SUMMARY OF YEAR 2010 DATA CHANGES

This document provides a summary of data changes for 2010 for hospitals, abstracting vendors, and regional registry data collectors. The changes to Volume I will be available in June. This document is divided into sections – Additions (New Data Items) and Changes (Revised Data Items).

ADDITIONS (New Data Items):

Grade Path Value
Describes the actual grade according to the grading system in Grade Path System.

Rationale: This item records the numeric grade reported in the pathology report. This item supplements but does not replace Grade/Differentiation.

Codes:
1 - Grade I or 1
2 - Grade II or 2
3 - Grade III or 3
4 - Grade IV or 4
Blank – No two, three or four grade system is available; Unknown

Field length: 1 character

Grade Path System
Indicates whether a two, three or four grade system was used in the pathology report.

Rationale: This item is used to show 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.

Codes:
2 - Two-grade system
3 - Three-grade system
4 - Four-grade system
Blank – No two, three or four grade system is available; Unknown

Field length: 1 character
**Lymph-vascular Invasion**
Indicates 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.

*Note: CCR requires this data item be collected for Penis and Testis only*

**Rationale:** Lymph-vascular invasion is an indicator of prognosis. This field is used by the CS algorithm to map AJCC T for some primary sites.

**Codes:**
- 0 – Absent/Not Identified
- 1 – Present/Identified
- 8 - Not applicable
- 9 – Unknown/Indeterminate

Field length: 1 character

**RX Sum--Treatment Status**
This data item is a summary of the status of all treatment modalities.

**Rationale:** This variable provides a yes/no summary of whether treatment has been given, including an option that indicates active surveillance (watchful waiting).

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

Field length: 1 character

**Date Case Initiated**
This generated data item records the date the electronic abstract is initiated in the reporting facility’s cancer registry database. This is a new NAACCR data item and replaces former CCR data item, *Date First Entered*.

**Codes:** Use the standard date format YYYYMMDD

Field length: 8 characters
**CS Mets at Dx Bone**
Identifies the presence of distant metastatic involvement of bone at time of diagnosis.  
*Note: This includes only bone, not the bone marrow.*

**Rationale:** The presence of metastatic bone 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 sites.

**Codes:**
- 0 - No
- 1 - Yes
- 8 - Not applicable
- 9 - Unknown

Field length: 1 character

**CS Mets at Dx Brain**
Identifies the presence of distant metastatic involvement of the brain at time of diagnosis.  
*Note: This includes only the brain, not spinal cord or other parts of the central nervous system.*

**Rationale:** 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 sites.

**Codes:**
- 0 - No
- 1 - Yes
- 8 - Not applicable
- 9 - Unknown

Field length: 1 character

**CS Mets at Dx Liver**
Identifies the presence of distant metastatic involvement of the liver at time of diagnosis.

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

**Codes:**
- 0 - No
- 1 - Yes
- 8 - Not applicable
- 9 - Unknown

Field length: 1 character
**CS Mets at Dx Lung**
Identifies the presence of distant metastatic involvement of the lung at time of diagnosis.  
*Note: This includes only the lung, not pleura or pleural fluid.*

**Rationale:** 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 sites.

**Codes:**  
0 - No  
1 - Yes  
8 - Not applicable  
9 - Unknown  

Field length: 1 character

**CS Site-Specific Factors 7 to 25**
Identifies additional information or prognostic factors that have an effect on stage or survival.

**Rationale:** Site-specific factors are used to record additional staging information to derive TNM and/or SEER Stage codes for particular site-histology schema.

**Codes:** The CCR will require the Site Specific Factors required by SEER. The required SSFs are those collected under CSv1, those needed to derive AJCC or SEER Summary Stage, plus a few SSFs considered clinically relevant. Some of the original SSFs 1-6 that were required have been made Obsolete and will no longer be required. For prostate, CS SSF4 (Apex Involvement) is not required for cases diagnosed 2010+; however, it continues to be required for cases diagnosed prior to 2010. Use code “988” [not applicable] for SSFs not collected for a specific-schema. For site-specific codes, please reference http://cancerstaging.org/cstage/manuals/index.html.

Field length: 3 characters

**CS Version Input Current**
This item indicates the version of CS input fields after they have been updated or recoded. This data item is recorded the first time the CS input fields are entered and should be updated each time the CS input fields are modified.

**Rationale:** Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

**Codes:**  
Digits 1 and 2 Major version number  
Digits 3 and 4 Minor version number  
Digits 5 and 6 Less significant changes  

Field length: 6 characters
**Derived AJCC-7 T**
**Derived AJCC-7 T Descript**
**Derived AJCC-7 N**
**Derived AJCC-7 N Descript**
**Derived AJCC-7 M**
**Derived AJCC-7 M Descript**
**Derived AJCC-7 Stage Grp**

These items are the derived 7th Edition AJCC staging elements from coded fields using the CS algorithm.

**Rationale:** *Derived AJCC TNM and Stage Group* can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

**Codes:** See the most current version of the Collaborative Stage Data Collection System Manual and Coding Instructions ([http://cancerstaging.org/cstage/manuals/index.html](http://cancerstaging.org/cstage/manuals/index.html)).

Field length: 2 characters for Derived T, N, M, and Stage Group; 1 for Derived T, N, M Descripts

**Path Reporting Fac ID 1-5**
Identifies the pathology facility that produced the report. Use the National Provider Identifier (NPI) if available. This data item replaces CCR data item, DX RX Report Facility ID.

Field length: 25 characters

**Path Report Numbers 1-5**
Unique sequential number assigned by a laboratory to the corresponding pathology report for the case. This data item replaces CCR data item, DX RX Report Number.

Field length: 8 characters

**Path Date Spec Collect 1-5**
Records 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, DX RX Report Date.

Field length: 14 characters
**Path Report Type 1-5**
This item reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry. This data item replaces CCR data item, DX RX Report Type. Data in the current DXRX Report Type field will be converted to the new codes.

**Codes:**
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  

Field length: 2 characters

**DATE FLAGS**
Explains why there is no appropriate value in the corresponding date field.

**Rationale:** The format used to transmit dates has been modified for interoperability with other electronic data systems. 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, these changes may be transparent to registrars.

Field length: 2 characters

**Date of Birth Flag**

**Codes:**
12  Date of birth cannot be determined  
Blank  Full or partial date recorded
**Date of Diagnosis Flag**

**Codes:**
- 12 Date of diagnosis cannot be determined
- Blank Full or partial date recorded

**Date of Multiple Tumors Flag**

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

**Date Conclusive DX Flag**

**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

**Date of 1st Contact Flag**

**Codes:**
- 12 Date of first contact cannot be determined
- Blank Full or partial date entered

**Date of Inpt Adm Flag**

**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
**Date of Inpt Disch Flag**

**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  

**RX Date—Surgery Flag**

**Codes:**
10  Unknown whether surgical procedure performed  
11  No surgical procedure performed  
12  Date cannot be determined for surgery performed during first course  
Blank  Full or partial date recorded  

**RX Date—Radiation Flag**

**Codes:**
10  Unknown whether radiation was given  
11  No radiation planned or given  
12  Date cannot be determined for radiation received during first course  
15  Radiation is planned; start date is not yet available  
Blank  Full or partial date recorded  

**RX Date—Chemo Flag**

**Codes:**
10  Unknown whether 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  

**RX Date—Hormone Flag**

**Codes:**
10  Unknown whether 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
RX Date—BRM Flag

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

RX Date—Other Flag

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

Date of Initial RX Flag

Codes:
10  Unknown if therapy administered
11  Therapy not administered
12  Therapy was administered but date is unknown
Blank  Full or partial date recorded

RX Date—DX/Stg Proc Flag

Codes:
10  Unknown whether a surgical diagnostic or staging procedure was performed
11  No surgical diagnostic or staging procedure was performed
12  Date cannot be determined for surgical diagnostic or staging performed
Blank  Full or partial date recorded

Date of Last Contact Flag

Codes:
12  Date cannot be determined
Blank  Full or partial entered
RX Date Mst Defin Srg Flag

Codes:
10  Unknown whether any surgery was performed
11  No surgical procedure performed
12  Date cannot be determined, but patient did receive first course surgery
Blank  Full or partial date recorded

RX Date Systemic Flag

Codes:
10  Unknown whether any systemic therapy was given
11  No systemic therapy planned or given
12  Date cannot be determined for systemic therapy received during first course
15  Systemic therapy is planned; start date is not yet available
Blank  Full or partial date recorded

Date Surg Proc 1 Flag

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

Date Surg Proc 2 Flag

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

Date Surg Proc 3 Flag

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
RX Date—Transplnt/Endocr Flag

Codes:
10 Unknown whether transplant/endocrine therapy was given
11 No transplant/endocrine therapy planned or given
12 Date cannot be determined for transplant/endocrine therapy received during first course
15 Transplant/endocrine therapy is planned; start date is not yet available
Blank Full or partial date recorded

CHANGES (Revised Data Items):

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

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

Codes:
00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10 Initial diagnosis AND part or all first course treatment or a decision not to treat done at the reporting facility, NOS
11 Initial diagnosis by staff physician AND part of first course treatment was done at the reporting facility
12 Initial diagnosis by staff physician AND all first course treatment or a decision not to treat was done at the reporting facility
13 Initial diagnosis AND part of first course treatment was done at the reporting facility
14 Initial diagnosis AND all first course treatment or a decision not to treat was done at the reporting facility
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 treatment was done at the reporting facility
22 Initial diagnosis elsewhere AND all treatment was done at the reporting facility
Patient appears in person at reporting facility

30 Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, staging workup after initial diagnosis elsewhere)
31 Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care
32 Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence
33 Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only
34 Type of case not required by CoC to be accessioned (for example, a benign colon cancer) having initial diagnosis AND part or all of first course treatment by reporting facility
35 Case diagnosed before program’s Reference Date, having initial diagnosis AND part or all of first course treatment by reporting facility
36 Type of case not required by CoC to be accessioned (for example, a benign colon tumor) having initial diagnosis elsewhere AND all or part of first course treatment by reporting facility.
37 Case diagnosed before program’s Reference Date, having initial diagnosis AND all or part of first course treatment by facility.
38 Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death.

Patient does not appear in person at reporting facility

40 Diagnosis AND all first course treatment given at the same staff physician’s office
41 Diagnosis and all first course treatment given in two or more different staff physician offices
42 Non-staff physician or non-CoC approved clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43 Pathology or other lab specimens only
49 Death certificate only
99 Case not required by CoC to be abstracted of unknown relationship to facility (not for use by CoC approved cancer programs for analytic cases.)

Field Length: Changed from 1 to 2 characters
**CS Extension**
Added new codes.

**Codes:** See the most current version of the Collaborative Stage Data Collection System Manual and Coding Instructions ([http://cancerstaging.org/cstage/manuals/index.html](http://cancerstaging.org/cstage/manuals/index.html)).

Field Length: Changed from 2 to 3 characters

**CS Lymph Nodes**
Added new codes.

**Codes:** See the most current version of the Collaborative Stage Data Collection System Manual and Coding Instructions ([http://cancerstaging.org/cstage/manuals/index.html](http://cancerstaging.org/cstage/manuals/index.html)).

Field Length: Changed from 2 to 3 characters

**CS Mets at Dx**
Added site/histology-specific codes.

**Codes:** See the most current version of the Collaborative Stage Data Collection System Manual and Coding Instructions ([http://cancerstaging.org/cstage/manuals/index.html](http://cancerstaging.org/cstage/manuals/index.html)).

**Diagnostic Confirmation**
Added code 3 effective with 2010 diagnoses, only for hematopoietic and lymphoid neoplasms 95903-99923.

**Code:**
3  Positive histology PLUS –
   Positive immunophenotyping AND/OR positive genetic studies

**Laterality**
Added code 5 for 2010 forward.

**Codes:**
5  Paired site, midline tumor
**Race 1-5**
Retired Code 09 – Asian Indian or Pakistani. These cases were converted to new code 15. Added the following codes.

**Codes:**
- 13 Kampuchean (Cambodian)
- 15 Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
- 16 Asian Indian
- 17 Pakistani

**Site-Specific Surgery Codes – Brain**
Added codes 21, 22, 30 for 2010 and forward.

**Code:**
- 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

**TNM Edition Number**
Added code 7 for 2010 and forward.

- 7 Seventh Edition (published 2009)

**RX Summ--Systemic Sur Seq**
Revised definition of Code 0.

**Code:**
- 0 No systemic therapy and/or surgical procedures; unknown if surgery and/or systemic therapy given.

**CS Version Original**
Changed from CS Version 1st

**CS Version Derived**
Changed from CS Version Latest

**Derived AJCC-6 T**
Changed from AJCC

**Derived AJCC-6 T Descript**
Changed from AJCC
**Derived AJCC-6 N**  
Changed from AJCC

**Derived AJCC-6 N Descript**  
Changed from AJCC

**Derived AJCC-6 M**  
Changed from AJCC

**Derived AJCC-6 M Descript**  
Changed from AJCC

**Derived AJCC-6 Stage Group**  
Changed from AJCC

**DATE FORMAT CHANGES:**

**Date of Birth/Birthdate**  
**Date of Diagnosis**  
**Date of Conclusive DX**  
**Date of Multiple Tumors**  
**Date of 1st Contact**  
**Date of Inpatient Adm**  
**Date of Inpatient Disch**  
**RX Date--Radiation**  
**RX Date--Chemo**  
**RX Date--Hormone**  
**RX Date--BRM**  
**RX Date--Other**  
**Date of Initial RX--SEER**  
**RX Date--DX/Stg Proc**  
**RX Date--Most Definitive Surg**  
**RX Date--Systemic**

Uses new date format of CCYYMMDD, or CCYYMM, or CCYY

**Rationale:** The format used to transmit dates has been modified for interoperability with other electronic data systems. Registry software may display dates in the traditional manner or in the interoperable format, and therefore, these changes may be transparent to registrars.
FIELD LENGTH CHANGES:

Addr at DX--No & Street
Length changed from 40 to 60

Addr at DX—Supplement
Length changed from 40 to 60

Addr at DX – City
Length changed from 20 to 50

Addr Current--No & Street
Length changed from 40 to 60

Addr Current—Supplement
Length changed from 40 to 60

CS Extension
Length changed from 2 to 3

CS Lymph Nodes
Length changed from 2 to 3

Follow Up Contact—Name
Length changed from 30 to 60

Follow Up Contact--No & St
Length changed from 40 to 60

Follow Up Contact—City
Length changed from 20 to 50

Follow Up Contact—Suppl
Length changed from 40 to 60

Name—Last
Length changed from 25 to 40

Name—First
Length changed from 14 to 40

Name--Middle
Length changed from 14 to 40

Name—Alias
Length changed from 15 to 40
Name--Maiden
Length changed from 15 to 40

RX Text—Surgery
Length changed from 150 to 1000

RX Text--Radiation (Beam)
Length changed from 150 to 1000

RX Text--Radiation Other
Length changed from 150 to 1000

RX Text—Chemo
Length changed from 200 to 1000

RX Text—Hormone
Length changed from 200 to 1000

RX Text—BRM
Length changed from 100 to 1000

RX Text—Other
Length changed from 100 to 1000

Text--DX Proc—PE
Length changed from 200 to 1000

Text--DX Proc--X-ray/Scan
Length changed from 250 to 1000

Text--DX Proc—Scopes
Length changed from 250 to 1000

Text--DX Proc--Lab Tests
Length changed from 250 to 1000

Text--DX Proc—Op
Length changed from 250 to 1000

Text--DX Proc—Path
Length changed from 250 to 1000

Text--Primary Site
Length changed from 40 to 100
Text--Histology Title
Length changed from 40 to 100

Text--Staging
Length changed from 300 to 1000

Text—Remarks
Length changed from 250 to 1000

Text--Place of Diagnosis
Length changed from 50 to 60

Text--Usual Occupation
Length changed from 40 to 100

Text--Usual Industry
Length changed from 40 to 100

TNM Clin T
Length changed from 2 to 4

TNM Clin N
Length changed from 2 to 4

TNM Clin M
Length changed from 2 to 4

TNM Clin Stage Group
Length changed from 2 to 4

TNM Path T
Length changed from 2 to 4

TNM Path N
Length changed from 2 to 4

TNM Path M
Length changed from 2 to 4

TNM Clin Stage Group
Length changed from 2 to 4