retreatment
A	Autopsy

* Not used in the 3rd or 4th edition of the AJCC manual.

V.7.4 TNM Staging Elements (Clinical and Pathological)

January 1, 2004 and Forward

Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, and Stage Group. See AJCC Cancer Staging Manual, Seventh Edition (Not available electronically).

V.7.5 AJCC Stage Group (Clinical and Pathological)

January 1, 2004 and Forward

Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, Stage Group. See AJCC Cancer Staging Manual, Seventh Edition (not available electronically).

When entering a stage summary code, be sure to include any letter used for the tumor, for example; 3A, 2C. If there is no letter, leave the second digit in the field blank. The codes are:

STAGE 0	0	STAGE IIC	2C
STAGE 0A	0A	STAGE III	3
STAGE 0IS	0S	STAGE IIIA	3A
STAGE I	1	STAGE IIIB	3B
STAGE IA	1A	STAGE IIIC	3C
STAGE IA1	A1	STAGE IV	4
STAGE IA2	A2	STAGE IVA	4A
STAGE IB	1B	STAGE IVB	4B
STAGE IB1	B1	STAGE IVC	4C
STAGE IB2	B2	OCCULT	OC
STAGE IC	1C	NOT APPLICABLE	88
STAGE IS	1S		
STAGE II	2	RECURRENT, UNKNOWN, STAGE X	99
STAGE IIA	2A		
STAGE IIB	2B		

January 1, 2004 and Forward

Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, Stage Group.

Prior to January 1, 2004

For cases diagnosed prior to January 1, 2004, the AJCC manual contains instructions for coding summaries of TNM staging.

V.7.6 TNM Coder (Clinical, Pathological, and Other)

Record the responsible person for performing the TNM staging on the case.

The TNM Coder (Clinical) and TNM Coder (Pathological) are to be used in conjunction with clinical and pathological TNM staging.

These fields will be transmitted to the state registry.

The codes are as follows:

0 NOT STAGED
1 MANAGING PHYSICIAN
2 PATHOLOGIST
3 PATHOLOGIST AND MANAGING PHYSICIAN
4 ***CANCER COMMITTEE CHAIR, CANCER LIAISON PHYSICIAN, REGISTRY PHYSICIAN ADVISOR***
5 CANCER REGISTRAR
6 ***CANCER REGISTRAR AND PHYSICIAN***
7 STAGING ASSIGNED AT ANOTHER FACILITY
8 CASE IS NOT ELIGIBLE FOR STAGING
9 UNKNOWN, NOT FOUND IN PATIENT RECORD

V.7.7 TNM Edition

Record which edition of TNM staging was used to stage a case. The codes are as follows:

00 NOT STAGED

01 FIRST EDITION

02 SECOND EDITION

03 THIRD EDITION

04 FOURTH EDITION

05 FIFTH EDITION

06 SIXTH EDITION

07 SEVENTH EDITION

88 NOT APPLICABLE (cases that do not have an AJCC staging scheme and staging was not done)

99 UNKNOWN

The TNM Edition field may be left blank.

V.7.8 Pediatric Stage

This scheme is to be used for the purpose of entering the stage for pediatric patients only.

January 1, 1996 and Forward

Pediatric Stage includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 or later.

Use Code 88 - not applicable, for patients twenty years of age and older.

Use code 99 for pediatric leukemia cases.

For cases diagnosed prior to 1996, both pediatric and non-pediatric, this field may be left blank.

Record the stage assigned by the Managing Physician.

The codes are as follows:

1	STAGE I
1A	STAGE IA (rhabdomyosarcomas & related sarcomas)
1B	STAGE IB (rhabdomyosarcomas & related sarcomas)
2	STAGE II
2A	STAGE IIA (rhabdomyosarcomas & related sarcomas)
2B	STAGE IIB (rhabdomyosarcomas & related sarcomas)
2C	STAGE IIC (rhabdomyosarcomas & related sarcomas)
3	STAGE III
3A	STAGE IIIA (liver, rhabdo. & related sarcomas, Wilms')
3B	STAGE IIIB (liver, rhabdo. & related sarcomas, Wilms')
3C	STAGE IIIC (Wilms' tumor)
3D	STAGE IIID (Wilms' tumor)
3E	STAGE IIIE (Wilms' tumor)
4	STAGE IV
4A	STAGE IVA (bone)
4B	STAGE IVB (bone)
4S	STAGE IVS (neuroblastoma)
5	STAGE V (Wilms' tumor/retinoblastoma)

A	STAGE A (neuroblastoma)
B	STAGE B (neuroblastoma)
C	STAGE C (neuroblastoma)
D	STAGE D (neuroblastoma)
DS	STAGE DS (neuroblastoma)
88	NOT APPLICABLE (not a pediatric case)
99	UNSTAGED, UNKNOWN

V.7.9 Pediatric Stage System

This scheme is to be used for pediatric patients only.

January 1, 2004 and Forward

Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, Stage Group.

Prior to January 1, 2004

For cases diagnosed prior to January 1, 2004, the AJCC manual contains instructions for coding summaries of TNM staging.

Pediatric Stage includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 or later.

Use Code 88 - not applicable, for patients twenty years of age and older.

For cases diagnosed prior to 1996, both pediatric and non-pediatric, this field may be left blank.

Record in this field the staging system used by the Managing Physician.

The codes are as follows:

00	NONE
01	AMERICAN JOINT COMMITTEE ON CANCER (AJCC)
02	ANN ARBOR
03	CHILDREN'S CANCER GROUP (CCG)
04	EVANS
05	GENERAL SUMMARY
06	INTERGROUP EWINGS
07	INTERGROUP HEPATOBLASTOMA

08	INTERGROUP RHABDOMYOSARCOMA
09	INTERNATIONAL SYSTEM
10	MURPHY
11	NATIONAL CANCER INSTITUTE (Pediatric Oncology)
12	NATIONAL WILMS' TUMOR STUDY
13	PEDIATRIC ONCOLOGY GROUP (POG)
14	REESE-ELLSWORTH
15	SEER EXTENT OF DISEASE
16	CHILDREN'S ONCOLOGY GROUP (COG)
88	NOT APPLICABLE
97	OTHER
99	UNKNOWN

V.7.10 Pediatric Stage Coder

This data item is to be used for pediatric cases only diagnosed January 1, 1996 and later. It identifies the person who staged the case.

The ACoS states that the managing physician is responsible for staging analytical cases. The CCR concurs and feels that this applies to non-analytic cases, also.

If the staging has not been done by the physician, the registrar does not have to stage the case. Enter 0 for not staged.

For patients older than twenty (20), enter 0.

For cases diagnosed prior to 1996, this field may be left blank. The codes are as follows:

0	NOT STAGED
1	MANAGING PHYSICIAN
2	PATHOLOGIST
3	OTHER PHYSICIAN
4	ANY COMBINATION OF 1, 2 OR 3
5	REGISTRAR
6	ANY COMBINATION OF 5 WITH 1, 2 OR 3
7	OTHER
8	STAGED, INDIVIDUAL NOT SPECIFIED

9	UNKNOWN IF STAGED

Part VI Treatment

VI.1 First Course of Treatment: General Instructions

In the treatment section, record all cancer directed therapy administered as part of the first course of treatment. It includes any therapeutic procedure directed at cancer tissue, whether in a primary or metastatic site, whatever the mode of treatment, and regardless of the sequence and degree of completion of any component part.

Effective with cases diagnosed January 1, 1998, a new definition for first course therapy was to be followed. In addition, note the definition for leukemias in see Section VI.1.1. Use the older definition for cases diagnosed prior to January 1, 1998.

The following rules are to be followed for first course therapy, and they are in the order of precedence:

1. If there is a documented, planned first course of therapy, first course ends at the completion of this treatment plan, regardless of the duration of the treatment plan.
2. If the patient is treated according to a facility's standards of practice, first course ends at the completion of the treatment.
3. First course therapy includes all treatment received before disease progression or treatment failure.
4. When there is no documentation of a treatment plan or progression, recurrence or a treatment failure, first course therapy ends one year after the date of diagnosis. Any treatment given after one year is second course therapy in the absence of a documented treatment plan or a standard of treatment.
5. If a patient refuses all treatment modalities and does not change his/her mind within a reasonable time frame, or if the physician opts not to treat the patient, record that there was no treatment in the first course.

If treatment is given for symptoms/disease progression after a period of "watchful waiting," this treatment is not considered part of first course. For example, if a physician and patient choose a "wait and watch" approach to prostate cancer or chronic lymphocytic leukemia and the patient becomes symptomatic, consider the symptoms to be an indication that the disease has progressed and that any further treatment is not part of first course. ***The data item RX-Treatment Status was added to summarize the status of all treatment modalities. This data item is a summary of whether treatment was given, including an option that identifies active surveillance or watchful waiting.***

The CCR expects every reporting facility that has a tumor registry to obtain information about the entire first course therapy from the medical record and, if necessary, the physicians themselves, regardless of where the treatment was

administered. If it cannot be determined whether an intended therapy was actually performed, record that it was recommended but it is not known whether the procedure was administered. (For example, Enter "Radiation therapy, recommended; unknown if given.") Reporting facilities preparing initial case reports for the sole purpose of meeting state mandatory reporting requirements may elect to record only the treatment documented in their medical records.

Abstractors are provided with two fields to record first course of treatment information. The first treatment field for each modality (except surgery) is known as "Treatment Summary." This field should include any first course treatment administered for that modality, regardless of where it was administered, including treatment administered at the reporting facility. The second treatment field for each modality (except surgery) is known as "Treatment At This Hospital." This field should only include first course treatment administered at the reporting facility, respective to each modality.

Note: For cases diagnosed January 1, 2010 and forward, referral to an oncologist is considered a recommendation. Registry personnel should follow-up on these cases to determine whether chemotherapy was administered or not, and code accordingly.

Prior to January 1, 2010, referral does not equal a recommendation.

VI.1.1 Special Situations

In Utero Diagnoses and Treatment

Beginning in 2009, the dates of diagnosis and treatment for tumors developed while in utero should reflect the dates on which they occur. In the past, these dates were assigned to the date the baby was born.

Treatment Performed Elsewhere

Record any part of the first course of treatment administered at another facility before the patient was admitted to the reporting facility or after discharge. Also record the name of the facility where the treatment was administered.

Leukemia

Leukemia is grouped or typed by how quickly the disease develops and worsens. Chronic leukemia gets worse slowly; acute leukemia, quickly.

Leukemias are also grouped by the type of white blood cell that is affected: lymphoid leukemia and myeloid leukemia.

First course for Leukemia and Hematopoietic Diseases

Definitions

Consolidation: Repetitive cycles of chemotherapy given immediately after the remission.
Induction: Initial intensive course of chemotherapy.
Maintenance: Chemotherapy given for a period of month or years to mAINTAIN REMISSION.
Remission: The bone marrow shows normal cellular characteristics (is normocellular), with less than 5% blasts, no signs or symptoms of the disease, no signs or symptoms of central nervous system leukemia or other extramedullary infiltration, and all of the following laboratory values within normal limits: white blood cell count and differential, hematocrit/hemoglobin level, and platelet count.

Treatment for leukemia is divided into three phases

1) Remission induction (chemotherapy and/or biologic response modifiers)
2) CNS prophylaxis or consolidation (irradiation to brain, chemotherapy)
3) Remission continuation or maintenance (chemotherapy or bone marrow transplants)

Coding First Course of Therapy for Leukemia and Hematopoietic Diseases

1) If a patient has a partial or complete remission during the first course of therapy

- ***a) Code all therapy that is "remission-inducing" as first course***
- ***b) Code all therapy that is "consolidation " as first course***
- ***c) Code all therapy that is "remission-maintaining" as first course***

Note: Do not record treatment given after the patient relapses (is no longer in remission)

2) Some patient do not have a remission. A change in the treatment plan indicates a failure to induce remission. If the patient does not have a remission:

- ***a) Record the treatment given in an attempt to induce a remission***
- ***b) Do not record treatment administered after the change in treatment plan***

For leukemia and lymphoma cases diagnosed January 1, 2010 and forward, refer to 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.

VI.1.2 Treatment Definitions

Certain treatment terms include:

Definitive Cancer Treatment

Therapy that normally modifies, controls, removes, or destroys proliferating tumor tissue, whether primary or metastatic, even if it cannot be considered curative for a particular patient in view of the extent of disease, incompleteness of treatment, apparent lack of response, size of the dose administered, mortality during surgery, or other reason. The term excludes therapy that has no effect on malignant tissue. Procedures administered for the sole purpose of relieving symptoms are therefore not considered to be cancer treatment.

Cancer Tissue

Proliferating malignant cells or an area of active production of malignant cells. Sometimes malignant cells are found in tissue in which they did not originate and are not reproducing. A procedure that removes cancer cells but does not attack a site of proliferation of the cells (thoracentesis, for example) is not considered cancer treatment.

Palliative

Ordinarily means (1) non-curative, or (2) alleviation of symptoms. If used for a procedure that is directed toward symptoms only, the therapy is not considered to be treatment (e.g., colostomy, removal of fluid—even if cancer cells are present—to ease pressure, neurosurgery to relieve pain).

Antineoplastic Drugs

Applies to medications that prevent the development, maturation, or spread of cancer cells. Included are drugs for chemotherapy (see Section VI.4), hormonal treatment (see Section VI.5), and immunotherapy (see Section VI.6). For cases diagnosed 1/1/2005 forward, registrars must use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy). SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.

Active Surveillance
See Watchful Waiting.

Disease Recurrence
For solid tumors, see the Multiple Primary and Histology Coding Rules manual and for hematopoietic and lymphoid neoplams see the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding manual and the Hematopoietic Database to determine disease recurrence.

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
A treatment option for patients with slow, indolent diseases, such as prostate cancer. The physician closely monitors the patient and delays treatment until the patient becomes symptomatic or exhibits other signs of disease progression, such as rising PSA. Also referred to as Active Surveillance.

VI.1.3 First Course of Treatment - Data Entry

Enter codes, dates, and written summaries to reflect the first course of treatment.

VI.1.3.1 First Course of Treatment - Codes

Numeric codes summarize each modality of treatment (surgery, radiation, chemotherapy, etc.). For each modality except surgery, code a summary of the entire first course of treatment. See Section VI.2 for coding each surgery field.

In the field provided, assign a separate code to that portion of the treatment administered at the reporting facility.

Beginning with cases diagnosed January 1, 1998, treatment given by a physician on the medical staff of a facility should not be recorded as treatment given at that reporting facility.

For cases diagnosed prior to January 1, 1998, treatment given in a staff physician's office should be recorded as if given at the reporting facility.

The codes for surgical procedures have one or two digits.

The codes for the reason no surgery, reason no radiation, reason no chemotherapy and reason no hormone therapy have been incorporated into each respective treatment modality field.

Other codes have two digits, with a 00 always meaning no procedure performed for that type of treatment.

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. Code as Chemotherapy.

Radioembolization: embolization combined with injecting small radioactive beads or coils into an organ or tumor. Code as Radiation therapy.

Tumor embolization with alcohol or tumor embolization NOS: the intentional blockage of an artery or vein to stop the flow of blood through the desired vessel. Code as Other therapy, see Section VI.8.1.

VI.1.3.2 First Course of Treatment – Dates

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, dates transmitted between facility registries and central registries changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner, or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. In traditional form, some dates also permit 88888888 or 00000000 for special meaning.
Interoperable dates are display in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date.
Consult your software vendor for specific data entry instructions.

Enter the date treatment was started for each modality. For instructions about entering dates, see Section I.1.6.4. If the treatment was administered in courses (as in a radiation therapy series) or included different procedures (for example, excisional biopsy and a resection), enter the date the first procedure was performed.

VI.1.3.3 First Course of Treatment - Text

In the text field following the Start Date field, describe the treatment as succinctly as possible. If more than one procedure was performed, describe each one in chronological order. Indicate where the procedure was performed, unless it was at the reporting facility. The text field may be left blank when the type of treatment was not provided. But if no cancer-directed surgery is performed, record the reason in the text field for surgery.

NOTE: There is no text field for bone marrow transplant and endocrine procedures. Record text information regarding bone marrow transplants and endocrine procedures in the immunotherapy text field.

VI.1.3.4 First Course of Treatment - Refused

If the patient or patient's guardian refuses surgery to the primary site, enter code 7 in the Reason for No Surgery field. Use code 87 in the respective treatment field if the patient or patient's guardian refuses that modality and record the fact in the text field. However, if a treatment that was originally refused was subsequently performed as part of the first course of treatment, enter the appropriate code for the procedure.

VI.1.3.5 No First Course of Treatment

If a patient did not receive any of the treatments described in Sections VI.2—VI.7, the surgery summary code would be 00 and all the other treatment summary fields would contain a 00. For example, the case might be Autopsy Only, or the patient might have received only symptomatic or supportive therapy. Explain briefly why no definitive treatment was given (for example, "terminal," "deferred"). If definitive treatment was refused, see Section VI.1.3.4 for coding instructions. A facility that is preparing initial case reports to only meet state mandatory reporting requirements may also use 00 if no treatment is documented in its medical records (code 99 should not be used in this situation).

The data item RX-Treatment Status was added to summarize the status of all treatment modalities. This data item is a summary of whether treatment was given, including an option that identifies active surveillance or watchful waiting.

Note: For cases diagnosed January 1, 2010 and forward, referral to an oncology specialist is considered a recommendation. Registry personnel should follow up on these cases to determine whether treatment was administered or not, and code accordingly.

Prior to January 1, 2010, referral does not equal a recommendation.

VI.1.3.6 First Course of Treatment - Unknown

In coding treatment, code 99 or 9 (unknown) should generally be used only for cases in which the first course of treatment is unknown. Enter 99 or 9 for each modality of treatment, leave the treatment date fields blank, and state briefly why the information is not available. Do not use code 99 or 9 for a component part of the treatment summary. For example, if surgical resection was performed and it is not known whether chemotherapy was administered, do not enter a 99 in the Chemotherapy field -- use code 00. If specific treatment is recommended, but it is not known whether it was administered, enter a statement to this effect and code the appropriate summary fields for Immunotherapy and Other Therapy with code 88 (code 8 for Surgery) and At This Hospital fields with code 00.

Note: For cases diagnosed January 1, 2010 and forward, referral to a specialist is considered a recommendation. Registry personnel should follow up on these cases to determine whether treatment was administered or not, and code accordingly.

Prior to January 1, 2010, referral does not equal a recommendation.

VI.2 First Course of Treatment: Surgery Introduction

In abstracting surgical treatment, the total or partial removal (except an incisional biopsy) of tumor tissue must be recorded in the text field, whether from a primary or metastatic site. Also record procedures that remove normal tissue--for example, dissection of non-cancerous lymph nodes--if they are part of the first course of treatment. (Brushings, washings, aspiration of cells and peripheral blood smears are not considered surgical procedures, but they might have to be recorded as diagnostic procedures.) See Section IV.1.

VI.2.1 Surgery of the Primary Site

See Appendix Q for Site-Specific Surgery Codes

Generally, cancer-directed surgery includes most procedures that involve removal of a structure (those with the suffix "ectomy") and such procedures as:

- Biopsy, excisional (which has microscopic residual disease or no residual disease)
- Biopsy, NOS, that removes all tumor tissue
- Chemosurgery (Moh's technique)
- Conization
- Cryosurgery
- Dessication and Curettage for bladder and skin tumors
- Electrocautery
- Fulguration for bladder, skin, and rectal neoplasms
- Laser therapy
- Local excision with removal of cancer tissue (including excisional biopsy but excluding incisional biopsy)
- Photocoagulation
- Splenectomy for lymphoma or leukemia

- Surgery removing metastatic malignant tissue
- Transurethral resection (TUR) with removal of tumor tissue of bladder or prostatic tumors

Do not code pre-surgical embolization of hypervascular tumors with particles, coils or alcohol. These pre-surgical embolizations are typically performed to make the resection of the primary tumor easier. Examples where pre-surgical embolization is used include meningiomas, hemangiomas, paragangliomas, and renal cell metastases in the brain.

For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is unavailable. Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix Q.

Refer to Appendix Q-1 for cases diagnosed prior to January 1, 2003. Refer to Appendix Q-2 for cases diagnosed on or after January 1, 2003.

Enter the procedures in chronological order. If more than three surgical procedures are performed on a patient, the earliest surgery and the most definitive surgery must be included.

Surgery of the Primary Site consists of three two-character fields which are to be used to record surgeries of the primary site only. If an en bloc resection is performed which removes regional tissue or organs with the primary site(s) part of a specific code definition, it should be coded. An en bloc resection is the removal of organs in one piece at one time.

Examples:

Patient undergoes a modified radical mastectomy. The breast and auxiliary contents are removed in one piece (en bloc).

Surgery would be coded 50 for modified radical mastectomy regardless of whether nodes were found by pathology in the specimen.

For non-en bloc resections, record the resection of a secondary or metastatic site in the Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s).

Refer to Appendix Q for the site-specific surgery codes. They are hierarchical with less specific (NOS) terms followed by more specific terms. See the example.

Examples:

50 Gastrectomy, NOS WITH removal of a portion of esophagus
51 Partial or subtotal gastrectomy

52 Near total or total gastrectomy

NOTE: Codes 10-90 have priority over code 99.
Codes 10-84 have priority over codes 90 and 99.
Codes 10-79 have priority over codes 80, 90 and 99, where 80 is site-specific surgery, not otherwise specified.

NOTE: If surgery removes the remaining portion of an organ, code the total removal of the organ.

NOTE: Biopsies that remove all gross tumor or leave only microscopic margins should be coded to surgery of the primary site.

The patient had a resection of a stomach remnant and portion of the esophagus at the time of their second procedure.

The first procedure was a partial gastrectomy, NOS - code 30.

The second procedure would be code 52 for a total gastrectomy.

A patient had a lobectomy--code 31--for cancer in August 1998. The remainder of the lung was surgically removed in November 1998.

The second procedure would be code 40--resection of whole lung.

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given.

Reminder: For cases diagnosed January 1, 2010 and forward, referral to a specialist is considered a recommendation. Registry personnel should follow-up on these cases to determine whether treatment was administered or not and code accordingly.

Note: Prior to January 1, 2010, referral does not equal a recommendation.

VI.2.2 Scope of Regional Lymph Node Surgery

These three one-character fields are to be used to record surgeries performed on regional lymph nodes. Record the farthest regional lymph node removed regardless of involvement with disease. There is no minimum number of nodes that must be removed. If a regional lymph node was aspirated or biopsied, code regional lymph node(s) removed, NOS (1).

For counting regional lymph nodes for a core needle biopsy or aspiration followed by a dissection, see Section V.5.13 Special Rules for Lymph Nodes.

January 1, 2003 and Forward

Starting with cases diagnosed January 1, 2003 forward, RX Summ, Scope of Reg LN Surg is not be coded according to site. It is coded using a single scheme for all sites. The three procedure fields must continue to be coded for 2003 forward cases. The codes for Scope of Regional LN's are as follows:

0	NONE No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	BIOPSY OR ASPIRATION OF REGIONAL LYMPH NODE, NOS Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease.
2	SENTINEL LYMPH NODE BIOPSY Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	NUMBER OF REGIONAL NODES REMOVED UNKNOWN OR NOT STATED; REGIONAL LYMPH NODE REMOVED, NOS Sampling or dissection of regional lymph node(s) and the number of nodes is unknown or not stated. The procedure is not specified as sentinel node biopsy.
4	1-3 REGIONAL LYMPH NODES REMOVED Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 OR MORE REGIONAL LYMPH NODES REMOVED Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.

6	SENTINEL NODE BIOPSY AND CODE 3,4, OR 5 AT SAME TIME, OR TIMING OUT NOT STATED Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 was performed, but timing was not stated in patient record.
7	SENTINEL NODE BIOPSY AND CODE 3,4, OR 5 AT DIFFERENT TIMES Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.
9	UNKNOWN OR NOT APPLICABLE It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary;primaries of the brain, meninges, spinal cord, cranial nerves and other part of the CNS (including the pituitary gland***, craniopharyngeal duct, and pineal gland***) , or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

Cases diagnosed prior to January 1, 2003 must be coded in a new field, Scope of Regional LN 98-02. Refer to Appendix Q-1 for these codes.

Each site contains a list of nodes which are regional. Any nodes not contained on these lists are distant and should be coded in Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

In Appendix Q-1 for head and neck primaries diagnosed prior to January 1, 2003, the fields are to be used for neck dissections. Codes 2-5 indicate only that a neck dissection procedure was performed. They do not imply that nodes were found during the pathologic examination of the surgical specimen. Code the neck dissection even if no nodes were found in the specimen.

VI.2.3 Number of Regional Lymph Nodes Examined

Record the number of lymph nodes identified in the pathology report during each surgical procedure of the regional lymph nodes. The codes are the same for all sites. Refer to Appendix Q-1 for these codes, which are to be entered in chronological order. If no regional lymph nodes were identified in the pathology report, leave the field blank even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or if the operative report documents removal of the nodes.

Note: This field is not cumulative. It does not replace or duplicate the "Regional Lymph Nodes Examined" field used in Extent of Disease coding.

Effective with cases diagnosed on or after January 1, 2003, the fields for Rx Summ-Reg LN Examined and Rx Hosp-Reg LN Examined are no longer required by the CCR and the CoC. Information regarding the number of lymph nodes has been incorporated into the scope fields. However, the summary field for cases diagnosed prior to January 1, 2003 must continue to be coded.

Use code 99 for an Unknown Primary Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease Primaries, Lymphoma, Brain (including the pituitary gland) and Primaries of Ill-Defined Sites.

VI.2.4 Surgery of Other Regional Sites, Distant Sites, or Distant Lymph Nodes

There are three one-character fields to be used to record removal of tissue other than the primary tumor or organ of origin. This would not be an en bloc resection. See example #1. Code the removal of non-primary site tissue which the surgeon may have suspected to be involved with malignancy even if the pathology was negative. Do not code the incidental removal of tissue for reasons other than malignancy. See example #2. These procedures are to be entered in chronological order. If no surgery was performed of other regional or distant sites or distant lymph nodes, leave the fields blank.

Starting with cases diagnosed January 1, 2003 forward, RX Summ - Surg Oth Reg/Dis and its corresponding procedure fields are not coded according to site. Rather, they are coded using a single scheme for all sites. The new codes are as follows:

0	NONE No surgical procedure of nonprimary site
1	NONPRIMARY SURGICAL PROCEDURE PERFORMED Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	NONPRIMARY SURGICAL PROCEDURE TO OTHER REGIONAL SITES Resection of regional site.
3	NONPRIMARY SURGICAL PROCEDURE TO DISTANT LYMPH NODE(S) Resection of distant lymph node(s).
4	NONPRIMARY SURGICAL PROCEDURE TO DISTANT SITE 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 nonprimary site was performed. Death certificate only.

NOTE: Use code 1 if any surgery is performed to treat tumors of Unknown or Ill-defined Primary sites (C76.0-76.8, C80.9) or for Hematopoietic/Reticuloendothelial/Immunoproliferative disease (C42.0, C42.1,

C42.3, C42.4, or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992.)

Cases diagnosed prior to January 1, 2003 are to be coded in a new field, Surgery Other 98-02. Refer to Appendix Q-1 for these codes.

This field is for all procedures that do not meet the definitions of Surgery of Primary Site or Scope of Regional Lymph Nodes.

Example #1

The patient has an excisional biopsy of a hard palate lesion removed from the roof of the mouth and a resection of a metastatic lung nodule during the same procedure.

Code the resection of the lung nodule as 4 (distant site).

Example #2

During a colon resection, the surgeon noted that the patient had cholelithiasis and removed the gallbladder.

Do not code removal of the gallbladder.

VI.2.5 Date of Surgery

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Enter the date of surgery performed for each surgical procedure. There are three date fields available to be used in conjunction with each definitive procedure performed. Procedures for this date field include Surgery of the Primary Site, Scope of Regional Lymph Node Surgery or Surgery of Other Regional/Distant Sites. These must be entered in chronological order.

Consult with your software vendor for specific data entry instructions.

VI.2.5.1 Date of Surgery Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

10	***Unknown whether any procedure performed***
11	***No procedure planned or performed***
12	***Date cannot be determined for procedure performed***
Blank	***Full or partial date recorded***

VI.2.6 Treatment Facility Number

These fields are used in conjunction with each surgical procedure performed. If the procedure was performed at the reporting facility, the ***CCR assigned reporting facility code should be entered.***

The fields are to be left blank if no cancer-directed surgery was performed.

Reporting facilities in alphabetic order.

Reporting facilities in code order.

VI.2.7 Surgical Margins of the Primary Site

This field is not required by the CCR effective with cases diagnosed January 1, 2000, but it is required by the ACoS. It describes the status of the surgical margins after each resection of the primary tumor.

For cases diagnosed after January 1, 2003, please refer to the Facility Oncology Registry Data Standards.

For cases diagnosed prior to January 1, 2003, please refer to Appendix Q-1 for the site-specific codes.

VI.2.8 Reconstructive Surgery - Immediate

January 1, 2003 and Forward

Beginning with cases diagnosed, January 1, 2003, this field is no longer required by the CCR or the CoC. Information with regards to reconstruction is incorporated into the Surgery of the Primary Site field.

Prior to January 1, 2003

The old field was retained and cases diagnosed prior to January 1, 2003 must continue to be coded.

For these cases, refer to Appendix Q-1.

Record the procedure in both the *Reconstructive Summary* and *At This Hospital* fields and in the surgery text field if it was performed subsequent to surgery as part of the planned first course of therapy. This procedure improves the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies.

VI.2.9 Reason for No Surgery of the Primary Site

If surgery of the primary site was performed, enter 0.

Reason for No Surgery only applies to the Surgery of the Primary Site field, not Scope of Regional Lymph Node Surgery or Surgery Other Regional/Distant Sites.

For sites where "Surgery of the Primary Site" is coded to 00 or 98 (hematopoietic included) use code 1.

Effective with cases diagnosed 1/1/2003, Code 5, *surgery not performed because patient died* was added. Definitions for codes 1, 2, and 6 were modified.

0	SURGERY OF THE PRIMARY SITE PERFORMED
1	SURGERY OF THE PRIMARY SITE NOT PERFORMED BECAUSE IT WAS NOT PART OF THE PLANNED FIRST COURSE TREATMENT
2	SURGERY OF THE PRIMARY SITE NOT PERFORMED BECAUSE OF CONTRAINDICATIONS 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 (code added in 2003)
6	SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT NOT PERFORMED. NO REASON WAS NOTED IN THE PATIENT'S RECORD
7	SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT REFUSED BY THE PATIENT, FAMILY MEMBER OR GUARDIAN. THE REFUSAL IS NOTED IN THE

	PATIENT'S RECORD.
8	SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT UNKNOWN IF PERFORMED. ***FURTHER FOLLOW-UP IS RECOMMENDED.***
9	NOT KNOWN IF SURGERY OF THE PRIMARY SITE WAS RECOMMENDED OR PERFORMED; DEATH CERTIFICATE ONLY AND AUTOPSY ONLY CASES

VI.2.10 Diagnostic or Staging Procedures

Record surgical procedures performed solely for establishing a diagnosis and or determining stage of disease. If there is more than one surgical diagnostic or staging procedure, record the first one performed. Some of the procedures should be recorded in the Operative Findings field.

Beginning with cases diagnosed January 1, 2003 forward, this field does not include palliative treatment/procedures. Palliative treatment/procedures are recorded in a separate field. The CCR does not require that palliative treatment/procedures be recorded but the CoC does require this field. Please consult the FORDS Manual for instructions regarding the palliative procedure field.

Surgical diagnostic or staging procedures include:

- Biopsy, incisional or NOS (if a specimen is less than or equal to 1 cm, assume the biopsy to have been incisional unless otherwise specified)

  Note: If a lymph node is biopsied or removed to diagnose or stage lymphoma, and that node is NOT the only node involved with lymphoma, used code 02. If there is only a single lymph node involved with lymphoma, use the data item Surgical Procedure of Primary Site to code these procedures.

- Dilation and curettage for invasive cervical cancer
- Dilation and curettage for invasive or in situ cancers of the corpus uteri, including choriocarcinoma
- Surgery in which tumor tissue is not removed, for example
- Bypass surgery—colostomy, esophagostomy, gastrostomy, nephrostomy, tracheostomy, urethrostomy, stent placement
-

NOTE: Removal of fluid (paracentesis or thoracentesis) even if cancer cells are present is not a surgical procedure. Do not code brushings, washings, or hematologic findings (peripheral blood smears). These are not considered surgical procedures.

- Exploratory surgery—celiotomy, cystotomy, gastrotomy, laparotomy, nephrotomy, thoracotomy

NOTE: If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).

Do Not Code:

- Brushings, washings, cell aspirations and hematologic findings (peripheral smears), as they are NOT considered surgical procedures and should not be coded in the Diagnostic or Staging Procedures field. Code positive brushings, washings and cell aspirations, and hematologic findings (peripheral smears) as cytologic diagnostic confirmation in the Diagnostic Confirmation field.
- Surgical procedures which aspirate, biopsy, or remove regional lymph nodes in effort to diagnose and/or stage disease in this data item. Use the data item Scope of Regional Lymph Node Surgery to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item Date of Surgical Diagnostic and Staging Procedure.
- Excisional biopsies with clear or microscopic margins in this data item. Use the data item Surgical Procedure of Primary Site to code these procedures.
- Palliative surgical procedures in this data item.

VI.2.10.1 Diagnostic or Staging Procedure Codes

00	NO SURGICAL DIAGNOSTIC OR STAGING PROCEDURE
01	INCISIONAL, NEEDLE, OR ASPIRATION BIOPSY OF OTHER THAN PRIMARY SITE (Code microscopic residual disease or no residual disease as Surgery of Other Regional Site[s], Distant Site[s], or Distant Lymph Nodes[s])
02	INCISIONAL, NEEDLE, OR ASPIRATION BIOPSY OF PRIMARY SITE (Code Microscopic residual disease or no residual disease as Surgery of Primary Site)
03	EXPLORATORY SURGERY ONLY (no biopsy)
04	BYPASS SURGERY OR OSTOMY ONLY (no biopsy)
05	COMBINATION OF 03 PLUS 01 OR 02
06	COMBINATION OF 04 PLUS 01 OR 02
07	DIAGNOSTIC OR STAGING PROCEDURE, NOS
09	UNKNOWN IF DIAGNOSTIC OR STAGING PROCEDURE DONE

NOTE: Give priority to:

Codes 01-07 over code 09.

Codes 01-06 over code 07.

Codes in the range 01-06 are hierarchial.

VI.2.11 Date of Diagnostic or Staging Surgical Procedures

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Enter the date of the earliest surgical diagnostic and/or staging procedure in this field.

Consult with your software vendor for specific data entry instructions.

VI.2.11 Date of Diagnostic or Staging Surgical Procedures Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

10	***Unknown whether a surgical diagnostic or staging procedure was performed***
11	***No surgical diagnostic or stating procedure was performed***
12	***Date cannot be determined for surgical diagnostic or staging performed***
Blank	***Full or partial date recorded***

VI.2.12 Sources for Information (Surgery)

To ascertain exactly what procedures were performed, read the operative and pathology reports thoroughly. Do not depend on the title of an operative report, because it might be incomplete. If the operative report is unclear about what tissue was excised, or the operative and pathology reports contain different information, use the pathology report unless there is reason to doubt its accuracy.

VI.2.13 Special Rules for Coding Ambiguous Cases (Surgery)

There are specific rules for coding certain ambiguous situations:

Excision of Multiple Primaries

If multiple primaries are excised at the same time, enter the appropriate code for each site.

Examples:

A total abdominal hysterectomy was performed for a patient with two primaries, one of the cervix and one of the endometrium.

Code each site as having had a total abdominal hysterectomy.

A total colectomy was performed on a patient with multiple primaries in several segments of the colon.

Code total colectomy for each of the primary segments.

Excisional Biopsy

Record an excisional biopsy as first surgical treatment, whether followed by further definitive surgery or not and whether or not residual tumor was found in a later resection. If there is no statement that the initial biopsy was excisional, yet no residual tumor was found at a later resection, assume that the biopsy was excisional.

Extranodal Lymphomas

When coding surgery for extranodal lymphomas, use the appropriate code for the extranodal site. For example, use a code for the stomach to code a lymphoma of the stomach.

VI.2.14 Systemic Therapy With Surgery Sequence

January 1, 2006 and Forward

For cases diagnosed 1/1/2006 forward, code the sequence in which systemic therapy and surgical procedures were performed as part of the first course of treatment.

Use the following codes:

0	No systemic therapy and /or surgical procedures; ***unknown if surgery and/or systemic therapy given.***
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before or after

	surgery
9	Sequence unknown

If first course of treatment includes (codes 10-90 in Surgery of the Primary Site fields, codes 1-7 in the Scope of Regional Lymph Node Surgery fields, and codes 1-8 in the Surgery of Other Regional(s), Distant Site(s), or Distant Lymph Node(s) fields) and systemic therapy, use codes 2-9. For all other cases, use code 0.

VI.3 First Course of Treatment: Radiation Therapy

The name or chemical symbol and method of administration of any radiation therapy that is directed toward tumor tissue or given prophylactically must be documented in the text field.

Do not include radiation for hormonal effect, such as irradiation of non-cancerous endocrine glands.

Do not include irradiation of the male breast to prevent gynecomastia.

January 1, 2008 and Forward

For cases diagnosed 1/1/2008 forward, the data item, Radiation Location Treatment is required by the CCR. This data item identifies the location of the facility in which radiation treatment was administered during first course of treatment.

January 1, 2003 and Forward

For cases diagnosed 1/1/2003 forward, *Radiation - Regional RX Modality and Radiation - Boost RX Modality*, are required to code first course radiation therapy. Software conversions of these two fields generate the Radiation Therapy Summary field.

Additional Note

The field "Radiation Therapy at this Hospital" will no longer be required by the CCR beginning with cases diagnosed 1/1/2003.

VI.3.1 Types of Radiation

The principal types of radiation therapy are the external administration of radioactive beams, implantation of radioactive material, and the internal administration of radioisotopes by other than implantation. Radioactive materials include the following:

Au^{198} gold

Co^{60} cobalt

$Cr^{32}PO_4$ phosphocol

$CrPO_4$ chromic phosphate

Cs cesium

I^{125} iodine

I^{131} iodine

Ir^{192} iridium

P^{32} phosphorus

Pb^{210} lead

Ra^{226} radium

Rn^{222} radon

Ru^{106} ruthenium

Sr^{90} strontium

Y^{90} yttrium

VI.3.1.1 Beam Radiation

Radiation is classified as beam when the source of radioactivity is outside the patient, as in a cobalt machine or linear accelerator. Examples of beam radiation are:

Betatron

Brachytron

Cobalt

Cyclotron

Grenz ray

Helium ion or other heavy particle beam

Linear accelerator (LINAC)

MeV

Neutron beam

Spray radiation

Stereotactic radiosurgery, such as gamma knife and proton beam

X-ray

VI.3.1.2 Radioactive Implants

Record the name or chemical symbol and method of administration of any radioactive material administered by implants, molds, seeds , needles, or intracavity applicators. (Heyman capsules, Fletcher suit, and Fletcher after loader are methods of isotope application. Interpret these terms as radioactive implants.)

Record High Dose Rate (HDR) and Low Dose Rate (LDR) Brachytherapy as radioactive implants - Code 2.

Code I-125 treatment for prostate cancer to brachytherapy (code 2) and treatment modality to low dose radiotherapy (LDR), code 53.

VI.3.1.3 Other Internal Radiation

Record the name or chemical symbol and method of administration of any radioactive material given orally, intracavitary, or by intravenous injection.

VI.3.2 Radiation Therapy Summary Codes

The following codes will be generated for recording radiation therapy in the summary field.

January 1, 2003 and Forward

Beginning with cases diagnosed 1/1/2003, *Radiation - Regional RX Modality* and *Radiation - Boost RX Modality*, are required to code first course radiation therapy. Also, radiation to the brain and CNS for lung and leukemia cases are to be coded in the *Radiation – Regional RX Modality* and *Radiation – Boost RX Modality* fields.

0	NONE
1	BEAM RADIATION
2	RADIOACTIVE IMPLANTS
3	RADIOISOTOPES
4	COMBINATION OF 1 WITH 2 OR 3
5	RADIATION, NOS (method or source not specified)
9	UNKNOWN IF RADIATION THERAPY RECOMMENDED OR GIVEN

Additional Note

The field "Radiation Therapy at this Hospital" will no longer be required by the CCR beginning with cases diagnosed 1/1/2003.

January 1, 1998 and Forward

Beginning with cases diagnosed January 1, 1998, radiation to the brain and central nervous system for lung cancers and leukemias only is to be recorded in the Radiation Summary and Radiation At This Hospital fields. Include prophylactic treatment and treatment of known spread to the CNS.

VI.3.3 Radiation - Regional RX Modality

Record the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment. The CCR requires the collection of this field. This data item and Radiation-Boost RX Modality are converted to generate the RX Summ-Radiation.

Radioembolization is embolization combined with injection of small radioactive beads or coils into an organ or tumor. Code Radiation Modality as brachytherapy, code 50, when tumor embolization is performed using a radioactive agent or radioactive seeds.

Code I-125 treatment for prostate cancer to brachytherapy, low dose radiotherapy (LDR), code 53.

The codes for Radiation-Regional RX Modality are as follows:

00	NO RADIATION TREATMENT; DIAGNOSED AT AUTOPSY
20	EXTERNAL BEAM, NOS
21	ORTHOVOLTAGE
22	COBALT-60, CESIUM-137
23	PHOTONS (2-5 MV)
24	PHOTONS (6-10 MV)
25	PHOTONS (11-19 MV)
26	PHOTONS (>19 MV)
27	PHOTONS (MIXED ENERGIES)
28	ELECTRONS
29	PHOTONS AND ELECTRONS MIXED
30	NEUTRONS, WITH OR WITHOUT PHOTONS/ELECTRONS
31	IMRT

32	CONFORMAL OR 3-D THERAPY
40	PROTONS
41	STEREOTACTIC RADIOSURGERY, NOS
42	LINAC RADIOSURGERY
43	GAMMA KNIFE
50	BRACHYTHERAPY, NOS
51	BRACHYTHERAPY, INTRACAVITARY, LDR
52	BRACHYTHERAPY, INTRACAVITARY, HDR
53	BRACHYTHERAPY, INTERSTITIAL, LDR
54	BRACHYTHERAPY, INTERSTITIAL, HDR
55	RADIUM
60	RADIOISOTOPES, NOS
61	STRONTIUM-89
62	STRONTIUM-90
98	OTHER, NOS
99	UNKNOWN; DEATH CERTIFICATE ONLY

Clarification: Intracavitary use of Cobalt-60 or Cesium-137 should be coded as 50 or 51. (See *FORDS Manual* for code definitions).

There is no hierarchy for this data item. If multiple radiation therapy modalities are used to treat the patient, code the dominant modality. In the rare occasion where 2 modalities are combined in a single volume (IMRT photons with an electron "patch" for example), code the appropriate radiation modality item to the highest level of complexity, i.e. the IMRT.

Note: For cases diagnosed January 1, 2010 and forward, referral to a radiation oncologist is considered a recommendation. Follow-up on these cases is required to determine whether radiation was administered or not, and code accordingly.

Prior to January 1, 2010, referral does not equal a recommendation.

Prior to January 1, 2003
*NOTE: For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to Vol. II, ROADS, and DAM rules and should not be used to record regional radiation for cases diagnosed on or later than January 1, 2003.

VI.3.4 Radiation - Boost RX Modality

Record the dominant modality of radiation therapy used to deliver the most clinically significant boost dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or IMRT. External beam boosts may consist of two or more successive phases with progressively smaller fields generally coded as a single entity.

The CCR requires the collection of this data item. This data item and Radiation-Regional RX Modality are converted to generate the RX Summ-Radiation.

Radioembolization is embolization combined with injection of small radioactive beads or coils into an organ or tumor. Code Radiation Modality as brachytherapy, code 50, when tumor embolization is performed using a radioactive agent or radioactive seeds.

The codes are as follows:

00	NO BOOST TREATMENT; DIAGNOSED AT AUTOPSY
20	EXTERNAL BEAM, NOS
21	ORTHOVOLTAGE
22	COBALT-60, CESIUM-137
23	PHOTONS (2-5 MV)
24	PHOTONS (6-10 MV)
25	PHOTONS (11-19 MV)
26	PHOTONS (>19 MV)
27	PHOTONS (MIXED ENERGIES)
28	ELECTRONS
29	PHOTONS AND ELECTRONS MIXED
30	NEUTRONS, WITH OR WITHOUT PHOTONS/ELECTRONS
31	IMRT
32	CONFORMAL OR3-D THERAPY
40	PROTONS
41	STEREOTACTIC RADIOSURGERY, NOS
42	LINAC RADIOSURGERY
43	GAMMA KNIFE

50	BRACHYTHERAPY, NOS
51	BRACHYTHERAPY, INTRACAVITARY, LDR
52	BRACHYTHERAPY, INTRACAVITARY, HDR
53	BRACHYTHERAPY, INTERSTITIAL, LDR
54	BRACHYTHERAPY, INTERSTITIAL, HDR
55	RADIUM
60	RADIOISOTOPES, NOS
61	STRONTIUM-89
62	STRONTIUM-90
98	OTHER, NOS
99	UNKNOWN; DEATH CERTIFICATE ONLY

Clarification: Intracavitary use of Cobalt-60 or Cesium-137 should be coded as 50 or 51. (See the FORDS Manual for code definitions).

There is no hierarchy for this data item. If multiple radiation therapy boost modalities are used to treat the patient, code the dominant modality.

Note: For cases diagnosed January 1, 2010 and forward, referral to a radiation oncologist is considered a recommendation. Follow-up on these cases is required to determine whether radiation was administered or not, and code accordingly.

Prior to January 1, 2010, referral does not equal a recommendation.

VI.3.5 Date of Radiation Therapy

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Record the date on which radiation therapy began at any facility as part of the first course treatment.

Consult with your software vendor for specific data entry instructions.

VI.3.5.1 Date Radiation Therapy Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

10	***Unknown whether radiation therapy was given***
11	***No radiation therapy planned or given***
12	***Date cannot be determined for radiation therapy received during first course***
15	***Radiation therapy is planned; start date is not yet available***
Blank	***Full or partial date recorded***

VI.3.6 Reason for No Radiation

The following codes are to be used to record the reason the patient did not undergo radiation treatment:

0	RADIATION TREATMENT PERFORMED
1	RADIATION TREATMENT NOT PERFORMED BECAUSE IT WAS NOT A PART OF THE PLANNED FIRST COURSE TREATMENT
2	RADIATION CONTRAINDICATED BECAUSE OF OTHER CONDITIONS OR OTHER PATIENT RISK FACTORS (CO-MORBID CONDITIONS, ADVANCED AGE, ETC)
5	RADIATION TREATMENT NOT PERFORMED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED TREATMENT
6	RADIATION TREATMENT WAS RECOMMENDED BUT NOT PERFORMED. NO REASON WAS NOTED IN THE PATIENT'S RECORD.
7	RADIATION TREATMENT WAS RECOMMENDED BUT REFUSED BY THE PATIENT, FAMILY MEMBER OR GUARDIAN. THE REFUSAL IS NOTED IN THE PATIENT'S RECORD.
8	RADIATION RECOMMENDED, UNKNOWN IF DONE
9	UNKNOWN IF RADIATION RECOMMENDED OR PERFORMED; DEATH CERTIFICATE AND AUTOPSY ONLY CASES

NOTE: Include radiation to the brain and central nervous system when coding this field.

January 1, 2003 and Forward

NOTE: Beginning with cases diagnosed 1/1/2003, Code 5 - radiation not performed because patient died was added. Definitions for codes 1, 2, and 6 were also modified.

VI.3.7 Radiation Sequence With Surgery

Code the sequence in which radiation and surgical procedures were performed as part of the first course of treatment. Use the following codes:

0	NOT APPLICABLE treatment did not include both surgery and radiation, or unknown whether both were administered; diagnosed at autopsy
2	RADIATION BEFORE SURGERY
3	RADIATION AFTER SURGERY
4	RADIATION BOTH BEFORE AND AFTER SURGERY
5	INTRAOPERATIVE RADIATION
6	INTRAOPERATIVE RADIATION WITH OTHER RADIATION GIVEN BEFORE OR AFTER SURGERY
9	SEQUENCE UNKNOWN, BUT BOTH SURGERY AND RADIATION WERE GIVEN

Use codes 2-9 if the first course of treatment includes (codes 10–90 in Surgery of the Primary Site fields, codes 1-7 in the Scope of Regional Lymph Node Surgery fields, and codes 1-8 in the Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) fields) and radiation.

For all other cases, use code 0.

VI.3.8 Location of Radiation Treatment

January 1, 2008 and Forward

Beginning January 1, 2008, code the location of the facility in which radiation treatment was administered during first course of treatment. Use the following codes:

0	NO RADIATION TREATMENT
1	ALL RADIATION TREATMENT AT THIS FACILITY
2	REGIONAL TREATMENT AT THIS FACILITY, BOOST ELSEWHERE
3	BOOST RADIATION AT THIS FACILITY, REGIONAL ELSEWHERE
4	ALL RADIATION TREATMENT ELSEWHERE
8	OTHER, NOS

9	UNKNOWN

VI.4 First Course of Treatment - Chemotherapy

Chemotherapy includes the use of any chemical to attack or treat cancer tissue, unless the chemical achieves its effect through change of the hormone balance or by affecting the patient's immune system. In coding consider only the agent, not the method of administering it, although the method of administration may be recorded. Chemotherapy typically is administered orally, intravenously, or intracavitary, and sometimes topically or by isolated limb perfusion. The drugs are frequently given in combinations that are referred to by acronyms or protocols. Do not record the protocol numbers alone. Two or more single agents given at separate times during the first course of cancer directed therapy are considered to be a combination regimen.

SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.

VI.4.1 Names of Chemotherapeutic Agents

In the text field, the generic or trade names of the drugs used for chemotherapy must be recorded. Include agents that are in the investigative or clinical trial phase.

January 1, 2005 and Forward

For cases diagnosed 1/1/2005 forward, registrars must use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy). SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.

VI.4.2 Chemotherapy Codes

Use the following codes for recording chemotherapy in the Summary field.

Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.

Use codes 00-87 for recording chemotherapy in the At This Hospital field.

00	NONE, CHEMOTHERAPY WAS NOT PART OF THE PLANNED FIRST COURSE OF THERAPY. DIAGNOSED AT AUTOPSY
01	CHEMOTHERAPY, NOS.
02	SINGLE-AGENT CHEMOTHERAPY.
03	MULTI-AGENT CHEMOTHERAPY ADMINISTERED AS FIRST COURSE THERAPY.

82	CHEMOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (i.e., COMORBID CONDITIONS, ADVANCED AGE).
85	CHEMOTHERAPY NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.
86	CHEMOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE OF THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
87	CHEMOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT 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 recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 00, 30 or 31.

Note: For cases diagnosed January 1, 2010 and forward, referral to a medical oncologist is considered a recommendation. Follow-up on these cases is required to determine whether chemotherapy was administered or not, and code accordingly.

Prior to January 1, 2010, referral does not equal a recommendation.

VI.4.3 Date of Chemotherapy

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Record the date on which chemotherapy began at any facility as part of first course of treatment.

Consult with your software vendor for specific data entry instructions.

VI.4.3.1 Date Chemotherapy Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

10	***Unknown whether any chemotherapy was given***
11	***No chemotherapy planned or given***
12	***Date cannot be determined for chemotherapy received during first course***
15	***Chemotherapy is planned; start date is not yet available***
Blank	***Full or partial date recorded***

VI.5 First Course of Treatment - Hormone (Endocrine) Therapy

Report the administration of hormones, anti-hormones, or steroids to attack cancer tissue by changing the patient's hormone balance. Record surgery performed for hormonal effect (such as castration) and radiation for hormonal effect for breast and prostate cancers only. When steroids are combined with chemotherapy, record their use, in addition to reporting the chemotherapy in the chemotherapy section.

SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.

VI.5.1 Hormones

Cancer-directed treatment with hormones and anti-hormones must be documented in the text field for all sites.

Report cancer directed use of adenocorticotrophic hormones for treatment of leukemias, lymphomas, multiple myelomas, and breast and prostate cancers. But report as hormone therapy any hormonal agent that is given in combination with chemotherapy (e.g., MOPP or COPP) for cancer of any site whether it affects the cancer cells or not.

January 1, 2005 Forward

For cases diagnosed 1/1/2005 forward, registrars must use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy). SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.

VI.5.1.1 Agents for Endometrial and Kidney Tumors

Refer to the SEER*Rx Web Site for more information.

VI.5.1.2 Agents For Thyroid Cancer

Refer to the SEER*Rx Web Site for further information.

VI.5.2 Hormone (Endocrine) Surgery

This data item is coded in the "Transplant/Endocrine Procedure" field see Section VI.7. For reporting purposes, endocrine surgery is defined as the total surgical removal of an endocrine gland (both glands or all of a remaining gland in the case of paired glands). Record endocrine surgery for treatment of cancer of the breast or prostate only. The procedures are:

- Adrenalectomy
- Hypophysectomy
- Oophorectomy (breast)
- Orchiectomy (prostate)

If tumor tissue is present in a gland removed in the course of endocrine therapy, record the procedure as surgical treatment also.

VI.5.3 Hormone (Endocrine) Radiation

This data item is coded in the "Transplant/Endocrine Procedure" field see Section VI.7. Report any type of radiation directed toward an endocrine gland to affect hormonal balance if:

- The treatment is for cancers of the breast and prostate.
- Both paired glands (ovaries, testes, adrenals) or all of a remaining gland have been irradiated.

VI.5.4 Hormone Therapy Codes

Use the following codes for recording hormone therapy in the Summary field. Use codes 00-87 for recording hormone therapy at this hospital. The codes for Reason No Hormone have been incorporated into this field.

00	NONE, HORMONE THERAPY WAS NOT PART OF THE PLANNED FIRST COURSE THERAPY.
01	HORMONE THERAPY ADMINISTERED AS FIRST COURSE THERAPY.
82	HORMONE THERAPY WAS NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (IE, COMORBID CONDITIONS, ADVANCED AGE).
85	HORMONE THERAPY WAS NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.
86	HORMONE THERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE THERAPY. 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 THE PATIENT RECORD.
88	HORMONE THERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
99	IT IS UNKNOWN WHETHER A HORMONAL AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 00, 30, or 31.

Note: For cases diagnosed January 1, 2010 and forward, referral to a medical oncologist is considered a recommendation. Follow-up on these cases is required to determine whether hormone therapy was administered or not, and code accordingly.

Prior to January 1, 2010, referral does not equal a recommendation.

VI.5.5 Date of Hormone Therapy

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Record the date on which hormone therapy began at any facility as part of first course of treatment.

Consult with your software vendor for specific data entry instructions.

VI.5.5.1 Date of Hormone Therapy Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

10	***Unknown whether any hormone therapy was given***
11	***No hormone therapy planned or given***
12	***Date cannot be determined for hormone therapy received during first course***
15	***Hormone therapy is planned; start date is not yet available***
Blank	***Full or partial date recorded***

VI.6 First Course of Treatment - Immunotherapy (Biological Response Modifier Therapy)

Immunotherapy/Biological response modifier therapy (BRM) is a generic term covering everything done to the immune system to alter it or change the host response to a cancer (defense mechanism).

SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.

VI.6.1 Immunotherapy Agents

Immunotherapy agents must be recorded in the text field.

January 1, 2005 and Forward

For cases diagnosed 1/1/2005 forward, registrars must use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy). SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.

Report the following as immunotherapy:

- ASILI (active specific intralymphatic immunotherapy)
- Blocking factors
- Interferon
- Monoclonal antibodies*
- Transfer factor (specific or non specific)
- Virus therapy

*Some monoclonal antibodies are used to deliver chemotherapy or radiation agents to the tumor, not to kill the tumor immunologically. Consult SEER*RX to determine how to appropriately code monoclonal antibodies. See the SEER Manual, p. 128.

VI.6.2 Immunotherapy Codes

January 1, 2003 and Forward

Effective with cases diagnosed 1/1/2003, this data item was modified. Codes for transplants and endocrine procedures were removed and were coded in a separate field called RX Summ - Transplnt/Endocr. The length of this field was changed from 1 to 2 characters. The codes for reason for no immunotherapy (BRM) given were incorporated into this scheme.

Use codes 00-87 for recording immunotherapy in the At This Hospital field.

Use the following codes for recording immunotherapy in the Summary field.

00	NONE, IMMUNOTHERAPY WAS NOT PART OF THE PLANNED FIRST COURSE OF THERAPY
01	IMMUNOTHERAPY ADMINISTERED AS FIRST COURSE THERAPY
82	IMMUNOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (i.e. COMORBID CONDITIONS, ADVANCED AGE).
85	IMMUNOTHERAPY WAS NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.
86	IMMUNOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF

	THE FIRST COURSE OF THERAPY. 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 THE PATIENT RECORD.
88	IMMUNOTHERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
99	IT IS UNKNOWN WHETHER AN IMMUNOTHERAPEUTIC AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 00, 30, or 31.

Note: For cases diagnosed January 1, 2010 and forward, referral to a medical oncologist is considered a recommendation. Follow-up on these cases is required to determine whether immunotherapy was administered or not, and code accordingly.

Prior to January 1, 2010, referral does not equal a recommendation.

VI.6.3 Date of Immunotherapy

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Record the date on which immunotherapy began at any facility as part of first course of treatment.

Consult with your software vendor for specific data entry instructions.

VI.6.3.1 Date of Immunotherapy Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

10	***Unknown whether immunotherapy was given***
11	***No immunotherapy planned or given***
12	***Date cannot be determined for immunotherapy received during first course***
15	***Immunotherapy is planned; start date is not yet available***
Blank	***Full or partial date recorded***

VI.7 First Course of Treatment - Transplant/Endocrine Procedures

Record systemic therapeutic procedures administered as part of first course of treatment. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. Information on transplants and endocrine procedures was removed from the Rx Summ-BRM (Immunotherapy) field and moved to this field. Bone marrow and stem cell procedures are now coded in this field along with endocrine surgery or radiation.

For cases prior to January 1, 2003, a conversion was required using both the Rx Summ - BRM (Immunotherapy) and Rx Summ - Hormone fields. Although the CoC did not add a corresponding "At this Hospital" field, the CCR required this field in order to provide consistency, since all of the other treatment fields except radiation have a hospital-level field during this time period.

Code systemic irradiation or total body irradiation (TBI) prior to bone marrow transplant as treatment. Any chemotherapy given in preparation for the TBI is also coded as treatment. Both irradiation and chemotherapy destroy cancer cells in the bone marrow.

VI.7.1 Transplant/Endocrine Codes

Use the following codes for recording transplant/endocrine procedures in the Summary field. Use codes 00-87 for recording transplant/endocrine procedures in the At This Hospital field.

00	NO TRANSPLANT PROCEDURE OR ENDOCRINE THERAPY WAS ADMINISTERED AS PART OF THE FIRST COURSE 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

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 WERE 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 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 WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
99	IT IS UNKNOWN WHETHER HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 00, 30 or 31.

Note: For cases diagnosed January 1, 2010 and forward, referral to a specialist for hematologic transplant or endocrine procedures is considered a recommendation. Follow-up on these cases is required to determine whether a procedure was performed or not, and code accordingly.

Prior to January 1, 2010, referral does not equal a recommendation.

VI.7.2 Date of Transplant/Endocrine Procedure

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Record the date on which the transplant/endocrine procedure took place at any facility as part of the first course treatment.

Consult with your software vendor for specific data entry instructions.

VI.8 First Course of Treatment - Other Therapy

Record definitive, cancer-directed treatment that cannot be assigned to any other category, for example:

- Hyperbaric oxygen (as adjunct to definitive treatment).
- Hyperthermia (given alone or in combination with chemotherapy, as in isolated heated limb perfusion for melanoma).
- ***Cancer vaccines are still in the experimental phase. Currently, clinical trials use cancer vaccines for brain, breast, colon, kidney, lung, melanoma, and ovary.***
- Any experimental drug that cannot be classified elsewhere.
- Double blind clinical trial information where the type of agent administered is unknown and/or there is any use of a placebo. However, after the code is broken, report the treatment under the appropriate category (a correction record should be submitted when the data are available).
- Unorthodox and unproven treatment, such as laetrile or krebiozen.

For Newly Reportable Hematopoietic Diseases (NRHD) only, specify in the Remarks field and use code 1 "Other Therapy" for the following:

- Transfusions/Plasmapheresis
- Phlebotomy/Blood Removal
- Supportive Care
- Aspirin
- Observation

VI.8.1 Other Therapy Codes

Use codes 0-7 for recording other therapy in the At This Hospital field.

0	NO OTHER CANCER DIRECTED THERAPY EXCEPT AS CODED ELSEWHERE. DIAGNOSED AT AUTOPSY.
1	OTHER CANCER DIRECTED THERAPY Examples: • Embolization using alcohol as an embolizing agent • Embolization to a site other than the liver where the embolizing agent is unknown • ***PUVA treatments for melanoma***
2	OTHER EXPERIMENTAL CANCER DIRECTED THERAPY (not included elsewhere)
3	DOUBLE BLIND CLINICAL TRIAL, CODE NOT YET BROKEN
6	UNPROVEN THERAPY
7	PATIENT OR PATIENT'S GUARDIAN REFUSED THERAPY WHICH WOULD HAVE BEEN CODED 1–3 ABOVE
8	OTHER CANCER DIRECTED THERAPY RECOMMENDED, UNKNOWN IF ADMINISTERED
9	UNKNOWN IF OTHER THERAPY RECOMMENDED OR ADMINISTERED. DEATH CERTIFICATE ONLY.

Note: For recording Therapy at this Hospital, do not use code 9 if Class of Case is coded to 00, 30, or 31.

Note: For cases diagnosed January 1, 2010 and forward, referral to a specialist is considered a recommendation. Follow-up on these cases is required to determine whether treatment was administered or not, and code accordingly.

Prior to January 1, 2010, referral does not equal a recommendation.

VI.8.2 Date of Other Therapy

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Record the date on which Other Therapy began at any facility as part of first course treatment.

Consult with your software vendor for specific data entry instructions.

VI.8.2.1 Date of Other Therapy Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

10	***Unknown whether other therapy was given***
11	***No other therapy planned or given***
12	***Date cannot be determined for other therapy received during first course***
15	***Other therapy is planned; start date is not yet available***
Blank	***Full or partial date recorded***

VI.9 RX Summary – Treatment Status (New)

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to summarize the status for all treatment modalities. It is used in conjunction with Date of Initial RX and/or Date of 1st Course RX-CoC and each modality of treatment with their respective date field to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date. Active surveillance (watchful waiting) is also documented. This data item is required by the CCR.

Codes

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

VI.9.1 Protocol Participation

January 1, 2001 and Forward

Beginning with cases diagnosed January 1, 2001, the CCR requires that this field be collected and transmitted to the CCR. The codes are as follows:

00	Not Applicable
National Protocols	
01	NSABP
02	GOG
03	RTOG
04	SWOG
05	ECOG
06	POG
07	CCG
08	CALGB
09	NCI
10	ACS
11	National Protocol, NOS
12	ACOS-OG
13	VA [Veterans Administration]
14	COG [Children's Oncology Group]
15	CTSU [Clinical Trials Support Unit]
16-50	National Trials
Locally Defined	
51-79	Locally Defined
80	Pharmaceutical
81-84	Locally Defined
85	In-House Trial
86-88	Locally Defined
89	Other
90-98	Locally Defined

99	Unknown

Part VII. Follow-Up

VII.1 Follow-Up Information

A function of the California cancer reporting system is annual monitoring of patients to ascertain survival rates.

Therefore, if follow-up information is available before an abstract is submitted, include the follow-up information in the abstract.

Facilities with cancer programs approved by ACoS must update follow-up data annually (consult ACoS Guidelines for requirements). Obtain the information from medical records (if the patient has been readmitted), or from the patient's physician, contact letters, and telephone calls.

Annual follow-up is not required for a hospital that does not have a tumor registry and is submitting an abstract only to meet state reporting requirements. The CCR does not impose follow-up requirements beyond what a hospital chooses to do for its own purposes. For example, if a hospital elects not to follow non analytic cases, the CCR will not expect to receive follow-up information for such cases.

Effective January 1, 2010 and forward, follow-up is still required for the following tumors, although they are categorized in Class of Case 34 or 36:

- ***Benign and borderline CNS tumors diagnosed between January 1, 2001 and December 31, 2003 (before the national benign and borderline CNS tumor reporting requirement was implemented)***
- ***VIN III***
- ***VAIN III***
- ***AIN III***

Effective January 1, 2010 and forward, follow-up is no longer required for borderline ovarian cases diagnosed January 1, 2001 and forward.

VII.1.1 Required Data

Some follow-up data items are optional for reporting to the CCR but might be required by the ACoS, for shared follow-up involving other institutions, or by the reporting facility for in-house data.

The CCR's required items are:

- Date of Last Patient Contact
- Vital Status
- Date Last Tumor Status
- Tumor Status

- Last Follow-up Facility
- Death information

VII.1.2 Sources of Follow-Up Information

Follow-up information must be based on documentation of contact with the patient in one of the following forms:

- Direct response to a letter or phone call to the patient or other contact person
- A report by the patient's physician
- Re-admission to the facility as an inpatient or outpatient
- Death certificate

It might be necessary to trace the patient through such agencies and organizations as the registrar of voters, welfare agencies, labor unions, religious groups, or the Office of the State Registrar for a death certificate.

VII.1.3 Current Status of Follow-Up Information

Current status is defined as contact with the patient within 15 months of the date the follow-up is reported.

Although current information is preferred, updated information that is not current should still be reported.

VII.1.4 Shared Follow-Up

In those cases where a patient is being followed by more than one reporting facility, the regional or the central registry may designate a facility responsible for follow-up in an effort to prevent physicians and patients from receiving requests for information from many sources.

Shared follow-up which discloses the source or name of the facility requires a signed agreement from each participating registry.

Follow-up may be shared without a signed agreement as long as the source is not disclosed.

This does not preclude a facility's registry from submission of more current information about its patients. Shared follow-up is instituted only by agreement among participating facilities in a region.

VII.2 Follow-Up Data Items

Follow-up data items provide information about the outcome of cancers and the results of treatment. A patient's survival time is calculated on the basis of Date of Diagnosis and Date of Last Contact.

See sections VII.2.1 through VII.2.13 for specific information.

VII.2.1 Date of Last Contact

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, see Section I.1.6.4 and Section I.1.6.5 for Coding and Entering Dates.

Enter the date the patient was last seen or heard from or the date of death. Do not enter the date the information was forwarded or received.

If no follow-up information has been received, enter the date of discharge from the hospital. All abstracts submitted for a patient must contain the same Date of Last Contact.

Consult with your software vendor for specific data entry instructions.

VII.2.1.1 Date of Last Contact Flag

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, this data item is used to explain why there is no appropriate value in the corresponding date field. Since only actual known dates are entered in interoperable date items, flags are used to explain the reason the date field is blank. Depending on the registry software being used, these changes may be transparent to the registrar.

Codes:

12	***Date cannot be determined***
Blank	***Full or partial date recorded***

VII.2.2 Vital Status

Enter the code representing whether the patient was still alive on the date of last contact. If a patient with more than one primary has died, be sure to record the fact in all the abstracts.

The codes are:

0	DEAD
1	ALIVE

VII.2.3 Date Last Tumor Status

Enter the date of the last information obtained on the primary (tumor) being followed. This field has been added for patients with multiple primaries.

VII.2.4 Tumor Status

Summarize the best available information about the status of the tumor on the date of last contact. The field applies only to the tumor for which the abstract is submitted, regardless of any other tumors the patient might have.

The codes are:

1	FREE—NO EVIDENCE OF THIS CANCER
2	NOT FREE—EVIDENCE STILL EXISTS OF THIS CANCER
9	UNKNOWN—STATUS OF THIS CANCER UNKNOWN

VII.2.5 Quality of Survival

Enter the code that best characterizes the patient's quality of survival. This item is not required by the CCR.

Codes

0	NORMAL ACTIVITY
1	SYMPTOMATIC AND AMBULATORY
2	AMBULATORY MORE THAN 50%, OCCASIONALLY NEEDS ASSISTANCE
3	AMBULATORY LESS THAN 50%, NURSING CARE NEEDED
4	BEDRIDDEN, MAY REQUIRE HOSPITALIZATION
8	NOT APPLICABLE, DEAD
9	UNKNOWN/UNSPECIFIED

Reporting facilities may use another coding system or scale adopted by the facility's cancer committee.

VII.2.6 Last Type of Follow-Up

There are two fields which are to be used to enter the source of the most recent follow-up information about the patient:

See Section VII.2.6.1- Last Type of Tumor Follow-Up

See Section VII.2.6.2 - Last Type of Patient Follow-Up

VII.2.6.1 Last Type of Tumor Follow-Up

This field is to be used to enter information representing the source of the most recent information on the tumor being followed. Reporting facilities ordinarily use codes from the first of the three following groups, i.e., 00-15, unless instructed otherwise by their regional or central registry.

Follow-up obtained by hospital from:		
	00	ADMISSION BEING REPORTED
	01	READMISSION TO REPORTING FACILITYL
	02	FOLLOW-UP REPORT FROM PHYSICIAN
	03	FOLLOW-UP REPORT FROM PATIENT
	04	FOLLOW-UP REPORT FROM RELATIVE
	05	OBITUARY
	07	FOLLOW-UP REPORT FROM HOSPICE
	08	FOLLOW-UP REPORT FROM OTHER FACILITY
	09	OTHER SOURCE
	11	TELEPHONE CALL TO ANY SOURCE
	12	SPECIAL STUDIES
	14	ARS (AIDS REGISTRY SYSTEM)
	15	COMPUTER MATCH WITH DISCHARGE DATA
Follow-up obtained by regional registry from:		
	20	LETTER TO A PHYSICIAN
	22	COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
	23	COMPUTER MATCH WITH HMO FILE
	25	NATIONAL DEATH INDEX

	26	COMPUTER MATCH WITH STATE DEATH TAPE
	29	COMPUTER MATCH, OTHER OR NOS
	30	OTHER SOURCE
	31	TELEPHONE CALL TO ANY SOURCE
	32	SPECIAL STUDIES
	34	ARS (AIDS REGISTRY SYSTEM)
	35	COMPUTER MATCH WITH DISCHARGE DATA
	36	OBITUARY
Follow-up obtained by central (state) registry from:		
	40	LETTER TO A PHYSICIAN
	41	TELEPHONE CALL TO ANY SOURCE
	52	COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
	53	COMPUTER MATCH WITH HMO FILE
	55	NATIONAL DEATH INDEX
	56	COMPUTER MATCH WITH STATE DEATH TAPE
	59	COMPUTER MATCH, OTHER OR NOS
	60	OTHER SOURCE
Follow-up obtained by hospitals or facilities usually done by the regional/central registry:		
	73	COMPUTER MATCH WITH HMO FILE
	76	COMPUTER MATCH WITH STATE DEATH TAPE
Additional Codes:		
	99	SOURCE UNKNOWN

VII.2.6.2 Last Type of Patient Follow-Up

This field is to be used to enter the code representing the source of the most recent information about the patient being followed. Reporting hospitals ordinarily use codes from the first of the three following groups, i.e., 00-15.

Follow-up obtained by hospital from:

	00	ADMISSION BEING REPORTED
	01	READMISSION TO REPORTING FACILITY
	02	FOLLOW-UP REPORT FROM PHYSICIAN
	03	FOLLOW-UP REPORT FROM PATIENT
	04	FOLLOW-UP REPORT FROM RELATIVE
	05	OBITUARY
	06	FOLLOW-UP REPORT FROM SOCIAL SECURITY ADMINISTRATION OR MEDICARE
	07	FOLLOW-UP REPORT FROM HOSPICE
	08	FOLLOW-UP REPORT FROM OTHER FACILITY
	09	OTHER SOURCE
	11	TELEPHONE CALL TO ANY SOURCE
	12	SPECIAL STUDIES
	13	EQUIFAX
	14	ARS (AIDS REGISTRY SYSTEM)
	15	COMPUTER MATCH WITH DISCHARGE DATA
	16	SSDI MATCH
Follow-up obtained by regional registry from:		
	20	LETTER TO A PHYSICIAN
	21	COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES FILE
	22	COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
	23	COMPUTER MATCH WITH HMO FILE
	24	COMPUTER MATCH WITH VOTER REGISTRATION FILE
	25	NATIONAL DEATH INDEX
	26	COMPUTER MATCH WITH STATE DEATH TAPE
	27	DEATH MASTER FILE (SOCIAL SECURITY)
	29	COMPUTER MATCH, OTHER OR NOS
	30	OTHER SOURCE
	31	TELEPHONE CALL TO ANY SOURCE
	32	SPECIAL STUDIES

	33	EQUIFAX
	34	ARS (AIDS REGISTRY SYSTEM)
	35	COMPUTER MATCH WITH DISCHARGE DATA
	36	OBITUARY
	37	COMPUTER MATCH WITH CHANGE OF ADDRESS SERVICE
	38	TRW
	39	REGIONAL REGISTRY FOLLOW-UP LIST
Follow-up obtained by central (state) registry from:		
	40	LETTER TO A PHYSICIAN
	41	TELEPHONE CALL TO ANY SOURCE
	48	Research Study Follow Up
	50	CMS (CENTER FOR MEDICARE & MEDICAID SERVICES)
	51	COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES FILE
	52	CALIFORNIA MEDICAL REVIEW INC
	53	COMPUTER MATCH WITH HMO FILE
	54	COMPUTER MATCH WITH VOTER REGISTRATION FILE
	55	NATIONAL DEATH INDEX
	56	COMPUTER MATCH WITH STATE DEATH TAPE
	57	COMPUTER MATCH WITH MEDI-CAL
	58	COMPUTER MATCH WITH SOCIAL SECURITY DEATH FILE
	59	COMPUTER MATCH, OTHER OR NOS
	60	OTHER SOURCE
	61	SOCIAL SECURITY - SSN
	62	SPECIAL STUDIES
	65	COMPUTER MATCH WITH OSHPD HOSPITAL DISCHARGE DATA BASE
	66	COMPUTER MATCH WITH NATIONAL CHANGE OF ADDRESS FILE
	67	SSA - EPIDEMIOLOGICAL VITAL STATUS
	68	PROPERTY TAX LINKAGE
	69	STATE DEATH TAPE (INCREMENTAL)
Follow-up obtained by hospitals or facilities usually done by the regional/central registry:		
	73	COMPUTER MATCH WITH HMO FILE

	76	COMPUTER MATCH WITH STATE DEATH TAPE
Regional Registry (Additional Codes)		
	80	SOCIAL SECURITY ADMINISTRATION
	81	PROPERTY TAX LINKAGE
	82	PROBE360
	83	SSDI - INTERNET
	84	E-PATH
	85	PATH LABS
	86	PATIENT
	87	RELATIVE
Unknown Source		
	99	SOURCE UNKNOWN

VII.2.7 Last Follow-Up Facility

Enter ***the CCR assigned reporting facility code for the reporting*** facility or agency that provided the most recent follow-up information.

Reporting facilities in alphabetic order.

Reporting facilities in code order.

VII.2.8 Next Type Follow-Up

Record the method of obtaining follow-up information about the patient for the next report. If the patient has died, leave the field blank.

The codes are:

0	SUBMIT A REQUEST FOR THE PATIENT'S CHART TO THE REPORTING FACILITY'S MEDICAL RECORDS DEPARTMENT
1	SEND A FOLLOW-UP LETTER TO THE PATIENT'S PHYSICIAN
2	SEND A FOLLOW-UP LETTER TO THE PERSON DESIGNATED AS THE CONTACT FOR THE PATIENT
3	CONTACT THE PATIENT OR DESIGNATED CONTACT BY TELEPHONE
4	REQUEST FOLLOW-UP INFORMATION FROM ANOTHER FACILITY
5	FOLLOW-UP BY A METHOD NOT DESCRIBED ABOVE

6	SEND A FOLLOW-UP LETTER TO THE PATIENT
7	PATIENT PRESUMED LOST, STOP PRINTING FOLLOW-UP LETTERS
8	* FOREIGN RESIDENT, FOLLOW-UP DISCONTINUED OR NOT INITIATED
9	DO NOT FOLLOW-UP (except code 8)

* Foreign residents may be followed at the hospital's option, in which case do not use code 8.

VII.2.9 Next Follow-Up Facility

Enter the ***CCR assigned reporting facility code*** of the hospital, facility, or agency responsible for the next follow-up of the patient.

Reporting facilities in alphabetic order.

Reporting facilities in code order.

VII.2.10 Follow-Up Physician

Enter the name or code number of the attending physician—not a resident or intern—responsible for the patient. If a different physician is to receive the next follow-up letter, enter that physician's name or code number. (For instructions about entering codes, see Section III.3.12.1.)

Enter code 99999999 if there is no Follow-Up Physician.

Enter code 99999999 if the Follow-Up Physician is "unknown" or "license number not assigned."

January 1, 2007 and Forward

Beginning with cases diagnosed January 1, 2007, enter the physician NPI code in the respective field, if it is available. See Appendix X for further details.

VII.2.11 Alternate Medical Record Number

An alternate medical record number, such as the patient's record number at the next follow-up facility, may be entered for the convenience of the facility performing the follow-up. The Alternate Medical Record Number field should usually be changed if the Next Follow-Up Hospital field is changed. The item is not required, and is not transmitted to the CCR.

VII.2.12 Recurrence Information

If a patient's primary tumor recurred after a period of complete remission, the Date of First Recurrence and Type of First Recurrence must be coded by American College of Surgeons-approved registries. The data are optional for reporting to the California Cancer Registry. Code only the first recurrence and do not update the fields except to correct data entry errors.

VII.2.12.1 Date of First Recurrence

Enter the date of first recurrence of a primary tumor that recurred after a period of complete remission. See Section I.1.6.4 for entering dates. If the exact date is not known, enter an estimate based on the best available information. If the patient was never free of the primary tumor or did not experience a recurrence, leave the field as zeros.

VII.2.12.2 Type of First Recurrence

Enter one of the following codes to indicate the type of first recurrence:

00	NONE, DISEASE FREE
01	IN SITU
06	RECURRENCE FOLLOWING DIAGNOSIS OF AN IN SITU LESION OF THE SAME SITE
10	LOCAL
11	TROCAR SITE
15	COMBINATION OF 10 AND 11
16	LOCAL RECURRENCE FOLLOWING AN IN SITU LESION OF THE SAME SITE
17	COMBINATION OF 16 WITH 10, 11 AND/OR 15
20	REGIONAL, NOS
21	REGIONAL TISSUE
22	REGIONAL LYMPH NODES
25	COMBINATION OF 21 AND 22
26	REGIONAL RECURRENCE FOLLOWING AN IN SITU LESION OF THE SAME SITE
27	COMBINATION OF 26 WITH 21, 22, AND/OR 25
30	ANY COMBINATION OF 10, 11, AND 20, 21 OR 22
36	ANY COMBINATION OF RECURRENCE FOLLOWING AN IN SITU LESION OF THE SAME SITE WITH 10, 11, 20, 21 OR 22

40	DISTANT RECURRENCE, AND THERE IS INSUFFICIENT INFORMATION AVAILABLE TO CODE TO 46-62
46	DISTANT RECURRENCE OF AN IN SITU TUMOR
51	DISTANT RECURRENCE OF INVASIVE TUMOR IN THE PERITONEUM ONLY. PERITONEUM INCLUDES PERITONEAL SURFACES OF ALL STRUCTURES WITHIN THE ABDOMINAL CAVITY AND/OR POSITIVE ASCITIC FLUID.
52	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE LUNG ONLY. LUNG INCLUDES THE VISCERAL PLEURA.
53	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE PLEURA ONLY. PLEURA INCLUDES THE PLEURAL SURFACE OF ALL STRUCTURES WITHIN THE THORACIC CAVITY AND/OR POSITIVE PLEURAL FLUID.
54	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE LIVER ONLY.
55	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN BONE ONLY. THIS INCLUDES BONES OTHER THAN THE PRIMARY SITE.
56	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE CNS ONLY. THIS INCLUDES THE BRAIN AND SPINAL CORD, BUT NOT THE EXTERNAL EYE.
57	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE SKIN ONLY. THIS INCLUDES SKIN OTHER THAN THE PRIMARY SITE.
58	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN LYMPH NODE ONLY. REFER TO THE STAGING SCHEME FOR A DESCRIPTION OF LYMPH NODES THAT ARE DISTANT FOR A PARTICULAR SITE.
59	DISTANT SYSTEMIC RECURRENCE OF AN INVASIVE TUMOR ONLY. THIS INCLUDES LEUKEMIA, BONE MARROW METASTASIS, CARCINOMATOSIS, GENERALIZED DISEASE.
60	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN A SINGLE DISTANT SITE (51-58) AND LOCAL, TROCAR AND/OR REGIONAL RECURRENCE (10-15, 20-25, OR 30).
62	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN MULTIPLE SITES (RECURRENCES THAT CAN BE CODED TO MORE THAN ONE CATEGORY 51-59).
70	SINCE DIAGNOSIS, PATIENT HAS NEVER BEEN DISEASE-FREE. THIS INCLUDES CASES WITH DISTANT METASTASIS AT DIAGNOSIS, SYSTEMIC DISEASE, UNKNOWN PRIMARY, OR MINIMAL DISEASE THAT IS NOT TREATED.
88	DISEASE HAS RECURRED, BUT THE TYPE OF RECURRENCE IS UNKNOWN
99	IT IS UNKNOWN WHETHER THE DISEASE HAS RECURRED OR IF THE PATIENT WAS EVER DISEASE-FREE

NOTE: The Distant Recurrence Sites field has been removed and incorporated into the Type of First Recurrence field.

VII.2.13 Death Information

If the patient has died, enter the code for the state or country where the death occurred in the Place of Death field. (The code for California is 097. See Appendix C, Appendix D1, and Appendix D2 for other codes.) If the patient is still alive, enter 997. Hospitals are not required to complete the *Cause of Death* field or *DC (Death Certificate) File No*. field.

To report that a patient has died, make every attempt to find the month and year of death. Approximations are acceptable when all attempts to find the date of death have failed.

VII.2.14 Follow-Up Remarks

This section was software specific and deleted in 2008. The information entered here was not transmitted to the CCR.

VII.3 Contact Name/Address File

The Contact Name/Address File is for generating follow-up letters to the patient or designated contact(s). Space is provided for the name and address of the patient and up to five contacts for information about the patient. Enter names and addresses exactly as they are to appear in the heading of the letter, using capital and lower case letters, punctuation, and special characters like # for number. But in the Phone field, enter the area code and number without spaces, dashes, or other marks.

A supplemental field has been added which provides the ability to record additional address information such as the name of a place or facility (i.e., a nursing home or name of an apartment complex). This supplemental field is limited to 60 characters.

VII.3.1 Follow-Up Resources

This section was software specific and deleted in 2008.

VII.3.2 Contact

In the Contact #1 fields enter the following:

- The patient's name preceded by Mr., Mrs., Ms., or followed by Jr. or Sr. (up to ***60*** characters and spaces
- The current street address or post office box (up to ***60*** characters and spaces)
- The current city (up to ***50*** characters and spaces)

- The two character Postal Service abbreviation for the state (see Appendix B for abbreviations)
- The zip code (up to ten characters and spaces

If the patient is under 18, enter a parent's name and address.

Addresses in foreign countries may be entered, including foreign postal codes.

Entry of a telephone number is required for all patients alive at the time the case is abstracted. Include the area code.

If the telephone number changes at the time of follow-up, it needs to be changed in this field. If there is no phone, enter all 0's.

In the Patient Address Current--Supplemental field, record the place or facility (i.e., nursing home or name of an apartment complex) of the patient's current usual residence. If the patient has multiple tumors, the address may be different for subsequent primaries. Update this data item if a patient's address changes. This supplemental field is limited to ***60*** characters.

VII.3.3 Contacts #2 through #6

If available in the abstracting software, enter the names, addresses, and phone numbers of up to six people designated as contacts for the case.

A supplemental follow-up contact field has been added. This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex. It can be used to generate a follow-up inquiry, and must correspond to the other fields in the follow-up contact address. If the patient has multiple tumors, Follow-Up Contact--Suppl should be the same. This supplemental field is limited to ***60*** characters.

Part VIII. Remarks and Extra Hospital Information

VIII.1 Remarks and Final Diagnosis

Textual information that does not fit into its designated field can be recorded in the Remarks area. Indicate the name of the field being extended and enter the overflow information. Also record other pertinent information for which there is no designated field.

The last two lines of this section are available for recording the final cancer diagnosis (FDX) as determined by a recognized medical practitioner. This information is ideally found in the discharge summary or progress notes. Record the date of the notation and the final diagnosis, including stage if given. If there is no final diagnosis in the medical record, please state FDX: NR; do not leave this field blank.

VIII.1.1 Required Data Items

Certain required data must be recorded in the Remarks section:

Other tumors See Section II.2.5.

Race of patient, when coded as "Other" or if there is conflicting race information. See Section III.2.9.

Parent or guardian of a child whose case is being reported. (Information about the parent is also entered in the Contact #1 area. Section VII.3.2.

VIII.1.2 Confidential Remarks

January 1, 2009

This section was software specific and was removed at the conclusion of 2008.

VIII.1.3 More Remarks

January 1, 2009

This section was software specific and was removed at the conclusion of 2008.

VIII.2 Regional Data

Use of the Regional Data fields is determined by the regional registry, which designates the codes to be entered.

VIII.3 Extra Facility Information

The Extra Facility Information fields (also called User Data) are provided for the convenience of the reporting hospital, which determines how they are to be used. All the fields may be left blank. The information is not sent to the CCR.

VIII.4 Clinical Indicators

These fields have been added for use by hospitals. There is space to record up to 30 clinical indicators.

VIII.5 Tumor History

These fields are available for recording the tumor history of the patient for each tumor.

Part IX. Transmittal of Case Information and Quality Control

IX.1 Transmittal of Case Information

All cases must be transmitted electronically and must be encrypted and password protected.

The frequency of transmittals must be arranged between the reporting facility and the regional or central registry, but must be quarterly at least. For very large facilities, monthly or even weekly transmittals might be appropriate to allow a more even work flow for quality control at the regional or central registry.

IX.1.1 Timeliness

Submit all reports to the regional or central registry assigned to the reporting facility. Unless the regional or central registry requests an immediate report on a patient or patients, do not submit an abstract until all the required information has been entered, but no later than six months after admission of the patient.

IX.1.2 Corrections

If errors or omissions are discovered after an abstract has been transmitted, the corrections and the reason they were entered must be sent to the regional registry or central registry if any of the following fields is changed.

Accession Number

Address at Diagnosis - City

Address at Diagnosis - No. & Street

Address at Diagnosis - Supplemental

Address At Diagnosis - State

Address At Diagnosis - Zip Code

Address At Diagnosis City USPS

Alias First Name

Alias Last Name

Ambiguous Terminology Diagnosis

Behavior Code ICD-O-3

Birth Date

Birthplace

Casefinding Source

Chemotherapy at This Hospital

Chemotherapy Summary

Class of Case

Comorbidity/Complication 1

Comorbidity/Complication 2

Comorbidity/Complication 3

Comorbidity/Complication 4

Comorbidity/Complication 5

Comorbidity/Complication 6

Comorbidity/Complication 7

Comorbidity/Complication 8

Comorbidity/Complication 9

Comorbidity/Complication 10

County of Residence at Diagnosis

CS Tumor Size

CS Tumor Size/Extension Evaluation

CS Extension

CS Lymph Nodes

CS Lymph Node Evaluation

CS Metastasis at Diagnosis

CS Mets at Diagnosis Evaluation

CS Site Specific Factor 1

CS Site Specific Factor 2

CS Site Specific Factor 3

CS Site Specific Factor 4

CS Site Specific Factor 5

CS Site Specific Factor 6

CS Site Specific Factor 7

CS Site Specific Factor 8

CS Site Specific Factor 9

CS Site Specific Factor 10

CS Site Specific Factor 11

CS Site Specific Factor 12

CS Site Specific Factor 13

CS Site Specific Factor 14

CS Site Specific Factor 15

CS Site Specific Factor 16

CS Site Specific Factor 17

CS Site Specific Factor 18

CS Site Specific Factor 19

CS Site Specific Factor 20

CS Site Specific Factor 21

CS Site Specific Factor 22

CS Site Specific Factor 23

CS Site Specific Factor 24

CS Site Specific Factor 25

CS Tumor Size/Ext Evaluation

CS Reg Nodes Evaluation

Mets Evaluation

Date of Birth

Date of Brith Flag

Date of Chemotherapy

Date of Chemotherapy Flag

Date of Conclusive Diagnosis

Date of Conclusive Diagnosis Flag

Date of Diagnosis

Date of Ciagnosis Flag

Date of Diagnostic or Staging Procedures

Date of Diagnostic or Staging Procedures Flag

Date of First Admission

Date of First Contact

Date of First Contact Flag

Date of Hormone Therapy

Date of Hormone Therapy Flag

Date of Initial Therapy

Date of Initial Therapy Flag

Date of Immunotherapy

Date of Immunotherapy (BRM) Flag

Date of Inpatient Admission

Date of Inpatient Admission Flag

Date of Inpatient Discharge

Date of Inpatient Discharge Flag

Date of Most Definitive Surgery

Date of Most Definitive Surgery Flag

Date of Multiple Tumors

Date of Multiple Tumors Flag

Date of Other Therapy

Date of Other Therapy Flag

Date of Radiation Therapy

Date of Radiation Therapy Flag

Date of Surgery

Date of Surgery Flag

Date of Surgery - Procedure 1

Date of Surgery - Procedure 1 Flag

Date of Surgery - Procedure 2

Date of Surgery - Procedure 2 Flag

Date of Surgery - Procedure 3

Date of Surgery - Procedure 3 Flag

Date of Systemic Therapy

Date of Systemic Therapy Flag

Date of Transplant/Endocrine Procedures

Date of Transplant/Endocrine Procedures Flag

Derived AJCC T

Derived AJCC N

Derived AJCC M

Derived AJCC Stage Group

Derived SS2000

Derived SS1977

Diagnostic Confirmation

Diagnostic or Staging Procedures at This Hospital

Diagnostic or Staging Procedure Summary

Discovered by Screening

DxRx Report Facility (1-5)

DxRx Report Number (1-5)

DxRx Report Date (1-5)

DxRx Report Type (1-5)

Extent of Disease - Extension

Extent of Disease - Extension (Path)

Extent of Disease - Lymph Node Involvement

First Name

Grade Path System

Grade Path Value

Histology - Behavior - (ICD-O-2)

Histology - Type - (ICD-O-3)

Histology - Grade/Differentiation

Histology - Type - (ICD-O-2)

Hormone Therapy at This Hospital

Hormone Therapy Summary

Hospital Number (Reporting)

Hospital Referred From

Hospital Referred To

ICD Revision Comorbidities

Immunotherapy at This Hospital

Immunotherapy Summary

Industry - Text

Last Name

Laterality

Lymph-Vascular Invasion

Maiden Name

Marital Status

Mets at DX - Bone

Mets at DX - Brain

Mets at DX - Liver

Mets at DX - Lung

Medical Record Number

Middle Name

Mother's First Name

Multiple Tumors Reported as One Primary

Multiplicity Counter

Name Suffix

Number of Regional Lymph Nodes

NPI Hospital Referred From

NPI Hospital Referred To

NPI Following Registry

NPI Physician Managing

NPI Physician Follow-up

NPI Physician Primary Surgeon

NPI Physician Radiation Oncologist

NPI Physician Medical Oncologist

NPI Reporting Facility

Examined - Summary

Occupation - Text

Other Therapy at This Hospital

Other Therapy Summary

Path Reporting Facility ID (1-5)

Path Report Number (1-5)

Path Date Specimen Collected (1-5)

Path Report Type (1-5)

Pathology Report Number - Biopsy/FNA

Pathology Report Number - Surgery

Patient No Research Contact Flag

Payment Source (Primary & Secondary)

Payment Source Text (Primary)

Pediatric Stage

Pediatric Stage Coder

Pediatric Stage System

Physicians

Protocol Participation

Race 1

Race 2

Race 3

Race 4

Race 5

Radiation Summary

Radiation - Regional Rx Modality

Radiation - Boost Treatment Modality

Radiation - Location of RX

Radiation/Surgery Sequence

Reason No Radiation

Reason for No Surgery

Regional Data

Regional Nodes Examined (Number)

Regional Nodes Positive (Number)

Religion

Scope of Regional Lymph Node Surgery at This Hospital

Scope of Regional Lymph Node Surgery - Procedure 1

Scope of Regional Lymph Node Surgery - Procedure 2

Scope of Regional Lymph Node Surgery - Procedure 3

Scope of Regional Lymph Node Surgery - Summary

Scope of Regional Lymph Node Surgery 98-02

Sequence Number - Hospital

Sex

Site - Primary (ICD-O-2)

Social Security Number

Social Security Number Suffix

Spanish/Hispanic Origin

Summary Stage 1977

Summary Stage 2000

Surgical Procedure/Other Site at This Hospital

Surgical Procedure/Other Site - Procedure 1

Surgical Procedure/Other Site - Procedure 2

Surgical Procedure/Other Site - Procedure 3

Surgical Procedure/Other Site - Summary

Surgical Procedure/Other Site 98-02

Surgery of Primary Site at This Hospital

Surgery of the Primary Site - Procedure 1

Surgery of the Primary Site - Procedure 2

Surgery of the Primary Site - Procedure 3

Surgery of Primary Site - Summary

Surgery of Primary Site 98-02

Surgery Summary - Reconstructive

Systemic/Surgery Sequence

Text-Diagnostic Procedures - Physical Examination

Text-Diagnostic Procedures - X-ray

Text-Diagnostic Procedures - Scopes

Text-Diagnostic Procedures - Tests

Text-Diagnostic Procedures - Operative

Text-Diagnostic Procedures - Pathological

Text-Site

Text-Histology

Text-Staging

Text Rx-Surgery

Text Rx-Radiation (Beam)

Text Rx-Radiation (Other)

Text Rx-Chemotherapy

Text Rx-Hormone Therapy

Text Rx-Immunotherapy

Text Rx-Other Therapy

Text-Remarks

Text-Final Diagnosis

TNM Coder (Clinical)

TNM Coder (Path)

TNM Edition

TNM M Code (Clinical)

TNM M Code (Path)

TNM N Code (Clinical)

TNM N Code (Path)

TNM Stage (Clinical)

TNM Stage (Path)

TNM T Code (Clinical)

TNM T Code (Path)

Transplant/Endocrine Procedures at This Hospital

Transplant/Endocrine Procedures- Summary

Treatment Hospital Number - Procedure 1

Treatment Hospital Number - Procedure 2

Treatment Hospital Number - Procedure 3

Treatment Summary (RX Sum)

Tumor Marker 1

Tumor Marker 2

Tumor Marker 3

Tumor Marker-CA-1

Tumor Size

Type of Admission

Type of Reporting Source

Year First Seen

In the text field displayed on the screen, enter an explanation of why the changes are being made. If the only reason is that the regional registry notified the hospital of the change or correction, simply enter the word "REGION" (use capital letters), beginning in the first space of the first line in the field.

Example:

A case has been transmitted as an Primary Unknown (site code C80.9), Carcinoma, NOS (histology 8010/3), and Stage Unknown (code 9), based on a biopsy of the brain. Four months later, the patient dies and an autopsy reveals that, in fact, the cancer was an oat cell carcinoma of the right upper lobe of the lung that had

metastasized widely at diagnosis. Change the site code to C34.1, laterality to code 1, histology to 8042/3, and stage to Distant Metastases, code 7. When the request for the reason for the changes appears, enter a statement such as "Autopsy final DX: oat cell CA, RUL lung, mets to left lung, hilar and mediastinal lymph nodes, brain, and liver."

IX.1.3 Deletons

Delete any duplicate records if a case is found to have been abstracted and sent to the regional or central registry more than once.

Delete a previously reported case if subsequent evidence disproves the presence of cancer, or if what was thought to be a new primary cancer is later found to be a manifestation of an earlier primary cancer.

All deletions must be reported to the regional or central registry.

IX.2 Quality Control

The CCR and regional registries have procedures for assuring the quality of the data produced by the reporting system. Staff from both the regional registry and the CCR visit cancer reporting facilities to perform quality control audits. The CCR has established uniform standards of quality for facility data in three areas: completeness, accuracy, and timeliness.

IX.2.1 Completeness

Completeness, the extent to which all required cases have been reported, is assessed by a casefinding audit performed at the reporting facility and by the monitoring of death certificates. The minimum acceptable level of completeness for a reporting facility is 97 percent. See Part II, Reportable Neoplasms, for a discussion of which cases must be abstracted. Descriptions of the protocols and procedures for evaluating completeness are available from the CCR.

IX.2.2 Accuracy

Accuracy is the extent to which the data submitted match the information in the medical record and have been correctly coded. It encompasses accurate abstracting, correct application of coding rules, and correct entry into and retrieval from the computer.

Accuracy is evaluated using various methods:

- Visual editing
- Computer edits
- Reabstracting audits

The CCR's regional registries perform visual editing on a percentage of the abstracts submitted by hospital registries. Feedback is provided to hospitals on the results of visual editing.

A visual editing accuracy rate was established at 97% in January 2000. This rate applies to cancer reporting facilities and not to individual cancer registry abstractors. The reporting facility is responsible for cancer reporting requirements, not specific individuals; therefore, an accuracy rate reflects the facility's compliance with regulations. Please refer to the CCR web site at www.ccrcal.org for the current list of visually edited data items.

Non-analytic cases are included in the accuracy rate. The regions visually edit them, although not as extensively as the analytic cases. Review is limited to verifying that there is supporting documentation to validate the coded data fields.

Computer edits are also used to assess the quality of data submitted. The CCR provides a standard set of edits for abstracting software. These edits are performed on data at the time of abstracting. The measure used to evaluate accuracy is the percent of a facility's cases that fail an edit. CCR's cases must pass the interfield edits specified in Cancer Reporting in California: Data Standards for Regional Registries and California Cancer Registry (California Cancer Reporting System Standards, Volume III).

The CCR's edit set contains a number of edits that require review . After review and confirmation that the abstracted information is correct, a flag must be set so that repeated review is not necessary and a case can be set to complete. See Appendix T for a list of these over-rides. Please follow the instructions provided by your facility abstracting software vendor for using these flags.

Another method of assessing accuracy is to reabstract cases in the facilities. A sample of cases from each facility is reabstracted by specially trained personnel. The measure used is the number of discrepancies found in related categories of items.

IX.2.3 Timeliness

Timeliness involves how quickly the reporting facility submits a case to a regional registry or central registry after admission of the patient. Regional registries and the central registry monitor the timeliness of data submitted by facilities. The standard established by the CCR is that 97 percent of cases must be received by the regional registry or central registry within six months of admission and 100 percent must be received within 12 months of admission.

Although every effort should be made to complete cases before they are transmitted to the regional registry or central registry, it is recognized that some cancer cases undergo treatment later than six-months from the date of admission. If these or other cases are going to exceed the six-month due date, they must be transmitted without treatment data and this must be documented on the abstract. This treatment information must be submitted later in a correction record. These correction records should not be sent in any later than two months after the six-month deadline, or eight months after the date of admission. If these corrections

will be sent in later than eight months because treatment has not been completed, the region or central registry must be notified.

Appendices

Appendix A: Histology Codes for Lymphomas and Leukemias

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, please refer to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic Database.

January 1, 1998 and Forward

LEUKEMIA TERMS. *Effective for cases diagnosed January 1, 1998, and after.*

The following rules are to be used. They are in priority order:

1. Code the FAB (French-American-British) classification. FAB is implied if the description includes "L" or "M" with a number such as "L2" or M5". If more than one FAB classification is listed, use the NOS code. Example:

   Path: "Acute myelogenous leukemia, probably M1 or M2...."

   Code to 9861/3, Acute myeloid leukemia, NOS

2. If the diagnostic statement lists a specific acute leukemia cell type, code that term. If more than one term is listed, use rules in ICD-O-2.

In addition to these rules, the following information will assist in assigning codes:

- "Maturation" and "differentiation" are synonymous.
- Code "acute non-lymphocytic leukemia" as 9861/3, acute myelogenous leukemia, NOS.
- Code "acute biphenotypic leukemia" or "mixed lineage leukemias" to 9801/3, acute leukemia, NOS.
- Terms equivalent to granulocytic are: myeloblastic, myelocytic, myelogenous, myeloid, non-lymphocytic.
- Terms equivalent to lymphocytic are: lymphoblastic, lymphoid, lymphatic.

ICD-O Code	Term
9821/3	Acute lymphoblastic leukemia, L1 type (*) Acute lymphocytic leukemia, L1 type (*) Acute lymphoid leukemia, L1 type (*) Acute lymphatic leukemia, L1 type (*)

	Lymphoblastic leukemia, L1 type (*) FAB L1 (*)
9826/3	FAB L3 (*)
9828/3	Acute lymphoblastic leukemia, L2 type Acute lymphocytic leukemia, L2 type Acute lymphoid leukemia, L2 type Acute lymphatic leukemia, L2 type Lymphoblastic leukemia, L2 type FAB L2
9840/3	FAB M6 (*)
9861/3	Acute myeloid leukemia, NOS (*) Acute myeloblastic leukemia, NOS (*) Acute granulocytic leukemia, NOS (*) Acute myelogenous leukemia, NOS (*) Acute myelocytic leukemia, NOS (*)
9866/3	FAB M3 (*)
9867/3	Acute myelomonocytic leukemia, NOS (*) FAB M4 (*)
9871/3	Acute myelomonocytic leukemia with eosinophils FAB M4E
9872/3	Acute myeloid leukemia, minimal differentiation Acute myeloblastic leukemia, minimal differentiation Acute granulocytic leukemia, minimal differentiation Acute myelogenous leukemia, minimal differentiation Acute myelocytic leukemia, minimal differentiation FAB M0
9873/3	Acute myeloid leukemia without maturation Acute myeloblastic leukemia without maturation Acute granulocytic leukemia, without maturation Acute myelogenous leukemia, without maturation Acute myelocytic leukemia, without maturation FAB M1
9874/3	Acute myeloid leukemia with maturation Acute myeloblastic leukemia with maturation Acute granulocytic leukemia, with maturation Acute myelogenous leukemia, with maturation Acute myelocytic leukemia, with maturation FAB M2
9891/3	FAB M5 (*) FAB M5A (*) FAB M5B (*)
9910/3	Megakaryoblastic leukemia, NOS (C42.1) FAB M7

(*) New terms for existing numbers

January 1, 1998 and Forward

LYMPHOMA TERMS. *Effective for cases diagnosed January 1, 1995, and after.*

ICD-O Code	Term
9673/3	Mantle cell lymphoma (*)
9688/3	T-cell rich B-cell lymphoma
9708/3	Subcutaneous panniculitic T-cell lymphoma
9710/3	Marginal zone lymphoma, NOS
9714/3	Anaplastic large cell lymphoma (ALCL), CD30+ (*)
9715/3	Mucosal-Associated Lymphoid Tissue (MALT) lymphoma
9716/3	Hepatosplenic γδ (gamma - delta) cell lymphoma
9717/3	Intestinal T-cell lymphoma Enteropathy associated T-cell lymphoma

(*) New terms for existing numbers

Appendix B: Postal Abbreviations for States and Territories of the United States

The CCR has adopted official USPS abbreviations for coding of States and Possessions, Street Suffixes, and Secondary Unit Designations. Please refer to the USPS website.

AL	ALABAMA	NH	NEW HAMPSHIRE
AK	ALASKA	NJ	NEW JERSEY
AS	AMERICAN SAMOA	NM	NEW MEXICO
AZ	ARIZONA	NY	NEW YORK
AR	ARKANSAS	NC	NORTH CAROLINA
CA	CALIFORNIA	ND	NORTH DAKOTA
CO	COLORADO	MP	NORTHERN MARIANA ISLANDS
CT	CONNECTICUT	OH	OHIO
DE	DELAWARE	OK	OKLAHOMA
DC	DISTRICT OF COLUMBIA	OR	OREGON

FL	FLORIDA	PW	PALAU
GA	GEORGIA	PA	PENNSYLVANIA
GU	GUAM	PR	PUERTO RICO
HI	HAWAII	RI	RHODE ISLAND
ID	IDAHO	SC	SOUTH CAROLINA
IL	ILLINOIS	SD	SOUTH DAKOTA
IN	INDIANA	TN	TENNESSEE
IA	IOWA	TX	TEXAS
KS	KANSAS	TT	TRUST TERRITORIES
KY	KENTUCKY	UM	US MINOR OUTLYING ISLANDS
LA	LOUISIANA	US	RESIDENT OF UNITED STATES, NOS
ME	MAINE	UT	UTAH
MD	MARYLAND	VT	VERMONT
MH	MARSHALL ISLANDS	VA	VIRGINIA
MA	MASSACHUSETTS	VI	VIRGIN ISLANDS
MI	MICHIGAN	DC	WASHINGTON, DISTRICT OF
FM	MICRONESIA, FEDERATED STATE OF	WA	WASHINGTON, STATE OF
MN	MINNESOTA	WV	WEST VIRGINIA
MS	MISSISSIPPI	WI	WISCONSIN
MO	MISSOURI	WY	WYOMING
MT	MONTANA	XX	NOT U.S., U.S. TERRITORY, NOT CANADA, AND COUNTRY IS KNOWN
NE	NEBRASKA	YY	NOT U.S., U.S. TERRITORY, NOT CANADA, AND COUNTRY IS UNKNOWN
NV	NEVADA	ZZ	RESIDENCE IS UNKNOWN

UNITED STATES MILITARY PERSONNEL SERVING ABROAD

AA	American Territories-US Military abroad
AE	Europe-US Military abroad
AP	Pacific-US Military abroad

CANADIAN PROVINCE/ TERRITORY

AB	ALBERTA	NS	NOVA SCOTIA
BC	BRITISH COLUMBIA	NU	NUNAVUT
CD	CANADA, NOS	ON	ONTARIO
MB	MANITOBA	PE	PRINCE EDWARD ISLAND
NB	NEW BRUNSWICK	QB	QUEBEC
NL	NEWFOUNDLAND AND LABRADOR	SK	SASKATCHEWAN
NT	NORTHWEST TERRITORIES	YT	YUKON TERRITORIES

Appendix C: Codes for States and Territoris of the United States and Provinces and Territories of Canada

US States/Territories

ALABAMA	037
ALASKA	091
AMERICAN SAMOA	121
ARIZONA	087
ARKANSAS	071
CALIFORNIA	097
COLORADO	083
CONNECTICUT	007
DELAWARE	017
DISTRICT OF COLUMBIA	022
FLORIDA	035
GEORGIA	033
GUAM	126

HAWAII	099
IDAHO	081
ILLINOIS	061
INDIANA	045
IOWA	053
KANSAS	065
KENTUCKY	047
LOUISIANA	073
MAINE	002
MARSHALL ISLANDS	131
MARYLAND	021
MASSACHUSETTS	005
MICRONESIA, FEDERATED STATES OF	123
MICHIGAN	041
MINNESOTA	052
MISSISSIPPI	039
MISSOURI	063
MONTANA	056
NEBRASKA	067
NEVADA	085
NEW HAMPSHIRE	003
NEW JERSEY	008
NEW MEXICO	086
NEW YORK	011
NORTH CAROLINA	025
NORTH DAKOTA	054
NORTHERN MARIANA ISLANDS	129
OHIO	043
OKLAHOMA	075
OREGON	095
PALAU	139
PENNSYLVANIA	014
PUERTO RICO	101

RHODE ISLAND	006
SOUTH CAROLINA	026
SOUTH DAKOTA	055
TENNESSEE	031
TEXAS	077
UTAH	084
VERMONT	004
VIRGINIA	023
VIRGIN ISLANDS	102
WASHINGTON, DISTRICT OF	022
WASHINGTON, STATE OF	093
WEST VIRGINIA	024
WISCONSIN	051
WYOMING	082
U.S.A., STATE UNKNOWN	000

Canadian Province / Territory

ALBERTA	224
BRITISH COLUMBIA	226
CANADA, NOS	220
MANITOBA	224
NEW BRUNSWICK	221
NEWFOUNDLAND AND LABRADOR	221
NORTHWEST TERRITORIES	225
NOVA SCOTIA	221
NUNAVUT	227
ONTARIO	223
PRINCE EDWARD ISLAND	221
QUEBEC	222
SASKATCHEWAN	224
YUKON TERRITORIES	225

Appendix D.1: Codes for Countries (Alpha)

In alphabetical order.

You can also view the codes in

Includes codes for U.S. states and territories.

ABYSSINIA	585
ADEN	629
AFARS/ISSAS	583
AFGHANISTAN	638
AFRICA, NOS	500
AFRICA-CENTRAL (OTHER WEST)	539
AFRICA-SUDANESE COUNTRIES	520
AFRICAN COASTAL ISLANDS	580
ALABAMA	037
ALASKA	091
ALBANIA	481
ALBERTA	224
ALGERIA	513
AMERICA, NORTH	260
AMERICAN SAMOA	121
ANATOLIA	611
ANDAMAN ISLANDS	641
ANDORRA	443
ANGOLA	543
ANGUILLA	245
ANNAM	665
ANTARCTICA	750
ANTIGUA	245
ANTILLES	245
ARABIA	629

ARABIAN PENINSULA	629
ARGENTINA	365
ARIZONA	087
ARKANSAS	071
ARMENIA	633
ARMENIA TURKISH	611
ARUBA	245
ASIA MINOR, NOS	610
ASIA, NOS	600
ASIA-ARAB COUNTRIES, NOS	620
ASIA-EAST, NOS	680
ASIA-MID-EAST, NOS	640
ASIA-NEAR EAST, NOS	610
ASIA-SOUTHEAST, NOS	650
ASIAN REPUBLICS OF FORMER USSR	634
ATLAN/CARIB US OTHER	109
ATLANTIC/CARIBBEAN AREA, U.S. POSSESSIONS	100
AUSTRALIA/AUST NEW GUINEA	711
AUSTRIA	436
AZERBAIDZHAN SSR	633
AZERBAIJAN	633
AZORES	445
BAHAMAS	247
BAHRAIN	629
BALEARIC ISL	443
BALTIC REPUBLIC, NOS	463
BALTIC STATES, NOS	463
BANGLADESH	645
BARBADOS	245

BARBUDA 245
BASUTOLAND 545
BAVARIA 431
BECHUANALAND 545
BELARUS 457
BELGIUM 433
BELIZE 252
BENIN 539
BERMUDA 246
BESSARABIA 456
BHUTAN 643
BIOKO 539
BOHEMIA 452
BOLIVIA 355
BOPHUTHATSWANA 545
BORNEO 673
BOSNIA-HERZOGOVINA 453
BOTSWANA 545
BRAZIL 341
BRITISH COLUMBIA 226
BRITISH GUIANA 331
BRITISH HONDURAS 252
BRUNEI 671
BULGARIA 454
BURKINA FASO 520
BURMA 649
BURUNDI 579
BYELORUSSIA 457
CABINDA 543
CAICOS ISLANDS 245

CALIFORNIA	097
CAMBODIA	663
CAMEROON	539
CANADA, NOS	220
CANADA-MARITIME PROVINCE	221
CANADA-NUNAVUT	227
CANADA-NW TERR/YUKON	225
CANADA-PRAIRIE PROVIINCE	224
CANAL ZONE	110
CANARY ISL	443
CANTON/ENDERBURY ISL	122
CAPE COLONY	545
CAPE VERDE ISL	445
CARIBBEAN ISL NEC	245
CARIBBEAN, NOS	245
CAROLINE ISL (MICRONESA, FEDERATED STATES OF)	123
CARTIER ISLANDS	711
CAUCASIAN REPUBLICS OF FORMER USSR	633
CAYMAN ISLANDS	245
CENTRAL AFRICA, NOS	500
CENTRAL AFRICAN REPUBLIC	539
CENTRAL AMERICA, NOS	250
CEYLON	647
CHAD	520
CHANNEL ISL	401
CHILE	361
CHINA, NOS	681
CHINA, PEOPLE'S REPUBLIC	682
CHINA, REPUBLIC OF	684

CHRISTMAS ISLAND	723
CISKEL	545
COCHIN CHINA	665
COCOS ISLANDS	711
COLOMBIA	311
COLORADO	083
COMOROS	580
CONGO BELGIAN	541
CONGO BRAZZAVILLE	539
CONGO FRENCH	539
CONGO LEOPOLDVILLE	541
CONNECTICUT	007
COOK ISL (NEW ZEALAND)	124
CORSICA	441
COSTA RICA	256
COTE D'IVOIRE	539
CRETE	471
CROATIA	453
CUBA	241
CURACAO	245
CYPRUS	495
CYRENAICA	517
CZECH REPUBLIC	452
CZECHOSLOVAKIA	452
DAHOMEY	539
DALMATIA	453
DELAWARE	017
DENMARK	425
DJIBOUTI	583
DOBRUJA	449

DOMINICA	245
DOMINICAN REPUBLIC	243
DUTCH EAST INDIES	673
DUTCH GUIANA	332
EAST AFRICA, NOS	570
EAST GERMANY	431
ECUADOR	345
EGYPT	519
EIRE	410
EL SALVADOR	254
ELLICE ISL	125
ENDERBURY ISL	122
ENGLAND	401
EQUATORIAL AFRICA	500
EQUATORIAL GUINEA	539
ERITREA	585
ESTONIA	458
ESTONIAN S.S.R.	458
ETHIOPIA	585
EUROPE, NOS	499
EUROPE-CENTRAL, NOS	499
EUROPE-EASTERN, NOS	499
EUROPE-GERMANIC, NOS	430
EUROPE-MEDITER ILS NEC	490
EUROPE-OTHER MAINLAND, NOS	470
EUROPE-ROMANCE LANG, NOS	440
EUROPE-SLAVIC, NOS	450
FALKLAND ISLANDS	381
FAROE ISLANDS	425
FERNANDO PO	539

FIJI	721
FINLAND	429
FLORIDA	035
FORMOSA	684
FOTUNA	721
FRANCE/MONACO	441
FREE STATE	545
FRENCH GUIANA	333
FUTUNA ISLANDS	721
GABON	539
GALAPAGOS ISLANDS	345
GAMBIA	539
GAZA STRIP	631
GEORGIA	033
GEORGIA (USSR)	633
GERMAN DEMOCRATIC REPUBLIC	431
GERMANIC COUNTRIES	430
GERMANY	431
GERMANY, EAST	431
GERMANY, FEDERAL REPUBLIC OF	431
GERMANY, WEST	431
GHANA	539
GIBRALTAR	485
GILBERT ISLANDS	122
GREAT BRITAIN, NOS	400
GREECE	471
GREENLAND	210
GRENADA	245
GRENADINES	245

GUADALOUPE	245
GUAM	126
GUATAMALA	251
GUERNSEY	401
GUIANA BRITISH	331
GUIANA DUTCH	332
GUIANA FRENCH	333
GUINEA	539
GUINEA PORTUGUESE	539
GUINEA-BISSAU	539
GUYANA	331
HAITI	242
HAWAII	099
HOLLAND	432
HONDURAS	253
HONG KONG	683
HUNGARY	475
ICELAND	421
IDAHO	081
ILLINOIS	061
INDIA	641
INDIANA	045
INDO-CHINA, NOS	660
INDONESIA	673
IOWA	053
IRAN	637
IRAQ	627
IRAQ-SAUDI ARABIAN NEUTRAL ZONE	620
IRELAND	410
ISLE OF MAN	401

ISRAEL	631
ISSAS	583
ITALY/SAN MARINO	447
IVORY COAST (COTE D'IVOIRE)	539
JAMAICA	244
JAN MAYEN	423
JAPAN	693
JAVA	673
JERSEY	401
JOHNSTON ATOLL	127
JORDAN	625
KAMEROON	539
KAMPUCHEA	663
KANSAS	065
KAZAKH SSR	634
KAZAKHSTAN	634
KENTUCKY	047
KENYA	575
KIRGHIZ SSR	634
KIRIBATI	122
KOREA	695
KOREA, NORTH	695
KOREA, SOUTH	695
KUWAIT	629
KYRGYSTAN	634
KYRGYZ	634
LABRADOR	221
LAOS	661
LAPLAND, NOS	420
LATIN AMERICA, NOS	265

LATVIA	459
LATVIAN S.S.R.	459
LEBANON	623
LEEWARD ISL	245
LESOTHO	545
LIBERIA	539
LIBYA	517
LIECHTENSTEIN	437
LINE ISL SOUTHERN	122
LITHUANIA	461
LITHUANIAN S.S.R.	461
LOUISIANA	073
LUXEMBOURG	434
MACAO	686
MACAU	686
MACEDONIA	453
MADAGASCAR	555
MADEIRA ISL	445
MAINE	002
MALAGASY REPUBLIC	555
MALAWI	551
MALAY PENINSULA	671
MALAYSIA/SINGAPORE/BRUNEI	671
MALDIVES	640
MALI	520
MALTA	491
MANITOBA	224
MARSHALL ISL	131
MARTINIQUE	245
MARYLAND	021

MASSACHUSETTS	005
MAURITANIA	520
MAURITIUS	580
MAYOTTE	580
MEDITERRANEAN ISLANDS, OTHER	490
MELANESIA (MELANESIAN ISL)	721
MESOPOTAMIA	610
MEXICO	230
MICHIGAN	041
MICRONESIA	723
MICRONESIAN ISL	723
MIDWAY ISL	132
MINNESOTA	052
MIQUELON	249
MISSISSIPPI	039
MISSOURI	063
MOLDAVIA	456
MOLDAVIAN S.S.R.	456
MOLDOVA	456
MONACO	441
MONGOLIA	691
MONTANA	056
MONTENEGRO	453
MONTSERRAT	245
MORAVIA	452
MOROCCO	511
MOZAMBIQUE	553
MYANMAR	649
NAMIBIA	545
NAMPO SHOTO SOUTHERN	133

NATAL	545
NAURU	723
NEBRASKA	067
NEPAL/BHUTAN/SIKKIM	643
NETHERLANDS	432
NETHERLANDS ANTILLES	245
NEVADA	085
NEVIS	245
NEW BRUNSWICK	221
NEW CALEDONIA	725
NEW ENGLAND	001
NEW GUINEA AUSTRALIAN	711
NEW GUINEA NORTHEAST	711
NEW GUINEA PAPUA	711
NEW GUINEA, NOS	673
NEW HAMPSHIRE	003
NEW HEBRIDES	721
NEW JERSEY	008
NEW MEXICO	086
NEW YORK	011
NEW ZEALAND	715
NEWFOUNDLAND	221
NICARAGUA	255
NIGER	520
NIGERIA	531
NIUE	715
NORFOLK ISLANDS	711
NORTH AFRICA, NOS	510
NORTH AMERICA	260
NORTH AMERICAN ISL, NOS	240

NORTH CAROLINA	025
NORTH DAKOTA	054
NORTHERN IRELAND	404
NORTHWEST TERRITORY	225
NORWAY	423
NOT US, NOS	998
NOVA SCOTIA	221
NYASALAND	551
OCEANA, NOS	720
OHIO	043
OKINAWA	693
OKLAHOMA	075
OMAN AND MUSCAT	629
ONTARIO	223
ORANGE FREE STATE	545
OREGON	095
ORKNEY ISLANDS	403
PACIFIC ISL, NOS	720
PACIFIC ISLANDS, TRUST TERRITORY	123
PAKISTAN EAST	645
PAKISTAN WEST	639
PAKISTAN, NOS	639
PALAU	139
PALESTINE ARAB	625
PALESTINE JEWISH	631
PALESTINIAN NATIONAL AUTHORITY-PNA	631
PANAMA	257
PAPUA	711
PARAGUAY	371

PENNSYLVANIA	014
PERSIA	637
PERSIAN GULF STATES, NOS	629
PERU	351
PHILIPPINES	675
PHOENIX ISLANDS	122
PITCAIRN	725
POLAND	451
POLYNESIA	725
POLYNESIA, NOS	720
POLYNESIAN ISL	725
PORTUGAL	445
PORTUGUESE GUINEA	539
PRINCE EDWARD ISL	221
PRINCIPE	543
PUERTO RICO	101
QATAR	629
QUATAR	629
QUEBEC	222
REPUBLIC OF CHINA	684
REPUBLIC OF IRELAND	410
REPUBLIC OF SOUTH AFRICA	545
REUNION	580
RHODE ISLAND	006
RHODESIA	547
RHODESIA NORTHERN	549
RHODESIA SOUTHERN	547
RIO MUNI	539
ROMANIA	449
RUANDA	577

RUMANIA	449
RUSSIA, NOS	455
RUSSIAN FEDERATION (FORMER U.S.S.R.)	455
RUSSIAN S.F.S.R.	455
RWANDA	577
RYUKYU ISL (JAPAN)	134
SAHARA	520
SAMOA AMERICAN	121
SAMOA, WESTERN	725
SAN MARINO	447
SAO TOME	543
SARDINIA	447
SASKATCHEWAN	224
SAUDI ARABIA	629
SCANDANAVIA NOS	420
SCOTLAND	403
SENEGAL	539
SERBIA	453
SEYCHELLES	580
SHETLAND ISLANDS	403
SIAM	651
SICILY	447
SIERRA LEONE	539
SIKKIM	643
SINGAPORE	671
SLAVIC COUNTRIES	450
SLAVONIA	453
SLOVAK REPUBLIC	452
SLOVAKIA	452
SLOVENIA	453

SOLOMON ISLANDS	721
SOMALI REPUBLIC	581
SOMALIA	581
SOMALILAND FRENCH	583
SOMALILAND, NOS	581
SOUTH AFRICA, NOS	540
SOUTH AMERICA, NOS	300
SOUTH AMERICAN ISLANDS	380
SOUTH CAROLINA	026
SOUTH DAKOTA	055
SOUTH WEST AFRICA	545
SOUTHERN EUROPE, NOS	499
SOUTHERN LINE ISLANDS	122
SPAIN/ANDORRA	443
SPANISH SAHARA	520
SRI LANKA	647
ST. CHRISTOPHER-NEVIS	245
ST. HELENA	580
ST. KITTS	245
ST. LUCIA	249
ST. PIERRE	249
ST. VINCENT	245
SUDAN	520
SUMATRA	673
SURINAM	332
SVALBARD	423
SWAN ISL	135
SWAZILAND	545
SWEDEN	427
SWITZERLAND	435

SYRIA	621
TADZHIK SSR	634
TAIWAN	684
TAJIKISTAN	634
TANGANYIKA	571
TANZANIA	571
TANZANYIKA	571
TENNESSEE	031
TEXAS	077
THAILAND	651
TIBET	685
TOBAGO	245
TOGO	539
TOKELAU ISL (NEW ZEALAND)	136
TONGA	725
TONKIN	665
TRANS-JORDAN	625
TRANSKEI	545
TRANSVAAL	545
TRANSYLVANIA	449
TRINIDAD	245
TRIPOLI	517
TRIPOLITANIA	517
TRUCIAL STATES	629
TUNISIA	515
TURKEY	611
TURKMEN SSR	634
TURKMENISTAN	634
TURKS ISLANDS	245
TUVALU ISLANDS	125

UGANDA	573
UKRAINE/MOLDAVIA	456
UKRANIAN S.S.R.	456
ULSTER	404
UNION OF SOUTH AFRICA	545
UNITED ARAB EMIRATES	629
UNITED ARAB REPUBLIC	519
UNITED KINGDOM, NOS	400
UNITED STATES, NOS	000
UNKNOWN	999
UPPER VOLTA	520
URUGUAY	375
URUNDI	579
US POSS-ATL/CARIB, NOS	100
US POSS-PACIFIC	120
US, NOS	000
US-CENTRAL MIDWEST, NOS	060
US-MOUNTAIN STATES, NOS	080
US-NEW ENGLAND, NOS	001
US-NORTH ATLANTIC, NOS	010
US-NORTH CENTRAL, NOS	040
US-NORTH MIDWEST, NOS	050
US-PACIFIC STATES, NOS	090
US-SOUTH MID ATLANTIC, NOS	020
US-SOUTH MIDWEST, NOS	070
US-SOUTHEASTERN, NOS	030
USSR, NOS	455
UTAH	084
UZBECK SSR	634
UZBEKISTAN	634

VANUATU	721
VATICAN CITY	447
VENDA	545
VENEZUELA	321
VERMONT	004
VIET NAM	665
VIETNAM	665
VIRGIN ISL - US	102
VIRGIN ISLANDS, BRITISH	245
VIRGINIA	023
WAKE ISLAND	137
WALES	402
WALLACHIA	449
WALLIS ISLANDS	721
WASHINGTON	093
WASHINGTON DC	022
WEST AFRICA, FRENCH	530
WEST AFRICAN COUNTRIES, OTHER	539
WEST BANK	631
WEST GERMANY	431
WEST INDIES	245
WEST INDIES, NOS	245
WEST VIRGINIA	024
WESTERN SAHARA	520
WESTERN SAMOA	725
WHITE RUSSIA	457
WINDWARD ISLANDS	245
WISCONSIN	051
WYOMING	082
YEMEN	629

YEMEN, PEOPLE'S DEMOCRATIC REPUBLIC	629
YEMEN, SOUTHERN	629
YUGOSLAVIA	453
YUKON	225
ZAIRE	541
ZAMBIA	549
ZANZIBAR	571
ZIMBABWE	547

Appendix D.2: Codes for Countries (Numeric)

In numerical order.

You can also view codes in alphabetical order.

Includes codes for U.S. states and territories.

000	UNITED STATES, NOS
000	US NOS
001	NEW ENGLAND
001	US-NEW ENGLAND, NOS
002	MAINE
003	NEW HAMPSHIRE
004	VERMONT
005	MASSACHUSETTS
006	RHODE ISLAND
007	CONNECTICUT
008	NEW JERSEY
010	US-NORTH ATLANTIC, NOS
011	NEW YORK
014	PENNSYLVANIA

017	DELAWARE
020	US-SOUTH MID ATLANTIC, NOS
021	MARYLAND
022	WASHINGTON DC
023	VIRGINIA
024	WEST VIRGINIA
025	NORTH CAROLINA
026	SOUTH CAROLINA
030	US-SOUTHEASTERN, NOS
031	TENNESSEE
033	GEORGIA
035	FLORIDA
037	ALABAMA
039	MISSISSIPPI
040	US-NORTH CENTRAL, NOS
041	MICHIGAN
043	OHIO
045	INDIANA
047	KENTUCKY
050	US-NORTH MIDWEST, NOS
051	WISCONSIN
052	MINNESOTA
053	IOWA
054	NORTH DAKOTA
055	SOUTH DAKOTA
056	MONTANA
060	US-CENTRAL MIDWEST, NOS
061	ILLINOIS

063	MISSOURI
065	KANSAS
067	NEBRASKA
070	US-SOUTH MIDWEST, NOS
071	ARKANSAS
073	LOUISIANA
075	OKLAHOMA
077	TEXAS
080	US-MOUNTAIN STATES, NOS
081	IDAHO
082	WYOMING
083	COLORADO
084	UTAH
085	NEVADA
086	NEW MEXICO
087	ARIZONA
090	US-PACIFIC STATES, NOS
091	ALASKA
093	WASHINGTON
095	OREGON
097	CALIFORNIA
099	HAWAII
100	US POSS-ATL/CARIB, NOS
101	PUERTO RICO
102	VIRGIN ISL - US
109	ATLAN/CARIB US OTHER
110	CANAL ZONE
120	US POSS-PACIFIC

121	AMERICAN SAMOA
121	SAMOA AMERICAN
122	CANTON/ENDERBURY ISL
122	ENDERBURY ISL
122	GILBERT ISLANDS
122	LINE ISLANDS, SOUTHERN
122	PHOENIX ISLANDS
122	SOUTHERN LINE ISLANDS
123	CAROLINE ISL, MICRONESIA (FEDERAL STATES OF)
124	COOK ISLAND (NEW ZEALAND)
125	TUVALU (ELLICE ISLANDS)
126	GUAM
127	JOHNSTON ATOLL
129	MARIANA ISL
131	MARSHALL ISL
132	MIDWAY ISL
133	NAMPO SHOTO SOUTHERN
134	RYUKYU ISLAND (JAPAN)
135	SWAN ISL
136	TOKELAU ISLAND (NEW ZEALAND)
137	WAKE ISLAND
139	PALAU
200	WESTERN HEMISPHERE, NOS
210	GREENLAND
220	CANADA, NOS
221	CANADA-MARITIME PROVINCE
221	LABRADOR
221	NEW BRUNSWICK

221	NEWFOUNDLAND
221	NOVA SCOTIA
221	PRINCE EDWARD ISL
222	QUEBEC
223	ONTARIO
224	ALBERTA
224	CANADA-PRAIRIE PROVINCE
224	MANITOBA
224	SASKATCHEWAN
225	CANADA-NW TERR/YUKON
225	NORTHWEST TERRITORY
225	YUKON
226	BRITISH COLUMBIA
227	CANADA- NUNAVUT
230	MEXICO
240	NORTH AMERICAN ISL, NOS
241	CUBA
242	HAITI
243	DOMINICAN REPUBLIC
244	JAMAICA
245	ANGUILLA
245	ANTIGUA
245	ANTILLES
245	ARUBA
245	BARBADOS
245	BARBUDA
245	CAICOS ISLANDS
245	CARIBBEAN ISL NEC

245	CAYMAN ISLANDS
245	CURACAO
245	DOMINICA
245	GRENADINES
245	GRENADA
245	GUADALOUPE
245	LEEWARD ISLANDS
245	MARTINIQUE
245	MONTSERRAT
245	NETHERLANDS ANTILLES
245	ST. CHRISTOPHER-NEVIS
245	ST. KITTS
245	ST. LUCIA
245	ST. VINCENT
245	TOBAGO
245	TRINIDAD
245	TURKS ISLANDS
245	VIRGIN ISLANDS, BRITISH
245	WEST INDIES, BRITISH
245	WEST INDIES, NOS
245	WINDWARD ISLANDS
246	BERMUDA
247	BAHAMAS
249	ST. PIERRE AND MIQUELON
250	CENTRAL AMERICA, NOS
251	GUATAMALA
252	BELIZE
252	BRITISH HONDURAS

253	HONDURAS
254	EL SALVADOR
255	NICARAGUA
256	COSTA RICA
257	PANAMA
260	AMERICA, NORTH
260	NORTH AMERICA, NOS
265	LATIN AMERICA, NOS
300	SOUTH AMERICA, NOS
311	COLOMBIA
321	VENEZUELA
331	BRITISH GUIANA
331	GUIANA BRITISH
331	GUYANA
332	DUTCH GUIANA
332	GUIANA DUTCH
332	SURINAM
333	FRENCH GUIANA
333	GUIANA FRENCH
341	BRAZIL
345	ECUADOR
345	GALAPAGOS ISLANDS
351	PERU
355	BOLIVIA
361	CHILE
365	ARGENTINA
371	PARAGUAY
375	URUGUAY

380	SOUTH AMERICAN ISLANDS
381	FALKLAND ISLANDS
400	GREAT BRITAIN, NOS
400	UNITED KINGDOM, NOS
401	CHANNEL ISL
401	ENGLAND
401	GUERNSEY
401	ISLE OF MAN
401	JERSEY
402	WALES
403	ORKNEY ISLANDS
403	SCOTLAND
403	SHETLAND ISLANDS
404	NORTHERN IRELAND
404	ULSTER
410	EIRE
410	IRELAND
410	REPUBLIC OF IRELAND
420	LAPLAND, NOS
420	SCANDANAVIA, NOS
421	ICELAND
423	JAN MAYEN
423	NORWAY
423	SVALBARD
425	DENMARK
425	FAROE ISLANDS
427	SWEDEN
429	FINLAND

430	EUROPE-GERMANIC, NOS
431	BAVARIA
431	GERMANY
432	HOLLAND
432	NETHERLANDS
433	BELGIUM
434	LUXEMBOURG
435	SWITZERLAND
436	AUSTRIA
437	LIECHTENSTEIN
440	EUROPE-ROMANCE LANG, NOS
441	CORSICA
441	FRANCE/MONACO
441	MONACO
443	ANDORRA
443	BALEARIC ISL
443	CANARY ISL
443	SPAIN/ANDORRA
445	AZORES
445	CAPE VERDE ISL
445	MADEIRA ISL
445	PORTUGAL
447	ITALY/SAN MARINO
447	SAN MARINO
447	SARDINIA
447	SICILY
447	VATICAN CITY
449	DOBRUJA

449	MOLDAVIA RUMANIA
449	ROMANIA
449	RUMANIA
449	TRANSYLVANIA
449	WALLACHIA
450	EUROPE-SLAVIC, NOS
451	POLAND
452	BOHEMIA
452	CZECH REPUBLIC
452	CZECHOSLOVAKIA
452	MORAVIA
452	SLOVAKIA
452	SLOVAK REPUBLIC
453	BOSNIA-HERZOGOVINA
453	CROATIA
453	DALMATIA
453	MACEDONIA
453	MONTENEGRO
453	SERBIA
453	SLAVONIA
453	SLOVENIA
453	YUGOSLAVIA (FORMER)
454	BULGARIA
455	RUSSIA, NOS (RUSSIAN S.F.S.R.)
455	RUSSIAN FEDERATION (FORMER) U.S.S.R
455	RUSSIA
455	USSR, NOS
456	BESSARABIA

456	MOLDAVIA
456	MOLDAVIAN SSR
456	UKRAINE/MOLDOVA
456	UKRANIAN SSR
457	BELARUS
457	BYELORUSSIA
457	WHITE RUSSIA
458	ESTONIA (ESTONIAN SSR)
459	LATVIA (LATVIAN SSR)
461	LITHUANIA (LITHUANIAN SSR)
463	BALTIC REPUBLIC(S), NOS
470	EUROPE-OTHER MAINLAND, NOS
471	CRETE
471	GREECE
475	HUNGARY
481	ALBANIA
485	GIBRALTAR
490	EUROPE-MEDITER ILS NEC
491	MALTA
495	CYPRUS
499	CENTRAL EUROPE, NOS
499	EASTERN EUROPE, NOS
499	EUROPE, NOS
499	NORTHERN EUROPE, NOS
499	SOUTHERN EUROPE, NOS
499	WESTERN EUROPE, NOS
500	EQUATORIAL AFRICA, NOS
500	AFRICA, NOS

500	CENTRAL AFRICA, NOS
510	NORTH AFRICA NOS
511	MOROCCO
513	ALGERIA
515	TUNISIA
517	CYRENAICA
517	LIBYA
517	TRIPOLITANIA
517	TRIPOLI
519	EGYPT
519	UNITED ARAB REPUBLIC
520	AFRICA-SUDANESE COUNTRIES
520	BURKINA FASO (UPPER VOLTA)
520	CHAD
520	MALI
520	MAURITANIA
520	NIGER
520	SAHARA
520	SUDAN
520	WESTERN (SPANISH) SAHARA
530	FRENCH WEST AFRICA, NOS
530	WEST AFRICA
531	NIGERIA
539	AFRICA-CENTRAL (OTHER WEST)
539	BENIN
539	CAMEROON
539	CENTRAL AFRICAN REPUBLIC
539	CONGO

539	CONGO FRENCH
539	CONGO BRAZZAVILLE
539	COTE D'IVOIRE (IVORY COAST)
539	DAHOMEY
539	EQUATORIAL GUINEA
539	FERNANDO PO
539	GABON
539	GAMBIA
539	GHANA
539	GUIANA BISSAU
539	GUIANA PORTUGUESE
539	GUINEA
539	KAMEROON
539	LIBERIA
539	PORTUGUESE GUINEA
539	RIO MUNI
539	SENEGAL
539	SIERRA LEONE
539	TOGO
540	SOUTH AFRICA, NOS
541	CONGO BELGIAN
541	CONGO LEOPOLDVILLE
541	CONGO/KINSHASA
541	ZAIRE
543	ANGOLA
543	CABINDA
543	PRINCIPE
543	SAO TOME

545	BASUTOLAND
545	BECHUANALAND
545	BOPHUTHATSWANA
545	BOTSWANA
545	CAPE COLONY
545	CISKEL
545	FREE STATE (ORANGE FREE STATE)
545	LESOTHO
545	NAMIBIA
545	NATAL
545	REPUBLIC OF SOUTH AFRICA
545	SOUTH WEST AFRICA
545	SWAZILAND
545	TRANSKEI
545	TRANSVAAL
545	UNION OF SOUTH AFRICA
545	VENDA
547	RHODESIA SOUTHERN
547	RHODESIA
547	ZIMBABWE
549	RHODESIA NORTHERN
549	ZAMBIA
551	MALAWI
551	NYASALAND
553	MOZAMBIQUE
555	MADAGASCAR
555	MALAGASY REPUBLIC
570	EAST AFRICA, NOS

571	TANGANYIKA
571	TANZANIA
571	TANZANYIKA
571	ZANZIBAR
573	UGANDA
575	KENYA
577	RUANDA
577	RWANDA
579	BURUNDI
579	URUNDI
580	AFRICAN COASTAL ISLANDS
580	COMOROS
580	MAURITIUS
580	MAYOTTE
580	REUNION
580	SEYCHELLES
580	ST. HELENA
581	SOMALIA
581	SOMALILAND, NOS
581	SOMALI REPUBLIC
583	AFARS/ISSAS
583	DJIBOUTI
583	ISSAS
583	SOMALILAND FRENCH
585	ABYSSINIA
585	ERITREA
585	ETHIOPIA
600	ASIA, NOS

610	ASIA-NEAR EAST, NOS
610	MESOPOTAMIA
611	ANATOLIA
611	ASIA MINOR, NOS
611	TURKEY
620	ASIA-ARAB COUNTRIES, NOS
620	IRAQ-SAUDI ARABIA NEUTRAL ZONE
621	SYRIA
623	LEBANON
625	JORDAN
625	PALESTINE ARAB
625	TRANS-JORDAN
627	IRAQ
629	ADEN
629	ARABIAN PENINSULA
629	ARABIA
629	BAHRAIN
629	KUWAIT
629	OMAN AND MUSCAT
629	PERSIAN GULF STATES, NOS
629	QATAR
629	QUATAR
629	SAUDI ARABIA
629	TRUCIAL STATES
629	UNITED ARAB EMIRATES
629	YEMEN
631	GAZA
631	ISRAEL

631	PALESTINE (PALESTINIAN NATIONAL AUTHORITY-PNA)
631	WEST BANK
633	ARMENIA
633	AZERBAIDZHAN SSR
633	AZERBAIJAN
633	CAUCASIAN REPUBLICS OF FORMER USSR
633	GEORGIA (USSR)
634	KAZAKHSTAN
634	KAZAKH SSR
634	KIRGHIZ SSR
634	KYRGYSTAN
634	OTHER ASIAN REPUBLICS OF FORMER USSR
634	TADZHIK SSR
634	TAJIKISTAN
634	TURKMEN SSR
634	TURMENISTAN
634	UZBECK SSR
634	UZBEKISTAN
637	IRAN
637	PERSIA
638	AFGHANISTAN
639	PAKISTAN NOS
639	PAKISTAN WEST
640	ASIA-MID-EAST, NOS
640	MALDIVES
641	ANDAMAN ISLANDS
641	INDIA
643	BHUTAN

643	NEPAL/BHUTAN/SIKKIM
643	SIKKIM
645	BANGLADESH
645	PAKISTAN EAST
647	CEYLON
647	SRI LANKA
649	BURMA
649	MYANMAR
650	ASIA-SOUTHEAST, NOS
651	SIAM
651	THAILAND
660	INDO-CHINA, NOS
661	LAOS
663	CAMBODIA
663	KAMPUCHEA
665	ANNAM
665	COCHIN CHINA
665	TONKIN
665	VIET NAM
665	VIETNAM
671	BRUNEI
671	MALAY PENINSULA
671	MALAYSIA/SINGAPORE/BRUNEI
671	SINGAPORE
673	BORNEO
673	DUTCH EAST INDIES
673	INDONESIA
673	JAVA

673	NEW GUINEA, NOS
673	SUMATRA
675	PHILIPPINES
680	ASIA-EAST, NOS
681	CHINA, NOS
682	CHINA, PEOPLE'S REPUBLIC
683	HONG KONG
684	CHINA, REPUBLIC OF
684	FORMOSA
684	REPUBLIC OF CHINA
684	TAIWAN
685	TIBET
686	MACAO
686	MACAU
691	MONGOLIA
693	JAPAN
693	OKINAWA
695	KOREA
695	NORTH KOREA
695	SOUTH KOREA
711	AUSTRALIA/AUST NEW GUINEA
711	CARTIER ISLANDS
711	COCOS ISLANDS
711	NEW GUINEA AUSTRALIAN
711	NEW GUINEA NORTHEAST
711	NEW GUINEA PAPUA
711	NORFOLK ISLANDS
711	PAPUA

715	NEW ZEALAND
715	NIUE
720	OCEANA, NOS
720	PACIFIC ISL, NOS
720	POLYNESIA, NOS
721	FIJI
721	FOTUNA
721	FUTUNA ISLANDS
721	MELANESIA (MELANESIA ISLANDS)
721	NEW HEBRIDES
721	SOLOMON ISLANDS
721	VANUATA
721	WALLIS ISLANDS
723	CHRISTMAS ISLAND
723	MICRONESIA (MICRONESIAN ISLANDS)
723	NAURU
725	NEW CALEDONIA
725	PITCAIRN
725	POLYNESIA (POLYNESIAN ISLANDS)
725	SAMOA, WESTERN
725	TONGA
725	WESTERN SAMOA
750	ANTARCTICA
998	NOT US NOS
999	UNKNOWN

Appendix E: Rules for Determining Residency of Military Personnel Assigned to Ships and Crews of Merchant Vessels

Cancer reporting facilities that serve patients in the U.S. Navy or Merchant Marine need detailed rules for determining whether their patients are residents of their region for purposes of cancer reporting. The rules for determining residency are the same as those used by the Census Bureau. The guidelines that follow were adapted from U.S. Department of Commerce publications.

Note: Also see Appendix B - Postal Code Abbreviations, for military personnel serving abroad.

NAVY PERSONNEL

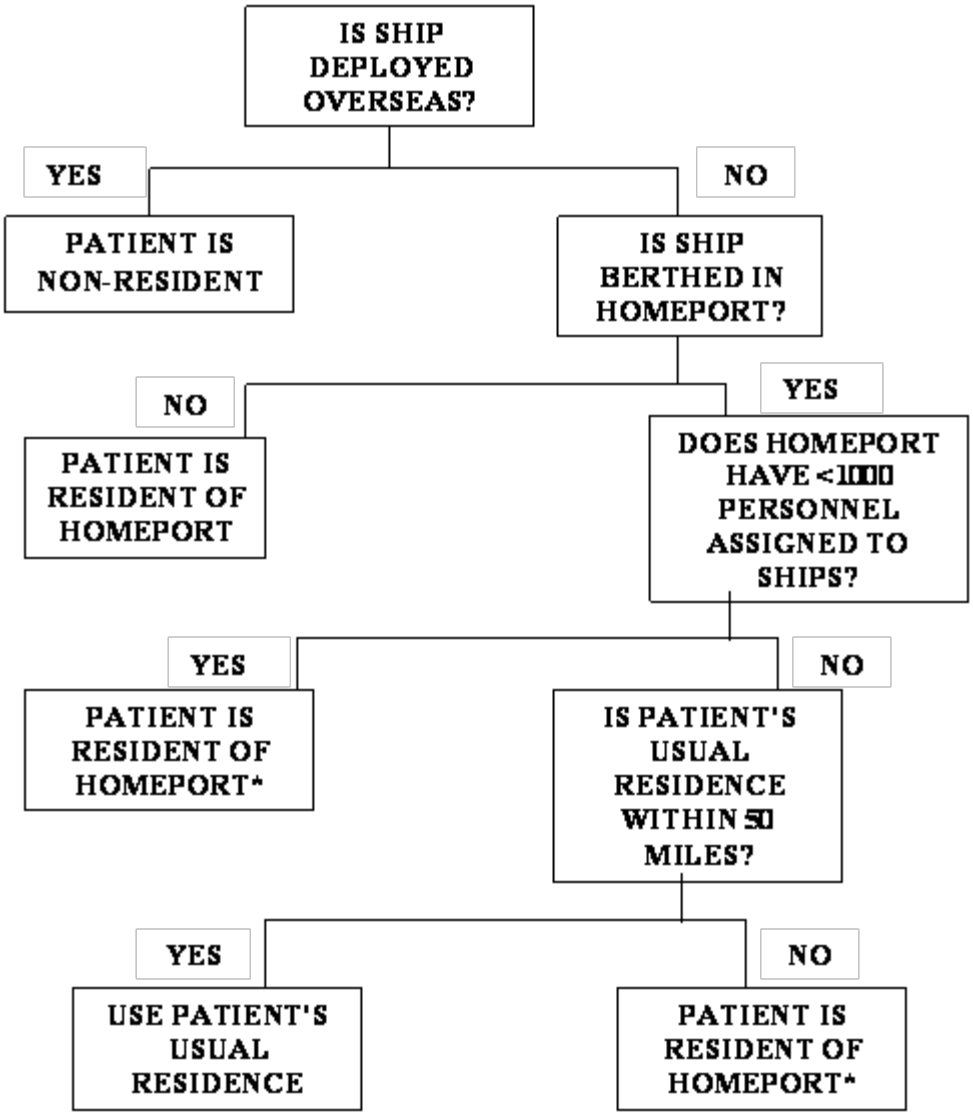
Patients diagnosed with cancer while their ships are deployed overseas are considered overseas residents for cancer-reporting purposes. For ships not deployed overseas, specific rules (shown in the chart below) apply. The Navy assigns a home port to each of its ships. If a ship that is not deployed overseas is not berthed in its home port, any crew member diagnosed with cancer is considered a resident of the home port. If the ship is berthed in its home port, and the home port has fewer than 1000 naval personnel assigned to ships, a crew member diagnosed with cancer is considered a resident of the ship. If, however, the home port has more than 1000 naval personnel assigned to ships and the cancer patient has a usual residence within 50 miles of the home port, the person's residence is the home, not the ship itself. If the patient's usual residence is more than 50 miles from the home port, he or she is considered to be a resident of the ship. For patients who are considered residents of a ship, code residence as the ship's home port unless the home port is contained in more than one municipality. In that case, code the patient's residence as the municipality immediately adjacent to the dock or pier where the ship is berthed.

CREWS OF MERCHANT VESSELS

Crews of U.S. vessels outside the U.S., or crews of vessels flying a foreign flag, are considered non-residents. If a U.S. vessel is not berthed in a U.S. port but is in territorial waters, and the port of destination is inside the U.S., a crew member diagnosed with cancer is considered a resident of the port of destination. If the destination is outside the U.S., the home port of the ship is considered the patient's residence. If a U.S. vessel is berthed in a U.S. port at the time of diagnosis, the patient is a resident of that port.

CHART

Summary of Rules for Determining Residency of Navy Personnel Assigned to Ships



* If home port is maintained in more than municipality, code patient as resident of the municipality immediately adjacent to the dock or pier where the ship is berthed.

Appendix F: California Hospital Codes Numbers

California Hospital lists by facility code or facility name are now posted on the CCR web site.

If you are using the online version of Volume 1, you can click the links that follow.

Reporting facilities in alphabetic order.

Reporting facilities in code order.

Appendix G.1: Codes for Religions (Numeric)

(in numerical order)	
01	NONE
02	AGNOSTIC
03	ATHEIST
04	*NONE, AGNOSTIC, ATHEIST (OLD)
05	*ROMAN CATHOLIC
05	CATHOLIC
06	CHRISTIAN, NOS
06	PROTESTANT, NOS
PROTESTANT DENOMINATIONS:	
07	*AFRICAN METHODIST EPISCOPAL (AME)
08	ANGLICAN
08	CHURCH OF ENGLAND
09	BAPTIST
10	COMMUNITY
11	CONGREGATIONAL
12	EPISCOPALIAN
13	LUTHERAN
14	METHODIST
15	PRESBYTERIAN
16	UNITARIAN

17	*PROTESTANT DENOMINATION, OTHER
18	CHRISTIAN REFORMED
19	DISCIPLES OF CHRIST
20	*DUTCH REFORMED
21	FIRST CHRISTIAN
22	INTERDENOMINATIONAL
23	MORAVIAN
24	NON-DENOMINATIONAL
25	SEAMAN'S CHURCH
26	TRINITY
27	UNIVERSAL
28	PROTESTANT, OTHER
ORTHODOX:	
29	ARMENIAN ORTHODOX
29	ORTHODOX, ARMENIAN
30	*COPTIC
31	GREEK ORTHODOX
31	ORTHODOX, GREEK
32	ORTHODOX, RUSSIAN
32	RUSSIAN ORTHODOX
33	SERBIAN ORTHODOX
33	ORTHODOX, SERBIAN
34	*LEBANESE MARONITE
34	*MARONITE
34	*ORTHODOX, CHRISTIAN, OTHER
34	*ORTHODOX, CHRISTIAN, NOS

CHRISTIAN SECTS:	
35	JEHOVAH'S WITNESSES
36	CHRISTIAN SCIENCE
37	MORMON
37	LATTER DAY SAINTS
38	SEVENTH-DAY ADVENTIST
39	FRIENDS
39	QUAKER
CHRISTIAN SECTS-OTHER:	
40	AMISH
41	MENNONITES
42	APOSTOLIC
43	ARMENIAN APOSTOLIC
44	ASSEMBLIES OF GOD
45	BRETHREN
45	BROTHERS
46	CHRISTIAN APOSTOLIC
47	CHURCH OF ARMEDIAN
48	CHURCH OF CHRIST
49	CHURCH OF GOD
50	CHURCH OF MESSIANITY
51	CHURCH OF THE DIVINE
52	CHURCH OF THE OPEN DOOR
53	CONGREGATIONAL HOLY
53	HOLY CONGREGATIONAL

54	COVENANT
55	DIVINE SCIENCE
56	EVANGELICAL
57	FUNDAMENTAL
58	FOURSQUARE
59	FULL GOSPEL
60	HOLINESS
61	HOLY INNOCENTS
62	NAZARENE
63	NEW APOSTOLIC
64	PENTECOSTAL
65	RELIGIOUS SCIENCE
66	SALVATION ARMY
67	SCIENCE OF MIND
68	UNITY
69	*CHRISTIAN SECTS, OTHER
70	JEWISH
71	*ORTHODOX JEWISH
71	*JEWISH ORTHODOX
WESTERN OTHER:	
72	BAHA'I
73	CRICKORIAN
73	ETHICAL CULTURE
73	GREGORIAN
73	LAWSONIAN
73	MASON

73	METAPHYSICS
73	OCCULT
73	PEACE OF MIND
73	PEOPLE'S
73	SELF-REALIZATION
73	SOCIETY OF LIFE
73	SPIRITUALIST
73	THEOSOPHY
73	TRUTH SEEKER
74	MOLIKAN
74	MOLOKAN
75	*WESTERN RELIGION OR CREED, OTHER
75	*WESTERN RELIGION OR CREED, NOS
76	KO
EASTERN RELIGIONS:	
77	BUDDHIST
77	*ZEN
77	*ZEN BUDDHISM
78	DROUZE
79	*CONFUCIANISM
79	*TAOISM
80	*JAIN
81	*NATION OF ISLAM
82	MOSLEM
82	MUSLIM
82	MOHAMMEDAN

83	HINDU
84	ISLAM
85	*PARSEE
85	ZOROASTRIAN
86	SHINTO
87	*SIKH
88	VEDANTA
89	ORIENTAL PHILOSOPHY
89	*EASTERN REGLIGION, OTHER
89	*EASTERN RELIGION, NOS
90	*AMERICAN INDIAN RELIGIONS
90	*NATIVE AMERICAN TRADITIONAL RELIGIONS
91	*HAITIAN/AFRICAN/BRAZILIAN RELIGIONS, OTHER
91	*SANTORIA
91	*VOODOO
92	*SHAMANISM
93	*OTHER TRADITIONAL OR NATIVE RELIGION
94	***Scientology***
98	*OTHER
99	UNSPECIFIED, UNKNOWN

*NEW OR REVISED LABEL

Appendix G.2: Codes for Religions (Alpha)

(in alphabetical order)	
AFRICAN METHODIST EPISCOPAL (AME)	07
AGNOSTIC	02
AMERICAN INDIAN RELIGIONS	90
AMISH	40
ANGLICAN	08
APOSTOLIC	42
ARMENIAN APOSTOLIC	43
ARMENIAN ORTHODOX	29
ASSEMBLIES OF GOD	44
ATHEIST	03
BAHA'I	72
BAPTIST	09
BRETHREN	45
BROTHERS	45
BUDDHIST	77
CATHOLIC	05
CHRISTIAN APOSTOLIC	46
CHRISTIAN REFORMED	18
CHRISTIAN SCIENCE	36
CHRISTIAN SECTS, OTHER	69
CHRISTIAN, NOS	06
CHURCH OF ARMEDIAN	47
CHURCH OF CHRIST	48
CHURCH OF ENGLAND	08

CHURCH OF GOD	49
CHURCH OF MESSIANITY	50
CHURCH OF THE DIVINE	51
CHURCH OF THE OPEN DOOR	52
COMMUNITY	10
CONFUCIANISM	79
CONGREGATIONAL HOLY	53
CONGREGATIONAL	11
COPTIC	30
COVENANT	54
CRICKORIAN	73
DISCIPLES OF CHRIST	19
DIVINE SCIENCE	55
DROUZE	78
DUTCH REFORMED	20
EASTERN RELIGION, NOS	89
EASTERN RELIGION, OTHER	89
EPISCOPALIAN	12
ETHICAL CULTURE	73
EVANGELICAL	56
FIRST CHRISTIAN	21
FOURSQUARE	58
FRIENDS	39
FULL GOSPEL	59
FUNDAMENTAL	57
GREEK ORTHODOX	31
GREGORIAN	73

HAITIAN/AFRICAN/BRAZILIAN RELIGIONS, OTHER	91
HINDU	83
HOLINESS	60
HOLY CONGREGATIONAL	53
HOLY INNOCENTS	61
INTERDENOMINATIONAL	22
ISLAM	84
JAIN	80
JEHOVAH'S WITNESS	35
JEWISH ORTHODOX	71
JEWISH	70
KO	76
LATTER DAY SAINTS	37
LAWSONIAN	73
LEBANESE MARONITE	34
LUTHERAN	13
MARONITE	34
MASON	73
MENNONITES	41
METAPHYSICS	73
METHODIST	14
MOHAMMEDAN	82
MOLIKAN	74
MOLOKAN	74
MORAVIAN	23
MORMON	37
MOSLEM	82

MUSLIM	82
NATION OF ISLAM	81
NATIVE AMERICAN TRADITIONAL RELIGIONS	90
NAZARENE	62
NEW APOSTOLIC	63
NON-DENOMINATIONAL	24
NONE, AGNOSTIC, ATHEIST (OLD)	04
NONE	01
OCCULT	73
ORIENTAL PHILOSOPHY	89
ORTHODOX, ARMENIAN	29
ORTHODOX, CHRISTIAN, NOS	34
ORTHODOX, CHRISTIAN, OTHER	34
ORTHODOX, GREEK	31
ORTHODOX, JEWISH	71
ORTHODOX, RUSSIAN	32
ORTHODOX, SERBIAN	33
OTHER TRADITIONAL OR NATIVE RELIGION	93
OTHER	98
PARSEE	85
PEACE OF MIND	73
PENTACOSTAL	64
PEOPLE'S	73
PRESBYTERIAN	15
PROTESTANT DENOMINATION, OTHER	17
PROTESTANT, NOS	06
PROTESTANT, OTHER	28

QUAKER	39
RELIGIOUS SCIENCE	65
ROMAN CATHOLIC	05
RUSSIAN ORTHODOX	32
SALVATION ARMY	66
SANTORIA	91
SCIENCE OF MIND	67
Scientology	***94***
SEAMAN'S CHURCH	25
SELF-REALIZATION	73
SERBIAN ORTHODOX	33
SEVENTH-DAY ADVENTIST	38
SHAMANISM	92
SHINTO	86
SIKH	87
SOCIETY OF LIFE	73
SPIRITUALIST	73
TAOISM	79
THEOSOPHY	73
TRINITY	26
TRUTH SEEKER	73
UNITARIAN	16
UNITY	68
UNIVERSAL	27
UNSPECIFIED, UNKNOWN	99
VEDANTA	88
VOODOO	91

WESTERN RELIGION OR CREED, NOS	75
WESTERN RELIGION OR CREED, OTHER	75
ZEN BUDDHISM	77
ZEN	77
ZOROASTRIAN	85

Appendix J: Patient Information Sheet

CCR suggests the following statement be used by hospitals and physicians in notifying their patients that cancer and other specific benign and borderline tumors are reportable entities:

CALIFORNIA CANCER REPORTING SYSTEM

PATIENT INFORMATION SHEET

California Department of Health Services (CDHS) is mandated under state law (Health and Safety Code, Section 103885) to gather information on the amount and type of cancer occurring throughout the state. Beginning January 1, 2001 and forward, diagnoses of borderline and benign primary intracranial and central nervous system (CNS) tumors are also reportable, as well as borderline ovarian cancer and Newly Reportable Hematopoietic Diseases (NRHD) listed below. The purpose of the law is to help identify preventable causes of cancer and specific borderline and benign tumors.

For the system to be useful, it must obtain complete and accurate counts of all new cancers and reportable tumors that occur. Therefore the new law requires hospitals and physicians to notify the appropriate regional registry of each new case of cancer and reportable tumor.

The information collected is confidential under California Health and Safety Code Sections 100330 and 103885, Civil Code, Sections 56.05 and 1798, Government Code, Sections 6250-62-65, and Federal Law PL 104-191. CDHS has more than 50 years' experience in handling confidential records. Laws, regulations and programmatic safeguards are in place throughout the system to assure that the identities of patients are not revealed. Some cancer patients may, however, be contacted later by CDHS or the regional cancer registries as part of their ongoing investigations into the causes of cancer.

NRHD include the following :

Chronic Myeloproliferative Diseases

- Polycythemia vera
- Chronic myeloproliferative disease
- Myelosclerosis with myeloid metaplasia
- Essential thrombocythemia
- Chronic neutrophilic leukemia
- Hypereosinophilic syndrome

Myelodysplastic Syndromes

- Refractory anemia
- Refractory anemia with sideroblasts
- Refractory anemia with excess blasts
- Refractory anemia with excess blasts
- in Transformation
- Refractory cytopenia with multilineage

Dysplasia

- Myelodysplastic syndrome with 5q-syndrome
- Therapy-related myelodysplastic syndrome
- Other New Diagnoses
- Langerhans cell histiocytosis, disseminated
- Acute biphenotypic leukemia
- Precursor lymphoblastic leukemia
- Aggressive NK cell leukemia
- Chronic neutrophilic leukemia
- Hypereosinophilic syndrome
- Leukemias with cytogenetic abnormalities
- Dendritic cell sarcoma.

Appendix K-1 : Codes for Casefinding (For Cases Diagnosed January 1, 2010 and Later)

Screening List of OF ICD-9-CM Codes for Casefinding

Certain ICD-9-CM* codes used by medical records departments for discharge diagnoses identify cases of malignant neoplasms that are reportable to the California Cancer Registry. Case finding procedures must include the review of medical records coded with the following numbers. Newly reportable diseases are followed by the ICD-O-3 morphology and behavior code in parentheses.

See Appendix K.2: Codes for Casefinding ICD-9-CM, Jan 1 to Dec 31, 2009

See Appendix K.3. Codes for Casefinding ICD-9-CM, Jan 1, 2007 to Dec 31, 2008

See Appendix K.4: Codes for Casefinding ICD-9-CM, prior to 2007

The following information is taken directly from the SEER web site: http://seer.cancer.gov/tools/casefinding/fy2010long.html

Fiscal Year 2010 Casefinding List: Expanded Version

Some ranges are expressed with only 1 decimal place (e.g. 237.0-237.9) while some codes within that range may have two decimal places (e.g. 237.71 and 237.72). All codes in the range are included.

These tables are also available in a printable version (PDF).

Comprehensive ICD-9-CM Casefinding Code List for Reportable Tumors (Effective Date: 1/1/2010)	
ICD-9-CM Code^	**Explanation of Code**
140.0 – 208.92	Malignant Neoplasms
209.00 – 209.29	Neuroendocrine tumors
209.30	Malignant poorly differentiated neuroendocrine carcinoma, any site *Reportable inclusion terms:* *High grade neuroendocrine carcinoma, any site* *Malignant poorly differentiated neuroendocrine tumor NOS*

209.31 – 209.36	Merkel cell carcinoma **Note: Effective date 10/1/09**
209.70 – 209.79	Secondary neuroendocrine tumors **Note: Effective Date 10/1/09** *Reportable inclusion terms:* *Secondary carcinoid +tumors* **Note: All neuroendocrine or carcinoid tumors specified as secondary are malignant**
225.0 – 225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3	Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch) *Reportable inclusion terms:* *Benign neoplasm of craniobuccal pouch, hypophysis, Rathke's pouch or sella turcica*
227.4	Benign neoplasm of pineal gland
227.9	Benign neoplasm; endocrine gland, site unspecified
228.02	Hemangioma; of intracranial structures *Reportable inclusion terms:* *Angioma NOS, Cavernous nevus, Glomus tumor, Hemangioma (benign)*
228.1	Lymphangioma, any site
230.0 – 234.9	Carcinoma in situ *Reportable inclusion terms:* *Intraepithelial neoplasia III*
236.0	Endometrial stroma, low grade (8931/1) *Reportable inclusion terms:* *Stromal endometriosis (8931/3 per ICD-O-3)* *Stromal myosis (endolymphatic) (8931/3 per ICD-O-3)* *Stromatosis, endometrial (8931/3 per ICD-O-3)*
237.0 – 237.9	Neoplasm of uncertain behavior [borderline] of endocrine glands and nervous system

238.4	Polycythemia vera (9950/3)
238.6	Neoplasm of uncertain behavior of other and unspecified sites and tissues, Plasma cells (Plasmacytoma, extramedullary, 9734/3) *Reportable inclusion terms:* *Plasmacytoma NOS (9731/3)* *Solitary myeloma (9731/3)*
238.7	Other lymphatic and hematopoietic tissues **Note: This code was expanded 10/2006. It is now a subcategory and is no longer valid for use for coding purposes. It should be included in extract programs for quality control purposes.)**
238.71	Essential thrombocythemia (9962/3) *Reportable inclusion terms:* *Essential hemorrhagic thrombocythemia* *Idiopathic (hemorrhagic) thrombocythemia*
238.72	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9983/3, 9985/3) *Reportable inclusion terms:* *Refractory anemia (RA) (9980/3)* *Refractory anemia with excess blasts-1 (RAEB-1) (9983/3)* *Refractory anemia with ringed sideroblasts (RARS) (9982/3)* *Refractory cytopenia with multilineage dysplasia (RCMD) (9985/3)* *Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) (9985/3)*
238.73	High grade myelodysplastic syndrome lesions (includes 9983/3) *Reportable inclusion terms:* *Refractory anemia with excess blasts-2 (RAEB-2)*
238.74	Myelodysplastic syndrome with 5q deletion (9986/3) *Reportable inclusion terms:* *5q minus syndrome NOS*
238.75	Myelodysplastic syndrome, unspecified (9985/3, 9987/3)

238.76	Myelofibrosis with myeloid metaplasia (9961/3) *Reportable inclusion terms:* *Agnogenic myeloid metaplasia* *Idiopathic myelofibrosis (chronic)* *Myelosclerosis with myeloid metaplasia*
238.77	Post transplant lymphoproliferative disorder (9987/3)
238.79	Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3) *Reportable inclusion terms:* *Lymphoproliferative disease (chronic) NOS (9970/1)* *Megakaryocytic myelosclerosis (9961/3)* *Myeloproliferative disease (chronic) NOS (9960/3)* *Panmyelosis (acute) (9931/3)*
239.6	Neoplasms of unspecified nature, brain
239.7	Neoplasms of unspecified nature; endocrine glands and other parts of nervous system
239.81 – 239.89	Neoplasms of unspecified nature; other specified sites **Note: Effective Date 10/1/09**
273.2	Other paraproteinemias *Reportable inclusion terms:* *Franklin's disease (heavy chain) (9762/3)* *Heavy chain disease (9762/3)* *Mu-chain disease (9762/3)*
273.3	Macroglobulinemia *Reportable inclusion terms:* *Waldenström's macroglobulinemia (9761/3)* *Waldenström's (macroglobulinemia) syndrome*
288.3	Eosinophilia Note: This code is for eosinophilia, which is not reportable. Do not abstract unless diagnosis is "Hypereosinophilic syndrome (9964/3)."

795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy
795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy
796.76	Papanicolaou smear of anus with cytologic evidence of malignancy
V10.0 – V10.89	Personal history of malignancy **Note: Screen for recurrences, subsequent primaries, and/or subsequent treatment**
V10.90	Personal history of unspecified malignant neoplasm **Note: Effective Date: 10/1/09. Screen for recurrences, subsequent primaries, and/or subsequent treatment**
V10.91	Personal history of malignant neuroendocrine tumor, carcinoid tumor, Merkel cell carcinoma **Note: Effective Date: 10/1/09. Screen for recurrences, subsequent primaries, and/or subsequent treatment**
V12.41	Personal history of benign neoplasm of the brain

The following codes are not reportable per se, but they should alert registrars to look for the first malignant neoplasm associated with these codes.

Supplementary List #1-ICD-9-CM Codes that Should Be Followed by or Associated with a Neoplasm Code	
ICD-9-CM Code^	Explanation of Code
258.02 – 258.03	Multiple endocrine neoplasia (MEN) type IIA and IIB (rare familial cancer syndrome) **Note: Use additional codes to identify any malignancies and other conditions associated with the syndrome**
285.22	Anemia in neoplastic disease **Note: Assign also a code for the neoplasm causing the anemia** **Excludes: anemia due to antineoplastic chemotherapy, new code 285.3**
289.83	Myelofibrosis (NOS) (9961/3) **Note: Not every case of myelofibrosis is associated with a malignancy. Review terms included in ICD-O-3 to determine if case is reportable. See ICD-9-CM**

338.3	Neoplasm related pain (acute, chronic); Cancer associated pain; Pain due to malignancy (primary/secondary); Tumor associated pain
511.81	Malignant pleural effusion **Note : Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned**
789.51	Malignant ascites **Note : Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned**

NOTE: Cases with these codes should be screened as registry time allows. These are neoplasm-related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm. Experience in the SEER registries has shown that using the supplementary list increases casefinding for benign brain and CNS, hematopoietic neoplasms, and other reportable diseases.

Supplementary List #2-ICD-9-CM Code List to Screen for Cancer Cases Not Identified by Other Codes (Effective Date: 1/1/2010)
ICD-9-CM Code^
042
079.4
079.50 – 079.59
209.40-209.69
210.0 – 229.9
235.0 – 236.6
238.0 – 239.9
253.6
259.2
259.8
273.0

273.1
273.9
275.42
277.88
279.00
279.02 – 279.06
279.10
279.12
279.13
279.2 – 279.9
284.81
284.89
284.9
285.0
285.3
288.03
289.89
323.81
379.59
528.01
630
686.01
695.89
701.2
710.3

710.4
785.6
790.93
795.8
795.81
795.82
795.89
999.31
999.81
E879.2
E930.7
E933.1
V07.31, V07.39
V07.8
V12.72
V15.3
V42.81
V42.82
V51.0
V52.4
V54.2
V58.0
V58.1
V58.11
V58.12

V58.42
V66.1
V66.2
V67.1
V67.2
V71.1
V76.0 – V76.9
V78.0 – V78.9
V82.71
V82.79
V82.89
V82.9
V84.01 – V84.09
V84.81
V86.0
V86.1
V87.41

NOTES:

- Prostatic Intraepithelial Neoplasia (PIN III) M-8148/2 is not required by SEER.
- Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will CONTINUE to report these cases and code behavior a /3 (malignant) .
- 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.
- These diseases are part of the paraneoplastic syndrome. “Paraneoplastic syndrome isn’t cancer. It’s a disease or symptom that is the consequence of

cancer but is not due to the local presence of cancer cells. A paraneoplastic syndrome may be the first sign of cancer."

^ *International Classification of Diseases, Ninth Revision, Clinical Modification, 2009.*

Appendix K-2: Codes for Casefinding (For Cases Diagnosed Jan 1 to Dec 31, 2009)

Screening List of OF ICD-9-CM Codes for Casefinding

Certain ICD-9-CM* codes used by medical records departments for discharge diagnoses identify cases of malignant neoplasms that are reportable to the California Cancer Registry. Case finding procedures must include the review of medical records coded with the following numbers. Newly reportable diseases are followed by the ICD-O-3 morphology and behavior code in parentheses.

The following information was taken directly from the SEER web site.

Fiscal Year 2009 Casefinding List

The Fiscal Year 2009 Comprehensive ICD-9-CM Casefinding and Supplementary ICD-9-CM Code Lists are to be used to identify cases diagnosed January 1, 2009 and later. The revised tables include new and expanded ICD-9-CM codes. The revised tables also now include paraneoplastic syndromes indicated by * in Explanation of Code.

The 2009 Comprehensive ICD-9-CM Casefinding Code List is designed to assist in casefinding activities that are performed to identify reportable neoplasms, including benign brain and CNS tumors which became reportable in 2004, among a variety of casefinding sources that use ICD-9-CM* codes (modified October 2008) to characterize a diagnosis.

Comprehensive ICD-9-CM Casefinding Code List for Reportable Tumors (Effective Date: 1/1/2009 forward)

ICD-9-CM Code^	Explanation of Code
140.0 – 208.9	Malignant Neoplasms
209.0 – 209.3	Neuroendocrine tumors (Effective date: 1/1/09)
225.0 – 225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3 – 227.4	Benign neoplasm of pituitary gland, pineal body, and other intracranial endocrine-related structures
227.9	Benign neoplasm; endocrine gland, site unspecified
228.02	Hemangioma; of intracranial structures
228.1	Lymphangioma, any site

230.0 – 234.9	Carcinoma in situ
236.0	Endometrial stroma, low grade (8931/1)
237.0 – 237.9	Neoplasm of uncertain behavior [borderline] of endocrine glands and nervous system
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)Extramedullary plasmacytoma (9734/3)
238.7	Other lymphatic and hematopoietic tissues (This code was discontinued as of 10/2006 but should be included in extract programs for quality control purposes)
238.71	Essential thrombocythemia (9962/3)
238.72	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9985/3)
238.73	High grade myelodysplastic syndrome lesions (includes 9983/3)
238.74	Myelodysplastic syndrome with 5q deletion (9986/3)
238.75	Myelodysplastic syndrome, unspecified (9985/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3)
238.77	Post transplant lymphoproliferative disorder (9987/3)
238.79	Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3)
239.6	Neoplasms of unspecified nature, brain
239.7	Neoplasms of unspecified nature; endocrine glands and other parts of nervous system
259.2	Carcinoid Syndrome
259.8	Other specified endocrine disorders
273.2	Gamma heavy chain disease (9762/3); Franklin's disease (9762/3)
273.3	Waldenstrom macroglobulinemia (9761/3)
285.22	Anemia in neoplastic disease
288.3	Hypereosinophilic syndrome (9964/3)
289.83	Myelofibrosis (NOS) (9961/3)
289.89	Other specified diseases of blood and blood-forming
511.81	Malignant pleural effusion (code first malignant neoplasm if known)
789.51	Malignant ascites (code first malignant neoplasm if known)
795.06	Papanicolaou smear of cervix with cytologic evidence of

	malignancy
795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy
795.76	Papanicolaou smear of anus with cytologic evidence of malignancy
V10.0 – V10.9	Personal history of malignancy (screen for recurrences, subsequent primaries, and/or subsequent treatment)

Many new codes and conditions have been added to the Supplementary ICD-9-CM Code List. It is recommended that each registry screen cases using the supplementary list as time permits. Experience among the SEER registries has proven that using the supplementary list significantly improves casefinding outcomes for benign brain and CNS tumors, hematopoietic and lymphoid neoplasms, and other reportable diseases.

NOTE: Cases with these codes should be screened only as registry time allows. Some codes represent neoplasm-related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm. Complete casefinding would include investigation of patient records with diagnoses represented on either list.

Supplementary ICD-9-CM Code List to Screen for Cancer Cases Not Identified by Other Codes (Effective Date: 1/1/09)

ICD-9-CM Code^	Explanation of Code
042	Acquired Immunodeficiency Syndrome (AIDS) (This is not a malignancy. Medical coders are instructed to add codes for AIDS-associated malignancies. Screen 042 for history of cancers that might not be coded.)
079.4	Human papillomavirus
079.50 – 079.59	Retrovirus (HTLV, types I, II and 2)
210.0 – 229.9	Benign neoplasms (screen for incorrectly coded malignancies or reportable by agreement tumors)
235.0 – 236.6	Neoplasms of uncertain behavior (screen for incorrectly coded malignancies or reportable by agreement tumors)
238.0 – 239.9	Neoplasms of uncertain behavior (screen for incorrectly coded malignancies or reportable by agreement tumors)
253.6	Syndrome of inappropriate secretion of antidiuretic hormone*
258.02 – 258.03	Multiple endocrine neoplasia (MEN) type IIA and IIB (rare familial cancer syndrome)
273.0	Polyclonal hypergammaglobulinemia (Waldenstrom) review for miscodes

273.1	Monoclonal gammopathy of undetermined significance (9765/1) (screen for incorrectly coded Waldenstrom macroglobulinemia or progression)
273.9	Unspecified disorder of plasma protein metabolism (screen for incorrectly coded Waldenstrom's macroglobulinemia)
275.42	Hypercalcemia*
279.00	Hypogammaglobulinemia (predisposed to lymphoma or stomach cancer)
279.02 – 279.06	Selective IgM immunodeficiency (associated with lymphoproliferative disorders)
279.10	Immunodeficiency with predominant T-cell defect, NOS
279.12	Wiskott-Aldrich Syndrome
279.13	Nezelof's Syndrome
279.2 – 279.9	Combined immunity deficiency – Unspecified disorder of immune mechanism
284.81	Red cell aplasia (acquired, adult, with thymoma)
284.89	Other specified aplastic anemias due to drugs (chemotherapy or immunotherapy), infection, radiation
288.03	Drug induced neutropenia
323.81	Encephalomyelitis; specified cause NEC*
338.3	Neoplasm related pain (acute, chronic); Cancer associated pain; Pain due to malignancy (primary/secondary); Tumor associated pain
379.59	Opsoclonia*
528.01	Mucositis due to antineoplastic therapy
686.01	Pyoderma gangrenosum*
695.89	Sweet's syndrome*
701.2	Acanthosis nigricans*
710.3	Dermatomyositis*
710.4	Polymyositis*

790.93	Elevated prostate specific antigen [PSA]
795.8	Abnormal tumor markers; Elevated tumor associated antigens [TAA]; Elevated tumor specific antigens [TSA]; Excludes: elevated prostate specific antigen [PSA] (790.93)
795.81	Elevated carcinoembryonic antigen [CEA]
795.82	Elevated cancer antigen 125 [CA 125]
795.89	Other abnormal tumor markers
999.31	Infection due to central venous catheter (porta-cath) (Effective Date: 1/1/2009)
999.81	Extravasation of vesicant chemotherapy (Effective Date: 1/1/2009)
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E933.1	Adverse effect of immunosuppressive drugs
V07.3	Other prophylactic chemotherapy (screen for incorrectly coded malignancies)
V07.8	Other specified prophylactic measure
V15.3	Irradiation: previous exposure to therapeutic or ionizing radiation
V42.81	Organ or tissue replaced by transplant, Bone marrow transplant
V42.82	Transplant; Peripheral stem cells
V51.0	Encounter for breast reconstruction following mastectomy (Effective Date: 1/1/2009)
V52.4	Breast prosthesis and implant (Effective Date: 1/1/2009)
V58.0	Encounter for radiation therapy
V58.1	Encounter for antineoplastic chemotherapy and immunotherapy (This code was discontinued as of 10/2006 but should be included in extract programs for quality control purposes)
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy

V58.42	Aftercare following surgery for neoplasm
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow up
V67.2	Chemotherapy follow up
V76.0 – V76.9	Special screening for malignant neoplasm
V78.0 – V78.9	Special screening for disorders of blood and blood-forming organs
V82.71	Screening for genetic disease carrier status
V82.79	Other genetic screening
V82.89	Genetic screening for other specified conditions
V82.9	Genetic screening for unspecified condition
V84.01 – V84.09	Genetic susceptibility to malignant neoplasm
V86.0	Estrogen receptor positive status [ER+]
V86.1	Estrogen receptor negative status [ER-]
V87.41	Personal history of antineoplastic chemotherapy

NOTES:

Prostatic Intraepithelial Neoplasia (PIN III) M-8148/2 will NOT be collected by SEER registries.

Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will CONTINUE to report these cases and code behavior a /3 (malignant). 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 registries.

The World Health Organization (WHO) diagnosis "B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma" is coded as 9823/3, and cross-referenced to 9670/3, malignant lymphoma, small B lymphocytic, NOS. If this WHO term is

used to describe malignancy in blood or bone marrow, code 9823/3; if the term is used to describe malignance in tissue, lymph nodes or any organ in combination with blood or bone marrow, code 9670/3.

^ *International Classification of Diseases, Ninth Revision, Clinical Modification, 2009.*

Appendix K-3: Codes for Casefinding (Between Jan 1, and Dec 31, 2008)

Screening List of OF ICD-9-CM Codes for Casefinding

Certain ICD-9-CM* codes used by medical records departments for discharge diagnoses identify cases of malignant neoplasms that are reportable to the California Cancer Registry. Case finding procedures must include the review of medical records coded with the following numbers. Newly reportable diseases are followed by the ICD-O-3 morphology and behavior code in parentheses.

The following information was taken directly from the SEER web site.

ICD-9-CM* CODE	
042	AIDS (review cases for AIDS-related malignancies)
140.0-208.9	Malignant neoplasms (primary and secondary)
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
225.0-227.4	Benign central nervous system neoplasms
230.0–234.9	Carcinoma in situ (exclude skin codes 232.0-232.9, and cervix code 233.1)
235.0–238.9	Neoplasms of uncertain behavior
236.2	Ovarian neoplasms of uncertain behavior (8442/1, 8451/1, 8462/1, 8472/1, 8473/1)
237.0–237.9	Central nervous system neoplasms of uncertain behavior
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)

238.71	Essential thrombocythemia (was 238.7; 9962/3) Essential (hemorrhagic) thrombocythemia Essential thrombocytosis Idiopathic (hemorrhagic) thrombocythemia Primary thrombocytosis
238.72	Low grade myelodysplastic syndrome lesions Refractory anemia (was 284.9; 9980/3) Refractory anemia with ringed sideroblasts (RARS) (was 285.0; 9982/3) Refractory cytopenia with multilineage dysplasia (RCMD) (was 238.7; 9985/3) Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) was 238.7; 9985/3)
238.73	High grade myelodysplastic syndrome lesions Refractory anemia with excess blasts-1 (RAEB-1) (was 285.0; 9983/3) Refractory anemia with excess blasts-2 (RAEB-2) (was 285.0; 9983/3)
238.74	Myelodysplastic syndrome with 5q deletion (was 238.7; 9986/3) 5q minus syndrome NOS Excludes: constitutional 5q deletion (758.39) (not reportable) high grade myelodysplastic syndrome with 5q deletion (238.73)
238.75	Myelodysplastic syndrome, unspecified (was 238.7; 9985/3, 9989/3)
238.76	Myelosclerosis with myeloid metaplasia (9961/3) Agnogenic myeloid metaplasia Idiopathic myelofibrosis (chronic) Myelosclerosis with myeloid metaplasia Primary myelofibrosis Excludes: myelofibrosis NOS (289.83) myelophthisic anemia (284.2) (not reportable) myelophthisis (284.2) (not reportable) secondary myelofibrosis (289.83)

238.79	Other lymphatic and hematopoietic tissues Lymphoproliferative disease (chronic) NOS (was 238.7; 9970/1) Megakaryocytic myelosclerosis (was 238.7; 9961/3) Myeloproliferative disease (chronic) NOS (was 238.7; 9960/3) Panmyelosis (acute) (was 238.7; 9931/3)
239.0–239.9	Neoplasms of unspecified nature
273.2	Gamma heavy chain disease Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
288.3	Hypereosinophilic syndrome (9964/3)
289.83	Myelofibrosis (9932/3) Myelofibrosis, NOS Secondary myelofibrosis Code first underlying disorder, such as: malignant neoplasm of breast (174.0-174.9, 175.0-175.9) Excludes: Idiopathic myelofibrosis (238.76) leukoerythroblastic anemia (238.2) (not reportable) myelofibrosis with myeloid metaplasia (238.76) myelophthisic anemia (284.2) (not reportable) myelophthisis (284.2) (not reportable) primary myelofibrosis (238.76)
289.89	Other specified diseases of blood and blood-forming organs
V07.3	Other prophylactic chemotherapy
V07.8	Other specified prophylactic measures
V10.0-V10.9	Personal history of malignant neoplasms

V58.0	Radiotherapy session
V58.1	Maintenance chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Follow-up exam following radiotherapy
V67.2	Follow-up exam following chemotherapy
V71.1	Observation for suspected malignant neoplasm
V76.0–V76.9	Special screening for malignant neoplasms
V86	Estrogen receptor status

Please Note:

- Code 042 is not a combination code of AIDS with specified malignancies.
- Prostatic Intraepithelial Neoplasia (PIN III), morphology code 8148/2 is not reportable to the CCR.
- Pilocytic/juvenile astrocytoma, morphology code 9421, is reportable as a /3 behavior code and is assigned a regular tumor sequence number per SEER requirements, effective with cases diagnosed 1/1/2001 and forward.
- Ovarian borderline cystadenomas, morphology codes 8442/1, 8451/1, 8462/1, 8472/1 and 8473/1, which changed behavior codes from /3 to /1 will continue to be reportable to the CCR. These tumors are to be sequenced following the American College of Surgeons guideline for benign tumors.

Appendix K-4: Codes for Casefinding (Prior to 2007)

Screening List of OF ICD-9-CM Codes for Casefinding

Certain ICD-9-CM* codes used by medical records departments for discharge diagnoses identify cases of malignant neoplasms that are reportable to the California Cancer Registry. Case finding procedures must include the review of medical records coded with the following numbers. Newly reportable diseases are followed by the ICD-O-3 morphology and behavior code in parentheses.

The following information was taken directly from the SEER website.

ICD-9-CM* CODE	

042	AIDS (review cases for AIDS-related malignancies)
140.0-208.9	Malignant neoplasms (primary and secondary)
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
225.0-227.4	Benign central nervous system neoplasms
230.0–234.9	Carcinoma in situ (exclude skin codes 232.0-232.9, and cervix code 233.1)
235.0–238.9	Neoplasms of uncertain behavior
236.2	Ovarian neoplasms of uncertain behavior (8442/1, 8451/1, 8462/1, 8472/1, 8473/1)
237.0–237.9	Central nervous system neoplasms of uncertain behavior
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.7	Chronic myeloproliferative disease (9960/3)
238.7	Myelosclerosis with myeloid metaplasia (9961/3)
238.7	Essential thrombocythemia (9962/3)
238.7	Refractory cytopenia with multilineage dysplasia (9985/3)
238.7	Myelodysplastic syndrome with 5q-syndrome (9986/3)
238.7	Therapy-related myelodysplastic syndrome (9987/3)
239.0–239.9	Neoplasms of unspecified nature
273.2	Gamma heavy chain disease Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
284.9	Refractory anemia (9980/3)
285.0	Refractory anemia with ringed sideroblasts (9982/3)
285.0	Refractory anemia with excess blasts (9983/3)
285.0	Refractory anemia with excess blasts in transformation (9984/3)

288.3	Hypereosinophilic syndrome (9964/3)
289.8	Acute myelofibrosis (9932/3)
V07.3	Other prophylactic chemotherapy
V07.8	Other specified prophylactic measures
V10.0-V10.9	Personal history of malignant neoplasms
V58.0	Radiotherapy session
V58.1	Maintenance chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Follow-up exam following radiotherapy
V67.2	Follow-up exam following chemotherapy
V71.1	Observation for suspected malignant neoplasm
V76.0–V76.9	Special screening for malignant neoplasms

** International Classification of Diseases, 9th Revision, Clinical Modification, 4th ed.*

Appendix L.1: Codes for California Counties (Alpha)

Name	**California County Code**	**US FIPS Code**	**Name**	**California County Code**	***US FIPS Code***
ALAMEDA	**001**	001	ORANGE	**030**	059
ALPINE	**002**	003	PLACER	**031**	061
AMADOR	**003**	005	PLUMAS	**032**	063
BUTTE	**004**	007	RIVERSIDE	**033**	065
CALAVERAS	**005**	009	SACRAMENTO	**034**	067
CALIFORNIA NOS	**000**	998	SAN BENITO	**035**	069
COLUSA	**006**	011	SAN	**036**	071

			BERNARDINO		
CONTRA COSTA	**007**	013	SAN DIEGO	**037**	073
DEL NORTE	**008**	015	SAN FRANCISCO	**038**	075
EL DORADO	**009**	017	SAN JOAQUIN	**039**	077
FRESNO	**010**	019	SAN LUIS OBISPO	**040**	079
GLENN	**011**	021	SAN MATEO	**041**	081
HUMBOLDT	**012**	023	SANTA BARBARA	**042**	083
IMPERIAL	**013**	025	SANTA CLARA	**043**	085
INYO	**014**	027	SANTA CRUZ	**044**	087
KERN	**015**	029	SHASTA	**045**	089
KINGS	**016**	031	SIERRA	**046**	091
LAKE	**017**	033	SISKIYOU	**047**	093
LASSEN	**018**	035	SOLANO	**048**	095
LOS ANGELES	**019**	037	SONOMA	**049**	097
MADERA	**020**	039	STANISLAUS	**050**	099
MARIN	**021**	041	SUTTER	**051**	101
MARIPOSA	**022**	043	TEHAMA	**052**	103
MENDOCINO	**023**	045	TRINITY	**053**	105
MERCED	**024**	047	TULARE	**054**	107
MODOC	**025**	049	TUOLUMNE	**055**	109
MONO	**026**	051	US NOT CALIF	**000**	998
MONTEREY	**027**	053	VENTURA	**056**	111
NAPA	**028**	055	YOLO	**057**	113
NEVADA	**029**	057	YUBA	**058**	115

Appendix L.2: Code for California Counties (Numeric)

California County Code	*US FIPS Code*	Name	California County Code	***US FIPS Code***	Name
000	*998*	CALIFORNIA NOS	**029**	*057*	NEVADA
000	*998*	US NOT CALIF	**030**	*059*	ORANGE
001	*001*	ALAMEDA	**031**	*061*	PLACER
002	*003*	ALPINE	**032**	*063*	PLUMAS
003	*005*	AMADOR	**033**	*065*	RIVERSIDE
004	*007*	BUTTE	**034**	*067*	SACRAMENTO
005	*009*	CALAVERAS	**035**	*069*	SAN BENITO
006	*011*	COLUSA	**036**	*071*	SAN BERNARDINO
007	*013*	CONTRA COSTA	**037**	*073*	SAN DIEGO
008	*015*	DEL NORTE	**038**	*075*	SAN FRANCISCO
009	*017*	EL DORADO	**039**	*077*	SAN JOAQUIN
010	*019*	FRESNO	**040**	*079*	SAN LUIS OBISPO
011	*021*	GLENN	**041**	*081*	SAN MATEO
012	*023*	HUMBOLDT	**042**	*083*	SANTA BARBARA
013	*025*	IMPERIAL	**043**	*085*	SANTA CLARA
014	*027*	INYO	**044**	*087*	SANTA CRUZ
015	*029*	KERN	**045**	*089*	SHASTA
016	*031*	KINGS	**046**	*091*	SIERRA
017	*033*	LAKE	**047**	*093*	SISKIYOU
018	*035*	LASSEN	**048**	*095*	SOLANO
019	*037*	LOS ANGELES	**049**	*097*	SONOMA
020	*039*	MADERA	**050**	*099*	STANISLAUS

021	*041*	MARIN	**051**	*101*	SUTTER
022	*043*	MARIPOSA	**052**	*103*	TEHAMA
023	*045*	MENDOCINO	**053**	*105*	TRINITY
024	*047*	MERCED	**054**	*107*	TULARE
025	*049*	MODOC	**055**	*109*	TUOLUMNE
026	*051*	MONO	**056**	*111*	VENTURA
027	*053*	MONTEREY	**057**	*113*	YOLO
028	*055*	NAPA	**058**	*115*	YUBA

Appendix M.1: Common Acceptable Symbols and Abbreviations (Terms)

(in order of terms)

Do not use non-standard abbreviations in abstracts. When abbreviating words in an address, refer to the USPS website. For short names of antineoplastic drugs, consult the SEER Rx. Other accepted abbreviations are:

Terms

	SYMBOLS
-	Minus, Negative
#	Number
#	Pound(s)
&	And
(sn)	(sentinel node)
/	Comparison
@	At
^	Above
+	Plus, Positive
<	Decrease, Less/Less than
=	Equal(s)
>	Greater/Greater than
>	Increase, More/More than
	ABBREVIATIONS
Abdomen (abdominal)	ABD
Abdominal perineal	AP
Abnormal	ABN

Above knee (amputation)	AK(A)
Absent/Absence	ABS
Abstract/Abstracted	ABST
Achilles tendon reflex	ATR
Acid phosphatase	ACID PHOS
Acquired Immune Deficiency Syndrome	AIDS
Activities of daily living	ADL
Acute granulocytic leukemia	AGL
Acute lymphocytic leukemia	ALL
Acute myelogenous leukemia	AML
Acute myocardial infarction	AMI
Acute renal failure	ARF
Acute Respiratory Distress (Disease) Syndrome	ARDS
Acute tubular necrosis	ATN
Adenocarcinoma	ADENOCA
Adenosine triphosphate	ATP
Adjacent	ADJ
Admission/Admit	ADM
Adrenal cortex	AC
Adrenal cortical hormone	ACH
Adrenocorticotrophic hormone	ACTH
Adult-onset Diabetes Mellitus	AODM
Affirmative	AFF
Against medicalAdvice	AMA
AIDS-related condition (complex)	ARC
AIDS-related disease	ARD
Air contrast barium enema	ACBE
Albumin	ALB
Alcohol	ETOH
Alkaline phosphatase	ALK PHOS
Alpha-fetoprotein	AFP
Also known As	AKA
Ambulatory	AMB
Amount	AMT
Amputation	AMP
Amyotrophic lateral sclerosis	ALS
Anal intraepithelial neoplasia, Grade I-III	AIN I-III
Anaplastic	ANAP
Angiography/Angiogram	ANGIO
Anterior	ANT
Anteroposterior	AP

Antidiuretic hormone	ADH
Antigen	AG
Aortic stenosis	A-STEN
Apparently	APPL‘Y
Appendix	APP
Approximately	APPROX
Arrhythmia	ARRHY
Arterial blood gases	ABG
Arteriosclerosis/Arteriosclerotic	AS
Arteriosclerotic cardiovascular disease	ASCVD
Arteriosclerotic heart disease	ASHD
Arteriosclerotic Peripheral Vascular Disease	ASPVD
Arteriovenous	AV
Arteriovenous malformation	AVM
Artery (ial)	ART
As soon As possible	ASAP
Ascending colon	A-COLON
Aspiration	ASP
Aspirin, Acetylsalicylic Acid	ASA
Atrial fibrillation	A FIB
Atrial flutter	A FLUTTER
Atrial premature complexes	APC
Atrial stenosis/insufficiency/incompetence	AI
Atypical ductal hyperplasia	ADH
Auscultation & percussion	A&P
Autoimmune hemolytic Anemia	AIHA
Autonomic nervous system	ANS
Autopsy	AUT
Average	AVG
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium enema	BE
Bartholin‘s, Urethral & Skene‘s	BUS
Basal cell carcinoma	BCC
Before noon	AM
Below knee (amputation)	BK(A)
Benign prostatic hypertrophy/hyperplasia	BPH
Bilateral	BIL
Bilateral salpingo-oophorectomy	BSO
Bile duct	BD

Biological response modifier	BRM
Biopsy	BX
Bipolar affective disorder	BAD
Black female	B/F
Black male	B/M
Bladder tumor	BT
Blood pressure	BP
Blood urea nitrogen	BUN
Blood volume	BV
Bone marrow biopsy	BMBx
Bone marrow transplant	BMT
Bone marrow	BM
Bowel movement	BM
Bowel Sounds	BS
Breast cancer type 1 or 2 susceptibility protein	BRCA 1 or 2
Breast self-examination	BSE
Breath Sounds	BRS
Bright Red Blood (per Rectum)	BRB (PR)
Brother	BRO
Calcium	CA
Capsule (s)	CAP(S)
Carbohydrate antigen 125	CA-125
Carcinoembryonic antigen	CEA
Carcinoma *in situ*	CIS
Carcinoma*	CA
Cardiovascular disease	CVD
CAT/CT scan/Computerized axial tomography	CT
CD117	c-KIT
Centigray	cGy
Centimeter	CM
Central nervous system	CNS
Cerebrospinal fluid	CSF
Cerebrovascular accident	CVA
Cervical intraepithelial neoplasia, Grade l-III	CIN I-III
Cervical spine	C-SPINE
Cervical vertebrae	C1-C7
Change	CHG
Chemotherapy	CHEMO/CTX
Chest X-ray	CXR
Chromogenic in situ hybridization	CISH
Chronic	CHR

Chronic granulocytic leukemia	CGL
Chronic lymphocytic leukemia	CLL
Chronic myeloid (myelocytic) leukemia	CML
Chronic obstructive lung disease	COLD
Chronic obstructive pulmonary disease	COPD
Chronic renal failure	CRF
Chronic ulcerative Colitis	CUC
Cigarettes	CIG
Circumferential resection margin	CRM
Clear	CLR
Cobalt 60	CO60
Collaborative stage	CS
College of American Pathology	CAP
Colon, Ascending	A-COLON
Colon, Sigmoid	SIG COLON
Colon, Transverse	TRANS-COLON
Colony-stimulating factor	C-SF
Complaint (-ning) of	C/O
Complete blood Count	CBC
Complete remission	CR
Congenital heart disease	CHD
Congestive heart failure	CHF
Consistent with	C/W
Continue/continuous	CONT
Contralateral	CONTRA
Coronary artery bypass graft	CABG
Coronary artery disease	CAD
Coronary Care unit	CCU
Cubic Centimeter	CC
Cystic fibrosis	CF
Cystoscopy	CYSTO
Cytology	CYTO
Date of birth	DOB
Date of Death	DOD
Dead on arrival	DOA
Decrease(d)	DECR
Deep inferior epigastric perforator reconstruction surgery	DIEP
Deep tendon reflex	DTR
Deep vein thrombosis	DVT
Deoxyribonucleic acid	DNA

Dermatology	DERM
Descending colon	D-COLON
Diabetes mellitus	DM
Diagnosis	DX
Diameter	DIAM
Diethylstilbestrol	DES
Differentiated/differential	DIFF
Digital rectal examination	DRE
Dilatation and curettage	D&C
Discharge	DISCH
Discontinue(d)	DC
Disease	DIS, DZ
Disseminated intravascular coagulopathy	DIC
Doctor	PMD, DR, MD
Ductal carcinoma *in situ*	DCIS
Ductal Intraepithelial Neoplasia 3	DIN 3
Dyspnea on exertion	DOE
Ears, nose, and throat	ENT
Electrocardiogram	ECG/EKG
Electroencephalogram	EEG
Electromyogram	EMG
Emergency room	ER
End stage renal disease	ESRD
Endoscopic retrograde cholangiopancreatography	ERCP
Enlarged	ENLGD
Esophagogastric junction	EGJ
Esophagogastro-duodenoscopy	EGD
Essential thrombocytopenia	ET
Estrogen receptor (assay)	ER, ERA
Evaluation	EVAL
Every	Q
Every day	QD
Examination	EXAM
Examination under Anesthesia	EUA
Excision/excised	EXC(D)
Expired	EXP
Exploratory	EXPL
Exploratory laparotomy	EXPL LAP
Extend/extension	EXT
Extended Care Facility	ECF
External*	EXT

Extracapsular spread/extension	ECS/ECE
Extremity*	EXT
Eyes, Ears, Nose and Throat	EENT
Family (Medical) History	F(M)H
Father	FA
Fever of unknown origin	FUO
Fine needle aspiration	FNA
Fine needle aspiration biopsy	FNAB
Fingerbreadth	FB
Floor of mouth	FOM
Fluid	FL
Fluorescence in situ hybridization	FISH
Fluoroscopy	FLURO
Follicular lymphoma international prognostic index	FLIPI
Follow-up	FU
For example	E.G.
Fracture	FX
Frequent/Frequency	FREQ
Frozen section	FS
Full thickness skin graft	FTSG
Gallbladder	GB
Gastroenterostomy	GE
Gastroesophageal	GE
Gastroesophageal reflux disease	GERD
Gastrointestinal	GI
Gastrointestinal stromal tumor	GIST
General/Generalized	GEN
Genitourinary	GU
Gleason grade	GG
Gleason score	GS
Grade	GR
Gram	GM
Grandfather, Great grandfather	GF, GGF
Grandmother, Great grandmother	GM, GGM
Gray, unit of absorbed radiation	Gy
Gynecology	GYN
Head, Eyes, Ears, Nose, Throat	HEENT
Hematocrit	HCT
Hematoxylin & eosin stain	H&E
Hemoglobin	HGB
Hepatitis A (virus)	HAV

Hepatitis B (virus)	HBV
Hepatitis C (virus)	HCV
Hepatitis D (virus)	HDV
Hepatosplenomegaly	HSM
High dose rate	HDR
High grade	HG
High power field	HPF
History	HX
History and physical	H&P
History of	HO, H/O
History of Present Illness	HPI
Hormone	HORM
Hospital	HOSP
Hour/Hours	HR(S)
Human chorionic gonadotropin	HCG
Human epidermal growth factor receptor 2	HER2/neu
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus Type III	HTLV-III
Hypertension	HTN
Hypertensive cardiovascular disease	HCVD
Hypertensive vascular disease	HVD
Hysterectomy	HYST
Idiopathic hypertrophic subaortic stenosis	IHSS
Idiopathic myelofibrosis	IMF
Idiopathic thrombocytopenia	ITP
Immunoglobulin	IG
Immunohistochemical	IHC
Impression	IMP
Incision & drainage	I&D
Includes/Including	INCL
Increase(d)	INCR
Inferior	INF
Inferior vena cava	IVC
Infiltrating	INFILT
Inflammatory bowel disease	IBD
Inpatient	IP
Insulin-dependent diabetes mellitus	IDDM
Intensity modulated radiation therapy	IMRT
Intensive care unit	ICU
Intercostal margin	ICM

Intercostal space	ICS
Intermittent positive pressure breathing	IPPB
Internal	INT
Internal Mammary Artery	IMA
Internal Prognostic Index	IPI
International Federation of Gynecology & Obstetrics	FIGO
International normalized ratio	INR
International Society of Urological Pathology	ISUP
Interstitial lung disease	ILD
Intramuscular	IM
Intrathecal	IT
Intravenous	IV
Intravenous cholangiogram	IVCA
Intravenous pyelogram	IVP
Invade(s)/invading/invasion	INV
Involve(s)/involvement/involving	INVL
Iodine	I
Iodine-131	I-131
Ipsilateral	IPSI
Irregular	IRREG
Isolated tumor cells	ITCs
Janus activated kinase 1 or 2	JAK 1 or 2
Jugular venous distention	JVD
Juvenile rheumatic arthritis	JRA
Kaposi sarcoma	KS
Kidneys, ureters, bladder	KUB
Kilogram	KG
Kilovolt	KV
Laboratory	LAB
Lactic dehydrogenase	LDH
Laparotomy	LAP
Large	LRG
Laryngeal Intraepithelial Neoplasia	LIN
Last menstrual period	LMP
Lateral	LAT
Left	L, LT
Left bundle branch block	LBBB
Left costal margin	LCM
Left lower extremity	LLE
Left lower lobe	LLL
Left lower quadrant	LLQ

Left salpingo-oophorectomy	LSO
Left upper extremity	LUE
Left upper lobe	LUL
Left upper outer quadrant	LUOQ
Left upper quadrant	LUQ
Licensed practical nurse	LPN
Light chain deposition disease	LCDD
Linear accelerator	LINAC
Liter	L
Liver, Kidney, Spleen (Bladder)	LKS(B)
Liver/spleen scan	LS SCAN
Lobular Carcinoma In Situ	LCIS
Low dose rate	LDR
Low grade	LG
Lower extremity	LE
Lower inner quadrant	LIQ
Lower outer quadrant	LOQ
Lumbar Puncture	LP
Lumbar spine	L-SPINE
Lumbar vertebra	L1-L5
Lumbosacral	LS
Lupus erythematosus	LUP ERYTH
Lymph node dissection	LND
Lymph node(s)	LN(S)
Lymphadenopathy	LAD/LAN
Lymphadenopathy-associated virus	LAV
Lymphvascular invasion	***LVI***
Macrophage colony-stimulating factor	M-CSF
Magnetic resonance cholangiopancreatography	MRCP
Magnetic resonance imaging	MRI
Main stem bronchus	MSB
Malignant	MALIG
Mandible/mandibular	MAND
Maxilla(ry)	MAX
Maximum	MAX
Mean diameter nucleoli	MLN
Medical center	MC
Medical Doctor	DR, MD
Medication	MED
Merkel cell carcinoma	MCC
Metastatic, Metastases/Metastasis	MET, METS

Methicillin Resistant Staphylococcus Aureus	MRSA
Methylguanine methyltransferase enzyme	MGMT
Microgram	MCG
Microscopic	MICRO
Microvascular density	MVD
Midclavicular Line	MCL
Middle lobe	ML
Millicurie (hours)	MC(H)
Milligram (hours)	MG(H)
Milliliter	ML
Millimeter	MM
Million (electron) volts	MV, MEV
Minimum	MIN
Minute	MIN
Mitral valve prolapse	MVP
Mixed combined immunodeficiency	MCID
Mixed connective tissue disease	MCTD
Moderate (ly)	MOD
Moderately differentiated	MD, MOD DIFF
Modified radical Mastectomy	Mab
Monoclonal antibodies	MRM
Monclonal gammopathy of unknown significance	MGUS
Mother	MO
Multifocal arterial tachycardia	MAT
Multifocal premature ventricular contraction	MPVC
Multiple	MULT
Multiple gated acquisition scan	MUGA
Multiple Myeloma	MM
Multiple sclerosis	MS
Myasthenia gravis	MG
Myocardial infarction	MI
Nausea and Vomiting	N&V
Neck vein distention	NVD
Negative	NEG
Neoplasm	NEOPL
Neurology	NEURO
No evidence of disease	NED
No significant findings	NSF
Non small cell carcinoma	NSCCA
Non-Hodgkins lymphoma	NHL
Normal	NL

Not applicable	NA
Not otherwise specified	NOS
Not recorded	NR
Nursing home	NH
Obstetrics	OB
Obstructed (-ing, -ion)	OBST
Operating room	OR
Operation	OP
Operative Report	OP RPT
Organic brain syndrome	OBS
Orthopedics	ORTHO
Otology	OTO
Ounce	OZ
Outpatient	OP
Packs Per day	PPD
Palpated (-able)	PALP
Pancreatic intraepithelial neoplasia, Grade III	PanIN III
Papanicolaou smear	PAP
Papillary	PAP
Past/personal (medical) history	PMH
Pathologic complete remission	pCR
Pathology	PATH
Patient	PT
Pediatrics	PEDS
Pelvic inflammatory disease	PID
Peptic ulcer disease	PUD
Percussion and Ausculation	P&A
Percutaneous	PERC
Percutaneous transhepatic cholecystogram	PTC
Peripheral vascular disease	PVD
Phosphorus 32	P32
Physical examination	PE
Physiotherapy/Physical therapy	PT
Platelets	PLT
Polycythemia vera	PV
Poorly differentiated	PD, POOR DIFF
Positive	POS
Positron emission tomography	PET
Possible	POSS
Posterior	POST
Posteroanterior	PA

Postoperative (-ly)	POST OP
Postoperative Day	POD
Pound(s)	LB(S)
Premature atrial contraction	PAC
Preoperative (-ly)	PRE OP
Prescription	RX
Present Illness	PI
Previous	PREV
Primary acquired melanosis	PAM
Primary care physician	PCP
Prior to admission	PTA
Probable (-ly)	PROB
Proctoscopy	PROCTO
Progesterone receptor (assay)	PR, PRA
Prostatic intraepithelial neoplasia, Grade III	PIN III
Prostatic specific antigen	PSA
Pulmonary	PULM
Pulmonary Artery	PA
Quadrant	QUAD
Radiation	RAD
Radiation absorbed dose	RAD
Radiation therapy	RT
Radical	RAD
Radioimmunoassay	RIA
Radium	RA
Received	REC‘D
Red blood cells (count)	RBC
Regarding	RE
Regional medical center	RMC
Regular	REG
Regular sinus Rhythm	RSR
Resection (ed)	RESEC
Respiratory	RESPIR
Review of outside films	ROF
Review of outside slides	ROS
Review of Systems	ROS
Rheumatic heart disease	RHD
Rheumatoid arthritis	RA
Right	R, RT
Right bundle branch block	RBBB
Right costal margin	RCM

Right inner quadrant	RIQ
Right lower extremity	RLE
Right lower lobe	RLL
Right lower quadrant	RLQ
Right middle lobe	RML
Right outer quadrant	ROQ
Right salpingo-oophorectomy	RSO
Right upper extremity	RUE
Right upper lobe	RUL
Right upper quadrant	RUQ
Rule Out	RO, R/O
Sacral Spine	S-SPINE
Sacral vertebra	S1-S5
Salpingo-oophorectomy	SO
Satisfactory	SATIS
Sequential Multiple Analysis (Biochem Profile)	SMA
Serum glutamic oxaloacetic transaminase	SGOT
Serum Glutamic Pyruvic Transaminase	SGPT
Severe combined immunodeficiency Syndrome	SCID
Short(ness) of breath	SOB
Sick Sinus Syndrome	SSS
Sister	SIS
Skilled Nursing Facility	SNF
Small	SM, SML
Small Bowel	SB, SML BWL
Small bowel obstruction	SBO
Specimen	SPEC
Spine, Lumbar	L-SPINE
Spine, Sacral	S-SPINE
Spine, Thoracic	T-SPINE
Split thickness Skin graft	STSG
Squamous	SQ
Squamous	SQUAM
Squamous cell carcinoma	SCC
Status post	S/P
Stereotactic radiosurgery	SRS
Subcutaneous	SUBCU, SUBQ
Summary Stage	SS
Superior vena cava	SVC
Surgery/Surgical	SURG
Suspicious/suspected	SUSP

Symptoms	SX
Syndrome of inappropriate ADH	SIADH
Systemic lupus erythematosus	SLE
Thoracic	T
Thoracic spine	T-SPINE
Thoracic Vertebra	T1-T12
Thrombotic thrombocytopenia purpura	TTP
Times	X
Total abdominal hysterectomy	TAH
Total abdominal hysterectomy-bilateral salpingo-oophorectomy	TAH-BSO
Total body irradiation	TBI
Total parenteral nutrition	TPN
Total vaginal hysterectomy	TVH
Transient ischemic attack	TIA
Transitional cell carcinoma	TCC
Transurethral resection	TUR
Transurethral resection bladder	TURB
Transurethral Resection Bladder (Tumor)	TURB(T)
Transurethral resection prostate	TURP
Transverse colon	TRANS-COLON
Transverse rectus abdominis myocutaneous	TRAM
Treatment	RX, TX
True vocal cord	TVC
Tuberculosis	TB
Tumor Size	TS
Twice a day (daily)	BID
Ultrasound	US
Undifferentiated	UNDIFF
Unknown	UNK
Upper extremity	UE
Upper gastrointestinal (series)	UGI
Upper inner quadrant	UIQ
Upper outer quadrant	UOQ
Upper respiratory infection	URI
Urinary tract infection	UTI
Vagina/Vaginal	VAG
Vaginal hysterectomy	VAG HYST
Vaginal intraepithelial neoplasia, Grade I-III	VAIN I-III
Vascular	VASC
Visceral pleural invasion	VPI

V-ki-RAS 2	KRAS
Vulvar intraepithelial neoplasia, Grade I-III	VIN I-III
Well differentiated WD,	WELL DIFF
White blood cells (count)	WBC
White female	W/F
White male	W/M
With	W/ or C
Within normal limits	WNL
Without	W/O
Wolff-Parkinson-White syndrome	WPW
Work-up	W/U
World Health Organization	WHO
Xray	XR
Year	YR

Appendix M.2: Common Acceptable Symbols and Abbreviations (Abbreviations)

Do not use non-standard abbreviations in abstracts. When abbreviating words in an address, refer to the USPS website. For short names of antineoplastic drugs, consult the SEER Rx. Other accepted abbreviations are:

	SYMBOLS
-	Minus, Negative
#	Number (usually placed before a number)
#	Pound(s) (usually placed after a number)
&	And
(sn)	(sentinel node)
/	Comparison
@	At
^	Above
+	Plus, Positive
<	Decrease, Less/Less than
=	Equal(s)
>	Greater/Greater than
>	Increase, More/More than
	ABBREVIATIONS
*	*Context-sensitive abbreviation: Meaning of the abbreviation should be readily apparent from the context in which it is used.*

A FIB	Atrial fibrillation
A FLUTTER	Atrial flutter
A&P	Auscultation & percussion
ABD	Abdomen (abdominal)
ABG	Arterial blood gases
ABN	Abnormal
ABS	Absent/Absence
ABST	Abstract/Abstracted
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
ADH *	Antidiuretic hormone
ADH *	Atypical ductal hyperplasia
ADJ	Adjacent
ADL	Activities of daily living
ADM	Admission/Admit
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Antigen
AGL	Acute granulocytic leukemia
AI	Atrial stenosis/insufficiency/incompetence
AIDS	Acquired Immune Deficiency Syndrome
AIHA	Autoimmune hemolytic Anemia
AIN I-III	Anal intraepithelial neoplasia, Grade I-III
AK(A) *	Above knee (amputation)
AKA *	Also known As
ALB	Albumin
ALK PHOS	Alkaline phosphatase
ALL	Acute lymphocytic leukemia
ALS	Amyotrophic lateral sclerosis
AM	Before noon
AMA	Against medicalAdvice
AMB	Ambulatory
AMI	Acute myocardial infarction
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
AP *	Anteroposterior
APC	Atrial premature complexes
APP	Appendix
APPL'Y	Apparently
APPROX	Approximately
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
A-STEN	Aortic stenosis
ATN	Acute tubular necrosis
ATP	Adenosine triphosphate
ATR	Achilles tendon reflex
AUT	Autopsy
AV	Arteriovenous
AVG	Average
AVM	Arteriovenous malformation
AX	Axilla(ry)
B/F	Black female
B/M	Black male
BA	Barium
BAD	Bipolar affective disorder
BCC	Basal cell carcinoma
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema

BID	Twice a day (daily)
BIL	Bilateral
BK(A)	Below knee (amputation)
BM *	Bone marrow
BM *	Bowel movement
BMBx	Bone marrow biopsy
BMT	Bone marrow transplant
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BRB (PR)	Bright Red Blood (per Rectum)
BRCA 1 or 2	Breast cancer type 1 or 2 susceptibility protein
BRM	Biological response modifier
BRO	Brother
BS	Bowel Sounds
BRS	Breath Sounds
BSE	Breast self-examination
BSO	Bilateral salpingo-oophorectomy
BT	Bladder tumor
BUN	Blood urea nitrogen
BUS	Bartholin‘s, Urethral & Skene‘s
BV	Blood volume
BX	Biopsy
C/O	Complaint (-ning) of
C/W	Consistent with
C1-C7	Cervical vertebrae
CA *	Calcium
CA *	Carcinoma
CA-125	Carbohydrate antigen 125
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CAP *	College of American Pathology
CAP(S) *	Capsule (s)
CBC	Complete blood Count
CC	Cubic Centimeter
CCU	Coronary Care unit
CEA	Carcinoembryonic antigen
CF	Cystic fibrosis
CGL	Chronic granulocytic leukemia
cGy	Centigray
CHD	Congenital heart disease
CHEMO/CTX	Chemotherapy

CHF	Congestive heart failure
CHG	Change
CHR	Chronic
CIG	Cigarettes
CIN I-III	Cervical intraepithelial neoplasia, Grade l-III
CIS	Carcinoma *in situ*
CISH	Chromogenic in situ hybridization
c-KIT	CD117
CLL	Chronic lymphocytic leukemia
CLR	Clear
CM	Centimeter
CML	Chronic myeloid (myelocytic) leukemia
CNS	Central nervous system
CO 60	Cobalt 60
COLD	Chronic obstructive lung disease
CONT	Continue/continuous
CONTRA	Contralateral
COPD	Chronic obstructive pulmonary disease
CR	Complete remission
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
CUC	Chronic ulcerative Colitis
CVA	Cerebrovascular accident
CVD	Cardiovascular disease
CXR	Chest X-ray
CYSTO	Cystoscopy
CYTO	Cytology
D&C	Dilatation and curettage
DC	Discontinue(d)
DCIS	Ductal carcinoma *in situ*
D-COLON	Descending colon
DECR	Decrease(d)
DERM	Dermatology
DES	Diethylstilbestrol
DIAM	Diameter
DIC	Disseminated intravascular coagulopathy

DIEP	Deep inferior epigastric perforator
DIFF	Differentiated/differential
DIN 3	Ductal Intraepithelial Neoplasia 3
DIS, DZ	Disease
DISCH	Discharge
DM	Diabetes mellitus
DNA	Deoxyribonucleic acid
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of Death
DOE	Dyspnea on exertion
DR, MD	Medical Doctor
DRE	Digital rectal examination
DTR	Deep tendon reflex
DVT	Deep vein thrombosis
DX	Diagnosis
E.G.	For example
ECF	Extended Care Facility
ECG/EKG	Electrocardiogram
ECS/ECE	Extracapsular spread/extension
EEG	Electroencephalogram
EENT	Eyes, Ears, Nose and Throat
EGD	Esophagogastro-duodenoscopy
EGJ	Esophagogastric junction
EMG	Electromyogram
ENLGD	Enlarged
ENT	Ears, nose, and throat
ER *	Emergency room
ER *, ERA	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography
ESRD	End stage renal disease
ET	Essential thrombocytopenia
ETOH	Alcohol
EUA	Examination under Anesthesia
EVAL	Evaluation
EXAM	Examination
EXC(D)	Excision/excised
EXP	Expired
EXPL	Exploratory
EXPL LAP	Exploratory laparotomy
EXT *	Extend/extension

EXT *	External
EXT *	Extremity
FA	Father
F(M)H	Family (Medical) History
FB	Fingerbreadth
FIGO	International Federation of Gynecology & Obstetrics
FISH	Fluorescence in situ hybridization
FL	Fluid
FLIPI	Follicular lymphoma international prognostic index
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
GB	Gallbladder
GE *	Gastroenterostomy
GE *	Gastroesophageal
GEN	General/Generalized
GERD	Gastroesophageal reflux disease
GF, GGF	Grandfather, Great grandfather
GG	Gleason grade
GI	Gastrointestinal
GIST	Gastrointestinal stromal tumor
GM *	Gram
GM *, GGM	Grandmothe, Great grandmother
GR	Grade
GS	Gleason score
GU	Genitourinary
Gy	Gray, unit of absorbed radiation
GYN	Gynecology
H&E	Hematoxylin & eosin stain
H&P	History and physical
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)
HEENT	Head, Eyes, Ears, Nose, Throat
HER2/neu	Human epidermal growth factor receptor 2
HG	High grade
HGB	Hemoglobin
HIV	Human Immunodeficiency Virus
HO, H/O	History of
HORM	Hormone
HOSP	Hospital
HPF	High power field
HPI	History of Present Illness
HPV	Human Papilloma Virus
HR(S)	Hour/Hours
HSM	Hepatosplenomegaly
HTLV-III	Human T-Lymphotrophic Virus Type III
HTN	Hypertension
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I	Iodine
I&D	Incision & drainage
I-131	Iodine-131
IBD	Inflammatory bowel disease
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IDDM	Insulin-dependent diabetes mellitus
IMF	Idiopathic myelofibrosis
IG	Immunoglobulin
IHC	Immunohistochemical
IHSS	Idiopathic hypertrophic subaortic stenosis
ILD	Interstitial lung disease
IM	Intramuscular
IMA	Internal Mammary Artery
IMP	Impression
IMRT	Intensity modulated radiation therapy
INCL	Includes/Including
INCR	Increase(d)

INF	Inferior
INFILT	Infiltrating
INR	International normalized ratio
INT	Internal
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement/involving
IP	Inpatient
IPI	Internal Prognostic Index
IPPB	Intermittent positive pressure breathing
IPSI	Ipsilateral
IRREG	Irregular
ISUP	International Society of Urological Pathology
IT	Intrathecal
ITCs	Isolated tumor cells
ITP	Idiopathic thrombocytopenia
IV	Intravenous
IVC	Inferior vena cava
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
JAK 1 or 2	Janus activated kinase 1 or 2
JRA	Juvenile rheumatic arthritis
JVD	Jugular venous distention
KG	Kilogram
KRAS	V-ki-RAS 2
KS	Kaposi sarcoma
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L *	Liter
L *, LT	Left
L1-L5	Lumbar vertebra
LAB	Laboratory
LAD/LAN	Lymphadenopathy
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LB(S)	Pound(s)
LBBB	Left bundle branch block
LCDD	Light chain deposition disease
LCIS	Lobular Carcinoma In Situ
LCM	Left costal margin
LDH	Lactic dehydrogenase

LDR	Low dose rate
LE	Lower extremity
LG	Low grade
LIN	Laryngeal Intraepithelial Neoplasia
LINAC	Linear accelerator
LIQ	Lower inner quadrant
LKS(B)	Liver, Kidney, Spleen (Bladder)
LLE	Left lower extremity
LLL	Left lower lobe
LLQ	Left lower quadrant
LMP	Last menstrual period
LN(S)	Lymph node(s)
LND	Lymph node dissection
LOQ	Lower outer quadrant
LP	Lumbar Puncture
LPN	Licensed practical nurse
LRG	Large
LS	Lumbosacral
LS SCAN	Liver/spleen scan
LSO	Left salpingo-oophorectomy
L-SPINE	Lumbar spine
LUE	Left upper extremity
LUL	Left upper lobe
LUOQ	Left upper outer quadrant
LUP ERYTH	Lupus erythematosus
LUQ	Left upper quadrant
LVI	***Lymphvascular invasion***
Mab	Monoclonal antibodies
MALIG	Malignant
MAND	Mandible/mandibular
MAT	Multifocal arterial tachycardia
MAX *	Maxilla(ry)
MAX *	Maximum
MC *	Medical center
MC *(H)	Millicurie (hours)
MCC	Merkel cell carcinoma
MCG	Microgram
MCID	Mixed combined immunodeficiency
MCL	Midclavicular Line
M-CSF	Macrophage colony-stimulating factor
MCTD	Mixed connective tissue disease

MD, MOD DIFF	Moderately differentiated
MED	Medication
MET, METS	Metastatic, Metastases/Metastasis
MG	Myasthenia gravis
MG(H)	Milligram (hours)
MGMT	Methylguanine methyltransferase enzyme
MGUS	Monclonal gammopathy of unknown significance
MI	Myocardial infarction
MICRO	Microscopic
MIN *	Minimum
MIN *	Minute
ML *	Middle lobe
ML *	Milliliter
MLN	Mean diameter nucleoli
MM *	Millimeter
MM *	Multiple Myeloma
MO	Mother
MOD	Moderate (ly)
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
MUGA	Multiple gated acquisition scan
MULT	Multiple
MV, MEV	Million (electron) volts
MVD	Microvascular density
MVP	Mitral valve prolapse
N&V	Nausea and Vomiting
NA	Not applicable
NED	No evidence of disease
NEG	Negative
NEOPL	Neoplasm
NEURO	Neurology
NH	Nursing home
NHL	Non-Hodgkins lymphoma
NL	Normal
NOS	Not otherwise specified
NR	Not recorded

NSCCA	Non small cell carcinoma
NSF	No significant findings
NVD	Neck vein distention
OB	Obstetrics
OBS	Organic brain syndrome
OBST	Obstructed (-ing, -ion)
OP *	Operation
OP *	Outpatient
OR	Operating room
ORTHO	Orthopedics
OTO	Otology
OZ	Ounce
P&A	Percussion and Ausculation
P32	Phosphorus 32
PA *	Posteroanterior
PA *	Pulmonary Artery
PAC	Premature atrial contraction
PALP	Palpated (-able)
PAM	Primary acquired melanosis
PanIN III	Pancreatic intraepithelial neoplasia, Grade III
PAP *	Papanicolaou smear
PAP *	Papillary
PATH	Pathology
PCP	Primary care physician
pCR	Pathologic complete remission
PD, POOR DIFF	Poorly differentiated
PE	Physical examination
PEDS	Pediatrics
PERC	Percutaneous
PET	Positron emission tomography
PI	Present Illness
PID	Pelvic inflammatory disease
PIN III	Prostatic intraepithelial neoplasia, Grade III
PLT	Platelets
PMD, DR, MD	Doctor
PMH	Past/personal (medical) history
POD	Postoperative Day
POS	Positive
POSS	Possible
POST	Posterior
POST OP	Postoperative (-ly)

PPD	Packs Per day
PR, PRA	Progesterone receptor (assay)
PRE OP	Preoperative (-ly)
PREV	Previous
PROB	Probable (-ly)
PROCTO	Proctoscopy
PSA	Prostatic specific antigen
PT *	Patient
PT *	Physiotherapy/Physical therapy
PTA	Prior to admission
PTC	Percutaneous transhepatic cholecystogram
PUD	Peptic ulcer disease
PULM	Pulmonary
PV	Polycythemia vera
PVD	Peripheral vascular disease
Q	Every
QD	Every day
QUAD	Quadrant
R, RT	Right
RA	Radium
RA	Rheumatoid arthritis
RAD *	Radiation
RAD *	Radiation absorbed dose
RAD *	Radical
RBBB	Right bundle branch block
RBC	Red blood cells (count)
RCM	Right costal margin
RE	Regarding
REC‘D	Received
REG	Regular
RESEC	Resection (ed)
RESPIR	Respiratory
RHD	Rheumatic heart disease
RIA	Radioimmunoassay
RIQ	Right inner quadrant
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
RMC	Regional medical center
RML	Right middle lobe
RO, R/O	Rule Out

ROF	Review of outside films
ROQ	Right outer quadrant
ROS *	Review of outside slides
ROS *	Review of Systems
OP RPT	Operative Report
RSO	Right salpingo-oophorectomy
RSR	Regular sinus Rhythm
RT	Radiation therapy
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
RX *	Prescription
RX *, TX	Treatment
S/P	Status post
S1-S5	Sacral vertebra
SATIS	Satisfactory
SB, SML BWL	Small Bowel
SBO	Small bowel obstruction
SCC	Squamous cell carcinoma
SCID	Severe combined immunodeficiency Syndrome
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum Glutamic Pyruvic Transaminase
SIADH	Syndrome of inappropriate ADH
SIG COLON	Sigmoid colon
SIS	Sister
SLE	Systemic lupus erythematosus
SM, SML	Small
SMA	Sequential Multiple Analysis (Biochem Profile)
SNF	Skilled Nursing Facility
SO	Salpingo-oophorectomy
SOB	Short(ness) of breath
SPEC	Specimen
SQ	Squamous
SQUAM	Squamous
SRS	Stereotactic radiosurgery
SS	Summary Stage
S-SPINE	Sacral Spine
SSS	Sick Sinus Syndrome
STSG	Split thickness Skin graft
SUBCU, SUBQ	Subcutaneous

SURG	Surgery/Surgical
SUSP	Suspicious/suspected
SVC	Superior vena cava
SX	Symptoms
T	Thoracic
T1-T12	Thoracic Vertebra
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy-bilateral salpingo-oophorectomy
TB	Tuberculosis
TBI	Total body irradiation
TCC	Transitional cell carcinoma
TIA	Transient ischemic attack
TPN	Total parenteral nutrition
TRAM	Transverse rectus abdominis myocutaneous
TRANS-COLON	Transverse colon
TS	Tumor Size
T-SPINE	Thoracic spine
TTP	Thrombotic thrombocytopenia purpura
TUR	Transurethral resection
TURB	Transurethral resection bladder
TURB(T)	Transurethral Resection Bladder (Tumor)
TURP	Transurethral resection prostate
TVC	True vocal cord
TVH	Total vaginal hysterectomy
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 I-III	Vaginal intraepithelial neoplasia, Grade I-III
VASC	Vascular
VIN I-III	Vulvar intraepithelial neoplasia, Grade I-III
VPI	Visceral pleural invasion
W/ or C	With
W/F	White female

W/M	White male
W/O	Without
W/U	Work-up
WBC	White blood cells (count)
WELL DIFF	Well differentiated WD,
WHO	World Health Organization
WNL	Within normal limits
WPW	Wolff-Parkinson-White syndrome
X	Times
XR	Xray
YR	Year

Appendix N: ICD-0-3 Codes to be Considered One Primary Site When Determining Multiple Primaries

For cases diagnosed January 1, 2010 and forward, or following installation of CSv2 software, refer to Collaborative Stage Data Collection System Coding Instructions.

ICD-0-3 Codes	Site Groupings
C01 C02	Base of tongue Other and unspecified parts of tongue
C05 C06	Palate Other and unspecified parts of mouth
C07 C08	Parotid gland Other and unspecified major salivary glands
C09 C10	Tonsil Oropharynx

C12 C13	Pyriform sinus Hypopharynx
C19 C20	Rectosigmoid junction Rectum
C23 C24	Gallbladder Other and unspecified parts of biliary tract
C30 C31	Nasal cavity and middle ear Accessory sinuses
C33 C34	Trachea Bronchus and lung
C37 C38.0-.3 C38.8	Thymus Heart and mediastinum Overlapping lesion of heart, mediastinum, and pleura
C40 C41	Bones, joints and articular cartilage of limbs Bones, joints and articular cartilage of other and unspec. sites
C51 C52 C57.7 C57.8-.9	Vulva Vagina Other specified female genital organs Overlapping lesion and female genital tract, NOS
C60 C63	Penis Other and unspecified male genital organs
C64 C65 C66 C68	Kidney Renal pelvis Ureter Other and unspecified urinary organs
C74 C75	Adrenal gland Other endocrine glands and related structures

Appendix O: Spanish Surnames

Click here to view a searchable Appendix O, Spanish Surnames

Note: This is a pdf file and therefore, it can also be printed.

Appendix Q 1: Surgery Codes

For Cases Diagnosed Prior to January 1, 2003

This outdated list remains available in the on-line version of this manual.

Appendix Q-2: Surgery Codes

For Cases Diagnosed on or after January 1, 2003

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surgery Codes - ANUS

C21.0-C21.8

(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal Ablation

No specimen sent to pathology from surgical events 10-15.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

[SEER Guideline: margins of resection may have microscopic involvement]

60 Abdominal perineal resection, NOS (APR; Miles procedure)

- 61 APR and sentinel node excision
- 62 APR and unilateral inguinal lymph node dissection
- 63 APR and bilateral inguinal lymph node dissection

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery or Scope of Regional Lymph Node

Surgery at This Facility.

Specimen sent to pathology from surgical events 20-63.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - BLADDER

C67.0-C67.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Intravesical therapy
- 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

Clarification: Use code 16 if local tumor destruction occurs via the use of BCG and more extensive surgery is not performed. When BCG is administered via Intravesical Therapy, also use code 16. In addition, also code the item under "Immunotherapy" as code 01.

No specimen sent to pathology from surgical events 10-16.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Radical cystectomy (male only)
[SEER Guideline: This code is used only for men. It involves removal of bladder

and prostate, with or without urethrectomy. The procedure is also called cystoprostatectomy. If a radical cystectomy is the procedure for a woman, use code 71.]

61 Radical cystectomy PLUS ileal conduit

62 Radical cystectomy PLUS continent reservoir or pouch, NOS

63 Radical cystectomy PLUS abdominal pouch (cutaneous)

64 Radical cystectomy PLUS in situ pouch (orthotopic)

When the procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64)

70 Pelvic exenteration, NOS

71 Radical cystectomy (female only); anterior exenteration

For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

72 Posterior exenteration

For females, also includes removal of vagina, rectum and anus. For males, also includes prostate, rectum and anus.

73 Total exenteration

Includes all tissue and organs removed for an anterior and posterior exenteration.

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery or Scope of Regional Lymph Node Surgery at This Facility.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - BONES, PERIPHERAL NERVES AND SOFT TISSUES

BONES, JOINTS, AND ARTICULAR CARTILAGE C40.0-C41.9
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0-C47.9
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C49.0-C49.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS [formerly SEER code 10 = local tumor destruction or excision]
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction [formerly SEER code 10 = local tumor destruction or excision]
No specimen sent to pathology from surgical event 15.

25 Local excision

26 Partial resection [formerly SEER code 20 = partial resection/internal hemipelvectomy (pelvis)]

30 Radical excision or resection of lesion WITH limb salvage

40 Amputation of limb

- 41 Partial amputation of limb
- 42 Total amputation of limb

50 Major amputation, NOS

- 51 Forequarter, including scapula
- 52 Hindquarter, including ilium/hip bone
- 53 Hemipelvectomy, NOS
- 54 Internal hemipelvectomy [formerly SEER code 20 = partial resection/internal hemipelvectomy (pelvis)]

Specimen sent to pathology from surgical events 25-54.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - BRAIN

Meninges C70.0-C70.9, Brain C71.0-C71.9,
Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0-C72.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Do not code laminectomies for spinal cord primaries.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 [Local] Tumor destruction, NOS
No specimen sent to pathology from surgical event 10.

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.

20 Local excision (biopsy) of ***tumor***, lesion or mass; ***excisional biopsy.***

21 Subtotal resection of tumor, lesion or mass in brain

22 Resection of tumor of spinal cord or nerve

30 Radical, total, gross resection of tumor, lesion or mass in brain

40 Partial resection of lobe of brain, when surgery cannot be coded as 20-30.

55 Gross total resection ***of lobe of brain (lobectomy)***

Codes 30-55 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events 20-55.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - BREAST

C50.0-C50.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS
No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

20 Partial mastectomy, NOS; less than total mastectomy, NOS [formerly SEER code 10]

- 21 Partial mastectomy WITH nipple resection [formerly SEER code 11 = nipple resection]
- 22 Lumpectomy or excisional biopsy [formerly SEER code 12]
- 23 Reexcision of the biopsy site for gross or microscopic residual disease [formerly SEER code 13]
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy) [formerly SEER codes 16 = segmental mastectomy, 14 = wedge resection, 15 = quadrantectomy, 17 = tylectomy]

Procedures coded 20-24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy
A subcutaneous mastectomy, *also called a nipple sparing mastectomy,* is the removal of breast tissue without the nipple and areolar complex or overlying skin. *It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.*

40 Total (simple) mastectomy, NOS

- 41 WITHOUT removal of uninvolved contralateral breast
- 43 Reconstruction NOS
  - 44 Tissue
  - 45 Implant
  - 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast

47 Reconstruction NOS

48 Tissue

49 Implant

75 Combined (Tissue and Implant)

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.

For single primaries only, code removal of involved contralateral breast under the data item Surgical Procedure/Other Site or Surgical Procedure/Other Site at This Facility.

If contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, whether it is done at the time of mastectomy or later.

50 Modified radical mastectomy

51 WITHOUT removal of uninvolved contralateral breast

53 Reconstruction, NOS

54 Tissue

55 Implant

56 Combined (Tissue and Implant)

52 WITH removal of uninvolved contralateral breast

57 Reconstruction, NOS

58 Tissue

59 Implant

63 Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.

[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen] [SEER Guideline: "tissue" for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants).]

If contralateral breast reveals a second primary, it is abstracted

separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item Surgical Procedure/Other Site or Surgical Procedure/Other Site at This Facility.

60 Radical mastectomy, NOS

- 61 WITHOUT removal of uninvolved contralateral breast
  - 64 Reconstruction, NOS
  - 65 Tissue
  - 66 Implant
  - 67 Combined (Tissue and Implant)
- 62 WITH removal of uninvolved contralateral breast
  - 68 Reconstruction, NOS
  - 69 Tissue
  - 73 Implant
  - 74 Combined (Tissue and Implant)

[SEER Guideline: Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes en bloc axillary dissection. For single primaries only, code removal of involved contralateral breast under the data item "Surgery of other regional sites, distant sites, or distant lymph nodes."]

70 Extended radical mastectomy

- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

[SEER Guideline: Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes removal of internal mammary nodes and en bloc axillary dissection. For single primaries only, code removal of involved contralateral breast under the data item "Surgery of other regional sites, distant sites, or distant lymph nodes."]

80 Mastectomy, NOS

Specimen sent to pathology for surgical events coded 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - CERVIX UTERI

C53.0-C53.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure.*

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Laser ablation
- 17 Thermal ablation

No specimen sent to pathology from surgical events 10-17.

20 Local tumor excision, NOS

- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 24 Cone biopsy WITH gross excision of lesion
- 29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH

- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

- 25 Dilatation and curettage; endocervical curettage (for in situ only)
- 28 Loop electrocautery excision procedure (LEEP)

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy

51 Modified radical hysterectomy

52 Extended hysterectomy

53 Radical hysterectomy; Wertheim procedure

54 Extended radical hysterectomy

60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries

61 WITHOUT removal of tubes and ovaries

62 WITH removal of tubes and ovaries

70 Pelvic exenteration

71 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

72 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20-74.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - COLON

C18.0-C18.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site*.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS

- 27 Excisional biopsy
- 26 Polypectomy, NOS
- 28 Polypectomy-endoscopic
- 29 Polypectomy-surgical excision

Any combination of 20 or 26-29 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy (NOS, endoscopic or surgical excision) or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

30 Partial colectomy, segmental resection

- 32 Plus resection of contiguous organ; example: small bowel, bladder

[SEER Guideline: codes 30-32 include but are not limited to: appendectomy (for an appendix primary only), enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures, segmental resection, e.g., cecectomy, sigmoidectomy]

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)

41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)

51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
[SEER Guideline: commonly used for familial polyposis or polyposis coli]

61 Plus resection of contiguous organ; example: small bowel, bladder

70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Colectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - CORPUS UTERI

C54.0-C55.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure.*

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electocautery Excision Procedure (LEEP)
- 16 Thermal ablation

No specimen sent to pathology from surgical events 10-16.

20 Local tumor excision, NOS; simple excision, NOS

- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

Any combination of 20 or 24-26 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

[Margins of resection may have microscopic involvement]
[SEER Guideline: Procedures in code 20 include but are not limited to: cryosurgery, electrocautery, excisional biopsy, laser ablation, thermal ablation]

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies).

31 WITHOUT tube(s) and ovary(ies)

32 WITH tube(s) and ovary(ies)

[SEER Guideline: for these procedures, the cervix is left in place.]

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies) **Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.**

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies) **Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.**

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy

61 Modified radical hysterectomy

62 Extended hysterectomy

63 Radical hysterectomy; Wertheim procedure

64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies) [formerly SEER code 70]

66 WITHOUT removal of tube(s) and ovary(ies) [formerly SEER code 71]

67 WITH removal of tube(s) and ovary(ies) [formerly SEER code 72]

75 Pelvic exenteration [formerly SEER code 80]

76 Anterior exenteration [formerly SEER code 81]

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

77 Posterior exenteration [formerly SEER code 82]

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

78 Total exenteration [formerly SEER code 83]

Includes removal of all pelvic contents and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

79 Extended exenteration [formerly SEER code 84]

Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20-79.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - ESOPHAGUS

C15.0-C15.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)***

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
[SEER Guideline: esophagectomy may be partial, total, or NOS]

- 51 WITH laryngectomy
- 52 WITH gastrectomy, NOS
- 53 Partial gastrectomy
- 54 Total gastrectomy
- 55 Combination of 51 WITH any of 5254

80 Esophagectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - HEMATOPOIETIC/RETICULOENDOTHELIAL/ IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE

C42.0, C42.1, C42.3, C42.4 for all histologies
Or
M-*9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992* for all sites

Codes

9 8	All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment. **Surgical procedures for hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative primaries are to be recorded using the data item Surgical Procedure/Other Site or Surgical Procedure/Other Site at this Facility.**
9 9	Death certificate only

NOTE: A hematopoietic case not otherwise specified in the list of standard exclusions (M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***) in the Surgery Code Appendix Q should be treated as an Unknown And Ill-Defined Primary Site.

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - KIDNEY, RENAL, PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal ablation

No specimen sent to pathology from this surgical event 10-15.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Procedures coded 30 include, but are not limited to:
Segmental resection
Wedge resection

40 Complete/total/simple nephrectomyfor kidney parenchyma
Nephroureterectomy
Includes bladder cuff for renal pelvis or ureter.

50 Radical nephrectomy

May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter.

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)
The other organs, such as colon or bladder, may be partially or totally removed.
[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Nephrectomy, NOS
Ureterectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - LARYNX

C32.0-C32.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from surgical events 10-15.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Stripping

30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS

- 31 Vertical laryngectomy
- 32 Anterior commissure laryngectomy
- 33 Supraglottic laryngectomy

40 Total or radical laryngectomy, NOS

41 Total laryngectomy ONLY

42 Radical laryngectomy ONLY

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - LIVER AND INTRAHEPATIC BILE DUCTS

C22.0-C22.1
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Alcohol (Percutaneous Ethanol Injection-PEI)
- 16 Heat-Radio-frequency ablation (RFA)
- 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10-17.

1/2008: Chemoembolization should only be coded in the Chemotherapy field. Do not code this in the surgery fields.

20 Wedge or segmental resection, NOS

- 21 Wedge resection
- 22 Segmental resection, NOS
  - 23 One
  - 24 Two
  - 25 Three
  - 26 Segmental resection AND local tumor destruction

30 Lobectomy, [simple or] NOS

- 36 Right lobectomy
- 37 Left lobectomy
- 38 Lobectomy AND local tumor destruction

50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)

- 51 Right lobectomy

52 Left lobectomy

59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS [formerly SEER code 80]

61 Total hepatectomy and transplant [formerly SEER code 70]

65 Excision of a bile duct (for an intra-hepatic bile duct primary only) [formerly SEER code 40]

66 Excision of a bile duct PLUS partial hepatectomy

75 Bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events 20-75.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - LUNG

C34.0-C34.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS [formerly SEER code 10]
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS

- 12 Laser ablation or cryosurgery [formerly SEER code 12 = laser ablation or excision]
- 13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction) [formerly SEER code 13 = cautery; fulguration]

No specimen sent to pathology from surgical events 12-13 and 15.

20 Excision or resection of less than one lobe, NOS

- 23 Excision, NOS [formerly SEER code 11 = Excision]
- 24 Laser excision [formerly SEER code 12 = laser ablation or excision]
- 25 Bronchial sleeve resection ONLY [formerly SEER code 14]
- 21 Wedge resection
- 22 Segmental resection, including lingulectomy

30 Resection of [at least one] lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)

- 33 Lobectomy WITH mediastinal lymph node dissection

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery or Scope of Regional Lymph Node Surgery at This Facility.

45 Lobe or bilobectomy extended, NOS

- 46 WITH chest wall
- 47 WITH pericardium
- 48 WITH diaphragm

55 Pneumonectomy, NOS [formerly SEER codes 40, 50, 51, 52, 53, 54]

- 56 WITH mediastinal lymph node dissection (radical pneumonectomy)

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery or Scope of Regional Lymph Node Surgery at This Facility.

NOTE: Peribronchial or hilar lymph nodes are not included in any of the lung surgery codes. If peribronchial or hilar nodes are dissected as part of a surgical procedure which involves the destruction, excision or resection of the primary tumor then the extent of the nodal dissection is recorded in the item "Scope of Regional Lymph Node Surgery" and the number of nodes dissected is recorded as part of the cumulative Regional Lymph Nodes Examined."

65 Extended pneumonectomy

66 Extended pneumonectomy plus pleura or diaphragm

70 Extended radical pneumonectomy
[SEER Guideline: an extended radical pneumonectomy is a radical pneumonectomy (including removal of mediastinal nodes) and the removal of other tissues or nodes]

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery or Scope of Regional Lymph Node Surgery at This Facility.

NOTE: Peribronchial or hilar lymph nodes are not included in any of the lung surgery codes. If peribronchial or hilar nodes are dissected as part of a surgical procedure which involves the destruction, excision or resection of the primary tumor then the extent of the nodal dissection is recorded in the item "Scope of Regional Lymph Node Surgery" and the number of nodes dissected is recorded as part of the cumulative "Regional Lymph Nodes Examined."

80 Resection of lung, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - LYMPH NODES

Lymph Nodes C77.0-C77.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS [formerly SEER code 10 under spleen and lymph nodes]
Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 15.

25 Local tumor excision, NOS
Less than a full chain, includes an excisional biopsy of a single lymph node.

30 Lymph node dissection, NOS

- 31 One chain
- 32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy

- 41 One chain
- 42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)

- 51 One chain
- 52 Two or more chains

60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy (Includes staging laparotomy for lymphoma.)

- 61 One chain
- 62 Two or more chains

Specimen sent to pathology for surgical events 25-62.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - ORAL CAVITY

Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9, Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9, Other Parts of Mouth C06.0-C06.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

[SEER Guideline: Codes 20-27 include shave and wedge resection]

30 Wide excision, NOS
Code 30 includes:
Hemiglossectomy
Partial glossectomy

40 Radical excision of tumor, NOS

- 41 Radical excision of tumor ONLY
- 42 Combination of 41 WITH resection in continuity with mandible (marginal,

segmental, hemi-, or total resection)

43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Codes 40-43 include:
Total glossectomy
Radical glossectomy

Specimen sent to pathology from surgical events 20-43.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - OVARY

C56.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

17 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 17.

25 Total removal of tumor or (single) ovary, NOS

- 26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
- 27 WITHOUT hysterectomy
- 28 WITH hysterectomy

Specimen sent to pathology from surgical events 25-28.

35 Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done [formerly SEER code 14]

- 36 WITHOUT hysterectomy [formerly SEER code 15]
- 37 WITH hysterectomy [formerly SEER code 16]

50 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done [formerly SEER code 20]

- 51 WITHOUT hysterectomy [formerly SEER code 21]
- 52 WITH hysterectomy [formerly SEER code 22]

55 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done [formerly SEER code 30]

- 56 WITHOUT hysterectomy [formerly SEER code 31]
- 57 WITH hysterectomy [formerly SEER code 32]

60 Debulking; cytoreductive surgery, NOS

- 61 WITH colon (including appendix) and/or small intestine resection (not incidental)
- 62 WITH partial resection of urinary tract (not incidental)
- 63 Combination of 61 and 62

Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may

or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.

70 Pelvic exenteration, NOS

71 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

72 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

80 (Salpingo-)oophorectomy, NOS

Specimen sent to pathology from surgical events 25-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - PANCREAS

C25.0-C25.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

25 Local excision of tumor, NOS [formerly SEER code 10]

30 Partial pancreatectomy, NOS; example: distal [formerly SEER code 20]

35 Local or partial pancreatectomy and duodenectomy [formerly SEER code 50]

- 36 WITHOUT distal/partial gastrectomy [formerly SEER code 51 "without subtotal gastrectomy"]
- 37 WITH partial gastrectomy (Whipple) [formerly SEER code 52 "with subtotal gastrectomy (Whipple)"]

40 Total pancreatectomy

60 Total pancreatectomy and subtotal gastrectomy or duodenectomy

70 Extended pancreatoduodenectomy

80 Pancreatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - PAROTID AND OTHER UNSPECIFIED GLANDS

Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS

- 31 Facial nerve spared
- 32 Facial nerve sacrificed
- 33 Superficial lobe ONLY
  - 34 Facial nerve spared
  - 35 Facial nerve sacrificed

36 Deep lobe (Total)
[SEER Guideline: with or without superficial lobe]

37 Facial nerve spared

38 Facial nerve sacrificed

40 Total parotidectomy, NOS; total removal of major salivary gland, NOS

41 Facial nerve spared

42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS

51 WITHOUT removal of temporal bone

52 WITH removal of temporal bone

53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - PHARYNX

Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9, Pyriform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from surgical events 10-15.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Stripping

30 Pharyngectomy, NOS

- 31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
- 32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
[SEER Guideline: code 40 includes mandibulectomy (marginal, segmental, hemi-, and/or laryngectomy) NOS]

[SEER Guideline: contiguous bone tissue refers to the mandible]

41 WITH Laryngectomy (laryngopharyngectomy)

42 WITH bone

43 WITH both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS

51 WITHOUT laryngectomy

52 WITH laryngectomy

Specimen sent to pathology from surgical events 20-52.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - PROSTATE

C61.9
(Except for M-*9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)*

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures*.

Codes

00 None; no surgery of primary site; autopsy ONLY

18 Local tumor destruction or excision, NOS [formerly SEER code 10]

19 Transurethral resection (TURP), NOS [formerly SEER code 11]

Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, [or excision] NOS

- 14 Cryoprostatectomy
- 15 Laser ablation
- 16 Hyperthermia
- 17 Other method of local tumor destruction

No specimen sent to pathology from surgical events 10-17.

20 Local tumor excision, NOS [formerly SEER code 10 = local tumor destruction or excision, NOS]

- 21 Transurethral resection (TURP), NOS [formerly SEER code 11 = transurethral resection (TURP) NOS]
- 22 TURPcancer is incidental finding during surgery for benign disease [formerly SEER code 12]
- 23 TURPpatient has suspected/known cancer [SEER code 13]

Any combination of 20-23 WITH

- 24 Cryosurgery
- 25 Laser
- 26 Hyperthermia

Specimen sent to pathology from surgical events 20-26.

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS; total prostatectomy, NOS [formerly SEER code 30 or 40]
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.
[SEER Guideline: in continuity with or en bloc means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Prostatectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - RECTOSIGMOID

C19.9
(Except for M-)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site*.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS

- 31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:

Anterior resection
Hartmann operation
Low anterior resection (LAR)
Partial colectomy, NOS
Rectosigmoidectomy, NOS
Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)
[SEER Guideline: Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation.]

50 Total proctectomy
[SEER Guideline: Procedures coded 50 include but are not limited to: abdominoperineal resection (A & P resection), anterior/posterior resection (A/P resection)/Mile's operation, Rankin's operation]

51 Total colectomy [SEER Guideline: removal of the colon from cecum to rectosigmoid or portion of rectum]

55 Total colectomy WITH ileostomy, NOS

56 Ileorectal reconstruction

57 Total colectomy WITH other pouch; example: Koch pouch

60 Total proctocolectomy, NOS [SEER Guideline: combination of 50 and 51]

65 Total proctocolectomy WITH ileostomy, NOS

66 Total proctocolectomy WITH ileostomy and pouch

Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.

70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration [SEER Guideline: Procedures that may be part of an en bloc resection include, but are not limited to: an oophorectomy and a rectal mucosectomy. Code 70 includes any colectomy (partial, hemicolectomy or total) with an en bloc resection of any other organs. There may be partial or total removal of other organs in continuity with the primary.]
[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Colectomy, NOS; Proctectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - RECTUM

C20.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site*.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS

- 27 Excisional biopsy
- 26 Polypectomy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 28 Curette and fulguration

30 Wedge or segmental resection; partial proctectomy, NOS
Procedures coded 30 include, but are not limited to:
Anterior resection
Hartmanns operation
Low anterior resection (LAR)
Transsacral rectosigmoidectomy

40 Pull through WITH sphincter preservation (coloanal anastomosis)

[SEER Guideline: Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbul'ls operation.]

50 Total proctectomy
Procedure coded 50 includes, but is not limited to:
Abdominoperineal resection (Miles Procedure)
[SEER Guideline: also called anterior/posterior (A/P) resection/Mile's operation, Rankin's operation]

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration
[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Proctectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - SKIN

C44.0-C44.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)

- 31 Shave biopsy followed by a gross excision of the lesion
- 32 Punch biopsy followed by a gross excision of the lesion
- 33 Incisional biopsy followed by a gross excision of the lesion
- 34 Mohs surgery, NOS
- 35 Mohs with 1-cm margin or less
- 36 Mohs with more than 1-cm margin

45 Wide excision or reexcision of lesion or minor (local) amputation with margins

more than 1 cm, NOS. Margins MUST be microscopically negative. [formerly SEER code 40 or 50 = wide excision or re-excision of lesion or minor (local) amputation, NOS, margins of excision are 1 cm or more, margins may be microscopically involved.]

46 WITH margins more than 1 cm and less than or equal to 2 cm

47 WITH margins greater than 2 cm

If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code, 20-36.

60 Major amputation [NOS]

Specimen sent to pathology for surgical events 21-60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - SPLEEN

Spleen C42.2
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)***

Note: Lymph Nodes surgery codes have been moved to a separate scheme

Codes

00	None; no surgery of primary site; autopsy ONLY
19	Local tumor destruction or excision, NOS [formerly SEER code 10 = local excision, destruction, NOS] Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).
21	Partial splenectomy
22	Total splenectomy
80	Splenectomy, NOS [formerly SEER code 20]
	Specimen sent to pathology for surgical events 21-80.
90	Surgery, NOS
99	Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - STOMACH

C16.0-C16.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Gastrectomy, NOS (partial, subtotal, hemi-)

- 31 Antrectomy, lower (distal-less than 40% of stomach)***
- 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:
Partial gastrectomy, including a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS

41 Near-total gastrectomy

42 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

50 Gastrectomy, NOS WITH removal of a portion of esophagus

51 Partial or subtotal gastrectomy

52 Near total or total gastrectomy

Codes 50-52 are used for gastrectomy resection when only portions of esophagus are included in procedure.

60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***

61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***

62 Near total or total gastrectomy, in continuity with the resection of other organs***

63 Radical gastrectomy, in continuity with the resection of other organs***

Codes 60-63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.
[SEER Guideline: codes 60-63 may include omentectomy]
[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Gastrectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - TESTIS

C62.0-C62.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures*.

Codes

00 None; no surgery of primary site; autopsy ONLY

12 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 12.

20 Local or partial excision of testicle

30 Excision of testicle WITHOUT cord

40 Excision of testicle WITH cord or cord not mentioned (radical orchiectomy)

80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - THYROID GLAND

C73.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

13 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 13.

25 Removal of less than a lobe, NOS [formerly SEER code 10]

- 26 Local surgical excision [formerly SEER code 11]
- 27 Removal of a partial lobe ONLY [formerly SEER code 12]

20 Lobectomy and/or isthmectomy

- 21 Lobectomy ONLY
- 22 Isthmectomy ONLY
- 23 Lobectomy WITH isthmus

30 Removal of a lobe and partial removal of the contralateral lobe

40 Subtotal or near total thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

Specimen sent to pathology from surgical events 25-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - OTHER SITES

C14.1-C14.8, C17.0-C17.9, C23.9, C24.0-C24.9, C26.0-C26.9, C30.0-C 30.1, C31.0-C31.9, C33.9, C37.9, C38.0-C38.8, C39.0-C39.9, C48.0-C48.8, C51.0-C51.9, C52.9, C57.0-C57.9, C58.9, C60.0-C 60.9, C63.0-C63.9, C68.0-C68.9, C69.0-C69.9, C74.0-C74.9, C75.0-C75.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS

- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation

- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be "debulking"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.

[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Specimen sent to pathology from surgical events 20-60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 Surery Codes - UNKNOWN AND ILL DEFINED PRIMARY SITES

C76.0-C76.8, C80.9
(Except for M-***9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992***)

Code

98 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item Surgical Procedure/Other Site or Surgical Procedure/Other Site at This Facility.

[99 Death certificate only]

Appendix R: ICD-O-3 Lymphatic and Hematopoietic Diseases - Subsequent Diagnoses

The CCR is concerned with identifying lymphomas and leukemias that are or might be treatment induced, usually as a result of chemotherapy plus radiotherapy or chemotherapy with alkylating agents.

The ICD-O-3 version of the hematopoietic primaries table is very different from the ICD-O-2 version in both format and medical understanding of these diseases. As a result, it is not possible to use the tables interchangeably. The first link indicated below, Definitions of Single and Subsequent Primaries for Hematologic Malignancies Based on ICD-O-3 Reportable Malignancies, Effective with Diagnoses 01/01/2001 and After, explains the reasoning that underlies the ICD-O-3 table.

From January 1, 2001 Forward

Use the ICD-O-3 table found in http://seer.cancer.gov/icd-o-3/hematopoietic_primaries.d03152001.pdf, if both diseases are diagnosed after January 1, 2001 or if a first diagnosis was prior to 2001, but a second diagnosis was after January 1, 2001.

Also review the following errata files.

http://seer.cancer.gov/icd-o-3/errata.d05222001.pdf

http://seer.cancer.gov/icd-o-3/errata.d05062003.pdf

Appendix S: DSQC Memos

Click here to open a searchable link to DSQC memos.

Appendix T: CNExT Over-Ride Flags and Edits

Edit Name	CNExT Edit #	Flag Name
Date First Admission, Date Diagnosis (Calif)	ED1014	Override, DateDx/DateAdm
Primary Site, Behavior Code (C/NET IF39)	ED2000	Override, Site/Behavior
Morphology--Type & Behavior (C/NET MORPH)	ED2004	Override, Histology
Primary Site, Stage, EOD (Calif)	ED2010	Override, Site/Stage
Age, Primary Site, Morphology (C/NET IF15)	ED2015	Override, Age/Site/Morph
Diagnostic Confirm, Seq Num--Hospital (C/NET IF23)	ED2017	Override, SeqNo/DxConf
Diagnostic Confirmation, Behavior (C/NET IF31)	ED2018	Override, Histology
Diagnostic Confirmation, Histol Type (C/NET IF48)	ED2019	Override, Leuk, Lymphoma

Seq Num--Hosp, Primary Site, Morph (C/NET IF22)	ED2022	Override, Ill-defined Site
Primary Site, Morphology-Type Check (C/NET IF25)	ED2024	Override, Site/Type
Laterality, Primary Site, Morphology (C/NET IF42)	ED2030	Override, Site/Lat/Morph
Primary Site, Laterality, EOD (C/NET IF41)	ED2030	Override, Site/Lat/EOD
Date of Diagnosis, Primary Site, EOD (C/NET IF40)	ED2040	Override, Site/EOD/DX Date
RX Summ--Surgery Type, Diag Conf (C/NET IF46)	ED3011	Override, Surg/DxConf
Race - Spanish Origin - Birthplace (Calif)	ED6013	Override, Race/Spanish/Birthpl
Spanish Origin - Birthplace (Calif)	ED6014	Override, Spanish/Birthplace
Type of Report (DC), Seq Num--Hospital(C/NET IF04)	ED6015	Override, Report Source
First Name, Sex (Calif)	ED7004	Override, FirstName/Sex
Accession Number, Class of Case, Seq Number(C/NET)	ED7007	Override, Accession/Class/Seq
		Override, COC Site/Type
Diagnostic Confirm, Seq Num--Hospital (C/NET IF23)	ED2017	Override, Seq/Dx Confirm
		Override, Seq/Site
		Override, Site/Lat/SeqNum
		Override, Site/TNM Stage
Summary Stage 2000, Site Dist Met 1 (CNET)	ED2029	Override, Stage/Dist Mets
Summary Stage 2000, Regional Nodes Pos (CNET)	ED2028	Override, Stage/Nodes Pos
Summary Stage 2000, TNM M (CNET)	ED2050	Override, Stage/TNM-M
Summary Stage 2000, TNM N (CNET)	ED2051	Override, Stage/TNM-N
Seq Num-Hosp, Primary Site, Morphology	ED2514	Override, Hosp Seq/Site

Appendix U : Table of Data Items and Their Required Status

Reporting requirements are not uniform for all cancer reporting facilities. Consult the following table to determine which data items must be reported:

Key to Symbols

no	Not required. It is optional for the facility to submit this data item value to the central registry.

yes	Required. The facility must submit this data item value to the central registry.
yes*	Required if available. If the information can be obtained, the facility must submit it to the central registry. If not available or not applicable, may be left blank.
conditional	Required on selected cases dependent on one or more conditions being true, such as the case's diagnosis date being before or after a certain date.
gen	Required, but the facility's registry software must generate the data item value based on a standard algorithm, rather than a user manually entering the data item value.

Items that are facility-generated are described in more detail, including allowable values in Cancer Reporting in California, Data Standards for Regional Registries and California Cancer Registry (California Cancer Reporting System Standards, Volume III).

Data Items and Their Required Status

Item Name	**Manual**	**RX Ctr**	**Hosp> CCR**
Abstractor	III.1.1	yes	yes
Accession Number (Hosp)	II.2.3	yes	yes
ACoS Approved Flag	III.1.6	yes	yes
Address at Diagnosis City	III.2.5	yes	yes
Address at Diagnosis No. & Street	III.2.5	yes	yes
Address at Diagnosis No. & Street - Supplemental	III.2.5	yes*	yes*
Address at Diagnosis - State	III.2.5	yes	yes
Address at Diagnosis - Zip Code	III.2.5	yes	yes
Age at Diagnosis	III.2.11	gen	gen
Alias First Name	III.2.1.6	yes*	yes*
Alias Last Name	III.2.1.5	yes*	yes*
Ambiguous Terminology Dx	II.1.6.3	yes	yes
Birthplace	III.2.12	yes	yes
Casefinding Source	III.3.8	yes	yes

Cause of Death	VII.2.14	no	no
Chemotherapy at This Hospital	VI.4	yes	yes
Chemotherapy Summary	VI.4	yes	yes
Class of Case	III.3.5	yes	yes
Coding Procedure	III.1.5	gen	yes
Comorbidity Complications 1	III.3.13	yes*	yes*
Comorbidity Complications 2	III.3.13	yes*	yes*
Comorbidity Complications 3	III.3.13	yes*	yes*
Comorbidity Complications 4	III.3.13	yes*	yes*
Comorbidity Complications 5	III.3.13	yes*	yes*
Comorbidity Complications 6	III.3.13	yes*	yes*
Comorbidity Complications 7	III.3.13	yes*	yes*
Comorbidity Complications 8	III.3.13	yes*	yes*
Comorbidity Complications 9	III.3.13	yes*	yes*
Comorbidity Complications 10	III.3.13	yes*	yes*
Contact City	VII.3	yes*	yes*
Contact Country	VII.3	yes*	yes*
Contact Name	VII.3	yes*	yes*
Contact State	VII.3	yes*	yes*
Contact Street	VII.3	yes*	yes*
Contact Street - Supplemental	VII.3	yes*	yes*
Contact Zip	VII.3	yes*	yes*
County of Residence at Diagnosis	III.2.5	yes	yes
CS Tumor Size	V.4.2	yes	yes
CS Extension	V.4.2	yes	yes
CS Tumor Size/Extension Evaluation	V.4.2	yes	yes
CS Lymph Nodes	V.4.2	yes	yes
CS Lymph Nodes Evaluation	V.4.2	yes	yes
CS Metastasis at Diagnosis	V.4.2	yes	yes
CS Metastasis at Diagnosis Bone	***V.4.2.1***	***yes***	***yes***
CS Metastasis at Diagnosis Brain	***V.4.2.2***	***yes***	***yes***
CS Metastasis at Diagnosis Liver	***V.4.2.3***	***yes***	***yes***

CS Metastasis at Diagnosis Lung	***V.4.2.4***	***yes***	***yes***
CS Metastasis Evaluation	V.4.2	yes	yes
CS Site Specific Factor 1	V.4.2	yes	yes
CS Site Specific Factor 2	V.4.2	yes	yes
CS Site Specific Factor 3	V.4.2	yes	yes
CS Site Specific Factor 4	V.4.2	yes	yes
CS Site Specific Factor 5	V.4.2	yes	yes
CS Site Specific Factor 6	V.4.2	yes	yes
CS Site Specific Factor 7	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 8	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 9	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 10	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 11	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 12	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 13	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 14	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 15	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 16	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 17	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 18	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 19	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 20	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 21	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 22	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 23	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 24	***V.4.2***	***yes***	***yes***
CS Site Specific Factor 25	***V.4.2***	***yes***	***yes***
CS Version Input Current	***V.4.2***	***yes***	***yes***
CS Version Latest	V.4.2	yes	yes
Date of Birth	III.2.10	yes	yes
Date of Birth Flag	***III.2.10.1***	***yes***	***yes***
Date Case Initiated	***Vol. 2***	***gen***	***gen***

Date of Conclusive DX	II.1.6.4	yes	yes
Date of Conclusive Dx Flag	***V.1.7.2***	***yes***	***yes***
Date of Chemotherapy	VI.1.3.2	conditional	yes*
Date of Chemotherapy Flag	***VI.4.3.1***	***yes***	***yes****
Date of Diagnosis	III.3.1	yes	yes
Date of Diagnosis Flag	***III.3.3.4***	***yes***	***yes***
Date of First Admission	III.3.1	yes	yes
Date of First Contact Flag	***III.3.1.1***	***yes***	***yes***
Date of Inpatient Admission	III.3.2	no	yes*
Date of Inpatient Admission Flag	***III.3.2.1***	***yes***	***yes***
Date of Inpatient Discharge	III.3.2	no	yes*
Date of Inpatient Discharge Flag	***III.3.2.2***	***yes***	***yes***
Date of Hormone Therapy	VI.1.3.2	conditional	yes*
Date of Hormone Therapy Flag	***VI.5.5.1***	***yes***	***yes****
Date of Immunotherapy	VI.1.3.2	conditional	yes*
Date of Immunotherapy Flag	***VI.6.3.1***	***yes***	***yes***
Date of Last Patient Contact or Death	VII.2.1	yes	yes
Date of Last Patient Contact or Death Flag	***VII.2.1.1***	***yes***	***yes***
Date of Last Tumor Status	VII.2.3	yes	yes
Date of Last Contact Flag	***VII.2.2.1***	***yes***	***yes***
Date of Most Definitive Surgery of the Primary Site	VI.2.5	gen	yes*
Date of Most Definitive Surgery of the Primary Site Flag	***VI.2.5***	***yes***	***yes***
Date of Multiple Tumors	V.1.7.4	yes	yes
Date of Multiple Tumors Flag	***V.1.7.4.1***	***yes***	***yes***
Date of Other Therapy	VI.1.3.2	conditional	yes*
Date of Other Therapy Flag	***VI.8.2.1***	***yes***	***yes****
Date of Radiation	VI.1.3.2	conditional	yes*
Date of Radiation Flag	***VI.3.5.1***	***yes***	***yes****
Date of Systemic Therapy	VI.1.3.2	gen	yes*
Date of Systemic Therapy Flag	***VI.1.3.2***	***yes***	***yes****

Date of Surgery	VI.1.3.2	gen	yes*
Date of Surgery Flag	***VI.2.5.1***	***yes***	***yes****
Date of Surgery Diagnostic or Staging Procedures	VI.2.12	conditional	yes*
Date of Surgery Diagnostic or Staging Procedures Flag	***V1.2.11.1***	***yes***	***yes***
Date of Surgery Procedures 1-3	VI.2.5	conditional	yes
Date of Surgery Procedures 1-3 Flag	***VI.2.5***	***yes***	***yes***
Date of Therapy	Vol III	no	no
Date of Transplant/Endocrine Procedures	VI.7.2	conditional	yes
Date of Transplant/Endocrine Procedures Flag	***VI.7.2.1***	***yes***	***yes***
Death File Number	VII.2.14	no	no
Derived AJCC***-7*** T	V.4.2	yes	yes
Derived AJCC***-7*** T Descriptor	V.4.2	yes*	yes*
Derived AJCC***-7*** N	V.4.2	yes	yes
Derived AJCC***-7*** N Descriptor	V.4.2	yes*	yes*
Derived AJCC***-7*** M	V.4.2	yes	yes
Derived AJCC***-7*** M Descriptor	V.4.2	yes*	yes*
Derived AJCC***-7*** Stage Group	V.4.2	yes	yes
Derived SS2000	V.4.2	yes	yes
Derived SS1977	V.4.2	yes	yes
Derived AJCC - Flag	V.4.2	yes	yes
Derived SS2000 - Flag	V.4.2	yes	yes
Derived SS1977 - Flag	V.4.2	yes	yes
Diagnostic Confirmation	IV.2	yes	yes
Discovered by Screening	III.3.15	no	no
EOD Extension	V.4	yes	yes
EOD Extension (Path)	V.4	yes	yes
EOD - Lymph Node Involvement	V.4	yes	yes
First Name	III.2.1.2	yes	yes
Follow up Contact Address Other	VII.3	yes*	yes
Follow up Contact Address Other -	VII.3	yes*	yes*

Supplemental			
Follow up Contact City Other	VII.3	yes*	yes
Follow up Contact Name Other	VII.3	yes*	yes
Follow up Contact State Other	VII.3	yes*	yes
Follow up Contact Zip Other	VII.3	yes*	yes
Follow up Last Type (Patient)	VII.2.6.2	yes	yes
Follow up Last Type (Tumor)	VII.2.6.1	yes	yes
Follow up Next Type	VII.2.8	yes*	yes*
Follow up Hospital (Next)	VII.2.9	no	no
Follow up Hospital (Last)	VII.2.7	yes	yes
Grade Path Value	***V.3.5.11***	***yes***	***yes***
Grade Path System	***V.3.5.12***	***yes***	***yes***
Histology Text	IV.1.7	yes	yes
Histology Behavior (ICD-O-2)	V.3.4	yes	yes
Histology Behavior (ICD-O-3)	V.3.4	yes	yes
Histology Grade/ Differentiation	V.3.5	yes	yes
Histology Type (ICD-O-2)	V.3	yes	yes
Histology Type (ICD-O-3)	V.3	yes	yes
Hormone Therapy at This Hospital	VI.5	yes	yes
Hormone Therapy Summary	VI.5	yes	yes
Hospital Number (Reporting)	III.1.4	yes	yes
Hospital Patient Number	Vol. 2	gen	yes
Hospital Referred From	III.3.10	yes	yes
Hospital Referred To	III.3.11	yes	yes
ICD Revision Comorbidities	III.3.14	yes	yes
ICD-O-3 Conversion Flag	Vol. 2	gen	yes
Immunotherapy at This Hospital	VI.6	yes	yes
Immunotherapy Summary	VI.6	yes	yes
Industry Text	III.2.13.2	no	yes
Last Name	III.2.1.1	yes	yes
Laterality	V.2	yes	yes
Lymph-Vascular Invasion	***V.5.14***	***conditional***	***conditional***

Maiden Name	III.2.1.4	yes*	yes*
Marital Status	III.2.6	yes	yes
Medical Record Number	III.2.2	yes*	yes*
Middle Name	III.2.1.3	yes*	yes*
Mothers First Name	III.2.1.9	yes*	yes*
Multiple Tumors Reported as One Primary	II.1.3.9.3	yes	yes
Multiplicity Counter	II.1.3.9.1	yes	yes
Name Suffix	III.2.1.8	yes*	yes*
Number of Regional Lymph Nodes Examined Surgery Summary	VI.2.2	gen	conditional
Number of Regional Lymph Nodes Examined Procedures 1-3	VI.2.3	yes	no
NPI Reporting Facility	III.1.4	yes*	yes*
NPI Hospital Referred From	III.3.10	yes*	yes*
NPI Hospital Referred To	III.3.11	yes*	yes*
NPI Following Registry	Appendix X	yes*	yes*
NPI Physician-Managing	III.3.12	yes*	yes*
NPI Physician-Primary Surgeon	III.3.12	yes*	yes*
NPI Physician-Follow-up	VII.2.10	yes*	yes*
NPI Physician 3	III.3.12	yes*	yes*
NPI Physician 4	III.3.12	yes*	yes*
NPI Physician Other 1	III.3.12	yes*	yes*
NPI Physician Other 2	III.3.12	yes*	yes*
NPI Archive FIN	Appendix X	no	no
Occupation Text	III.2.13.1	yes	yes
Other Therapy at This Hospital	VI.7	yes	yes
Other Therapy Summary	VI.7	yes	yes
Over-ride Flags	Appendix T	yes	yes
Path Date Specimen Collected 1-5	***IV.4.3***	***yes****	***yes****
Path Report Numbers 1-5	***IV.4.2***	***yes****	***yes****

Path Report Type 1-5	***IV.4.4***	***yes****	***yes****
Path Reporting Facility ID 1-5	***IV4.1***	***yes****	***yes****
Patient No Research Contact Flag	III.2.14	yes	yes
Payment Source (Primary)	III.3.9	yes	yes
Payment Source (Secondary)	III.3.9	yes*	yes*
Payment Source Text	III.3.9	yes	yes
Pediatric Stage	V.7.8	yes*	yes*
Pediatric Stage Coder	V.7.10	yes*	yes*
Pediatric Stage System	V.7.9	yes*	yes*
Phone Number (Patient)	III.2.4	yes*	yes*
Physician (Managing)	III.3.12	yes	yes
Physician (Following)	VII.2.10	yes*	yes*
Physician (Medical Oncologist)	III.3.12	yes*	yes*
Physician (Other)	III.3.12	yes*	yes*
Physician (Other)	III.3.12	yes*	yes*
Physician (Radiation Oncologist)	III.3.12	yes*	yes*
Physician (Referring)	III.3.12	yes*	yes*
Physician (Surgeon)	III.3.12	yes*	yes*
Place of Death	VII.2.14	yes*	yes*
Place of Diagnosis	III.3.4	yes*	yes*
Protocol Participation	VI.9	yes*	yes*
Quality of Survival	VII.2.5	no	no
Race 1	III.2.9	yes	yes
Race 2	III.2.9	yes	yes
Race 3	III.2.9	yes	yes
Race 4	III.2.9	yes	yes
Race 5	III.2.9	yes	yes
Radiation at This Hospital	VI.3	no	no
Radiation - Boost RX Modality	VI.3.4	yes	yes
Radiation - Location of Treatment	VI.3.8	yes	yes
Radiation - Regional RX Modality	VI.3.3	yes	yes
Radiation Summary	VI.3	yes	yes

Radiation/Surgery Sequence	VI.3.4	yes	yes
Reason for No Radiation	VI.3.3	yes	yes
Reason for No Surgery	VI.2.10	yes	yes
Recurrence Date	VII.2.13.1	no	no
Recurrence Sites	VII.2.13.3	no	no
Recurrence Type	VII.2.12.2	no	no
Regional Data	--	no	yes*
EOD- Regional Nodes Examined	V.4	yes	yes
EOD- Regional Nodes Positive	V.4	yes	yes
Religion	III.2.8	yes	yes
Scope of Regional Lymph Node Surgery 98-02 Summary	VI.2.2	gen	conditional
Scope of Regional Lymph Node Surgery Summary	VI.2.2	gen	yes
Scope of Regional Lymph Node Surgery Procedures 1-3	V.7.12	yes	yes
Sequence Number	II.2.4	yes	yes
Sex	III.2.7	yes	yes
Site Text	IV.1	yes	yes
Site, Primary	V.1.1	yes	yes
Social Security Number	III.2.3	yes*	yes*
Social Security Number Suffix	III.2.3	yes*	yes*
Spanish/Hispanic Origin	III.2.9.2	yes	yes
Stage-Alternate	V.5.6	yes*	yes*
Staging Text	IV.3.5	yes	yes
Summary Stage 1977	V.5	conditional	conditional
Summary Stage 2000	V.5	conditional	conditional
Surgery at This Hospital Diagnostic or Staging Procedure	VI.2.11	yes	yes
Surgery at This Hospital Reconstructive	VI.2.8	no	no
Surgery at This Hospital	VI.2.1	gen	no
Surgery of Primary Site 9802 Summary	VI.2.1	gen	conditional
Surgery of Primary SiteSummary	VI.2.1	gen	yes

Surgery of Primary Site Procedures 1-3	VI.2.1	yes	yes
Surgery of Other Site Summary 98-02	VI.2.4	gen	conditional
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)Summary	VI.2.4	gen	yes
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) Procedures 1-3	VI.2.4	yes	yes
Surgery Summary Diagnostic or Staging Procedure	VI.2.11	yes	yes
Surgery Summary Reconstructive	VI.2.8	yes	yes
Surgical Margins Procedures 1-3	VI.2.7	no	no
Surgical Margins Summary	VI.2.7	gen	no
Systemic/Surgery Sequence	VI.2.14	yes	yes
Text RX Chemotherapy	VI.4	yes*	yes*
Text RX Hormone Therapy	VI.5	yes*	yyes*
Text RX Immunotherapy	VI.6	yes*	yes*
Text RX Other Therapy	VI.7	yes*	yes*
Text RX Radiation (Beam)	VI.3	yes*	yes*
Text RX Radiation (Other)	VI.3	yes*	yes*
Text RX Radiation Boost RX Modality	VI.3	yes*	yes*
Text RX Radiation Regional RX Modality	VI.3	yes*	yes*
Text RX Surgery	VI.2	yes*	yes*
Text DxProc Lab Tests	IV.1.5	yes*	yes*
Text DxProc Operative	IV.1.6	yes*	yes*
Text DxProc Pathological	IV.1.7	yes*	yes*
Text DxProc PE	IV.1.2	yes*	yes*
Text DxProc Scopes	IV.1.4	yes*	yes*
Text DxProc Xray	IV.1.3	yes*	yes*
Text Remarks	VIII.1	yes*	yes*
TNM Coder (Clinical)	V.7.6	yes*	yes*
TNM Coder (Path)	V.7.6	yes*	yes*
TNM Edition	V.7.7	yes*	yes*
TNM Stage (Clinical)	V.7.5	yes*	yes*

TNM Stage (Path)	V.7.5	yes*	yes*
TNM M Code (Clinical)	V.7.4	yes*	yes*
TNM M Code (Path)	V.7.4	yes*	yes*
TNM N Code (Clinical)	V.7.4	yes*	yes*
TNM N Code (Path)	V.7.4	yes*	yes*
TNM T Code (Clinical)	V.7.4	yes*	yes*
TNM T Code (Path)	V.7.4	yes*	yes*
Transplant/Endocrine Procedures At This Hospital	VI.7.1	yes	yes
Transplant/Endocrine Procedures Summary	VI.7.1	yes	yes
Treatment Hospital Number-Procedure 1-3	VI.2.6	yes	yes
Treatment Status	***VI.9***	***yes***	***yes***
Tumor Markers 1-3	V.6	conditional	conditional
Tumor Marker-CA-1	V.6.4	conditional	conditional
Tumor Size	V.4	yes	yes
Tumor Status	VII.2.4	yes	yes
Type of Admission	III.3.7	yes	yes
Type of Reporting Source	III.3.6	yes	yes
Vendor Version	Vol. 2	yes	gen
Vital Status	VII.2.2	yes	yes
Year First Seen	II.2.1	no	yes

Appendix V: Brain and CNS Site/Histology Listing

Based on ICD-O-3 SEER Site/Histology Validation list
Reviewed by Neuropathologists: Drs. Roger McLendon, Janet Bruner, Steven Moore
SEER: Lynn Ries
CBTRUS: Dr. Bridget McCarthy, Carol Kruchko

Underlined bold type indicates histology codes with a benign or uncertain behavior code that have been added by CBTRUS and are not contained in the ICD-O-3 SEER Site/Histology Validation List.

Bold type indicates histology codes with a malignant behavior code that have been added by CBTRUS and are not contained in the ICD-O-3 SEER Site/Histology Validation List.

MENINGES (CEREBRAL,SPINAL) C700-C709

NEOPLASM 800

8000/0 Neoplasm, benign

8000/1 Neoplasm, uncertain whether benign or malignant

8000/3 Neoplasm, malignant

8001/0 Tumor cells, benign

8001/1 Tumor cells, uncertain whether benign or malignant

8001/3 Tumor cells, malignant

8005/3 Malignant tumor, clear cell type

NEVI & MELANOMAS 872

8720/3 Malignant melanoma, NOS

8728/0 Diffuse melanocytosis

8728/1 Meningeal melanocytoma

8728/3 Meningeal melanomatosis

SARCOMA, NOS 880

8800/0 Soft tissue tumor, benign

8800/3 Sarcoma, NOS

8801/3 Spindle cell sarcoma

8805/3 Undifferentiated sarcoma

8806/3 Desmoplastic small round cell tumor

FIBROMATOUS NEOPLASMS	881	**8810/0 Fibroma, NOS** **8810/3 Fibrosarcoma, NOS** **8815/0 Solitary fibrous tumor**
LIPOMATOUS NEOPLASMS	885	**8850/0 Lipoma, NOS** **8851/0 Fibrolipoma**
ANGIOLIPOMA	886	**8861/0 Angiolipoma, NOS**
MYOMATOUS NEOPLASMS	889	**8890/3 Leiomyosarcoma, NOS**
EMBRYONAL RHABDOMYOSARCOMA	891	**8910/3 Embryonal rhabdomyosarcoma, NOS**
TERATOMA	908	**9080/0 Teratoma, benign** **9080/1 Teratoma, NOS** **9080/3 Teratoma, malignant, NOS** **9084/0 Dermoid cyst, NOS** **9084/3 Teratoma with malig. transformation**
BLOOD VESSEL TUMORS	912	**9120/0 Hemangioma, NOS** **9121/0 Cavernous hemangioma**

HEMANGIOPERICYTOMA	915	
		9150/0 Hemangiopericytoma, benign
		9150/1 Hemangiopericytoma, NOS
		9150/3 Hemangiopericytoma, malignant
HEMANGIOBLASTOMA	916	
		9161/1 Hemangioblastoma
OSSEOUS & CHONDROMATOUS NEOPLASMS	924	
		9240/3 Mesenchymal chondrosarcoma
MENINGIOMA	953	
		9530/0 Meningioma, NOS
		9530/1 Meningiomatosis, NOS
		9530/3 Meningioma, malignant
		9531/0 Meningothelial meningioma
		9532/0 Fibrous meningioma
		9533/0 Psammomatous meningioma
		9534/0 Angiomatous meningioma
		9537/0 Transitional meningioma
		9538/1 Clear cell meningioma
		9538/3 Papillary meningioma
		9539/1 Atypical meningioma
		9539/3 Meningeal sarcomatosis
MALIGNANT LYMPHOMA, NOS	959	
		9590/3 Malignant lymphoma, NOS

		9591/3 Malignant lymphoma, non-Hodgkin
		9596/3 Composite Hodgkin and non-Hodgkin lymphoma
HODGKIN LYMPHOMA	965	
		9650/3 Hodgkin lymphoma, NOS
		9651/3 Hodgkin lymphoma, lymphocyte-rich
		9652/3 Hodgkin lymphoma, mixed cellularity, NOS
		9653/3 Hodgkin lymphoma, lymphocytic deplet., NOS
		9654/3 Hodgkin lymphoma, lymphocyt. deplet., diffuse fibrosis
		9655/3 Hodgkin lymphoma, lymphocyt. deplet., reticular
		9659/3 Hodgkin lymphoma, nodular lymphocyte predom.
HODGKIN LYMPHOMA, NOD. SCLER.	966	
		9661/3 Hodgkin granuloma
		9662/3 Hodgkin sarcoma
		9663/3 Hodgkin lymphoma, nodular sclerosis, NOS
		9664/3 Hodgkin lymphoma, nod. scler., cellular phase
		9665/3 Hodgkin lymphoma, nod. scler., grade 1
		9667/3 Hodgkin lymphoma, nod. scler., grade 2
ML, SMALL B-CELL LYMPHOCYTIC	967	
		9670/3 ML, small B lymphocytic, NOS
		9671/3 ML, lymphoplasmacytic

		9673/3 Mantle cell lymphoma
		9675/3 ML, mixed sm. and lg. cell, diffuse
ML, LARGE B-CELL, DIFFUSE	968	
		9680/3 ML, large B-cell, diffuse
		9684/3 ML, large B-cell, diffuse, immunoblastic, NOS
		9687/3 Burkitt lymphoma, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9690/3 Follicular lymphoma, NOS
		9691/3 Follicular lymphoma, grade 2
		9695/3 Follicular lymphoma, grade 1
		9698/3 Follicular lymphoma, grade 3
		9699/3 Marginal zone B-cell lymphoma, NOS
T-CELL LYMPHOMAS	970	
		9701/3 Sezary syndrome
		9702/3 Mature T-cell lymphoma, NOS
		9705/3 Angioimmunoblastic T-cell lymphoma
OTHER SPEC. NON-HODGKIN LYMPHOMA	971	
		9714/3 Anaplastic large cell lymphoma, T-cell and Null cell type
		9719/3 NK/T-cell lymphoma, nasal and nasal-type
PRECURS. CELL	972	

LYMPHOBLASTIC LYMPH.		9727/3 Precursor cell lymphoblastic lymphoma, NOS
		9728/3 Precursor B-cell lymphoblastic lymphoma
		9729/3 Precursor T-cell lymphoblastic lymphoma
PLASMA CELL TUMORS	973	
		9731/3 Plasmacytoma, NOS
		9734/3 Plasmacytoma, extramedullary
MAST CELL TUMORS	974	
		9740/3 Mast cell sarcoma
		9741/3 Malignant mastocytosis
NEOPLASMS OF HISTIOCYTES AND ACCESSORY LYMPHOID CELLS	975	
		9750/3 Malignant histiocytosis
		9754/3 Langerhans cell histiocytosis, disseminated
		9755/3 Histiocytic sarcoma
		9756/3 Langerhans cell sarcoma
		9757/3 Interdigitating dendritic cell sarcoma
		9758/3 Follicular dendritic cell sarcoma

BRAIN, C710-C714 & C717-C719, (EXCL. VENTRICLE, CEREBELLUM)
SPINAL CORD C720 , CAUDA EQUINA C721 & CRANIAL NERVES, C722-C725

NEOPLASM	800	
		8000/0 Neoplasm, benign
		8000/1 Neoplasm, uncertain whether benign or malignant

		8000/3 Neoplasm, malignant
		8001/0 Tumor cells, benign
		8001/1 Tumor cells, uncertain whether benign or malignant
		8001/3 Tumor cells, malignant
		8002/3 Malignant tumor, small cell type
		8003/3 Malignant tumor, giant cell type
		8004/3 Malignant tumor, spindle cell type
		8005/3 Malignant tumor, clear cell type
PARAGANGLIOMA	868	
		8680/1 Paraganglioma, NOS
NEVI & MELANOMAS	872	
		8720/3 Malignant melanoma
SARCOMA, NOS	880	
		8800/0 Soft tissue tumor, benign
		8800/3 Sarcoma, NOS
		8801/3 Spindle cell sarcoma
		8805/3 Undifferentiated sarcoma
		8806/3 Desmoplastic small round cell tumor
LIPOMATOUS NEOPLASMS	885	
		8850/0 Lipoma, NOS
		8851/0 Fibrolipoma
		8851/3 Liposarcoma

GERM CELL TUMORS	906	
		9060/3 Dysgerminoma
		9064/3 Germinoma
EMBRYONAL CARCINOMA	907	
		9070/3 Embryonal carcinoma, NOS
		9071/3 Yolk Sac Tumor
TERATOMA	908	
		9080/0 Teratoma, benign
		9080/1 Teratoma, NOS
		9080/3 Teratoma, malignant, NOS
		9081/3 Teratocarcinoma
		9085/3 Mixed germ cell tumor
TROPHOBLASTIC NEOPLASMS	910	
		9100/3 Choriocarcinoma, NOS
BLOOD VESSEL TUMORS	912	
		9120/0 Hemangioma, NOS
		9121/0 Cavernous hemangioma
		9122/0 Venous hemangioma
HEMANGIOENDOTHELIOMA	913	
		9131/0 Capillary hemangioma
HEMANGIOPERICYTOMA	915	

		9150/1 Hemangiopericytoma, NOS
HEMANGIOBLASTOMA	916	
		9161/1 Hemangioblastoma
CHORDOMA	937	
		9370/3 Chordoma,
		9371/3 Chondroid chordoma
		9372/3 Dedifferentiated chordoma
GLIOMA	938	
		9380/3 Glioma, malignant
		9381/3 Gliomatosis cerebri
		9382/3 Mixed glioma
		9383/1 Subependymoma
		9384/1 Subependymal giant cell astroctyoma
EPENDYMOMA, NOS	939	
		9391/3 Ependymoma, NOS
		9392/3 Ependymoma, anaplastic
		9393/3 Papillary Ependymoma
		9394/1 Myxopapillary ependymoma
ASTROCYTOMA, NOS	940	
		9400/3 Astrocytoma, NOS
		9401/3 Astrocytoma, anaplastic
PROTOPLASMIC ASTROCYTOMA	941	
		9410/3 Protoplasmic astrocytoma

		9411/3 Gemistocytic astrocytoma
		9412/1 Desmoplastic infantile astrocytoma
		9413/0 Dysembryoplastic neuroepithelial tumor
FIBRILLARY ASTROCYTOMA	942	
		9420/3 Fibrillary astrocytoma
		9421/1 Pilocytic astrocytoma
		9423/3 Polar spongioblastoma
		9424/3 Pleomorphic xanthoastrocytoma
ASTROBLASTOMA	943	
		9430/3 Astroblastoma
GLIOBLASTOMA, NOS	944	
		9440/3 Glioblastoma, NOS
		9441/3 Giant cell glioblastoma
		9442/1 Gliofibroma
		9442/3 Gliosarcoma
		9444/1 Chordoid glioma
OLIGODENDROGLIOMA, NOS	945	
		9450/3 Oligodendroglioma, NOS
		9451/3 Oligodendroglioma, anaplastic
OLIGODENDROBLASTOMA	946	
		9460/3 Oligodendroblastoma
PRIMITIVE NEUROECTODERMAL	947	
		9473/3 Primitive neuroectodermal

		tumor, NOS
GANGLIONEUROBLASTOMA	949	
		9490/0 Ganglioneuroma
		9490/3 Ganglioneuroblastoma
		9492/0 Gangliocytoma
NEUROBLASTOMA, NOS	950	
		9500/3 Neuroblastoma, NOS
		9501/3 Medulloepithelioma, NOS
		9502/3 Teratoid medulloepithelioma
		9503/3 Neuroepithelioma, NOS
		9505/1 Ganglioglioma, NOS
		9505/3 Ganglioglioma, anaplastic
		9508/3 Atypical teratoid/rhabdoid tumor
MENINGIOMA	953	
		9530/0 Meningioma, NOS
		9530/1 Mengiomatosis, NOS
		9530/3 Meningioma, malignant
		9531/0 Meningotheliomatous meningioma
		9532/0 Fibrous meningioma
		9533/0 Psammomatous meningioma
		9534/0 Angiomatous meningioma
		9537/0 Transitional meningioma
		9538/1 Clear cell meningioma
		9538/3 Papillary meningioma

		9539/1 Atypical meningioma
		9539/3 Meningeal sarcomatosis
NEUROFIBROSARCOMA	954	
		9540/0 Neurofibroma, NOS
		9540/1 Neurofibromatosis, NOS
		9540/3 Malignant peripheral nerve sheath tumor
		9541/0 Melanotic neurofibroma
PLEXIFORM NEUROFIBROMA	955	
		9550/0 Plexiform neurofibroma
NEURILEMOMA	956	
		9560/0 Neurilemoma, NOS
		9560/1 Neurinomatosis
		9560/3 Neurilemoma, malignant
		9561/3 Triton tumor, malignant
		9562/0 Neurothekeoma
NEUROMA	957	
		9570/0 Neuroma, NOS
		9571/0 Perineurioma, NOS
		9571/3 Perineurioma, malignant
MALIGNANT LYMPHOMA, NOS	959	
		9590/3 Malignant lymphoma, NOS
		9591/3 Malignant lymphoma, non-Hodgkin

		9596/3 Composite Hodgkin and non-Hodgkin lymphoma
ML, SMALL B-CELL LYMPHOCYTIC	967	
		9670/3 ML, small B lymphocytic, NOS
		9671/3 ML, lymphoplasmacytic
		9673/3 Mantle cell lymphoma
		9675/3 ML, mixed sm. and lg. cell, diffuse
ML, LARGE B-CELL, DIFFUSE	968	
		9680/3 ML, large B-cell, diffuse
		9684/3 ML, large B-cell, diffuse, immunoblastic, NOS
		9687/3 Burkitt lymphoma, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9690/3 Follicular lymphoma, NOS
		9691/3 Follicular lymphoma, grade 2
		9695/3 Follicular lymphoma, grade 1
		9698/3 Follicular lymphoma, grade 3
		9699/3 Marginal zone B-cell lymphoma, NOS
T-CELL LYMPHOMAS	970	
		9701/3 Sezary syndrome
		9702/3 Mature T-cell lymphoma, NOS
		9705/3 Angioimmunoblastic T-cell lymphoma
OTHER SPEC. NON-	971	

HODGKIN LYMPHOMA		9714/3 Large cell lymphoma
		9719/3 NK/T-cell lymphoma, nasal and nasal-type
PRECURS. CELL LYMPHOBLASTIC LYMPH.	972	
		9727/3 Precursor cell lymphoblastic lymphoma, NOS
		9728/3 Precursor B-cell lymphoblastic lymphoma
		9729/3 Precursor T-cell lymphoblastic lymphoma
PLASMA CELL TUMORS	973	
		9731/3 Plasmacytoma, NOS
		9734/3 Plasmacytoma, extramedullary
NEOPLASMS OF HISTIOCYTES AND ACCESSORY LYMPHOID CELLS	975	
		9750/3 Malignant histiocytosis
		9754/3 Langerhans cell histiocytosis, disseminated
		9755/3 Histiocytic sarcoma
		9756/3 Langerhans cell sarcoma
		9757/3 Interdigitating dendritic cell sarcoma
		9758/3 Follicular dendritic cell sarcoma
LEUKEMIA	993	
		9930/3 Myeloid sarcoma

VENTRICLE C715

NEOPLASM	800	

		8000/0 Neoplasm, benign
		8000/1 Neoplasm, uncertain whether benign or malignant
		8000/3 Neoplasm, malignant
		8001/0 Tumor cells, benign
		8001/1 Tumor cells, uncertain whether benign or malignant
		8001/3 Tumor cells, malignant
		8005/3 Malignant tumor, clear cell type
TERATOMA	908	
		9085/3 Mixed germ cell tumor
MISCELLANEOUS TUMORS	937	
		9370/3 Chordoma, NOS
		9371/3 Chondroid chordoma
		9372/3 Dedifferentiated chordoma
GLIOMA	938	
		9380/3 Glioma, malignant
		9381/3 Gliomatosis cerebri
		9382/3 Mixed glioma
		9383/1 Gliomatosis cerebri
		9384/1 Subependymal giant cell astrocytoma
EPENDYMOMA, NOS	939	
		9390/0 Choroid plexus papilloma, NOS
		9390/1 Atypical choroid plexus papilloma
		9390/3 Choroid plexus papilloma,

		malignant
		9391/3 Ependymoma, NOS
		9392/3 Ependymoma, anaplastic
		9393/3 Papillary ependymoma
ASTROCYTOMA, NOS	940	
		9400/3 Astrocytoma, NOS
		9401/3 Astrocytoma, anaplastic
PROTOPLASMIC ASTROCYTOMA	941	
		9410/3 Protoplasmic astrocytoma
		9411/3 Gemistocytic astrocytoma
FIBRILLARY ASTROCYTOMA	942	
		9420/3 Fibrillary astrocytoma
		9421/1 Pilocytic astrocytoma
		9423/3 Polar spongioblastoma
		9424/3 Pleomorphic xanthoastrocytoma
ASTROBLASTOMA	943	
		9430/3 Astroblastoma
GLIOBLASTOMA, NOS	944	
		9440/3 Glioblastoma, NOS
		9441/3 Giant cell glioblastoma
		9442/3 Gliosarcoma
		9444/1 Chordoid glioma
OLIGODENDROGLIOMA, NOS	945	
		9450/3 Oligodendroglioma, NOS

		9451/3 Oligodendroglioma, anaplastic
PRIMITIVE NEUROECTODERMAL	947	
		9473/3 Primitive neuroectodermal tumor (PNET)
GANGLIONEUROBLASTOMA	949	
		9490/0 Ganglioneuroma
		9490/3 Ganglioneuroblastoma
		9492/0 Gangliocytoma
NEUROBLASTOMA, NOS	950	
		9500/3 Neuroblastoma, NOS
		9501/3 Medulloepithelioma, NOS
		9502/3 Teratoid medulloepithelioma
		9503/3 Neuroepithelioma, NOS
		9505/1 Ganglioglioma, NOS
		9505/3 Ganglioglioma, anaplastic
		9506/1 Central neurocytoma
		9508/3 Atypical teratoid/rhabdoid tumor
MENINGIOMAS	953	
		9530/0 Meningioma, NOS
		9530/1 Meningiomatosis, NOS
		9530/3 Meningioma, malignant
		9531/0 Meningotheliomatous meningioma
		9532/0 Fibrous meningioma
		9533/0 Psammomatosis meningioma
		9534/0 Angiomatous

		meningioma
		9537/0 Transitional meningioma
		9538/1 Clear cell meningioma
		9538/3 Papillary meningioma
MALIGNANT LYMPHOMA, NOS	959	
		9590/3 Malignant lymphoma, NOS
		9591/3 Malignant lymphoma, non-Hodgkin
		9596/3 Composite Hodgkin and non-Hodgkin lymphoma
ML, SMALL B-CELL LYMPHOCYTIC	967	
		9670/3 ML, small B lymphocytic, NOS
		9671/3 ML, lymphoplasmacytic
		9673/3 Mantle cell lymphoma
		9675/3 ML, mixed sm. and lg. cell, diffuse
ML, LARGE B-CELL, DIFFUSE	968	
		9680/3 ML, large B-cell, diffuse
		9684/3 ML, large B-cell, diffuse, immunoblastic, NOS
		9687/3 Burkitt lymphoma, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9690/3 Follicular lymphoma, NOS
		9691/3 Follicular lymphoma, grade 2
		9695/3 Follicular lymphoma, grade 1
		9698/3 Follicular lymphoma, grade 3
		9699/3 Marginal zone B-cell

		lymphoma, NOS
T-CELL LYMPHOMAS	970	
		9701/3 Sezary syndrome
		9702/3 Mature T-cell lymphoma, NOS
		9705/3 Angioimmunoblastic T-cell lymphoma
OTHER SPEC. NON-HODGKIN LYMPHOMA	971	
		9714/3 Anaplastic large cell lymphoma, T-cell and Null cell type
		9719/3 NK/T-cell lymphoma, nasal and nasal-type
PRECURS. CELL LYMPHOBLASTIC LYMPH.	972	
		9727/3 Precursor cell lymphoblastic lymphoma, NOS
		9728/3 Precursor B-cell lymphoblastic lymphoma
		9729/3 Precursor T-cell lymphoblastic lymphoma
PLASMA CELL TUMORS	973	
		9731/3 Plasmacytoma, NOS
		9734/3 Plasmacytoma, extramedullary
NEOPLASMS OF HISTIOCYTES AND ACCESSORY LYMPHOID CELLS	975	
		9750/3 Malignant histiocytosis
		9754/3 Langerhans cell histiocytosis, disseminated
		9755/3 Histiocytic sarcoma
		9756/3 Langerhans cell sarcoma

9757/3 Interdigitating dendritic cell sarcoma

9758/3 Follicular dendritic cell sarcoma

CEREBELLUM C716

NEOPLASM 800

8000/0 Neoplasm, benign

8000/1 Neoplasm, uncertain whether benign or malignant

8000/3 Neoplasm, malignant

8001/0 Tumor cells, benign

8001/1 Tumor cells, uncertain whether benign or malignant

8001/3 Tumor cells, malignant

8005/3 Malignant tumor, clear cell type

SARCOMA, NOS 880

8800/0 Soft tissue tumor, benign

8800/3 Sarcoma, NOS

8805/3 Undifferentiated sarcoma

8806/3 Desmoplastic small round cell tumor

FIBROMATOUS NEOPLASMS 881

8810/3 Fibrosarcoma, NOS

8815/0 Solitary fibrous tumor

LIPOMATOUS NEOPLASMS 885

8850/0 Lipoma, NOS

GERM CELL NOEPLASMS	908	
		9080/0 Teratoma, benign
		9080/1 Teratoma, NOS
		9080/3 Teratoma, malignant, NOS
		9084/0 Dermoid cyst, NOS
BLOOD VESSEL TUMORS	912	
		9120/0 Hemangioma, NOS
HEMANGIOENDOTHELIOMA	913	
		9131/0 Capillary hemangioma
HEMANGIOPERICYTOMA	915	
		9150/1 Hemangiopericytoma, NOS
HEMANGIOBLASTOMA	916	
		9161/1 Hemangioblastoma
CHORDOMA	937	
		9370/3 Chordoma, NOS
		9371/3 Chondroid chordoma
		9372/3 Dedifferentiated chordoma
GLIOMA	938	
		9380/3 Glioma, malignant
		9381/3 Gliomatosis cerebri
		9382/3 Mixed glioma
		9383/1 Subependymoma

EPENDYMOMA, NOS	939	
		9391/3 Ependymoma, NOS
		9392/3 Ependymoma, anaplastic
		9393/3 Papillary ependymoma
ASTROCYTOMA, NOS	940	
		9400/3 Astrocytoma, NOS
		9401/3 Astrocytoma, anaplastic
PROTOPLASMIC ASTROCYTOMA	941	
		9410/3 Protoplasmic astrocytoma
		9411/3 Gemistocytic astrocytoma
FIBRILLARY ASTROCYTOMA	942	
		9420/3 Fibrillary astrocytoma
		9421/1 Pilocytic astrocytoma
		9424/3 Pleomorphic xanthoastrocytoma
ASTROBLASTOMA	943	
		9430/3 Astroblastoma
GLIOBLASTOMA, NOS	944	
		9440/3 Glioblastoma, NOS
		9441/3 Giant cell glioblastoma
		9442/3 Gliosarcoma
OLIGODENDROGLIOMA,	945	

NOS		9450/3 Oligodendroglioma, NOS
		9451/3 Oligodendroglioma, anaplastic
MEDULLOBLASTOMA, NOS	947	
		9470/3 Medulloblastoma, NOS
		9471/3 Desmoplastic medulloblastoma
		9472/3 Medullomyoblastoma
		9473/3 Primitive neuroectodermal tumor
		9474/3 Large cell medulloblastoma
CEREBELLAR SARCOMA, NOS	948	
		9480/3 Cerebellar sarcoma, NOS
GANGLIONEUROBLASTOMA	949	
		9490/0 Ganglioneuroma
		9490/3 Ganglioneuroblastoma
		9492/0 Gangliocytoma
		9493/0 Dysplastic gangliocytoma of cerebellum (Lhermitte-Duclos)
NEUROBLASTOMA, NOS	950	
		9500/3 Neuroblastoma, NOS
		9501/3 Medulloepithelioma, NOS
		9502/3 Teratoid medulloepithelioma
		9503/3 Neuroepithelioma, NOS
		9505/1 Ganglioglioma, NOS
		9506/1 Central neurocytoma
		9508/3 Atypical teratoid/rhabdoid tumor
MENINGIOMAS	953	

		9530/0 Meningioma, NOS
		9530/1 Meningiomatosis, NOS
		9530/3 Meningioma, malignant
		9531/0 Meningotheliomatous meningioma
		9532/0 Fibrous meningioma
		9533/0 Psammomatous meningioma
		9534/0 Angiomatous meningioma
		9537/0 Transitional meningioma
		9538/1 Clear cell meningioma
		9538/3 Papillary meningioma
MALIGNANT LYMPHOMA, NOS	959	
		9590/3 Malignant lymphoma, NOS
		9591/3 Malignant lymphoma, non-Hodgkin
		9596/3 Composite Hodgkin and non-Hodgkin lymphoma
ML, SMALL B-CELL LYMPHOCYTIC	967	
		9670/3 ML, small B lymphocytic, NOS
		9671/3 ML, lymphoplasmacytic
		9673/3 Mantle cell lymphoma
		9675/3 ML, mixed sm. and lg. cell, diffuse
ML, LARGE B-CELL, DIFFUSE	968	
		9680/3 ML, large B-cell, diffuse
		9684/3 ML, large B-cell, diffuse, immunoblastic, NOS

		9687/3 Burkitt lymphoma, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9690/3 Follicular lymphoma, NOS
		9691/3 Follicular lymphoma, grade 2
		9695/3 Follicular lymphoma, grade 1
		9698/3 Follicular lymphoma, grade 3
		9699/3 Marginal zone B-cell lymphoma, NOS
T-CELL LYMPHOMAS	970	
		9701/3 Sezary syndrome
		9702/3 Peripheral T-cell lymphoma, NOS
		9705/3 Angioimmunoblastic T-cell lymphoma
OTHER SPEC. NON-HODGKIN LYMPHOMA	971	
		9714/3 Anaplastic large cell lymphoma, T-cell and Null cell type
		9719/3 NK/T-cell lymphoma, nasal and nasal-type
PRECURS. CELL LYMPHOBLASTIC LYMPH.	972	
		9727/3 Precursor cell lymphoblastic lymphoma, NOS
		9728/3 Precursor B-cell lymphoblastic lymphoma
		9729/3 Precursor T-cell lymphoblastic lymphoma
PLASMA CELL TUMORS	973	
		9731/3 Plasmacytoma, NOS

		9734/3 Plasmacytoma, extramedullary
NEOPLASMS OF HISTIOCYTES AND ACCESSORY LYMPHOID CELLS	975	
		9750/3 Malignant histiocytosis
		9754/3 Langerhans cell histiocytosis, disseminated
		9755/3 Histiocytic sarcoma
		9756/3 Langerhans cell sarcoma
		9757/3 Interdigitating dendritic cell sarcoma
		9758/3 Follicular dendritic cell sarcoma

OTHER NERVOUS SYSTEM C728-C729

NEOPLASM	800	
		8000/0 Neoplasm, benign
		8000/1 Neoplasm, uncertain whether benign or malignant
		8000/3 Neoplasm, malignant
		8001/0 Tumor cells, benign
		8001/1 Tumor cells, uncertain whether benign or malignant
		8001/3 Tumor cells, malignant
		8002/3 Malignant tumor, small cell type
		8003/3 Malignant tumor, giant cell type
		8004/3 Malignant tumor, spindle cell type
		8005/3 Malignant tumor, clear cell type
SARCOMA, NOS	880	

		8800/0 Soft tissue tumor, benign
		8800/3 Sarcoma, NOS
		8801/3 Spindle cell sarcoma
		8802/3 Giant cell sarcoma
		8803/3 Small cell sarcoma
		8804/3 Epithelioid sarcoma
		8805/3 Undifferentiated sarcoma
		8806/3 Desmoplastic small round cell tumor
LIPOMATOUS NEOPLASMS	885	
		8850/0 Lipoma, NOS
		8850/1 Atypical lipoma
		8850/3 Liposarcoma, NOS
ANGIOLIPOMA	886	
		8861/0 Angiolipoma
MYOMATOUS NEOPLASMS	889	
		8890/0 Leiomyoma, NOS
		8890/1 Leiomyomatosis, NOS
		8890/3 Leiomyosarcoma, NOS
		8897/1 Smooth muscle tumor, NOS
RHABDOMYOSARCOMA	890	
		8900/0 Rhabdomyoma, NOS
		8900/3 Rhabdomyosarcoma, NOS
EMBRYONAL	891	

RHABDOMYOSARCOMA		**8910/3 Embryonal rhabdomyosarcoma, NOS**
ALVEOLAR RHABDOMYOSARCOMA	892	**8920/3 Alveolar rhabdomyosarcoma**
GERM CELL TUMORS	906	**9064/3 Germinoma**
TERATOMA	908	**9080/1 Teratoma, NOS** **9080/3 Teratoma, malignant, NOS** **9082/3 Malignant teratoma, undiff.** **9084/0 Dermoid cyst, NOS** **9084/3 Teratoma with malig. transformation**
BLOOD VESSEL TUMORS	912	**9120/0 Hemangioma, NOS** **9120/3 Hemangiosarcoma** **9121/0 Cavernous hemangioma**
HEMANGIOENDOTHELIOMA	913	**9130/0 Hemangioendothelioma, benign** **9130/1 Hemangioendothelioma, NOS** **9130/3 Hemangioendothelioma, malignant**

KAPOSI SARCOMA	914	
		9140/3 Kaposi sarcoma
HEMANGIOPERICYTOMA	915	
		9150/0 Hemangiopericytoma, benign
		9150/1 Hemangiopericytoma, NOS
		9150/3 Hemangiopericytoma, malignant
HEMANGIOBLASTOMA	916	
		9161/1 Hemangioblastoma
MISCELLANEOUS BONE TUMORS	926	
		9260/3 Ewing sarcoma
CHORDOMA	937	
		9370/3 Chordoma, NOS
		9371/3 Chondroid chordoma
		9372/3 Dedifferentiated chordoma
NEUROBLASTOMA, NOS	950	
		9500/3 Neuroblastoma, NOS
		9501/3 Medulloepithelioma, NOS
		9502/3 Teratoid medulloepithelioma
		9503/3 Neuroepithelioma, NOS
		9508/3 Atypical teratoid/rhabdoid tumor
MENINGIOMA	953	

		9530/0 Meningioma, NOS
		9530/1 Meningiomatosis, NOS
		9530/3 Meningioma, malignant
		9531/0 Meningotheliomatous meningioma
		9532/0 Fibrous meningioma
		9533/0 Psammomatous meningioma
		9534/0 Angiomatous meningioma
		9537/0 Transitional meningioma
		9538/1 Clear cell meningioma
		9538/3 Papillary meningioma
NEUROFIBROSARCOMA	954	
		9540/0 Neurofibroma, NOS
		9540/1 Neurofibromatosis, NOS
		9540/3 Malignant peripheral nerve sheath tumor
		9541/0 Melanotic neurofibroma
PLEXIFORM NEUROFIBROMA	955	
		9550/0 Plexiform neurofibroma
NEURILEMOMA	956	
		9560/0 Neurilemmoma, NOS
		9560/3 Neurilemmoma, malignant
		9561/3 Triton tumor, malignant
		9562/0 Neurothekeoma
NEUROMA	957	
		9570/0 Neuroma, NOS

		9571/0 Perineurioma, NOS
		9571/3 Perineurioma, malignant
MALIGNANT LYMPHOMA, NOS	959	
		9590/3 Malignant lymphoma, NOS
		9591/3 Malignant lymphoma, non-Hodgkin
		9596/3 Composite Hodgkin and non-Hodgkin lymphoma
HODGKIN LYMPHOMA	965	
		9650/3 Hodgkin lymphoma, NOS
		9651/3 Hodgkin lymphoma, lymphocyte-rich
		9652/3 Hodgkin lymphoma, mixed cellularity, NOS
		9653/3 Hodgkin lymphoma, lymphocytic deplet., NOS
		9654/3 Hodgkin lymphoma, lymphocyt. deplet., diffuse fibrosis
		9655/3 Hodgkin lymphoma, lymphocyt. deplet., reticular
		9659/3 Hodgkin lymphoma, nodular lymphocyte predom.
HODGKIN LYMPHOMA, NOD. SCLER.	966	
		9661/3 Hodgkin granuloma
		9662/3 Hodgkin sarcoma
		9663/3 Hodgkin lymphoma, nodular sclerosis, NOS
		9664/3 Hodgkin lymphoma, nod. scler., cellular phase
		9665/3 Hodgkin lymphoma, nod. scler., grade 1
		9667/3 Hodgkin lymphoma, nod. scler.,

		grade 2
ML, SMALL B-CELL LYMPHOCYTIC	967	
		9670/3 ML, small B lymphocytic, NOS
		9671/3 ML, lymphoplasmacytic
		9673/3 Mantle cell lymphoma
		9675/3 ML, mixed sm. and lg. cell, diffuse
ML, LARGE B-CELL, DIFFUSE	968	
		9680/3 ML, large B-cell, diffuse
		9684/3 ML, large B-cell, diffuse, immunoblastic, NOS
		9687/3 Burkitt lymphoma, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9690/3 Follicular lymphoma, NOS
		9691/3 Follicular lymphoma, grade 2
		9695/3 Follicular lymphoma, grade 1
		9698/3 Follicular lymphoma, grade 3
		9699/3 Marginal zone B-cell lymphoma, NOS
T-CELL LYMPHOMAS	970	
		9701/3 Sezary syndrome
		9702/3 Mature T-cell lymphoma, NOS
		9705/3 Angioimmunoblastic T-cell lymphoma
OTHER SPEC. NON-HODGKIN LYMPHOMA	971	
		9714/3 Anaplastic large cell lymphoma, T-cell and Null cell type

		9719/3 NK/T-cell lymphoma, nasal and nasal-type
PRECURS. CELL LYMPHOBLASTIC LYMPH.	972	
		9727/3 Precursor cell lymphoblastic lymphoma, NOS
		9728/3 Precursor B-cell lymphoblastic lymphoma
		9729/3 Precursor T-cell lymphoblastic lymphoma
PLASMA CELL TUMORS	973	
		9731/3 Plasmacytoma, NOS
		9734/3 Plasmacytoma, extramedullary
MAST CELL TUMORS	974	
		9740/3 Mast cell sarcoma
		9741/3 Malignant mastocytosis
NEOPLASMS OF HISTIOCYTES AND ACCESSORY LYMPHOID CELLS	975	
		9750/3 Malignant histiocytosis
		9754/3 Langerhans cell histiocytosis, disseminated
		9755/3 Histiocytic sarcoma
		9756/3 Langerhans cell sarcoma
		9757/3 Interdigitating dendritic cell sarcoma
		9758/3 Follicular dendritic cell sarcoma
LYMPHOID LEUKEMIAS	982	
		9827/3 Adult T-cell leukemia/lymphoma (HTLV-1

positive)

MYELOID LEUKEMIAS 986

9861/3 Acute myeloid leukemia, NOS

OTHER LEUKEMIAS 993

9930/3 Myeloid sarcoma

PITUITARY GLAND and CRANIOPHARYNGEAL DUCT C751-C752

NEOPLASM 800

8000/0 Neoplasm, benign

8000/1 Neoplasm, uncertain whether benign or malignant

8000/3 Neoplasm, malignant

8001/0 Tumor cells, benign

8001/1 Tumor cells, uncertain whether benign or malignant

8001/3 Tumor cells, malignant

8005/0 Clear cell tumor, NOS

8005/3 Malignant tumor, clear cell type

CARCINOMA, NOS 801

8010/0 Epithelial tumor, benign

8010/2 Carcinoma in situ, NOS

8010/3 Carcinoma, NOS

ADENOCARCINOMA, NOS 814

8140/0 Adenoma, NOS

8140/2 Adenocarcinoma in situ

8140/3 Adenocarcinoma, NOS

		8146/0 Monomorphic adenoma
PAPILLARY ADENOMA, NOS	826	**8260/0 Papillary adenoma, NOS**
CHROMOPHOBE CARCINOMA	827	**8270/0 Chromophobe adenoma** 8270/3 Chromophobe carcinoma **8271/0 Prolactinoma** **8272/0 Pituitary adenoma, NOS** 8272/3 Pituitary carcinoma, NOS
ACIDOPHIL CARCINOMA	828	**8280/0 Acidophil adenoma** 8280/3 Acidophil carcinoma **8281/0 Mixed acidophil-basophil adenoma** 8281/3 Mixed acidophil-basophil carcinoma
OXYPHILIC ADENOCARCINOMA	829	**8290/0 Oxyphilic adenoma** 8290/3 Oxyphilic adenocarcinoma
BASOPHIL CARCINOMA	830	**8300/0 Basophil adenoma** 8300/3 Basophil carcinoma
CLEAR CELL ADENOCA., NOS	831	**8310/0 Clear cell adenoma**

GRANULAR CELL CARCINOMA	832	
		8320/3 Granular cell carcinoma
		8323/0 Mixed cell adenoma
		8323/3 Mixed cell adenocarcinoma
SOFT TISSUE TUMORS	880	
		8800/0 Soft tissue tumor, benign
		8800/3 Sarcoma, NOS
LIPOMATOUS NEOPLASMS	885	
		8850/0 Lipoma, NOS
DYSGERMINOMA	906	
		9060/3 Dysgerminoma
		9064/3 Germinoma
		9065/3 Germ cell tumor, nonseminomatous
EMBRYONAL CARCINOMA, NOS	907	
		9070/3 Embryonal carcinoma, NOS
		9071/3 Yolk sac tumor
		9072/3 Polyembryoma
TERATOMA, NOS	908	
		9080/0 Teratoma, benign
		9080/1 Teratoma, NOS
		9080/3 Teratoma, malignant, NOS
		9081/3 Teratocarcinoma
		9082/3 Malignant teratoma, undiff.
		9083/3 Malignant teratoma, intermediate
		9084/3 Teratoma with malig.

		transformation
		9085/3 Mixed germ cell tumor
CRANIOPHARYNGIOMA	935	
		9350/1 Craniopharyngioma
		9351/1 Adamantinomatous craniopharyngioma
		9352/1 Papillary craniopharyngioma
CHORDOMA	937	
		9370/3 Chordoma
		9371/3 Chondroid chordoma
		9372/3 Dedifferentiated chordoma
NEUROBLASTOMA, NOS	950	
		9500/3 Neuroblastoma, NOS
		9501/3 Medulloepithelioma, NOS
		9502/3 Teratoid medulloepithelioma
		9503/3 Neuroepithelioma, NOS
		9505/3 Ganglioglioma, anaplastic
GRANULAR CELL TUMORS	958	
		9580/0 Granular cell tumor, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9699/3 Marginal zone B-cell lymphoma, NOS

PINEAL GLAND C753

NEOPLASM	800

		8000/0 Neoplasm, benign
		8000/1 Neoplasm, uncertain whether benign or malignant
		8000/3 Neoplasm, malignant
		8001/0 Tumor cells, benign
		8001/1 Tumor cells, uncertain whether benign or malignant
		8001/3 Tumor cells, malignant
CARCINOMA, NOS	801	
		8010/0 Epithelial tumor, benign
DYSGERMINOMA	906	
		9060/3 Dysgerminoma
		9064/3 Germinoma
		9065/3 Germ cell tumor, nonseminomatous
EMBRYONAL CARCINOMA, NOS	907	
		9070/3 Embryonal carcinoma, NOS
		9071/3 Yolk sac tumor
		9072/3 Polyembryoma
TERATOMA, NOS	908	
		9080/0 Teratoma, NOS
		9080/3 Teratoma, malignant, NOS
		9081/3 Teratocarcinoma
		9082/3 Malignant teratoma, undiff.
		9083/3 Malignant teratoma, intermediate
		9084/0 Dermoid cyst, NOS
		9084/3 Teratoma with malig. transformation

		9085/3 Mixed germ cell tumor
PINEALOMA, MALIGNANT	936	
		9360/1 Pinealoma, NOS
		9361/1 Pineocytoma
		9362/3 Pineoblastoma
CHORDOMA	937	
		9370/3 Chordoma, NOS
		9371/3 Chondroid chordoma
		9372/3 Dedifferentiated chordoma
PRIMITIVE NEUROECTODERMAL	947	
		9473/3 Primitive neuroectodermal tumor, NOS
GANGLIONEUROBLASTOMA	949	
		9490/3 Ganglioneuroblastoma
		9492/0 Gangliocytoma
NEUROBLASTOMA, NOS	950	
		9500/3 Neuroblastoma, NOS
		9501/3 Medulloepithelioma, NOS
		9502/3 Teratoid medulloepithelioma
		9503/3 Neuroepithelioma, NOS
		9505/1 Ganglioglioma, NOS
		9505/3 Ganglioglioma, anaplastic
ML, LARGE B-CELL, DIFFUSE	968	
		9680/3 ML, large B-cell, diffuse

FOLLIC. & MARGINAL LYMPH, NOS	969	
		9699/3 Marginal zone B-cell lymphoma, NOS

Appendix W: Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics

Appendix W consists of the Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics. This listing is an appendix to the 2004 SEER Race Coding Guidelines.

As a reminder, the CCR has added code 90 for Other South Asian. Please note that code 90 is not included in Appendix W because it is a code added by the CCR.

Refer to Section III.2.9 for more detailed race coding information.

Races to be coded as 90 include:

Bangladeshi
Bhutanese
Nepalese
Sikkimese
Sri Lankan

Do not use code 96 as Appendix W indicates for the races listed above.

Appendix W.1: Race and Nationality Descriptions (Numeric)

Note: Use these lists only when race is not stated but other information is provided in the medical record.

References:

1. *Race and Ethnicity Code Set, Version 1.0, Centers for Disease Control and Prevention, March 2000.*
2. *Instruction manual, part 4: Classification And Coding Instructions For Death Records, 1999-2001, Division of Vital Statistics, National Center for Health Statistics, undated*

Key

Use this code unless patient is stated to be Native American (Indian) or other race

* *Terms listed in reference 2, above.*

! *Description of religious affiliation rather than stated nationality or ethnicity; should be used with caution when determining appropriate race code.*

CODE 01 WHITE

Afghan, Afghanistani
Afrikaner
Albanian
Algerian*
Amish*
Anglo-Saxon*
Arab, Arabian
Argentinian*
Armenian
Assyrian
Australian*
Austrian*
Azores*
Basque*
Bavarian*
Bolivian*
Bozniak/Bosnian
Brava/Bravo*
Brazilian
Bulgarian
Cajun
Californio
Canadian*
Caucasian*
Central American
Chechnyan
Chicano*
Chilean
Colombian*
Costa Rican*
Croat/Croatian
Crucian*
Cuban (*unless specified as Black*)*
Cypriot
Czechoslovakian*
Eastern European
Ebian*
Ecuadorian*
Egyptian

English
English-French*
English-Irish*
European*
Finnish*
French
French Canadian*
Georgian*
German
Greek*
Guatemalan
Gypsy*
Hebrew*!
Herzegovenian
Hispanic*
Honduran
Hungarian*
Iranian, Iran
Iraqi
Irish
Islamic*!
Israeli
Italian
Jordanian*
Kurd/Kurdish
Kuwaitian*
Ladina/Ladino*
Latin American*
Latino
Latvian*
Lebanese
Libyan*
Lithuanian*
Maltese*
Marshenese*
Mauritian*
Moroccan*
Mediterranean*
Mexican
Middle Eastern
Moroccan*
Moslem*!
Muslim*
Near Easterner
Nicaraguan
Nordic*
North African
Norwegian*

Other Arab
Palestinian
Panamanian
Paraguayan
Parsi*
Persian*
Peruvian*
Polish
Portuguese*
Puerto Rican (*unless specified as Black*)
Romanian*
Rumanian
Russian*
Salvadoran
Saudi Arabian*
Scandanavian*
Scottish, Scotch
Semitic*!
Serbian*
Servian*
Shiite!
Sicilian*
Slavic, Slovakian*
South American
Spanish*, Spaniard
Sunni*!
Swedish*
Syrian
Tunisian*
Turkish, Turk*
Ukranian*
United Arab Emirati
Uruguayan
Venezuelan*
Welsh*
White
Yemenite*
Yugoslavian*
Zoroastrian*

CODE 02 BLACK OR AFRICAN AMERICAN

African
African American
Afro-American
Bahamian
Barbadian
Bilalian*

Black
Botswana
Cape Verdean*
Dominica Islander (*unless specified as White*)
Dominican/Dominican Republic (*unless specified as White*)
Eritrean*
Ethiopian
Ghanian*
Haitian
Hamitic*
Jamaican
Kenyan*
Liberian
Malawian*
Mugandan*
Namibian
Nassau*
Negro
Nigerian
Nigritian
Nubian*
Other African
Santo Domingo*
Seychelloise*
Sudanese*
Tanzanian*
Tobagoan
Togolese*
Trinidadian
West Indian
Zairean

CODE 03 AMERICAN INDIAN AND ALASKA NATIVE
(see separate list of tribes)
Alaska Native
Aleut
American Indian
Central American Indian
Eskimo
Meso American Indian
Mexican American Indian
Native American
South American Indian
Spanish American Indian

ASIAN RACE CODES
Code Definition

96 Amerasian
16 Asian Indian
15 Asian Indian or Pakistani, NOS
96 Asian
96 Asiatic
96 Bangladeshi
96 Bhutanese
96 Bornean
96 Bruneian
96 Burmese
13 Cambodian
96 Celebesian
96 Ceram
96 Ceylonese
04 Chinese
96 Eurasian
06 Filipino
12 Hmong
09 Indian (from India) Retired as of 1/1/2010, replaced by 15, 16, and 17.
96 Indo-Chinese
96 Indonesian
05 Iwo Jiman
05 Japanese
96 Javanese
13 Kampuchean
08 Korean
11 Laotian
96 Maldivian
96 Madagascar
96 Malaysian
96 Mongolian
96 Montagnard
96 Nepalese
05 Okinawan
96 Oriental
96 Other Asian
17 Pakistani
96 Sikkimese
96 Singaporean
96 Sri Lankan
96 Sumatran
04 Taiwanese
14 Thai
96 Tibetan
10 Vietnamese
96 Whello
96 Yello

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER CODES

Code	Definition
20	Bikinian
20	Carolinian
21	Chamorro
20	Chuukese
25	Cook Islander
20	Eniwetok, Enewetak
31	Fijian
22	Guamanian
07	Hawaiian
20	Kirabati
20	Kosraean
20	Kwajalein
97	Maori
20	Mariana Islander
20	Marshallese
30	Melanesian
20	Micronesian, NOS
07	Native Hawaiian
97	Nauruan
30	New Caledonian
30	New Hebrides
97	Other Pacific Islander
97	Pacific Islander
20	Palauan
32	Papua New Guinean
07	Part Hawaiian
20	Pohnpeian
25	Polynesian
20	Ponapean
20	Saipanese
27	Samoan
30	Solomon Islander
26	Tahitian
20	Tarawan
20	Tinian
25	Tokelauan
28	Tongan
20	Trukese
25	Tuvaluan
30	Vanuatuan
20	Yapese

98 OTHER RACE, NOT ELSEWHERE CLASSIFIED

Do not use this code for Hispanic, Latino or Spanish, NOS.

OTHER RACE DESCRIPTIONS

Note 1: The following descriptions of ethnic origin cannot be coded to a specific race code. Look for other descriptions of race in the medical record. If no further information is available, code as 99 Unknown.

Aruba Islander
Azerbaijani
Belizean
Bermudan
Cayenne
Cayman Islander
Creole
Guyanese
Indian (*not specified as Native American, Eastern Indian, Northern, Central, or South American Indian*)
Mestizo
Morena
South African
Surinam
Tejano

Note 2: The following terms self-reported in the 2000 Census cannot be coded to a specific race code. Look for other descriptions of race in the medical record. If no further information is available, code as 99 Unknown.

Biracial
Interracial
Mixed
Multiethnic
Multinational
Multiracial

Indian Tribes of the United States, Canada and Mexico (Race Code 03)
Source: National Center for Health Statistics: Appendix C, *Instruction Manual, part 4: Classification and Coding Instructions For Death Records, 1999-2001*.

Abnaki
Absentee-Shawnee
Acoma
Ak Chin
Alabama-Coushatt Tribes of Texas
Alsea
Apache
Arapaho
Arikara
Assiniboin

Atacapa
Athapaskan
Atsina
Aztec
Bear River
Beaver
Bella Coola
Beothuk
Blackfoot
Boold Piegan
Blue Lake
Brotherton
Caddo
Cakchiquel-lenca
Calapooya
Carrier
Catawba
Cattaraugus
Cayuga
Cayuse
Chasta Costa
Chehalis
Chemehuevi
Cherokee
Chetco
Cheyenne
Cheyenne River Sioux
Chickahominy
Chickasaw
Chinook
Chipewyan
Chippewa
Chippewa-Ojibwa
Chiricahua Apache
Chitimacha
Choctaw
Chol
Chontal
Chorti
Chuckchansi
Chumash
Clallam
Clatsop
Clackamus
Clear Lake
Coast Salish
Cochimi
Cochiti

Cocopa
Coeur D'Alene Tribe of Idaho
Cocopah
Columbia
Colville
Comox
Comanche
Concow
Conquille
Coushatta
Covelo
Cow Creek
Cowichan
Cowlitz
Coyotero Apache
Cree
Creek
Crow
Crow Creek Sioux
Dakota
Delaware
Diegueno
Digger
Dog Rib
Duckwater
Eskimo
Euchi
Eyak
Flathead
Fort Hall Res. Tribe of Idaho
French Indian
Gabrieleno
Galice Creek
Gay Head
Gosiute
Gros Ventre
Haida
Han
Hare
Hat Creek
Hawasupai
Hidatsa
Hoh
Hoopa
Hopi
Houma
Hualapai
Huastec

Humboldt Bay
Hupa
Huron
Illinois
Ingalik
Iowa
Iroquois
Isleta
Jemez
Joshua
Juaneno
Jicarilla Apache
Kaibah
Kalispel
Kanosh Band of Paiutes
Kansa
Karankawa
Karok
Kaska
Kaw
Kawai
Keresan Pueblos
Kern River
Kichai
Kickapoo
Kiowa
Kiowa Apache
Kitamat
Klamath
Klikitat
Koasati
Kootenai Tribe of Idaho
Kusa
Kutchin
Kutenai
Kwakiutl
Lac Courte Dreille
Laguna
Lakmuit
Lipan Apache
Lower Brule Sioux
Luiseno
Lummi
Maidu
Makah
Malecite
Mandan
Maricopa

Mary's River
Mashpee
Mattaponi
Maya
Mayo
Mdewakanton Sioux
Menominee
Menomini
Mequendodon
Mescalero Apache
Miami
Micmac
Mission Indians
Missouri
Miwok
Mixe
Mixtec
Modoc
Mohave
Mohawk
Mohegan
Molala
Monachi
Mono
Montagnais
Montauk
Muckleshoot
Munsee
Nambe
Namsemond
Nanticoke
Narragansett
Naskapi
Natchez
Navaho
Navajo
Nez Perce
Niantic
Nipmuck
Nisenan-Patwin
Nisqually
Nomelaki
Nooksak
Nootka
Northern Paiute
Oglala Sioux
Okanogan
Omaha

Oneida
Onondaga
Opata
Opato
Osage
Oto
Otoe
Otomi
Ottawa
Ozette
Paiute
Pamunkey
Panamint
Papago
Passamaquoddy
Patwin
Pawnee
Pen d'Oreille
Penobscot
Peoria
Pequot
Picuris
Pima
Pit River
Pojoaque
Pomo
Ponca
Poosepatuck
Potawatomi
Potomac
Powhatan
Pueblos
Puyallup
Quapaw
Quechan
Quileute
Quinaielt
Quinault
Rappahannock
Rogue River
Rosebud Sioux
Sac and Fox
Saginaw
Salish
Sandia
San Felipe
San Ildefonso
San Juan

San Lorenzo
San Luis Obispo
San Luiseno
Sanpoil
Sanpoil Nespelem
Sant'ana
Santa Barbara
Santa Clara
Santa Ynez
Santee
Santee Sioux
Santiam
Sauk and Fox
Scaticook
Sekane
Seminole
Seneca
Seri
Shasta
Shawnee
Shinnecock
Shivwits Band of Paiutes
Shoshone
Shoshone-Bannock
Shuswap
Siouans
Sioux
Sisseton
Sisseton-Wahpeton Sioux
Siuslaw
Skagit Suiattle
Skokomish
Slave
Smith River
Snake
Snohomish
Snoqualmi
Songish Southern Paiute
Squaxin
Stockbridge
Sumo-Mosquito
Suquamish
Swinomish
Taimskin
Tanana
Tanoan Pueblos
Taos
Tarahumare

Tarascan
Tawakoni
Tejon
Tenino or Warm Springs
Tesuque
Teton
Teton Sioux
Tillamook
Timucua
Thlinget
Tolowa
Tonawanda
Tonkawa
Tonto Apache
Topinish
Totonac
Tsimshian
Tulalip
Tule River Indians
Tunica
Tuscarora
Tututni
Umatilla
Umpqua
Upper Chinook
Ute
Waca
Waicuri-Pericue
Wailaki
Walapai
Walla Walla
Wampanoag
Wapato
Warm Springs
Wasco
Washo
Washoe
Western Apache
Western Shoshone
Whilkut
Wichita
Wikchamni
Wind River Shoshone
Winnebago
Wintu
Wintun
Wishram
Wyandotte

Xicaque
Yahooskin
Yakima
Yamel
Yana
Yankton
Yanktonnais Sioux
Yaqui
Yaquina
Yavapai
Yawilmani
Yellow Knife
Yerington Paiute
Yokuts
Yokuts-Mono
Yomba Shoshone
Yuchi
Yuki
Yuma
Yurok
Zacatec
Zapotec
Zia
Zoque
Zuni

Appendix W.2: Race and Nationality Descriptions (Alphabetic)

Note: Use these lists only when race is not stated but other information is provided in the medical record.

References:

1. *"Race and Ethnicity Code Set, Version 1.0," Centers for Disease Control and Prevention, March 2000.*
2. *"Instruction manual, part 4: Classification And Coding Instructions For Death Records, 1999-2001," Division of Vital Statistics, National Center for Health Statistics, undated*

Key

Use this code unless patient is stated to be Native American (Indian) or other race

* *Terms listed in reference 2, above.*

! *Description of religious affiliation rather than stated nationality or ethnicity; should be used with caution when determining appropriate race code.*

A

03 Abnaki
03 Absentee-Shawnee
03 Acoma
01 Afghan, Afghanistani
02 African
02 African American
01 Afrikaner
02 Afro-American
03 Ak Chin
03 Alabama-Coushatt Tribes of Texas
03 Alaska Native
01 Albanian
03 Aleut
01 Algerian*
03 Alsea
96 Amerasian
03 American Indian
01 Amish*
01 Anglo-Saxon*
03 Apache
01 Arab, Arabian
03 Arapaho
01 Argentinian*
03 Arikara
01 Armenian
96 Asian
16 Asian Indian
15 Asian Indian or Pakistani, NOS
96 Asiatic
03 Assiniboin
01 Assyrian
03 Atacapa
03 Athapaskan
03 Atsina
01 Australian*
01 Austrian*
01 Azores*
03 Aztec

B

02 Bahamian
96 Bangladeshi
02 Barbadian
01 Basque*
01 Bavarian*
03 Bear River
03 Beaver

03	Bella Coola
03	Beothuk
96	Bhutanese
20	Bikinian
02	Bilalian*
02	Black
03	Blackfoot
03	Blue Lake
01	Bolivian*
03	Boold Piegan
96	Bornean
02	Botswana
01	Bozniak/Bosnian
01	Brava/Bravo*
01	Brazilian
03	Brotherton
96	Bruneian
01	Bulgarian
96	Burmese

C

03	Caddo
01	Cajun
03	Cakchiquel-lenca
03	Calapooya
01	Californio
13	Cambodian
01	Canadian*
02	Cape Verdean*
20	Carolinian
03	Carrier
03	Catawba
03	Cattaraugus
01	Caucasian*
03	Cayuga
03	Cayuse
96	Celebesian
01	Central American
03	Central American Indian
96	Ceram
96	Ceylonese
21	Chamorro
03	Chasta Costa
01	Chechnyan
03	Chehalis
03	Chemehuevi
03	Cherokee
03	Chetco

03	Cheyenne
03	Cheyenne River Sioux
01	Chicano*
03	Chickahominy
03	Chickasaw
01	Chilean
04	Chinese
03	Chinook
03	Chipewyan
03	Chippewa
03	Chippewa-Ojibwa
03	Chiricahua Apache
03	Chitimacha
03	Choctaw
03	Chol
03	Chontal
03	Chorti
03	Chuckchansi
03	Chumash
20	Chuukese
03	Clackamus
03	Clallam
03	Clatsop
03	Clear Lake
03	Coast Salish
03	Cochimi
03	Cochiti
03	Cocopa
03	Cocopah
03	Coeur D'Alene Tribe of Idaho
01	Colombian*
03	Columbia
03	Colville
03	Comanche
03	Comox
03	Concow
03	Conquille
25	Cook Islander
01	Costa Rican*
03	Coushatta
03	Covelo
03	Cow Creek
03	Cowichan
03	Cowlitz
03	Coyotero Apache
03	Cree
03	Creek
01	Croat/Croatian

03 Crow
03 Crow Creek Sioux
01 Crucian*
01 Cuban (*unless specified as Black*)*
01 Cypriot
01 Czechoslovakian*

D

03 Dakota
03 Delaware
03 Diegueno
03 Digger
03 Dog Rib
02 Dominica Islander (*unless specified as White*)
02 Dominican/Dominican Republic (*unless specified as White*)
03 Duckwater

E

01 Eastern European
01 Ebian*
01 Ecuadorian*
01 Egyptian
01 English
01 English-French*
01 English-Irish*
20 Eniwetok, Enewetak
02 Eritrean*
03 Eskimo
02 Ethiopian
03 Euchi
96 Eurasian
01 European*
03 Eyak

F

31 Fijian
06 Filipino
01 Finnish*
03 Flathead
03 Fort Hall Res. Tribe of Idaho
01 French
01 French Canadian*
03 French Indian

G

03 Gabrieleno
03 Galice Creek
03 Gay Head

01 Georgian*
01 German
02 Ghanian*
03 Gosiute
01 Greek*
03 Gros Ventre
22 Guamanian
01 Guatemalan
01 Gypsy*

H

03 Haida
02 Haitian
02 Hamitic*
03 Han
03 Hare
03 Hat Creek
07 Hawaiian
03 Hawasupai
01 Hebrew*!
01 Herzegovenian
03 Hidatsa
01 Hispanic*
12 Hmong
03 Hoh
01 Honduran
03 Hoopa
03 Hopi
03 Houma
03 Hualapai
03 Huastec
03 Humboldt Bay
01 Hungarian*
03 Hupa
03 Huron

I

03 Illinois
09 Indian (from India) Retired as of 1/1/2010, replaced by 15, 16, 17.
96 Indo-Chinese
96 Indonesian
03 Ingalik
03 Iowa
01 Iranian, Iran
01 Iraqi
01 Irish
03 Iroquois
01 Islamic*!

03 Isleta
01 Israeli
01 Italian
05 Iwo Jiman

J

02 Jamaican
05 Japanese
96 Javanese
03 Jemez
03 Jicarilla Apache
01 Jordanian*
03 Joshua
03 Juaneno

K

03 Kaibah
03 Kalispel
13 Kampuchean
03 Kanosh Band of Paiutes
03 Kansa
03 Karankawa
03 Karok
03 Kaska
03 Kaw
03 Kawai
02 Kenyan*
03 Keresan Pueblos
03 Kern River
03 Kichai
03 Kickapoo
03 Kiowa
03 Kiowa Apache
20 Kirabati
03 Kitamat
03 Klamath
03 Klikitat
03 Koasati
03 Kootenai Tribe of Idaho
08 Korean
20 Kosraean
01 Kurd/Kurdish
03 Kusa
03 Kutchin
03 Kutenai
01 Kuwaitian*
20 Kwajalein
03 Kwakiutl

L

03	Lac Courte Dreille
01	Ladina/Ladino*
03	Laguna
03	Lakmuit
11	Laotian
01	Latin American*
01	Latino/Latina
01	Latvian*
01	Lebanese
02	Liberian
01	Libyan*
03	Lipan Apache
01	Lithuanian*
03	Lower Brule Sioux
03	Luiseno
03	Lummi

M

96	Madagascar
03	Maidu
03	Makah
02	Malawian*
96	Malaysian
96	Maldivian
03	Malecite
01	Maltese*
03	Mandan
97	Maori
20	Mariana Islander
03	Maricopa
20	Marshallese
01	Marshenese*
03	Mary's River
03	Mashpee
03	Mattaponi
01	Mauritian*
03	Maya
03	Mayo
03	Mdewakanton Sioux
01	Mediterranean*
30	Melanesian
03	Menominee
03	Menomini
03	Mequendodon
03	Mescalero Apache
03	Meso American Indian

01	Mexican
03	Mexican American Indian
03	Miami
03	Micmac
20	Micronesian, NOS
01	Middle Eastern
03	Mission Indians
03	Missouri
03	Miwok
03	Mixe
03	Mixtec
03	Modoc
03	Mohave
03	Mohawk
03	Mohegan
03	Molala
03	Monachi
96	Mongolian
03	Mono
03	Montagnais
96	Montagnard
03	Montauk
01	Moroccan*
01	Moroccan*
01	Moslem*!
03	Muckleshoot
02	Mugandan*
03	Munsee
01	Muslim*!

N

03	Nambe
02	Namibian
03	Namsemond
03	Nanticoke
03	Narragansett
03	Naskapi
02	Nassau*
03	Natchez
07	Native Hawaiian
97	Nauruan
03	Navaho
03	Navajo
01	Near Easterner
02	Negro
96	Nepalese
30	New Caledonian
30	New Hebrides

03	Nez Perce
03	Niantic
01	Nicaraguan
02	Nigerian
02	Nigritian
03	Nipmuck
03	Nisenan-Patwin
03	Nisqually
03	Nomelaki
03	Nooksak
03	Nootka
01	Nordic*
01	North African
03	Northern Paiute
01	Norwegian*
02	Nubian*
	O
03	Oglala Sioux
03	Okanogan
05	Okinawan
03	Omaha
03	Oneida
03	Onondaga
03	Opata
03	Opato
96	Oriental
03	Osage
02	Other African
01	Other Arab
96	Other Asian
97	Other Pacific Islander
98	Other race, not elsewhere classified
03	Oto
03	Otoe
03	Otomi
03	Ottawa
03	Ozette
	P
97	Pacific Islander
03	Paiute
17	***Pakistani***
20	Palauan
01	Palestinian
03	Pamunkey
01	Panamanian
03	Panamint

03 Papago
32 Papua New Guinean
01 Paraguayan
01 Parsi*
07 Part Hawaiian
03 Passamaquoddy
03 Patwin
03 Pawnee
03 Pen d'Oreille
03 Penobscot
03 Peoria
03 Pequot
01 Persian*
01 Peruvian*
03 Picuris
03 Pima
03 Pit River
20 Pohnpeian
03 Pojoaque
01 Polish
25 Polynesian
03 Pomo
20 Ponapean
03 Ponca
03 Poosepatuck
01 Portuguese*
03 Potawatomi
03 Potomac
03 Powhatan
03 Pueblos
01 Puerto Rican (*unless specified as Black*)
03 Puyallup

Q

03 Quapaw
03 Quechan
03 Quileute
03 Quinaielt
03 Quinault

R

03 Rappahannock
03 Rogue River
01 Romanian*
03 Rosebud Sioux
01 Rumanian
01 Russian*

S

03	Sac and Fox
03	Saginaw
20	Saipanese
03	Salish
01	Salvadoran
27	Samoan
03	San Felipe
03	San Ildefonso
03	San Juan
03	San Lorenzo
03	San Luis Obispo
03	San Luiseno
03	Sandia
03	Sanpoil
03	Sanpoil Nespelem
03	Santa Barbara
03	Santa Clara
03	Santa Ynez
03	Sant'ana
03	Santee
03	Santee Sioux
03	Santiam
02	Santo Domingo*
01	Saudi Arabian*
03	Sauk and Fox
01	Scandanavian*
03	Scaticook
01	Scottish, Scotch
03	Sekane
03	Seminole
01	Semitic*!
03	Seneca
01	Serbian*
03	Seri
01	Servian*
02	Seychelloise*
03	Shasta
03	Shawnee
01	Shi'ite!
03	Shinnecock
03	Shivwits Band of Paiutes
03	Shoshone
03	Shoshone-Bannock
03	Shuswap
01	Sicilian*
96	Sikkimese
96	Singaporean

03	Siouans
03	Sioux
03	Sisseton
03	Sisseton-Wahpeton Sioux
03	Siuslaw
03	Skagit Suiattle
03	Skokomish
03	Slave
01	Slavic, Slovakian*
03	Smith River
03	Snake
03	Snohomish
03	Snoqualmi
30	Solomon Islander
03	Songish Southern Paiute
01	South American
03	South American Indian
03	Spanish American Indian
01	Spanish*, Spaniard
03	Squaxin
96	Sri Lankan
03	Stockbridge
02	Sudanese*
96	Sumatran
03	Sumo-Mosquito
01	Sunni*!
03	Suquamish
01	Swedish*
03	Swinomish
01	Syrian

T

26	Tahitian
03	Taimskin
04	Taiwanese
03	Tanana
03	Tanoan Pueblos
02	Tanzanian*
03	Taos
03	Tarahumare
03	Tarascan
20	Tarawan
03	Tawakoni
03	Tejon
03	Tenino or Warm Springs
03	Tesuque

03	Teton
03	Teton Sioux
14	Thai
03	Thlinget
96	Tibetan
03	Tillamook
03	Timucua
20	Tinian
02	Tobagoan
02	Togolese*
25	Tokelauan
03	Tolowa
03	Tonawanda
28	Tongan
03	Tonkawa
03	Tonto Apache
03	Topinish
03	Totonac
02	Trinidadian
20	Trukese
03	Tsimshian
03	Tulalip
03	Tule River Indians
03	Tunica
01	Tunisian*
01	Turkish, Turk*
03	Tuscarora
03	Tututni
25	Tuvaluan
	U
01	Ukranian*
03	Umatilla
03	Umpqua
01	United Arab Emirati
03	Upper Chinook
01	Uruguayan
03	Ute
	V
30	Vanuatuan
01	Venezuelan*
10	Vietnamese
	W
03	Waca
03	Waicuri-Pericue
03	Wailaki

03	Walapai
03	Walla Walla
03	Wampanoag
03	Wapato
03	Warm Springs
03	Wasco
03	Washo
03	Washoe
01	Welsh*
02	West Indian
03	Western Apache
03	Western Shoshone
96	Whello
03	Whilkut
01	White
03	Wichita
03	Wikchamni
03	Wind River Shoshone
03	Winnebago
03	Wintu
03	Wintun
03	Wishram
03	Wyandotte

X

03	Xicaque

Y

03	Yahooskin
03	Yakima
03	Yamel
03	Yana
03	Yankton
03	Yanktonnais Sioux
20	Yapese
03	Yaqui
03	Yaquina
03	Yavapai
03	Yawilmani
96	Yello
03	Yellow Knife
01	Yemenite*
03	Yerington Paiute
03	Yokuts
03	Yokuts-Mono
03	Yomba Shoshone
03	Yuchi
01	Yugoslavian*

03 Yuki
03 Yuma
03 Yurok

Z

03 Zacatec
02 Zairean
03 Zapotec
03 Zia
03 Zoque
01 Zoroastrian*!
03 Zuni

Note: The following terms cannot be coded to a specific race code. Look for other descriptions of race in the medical record. If no further information is available, code as 99 Unknown.

Aruba Islander
Azerbaijani
Belizean
Bermudan
Biracial
Cayenne
Cayman Islander
Creole
Guyanese
Indian (*not specified as Native American, Eastern Indian, Northern, Central, or South American Indian*)
Interracial
Mestizo
Mixed
Morena
Multiethnic
Multinational
Multiracial
South African
Surinam
Tejano

Appendix X: National Provider Identifier (NPI) Codes

The National Provider Identifier (NPI) is a unique identification number for health care providers. It is scheduled for 2007 implementation by the Centers for Medicare and Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health care providers have started the process of obtaining NPI

codes, and hospitals have until May 2007 to meet the HIPAA deadline. NPI numbers are being distributed by CMS to all health care providers in the United States. CMS has mandated use of the assigned NPI in all administrative and financial transactions between "large" health plans and CMS starting in May 2007. For billing purposes, these providers will be required to use NPI codes by May 2007, but indications are that some health care facilities will start using these codes in advance of this deadline. If a facility starts to use the NPI codes, that information should be available from the provider's billing department.

NPI numbers are only assigned to health care providers who meet the definition of a "covered entity, " and this only includes individuals and entities licensed to provide health care. NPI's are not being issued to physicians who have opted out of government programs; entities that bill or are paid for health care services furnished by other health care providers; or clearing houses, vendors, administrative, and billing services (*Federal Register* [Friday, January 23, 2004]).

Registries should be able to record the NPI for their hospital or individual physicians with January 1, 2007, diagnoses. It is necessary, however, to be aware that NPI's may not have been assigned to all eligible parties by January 1, 2007. Historic facilities or physicians may no longer be in business or licensed and therefore, may not have an NPI assigned.

The NPI is a 10 byte numeric data item. The NPI consists of 9 numeric digits followed by one numeric check digit. The NPI will not have embedded intelligence. The NPI format and check digit calculation will be compatible with the card issuer identifier on a standard health identification card. The card standard was developed by the National Committee for Information Technology Standards (NCITS), which is accredited by the American National Standards Institute. NPI's will be issued initially with the first digit equal to 1 or 2. NPIs with the first digit equal to 1 are assigned to individual health care providers (i.e., physicians); hospitals or other entities that provide health care services will be assigned the first digit of NPI equal to 2. These digits will not be used as the first digits for other card issuer identifiers. NPI numbers will be generated using a scattering algorithm that has the capability to use all possible numeric combinations beginning with 1 or 2. Each NPI generated will be unique, without requiring database access for verification.

When a facility starts to use the NPI codes, that information should be entered and transmitted in the appropriate NPI data item fields. It is anticipated that the implementation of the NPI will vary by facility, provider, and data collection reporting software. Hospital registries should become aware of how the NPI will be implemented in their specific software.

The following data items are all components of the NPI implementation effort.

NPI--Registry ID (NAACCR #45)
The National Provider Identifier (NPI) code that represents the data transmission source. This item stores the NPI of the facility registry that transmits the record.

NPI--Reporting Facility (NAACCR #545)
The NPI code for the facility submitting the data in the record.

NPI--Inst Referred From (NAACCR #2415)
The NPI code that identifies the facility that referred the patient to the reporting facility.

NPI--Inst Referred To (NAACCR #2425)
The NPI code that identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

NPI--Following Registry (NAACCR # 2445)
The NPI code that records the registry responsible for following the patient.

NPI--Physician—Managing (NAACCR # 2465)
The NPI code that identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

NPI--Physician--Follow-Up (NAACCR # 2475)
The NPI code for the physician currently responsible for the patient's medical care.

NPI--Physician--Primary Surg (NAACCR # 2485)
The NPI code for physician who performed the most definitive surgical procedure.

NPI--Physician 3 (NAACCR # 2495)
The NPI code for another physician involved in the care of the patient.

NPI--Physician 4 (NAACCR # 2505)
The NPI code for another physician involved in the care of the patient.

Appendix Y: Index to Site Specific Factors

Click here to open an interactive appendix to Site Specific Factors.

http://ccrcal.org/DSQC_DMO/SSF-Index to Site Specific Factors/Vol_1_2010_Appendix_Y_CSV2.htm