CANCER REPORTING IN CALIFORNIA:

ABSTRACTING AND CODING PROCEDURES FOR HOSPITALS

CALIFORNIA CANCER REPORTING SYSTEM STANDARDS

VOLUME ONE

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PREFACE TO THE SEVENTH EDITION

The staff of the Data Standards and Quality Control (DSQC) Unit of the California Cancer Registry would like to present the seventh edition of *Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, Volume I*, dated July 2003. Change bars have been used to delineate changes to this document. A revision of the sixth edition of the manual, published in October 2001, was necessary due to extensive changes in data item requirements from the American College of Surgeons, Commission on Cancer. Many of these data items are required by NCI's SEER Program, and the State of California is comprised of three SEER registries. In addition, many of the same data items were required by the Center for Disease Control and Prevention's National Program of Cancer Registries of which California is a member state. In addition to changes in requirements, feedback from hospital registrars and regional registry staff have resulted in modifications and clarifications to this document.

A document summarizing changes for 2003 -- Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, California Cancer Reporting System Standards, Volume I, Summary of Year 2003 Data Changes -- was sent to hospitals and regional registries earlier this year. Another document -- Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, California Cancer Reporting System Standards, Volume I, Changes and Clarifications – 7th Edition -- accompanies this document. The first document provided an overview of 2003 data changes. The second document provides a detailed summary of the changes in Volume I, including those related to 2003 data changes.

I want to acknowledge Winny Roshala, BA, CTR for her work in revising this document. In addition, I want to acknowledge other members of the DSQC Unit who assisted with sections of the document– Dawn Leytem, CTR, Cheryl Tatum, BA, CTR and Lydia Jacobs, CTR and Scott Wood, BA for his technical expertise in making all of the formatting and editing changes.

For reporting facilities in California, please send corrections, comments, and suggestions regarding this manual or requests for additional copies to your regional registry. They will send this information to our unit. If individuals or facilities that are not part of the California reporting system need copies, they may contact the Data Standards and Quality Control Unit at the following address:

California Cancer Registry
Public Health Institute
1700 Tribute Road, Suite 100
Sacramento, CA 95815-4402

This document can be found on CCR's web site at www.ccrcal.org.

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

Nancy C. Schlag, B.S., CTR
Data Standards and Quality Control

PART I
INTRODUCTION

Section 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

One of the principal mechanisms for collecting epidemiological information is the cancer registry. A registry is the administrative system for maintaining a register, or listing, of cancer patients and pertinent data about their condition. 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.

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 Cancer Surveillance Section of the Department of Health Services (DHS), 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 33 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 enable the Department of Health Services 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." For the sake of efficiency and responsiveness to local needs, responsibility for receiving and evaluating reports from hospitals in designated areas is assigned to regional registries.

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 Department of Health Services, 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, unless prior informed consent is received from the patient. Section 100330 of the code states:

Reporting Cancer Statistics

> All records of interviews, written reports and statements procured by the state [D]epartment [of Health Services] 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, sanatarium, 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. A regional registry may modify this policy on the recommendation of its advisory committee representing local medical-care facilities and physicians, provided that strict procedures are developed to prevent the disclosure of confidential data about patients.

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.)

I.1.5 CASEFINDING

The foundation of the State's cancer-reporting system is the hospital, and a key to successful registration is a 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. One component of the State's cancer reporting system is the periodic determination of the vital status and condition of registered patients (see Section VII, Follow-up Information). Casefinding should therefore include an identification system for patients who are readmitted to the hospital or are treated on an outpatient basis, whether for the reported cancer or another condition.

I.1.6 REPORTING

The hospital must report every case of cancer first seen there 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). Effective with cancer cases reported January 1, 1992, patients receiving transient care to avoid interrupting therapy initiated elsewhere (equipment failure at the original facility or while vacationing) and patients with active cancer who are admitted for other medical conditions are no longer to be reported to the California Cancer Registry. (NOTE: Some regional registries have elected not to implement this change. Contact your regional registry with questions about their reporting requirements.)

Examples

A patient with active cancer is admitted to the reporting facility with a myocardial infarction and no work up or treatment is done for the cancer. The case does not need to be reported.

A patient admitted to Hospital A with a diagnosis of cancer is sent to Hospital B for a bone scan due to equipment failure at Hospital A. The case must be reported by Hospital A, but does not need to be reported by Hospital B.

A patient with active cancer is admitted to the reporting facility due to a motor vehicle accident and no work up or treatment is done for the cancer. The case does not need to be reported.

A report is required whether or not the case was diagnosed elsewhere previously. However, a report is not required if the case was first seen for cancer at the hospital before the region's reference date and is admitted again after that date. The case of a patient hospitalized at the reporting hospital on the region's reference date must be reported if it is diagnosed as cancer on or after the region's reference date. If in doubt about whether or not to report a case, prepare a report or consult the regional registry.

Examples

(1) The region's reference date is 1/1/87, and a patient was admitted in February of 1987 with recurrent disease. However, the patient's initial diagnosis and treatment occurred at the reporting hospital in January of 1986. The case does not need to be reported.

(2) The region's reference date is 6/1/87. A patient was admitted to hospital A in June for part of the first course of treatment. The record states that the patient was diagnosed at hospital B in May of 1987. Hospital A must report the case.

(3) The region's reference date is 1/1/88, and a patient was admitted in February of 1988 for treatment of a recurrence. The place and date of the original diagnosis are not known. The case must be reported.

(4) The region's reference date is 1/1/88, and a patient was admitted on 12/29/87 for evaluation. Cancer was diagnosed on 1/5/88, and the patient was discharged on 1/8/88. The case must be reported.

(5) The region's reference date is 1/1/88. A patient was admitted on 12/29/87, and a biopsy done on 12/30/87 revealed colon cancer. A colectomy was performed on 1/2/88, and the patient was discharged on 1/6/88. The case does not need to be reported.

(6) The region's reference date is 7/1/88. A patient was admitted on 7/5/88 for resection of a cervix cancer which had been diagnosed by biopsy in a staff physician's office on 6/20/88. The case must be reported.

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's Disease, and leukemia, but excluding basal cell and squamous cell carcinoma of the skin." 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.

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. 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. (For rules on reportability of neoplasms see Section II.1.)

I.1.6.2 Reporting Methods. Information about cancer cases is reported to the CCR in the form of abstracts, which summarize pertinent information about individual cases (Please refer to Appendix U—Data Items and Their Required Status). The CCR provides software, called CNExT (see Section I.2), for preparing the abstracts in accordance with reporting requirements. Although the CNExT abstracting system is emphasized in this manual, the codes and definitions apply to any method of reporting in the California system. Before the introduction of CNExT, data were entered manually on a form called the Confidential Report of Neoplasm. If in doubt about how certain fields should be filled in, the regional registry should be contacted. For use of a computerized abstracting system other than CNExT, consult the system's manual or contact the vendor.

Whatever 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.

The order in which the registrar enters data is up to the individual, except for required identification procedures in CNExT. Many experienced registrars prefer to fill in the section on diagnostic procedures first, because the various reports contain much of the information needed for key fields. But whatever the order, every required field 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. In most instances the required number of digits or characters is specified by lines or dots at the bottom of the field. Always start at the left.

I.1.6.4 Entering Dates. When a date is requested, enter the number of the month, then the day, then the four-digit year. On the screen, the fields for the month, day, and year are separated by slashes. If the number of a month or day has only one digit (January-September, first-ninth), enter a 0 before the digit. Enter 99 for an unknown month or unknown day. If the year is not known, enter 9's in all the fields (99/99/9999).

Examples

January 1, 1988	**=**	**01/01/1988**
February 10, 1965	**=**	**02/10/1965**
December 3, 1951	**=**	**12/03/1951**
November ?, 1975	**=**	**11/99/1975**
May 19, 193?	**=**	**99/99/9999**

I.1.6.5 Coding Sources. A registry must have certain reference works for coding, in addition to this manual:

Collaborative Staging Task Force of the American Joint Committee on Cancer. ***Collaborative Staging Manual and Coding Instructions.*** *Version 1.0. 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.*

Fritz, A., Percy, C. et al, eds. ***International Classification of Diseases for Oncology***. 3rd ed. Geneva: World Health Organization, 2000.

Percy, C., VanHolten, V., and Muir, C., eds. ***International Classification of Diseases for Oncology.*** 2nd ed. Geneva: World Health Organization, 1990.

SEER (Surveillance, Epidemiology, and End Results Program). ***SEER Extent of Disease—1988 Codes and Coding Instructions.*** 3rd ed. [Bethesda]: National Institutes of Health, National Cancer Institute, 1998. NIH Pub. No. 98-1999.

SEER (Surveillance, Epidemiology, and End Results Program). ***Summary Staging Guide for the Cancer Surveillance, Epidemiology and End Results Reporting (SEER) Program.*** [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, April 1977, reprinted July 1986.

SEER (Surveillance, Epidemiology, and End Results Program). ***Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs.*** 3d ed. [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, 1994.

AJCC (American Joint Committee on Cancer). ***Manual for Staging of Cancer***. 6th ed. New York: Springer-Verlag, 2002.

C/NET Solutions. ***CNExT User Manual.*** [Berkeley]: Public Health Institute, CNEXT Project.

References that are very helpful, although not necessary, for abstracting and coding include:

ACoS (American College of Surgeons Commission on Cancer). Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data Standards (FORDS). Chicago: American College of Surgeons Commission on Cancer, January 2003, *revised for 2004.*

Reporting Cancer Statistics

California Cancer Registry. ***California Cancer Registry Inquiry System,*** Version 2002.1.

SEER (Surveillance, Epidemiology, and End Results Program). ***SEER Inquiry System: Resolved Questions.***

SEER (Surveillance, Epidemiology, and End Results Program). ***SEER Program: Comparative Staging Guide for Cancer.*** [Bethesda]: National Institutes of Health, National Cancer Institute, 1993. NIH Pub. No. 93-3640.

SEER (Surveillance, Epidemiology, and End Results Program). ***The SEER Program Coding and Staging Manual 2004.*** *4th* ed. [Bethesda]: National Institutes of Health, National Cancer Institute, *2004.* NIH Pub. No. *04-5581*

Shambaugh, E., ed-in-chief. ***SEER Program: Self-Instructional Manual for Cancer Registrars.*** [Bethesda]: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, various years.

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.

World Health Organization. ***International Classification of Diseases for Oncology.*** Geneva: World Health Organization, 1976.

Percy, C., and VanHolten, V. ***International Classification of Diseases for Oncology.*** Field Trial Edition. Geneva: World Health Organization, 1988.

U.S. Postal Service National Zip Code & Post Office Directory.

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 workups. 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 computerized 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

Although the American College of Surgeons (ACoS) does not require hospitals to abstract non-analytic cases, a population-based registry like California's must record all cases, regardless of place of diagnosis or class of case. For definitions of non-analytic and analytic cases and class of case, see Section III.3.5. The CCR therefore requires that non-analytic cases—classes 3, 4, 5, and 9—be abstracted and submitted to the regional registry.

I.1.8.1 Autopsy Only Cases. Abstracting requirements for Autopsy Only (Class 5) cases are the same as those for analytic cases.

I.1.8.2 Class 3, 4, and 9 Cases. Reporting requirements for cases included in classes 3, 4, and 9 are less stringent than those for other cases. The reporting hospital's medical record often does not contain the required data, or contains only second-hand 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 may be limited to a brief statement of the patient's history and the reason for the present admission. Enter the statement in the Physical Exam text area.

Examples

(1) Leukemia diagnosed 5/87 in San Francisco, in remission since 6/87, now adm. for treatment of relapse.

(2) Colon cancer dx'd 1 year PTA. Now has widespread mets, adm. for terminal care.

Section I.2
CNExT

To facilitate the compilation and reporting of cancer data, the CCR has developed a computerized system that enables hospital registrars to enter the required information on personal computers. Called CNExT, the system provides reporting hospitals with a number of advantages over the old method of entering data manually on the Confidential Report of Neoplasm forms:

- Many codes are entered automatically.
- On-line help manuals from the California Cancer Registry - Volume I, NAACCR, SEER and the ACoS FORDS.
- Any case can be updated easily in a few minutes.
- Edits are performed on each record before it is added to the master file, as a quality control.
- Transmittal of cases and corrections to the regional registry is simplified.
- Lists of patients due for their annual follow-up are generated automatically.
- The reporting hospital has convenient access to data for producing summary reports and statistics, computing survival rates, and responding to requests for information.

The CCR provides CNExT software to reporting hospitals in California, and regional registries provide ongoing and free support for users of the system.

PART II
REPORTABLE NEOPLASMS

Section II.1
Determining Reportability

Every hospital 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 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. They are to be coded with a behavior code of /1. 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

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.

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, and for successful use of the data by 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. Be careful to distinguish metastatic lesions from new primaries. Metastasis is the dissemination of tumor cells from the primary site to a remote part of the body. The new lesion is not a primary tumor. Again, the 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. If a patient has two or more independent primary tumors—that is, multiple neoplasms—each one must be abstracted and reported. (For definitions and rules, see Sections II.1.3 and 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. For determining histology, remember that differences in histologic type are based on the first three digits of the histology code except for lymphatic and hematopoietic cancers.

II.1.3.1 Single Primaries. Under the rules, 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.3.3.3.6.)

II.1.3.2 Multiple Primaries. The following are to be considered separate primaries:

- A new cancer with the same histology 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 lesion only is required.

  Exception #2: Effective with cases diagnosed January 1, 1995, 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 and 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.

II.1.3.3 Paired Sites. (See Section V.2 for discussion of laterality.) If only one histologic type is reported, and if both sides of a paired site are involved within two months of diagnosis, ascertain whether the patient has one or two independent primaries. (The determination is generally made by the pathologist.) If the record shows one primary, submit one abstract and code the laterality to '4'. If the record shows two independent primaries, submit two independent abstracts, one for each side, and code laterality appropriately. If the record contains no information about the number of primaries, submit one abstract, and code laterality to '4'. Prepare a single abstract for the following bilateral primaries and code the laterality to '4':

- Bilateral ovarian primaries.
- Bilateral retinoblastomas.
- Bilateral Wilms' tumors.

Bilateral lung cancer cases often present problems in determining whether one or two abstracts should be submitted. Use the following as a guide:

- If a second lung cancer with the same histology is diagnosed in the opposite lung more than two months after the first, abstract as two primaries unless stated to be metastatic.

- If a bilateral lung cancer (regardless of the time frame) has a surgical resection performed on each side, abstract as two primaries.

II.1.3.4 Breast Ductal and Lobular Carcinomas. Prepare a single abstract for certain combinations of ductal and lobular carcinomas occurring in the same breast within two months of each other (see Section V.1 for coding the primary site). ICD-O-2 has assigned morphology 8522 to this combination. Code as follows:

- Infiltrating duct carcinoma (8500/3) and lobular carcinoma (8520/3) —code 8522/3.

- Infiltrating duct carcinoma (8500/3) and lobular carcinoma in situ (8520/2) —code 8522/3.

- Intraductal carcinoma (8500/2) and lobular carcinoma (8520/3) —code 8522/3.

- Intraductal carcinoma (8500/2) and lobular carcinoma in situ (8520/2) —code 8522/2.

- Infiltrating duct mixed with other types of carcinoma (i.e. - duct and cribriform, mucinous, tubular or colloid carcinoma) - code 8523/3.

- Infiltrating lobular mixed with other types of carcinoma - code 8524/3.

Prepare separate abstracts for a ductal lesion in one breast and a lobular lesion in the other breast, whether or not they occur within two months of each other.

II.1.3.5 Intraductal Carcinoma and Paget's Disease. Enter code 8543/3 for a combination of intraductal carcinoma (8500/2) and Paget's Disease (8540/3).

II.1.3.6 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 page "Definitions of Single and Subsequent Primaries" in Appendix R explains the reasoning underlying the ICD-O-3 table. If both diseases are diagnosed after January 1, 2001, use the ICD-O-3 table in Appendix R. If the first diagnosis was prior to 2001 and the second diagnosis was after January 1, 2001, use the ICD-O-3 table in Appendix R. If both diagnoses are prior to January 1, 2001, use the ICD-O-2 table below.

Determining Reportability

(1) <u>Hodgkin's disease (9650-9667).</u>

Report as a second or subsequent *primary:*
Non-Hodgkin's lymphoma (9591-9595, 9670-9686, 9688, 9690-9698, 9702-9717)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Any leukemia (9800-9940)

Do not report as a subsequent *primary:*
Malignant lymphoma, NOS (9590)
Hodgkin's disease[1] (9650-9667)

(2) <u>Malignant lymphoma, NOS[2] (9590).</u>

Report as a second or subsequent *primary:*
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
Mast cell tumor (9740, 9741)
Acute leukemia, NOS (9801)
Non-lymphocytic leukemias (9840-9842, 9860-9910)
Myeloid sarcoma (9930)
Acute panmyelosis (9931)
Acute myelofibrosis (9932)
Hairy cell leukemia (9940)
Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:
Malignant lymphoma, NOS (9590)
Non-Hodgkin's lymphoma[3] (9591-9595, 9670-9686, 9688, 9690-9698, 9702-9717)
Hodgkin's disease[3] (9650-9667)
True histiocytic lymphoma (9723)
Plasmacytoma[3] or multiple myeloma (9731, 9732)
Waldenstrom's macroglobulinemia (9761)
Leukemia, NOS (9800)
Chronic leukemia, NOS (9803)
Lymphoid or lymphocytic leukemia (9820-9828)
Plasma cell leukemia (9830)
Lymphosarcoma cell leukemia (9850)
Immunoproliferative disease, NOS (9760)

(3) <u>Non-Hodgkin's lymphoma[2] (9591-9595, 9670-9686,</u> 9688, 9690-9698, 9711-9717).

Report as a second or subsequent primary:
Hodgkin's disease (9650-9667)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
Mast cell tumor (9740, 9741)
Acute leukemia, NOS (9801)
Non-lymphocytic leukemias (9840-9842, 9860-9910)
Myeloid sarcoma (9930)
Acute panmyelosis (9931)
Acute myelofibrosis (9932)
Hairy cell leukemia (9940)
Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:
Malignant lymphoma, NOS[1] (9590)
Non-Hodgkin's lymphoma[1] (9591-9595, 9670-9686, 9688, 9690-9698, 9702-9717)
True histiocytic lymphoma (9723)
Plasmacytoma[3] or multiple myeloma (9731, 9732)
Waldenstrom's macroglobulinemia (9761)
Leukemia, NOS (9800)
Chronic leukemia, NOS (9803)
Lymphoid or lymphocytic leukemia (9820-9828)
Plasma cell leukemia (9830)
Lymphosarcoma cell leukemia (9850)
Immunoproliferative disease, NOS (9760)

(4) <u>Burkitt's lymphoma (9687).</u>

Report as a second or subsequent primary:
Specific non-Hodgkin's lymphoma (9593-9594, 9670-9686, 9688, 9690-9698, 9702-9717)
Hodgkin's disease (9650-9667)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Acute leukemia, NOS unless specified as Burkitt's type (9801)
Chronic leukemia, NOS (9803)
Chronic lymphocytic leukemia (9823)
Plasma cell leukemia (9830)
Non-lymphocytic leukemias (9840-9842, 9860-9910)
Lymphosarcoma cell leukemia (9850)
Myeloid sarcoma (9930)

Acute panmyelosis (9931)
Acute myelofibrosis (9932)
Hairy cell leukemia (9940)
Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:
Malignant lymphoma, NOS (9590, 9591, 9595)
Lymphosarcoma (9592)
Burkitt's lymphoma (9687)
Burkitt's leukemia (9826)
Lymphoid or lymphocytic leukemia (9820-9822, 9824, 9825, 9827)

(5) <u>Cutaneous and peripheral T-cell lymphomas (9700-9709).</u>
Report as a second or subsequent primary:
Specific non-Hodgkin's lymphoma (9593-9594, 9670-9688, 9690-9698, 9711-9717)
Hodgkin's disease (9650-9667)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Lymphoid or lymphocytic leukemia specified as B-cell (9820-9827)
Plasma cell leukemia (9830)
Non-lymphocytic leukemia (9840-9842, 9860-9910)
Lymphosarcoma cell leukemia (9850)
Myeloid sarcoma (9930)
Acute panmyelosis (9931)
Acute myelofibrosis (9932)
Hairy cell leukemia (9940)
Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:
Malignant lymphoma, NOS (9590, 9591, 9595)
Lymphosarcoma (9592)
Cutaneous and peripheral T-cell lymphomas (9700-9709)
Leukemia, NOS (9800)
Acute leukemia, NOS (9801)
Chronic leukemia, NOS (9803)
Lymphoid or lymphocytic leukemia unless specifically identified as B-cell (9820-9828)

(6) <u>Malignant histiocytosis or Letterer-Siwe's disease or true histiocytic lymphoma (9720, 9722, 9723).</u>

Report as a second or subsequent primary:
Specific non-Hodgkin's lymphoma (9592-9594, 9670-9686, 9688, 9690-9698, 9702-9717)
Hodgkin's disease (9650-9667)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
Plasmacytoma or multiple myeloma (9731, 9732)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Leukemia except hairy cell and leukemic reticuloendotheliosis (9800-9932)

Do not report as a subsequent primary:
Malignant lymphoma, NOS (9590, 9591, 9595)
Malignant histiocytosis or Letterer-Siwe's disease or true histiocytic lymphoma (9720, 9722, 9723)
Hairy cell leukemia (9940)
Leukemic reticulendotheliosis (9941)

(7) <u>Plasmacytoma or multiple myeloma (9731, 9732).</u>

Report as a second or subsequent primary:
Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma (9592-9594, 9670, 9672-9676, 9683, 9685, 9686, 9688, 9690-9697, 9702-9713, 9715-9717)
Hodgkin's disease (9650-9667)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Leukemia except plasma cell (9800-9828, 9840-9941)

Do not report as a subsequent primary:
Malignant lymphoma, NOS (9590, 9591, 9595)
Immunoblastic or large cell lymphoma* (9671, 9680-9682, 9684, 9698, 9714)
Plasmacytoma or multiple myeloma (9731, 9732)
Waldenstrom's macroglobulinemia (9761)
Plasma cell leukemia (9830)

*Occasionally, multiple myeloma develops an immunoblastic or large cell lymphoma phase. Report the case as multiple myeloma and as one primary.

(8) <u>Mast cell tumor (9740, 9741).</u>

Report as second or subsequent primary:
Non-Hodgkin's lymphoma (9590-9594, 9670-9688, 9690-9698, 9702-9717)
Hodgkin's disease (9650-9667)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Lymphoid or lymphocytic leukemia (9820-9828)
Chronic lymphocytic leukemia (9823)
Plasma cell leukemia (9830)
Non-lymphocytic leukemias (9840-9842, 9860-9880, 9910)
Lymphosarcoma cell leukemia (9850)
Myeloid sarcoma (9930)
Acute panmyelosis (9931)
Acute myelofibrosis (9932)
Hairy cell leukemia (9940)
Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:
Mast cell tumor (9740, 9741)
Leukemia, NOS (9800)
Acute leukemia, NOS (9801)
Chronic leukemia, NOS (9803)
Monocytic leukemia (9890-9894)
Mast cell leukemia (9900)

(9) <u>Immunoproliferative disease, NOS (9760)</u>
<u>or Waldenstrom's macroglobulinemia (9761).</u>

Report as a second or *subsequent primary:*
Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma
(9593-9594, 9673-9677, 9683, 9685-9686, 9688, 9690-9697, 9702-9713, 9715-9717)
Hodgkin's disease (9650-9667)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Mast cell tumor (9740, 9741)
Leukemia except plasma cell (9800-9827, 9840-9941)

Do not report as a subsequent primary:
Malignant lymphoma, NOS (9590, 9591, 9595)
Lymphosarcoma (9592)
Malignant lymphoma, lymphocytic (9670, 9672)
Immunoblastic or large cell lymphoma (9671, 9680-9682, 9684, 9698, 9714)
Plasmacytoma or multiple myeloma (9731, 9732)

Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Plasma cell leukemia (9830)

(10) Leukemia, NOS (9800).

Report as a second or subsequent primary:
Non-Hodgkin's lymphoma[2] (9590-9594, 9670-9688, 9690-9698, 9702-9717)
Hodgkin's disease (9650-9667)
Mycosis fungoides (9700)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)

Do not report as a subsequent primary:
Sezary's disease[3] (9701)
Any leukemia* (9800-9941)

*NOTE: Leukemia, NOS (9800) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

(11) Acute leukemia, NOS (9801).

Report as a second or subsequent primary:
Non-Hodgkin's lymphoma (9590-9594, 9670-9688, 9690-9698, 9702-9717)
Hodgkin's disease (9650-9667)
Mycosis fungoides (9700)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)

Do not report as a subsequent primary:
Sezary's disease[3] (9701)
Any leukemia* (9800-9941)

*NOTE: Leukemia, NOS (9800) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

(12) Chronic leukemia, NOS (9803).

Report as a second or subsequent primary:
Hodgkin's disease (9650-9667)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
Mast cell tumor (9740, 9741)

Do not report as a subsequent primary:
Non-Hodgkin's lymphoma[2] (9590-9594, 9670-9686, 9688, 9690-9698, 9702-9717)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Any leukemia* (9800-9941)

*NOTE: Leukemia, NOS (9800) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

(13) Lymphocytic leukemia (9820-9828).

Report as a second or subsequent primary:
Hodgkin's disease (9650-9667)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
Plasmacytoma or multiple myeloma (9731, 9732)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Non-lymphocytic leukemia* (9840-9842, 9860-9910)
Myeloid sarcoma* (9930)
Acute panmyelosis* (9931)
Acute myelofibrosis* (9932)

Do not report as a subsequent primary:
Malignant lymphoma, NOS[2] (9590, 9591)
Non-Hodgkin's lymphoma[1, 2] (9592-9595, 9670-9688, 9690-9698, 9702-9717)
Mycosis fungoides or Sezary's disease[1] (9700, 9701)
True histiocytic lymphoma (9723)
Leukemia, NOS (9800)
Acute leukemia, NOS (9801)
Chronic leukemia (9803)
Lymphocytic leukemia[1] (9820-9828)
Plasma cell leukemia[1] (9830)
Lymphosarcoma cell leukemia[1] (9850)
Hairy cell leukemia[1] (9940)
Leukemic reticuloendotheliosis (9941)

*If diagnosed within four months of the diagnosis of lymphocytic leukemia, NOS, (9820) or acute lymphocytic leukemia (9821), one of the diagnoses is probably wrong. The case should be reviewed.

(14) <u>Plasma cell leukemia (9830).</u>

Report as a second or subsequent primary:
Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717)
Hodgkin's disease (9650-9667)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Mast cell tumor (9740, 9741)
Non-lymphocytic leukemias (9840-9842, 9860-9910)
Myeloid sarcoma (9930)
Acute panmyelosis (9931)
Acute myelofibrosis (9932)

Do not report as a subsequent primary:
Plasmacytoma[3] or multiple myeloma (9731, 9732)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Leukemia, NOS (9800)
Acute leukemia, NOS (9801)
Chronic leukemia, NOS (9803)
Lymphocytic leukemia (9820-9828)
Plasma cell leukemia (9830)
Lymphosarcoma cell leukemia (9850)
Hairy cell leukemia (9940)
Leukemic reticuloendotheliosis (9941)

(15) <u>Lymphosarcoma cell leukemia (9850).</u>

Report as a second or subsequent primary:
Hodgkin's disease (9650-9667)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)

Mast cell tumor (9740, 9741)
Non-lymphocytic leukemia (9840-9842, 9860-9941)

Do not report as a subsequent primary:
Non-Hodgkin's lymphoma (9590-9595, 9670-9688, 9690-9698, 9702-9717)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Leukemia, NOS (9800)

Acute leukemia, NOS (9801)
Chronic leukemia, NOS (9803)
Lymphocytic leukemias (9820-9828)
Plasma cell leukemia (9830)
Lymphosarcoma cell leukemia (9850)

(16) <u>Non-lymphocytic leukemias (9840-9842, 9860-9894, 9910-9932).</u>

Report as a second or subsequent primary:
Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717)
Hodgkin's disease (9650-9667)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Lymphocytic leukemia (9820-9828)
Plasma cell leukemia (9830)
Lymphosarcoma cell leukemia (9850)
Mast cell leukemia (9900)
Hairy cell leukemia (9940)
Leukemic reticuloendotheliosis (9941)

Do not report as a subsequent primary:
Leukemia, NOS (9800)
Acute leukemia, NOS (9801)
Chronic leukemia, NOS (9803)
Non-lymphocytic leukemias[1] (9840-9842, 9860-9894, 9910-9932)

(17) <u>Mast cell leukemia (9900).</u>

Report as a second or subsequent primary:
Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717)
Hodgkin's disease (9650-9667)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)

Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Any other leukemia (9820-9894, 9910-9941)

Do not report as a subsequent primary:
Mast cell tumor (9740, 9741)
Leukemia, NOS (9800)
Acute leukemia, NOS (9801)
Chronic leukemia, NOS (9803)
Mast cell leukemia (9900)

(18) Hairy cell leukemia or leukemic reticuloendotheliosis (9940, 9941).
Report as a second or subsequent primary:
Non-Hodgkin's lymphoma (9590-9595, 9670-9686, 9688, 9690-9698, 9702-9717)
Hodgkin's disease (9650-9667)
Burkitt's lymphoma (9687)
Mycosis fungoides or Sezary's disease (9700, 9701)
True histiocytic lymphoma (9723)
Plasmacytoma or multiple myeloma (9731, 9732)
Mast cell tumor (9740, 9741)
Immunoproliferative disease, NOS (9760)
Waldenstrom's macroglobulinemia (9761)
Any non-lymphocytic leukemias (9800-9804, 9830-9932)
Lymphocytic leukemia (9821-9828)

Do not report as a subsequent primary:
Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722)
Lymphocytic leukemia, NOS (9820)
Hairy cell leukemia or leukemic reticuloendotheliosis (9940, 9941)

Footnotes

1. Code to the term with the higher histology code.
2. If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, code only as chronic lymphocytic leukemia (9823/3). If chronic lymphocytic leukemia is not confirmed, code only the lymphoma.
3. This is presumably the correct diagnosis. Code the case to this histology.

II.1.3.7 Kaposi's Sarcoma. Kaposi's Sarcoma (9140/3) is to be reported only once.

II.1.3.8 Familial Polyposis. Prepare one abstract when multiple independent carcinomas of the colon—or the colon and rectum—are reported for a patient with familial polyposis. Code the primary site as C18.9 and the histology as 8220/3.

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):

8000-8004 Neoplasms, malignant, NOS, of the skin
8010-8045 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 Exceptions. Note the following 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).

ACoS Requirements. Hospitals may include other sites to comply with the requirements of the American College of Surgeons or the hospital's cancer committee. However, these should not be reported to the regional 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.

II.1.6.1 Reportable. Report the tumor if any of the following terms is used:

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

Approaching (malignancy)	Questionable (malignancy)
Cannot be ruled out	Rule out (malignancy)
Equivocal (for malignancy)	Suggests (malignancy)
Possible (malignancy)	Very close to (malignancy)
Potentially malignant	Worrisome (for malignancy)

*Without additional information.

Exception: 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 for coding 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 should be notified of the case. When in doubt about whether or not to submit a report, either consult the regional registry or report the case.

II.1.8 NEWLY REPORTABLE HEMATOPOIETIC DISEASES (NRHD)

Newly Reportable Hematopoietic Diseases (NRHD) are defined as any of the myeloproliferative or myelodysplastic diseases that changed behavior from /1 borderline to /3 malignant in ICD-O-3. Abstract and report only NRHD cases diagnosed 1/1/2001 forward. If disease is known prior to 2001, do not report the case. NRHD cases diagnosed prior to 1/1/2001 undergoing active treatment at your facility are not reportable cases. NRHD include the following:

CHRONIC MYELOPROLIFERATIVE DISEASES	
Polycythemia vera	9950/3
Chronic myeloproliferative disease	9960/3
Myelosclerosis with myeloid metaplasia	9961/3
Essential thrombocythemia	9962/3
Chronic neutrophilic leukemia	9963/3
Hypereosinophilic syndrome	9964/3
MYELODYSPLASTIC SYNDROMES	
Refractory anemia	9980/3
Refractory anemia with sideroblasts	9982/3
Refractory anemia with excess blasts	9983/3
Refractory anemia with excess blasts in Transformation	9984/3
Refractory cytopenia with multilineage Dysplasia	9985/3
Myelodysplastic syndrome with 5q-syndrome	9986/3
Therapy related myelodysplastic syndrome	9987/3
OTHER NEW DIAGNOSES	
Langerhans cell histiocytosis, disseminated	9754/3
Acute biphenotypic leukemia	9805/3
Precursor lymphoblastic leukemia	983_/3
Aggressive NK cell leukemia	9948/3
Chronic neutrophilic leukemia	9963/3
Hypereosinophilic syndrome	9964/3

Leukemias with cytogenetic abnormalities
Dendritic cell sarcoma
Other new terms in the lymphomas and leukemias

Compare diagnoses to check for transition to another hematopoietic disease. Use the ICD-O-3 Hematopoietic Primaries Table.
For treatment information specific to NRHD, see Section VI.8.

II.1.9 INTRACRANIAL/CNS TUMORS

Although the CCR has required reporting of all intracranial and CNS benign and borderline tumors since 1/1/2001, the National Benign Brain Tumor Cancer Registries Amendment Act, signed into law in October 2002, created Public law 107-260, requiring the collection of benign and borderline intracranial and CNS tumors beginning with cases diagnosed 1/1/2004 forward. *The CCR still requires that follow up be performed on these cases.*Due to this national implementation, several elements of reporting these entities have changed.

II.1.9.1 Reportability. 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)

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.

Reportable Terminology. For non-malignant brain and CNS primaries, the terms "tumor" and "neoplasm" are diagnostic and reportable. 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. In order to be reportable, there must be a corresponding ICD-0-3 histology code for any CNS tumor related diagnosis.

II.1.9.2 Determining Multiple Primaries. Determining the number of primaries for non-malignant CNS tumors requires a review of the following:

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 groupings to determine same histology for non-malignant brain tumors

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 1-4, 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 single primary

- If same site and same histology and laterality is both sides then separate primaries

Counting Non-Malignant Primaries

Same Histology								
Tumor		Timing (months)	Same Site			Different Site		
1st	2nd		Same side	Other side	Unkn side	Same side	Other side	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		Timing (months)	Same Site			Different Site		
1st	2nd		Same side	Other side	Unkn side	Same side	Other side	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

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
Different Histology			**unless one histology is a specific subtype of the other					
Tumor		Timing (months)	Same Site			Different Site		
1st	2nd		Same side	Other side	Unkn side	Same side	Other side	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. *Since 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.*

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.

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.

II.1.9.4 Sequence Number. 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. 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. Always assign code 9 for non-malignant tumors. Do not code WHO grade in the 6th digit histology data field.

II.1.9.7 WHO Grade. 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.

II.1.9.8. Staging.
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. For intracranial and CNS benign and borderline tumor cases diagnosed January 1, 2004 forward, apply Collaborative Staging.

II.1.10 BORDERLINE OVARIAN TUMORS

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
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

For cases diagnosed prior to January 1, 2004, these cases are to be staged according to the ovary scheme in the EOD Manual. Apply the Collaborative Staging ovary scheme for cases diagnosed on or after January 1, 2004. Follow-up is required for these cases.

Section 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. Before abstracting a case, use CNExT's Name Search function to ascertain whether the patient already has an accession number. If the patient does not, an accession number must be assigned. (NOTE: On some screens CNExT displays the accession and sequence numbers as an eleven-digit accession/sequence number, while on others the numbers appear in separate fields.)

II.2.1 YEAR FIRST SEEN

A request for the year first seen appears on the Abstract New Case screen. 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. Assigned 1993 as the year first seen for this primary.

II.2.2 CNExT GENERATED NUMBERS

After the first year seen is entered, a nine-digit accession number and two-digit sequence number generated by CNExT appears on the screen. If needed, the numbers can be changed by entering numbers over the suggested values. CNExT will display an error message if you enter a duplicate number.

II.2.3 ACCESSION NUMBER

If a patient had another tumor that was recorded in the hospital's registry, enter the accession number assigned at that time. If this is the first report by the hospital for the patient, use the nine-digit accession number generated by CNExT. Or the hospital may assign its own accession number in place of CNExT's. The first four digits represent the year first seen for the patient (see Section II.2.1). The last five digits represent the approximate chronological order of the abstracts prepared for that year.

Examples

(1) If the patient was admitted or the tumor was diagnosed on February 11, 1985, the first two digits are 85. If the abstract for the reported tumor was the 285th prepared for 1985, the accession number is 198500285.

(2) Two abstracts are being prepared for a patient with one primary tumor diagnosed in 1987 and another in 1988. The first four digits of the accession number are 1987, and the next five represent the abstract's place in the chronological order of cases reported for 1987. The same accession number must be used for the second and subsequent abstracts. (However, the year first seen for the first tumor is 87, and for the second it is 88.)

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.

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
..
35 THIRTY-FIFTH OF THIRTY-FIVE 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 TUMOR
61 FIRST OF TWO OR MORE TUMORS
62 SECOND OF TWO OR MORE 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, borderline ovarian tumors and benign and uncertain behavior CNS tumors and cases that are reportable by agreement will be sequenced using numeric codes (60-87). NOTE: Alphabetic sequence codes are no longer allowed.

For Newly Reportable Hematopoietic Diseases (NRHD), the sequencing begins with cases diagnosed 1/1/2001 forward.

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, first see Section V.5, Stage at Diagnosis; then, if necessary, Section V.4, Extent of Disease; then, Section V.3.5, Grade and Differentiation. If none reveals 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 00, one tumor only.

II.2.5 OTHER TUMORS

Record on the Remarks screen (see Section VIII.1) 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

Section III.1
Registry Information

Registry Information fields are primarily for identification and document control by the regional registry.

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. If the initials are unknown, enter XXX.

III.1.2 SUSPENSE FLAG

When adding a new case in CNExT, choose from the four options for suspense flag: potential, initiated, non-reportable, or historic. CNExT automatically edits the abstract to make sure all required entries have been made, and a message lists omissions. When a case passes edits, you have the option of setting the case to complete or holding it for further treatment information. When completed, the abstract is placed in a queue for transmission to the regional registry.

III.1.3 YEAR FIRST SEEN, ACCESSION NUMBER, AND SEQUENCE NUMBER

The year first seen, accession number, and sequence number for the case (see Sections II.2.1, II.2.3, and II.2.4) are displayed. Enter corrections by typing over the old number(s).

III.1.4 REPORTING HOSPITAL

Enter the reporting hospital's CCR-assigned code (see Appendices F1 and F2) or the hospital's name. In CNExT, select the hospital from the Reporting Hospital drop-down list.

III.1.5 CNExT AUTOMATIC ENTRIES

The following fields in CNExT (under Registry/Activity History) are entered automatically by the system:

- Date Case First Entered.
- Date Case Completed (appears when case becomes complete).
- Coding Procedure (designates the set of codes and rules used to abstract the case.)
- Date Case Last Changed.
- Source Of Change.
- Follow-up Last Changed.
- Tumor Record Number.
- Sequence Number.
- Vendor Version.

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.

Section III.2
Patient Identification

The CCR and regional registries rely on patient-identification information for matching data in the abstract with data about the patient from other sources. It is imperative, therefore, that hospitals use the same rules for entering names, dates, and other information.

III.2.1 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, and do not enter any 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. (On the Contact screen—see Section VII.3—names may be entered in order, and with prefixes and suffixes, suitable for addressing correspondence.)

III.2.1.1 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 25 characters, enter only the first 25. If the patient has no last name or the name cannot be determined, enter NLN.

III.2.1.2 First Name. For the first name enter no more than the first 14 letters. 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.

III.2.1.3 Middle Name. Enter the middle name, up to 14 letters, 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 15 characters, enter only the first 15. Leave the field blank if maiden name is not applicable or it is not known.

III.2.1.5 Alias Last Name In the Alias Last Name Field field enter up to 15 characters of:

- 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 15 characters of:

- An alias (also known as, or AKA) first name used by the patient.

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 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.

Patient Identification

Examples		
(1)	Religious name:	Sister Mary Anthony
	Secular name:	Jane Smith
	Report as:	(last name) Smith (first name) Jane (alias) Anthony
(2)	Religious name:	Sister Mary Anthony
	Secular name:	Smith (first name unknown)
	Report as:	(last name) Smith (first name) Sister (alias) Anthony
(3)	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. The CCR would prefer that this field be used to capture such name suffixes as Jr, Sr, III, IV and that MD, PhD not be entered. They can be used, but will be stripped off at the regional 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 14 characters in length. If 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. When entering a number, always start in the first space. 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. 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.)

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
Leave the field blank.

III.2.4 PHONE NUMBER (PATIENT)

This field is to be used for entering the patient's current telephone number including the area code. If there is no phone, enter all 0's. If the phone number is unknown, leave blank. When the telephone number is changed during follow up, this field should be updated with the most current telephone number. (CNExT automatically keeps this field consistent with the Contact #1 (Patient) telephone number.)

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 current address. (The patient's current mailing address is entered on the Contact screen for follow-up purposes.) 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 regional registries use automated data processing methods that reject non-standard entries. The data are used for grouping cases by geographical area.

III.2.5.1 Rules. 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 class 3 (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 Data Entry

NUMBER and STREET

Use up to 40 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 40 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."

A new field, Patient Address at Diagnosis Supplemental, provides the ability to record additional address information such as the name of a place or facility (ie, a nursing home or name of an apartment complex) at the time of diagnosis. Use up to 40 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.

CITY

Enter a maximum of 20 letters 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"). Certain abbreviations may be used (consult the regional registry for acceptable abbreviations). 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.

STATE

For states in the U.S. and Canadian provinces, enter the standard two-letter Postal Service abbreviation. (California is CA. For other states, U.S. Territories and Canadian provinces, see Appendix B.) *For U.S. Territories with a postal abbreviation, such as Guam (GU), use the abbreviation or if no postal abbreviation enter "ZZ," not applicable. If the residence was in the U.S. or Canada, but the state or province is unknown, or the place of residence is unknown, enter "ZZ." For residents of countries other than the U.S. and Canada, and the country is known, enter "XX". For residents of countries other than the U.S. and Canada, and the country is unknown, enter "YY".*

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

COUNTY

For California residents, enter the code for the county of residence at the time of diagnosis. (Appendix L contains a list of the codes used. CNExT automatically supplies the code if the county's name is entered.) Consult maps or reference works as needed to determine the correct county. Enter code 000 if the county of residence is not known or if it is a state and is other than California and its name is known. Enter code 220 for Canada, NOS, or the specific code for the known Canadian province (Canadian province codes are listed in Appendix C). If residence was in a foreign country, enter the country and CNExT will supply the code. (Country codes are listed in Appendix D.) If the state or country is not known, enter code 999.

NOTE: To maintain consistency in the CCR database, codes must be entered as described above for state and county/country.

III.2.6 MARITAL STATUS

Studies have shown a correlation between marital status and the incidence and sites of cancer, and that these patterns are different among races. So that further analyses can be carried out to identify high-risk groups, report the patient's marital status at the time of first diagnosis. Use the following codes:

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 (persons with sex chromosome abnormalities)
4 TRANSSEXUAL (persons who have undergone sex-change surgery)
9 UNKNOWN

III.2.8 RELIGION

Enter the code for the patient's religion or creed (see Appendix G for codes), or enter the name of the religion and CNExT automatically provides the code. CNExT currently defaults this field to 99. Use code 99 if the religion is not stated.

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 different ethnic groups generate hypotheses for researchers to investigate. 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.

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

Scenarios Demonstrating Conflicting Race Information:

A. Name: June Hashimoto
Race: White
Birthplace: Unknown
Marital Status: Single

B. Name: Bob Nguyen
Race: White
Birthplace: Mexico

C. Name: Robert Jackson
Race: Mexican
Birthplace: California

D. Name: Moon Smith
Race: Japanese
Birthplace: California
Marital Status: Married

E. Name: Maria Tran
Race: White
Birthplace: Spain
Marital Status Separated

F. Name Carlos Johnson
Race: Black
Ethnicity: Hispanic
Birthplace: California

G. Name: Arlene Thompson
Race: Filipino
Birthplace: California
Marital Status: Divorced

A text statement indicating patient's race, i.e., "Pt is Japanese", is required for conflicting types of cases. This information must be entered in either the physical exam or remarks text fields.

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 continue to document race in the physical exam or remarks fields. Remember to search beyond the facesheet 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 have been 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. 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, n*o "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.

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.

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.

1. *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 Editing Guidelines below for further instructions.*

2. *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.*

3. 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.*

4. *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.*
   Example 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 Appendix W.
Record states: "this patient was Nigerian..." Code race as 02 Black 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.

5. 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.*

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

7. *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.*

8. *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.

III.2.9.1 Codes For Race Fields. 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 ASIAN INDIAN, PAKISTANI
10 VIETNAMESE
11 LAOTIAN
12 HMONG
13 KAMPUCHEAN (CAMBODIAN)
14 THAI
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

**Note: these races were previously coded 09 - Asian Indian. Per the 2004 SEER Race Coding Guideline, these cases are coded as 96 Other Asian. For consistency in these codes over time, the CCR created a new code, code 90 for Other South Asian. These cases will be converted from 90 to 96 for calls for data.*

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).

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

Afghan	Czechoslovakian	Lebanese	Spanish
Albanian	Dominican**	Mexican*	Syrian
Algerian	Egyptian	Moroccan	Tunisian
Arabian	Greek	Palestinian	Turkish
Armenian	Gypsy	Polish	Yugoslavian
Australian	Hungarian	Portuguese	
Austrian	Iranian	Puerto Rican**	
Bulgarian	Iraqi	Rumanian	
Caucasian	Israeli	Russian	
Central American*	Italian	Saudi Arabian	
Cuban**	Jordanian	Slavic	
Cypriot	Latino	South American*	

* 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 of population. 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

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, 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 and Filipinos frequently have Spanish surnames but are not considered to be of Spanish origin in the sense meant here.) Enter code 0 for Portuguese and Brazilians, because they are not Spanish. If the record does not state an origin that can be assigned to codes 1–5 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. 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

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

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

(3) 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.

*The instructions in Section III.2.9.2 are effective with cases diagnosed January 1, 1994. Code 7 is effective with January 1, 1994 cases.

**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 BIRTH DATE

When recording a patient's date of birth, enter the month first, then the day, then the year (see Section I.1.6.4). Always use two digits for the month and day, and four digits for the year. If the month or day has one digit, enter 0 before the number. The year is divided into two parts, the century (18--or 19--) and the year. Enter 99 for a month or day that is not known. If the year is not known, enter 9999 and also code the month and day as unknown. If the record only states the patient's age, calculate the year by subtracting the age from the diagnosis date. The codes are:

MONTH	01-12 (January-December) 99 (unknown)
DAY	01-31 99 (unknown)
CENTURY	18-19 99 (unknown)
YEAR	00-99 99 (unknown)

Examples

The date February 5, 1943, is entered 02051943. If the exact day is not known, the entry is 02991943. If the month and day are stated, but not the year, the entry is 99999999.

III.2.11 AGE AT DIAGNOSIS

Age at first diagnosis is calculated automatically by CNExT if the birth date and diagnosis date are entered.

III.2.12 BIRTHPLACE

Enter the name of the state, territory, or country where the patient was born. CNExT automatically enters the code. If the birthplace is in the United States, but the state is not known, enter 000. If the place of birth is not known, enter 999.

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 or regional registry 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 40 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 40 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. Enter—

Occupation:	Child—MO: biology professor
Industry:	MO: University

III.2.14 PATIENT NO RESEARCH CONTACT FLAG

This flag is to be set to 1 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. If there is no information with regard to the patient's not wanting inclusion in a research study(ies), this flag should remain set to 0. Code 1--Hospital First Notified--would be entered. Codes 2 and 3 are for regional and central registry use. The regions will share this information with each other during routine case sharing between the regions. Code 4 - Out of State 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. CNExT will pre-fill with 0. The codes are:

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

Section III.3
Case Identification

While some of the data reported on the Case Identification screen 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. (The previously entered Year First Seen [see Section II.2.1] is displayed on the screen and can be corrected by typing over the old numbers.)

III.3.1 DATE OF FIRST ADMISSION

Enter the date the patient was first seen at the reporting hospital with a reportable neoplasm, according to the following (see Section I.1.6.4 for entering dates):

For Inpatients enter the first date of admission as an inpatient for the reportable neoplasm, or the date when diagnosis of a reportable neoplasm was made during a long-term hospitalization for another condition. For Outpatients enter the date first diagnosed, treated, or seen as an outpatient for the reportable neoplasm.

III.3.2 DATES OF INPATIENT ADMISSION AND INPATIENT DISCHARGE

Enter the dates of the 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 therapy. If the patient has not had cancer therapy, use the dates of inpatient admission and discharge for diagnostic evaluation. (See Section I.1.6.4 for entering dates.)

III.3.3 DATE OF DIAGNOSIS

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.

Examples

(1) 6/4/86. Chest X-ray shows mass in right upper lobe.
6/6/86 Bronchial washings are positive for carcinoma.
The diagnosis date is 6/6/86, because the term "mass" does not constitute a diagnosis of cancer.

(2) 5/20/86. Mammogram—suspicious for carcinoma, left breast, upper outer quadrant.
6/3/86. Fine needle aspiration, left breast—positive for carcinoma.

The date of diagnosis is 5/20/86, because the term "suspicious" constitutes a presumptive diagnosis of cancer. (See Section II.1.6 for vague or ambiguous terms.)

(3) 7/9/86 Cervical lymph node biopsy shows papillary carcinoma. Review of slides from a thyroidectomy performed in April 1984 reveals foci of papillary carcinoma not diagnosed at the time and now thought to be the primary tumor.

Backdate the diagnosis date to 04/99/84, the date of the earliest evidence.

III.3.3.1 Coding. Enter the month, then the day, then the year, using two digits for each. Enter "99" for any unknown part of the date. If the year is not known, the month and day should also be entered as unknown.

III.3.3.2 Vague Dates. Following are coding procedures for vague dates:

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.
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, approximate a date when the exact date cannot be determined. It is preferable to approximate a month or year than to enter "unknown." The date of first cancer therapy may be used as the date of diagnosis if the therapy was initiated before definitive confirmation of the diagnosis.

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 INFOR-MATION AVAILABLE	Enter "unknown."

III.3.5 CLASS OF CASE

The class code identifies cases that are usually included in the reporting hospital's treatment and survival statistics. For coding class of case, consider the office of a physician on the hospital's medical staff as an extension of the hospital. See Section VI.1.3.1 for instructions for coding treatment given in a staff physician's office. Class of case is divided into two basic categories, analytic and non-analytic. Analytic cases are those included in treatment and survival analyses, and non-analytic cases are those that are not included. (See Section I.1.8 for data required in abstracts for non-analytic cases.)

Beginning with cases diagnosed 1/1/2003, code 7 - Pathology Report Only and code 8 - Death Certificate Only were added. Code 8 is only used by central registries. The codes are:

Analytic

0 FIRST DIAGNOSED AT REPORTING HOSPITAL SINCE ITS REFERENCE DATE, BUT ENTIRE FIRST COURSE OF THERAPY* GIVEN ELSEWHERE. Although not treated at the reporting hospital or in a staff physician's office, a class 0 case is known to have received treatment. Included are:

- Patient who elected to be treated elsewhere.
- Patient referred to another facility for any reason, such as lack of equipment, proximity of other facility to patient's residence, financial, social, or rehabilitative considerations.

1 FIRST DIAGNOSED AT REPORTING HOSPITAL SINCE ITS REFERENCE DATE, AND EITHER (a) RECEIVED ALL OR PART OF FIRST COURSE OF THERAPY* AT THE HOSPITAL, OR (b) WAS NEVER TREATED. Included are:

- Patient diagnosed in a physician's office** and admitted to the reporting hospital for all or part of the first course of therapy.
- Patient diagnosed but not treated at the reporting hospital and all or part of the first course of therapy was given in the physician's office.
- Patient diagnosed at reporting hospital who refused treatment.
- Patient diagnosed at reporting hospital but was not treatable due to age, advanced disease, an unrelated medical condition, or other reason.
- Specific treatment recommended but not given at reporting hospital, unknown whether given elsewhere.
- Patient diagnosed at reporting hospital but not known to have been treated.

2 FIRST DIAGNOSED AT ANOTHER HOSPITAL AND EITHER (a) RECEIVED ALL OR PART OF THE FIRST COURSE OF THERAPY* AT THE REPORTING HOSPITAL AFTER ITS REFERENCE DATE, OR (b) PLANNING OF THE FIRST COURSE OF THERAPY WAS DONE PRIMARILY AT THE REPORTING HOSPITAL. Included are:

- Patient diagnosed at another hospital but not treated until admission to the reporting hospital, regardless of interval between diagnosis and treatment.
- Patient diagnosed and surgically treated at another hospital who is then admitted to the reporting hospital for radiation therapy that completes the planned first course of treatment.

- Any case the reporting hospital considered to be analytic—i.e., the planning/management decisions were made at the hospital, even if the treatment was actually administered elsewhere, and the follow-up care of the patient is the responsibility of the reporting hospital.

Non-Analytic

3 FIRST DIAGNOSED AT ANOTHER HOSPITAL AND EITHER (a) ENTIRE FIRST COURSE OF THERAPY* WAS GIVEN ELSEWHERE, (b) WAS NEVER TREATED, or (c) UNKNOWN IF TREATED. Included are:

- Patient diagnosed and first course of therapy completed elsewhere, later admitted to the reporting hospital with disease.
- Unable to determine whether or not treatment given at the reporting hospital was part of the first course of therapy.
- Patient previously hospitalized elsewhere and the reporting hospital was not involved in planning and/or carrying out the first course of therapy.

4 FIRST DIAGNOSED AT REPORTING HOSPITAL BEFORE ITS REFERENCE DATE. (Class 4 cases are reportable to the regional registry only if the reporting hospital's reference date is later than the regional registry's reference date.)

5 FIRST DIAGNOSED AT AUTOPSY. Includes incidental finding of cancer at the time an autopsy was performed at reporting hospital. If there had been a diagnosis of cancer before death, the case is a Class 1 or 2 that was confirmed at autopsy. (See Section III.3.3 for rules applicable to determination of date of diagnosis.) Use code 5 if the cancer was first discovered at autopsy in a patient with a different admitting diagnosis.

6 DIAGNOSED AND RECEIVED ALL OF THE FIRST COURSE OF TREATMENT IN A STAFF PHYSICIAN'S OFFICE. (PER THE AMERICAN COLLEGE OF SURGEONS, THESE CASES ARE NON-ANALYTIC AND REPORTABILITY IS OPTIONAL.)***

7 PATHOLOGY REPORT ONLY. PATIENT DOES NOT ENTER THE REPORTING FACILITY AT ANY TIME FOR DIAGNOSIS OR TREATMENT. THIS CATEGORY EXCLUDES CASES DIAGNOSED AT AUTOPSY.

8 DIAGNOSIS WAS ESTABLISHED BY DEATH CERTIFICATE ONLY. USED BY CENTRAL REGISTRIES ONLY.

9 PATIENT TREATED AT REPORTING HOSPITAL BUT DATE OF DIAGNOSIS IS UNKNOWN AND CANNOT BE REASONABLY ESTIMATED.

* See Section VI.1 for definition of first course of treatment.

** If the diagnosing physician is known not to be on the hospital's medical staff (e.g., is from another town), code the case as class 2.
***: These cases are not required. If hospitals choose to collect them, they may do so.

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. If there are several sources, report the one with the lowest code number. The codes are:

1	HOSPITAL INPATIENT/OUTPATIENT OR CLINIC**
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

* Codes 4, 5, and 7 are not used by hospitals.
** Code 2 was used for CLINIC (hospital outpatient or private) before 1988, and thus appears in some older cases.

NOTE: For Class 6 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 types 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)

*Abstracts are not required for cases with these types of admission.

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. The field is preset to code 10 when CNExT is installed at a cancer-reporting facility. To enter a different code, type over the 10. The codes are:

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)

NOTE: Codes 10-29 can be used by cancer-reporting facilities whichever way will best serve them in their casefinding efforts. There is no "correct" code to use.

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
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. 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
28	*HMO*
29	*PPO*
31	MEDICAID
35	MEDICAID ADMINISTERED THROUGH A MANAGED CARE PLAN
36	MEDICAID WITH MEDICARE SUPPLEMENT
50	MEDICARE
51	MEDICARE WITH SUPPLEMENT
52	MEDICARE WITH MEDICAID SUPPLEMENT
53	TRICARE
54	MILITARY
55	VETERANS AFFAIRS
56	INDIAN/PUBLIC HEALTH SERVICE
60	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.

III.3.10 HOSPITAL REFERRED FROM

If the diagnosis was made before admission (diagnosed PTA), enter the six-digit code number of the hospital or other facility at which the patient was previously seen for the disease. CNExT left fills this 10 character field with zeroes. (Appendices F1 and F2 contain the code numbers of all facilities in California and some out-of-state facilities.) If the patient was seen in more than one facility before admission, enter the one in which the patient was seen most recently. If the patient was diagnosed in the office of a physician who is on the reporting hospital's medical staff, and the case is Class 0 or 1, enter 999993, Staff Physician. But if the physician is not on the hospital's medical staff, and the case is Class 2 or 3, enter 999996, Physician Only. If the patient was not referred, enter zeroes. CNExT users may leave blank when first entering a case, and CNExT will prefill with zeroes. If it is not known where the patient was diagnosed or most recently seen, enter 999999, Unknown Hospital.

III.3.11 HOSPITAL 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 six-digit code number (see Appendix F1 and F2 for codes). CNExT left fills this 10 character field with zeroes. If the place of treatment is the office of a physician on the hospital's medical staff, enter 999993, Staff Physician. If it is not known where the patient was subsequently seen, enter 999999, Unknown Hospital. If the patient is not referred, enter zeroes. CNExT users may leave blank when first entering a case, and CNExT will prefill with zeroes.

III.3.12 PHYSICIANS

Each hospital must maintain its own roster of physicians and their code numbers. The codes are based on the physicians' California license numbers. As new physicians who treat cancer patients join the hospital staff, they should be added to the roster, with their license 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 License Numbers. State physician's license numbers have been expanded to nine characters. The CCR, CNExT, and MDLOOK only use eight 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. The same instructions apply for dentists. For osteopaths, enter the entire eight character code including a leading O (alpha character). The following are examples:

Physician - A00023456 would be entered A0023456
Dentist - D00056789 would be entered D0056789
Osteopath - O20A4422 would be entered O20A4422

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 Codes. The first field is to be used to enter the attending physician. This field may not be blank. If there is no attending physician, or if it cannot be determined who the attending physician is, the code for unknown physician or license number not assigned (99999999) must be entered. If the attending physician is the same as another physician, (i.e., the medical oncologist) the license number must be entered in both places.

The second field is to be used to enter the referring physician, the third field is to be used for coding the surgeon, the fourth field is to be used for coding the medical oncologist, and the fifth field is to be used for coding the radiation oncologist. The last two fields may be used to code any other physician. The following physician has its own designated field. Use the following codes for Surgeon, Radiation Oncologist, and Medical Oncologist when applicable:

Surgeon

00000000	No surgery and no surgical consultation performed
88888888	Non-surgeon performed procedure

Radiation Oncologist

00000000	No radiation therapy or radiation therapy consult performed
88888888	Non-radiation therapist performed procedure

Medical Oncologist

00000000	No chemotherapy or chemotherapy consult was performed
88888888	Non-medical oncologist gave systemic therapy

NOTE: These fields are to be used for entering physician license numbers only. They are not to be used for entering facilities or physician's groups. There are fields designated for this purpose.

III.3.13 Comorbidity/Complications 1-6. *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 1-6 will be collected from CoC facilities. Refer to the FORDS Manual for instructions.

PART IV
DIAGNOSTIC PROCEDURES

Section IV.1
Diagnostic Procedures Performed

Report the results of physical examinations and diagnostic procedures for all analytic cases and for autopsy only (class 5) cases. Reporting diagnostic procedures is optional for non-analytic cases. (See Section III.3.5 for definitions of analytic and non-analytic cases.) 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.

IV.1.1 GENERAL INSTRUCTIONS

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 for common acceptable abbreviations). Enter text for both site and histology in the fields designated. The date of diagnosis is listed on the Case Identification screen and on the Cancer ID screen (see Section III.3.3). If the medical records indicate that the case was actually first diagnosed on a different date, make the correction by typing over the date shown in the Date of Diagnosis field.

IV.1.1.1 Location. Record where the tumor is located in the primary site, such as the lobe, quadrant, etc.

IV.1.1.2 Size. Record dimensions of the tumor as stated by the examiner, whether the measurement is in millimeters, centimeters, or inches, or the size is described in terms of a fruit, nut, or other object. Be sure to specify the unit of measurement. Also note such descriptions as "diffuse," "entire circumference," "widespread."

When a pathology report describes tumor size as invasive with a minor component of in situ, then code the total tumor size. For all sites except breast, minor component is defined as: less than 5%, foci of tumor, or stated as “minor component.” According to the expanded breast EOD tumor size codes, minimal tumor is described as <25%.

When interpreting the terms focus, focal, and foci as they pertain to tumor size, focus and foci are microscopic descriptions and are coded 001 when no other information is available. Focal refers to an area of involvement, focal should be coded 999.

Examples of diagnoses from pathology reports followed by the correct tumor size:

- focal adenocarcinoma – TS 999
- microfocus of adenocarcinoma – TS 001
- multiple foci of adenocarcinoma in specimen – TS 001
- multifocal adenocarcinoma in specimen TS – 999
- microscopic focus of adenocarcinoma in multiple fragments – TS 001
- focal adenocarcinoma in chips – TS 999
- focal adenocarcinoma in 5% of specimen – TS 999

Although the SEER EOD rules state to always code the size of the tumor, not the size of the polyp, ulcer, or cyst, if an ulcerated mass is pathologically confirmed to be malignant, it is acceptable to code the size of tumor based on the size of this mass in the absence of a more precise tumor size description.

IV.1.1.3 Extension. Enter details about the direct extension to other organs or structures, and any mention of probable involvement of a distant site. Among the terms sometimes used to indicate tumor involvement are "organomegaly," "visceromegaly," "ascites," "pleural effusion", "masses," and "induration."

IV.1.1.4 Lymph Nodes. The physician's statement about the possibility of tumor involvement of lymph nodes is especially important. Record terms used in describing the palpability and mobility of accessible lymph nodes—such as "discrete," "freely movable," "slightly fixed," "matted," "attached to deep structures." Identify nodes as specifically as possible, including the number, size, and whether they are ipsilateral, contralateral, or bilateral. Size is particularly important for head, neck, and breast tumors.

IV.1.2 PHYSICAL EXAMINATION

Record the date(s) of the patient's physical examination(s) 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

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, note the results of each study in the series. Enter a description of the primary tumor, including size, location, and whether or not multifocal. Enter "none" if no X-rays or scans were performed.

IV.1.4 SCOPES

Note 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

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 (see Section IV.2), *unless more specific information is given in the cytogenetic report. 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 cytogenetic and molecular biological data* results can be recorded here. Enter "none" if no pertinent laboratory tests were performed.

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 (see Section VI.2.1-9), record pertinent findings. Note tumor size, if given, and any statements about observed nodes, even if they are not involved.

IV.1.7 PATHOLOGY

Record all tumor-related gross (non-microscopic) and microscopic cytologic and histologic findings (see Section V.3.3), whether positive or negative, and include differentiation. (For details about microscopic diagnoses, see Section IV.2; for grade and differentiation, see Section V.3.5). Also enter the dates, source of specimen(s), pathology report number, size of the largest tumor, and other details needed to:

- Describe the location of the primary site or subsite and laterality of the primary tumor (see sections V.1 and V.2 for discussions of site and laterality).
- Record the histologic diagnosis and identify the appropriate ICD-O code (see sections V.3.2 and V.3.3).
- Describe multiple tumors and multiple sites of origin.
- Document the extent of disease (see Section V.4) and stage at diagnosis (see Section V.5).
- 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.

IV. 1.7.1 Pathology Report Number - Biopsy/FNA Record the pathology report number for the first positive biopsy or fine needle aspirate (FNA) performed at your facility. This field may be left blank if biopsy/FNA was not performed or the results were negative.

IV.1.7.2 Pathology Report Number - Surgery Record the surgical pathology report number for the first definitive surgical resection performed at your facility on the patient's cancer. This should be recorded whether there was cancer present or not in the surgical specimen. This field may be left blank if definitive surgery was not performed.

***Pathology Report Number - Biopsy/FNA** and **Pathology Report Number - Surgery** need not be entered in the text field if there is only one pathology report, or if it is clear from the information recorded which number belongs to which specimen.

Record pathology report numbers in the text field for all additional pathology reports (including outside pathology, if available).

Do not record pathology report numbers from autopsies in these fields.

Section 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, 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 should be studied to determine what methods were used to confirm the diagnosis of cancer, and the most conclusive method should be coded in the confirmation field. Since the confirmation field covers the patient's entire medical history in regard to the primary tumor, follow-up data (see Section VII.1) might change the coding. Although there is a priority order based on the most conclusive method of diagnosis, the clinical source utilized by the clinician to establish the cancer diagnosis should be used to select the best diagnostic confirmation code. 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.

4 POSITIVE MICROSCOPIC CONFIRMATION, METHOD NOT SPECIFIED
Cases with a history of microscopic confirmation, but with no information about whether based on examination of tissue or cells.

Diagnostic Confirmation

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. But 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
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.)

PART V
TUMOR DATA

Section V.1
Primary Site

One of the major concerns of the CCR is the identification of the original (primary) site of a tumor—not the 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 four-digit number preceded by a T, standing for topography. In the topography section, the first three digits stand for the part of the body and the fourth digit for a specific area in the part. Listings are arranged in the numerical order of the first three digits. When entering the code, omit the period following the third digit.

*Beginning with cases diagnosed January 1, 2001, the ICD-O-3 (International Classification of Diseases for Oncology, Third Edition, 2000) must be used for coding primary site. For cases diagnosed prior to January 1, 2001, ICD-O-2 must be used.

NOTE: For cases with unknown date of diagnosis collected 1/1/2001 and after, use ICD–O–3 to code site/histology/behavior/grade.

Primary Site

Examples

(1) All entries under lung have the first three digits C34, followed by a fourth 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.

V.1.2 IDENTIFICATION OF SEPARATE SITES

A principal way of determining how many primary tumors a patient has is the identification of separate sites (for further discussion of primaries, see Sections II.1.2 and II.1.3). For colon, rectum, anus, and anal canal, bone, peripheral nerves and autonomic nervous system, connective tissue, and melanoma of skin, each subcategory (4-characters) as delineated in ICD-O-3 is considered to be a separate site. The site groups shown in Appendix N are each to be considered one site when determining multiples. For all other sites, each category (3-characters) as delineated in ICD-O–3 is considered to be a separate site. If tumors of the same histology occur in more than one subsite within two months of each other, record them as a single primary and code the **.**9 topographic subcategory. For paired organs, see Section II.1.3.3.

Example

Independent tumors occurring in the transverse colon (C18.4 and descending colon (C18.6) must be reported separately as different primaries, whatever their histologic types and whether or not they appear within two months of each other. Base of tongue (C01.9) and border of tongue (C02.1) are considered subsites of the tongue and would be treated as one site--either overlapping lesion of parts of the tongue (C02.8) or tongue, NOS (C02.9). Report tumors of the same histology appearing in the trigone of the urinary bladder (C67.0) and the lateral wall of the urinary bladder (C67.2) as a single primary and enter code C679.

V.1.3 INDEFINITE AND METASTATIC SITES

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

NOS. The 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. For diagnoses referring to regions and ill-defined sites of the body, such as "head," "thorax," "abdomen," "pelvis," "upper limb," "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. The primary site is not known, and the only information available is the metastatic, or secondary, site.

V.1.4 SPECIAL CONDITIONS

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).

Lymphoma. Code as an extranodal site—for example, stomach, lung, skin—when there is no nodal involvement of any kind or if it is stated in the medical record that the origin was an extranodal site. If no primary site is given, code as lymph nodes, NOS (C77.9), rather than primary unknown (C80.9).

Lymphoreticular Process. Code malignant lymphoreticular process as site C42.3, reticuloendothelial system, NOS. However, for lymphoreticular process further classifiable as myeloproliferative arising in the bone marrow, code site as bone marrow (C42.1). For lymphoreticular process classified as lymphoproliferative arising in the lymph tissue, code site as lymph node, NOS (C77.9).

Leukemia. Code the primary site as bone marrow, C42.1.

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 on the CCR website: www.ccrcal.org. Click on Registrar Resources, then Data Standards and Quality Control Memorandums, go to DSQC Memo 2000-04, page 2.

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)	Most likely (malignant)
Appears to	Presumed (malignant)
Comparable with	Probable (malignancy)
Compatible with (a malignancy)	Suspect or suspected (malignancy)
Consistent with (a malignancy)	Suspicious (of malignancy)
Favor (a malignancy)	Typical (of/for malignancy)

Primary Site

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

Approaching (malignancy)	Questionable (malignancy)
Cannot be ruled out	Rule out (malignancy)
Equivocal (for malignancy)	Suggests (malignancy)
Possible (malignancy)	Very close to (malignancy)
Potentially malignant	Worrisome (for malignancy)

Section 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.

V.2.1 CODING

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)
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 (not 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- 4 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

Midline tumors are coded Laterality = 9.

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, 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
C74.0-C74.9 Adrenal gland
C75.4 Carotid body

V.2.3 SITE CODING RESTRICTIONS

Beginning with cases diagnosed 1/1/2004 forward, the Laterality field must only be coded for sites listed in Volume I, Section V.2.2 and for benign and malignant CNS tumors. Code all other non-paired sites to 0. Prior to 1/1/2004, completion of this field was optional for sites not listed in Section V.2.2.

Section 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), and (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

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.

Cases diagnosed prior to January 1, 2001, should 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 on the report, 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. 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. It is always appropriate to ask for advice about coding from a pathologist or clinician familiar with the case. (Be sure to document the physician's answer to your query in a text field.)

V.3.3.1 Sources for Determining Histology. In coding histology, use all pathology reports regarding the tumor. The specimen taken from a resection is usually the most representative, unless all the cancerous material was removed during a biopsy. An AJCC staging form may also be used if it is signed by a physician. Other diagnostic procedures or the final clinical diagnosis may be used as the basis for coding histology only if no pathology report is available. Document on the abstract every source of information used.

V.3.3.2 Basic Rule. Before attempting to code histology, determine whether the case involves a single primary or multiple primaries (see Section II.1.3). Base the code on the best information in the report(s), whatever section it appears in. If the final diagnosis states a specific histologic type, enter the code for that type. However, if the microscopic description or a comment contains a definitive statement of a more specific type (i.e., one with a higher code number), enter the more specific code.

For the hematopoeitic diseases, code to the more specific morphology, if that can be determined, which may not be the numerically higher code number. When in doubt which code to use, consult a medical advisor or pathologist.

V.3.3.3 Variations in Terminology. Difficulties in selecting the correct code often occur because different histological terms are used to describe the same tumor in different pathology reports or in different parts of the same report. They might describe the same histology, subtypes of the same histology, the histologies of different parts of the same tumor, or a mixed histology. (See Section II.1.3 for rules about whether tumors with mixed histologies are to be considered single or separate primaries.) Various mixed histologies are assigned their own code numbers in ICD-O–3. Many of these are found in the index under "Mixed" and "Mixed Tumor," but others are listed under one or the other histologic type. For example, mixed adenocarcinoma and squamous cell carcinoma of the cervix is coded as adenosquamous carcinoma (8560/3) and indexed under "Mixed." However, not all mixed histologies have their own numbers in ICD-O–3. When coding mixed histologies or tumors described with more than one term, behavior is a key factor (for explanation of behavior codes, see Section V.3.4). Use the following rules.

Single Lesion, Same Behavior. If two histologic types or subtypes existing in the same primary tumor have the same behavior code, select the appropriate morphology code **using the following rules in order:**

(1) Use a combination code if one exists.

Examples

(1) Predominantly lobular with a ductal component. Use the combination code for lobular and ductal carcinoma.

(2) Invasive breast carcinoma—predominantly lobular with foci of ductal carcinoma. Use the combination code for lobular and ductal carcinoma.

(2) If one term appears in ICD-O-3 as an NOS (e.g., "carcinoma" appears as "carcinoma, NOS") and the other is more specific, use the more specific term.

Examples

(1) Adenocarcinoma, NOS, (8140/3) of the sigmoid colon with mucin-producing features. Code as mucin-producing adenocarcinoma (8481/3).

(2) Invasive carcinoma, NOS, probably squamous cell type. Code as squamous cell carcinoma (8070/3), because it is more specific than carcinoma, NOS (8010/3).

(3) Adenocarcinoma, NOS of the prostate, focally cribriform. Code cribriform carcinoma (8201/3) since it is more specific than adenocarcinoma.

(3) Code the histology of the majority of the tumor if there is no combination code (Rule #1) and neither term is equivalent to an NOS term (Rule #2) in ICD-O-3. Such phrases as "predominantly...", "with features of...", and "...type" indicate that the description applies to the majority of the tumor. Phrases that do not describe the majority of the tumor (e.g., "with foci of...," "areas of...,", "elements of...", "component of...", "pattern...", and "...focus of/focal") are to be ignored when both terms are specific and no combination code exists.

Example

Predominantly leiomyosarcoma associated with foci of well-developed chondrosarcoma. Code as leiomyosarcoma.

(4) If no combination code is available (Rule #1) and one term is not more specific then another (Rule #2) and the majority of the tumor is not indicated (Rule #3), use the term that has the higher histology code in ICD-O-3.

Example

Tubular carcinoma (8211/3) and medullary carcinoma (8510/3). Code as medullary carcinoma (8510/3).

Single Lesion, Different Behavior. If the behavior codes are different, select the morphology code with the higher behavior number.

Example

Squamous cell carcinoma in situ (8070/2) and papillary squamous cell carcinoma (8052/3). Code as papillary squamous cell carcinoma (8052/3).

Exception: If the histology of the invasive component is an NOS term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma), use the specific term associated with the in situ component, but enter an invasive behavior code.

Example

Squamous cell carcinoma in situ (8070/2) with areas of invasive carcinoma (8010/3). Code as squamous cell carcinoma (8070/3).

Multiple Lesions Considered a Single Primary. When multiple lesions are considered a single primary (see Section II.1.3 for criteria), apply the following rules:

- If one lesion is described with an NOS term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma) and the other with an associated term that is more specific (e.g., large cell carcinoma, mucinous adenocarcinoma, spindle cell sarcoma, respectively), code the more specific term.

- If the histologies of multiple lesions can be represented by a combination code, use that code.

When both an adenocarcinoma (8140/3) and an adenocarcinoma (in situ or invasive) in a polyp or adenomatous polyp (8210) arise in the same segment of either the colon or rectum, code as adenocarcinoma (8140/3). The same applies to an adenocarcinoma and an

adenocarcinoma (in situ or invasive) in a tubulovillous or villous adenoma (8261 or 8263). When both a carcinoma (8010/3) and a carcinoma (in situ or invasive) in a polyp or adenomatous polyp (8210) arise in the same segment of either the colon or rectum, code as carcinoma (8010/3).

V.3.3.4 Unspecified Malignancies. For such unspecific terms as "malignant tumor," "malignant neoplasm," and "cancer," enter the code for neoplasm (8000). (For diagnostic confirmation, see Section IV.2.) If a diagnosis is based only on a cytology report stating "malignant cells," use code 8001 (malignant cells, NOS).

V.3.3.5 Metastatic Site. If a histologic or cytologic diagnosis is based only on tissue or fluid from a metastatic site, assume that the primary tumor had the same histology, and code the behavior as 3 (malignant, primary site). (For explanation of behavior, see Section V.3.4.)

V.3.3.6 Lymphoma Codes. Lymphomas present some unique coding difficulties because of the complexity of the classification and the variety of terminologies in use. The following rules will be helpful in choosing the correct ICD-O–3 code for the histologic type:

- Terminology from the WHO Classification of Hematopoietic Neoplasms (Table 13, pp. 16-18 in ICD-O-3) is preferred over older terminology.

- In the new classification, the following terms have equivalent meanings:
    - Follicular lymphoma = follicle center cell lymphoma
    - Mantle cell lymphoma = mantle zone lymphoma
    - Anaplastic large B-cell lymphoma = diffuse large cell lymphoma

- Do not code grade 1, 2 or 3 for follicular lymphoma or Hodgkin's lymphoma in the 6th digit grade field. The grade refers to the type of cell, not the differentiation.

- If two diagnoses are given, code the more specific term, which may not be the one with the higher code number.

- The terms lymphoma, malignant lymphoma, and non-Hodgkin's lymphoma are used interchangeably.

- Avoid using non-specific or unclassified lymphoma terms if there are specific diagnoses that can be coded.

- In older classifications, some terms have equivalent meanings, for example,

  Centroblastic = non-cleaved
  Centrocytic = cleaved
  Follicular = nodular
  Histiocytic = large (cell)
  Lymphocytic = small (cell)
  Mixed lymphocytic and histiocytic = mixed small and large (cell).

- When the term "mixed cellularity" is used with non-Hodgkin's lymphoma, it means mixed lymphocytic-histiocytic lymphoma.

V.3.3.7 Special Cases. Note the rules for coding certain special cases.

Renal Adenocarcinoma. Code as renal cell carcinoma (8312/3). The word "cell," as used in ICD-O–3, is generally optional and often not found in hospital reports.

Lymphocytic Lymphoma (small cell type) And Chronic Lymphocytic Leukemia. When a case is diagnosed in a lymph node(s) or extranodal site or organ, prepare one abstract with the site and histologic type coded as lymphoma. When a case is diagnosed in the blood or bone marrow, and there is no lymph node or organ involvement, prepare one abstract with the site and histologic type coded as leukemia. (See also Section II.1.3.6 for rules about reporting lymphoma and leukemia.)

Malignant Lymphoreticular Process. Code as malignant neoplasm, NOS (8000/3). However, for lymphoreticular process further classifiable as myeloproliferative arising in the bone marrow, code as malignant myeloproliferative disease (9960/3). For lymphoreticular process classified as lymphoproliferative arising in the lymph tissue, code as malignant lymphoproliferative disease (9970/3).

(Adeno)carcinoma in a Polyp. Adenocarcinoma in a polyp should be coded 8210 even if it is stated only in the microscopic description and not in the final diagnosis.

Mucinous Adenocarcinoma. The tumor must be at least 50% mucinous, mucin-producing, or signet ring to be coded to the specific histology.

Code mucinous adenocarcinoma arising in a villous adenoma and mucinous adenocarcinoma arising in a villous glandular polyp to 8480/3, mucinous adenocarcinoma.

T-Cell Large Granular Lymphocytic Leukemia. Pathologic confirmation is required for a diagnosis of T-cell large granular lymphocytic leukemia and these cases should be reported with a behavior code of /3. Do not report cases with a behavior of /1.

Although T-cell large granular lymphocytic leukemia (code 9831) is a very indolent form of leukemia and therefore assigned a behavior code of /1 in ICD–O–3, the World Health Organization Table 13 on page 17 of the ICD–O–3 lists this entity with a behavior code of /3. Infrequently this entity is symptomatic enough to be confirmed pathologically, thus the CCR is requiring pathologic confirmation for this diagnosis and that these cases be reported with a behavior code of /3.

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.) The codes are:

*/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
**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.) Therefore, 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 lesion 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 (anal intraepithelial neoplasia Grade II-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
Precancerous melanosis
Preinvasive
Queyrat's erythroplasia
Stage 0
VAIN III (vaginal intraepithelial neoplasia, Grade III)*
VIN III (vulvar intraepithelial neoplasia, Grade III)*

*Cases diagnosed January 1992 and later
**Cases diagnosed January 2001 and later.
All other terms have been reportable since the region's reference date.

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. However, 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 different pathologic specimens, it is better to code a known grade over an unknown grade. 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. 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.

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 lesion. 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.

Example

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.

Example

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.

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
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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

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. If there is a tissue diagnosis, however, 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

*For cases diagnosed prior to January 1, *2003*, code Gleason's 7 to grade code 2.
The exception, for cases diagnosed prior to January 1, *2003*, is if the pathology report states that the tumor is moderately to poorly differentiated and Gleason's score is reported as 7, assign code 3. For cases diagnosed January 1, *2003* forward, code Gleason's 7 to grade 3.

If only the predominant pattern (1-5) is mentioned in the medical record, enter the code as follows:

Gleason's Pattern	**Grade**	**Code**
1, 2	I	1
3	II	2
4, 5	III	3

Effective with prostate cases diagnosed January 1, 2004 forward, the priority order for coding grade of tumor is:

1. Gleason's grade
2. Terminology (well diff, mod diff…)
3. Histologic (grade I, grade II…)
4. Nuclear grade

V.3.5.7 Lymphomas and Leukemias. In ICD-O-3, the WHO Classification of Hematopoietic and Lymphoid Neoplasms is followed. Under this classification, two groups are identified, lymphoid neoplasms and myeloid neoplasms.

Lymphoid neoplasms consist of:
B-cell, T-cell, NK-cell lymphomas
Hodgkin's lymphoma
Lymphocytic leukemias
Other lymphoid malignancies

Myeloid neoplasms consist of:
Myeloproliferative diseases
Myelodysplastic diseases and syndromes
Myeloid leukemias
Acute biphenotypic leukemias

Codes 5 (T-cell), 6 (B-cell), and 7 (Null-cell) for lymphomas and leukemias are based on immunological or biochemical test results (marker studies), or on a pathology report. Beginning with cases diagnosed January 1, 1995, T-precursor was added to code 5 and a new code was added - code 8 - NK cell (natural killer cell). Code any statement of T-cell, B-cell, or Null-cell involvement (non-T/non-B is a synonym for Null-cell), whether or not marker studies are documented in the medical record. These codes have precedence over those for grades I–IV. If information about T-, B-, or Null-cell codes is unavailable, but a grade (such as well differentiated or poorly differentiated) is given, use the code for the grade. For lymphomas, do not code the descriptions "high grade," "low grade," or "intermediate grade" in the Grade or Differentiation field. They refer to categories in the Working Formulation of lymphoma diagnoses and not to histologic grade.

Do not code grade 1, 2 or 3 for follicular lymphoma or Hodgkin's lymphoma in the 6th digit field. The grade refers to the type of cell, not the differentiation.

V.3.5.8 Bloom-Richardson Grade for Breast Cancer Beginning with breast cancer cases diagnosed January 1, 1996, the Bloom-Richardson grading system may be used.

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

1) degree of tumor tubule formation
2) tumor mitotic activity
3) 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** — **Score**
  - (low power scanning (X100), find most mitotically active 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)** **Score**

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 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 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. Effective January 1, 2004 forward, use grade or differentiation information from the breast histology in the following order:

1. *Bloom-Richardson scores 3-9*
2. *Bloom-Richardson grade (low, intermediate, high)*
3. *Nuclear grade*
4. *Terminology (well diff, mod diff…)*
5. *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 Scores	***Bloom Richardson Grade***	***Nuclear Grade***	***Terminology***	***Histologic Grade***	***Code***
3-5 points	*Low Grade*	*1/3, 1/2*	*Well Differentiated*	*I/III or 1/3*	*1*
6, 7 points	*Intermediate Grade*	*2/3*	*Moderately Differentiated*	*II/III or 2/3*	*2*
8, 9 points	*High Grade*	*2/2, 3/3*	*Poorly Differentiated*	*III/III or 3/3*	*3*

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

V.3.5.10 Fuhrman's Grade for Renal Cell Carcinoma

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).

V.3.6 EDITS OF PRIMARY SITE/HISTOLOGY CODES

Certain combinations of histology and primary site codes indicate errors in coding. Computers used by the CCR and regional registries to edit data submitted by hospitals reject these combinations, and the data must be corrected. Disallowed combinations are of two types—those involving the first four digits of the histology field (morphology code), and 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. The regional registry will provide 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 & specialized gonadal 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-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
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	C76._	Other and ill-defined sites
7. 9500	Neuroblastoma, NOS	with	C64.9	Kidney, NOS

*Site C40.0-C41.9 (bone) with histology 8070 (squamous cell carcinoma) is possible.

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

Section V.4
Coding Systems

V.4.1 Extent of Disease

The ten-digit Extent of Disease (EOD) code has five components: (1) size of the tumor (three digits), (2) extent to which the primary tumor has spread (two digits), (3) lymph node involvement (one digit), (4) number of nodes found positive in a pathological examination of regional lymph nodes (two digits), and (5) number of regional nodes examined by the pathologist. In effect, the EOD is a coded descriptive summary of the tumor, including clinical as well as pathologic findings and observations made during surgery. Coding must be supported by textual information entered under Diagnostic Procedures (see Section IV.1).

Beginning with cases diagnosed January 1, 1994, Extent of Disease coding will be required for all California reporting facilities, and all EOD fields are to be coded. (Blanks will not be allowed.) Cases diagnosed prior to 1994, may be left blank. SEER area facilities have earlier dates for coding EOD. (Region 8 cases diagnosed January 1, 1988 or later must have EOD coding. Region 1 and Region 9 cases diagnosed January 1, 1992 or later must have EOD coding.)

Beginning with cases diagnosed January 1, 1995, there will be different rules for coding prostate cases. The two-month rule for assigning extent of disease codes has been changed to four months and a new extension field has been added for coding cases which undergo prostatectomy.

Tumor Size, [number of] Regional Nodes Positive, and [number of] Regional Nodes Examined are also required items for hospitals with ACoS-approved programs. Please refer to the ACoS FORDS Manual for codes and coding instructions.

Beginning with cases diagnosed January 1, 1998, new codes, new site-specific coding schemes and a new timeframe for assigning codes have been added. In addition, rules for coding have been revised. Please refer to the SEER Extent of Disease–1988: Codes and Coding Instructions, Third Edition (1998) for detailed codes and instructions.

Cases diagnosed prior to January 1, 1998 are to be coded using previous guidelines and coding schemes.

NOTE: The EOD Manual contains a new guideline - "Distinguishing Noninvasive and Invasive Bladder Cancer" which is to be implemented for cases diagnosed January 1, 1999 according to instructions from SEER. The CCR is implementing the use of this guideline as a pilot effective with cases diagnosed January 1, 1998.

For breast cancer cases, use the SEER revised breast cancer EOD codes. The revised codes were distributed via DSQC Memo #2002-05, June 12, 2002. These codes will be effective through December 31, 2003 diagnosis year.

Extent of Disease Coding is required on all cases diagnosed prior to January 1, 2004. With the implementation of Collaborative Staging, the Regional Nodes Positive and Examined fields are the same fields for CS and for EOD. However, effective with cases diagnosed January 1, 2004 forward, the codes for Regional Nodes Positive have changed. Cases diagnosed prior to January 1, 2004 will be converted.

NOTE: Any cases entered after the conversion process should apply the new codes regardless of date of diagnosis. The new codes are as follows:

Regional Nodes Positive Codes

Code	***Description***
00	*All nodes examined are negative.*
01-89	*1-89 nodes are positive. (Code exact number of nodes positive)*
90	*90 or more nodes are positive.*
95	*Positive aspiration of lymph node(s) was performed.*
97	*Positive nodes are documented, but the number is unspecified.*
98	*No nodes were examined.*
99	*It is unknown whether nodes are positive; not applicable; not stated in patient record.*

V.4.2 Collaborative Staging

Beginning with cases diagnosed January 1, 2004 forward and for cases with an unknown date of diagnosis first seen at your facility after January 1, 2004, 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 (Derived AJCC T, Derived AJCC N, Derived AJCC M, Derived AJCC Stage Group, Derived SS1977, and Derived SS2000) for all cases. These required data items include:

CS Tumor Size
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

**Definition changes were made to codes 90-97. See Section V.4.1 for the table of new codes for Regional Nodes Positive.*

The following Collaborative Staging data items are not required by the CCR, but are to be sent from CoC approved facilities:

CS Tumor Size/Extension Evaluation
CS Lymph Node Evaluation
CS Metastasis Evaluation
Derived AJCC T Descriptor
Derived AJCC N Descriptor
Derived AJCC M Descriptor

Please refer to the Collaborative Staging Manual for coding instructions.
Cases diagnosed prior to January 1, 2004 should continue to use the EOD fields with the exception of the Regional Nodes Positive field.

Section V.5
Stage at Diagnosis

While Extent of Disease is a detailed description of the spread of the disease from the site of origin, stage is a grouping of cases into broad categories—for example, localized, regional, and distant. 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. Cases diagnosed prior to January 1, 1994 must continue to be staged using SEER Summary Staging.

Although Summary Stage is not required by the CCR, it is required by NAACCR and NPCR. It is also used by some of the regional registries and a good many hospital registrars. A new Summary Staging Manual will be used with cases diagnosed on or after January 1, 2001. This document is available from SEER. 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 Manual 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 sections V.5.8–V.5.12 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)
8 NOT APPLICABLE (for coding benign brain tumors, effective with cases diagnosed 1/1/2004 forward)
9 UNSTAGEABLE (stage cannot be determined from available information)
Blank NOT DONE

V.5.2 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 sec-tions V.3.4.3 and 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 SEER Extent of Disease Code Manual, 3rd Edition, for a list of ambiguous terms.

V.5.4 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 longer. 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.

- A field for recording other staging systems, such as Duke's, is available in CNExT.

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 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 (see also 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 Behavior Code. If a tumor is staged in situ, the behavior code (see Section V.3.4) is 2.

V.5.9 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 and there is no evidence of metastasis to other parts of the body.

V.5.9.1 Inaccessible Sites. Clinical diagnosis alone is often insufficient for staging a tumor as localized when the primary site and regional lymph nodes are inaccessible, such as with the esophagus, lung, or pancreas. Without confirmation during surgery or an autopsy, it is usually preferable to code the stage as 9 (unstageable). But if the physician has staged the case as localized, or if clinical reports (such as CT scans) provide enough information to rule out spread of disease, stage 1 (localized) may be used. If surgery has been performed, study the operative report for evidence of direct extension or metastasis. If no such evidence has been found, and radiological examination has produced none, classify the tumor as localized.

V.5.9.2 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 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 "satellite" nodules—that is, lesions secondary to the primary one—might not be localized. Refer to the *Summary Staging Guide* for rules about satellite lesions.

V.5.9.4 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 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 Regional, Direct Extension Only (Code 2) . Sometimes 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 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

(1) 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.

(2) Statements like "carcinoma of the breast with axillary 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 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 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 Regional, NOS (Code 5) . If available information states only that a cancer has spread regionally, stage as code 5. Also use code 5 for a nodal lymphoma described as regional (sometimes stated in the record as Stage II—see sections V.5.6 and V.7.5).

V.5.11 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 Manual.*
- 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, kidney). Also included in code 7 are systemic diseases such as leukemia and multiple myeloma.

V.5.12 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 (class 3), code 9 is appropriate unless the stage at the time of the initial diagnosis is known.

V.5.13 SPECIAL RULES FOR LYMPH NODES

Special rules apply to staging lymph nodes:

For solid tumors, the terms "fixed" or "matted" and "mass in the mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are considered involvement of lymph nodes. Any other terms, such as "palpable", "enlarged", "visible swelling", "shotty", or "lymphadenopathy" should be ignored; look for a statement of involvement, either clinical or pathological.

For lymphomas, <u>any</u> mention of lymph nodes is indicative of involvement.

For lung primaries, if at mediastinoscopy or x-ray, the description states mass/adenopathy/ enlargement of any of the lymph nodes listed under code 2 of the EOD – Lymph Nodes field, assume those lymph nodes are involved. Mediastinal lymph nodes > 1 cm are considered enlarged.

Section V.6
Tumor Markers

Three fields are available for collecting information about prognostic indicators referred to as tumor markers. Tumor-marker information is currently required on the status of estrogen and progesterone receptors for (ERA and PRA) breast cancers (sites C50.0-C50.9) diagnosed on or after January 1, 1990.

Beginning with January 1, 1996 cases, facilities which collect ACoS data items were allowed to use these fields for other sites. The codes are the same. Please refer to the ROADS Manual for further information.

Beginning with January 1, 1998 diagnoses, the CCR requires that tumor markers be collected for prostate - acid phosphatase (PAP) and prostate specific antigen (PSA) and for testicular cancers - alpha-feto protein (AFP), human chorionic gonadotropin (hCG), and lactate dehydro-genase (LDH). Ranges for testicular cancer tumor markers have been added in codes 4-6.

Beginning with January 1, 2000 diagnoses, Tumor Marker I may be used to record carcinoembryonic antigen (CEA) for colorectal cancers and CA-125 for ovarian cancers.

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker – Tumor Marker – California 1(Her2/neu) is still a required data item for the CCR and will continue to be collected in its designated field.

V.6.1 TUMOR MARKER 1

Use the following codes for ERA for breast-cancer cases diagnosed on or after January 1, 1990, PAP for prostate cancer cases and AFP for testicular cancer cases diagnosed after January 1, 1998, and CEA for colorectal cancer cases and CA-125 for ovarian cancer cases diagnosed after January 1, 2000:

0 TEST NOT DONE (includes cases diagnosed at autopsy)

1 TEST DONE, RESULTS POSITIVE

2 TEST DONE, RESULTS NEGATIVE

3 TEST DONE, RESULTS BORDERLINE OR UNDETERMINED WHETHER POSITIVE OR NEGATIVE

4 RANGE 1: < 1,000 NG/ML (S1)

5 RANGE 2: 1,000 - 10,000 NG/ML (S2)

6 RANGE 3: > 10,000 NG/ML (S3)

8 TEST ORDERED, RESULTS NOT IN CHART

9 UNKNOWN IF TEST DONE OR ORDERED; NO INFORMATION (includes death-certificate-only cases

For breast-cancer cases diagnosed before January 1, 1990, for prostate and testicular cancers before January 1, 1998 and for other sites not mentioned above, enter:

9 NOT APPLICABLE

Use codes 0, 1, 2, 3, 8, and 9 for breast and prostate.

Use codes 0, 2, 4, 5, 6, 8, and 9 for testicular cancer.

Record the lowest (nadir) value of AFP after orchiectomy if serial serum tumor makers are done during the first course of treatment.

Do not record the results of tumor-marker studies that are not performed on the primary tumor.

Breast tumors too small to evaluate with the conventional estrogen-receptor assays might be measured by immunostaining, which is a procedure for identifying antigens in body fluids, in aspirations of tumor masses, or in biopsy specimens. The procedure is based on an antigen-antibody reaction. If immunostaining results are available, use them to code Estrogen-Receptor Status.

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker – Tumor Marker –California 1(Her2/neu) is still a required data item for the CCR and will continue to be collected in its designated field.

V.6.2 TUMOR MARKER 2

Use the following codes for PRA for breast-cancer cases diagnosed on or after January 1, 1990, and for PSA for prostate cancer cases and hCG for testicular cancer cases diagnosed after January 1, 1998:

0 TEST NOT DONE (includes cases diagnosed at autopsy)

1 TEST DONE, RESULTS POSITIVE

2 TEST DONE, RESULTS NEGATIVE

3 TEST DONE, RESULTS BORDERLINE OR UNDETERMINED WHETHER POSITIVE OR NEGATIVE

4 RANGE 1: < 5,000 mIU/ml (S1)

5 RANGE 2: 5,000 - 50,000 mIU/ml (S2)

6 RANGE 3: > 50,000 mIU/ml (S3)

8 TEST ORDERED, RESULTS NOT IN CHART

9 UNKNOWN IF TEST DONE OR ORDERED; NO INFORMATION (includes death-certificate-only cases)

For breast-cancer cases diagnosed before January 1, 1990, for cancers of the prostate and testis before January 1, 1998 and for all other sites, enter:

9 NOT APPLICABLE

Use codes 0, 1, 2, 3, 8 and 9 for breast and prostate.

Use codes 0, 2, 4, 5, 6, 8 and 9 for testis.

Record the lowest (nadir) value of hCG after orchiectomy if serial serum tumor markers are done during the first course of treatment.

Breast tumors too small to evaluate with the conventional progesterone-receptor assays might be measured by immunostaining, which is a procedure for identifying antigens in body fluids, in aspirations of tumor masses, or in biopsy specimens. The procedure is based on an antigen-antibody reaction. If immunostaining results are available, use them to code Progesterone–Receptor Status.

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker – Tumor Marker –California 1(Her2/neu) is still a required data item for the CCR and will continue to be collected in its designated field.

V.6.3 TUMOR MARKER 3

0 TEST NOT DONE (includes cases diagnosed at autopsy)

1 TEST DONE, RESULTS POSITIVE

2 TEST DONE, RESULTS NEGATIVE

3 TEST DONE, RESULTS BORDERLINE OR UNDETERMINED WHETHER POSITIVE OR NEGATIVE

4 RANGE 1: < 1.5 * N (S1)

5 RANGE 2: 1.5 - 10 * N (S2) NOTE: N = the upper limit of normal

6 RANGE 3: > 10 * N (S3)

8 TEST ORDERED, RESULTS NOT IN CHART

9 UNKNOWN IF TEST DONE OR ORDERED; NO INFORMATION (includes death-certificate-only cases)

For testis cases before January 1, 1998 and all other sites, enter:

9 NOT APPLICABLE

For testicular cancer cases diagnosed on or after January 1, 1998, record the status of the Lactate Dehydrogenase (LDH) level as follows:

0 NOT DONE (SX)

2 WITHIN NORMAL LIMITS (SO)

4 RANGE 1 (S1) <1.5 x UPPER LIMIT OF NORMAL FOR LDH ASSAY

5 RANGE 2 (S2) 1.5 - 10 x UPPER LIMIT OF NORMAL FOR LDH ASSAY

6 RANGE 3 (S3) >10 x UPPER LIMIT OF NORMAL FOR LDH ASSAY

8 ORDERED, BUT RESULTS NOT IN CHART

9 UNKNOWN OR NO INFORMATION

For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields. The California tumor marker – Tumor Marker –California 1(Her2/neu) is still a required data item for the CCR and will continue to be collected in its designated field.

V.6.4 TUMOR MARKER-CALIFORNIA-1

Tumor Marker-California-1 is a tumor marker for breast cancer--Her2/neu (also known as c-erbB2 or ERBB2). The codes are as follows:

0 TEST NOT DONE (include cases diagnosed at autopsy)

1 TEST DONE, RESULTS POSITIVE

2 TEST DONE, RESULTS NEGATIVE

3 TEST DONE, RESULTS BORDERLINE OR UNDETERMINED WHETHER POSITIVE OR NEGATIVE

8 TESTS ORDERED, RESULTS NOT IN CHART

9 UNKNOWN IF TEST DONE OR ORDERED, NO INFORMATION (includes death certificate only cases)

For breast cancer cases prior to January 1, 1999 or all other sites, enter:

9 NOT APPLICABLE

Section V.7
AJCC Staging and Other ACoS Items

Hospitals with American College of Surgeons (ACoS)-approved registries are required to employ the TNM classification system for staging developed by the American Joint Committee on Cancer (AJCC). Clinical and pathological TNM staging are required by ACoS. The CCR does not require hospitals to report TNM; however, it does request that if TNM (clinical and pathological only) is collected it be transmitted to the regional registry and then sent on to the CCR. There are a number of other data items in this section which hospitals may be required to collect either by ACoS or the CCR.

V.7.1 THE TNM SYSTEM

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), and M (distant metastasis). For those sites not included in the AJCC Manual for Staging of Cancer, the Summary Staging Guide for Surveillance Epidemiology and End Results Group (SEER) is to be used. For a list of these sites, please refer to the *AJCC Manual for Staging of Cancer, 6th Edition.*

V.7.2 DATA ENTRY

In entering data, do not include the letters T, N, or M, even though they are part of the code. Fill in the digits from left to right, leaving the second digit blank if there is no entry for it.

V.7.3 TNM STAGE BASIS

TNM Basis indicates the nature of the information on which AJCC staging is based. The *Manual for Staging of Cancer* provides specific recommendations about which information should be used for each type of staging at each primary site. This field has been prefilled for clinical and pathological staging

AJCC Staging and Other AcoS Items

V.7.4 TNM STAGING ELEMENTS (CLINICAL) AND (PATHOLOGICAL)

Consult the AJCC manual for detailed information by site for assigning the appropriate numbers to each element for both clinical and pathological TNM elements. Enter only the numbers, not the letter T, N, or M. If only one number follows a T or N, enter it in the first space of the field, leaving the second space blank. Additional spaces have been added so that there are now three spaces available to record the "T" and the "N" and two spaces to record the "M". The TNM codes generally used are:

T CODES:

TX = X
TO = 0
Ta = A
Tis = IS
Tispu = SU
Tispd = SD
T1mic = 1M
T1 = 1
T1A = 1A
T1A1 = A1
T1A2 = A2
T1B = 1B
T1B1 = B1
T1B2 = B2
T1C = 1C
T2 = 2
T2A = 2A
T2B = 2B
T2C = 2C
T3 = 3
T3A = 3A
T3B = 3B
T3C = 3C
T4 = 4
T4A = 4A
T4B = 4B
T4C = 4C
T4D = 4D
Not applicable = 88

N CODES:

NX = X
N0 = 0
N0(i-) = 1-
N0(i+) =1+
N0(mol-) =M-
N0(mol+) =M+
N1 = 1
N1mi =1M
N1A =1A
N1B = 1B
N1C = 1C
N2 = 2
N2A =2A
N2B = 2B
N2C = 2C
N3 = 3
N3A = 3A
N3B = 3B
N3C = 3C
Not applicable = 88

AJCC Staging and Other ACoS Items

M CODES:

MX	= X
M0	= 0
M1	= 1
M1A	= 1A
M1B	= 1B
M1C	= 1C
Not applicable	= 88

Prostate cancer has codes M1a, b, and c. Codes indicate metastases to:

M1a Nonregional lymph node(s)
M1b Bone(s)
M1c Other site(s)

Malignant melanoma of the skin and of the eyelid have codes M1a, b and c. Codes indicate metastases to:

M1a Skin or subcutaneous tissue or lymph node(s) beyond the regional lymph nodes
M1b Lung metastasis
M1c Visceral metastasis at any site associated with an elevated serum lactic dehydrogenase (LDH).

V.7.5 AJCC STAGE GROUP (CLINICAL AND PATHOLOGICAL)

The AJCC manual contains instructions for coding summaries of TNM staging. 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 IIA	= 2A
STAGE 0A	= 0A	STAGE IIB	= 2B
STAGE 0IS	= 0S	STAGE IIC	= 2C
STAGE I	= 1	STAGE III	= 3
STAGE IA	= 1A	STAGE IIIA	= 3A
STAGE IA1	= A1	STAGE IIIB	= 3B
STAGE IA2	= A2	STAGE IIIC	= 3C
STAGE IB	= 1B	STAGE IV	= 4
STAGE IB1	= B1	STAGE IVA	= 4A
STAGE IB2	= B2	STAGE IVB	= 4B
STAGE IS	= 1S	*OCCULT*	= *OC*
STAGE II	= 2	NOT APPLICABLE = 88	
		RECURRENT, UNKNOWN, STAGE X = 99	

V.7.6 TNM CODER (CLINICAL), (PATHOLOGICAL), AND (OTHER)

Record who was responsible 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 regional and state registries. CNExT will have the TNM Coder (Other) field available for hospitals, but it will not be transmitted. The codes are as follows:

0 NOT STAGED
1 MANAGING PHYSICIAN
2 PATHOLOGIST
3 PATHOLOGIST AND MANAGING PHYSICIAN
4 ANY COMBINATION OF 1, 2 OR 3
5 REGISTRAR
6 ANY COMBINATION OF 5 WITH 1, 2 OR 3
7 STAGING ASSIGNED AT ANOTHER FACILITY
8 CASE IS NOT ELIGIBLE FOR STAGING
9 UNKNOWN IF STAGED

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
88 NOT APPLICABLE (cases that do not have an AJCC staging scheme and staging was not done)
99 UNKNOWN

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. This includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 or later. For patients twenty years of age and older, this field would be coded 88 - not applicable. 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. This includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 and later. For patients twenty years of age and older, this field must be coded 88. 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

Section VI.1
First Course of Treatment:
General Instructions

In the treatment section, record all cancer treatment administered as part of the first course of therapy. 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 is to be followed. In addition, there is a new definition for leukemias (see Section VI.1.1). Use old 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. If there is no documentation of a planned first course of therapy or standard of practice, first course therapy includes all treatment received before disease progression or treatment failure. If it is undocumented whether there is disease progression/treatment failure and the treatment in question begins more than one year after diagnosis, assume that the treatment is not part of first course.

4. 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.

First Course of Treatment: General Instructions

The CCR expects every hospital 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 in tended therapy was actually performed, record that it was recommended but it is not known whether the procedure was administered. (Enter, for example, "Radiation therapy, recommended; unknown if given.") Hospitals 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.

VI.1.1 SPECIAL SITUATIONS

Note the rules for certain special situations:

Treatment Performed Elsewhere (class 0–2 analytic cases only). Record any part of the first course of treatment administered at another facility before the patient was admitted to the reporting hospital or after discharge. Also record the name of the facility where the treatment was administered.

Leukemia. If a complete or partial remission of leukemia occurs during the first course of therapy for the leukemic process, report all therapy considered to be remission-inducing and remission-maintaining for the first remission. Disregard all treatment received after the lapse of the first remission. If a remission does not occur during the first course of therapy, record all treatment that attempted to induce the remission. Disregard all treatment which was administered as a subsequent attempt to induce remission.

VI.1.2 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. Some times 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 proce dure 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). CCR has adopted the SEER Self Instructional Manual for Tumor Registrars: Book 8, 3rd ed. (1994) as its official list of cancer drugs. Consult the manual to identify which drugs constitute cancer directed treatment. (New drugs might not appear in the manual. Include them if they meet the definition of cancer directed treatment here in Section VI.1.2.)

VI.1.3 DATA ENTRY

Data entry for the treatment provided consists of codes, dates, and written summaries.

VI.1.3.1 Codes. Number codes summarize each modality of treatment (surgery, radiation, chemotherapy, etc.). For each modality except surgery (see Section VI.2 for coding each surgery field), code a summary of the entire first course of treatment. In the field provided, assign a separate code to that portion of the treatment administered at the reporting hospital. 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. For the convenience of the abstractor, CNEXT always displays a 00 in a non surgery field so that no data entry is required if no treatment of that type was provided. If treatment was administered, type over the 00 when entering the code.

VI.1.3.2 Dates. 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. For any type of treatment that is not known to have been given, leave the date field blank. They will be filled in with zeros by CNExT .However, if a type of treatment is known to have been given but the date is not known, enter 9's.

The Date of Systemic Therapy will be generated from Date of Chemotherapy, Date of Hormone, Date of Immuno, and Date of Transplant/Endocrine Procedures effective with cases diagnosed 1/1/03.

VI.1.3.3 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 hospital. (See illustration I.1 in Section I.1.) The text field may be left blank when the type of treatment was not provided. But if no cancer 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 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 gaurdian 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 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 hospital 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).

VI.1.3.6 Unknown if Treated. In coding treatment, code 99 or 9 (unknown) should generally be used only for class 3 non-analytic cases for which the first course of treatment is unknown (for discussion of class of case, see Section III.3.5). 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.

Section VI.2
First Course of Treatment:
Surgery Introduction

In abstracting surgical treatment, record the total or partial removal (except an incisional biopsy) of tumor tissue, 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.)

Beginning with cases diagnosed January 1, 1996, the surgery field was separated into three fields: one for surgery of the primary site, one for diagnostic, staging or palliative procedures, and one for reconstructive surgery.

Beginning with cases diagnosed January 1, 1998, new surgery codes, definitions, and fields from the American College of Surgeons have been added. Even though they are effective with 1998 cases, they are to be used for cases diagnosed prior to 1998. CNExT converted surgery codes for cases prior to 1998 to the new codes.

Beginning with cases diagnosed January 1, 2003, the surgery codes, definitions, and fields have been reformulated again. Surgical Approach, Number of Regional Lymph Nodes Examined, and Reconstructive Surgery have been dropped, and all remaining fields except Surgery of the Primary Site now have a simplified coding scheme; Surgery of the Primary Site has been assigned new site-specific codes, and Reconstructive Surgery has been folded into the Surgery to the Primary Site codes. Again, CNExT converted the codes for older cases to match the new coding scheme. The fields are:

Surgery of the Primary Site

Scope of Regional Lymph Node Surgery

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Treatment Hospital

In addition to the new surgery codes from the ACoS, the CCR is requiring that hospitals record multiple surgical procedures performed on a patient. To this end, each of the surgery fields have space to code up to three procedures. There are also three date fields and three fields for entering the code for the treatment hospital.

Cases diagnosed prior to January 1, 2003, must be coded in three new fields. They are:

Surgical Procedure of Primary Site 98-02

Scope of Regional Lymph Node Surgery 98-02

Surgical Procedure/Other Sites 98-02

Note: These fields are to be left blank for cases diagnosed January 1, 2003 and later.

Effective with cases diagnosed January 1, 2004, the CCR requires completion of the surgical procedure at this hospital fields:

Surgery of the Primary Site At This Hospital

Scope of Regional Lymph Nodes At This Hospital

Surgery of Other/Distant Sites At This Hospital

These fields are computed by CNExT using the procedure and treatment hospital number fields. Facilities not using CNExT are to enter the code for each of these fields.

VI.2.1 SURGERY OF THE PRIMARY SITE

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
- Transurethral resection (TUR) with removal of tumor tissue of bladder or prostatic tumors

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.

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 as 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.

Example

Patient undergoes a modified radical mastectomy. The breast and axillary 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). Please refer to Appendix Q for the site-specific surgery codes.

Example

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.

Examples

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.

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. The Summary field will be computed automatically by CNExT and will contain the most definitive surgical procedure performed on a patient. If surgery is not performed, the fields may be left blank. They will be filled with 00 by CNExT.

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).

Starting with cases diagnosed January 1, 2003 forward, RX Summ -- Scope of Reg LN Surg will not be coded according to site. It will be coded using a single scheme for all sites. The three procedure fields will 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 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 and central nervous system; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

Cases diagnosed prior to January 1, 2003 are to 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, these fields are to be used for neck dissections. Codes 2-5 indicate only that a neck dissection procedure was done, 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.

For Unknown Primary, Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease Primaries, Lymphoma, Brain, and Primaries of Ill-Defined Sites, use code 9.

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. Please refer to Appendix Q-1 for these codes. These 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. CNEXT will fill the fields with 00. The Summary field will be computed automatically by CNEXT. It will contain the number of nodes associated with the highest coded regional lymph node surgery. If no nodes were identified in the specimen from this procedure, then the Summary field will contain 00. 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.

For Unknown Primary, Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease Primaries, Lymphoma, Brain and Primaries of Ill-Defined Sites, use code 99.

VI.2.4 SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), 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. They will be filled with 0 by CNExT. The Summary field will be computed automatically by CNExT.

Starting with cases diagnosed January 1, 2003 forward, RX Summ - Surg Oth Reg/Dis and its corresponding procedure fields will not be coded according to site. It will be 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 9750, 9760-9764, 9800-9820, 9826, 9831-9964, 9980-9989).

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 (resection of 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

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. They are to be left blank if no surgery is performed. They will be filled in with zeros by CNExT. The Summary field will be computed automatically by CNExT and will contain the earliest date of surgery.

Beginning with cases diagnosed 1/1/2003, a new data item, Rx Date-Most Definitive Surgery of the Primary Site, is required by the CCR. Since the CCR is already collecting multiple procedure fields, this data item will be generated. The generated data item will identify the date for the most definitive surgical procedure of the primary site from the three procedure fields.

VI.2.6 TREATMENT HOSPITAL NUMBER

These fields are to be used in conjunction with each definitive surgery performed. If the procedure was performed at the reporting facility, the hospital number can be filled in using a function key in CNExT. The hospital number for procedures performed at other facilities will have to be entered using autocoding. The fields are to be left blank if no cancer-directed surgery was performed. The Summary field will be computed by CNExT and will contain the treatment hospital number for the most definitive or highest code surgical procedure. The Summary field will be available in CNExT but will not be transmitted to the regions or CCR.

VI.2.7 SURGICAL MARGINS

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 prior to January 1, 2003, please refer to Appendix Q-1 for the site-specific codes. For cases diagnosed after January 1, 2003, please refer to the FORDS Manual.

VI.2.8 RECONSTRUCTIVE SURGERY - IMMEDIATE

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. This field is no longer required by the CCR or the CoC beginning with cases diagnosed January 1, 2003. Information with regards to reconstruction has been incorporated into the Surgery of the Primary Site field. The old field has been retained and cases diagnosed prior to January 1, 2003 must continue to be coded. For these cases, refer to Appendix Q-1.

VI.2.9 REASON FOR NO SURGERY

Effective with cases diagnosed 1/1/2003, a new code, Code 5, surgery not performed because patient died has been added and the definitions for codes 1, 2, and 6 have been modified. 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

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

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

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 (see Section IV.1.6).

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)
- 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
- Exploratory surgery—celiotomy, cystotomy, gastrotomy, laparotomy, nephrotomy, thoracotomy

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.

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:

- 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 WAS PERFORMED

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.
The highest code in the range 01-06.

VI.2.11 DATE OF DIAGNOSTIC OR STAGING PROCEDURE

Enter the date of the earliest surgical diagnostic and/or staging procedure in this field.

Codes (in addition to valid dates)

00000000 No diagnostic procedure performed; autopsy only case

99999999 The date is unknown, or death certificate only case

VI.2.12 SOURCES FOR INFORMATION

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

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

(1) If 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.

(2) If 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.

Section VI.3
First Course of Treatment:
Radiation

Record the name or chemical symbol and method of administration of any radiation therapy that is directed toward tumor tissue or given prophylactically. 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.

Beginning with cases diagnosed 1/1/2003, and any cases entered after the software conversion, two fields, Radiation - Regional RX Modality and Radiation - Boost RX Modality, are required to code first course radiation therapy. Software conversions of these two fields will generate the Radiation Therapy Summary field.

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	P^{32}	phosphorus
Co^{60}	cobalt	Pb^{210}	lead
CrO_4P	chromic phosphate	Ra^{226}	radium
$Cr^{32}PO_4$	phosphocol	Rn^{222}	radon
Cs	cesium	Ru^{106}	ruthenium
I^{125}	iodine	Sr^{90}	strontium
I^{131}	iodine	Y^{90}	yttrium
Ir^{192}	iridium		

VI.3.1.1 Beam (Teletherapy) . 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	Linear accelerator (LINAC)
Brachytron	MeV
Cobalt	Neutron beam
Cyclotron	Spray radiation
Grenz ray	Stereotactic radiosurgery, such as gamma knife and proton beam
Helium ion or other heavy particle 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.

VI.3.1.3 Other Internal Radiation. Record the name or chemical symbol and method of administration of any radioactive material given orally, intracavitarily, or by intravenous injection. (I^{131}-labeled immunoglobin is coded both as Radioisotopes and Immunotherapy—see Section VI.6.)

VI.3.2 RADIATION CODES

The following codes will be generated for recording radiation therapy in the summary field.

Beginning with cases diagnosed 1/1/2003, and any cases entered after the software conversion, two fields, Radiation - Regional RX Modality and Radiation - Boost RX Modality, are required to code first course radiation therapy. Software conversions of these two fields will generate the Radiation Therapy Summary field.

The field "Radiation Therapy at this Hospital" will no longer be required by the CCR beginning with cases diagnosed 1/1/2003.

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

NOTE: Code 6 may appear in old cases that were converted to the 1988 codes. SEER converted old code 2, Other Radiation, to code 6.

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.

Beginning with cases diagnosed on or after January 1, 2003 or cases entered after the software conversion, 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. As stated previously, software conversion of these two fields will generate the Radiation Therapy Summary field.

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. As noted above, this data item and Radiation - Boost RX Modality will be converted to generate the RX Summ - Radiation.

There is no corresponding "At this Hospital" field. 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, NOS
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
80* COMBINATION MODALITY, SPECIFIED*
85* COMBINATION MODALITY, NOS*
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 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 field. As noted above, this data item and Radiation - Regional RX Modality will be converted to generate the RX Summ - Radiation. There is no corresponding "At this Hospital" field. 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/ELECTRON
31 IMRT
32 CONFORMAL OR 3-D THERAPY
40 PROTONS
41 STEREOTACTIC RADIOSURGERY, NOS
42 LINAC RADIOSURGERY, NOS
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.

VI.3.5 DATE OF RADIATION THERAPY

Record the date on which radiation therapy began at any facility as part of the first course treatment. If radiation therapy was not administered, enter 0's. *If radiation therapy is planned, but had not started at the time the case is transmitted to the regional registry, enter 8's.* If radiation therapy is known to have been given but the date is not known, enter 9's.

00000000 NO RADIATION THERAPY ADMINISTERED; AUTOPSY ONLY CASE.

88888888 WHEN RADIATION THERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP. *FOR CoC APPROVED FACILITIES*, THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW-UP.

NOTE: THE CCR REQUIRES THE USE OF 8'S IN THIS FIELD FOR CASES UNDERGOING RADIATION THERAPY LATER THAN SIX MONTHS FROM THE DATE OF ADMISSION. See Timeliness Section IX.2.3.

99999999 THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

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.

NOTE: Beginning with cases diagnosed 1/1/2003, a new code - 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

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 Site(s), or Distant Lymph Node(s) fields) and radiation, use codes 2-9. For all other cases, use code 0.

Section 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 intracavitarily, 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.

VI.4.1 NAMES OF CHEMOTHERAPEUTIC AGENTS

In the text field, record the generic or trade names of the drugs used for chemotherapy. Include agents that are in the investigative or clinical trial phase. See the *SEER Self-Instructional Manual for Tumor Registrars: Book 8*, 3rd ed. (1994) for a comprehensive list of chemotherapeutic agents in use at the time of its publication.

VI.4.2 CHEMOTHERAPY CODES

Use the following codes for recording chemotherapy in the Summary field. 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 MULTIAGENT CHEMOTHERAPY ADMINISTERED AS FIRST COURSE THERAPY

82 CHEMOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED DUE TO CONTRAINDICATIONS.

85 CHEMOTHERAPY NOT ADMINISTERED BECAUSE THE PATIENT DIED.

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.

VI.4.3 DATE OF CHEMOTHERAPY

Record the date on which chemotherapy began at any facility as part of first course of treatment. If chemotherapy was not administered, leave the date field blank. *If chemotherapy is planned, but had not started at the time the case is transmitted to the regional registry, enter 8's.* If chemotherapy is known to have been given but the date is not known, enter 9's.

00000000 NO CHEMOTHERAPY ADMINISTERED; AUTOPSY ONLY CASE.

88888888 WHEN CHEMOTHERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP. *FOR CoC APPROVED FACILITIES,* THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW UP.

NOTE: THE CCR REQUIRES THE USE OF 8's IN THIS FIELD FOR CASES UNDERGOING CHEMOTHERAPY LATER THAN SIX MONTHS FROM THE DATE OF ADMISSION. See Timeliness Section IX.2.3.

99999999 THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

Section VI.5
First Course of Treatment:
Hormone Therapy

Report the administration of hormones, antihormones, 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.

VI.5.1 HORMONES

Report cancer directed treatment with hormones and antihormones 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 Prednisone that is given in combination with chemotherapy (e.g., MOPP or COPP) for cancer of any site. For a list of hormonal agents see *SEER Self Instructional Manual for Tumor Registrars: Book 8,* 3rd ed. (1994).

VI.5.1.1 Agents for Endometrial and Kidney Tumors. Agents commonly used in the treatment of endometrial cancer and cancer of the kidney include:

Delalutin	Norlutate
Depo-Provera	Norlutin
Hydroxyprogesterone	Progestone
Medroxyprogesterone	Progesterone
Megace	Progestin
Megestrol acetate	Progestoral
Methyl progesterone	Proluton
Norethindrone	Provera

VI.5.1.2 Agents For Thyroid Cancer. Agents commonly used in the treatment of thyroid cancer include:

Cytomel	Thyroglobulin
Levothyroxine	Thyroid (extract)
Liothyronine	Thyrolar
Proloid	Thyroxine
Synthroid	TRIT
Triiothyronine	

Thyroid stimulating hormone (TSH) is replacement therapy and not tumor directed. But the administration of thyroid hormone following a thyroidectomy is definitive hormonal treatment, since thyroid extract has a dual role: replacement therapy and inhibition of recurrence and metastasis. Exogenous dessicated thyroid is treatment following both subtotal and total thyroidectomy

VI.5.2 HORMONE (ENDOCRINE) SURGERY

This data item is coded in the "Transplant/Endocrine Procedure" field (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 (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. *DIAGNOSED AT AUTOPSY.*

01 HORMONE THERAPY ADMINISTERED AS FIRST COURSE THERAPY.

82 HORMONE THERAPY WAS NOT RECOMMENDED/ ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (I.E., 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.

First Course of Treatment: Hormone Therapy

VI.5.5 DATE OF HORMONE THERAPY

Record the date on which hormone therapy began at any facility as part of first course of treatment. If hormone therapy was not administered, leave the date field blank. *If hormone therapy is planned, but had not started at the time the case is transmitted to the regional registry, enter 8's.* If hormone therapy is known to have been given but the date is not known, enter 9's.

00000000 NO HORMONE THERAPY ADMINISTERED; AUTOPSY ONLY CASE

88888888 WHEN HORMONE THERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP. *FOR CoC APPROVED FACILITIES,* THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW UP.

NOTE: THE CCR REQUIRES THE USE OF 8's IN THIS FIELD FOR CASES UNDERGOING HORMONE THERAPY LATER THAN SIX MONTHS FROM THE DATE OF ADMISSION. See the Timeliness Section IX.2.3.

99999999 THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

Section 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).

VI.6.1 IMMUNOTHERAPY AGENTS

In addition to the agents listed in the *SEER Self-Instructional Manual for Tumor Registrars: Book 8*, 3rd ed. (1994), report the following as immunotherapy:

ASILI (active specific intralymphatic immunotherapy)
Blocking factors
Interferon
Monoclonal antibodies
Transfer factor (specific or non-specific)
Vaccine therapy
Virus therapy

VI.6.2 IMMUNOTHERAPY CODES

Effective with cases diagnosed 1/1/2003, this data item has been modified. Codes for transplants and endocrine procedures have been removed and are coded in a separate field called – RX Summ – Transplnt/Endocr. The length of this field has been changed from 1 to 2 characters. The codes for reason for no immunotherapy (BRM) given have been incorporated into this scheme. A conversation will be required.

Use the following codes for recoding immunotherapy in the Summary field. Use codes 00-87 for recoding immunotherapy in the At This Hospital Field.

00 NONE, IMMUNOTHERAPY WAS NOT PART OF THE PLANNED FIRST COURSE OF THERAPY. *DIAGNOSED AT AUTOPSY.*

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.

VI.6.3 DATE OF IMMUNOTHERAPY

Record the date on which immunotherapy began at any facility as part of first course of treatment. If immunotherapy was not administered, leave the date field blank. *If immunotherapy is planned, but had not started at the time the case is transmitted to the regional registry, enter 8's.* If immunotherapy is known to have been given but the date is not known, enter 9's.

00000000 NO IMMUNOTHERAPY ADMINISTERED; AUTOPSY ONLY CASE.

88888888 WHEN IMMUNOTHERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP. *FOR CoC APPROVED FACILITIES,* THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW UP.

NOTE: THE CCR REQUIRES THE USE OF 8's IN THIS FIELD FOR CASES UNDERGOING IMMUNOTHERAPY LATER THAN SIX MONTHS FROM THE DATE OF ADMISSION. See the Timeliness Section IX.2.3.

99999999 THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

Section 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. A conversion will be required for cases diagnosed prior to January 1, 2003 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 will be requiring this field in order to provide consistency, i.e.; all of the other treatment fields except radiation have a hospital-level field.

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.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. *DIAGNOSED AT AUTOPSY.*

10 A BONE MARROW TRANSPLANT PROCEDURE WAS ADMINISTERED, BUT THE TYPE WAS NOT SPECIFIED.

11 BONE MARROW TRANSPLANT-AUTOLOGOUS

12 BONE MARROW TRANSPLANT-ALLOGENEIC

20 STEM CELL HARVEST *AND INFUSION*

30 ENDOCRINE SURGERY AND/OR ENDOCRINE RADIATION THERAPY

40 COMBINATION OF ENDOCRINE SURGERY AND/OR RADIATION WITH A TRANSPLANT PROCEDURE. (COMBINATION OF CODES 30 AND 10, 11, 12, OR 20.)

First Course of Treatment: Transplant/Endocrine Procedures

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 ENDORCRINE SURGERY/RADIATION WERE NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.

86 HEMATOLOGIC TRANSPLANT AND/OR ENDORCRINE 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 ENDORCRINE 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.

V1.7.2 DATE OF TRANSPLANT/ENDOCRINE PROCEDURE

Record the date on which transplant/endocrine therapy began at any facility as part of first course of treatment. If transplant/endocrine therapy was not administered, leave the date field blank. *If transplant/endocrine therapy is planned, but had not started at the time the case is initially transmitted to the regional registry, enter 8's.* If transplant/endocrine therapy is known to have been given but the date is not known, enter 9's.

00000000 NO TRANSPLANT/ENDOCRINE THERAPY ADMINISTERED; AUTOPSY ONLY CASE.

88888888 WHEN TRANPLANT/ENDOCRINE THERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP. *FOR CoC APPROVED FACILITIES*, THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW-UP.

NOTE: *THE CCR REQUIRES THE USE OF 8's IN THIS FIELD FOR CASES UNDERGOING TRANSPLANT/ENDOCRINE THEARPY LATER THAN SIX MONTHS FROM THE DATE OF ADMISSION. See the Timeliness Section IX.2.3.*

99999999 THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

Section VI.8
First Course Treatment: Other Therapy

Record definitive, cancer directed treatment that cannot be assigned to any other category, for example:

- Tumor embolization (arterial block), if the surgeon's intent is to kill tumor cells.
- Hyperbaric oxygen (as adjunct to definitive treatment).
- Hyperthermia (given alone or in combination with chemotherapy, as in isolated heated limb perfusion for melanoma).
- 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 the following codes for recording other therapy in the Summary field. 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
2 OTHER EXPERIMENTAL CANCER DIRECTED THERAPY (not included elsewhere)
3 DOUBLE BLIND CLINICAL TRIAL, CODE NOT YET BROKEN
6 UNPROVEN THERAPY
7 PATIENT OR PATIENTS 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.*

VI.8.2 DATE OF OTHER THERAPY

Record the date on which Other Therapy began at any facility as part of first course treatment. If Other Therapy was not administered, leave the date field blank. If Other Therapy was known to have been given, but the date is unknown, enter 9's.

00000000	NO OTHER THERAPY ADMINISTERED; AUTOPSY ONLY CASE
99999999	THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

Section VI.9
Protocol Participation

Beginning with cases diagnosed January 1, 2001, the CCR requires that this field be collected and transmitted to the regional registry and to the CCR. CNExT already includes this data item although it may not have been collected by all facilities in the past. 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

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

Section VII.1
Follow-Up Information

A very important aspect of the California cancer reporting system is the annual monitoring of patients throughout their lives to ascertain survival rates. If any follow-up information is available before an abstract is submitted, include it in the abstract. Hospitals 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), the patient's physician, contact letters, and telephone calls. Any follow-up information obtained must be reported to the regional registry. 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 cases of carcinoma in situ of the cervix, or non-analytic cases, the CCR will not expect to receive follow-up information for such cases. Information entered in the CNExT follow-up information fields is transmitted automatically to the regional registry.

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 hospital 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 Hospital.
- Death information.

VII.1.2 SOURCES OF FOLLOW-UP INFORMATION

Follow-up information must be based on documentation of a contact with the patient in the form of direct response to a letter or phone call to the patient or other contact, a report by the patient's physician, readmission to the hospital as an inpatient or outpatient, or a 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 CURRENCY OF INFORMATION

Information must be current. Currency is defined as contact with the patient within 15 months of the date the follow-up is reported. 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 hospital, the regional registry may designate a hospital 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 hospital requires a signed agreement from each participating registry. Otherwise, follow-up may be shared without a signed agreement as long as the source is not disclosed. However, this does not preclude a hospital registry's submission of more current information about its patients.

Section 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.

VII.2.1 DATE OF LAST CONTACT

Enter the date the patient was last seen or heard from or the date of death, not the date the information was forwarded or received. If no follow-up information has been received, enter the date of discharge from the hospital. Never use the code for unknown year, "9999," and do not leave the field blank. (For instructions about entering dates, see Section I.1.6.4.)

All abstracts submitted for a patient must contain the same Date of Last Contact.

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

This field has been added for patients with multiple primaries. Enter the date of the last information obtained on the primary (tumor) being followed.

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. The CNExT codes are:

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 hospitals that do not have CNExT may use another coding system or scale adopted by the hospital's cancer committee.

This item is not required by the CCR.

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.

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 hospitals ordinarily use codes from the first of the three following groups, i.e., 00-15, unless instructed otherwise by their regional registry.

Follow-up obtained by hospital from:
00 ADMISSION BEING REPORTED
01 READMISSION TO REPORTING HOSPITAL
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 HOSPITAL
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 Data Items

Follow-up obtained by regional registry from:

20 LETTER TO A PHYSICIAN
21 COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES
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 SOCIAL SECURITY, DEATH MASTER FILE
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-MATCHING USING ADDRESS SERVICE
38 TRW CREDIT
39 REGIONAL REGISTRY FOLLOW-UP LISTING

Follow-up obtained by central (state) registry from:

40 LETTER TO A PHYSICIAN
41 TELEPHONE CALL TO ANY SOURCE
50 CMS (CENTER FOR MEDICARE AND MEDICAID SERVICES)
51 DEPARTMENT OF MOTOR VEHICLES
52 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
53 COMPUTER MATCH WITH HMO FILE
54 CALVOTER REGISTRATION
55 NATIONAL DEATH INDEX
56 STATE DEATH TAPE-DEATH
57 MEDI-CAL ELIGIBILITY
58 SOCIAL SECURITY - DEATHS
59 COMPUTER MATCH, OTHER OR NOS
60 OTHER SOURCE
61 SOCIAL SECURITY - SSN
62 SPECIAL STUDIES
65 HOSPITAL DISCHARGE DATA - OSHPD
66 NATIONAL CHANGE OF ADDRESS (NCOA)
67 SOCIAL SECURITY ADMINISTRATION – EPIDEMIOLOGICAL VITAL STATUS
68 PROPERTY TAX LINKAGE
69 STATE DEATH TAPE – DEATH CLEARANCE (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

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

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 HOSPITAL
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 HOSPITAL
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

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
50 CMS (CENTER FOR MEDICARE AND MEDICAID SERVICES)
51 COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES FILE
52 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
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 SOCIAL SECURITY ADMINISTRATION – EPIDEMIOLOGICAL VITAL STATUS
68 PROPERTY TAX LINKAGE
69 STATE DEATH TAPE – DEATH CLEARANCE (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
80 SOCIAL SECURITY ADMINISTRATION
81 PROPERTY TAX LINKAGE
82 PROBE360
83 SSDI - INTERNET
84 E-PATH
85 PATH LABS
86 PATIENT
87 RELATIVE

99 SOURCE UNKNOWN

VII.2.7 LAST FOLLOW-UP HOSPITAL

Enter the six-digit code or name of the hospital, facility, or agency that provided the most recent follow-up information. (See Appendices F1 and F2 for codes.)

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 HOSPITAL'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 HOSPITAL
5 FOLLOW-UP BY A METHOD NOT DESCRIBED ABOVE
6 SEND A FOLLOW-UP LETTER TO THE PATIENT

VII.2.9 NEXT FOLLOW-UP HOSPITAL

Enter the six-digit code number or name of the hospital, facility, or agency responsible for the next follow-up of the patient (see Appendices F1 and F2 for codes). Leave the field blank if the patient is deceased or not to be followed.

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.)

VII.2.11 ALTERNATE MEDICAL RECORD NUMBER

An alternate medical record number, such as the patient's record number at the next follow-up hospital, may be entered for the convenience of the hospital 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 submitted to the regional registry.

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 fields 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 blank.

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 Appendices C and D for other codes.) *If the patient is still alive, use code 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

For the convenience of the hospital, CNExT provides three lines of text in the Follow–Up area of the abstract for recording information useful in following the patient. Information entered on the line labeled "FU Resource Remarks" can be printed on a follow-up letter. Use of the Follow-Up Remarks fields is optional, and information entered there is not sent to the regional registry.

Section 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 (ie, a nursing home or name of an apartment complex). This supplemental field is limited to 40 characters.

VII.3.1 FOLLOW-UP RESOURCES

Please refer to the *CNExT Supplemental Data Manual* for instructions in the use of the Follow-up Resources. These fields allow the user to customize how follow-up is to be done; e.g. requesting the medical record, writing the patient, etc. The resources may be left blank if the patient is dead.

VII.3.2 CONTACT #1

In the Contact #1 fields, enter the patient's name preceded by Mr., Mrs., Ms., or followed by Jr. or Sr. (up to 30 characters and spaces), the current street address or post office box (up to 40 characters and spaces), the current city (up to 20 characters and spaces), the two character Postal Service abbreviation for the state (see Appendix B for abbreviations), and 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. (CNExT automatically keeps this consistent with the Current Telephone Number field.) Use the 50 character remarks field to record any information that might be useful when the next follow up letter is generated. Information in all Contact #1 fields except the Remarks field is transmitted to the regional registry.

In the Patient Address Current--Supplemental field, record the place or facility (ie nursing home or name of an apartment complex) of the patient's current usual redidence. 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 40 characters.

VII.3.3 CONTACTS #2 THROUGH #6

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 40 characters.

PART VIII
REMARKS AND EXTRA HOSPITAL INFORMATION

Section VIII.1
Remarks

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. If there is no final diagnosis in the medical record, leave this field blank.

VIII.1.1 REQUIRED DATA ITEMS

Certain required data must be recorded on the Remarks screen:

- 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—see Section VII.3.2).

VIII.1.2 CONFIDENTIAL REMARKS

In the Confidential Remarks field, enter sensitive information that is not required by the CCR but which the hospital wants to collect—for example, the patient's history of alcohol or drug abuse, abortions, sexual preference, diagnosis of AIDS or HIV status. The information will not be transmitted with the abstract.

VIII.1.3 MORE REMARKS

Additional confidential text information may be recorded in the More Remarks area. The text in this area will not be transmitted or recorded on the CNExT abstract.

Section VIII.2
Regional Data

Use of the Regional Data fields is determined by the regional registry, which designates the codes to be entered.

Section VIII.3
Extra Hospital Information

The Extra Hospital 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 regional registry.

Section VIII.4
Clinical Indicators

These fields have been added for use by hospitals. There is space to record up to 30 clinical indicators.

Section 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

Section IX.1
Transmittal of Case Information

The method of transmitting abstracted information to the regional registry varies with each reporting facility. Facilities can either mail diskettes, use a modem to send the information electronically or send hard copy abstracts to their regional registry. All electronic data that are mailed or transmitted in any form between cancer reporting facilities and regional registries must be encrypted and password protected. For facilities using CNExT software, there is an option allowing them to perform this function before transmitting a file to their regional registry.

Paper or hard copy abstracts should be placed in an envelope that is sealed, marked confidential, and accompanied by a statement on the outside alerting the recipient that the sealed envelope contains confidential information that is intended for the regional registry. The statement should request that if the person who receives the confidential package is not the intended recipient, they should return it to the sender. The sealed, marked envelope with attached statement should then be placed in another envelope and sent by a secure delivery service including U.S. Post Office (first class) or some form of traceable, delivery service.

This policy also pertains to abstracts returned to the facility from the regional registry for inquiries or corrections.

The frequency of transmittals must be arranged between the reporting hospital and the regional registry, but should be quarterly at least. For very large hospitals, monthly or even weekly transmittals might be appropriate to allow an even work flow at the regional registry.

IX.1.1 TIMELINESS

Submit all reports to the regional registry assigned to the reporting hospital. Unless the regional 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 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
Alias First Name
Alias Last Name
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
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
Date of Chemotherapy
Date of Diagnosis
Date of Diagnostic or Staging Procedures
Date of First Admission
Date of Hormone Therapy
Date of Immunotherapy
Date of Inpatient Admission
Date of Inpatient Discharge
Date of Most Definitive Surgery
Date of Other Therapy
Date of Radiation Therapy
Date of Surgery
Date of Systemic Therapy
Date of Transplant/Endocrine Procedure
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
Extent of Disease - Extension
Extent of Disease - Extension (Path)
Extent of Disease - Lymph Node Involvement
First Name
Histology - Behavior - (ICD-O-2)
Histologic 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
Immunotherapy at This Hospital
Immunotherapy Summary
Industry - Text
Last Name

Laterality
Maiden Name
Marital Status
Medical Record Number
Middle Name
Mother's First Name
Name Suffix
Number of Regional Lymph Nodes Examined – Summary
Occupation - Text
Other Therapy at This Hospital
Other Therapy Summary
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/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 - Summary
Sequence Number - Hospital
Sex
Site - Primary (ICD-O-2)
Social Security Number
Social Security Number Suffix
Spanish/Hispanic Origin
Summary Stage
Summary Stage 2000
Surgical Procedure/Other Site at This Hospital
Surgical Procedure/Other Site - Summary
Surgery of Primary Site at This Hospital
Surgery Primary Site - Summary
Surgery Summary – Reconstructive
Text-Diagnostic Procedures-Physical Examination
Text-Diagnostic Procedures-X-ray
Text-Diagnostic Procedures-Scopes
Text-Diagnostic Procedures-Lab Tests
Text-Diagnostic Procedures-Operative
Text-Diagnostic Procedures-Pathological
Text-Site
Text-Histology
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
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

When one of the above fields is changed in an abstract that has already been transmitted, CNExT automatically creates a correction record and places it in a file for transmittal. (See the *CNExT Online Help Manual* for transmittal instructions.) When the new data are entered, CNExT displays a request for the reason for the correction. 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 to the regional registry as 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. Access CNExT's Update Case function to 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 DELETIONS

Delete any duplicate records if a case is found to have been abstracted more than once. Also 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 registry. When a case is deleted from the hospital's registry, CNExT generates a deletion record for transmittal to the regional registry. (See the *CNExT Online Help Manual* for transmittal instructions.) When the case is deleted, CNExT displays a request for the reason for the deletion. Enter an explanation in the text field displayed on the screen.

Transmittal of Case Information

Example

After a case of "probable lymphoma" had been reported, the patient was referred to a specialty center where additional workup and repeat biopsies were performed. The final diagnosis was changed to "atypical lymphocytic infiltrates," and physicians decided to follow the patient closely but not treat the condition. Since the patient is now deemed not to have cancer, delete the case from the hospital's registry. CNExT automatically creates a deletion record to be used to notify the regional registry, and requests the reason for the deletion. Enter a statement such as "Patient referred to XYZ University, where DX changed to 'atypical lymphocytic infiltrates.' No treatment given. Patient will be followed closely."

Section 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 hospital 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 monitoring of death certificates. The minimum acceptable level of completeness for a reporting facility is 97 percent. (See Section 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.

Regional registries use computer edits to assess the quality of data submitted. The CCR provides a standard set of edits for regions, and many of the same edits are performed on CNExT data at the time of abstracting. The measure used to evaluate accuracy is the percent of a hospital's cases that fail an edit. CCR's standards specify that, for computerized data, all submitted codes must be valid as described in this manual and in *Cancer Reporting in California: Data Standards for Regional Registries and California Cancer Registry* (California Cancer Reporting System Standards, Vol.3). Data submitted via CNExT automatically meet these standards.

The CCR's software 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. Many hospital registry software programs also contain these over-ride flags. See Appendix T for a list of these over-rides. Please follow the instructions provided by your hospital software vendor for using these flags.

In addition to computer edits to assess accuracy, regional registries perform visual editing on 100% of the abstracts submitted by hospital registries. Feedback is routinely provided to hospitals on visual editing.

Beginning January 1, 2000, the California Cancer Registry implemented visual editing standards. The purpose of these standards is to provide consistency in the visual editing process and to quantify the accuracy of cancer data from cancer reporting facilities.

Initially, thirteen data items were included in this standard. They are as follows:

- County of Residence at Diagnosis
- Sex
- Race
- Spanish/Hispanic Origin
- Date of Diagnosis
- Diagnostic Confirmation
- Site/Subsite*
- Laterality (only paired sites listed in Volume I)
- Histology
- Tumor Size
- EOD - Extension (for prostate--count as one discrepancy)*
- EOD - Lymph Node Involvement
- Number of Regional Nodes Positive/Examined*

*Counted as one discrepancy

The visual editing accuracy rate for the thirteen data items was established at 97%. These data items were selected because they affect the overall quality for data usage. 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.

Non-analytic cases are included in the accuracy rate. The regions visually edit them, although not as extensively as analytic cases. Review is limited to verifying that there is supporting documentation to validate the coded data field.

Beginning July 1, 2001, the CCR's Regional Registries began visual editing treatment data items in addition to tumor data items. A total of nineteen treatment data items were added to the list of data items to be visually edited. One discrepancy will be counted for each treatment modality grouping. For example, a discrepancy in Date of Hormone Therapy and a discrepancy in Hormone Therapy would be counted as only one discrepancy.

These data items will be included in the semi-annual accuracy rate using a phased approach. For the period July 1, 2001 to December 31, 2001, visual editing of treatment items will not be included in calculating accuracy rates, but they will be tracked and feedback will be provided to hospital registrars. Beginning in *January 2005*, discrepancies in treatment fields will be counted towards the overall facility accuracy rate, and will be reported in the six-month accuracy rates.

In July 2004, Collaborative Staging fields will be added to the list of data items visually edited by the regional registries. Discrepancies will be counted in a facility's accuracy rate beginning July 1, 2005.

Another method of assessing accuracy is to reabstract cases in the hospitals. 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 hospital submits a case to a regional registry after admission of the patient. Regional registries monitor the timeliness of data submitted by hospitals. The standard set by CCR is that 97 percent of cases must be received by the regional 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, 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 must be notified.

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APPENDIX A
NEW HISTOLOGY CODES FOR LYMPHOMAS AND LEUKEMIAS

NEW 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 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 ot 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

ICD-O Code	Term
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 term(s) for an existing number

APPENDIX B
POSTAL ABBREVIATIONS FOR STATES AND TERRITORIES OF THE UNITED STATES

AL ALABAMA
AK ALASKA
AS AMERICAN SAMOA
AZ ARIZONA
AR ARKANSAS
CA CALIFORNIA
CO COLORADO
CT CONNECTICUT
DE DELAWARE
DC DISTRICT OF COLUMBIA
FL FLORIDA
GA GEORGIA
GU GUAM
HI HAWAII
ID IDAHO
IL ILLINOIS
IN INDIANA
IA IOWA
KS KANSAS
KY KENTUCKY
LA LOUISIANA
ME MAINE
MD MARYLAND
MH MARSHALL ISLANDS
MA MASSACHUSETTS
MI MICHIGAN
FM MICRONESIA, FERERATED STATE OF
MN MINNESOTA
MS MISSISSIPPI
MO MISSOURI
MT MONTANA
NE NEBRASKA
NV NEVADA
NH NEW HAMPSHIRE
NJ NEW JERSEY
NM NEW MEXICO
NY NEW YORK
NC NORTH CAROLINA
ND NORTH DAKOTA
MP NORTHERN MARIANA ISLANDS
OH OHIO
OK OKLAHOMA
OR OREGON
PW PALAU
PA PENNSYLVANIA
PR PUERTO RICO
RI RHODE ISLAND
SC SOUTH CAROLINA
SD SOUTH DAKOTA
TN TENNESSEE
TT TRUST TERRITORIES
TX TEXAS
UT UTAH
VT VERMONT
VA VIRGINIA
VI VIRGIN ISLANDS
DC WASHINGTON, DISTRICT OF
WA WASHINGTON, STATE OF
WV WEST VIRGINIA
WI WISCONSIN
WY WYOMING
XX *NOT U.S., U.S. TERRITORY, NOT CANADA, AND COUNTRY IS KNOWN*
YY NOT U.S., *U.S. TERRITORY,* NOT CANADA, *AND COUNTRY IS UNKNOWN*
ZZ *U.S. NOS, U.S. TERRITORY, NOS; CANADA, NOS, RESIDENCE IS UNKNOWN*

CANADIAN PROVINCE/ TERRITORY

AB ALBERTA
BC BRITISH COLUMBIA
MB MANITOBA
NB NEW BRUNSWICK
NL NEWFOUNDLAND AND LABRADOR
NT NORTHWEST TERRITORIES
NS NOVA SCOTIA
NU NUNAVUT
ON ONTARIO
PE PRINCE EDWARD ISLAND
QC QUEBEC
SK SASKATCHEWAN
YT YUKON TERRITORIES
XX CANADA, NOS

APPENDIX C
CODES FOR STATES AND TERRITORIES OF THE UNITED STATES

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

(in alphabetical order, 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, NOS	600
ASIA-ARAB COUNTRIES, NOS	620
ASIA-EAST, NOS	680
ASIA-MID-EAST, NOS	640
ASIA MINOR, NOS	610
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

Codes for Countries (in alphabetical order)

CANAL ZONE	110
CANARY ISL	443
CANTON/ENDERBURY ISL	122
CAPE COLONY	545
CAPE VERDE ISL	445
CARIBBEAN, NOS	245
CARIBBEAN ISL NEC	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
CZECHOSLOVAKIA	452
CZECH REPUBLIC	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
FAROE ISLANDS	425
FALKLAND ISLANDS	381
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
GERMANIC COUNTRIES	430
GERMANY	431
GERMAN DEMOCRATIC REPUBLIC	431
GERMANY, EAST	431
GERMANY, FEDERAL REPUBLIC OF	431
GERMANY, WEST	431
GHANA	539

Codes for Countries (in alphabetical order)

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-BISSAU	539
GUINEA PORTUGUESE	539
GUINEA	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
KYRGYZ	634
KYRGYSTAN	634
LABRADOR	221
LAOS	661
LAPLAND, NOS	420
LATIN AMERICA, NOS	265
LATVIAN S.S.R.	459
LATVIA	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

Codes for Countries (in alphabetical order)

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 ANTILLES	245
NETHERLANDS	432
NEVADA	085
NEVIS	245
NEW BRUNSWICK	221
NEW CALEDONIA	725
NEW ENGLAND	001
NEW GUINEA, NOS	673
NEW GUINEA AUSTRALIAN	711
NEW GUINEA NORTHEAST	711
NEW GUINEA PAPUA	711
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, NOS	639
PAKISTAN WEST	639
PALAU	139
PALESTINE ARAB	625
PALESTINE JEWISH	631
PALASTINIAN 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 SOUTH AFRICA	545

Codes for Countries (in alphabetical order)

REPUBLIC OF CHINA	684
REPUBLIC OF IRELAND	410
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
SLOVAK REPUBLIC	452
SLOVAKIA	452
SLOVENIA	453
SLAVONIA	453
SOLOMON ISLANDS	721
SOMALI REPUBLIC	581
SOMALIA	581
SOMALILAND, NOS	581
SOMALILAND FRENCH	583
SOUTH AFRICA, NOS	540
SOUTH AMERICAN ISLANDS	380
SOUTH AMERICA, NOS	300
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. KITTS	245
ST. HELENA	580
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

Codes for Countries (in alphabetical order)

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, NOS	000
US POSS-ATL/CARIB, NOS	100
US POSS-PACIFIC	120
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
UZBEKISTAN	634
UZBECK SSR	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 DC	022
WASHINGTON	093
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, SOUTHERN	629
YEMEN, PEOPLE'S DEMOCRATIC REPUBLIC	629
YUGOSLAVIA	453
YUKON	225
ZAIRE	541
ZAMBIA	549
ZANZIBAR	571
ZIMBABWE	547

APPENDIX D.2
CODES FOR COUNTRIES

(In numerical order, includes codes for U.S. states and territories)

000	UNITED STATES, NOS
000	US NOS
001	US-NEW ENGLAND, NOS
001	NEW ENGLAND
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	SOUTHERN LINE ISLANDS
122	PHOENIX 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

Codes for Countries (in numerical order)

210	GREENLAND
220	CANADA, NOS
221	CANADA-MARITIME PROVINCE
221	NOVA SCOTIA
221	NEWFOUNDLAND
221	NEW BRUNSWICK
221	PRINCE EDWARD ISL
221	LABRADOR
222	QUEBEC
223	ONTARIO
224	CANADA-PRAIRIE PROVINCE
224	MANITOBA
224	SASKATCHEWAN
224	ALBERTA
225	CANADA-NW TERR/YUKON
225	YUKON
225	NORTHWEST TERRITORY
226	BRITISH COLUMBIA
227	CANADA- NUNAVUT
230	MEXICO
240	NORTH AMERICAN ISL, NOS
241	CUBA
242	HAITI
243	DOMINICAN REPUBLIC
244	JAMAICA
245	CARIBBEAN ISL NEC
245	ANTILLES
245	NETHERLANDS ANTILLES
245	VIRGIN ISLANDS, BRITISH
245	MONTSERRAT
245	GUADALOUPE
245	MARTINIQUE
245	ST. CHRISTOPHER-NEVIS
245	ST. KITTS
245	ANGUILLA
245	GRENADINES
245	TURKS ISLANDS
245	CAYMAN ISLANDS
245	ST. VINCENT
245	CAICOS ISLANDS
245	BARBADOS
245	ANTIGUA
245	ARUBA
245	BARBUDA
245	CURACAO
245	DOMINICA
245	GRENADA
245	ST. LUCIA
245	TOBAGO
245	TRINIDAD
245	WEST INDIES, BRITISH
245	LEEWARD ISLANDS
245	WEST INDIES, NOS
245	WINDWARD ISLANDS
246	BERMUDA
247	BAHAMAS
249	ST. PIERRE AND MIQUELON
250	CENTRAL AMERICA, NOS
251	GUATAMALA
252	BRITISH HONDURAS
252	BELIZE
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	GUYANA
331	BRITISH GUIANA
331	GUIANA BRITISH
332	SURINAM
332	DUTCH GUIANA
332	GUIANA DUTCH
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	UNITED KINGDOM, NOS
400	GREAT BRITAIN, NOS
401	ISLE OF MAN
401	ENGLAND
401	CHANNEL ISL
401	JERSEY
401	GUERNSEY
402	WALES
403	SCOTLAND
403	SHETLAND ISLANDS
403	ORKNEY ISLANDS
404	NORTHERN IRELAND
404	ULSTER
410	IRELAND
410	REPUBLIC OF IRELAND

Codes for Countries (in numerical order)

410	EIRE
420	SCANDANAVIA, NOS
420	LAPLAND, NOS
421	ICELAND
423	NORWAY
423	JAN MAYEN
423	SVALBARD
425	DENMARK
425	FAROE ISLANDS
427	SWEDEN
429	FINLAND
430	EUROPE-GERMANIC, NOS
431	GERMANY
431	BAVARIA
432	NETHERLANDS
432	HOLLAND
433	BELGIUM
434	LUXEMBOURG
435	SWITZERLAND
436	AUSTRIA
437	LIECHTENSTEIN
440	EUROPE-ROMANCE LANG, NOS
441	FRANCE/MONACO
441	MONACO
441	CORSICA
443	SPAIN/ANDORRA
443	ANDORRA
443	CANARY ISL
443	BALEARIC ISL
445	PORTUGAL
445	AZORES
445	MADEIRA ISL
445	CAPE VERDE ISL
447	ITALY/SAN MARINO
447	SAN MARINO
447	SARDINIA
447	SICILY
447	VATICAN CITY
449	RUMANIA
449	ROMANIA
449	TRANSYLVANIA
449	DOBRUJA
449	MOLDAVIA RUMANIA
449	WALLACHIA
450	EUROPE-SLAVIC, NOS
451	POLAND
452	CZECHOSLOVAKIA
452	BOHEMIA
452	CZECH REPUBLIC
452	MORAVIA
452	SLOVAKIA
452	SLOVAK REPUBLIC
453	YUGOSLAVIA (FORMER)
453	BOSNIA-HERZOGOVINA
453	CROATIA
453	DALMATIA
453	SERBIA
453	MACEDONIA
453	MONTENEGRO
453	SLAVONIA
453	SLOVENIA
454	BULGARIA
455	RUSSIAN FEDERATION (FORMER) U.S.S.R
455	USSR, NOS
455	RUSSIA
455	RUSSIA, NOS (RUSSIAN S.F.S.R.)
456	UKRAINE/MOLDOVA
456	MOLDAVIA
456	BESSARABIA
456	MOLDAVIAN SSR
456	UKRANIAN SSR
457	BYELORUSSIA
457	WHITE RUSSIA
457	BELARUS
458	ESTONIA (ESTONIAN SSR)
459	LATVIA (LATVIAN SSR)
461	LITHUANIA (LITHUANIAN SSR)
463	BALTIC REPUBLIC(S), NOS
470	EUROPE-OTHER MAINLAND, NOS
471	GREECE
471	CRETE
475	HUNGARY
481	ALBANIA
485	GIBRALTAR
490	EUROPE-MEDITER ILS NEC
491	MALTA
495	CYPRUS
499	EUROPE, NOS
499	CENTRAL EUROPE, NOS
499	EASTERN EUROPE, NOS
499	NORTHERN EUROPE, NOS
499	SOUTHERN EUROPE, NOS
499	WESTERN EUROPE, NOS
500	AFRICA, NOS
500	CENTRAL AFRICA, NOS
500	EQUATORIAL AFRICA, NOS
510	NORTH AFRICA NOS
511	MOROCCO
513	ALGERIA
515	TUNISIA
517	LIBYA
517	CYRENAICA
517	TRIPOLITANIA
517	TRIPOLI
519	EGYPT

Codes for Countries (in numerical order)

519 UNITED ARAB REPUBLIC
520 AFRICA-SUDANESE COUNTRIES
520 BURKINA FASO (UPPER VOLTA)
520 SUDAN
520 SAHARA
520 NIGER
520 MAURITANIA
520 MALI
520 CHAD
520 WESTERN (SPANISH) SAHARA
530 WEST AFRICA
530 FRENCH WEST AFRICA, NOS
531 NIGERIA
539 AFRICA-CENTRAL (OTHER WEST)
539 TOGO
539 SIERRA LEONE
539 SENEGAL
539 RIO MUNI
539 PORTUGUESE GUINEA
539 LIBERIA
539 KAMEROON
539 COTE D'IVOIRE (IVORY COAST)
539 GUINEA
539 GHANA
539 GAMBIA
539 GABON
539 FERNANDO PO
539 EQUATORIAL GUINEA
539 DAHOMEY
539 CONGO
539 CONGO FRENCH
539 CONGO BRAZZAVILLE
539 CENTRAL AFRICAN REPUBLIC
539 CAMEROON
539 BENIN
539 GUIANA BISSAU
539 GUIANA PORTUGUESE
540 SOUTH AFRICA, NOS
541 ZAIRE
541 CONGO BELGIAN
541 CONGO LEOPOLDVILLE
541 CONGO/KINSHASA
543 ANGOLA
543 SAO TOME
543 PRINCIPE
543 CABINDA
545 NAMIBIA
545 REPUBLIC OF SOUTH AFRICA
545 UNION OF SOUTH AFRICA
545 TRANSVAAL
545 SWAZILAND
545 SOUTH WEST AFRICA
545 FREE STATE (ORANGE FREE STATE)
545 NATAL
545 LESOTHO
545 CAPE COLONY
545 BOTSWANA
545 BECHUANALAND
545 BASUTOLAND
545 TRANSKEI
545 VENDA
545 CISKEL
545 BOPHUTHATSWANA
547 ZIMBABWE
547 RHODESIA SOUTHERN
547 RHODESIA
549 ZAMBIA
549 RHODESIA NORTHERN
551 MALAWI
551 NYASALAND
553 MOZAMBIQUE
555 MADAGASCAR
555 MALAGASY REPUBLIC
570 EAST AFRICA, NOS
571 TANZANIA
571 ZANZIBAR
571 TANZANYIKA
571 TANGANYIKA
573 UGANDA
575 KENYA
577 RWANDA
577 RUANDA
579 BURUNDI
579 URUNDI
580 AFRICAN COASTAL ISLANDS
580 MAYOTTE
580 SEYCHELLES
580 MAURITIUS
580 REUNION
580 COMOROS
580 ST. HELENA
581 SOMALIA
581 SOMALILAND, NOS
581 SOMALI REPUBLIC
583 AFARS/ISSAS
583 SOMALILAND FRENCH
583 ISSAS
583 DJIBOUTI
585 ETHIOPIA
585 ABYSSINIA
585 ERITREA
600 ASIA, NOS
610 ASIA-NEAR EAST, NOS
610 MESOPOTAMIA
611 TURKEY

Codes for Countries (in numerical order)

611	ANATOLIA
611	ASIA MINOR, NOS
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	ARABIAN PENINSULA
629	YEMEN
629	UNITED ARAB EMIRATES
629	SAUDI ARABIA
629	QUATAR
629	QATAR
629	OMAN AND MUSCAT
629	KUWAIT
629	BAHRAIN
629	ARABIA
629	ADEN
629	TRUCIAL STATES
629	PERSIAN GULF STATES, NOS
631	ISRAEL
631	GAZA
631	WEST BANK
631	PALESTINE (PALESTINIAN NATIONAL AUTHORITY-PNA)
633	CAUCASIAN REPUBLICS OF FORMER USSR
633	AZERBAIDZHAN SSR
633	AZERBAIJAN
633	ARMENIA
633	GEORGIA (USSR)
634	OTHER ASIAN REPUBLICS OF FORMER USSR
634	TURKMEN SSR
634	UZBEKISTAN
634	TURMENISTAN
634	KAZAKHSTAN
634	TAJIKISTAN
634	KYRGYSTAN
634	UZBECK SSR
634	KAZAKH SSR
634	TADZHIK SSR
634	KIRGHIZ SSR
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	NEPAL/BHUTAN/SIKKIM
643	BHUTAN
643	SIKKIM
645	BANGLADESH
645	PAKISTAN EAST
647	SRI LANKA
647	CEYLON
649	BURMA
649	MYANMAR
650	ASIA-SOUTHEAST, NOS
651	THAILAND
651	SIAM
660	INDO-CHINA, NOS
661	LAOS
663	CAMBODIA
663	KAMPUCHEA
665	VIET NAM
665	VIETNAM
665	TONKIN
665	ANNAM
665	COCHIN CHINA
671	MALAYSIA/SINGAPORE/BRUNEI
671	SINGAPORE
671	BRUNEI
671	MALAY PENINSULA
673	INDONESIA
673	DUTCH EAST INDIES
673	NEW GUINEA, NOS
673	SUMATRA
673	JAVA
673	BORNEO
675	PHILIPPINES
680	ASIA-EAST, NOS
681	CHINA, NOS
682	CHINA, PEOPLE'S REPUBLIC
683	HONG KONG
684	TAIWAN
684	CHINA, REPUBLIC OF
684	REPUBLIC OF CHINA
684	FORMOSA
685	TIBET
686	MACAU
686	MACAO
691	MONGOLIA
693	JAPAN
693	OKINAWA
695	KOREA
695	NORTH KOREA
695	SOUTH KOREA

Codes for Countries (in numerical order)

711	AUSTRALIA/AUST NEW GUINEA
711	NEW GUINEA AUSTRALIAN
711	NEW GUINEA NORTHEAST
711	NEW GUINEA PAPUA
711	PAPUA
711	CARTIER ISLANDS
711	COCOS ISLANDS
711	NORFOLK ISLANDS
715	NEW ZEALAND
715	NIUE
720	PACIFIC ISL, NOS
720	OCEANA, NOS
720	POLYNESIA, NOS
721	MELANESIA (MELANESIA ISLANDS)
721	FIJI
721	VANUATA
721	NEW HEBRIDES
721	SOLOMON ISLANDS
721	FUTUNA ISLANDS
721	FOTUNA
721	WALLIS ISLANDS
723	MICRONESIA (MICRONESIAN ISLANDS)
723	NAURU
723	CHRISTMAS ISLAND
725	POLYNESIA (POLYNESIAN ISLANDS)
725	NEW CALEDONIA
725	TONGA
725	SAMOA, WESTERN
725	PITCAIRN
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.

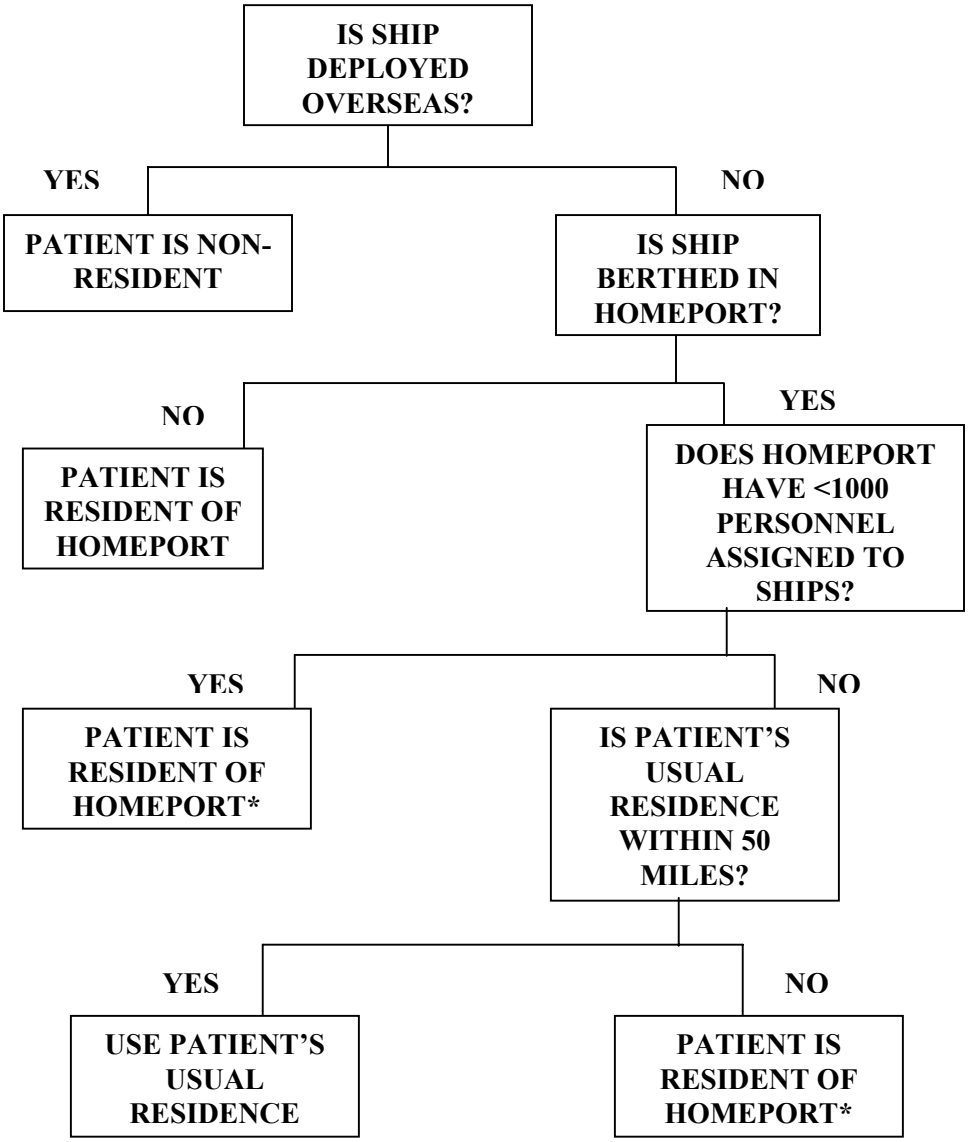
NAVY PERSONNEL

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 homeport to each of its ships. If a ship that is not deployed overseas is not berthed in its homeport, any crew member diagnosed with cancer is considered a resident of the homeport. If the ship is berthed in its homeport, and the homeport 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 homeport has more than 1000 naval personnel assigned to ships and the cancer patient has a usual residence within 50 miles of the homeport, the person's residence is the home, not the ship itself. If the patient's usual residence is more than 50 miles from the homeport, 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 homeport unless the homeport 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 homeport 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 homeport 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.1
CALIFORNIA HOSPITAL CODE NUMBERS
(in alphabetical order)

The first two digits of the hospital code number represent the California county code (minus the leading 0) where the hospital or reporting facility is located. Mercy General Sacramento (340947) is in Sacramento County (034).

Hospitals with similar names can be differentiated by the county code. Mission Community Hospital (190524) is in Los Angeles County (019), whereas Mission Community (301262) is in Orange County (030).

There are facilities, which have general names, such as Radiation Therapy Med Grp, but have a specific hospital code number (331155). Therefore, this hospital code number should not be used for another facility with the same name located in a different county.

"OLD" after the hospital name indicates that the hospital number is an inactive reporting source, e.g., hospital closed or merged.

AGNEWS DEVEL CTR	430700
AIM 1 COLORECTOL STUDY	000203
ALABAMA STATE REG	989037
ALAMEDA COUNTY MED CTR	010737
ALAMEDA HOSPITAL	010735
ALAMEDA RAD ONCOLOGY	010738
ALASKA STATE REG	989091
ALEXIAN BROTHERS (OLD)	430705
ALHAMBRA COMMUNITY	190017
ALISAL COMMUNITY (OLD)	270706
ALLIANCE COMMUNITY	150775
ALTA BATES ALBANY (OLD)	013636
ALTA BATES/HERRICK	010739
ALTA HOSPITAL DIST	540680
ALVARADO COMMUNITY	370652
ALVARADO EAST (OLD)	370749
ALVARADO MED CTR	370652
AMADOR	030786
AMI VALLEY MED CTR	370697
ANACAPA ADVENTIST (OLD)	560468
ANAHEIM GENERAL	301097
ANAHEIM MEM OUTPT (OLD)	301761
ANAHEIM MEM WEST (OLD)	301761
ANAHEIM MEMORIAL	301098
ANAHEIM MEMORIAL EAST	301098
ANGELS	361168
ANTELOPE VALLEY	190034
ANTELOPE VALLEY RAD ONC	193005
APPLE VALLEY RAD ONC	361330
ARCADIA METHODIST	190529
ARIZONA CANCER REGISTRY	989087
ARKANSAS STATE REG	989071
ARROWHEAD REG MED CTR	361320
ARROYO GRANDE COMM	400466
ATASCADERO STATE	400683
ATLANTA SEER	800033
AUBURN FAITH COMM	310791
AUBURN RAD ONC CTR	311010
AUBURN SURGERY CENTER	314010
AVALON MEMORIAL (OLD)	190044
AVALON MUNICIPAL	190045
AVENAL DISTRICT (OLD)	160681
BAKERSFIELD COMM RAD (OLD)	150778
BAKERSFIELD COMMUNITY	150775
BAKERSFIELD HEART HOSP	150050
BAKERSFIELD MEM	150722
BARLOW	190052
BARSTOW COMMUNITY	361105
BARTON MEMORIAL	090793
BAY AREA REG CANCER CTR	070650
BAY HARBOR	190057
BAY MEDICAL CENTER	370658
BAY RADIOLOGY MED GRP (OLD)	370660
BEACH COMMUNITY (OLD)	301109
BEALE AFB	589990
BEAR VALLEY COMMUN	361110
BELLFLOWER DOCTORS	190066
BELLWOOD GENERAL	190069
BEN SCHAFFER CA INST	390820
BEVERLY GLEN (OLD)	190078
BEVERLY HILLS (OLD)	190080
BEVERLY HILLS MED (OLD)	190488
BEVERLY HOSPITAL	190081
BEVERLY ONC & IMAGING CTR	193010
BIGGS GRIDLEY MEM	040802
BLOSS MEM DISTRICT (OLD)	240803
BOYD, DAVID MD OLD	370000
BREA COMMUNITY	301126

BREAST CENTER, THE	199997
BROADWAY VALLEJO (OLD)	481015
BROOKDALE (OLD)	019997
BROOKSIDE	070904
BROOKWOOD	490907
BROTMAN MED CTR	190110
BUENA PARK COMMUN (OLD)	301242
BUENA PARK DOCTORS OLD	301109
BUENAVENTURA MEDCTR	560476
BURBANK COMMUNITY	190114
CA FDN SN BARBARA RAD CTR	420530
CA FOUNDATION SN BARBARA	420530
CA GARDENA (OLD)	190312
CA PODIATRY (OLD)	380769
CAL ENDOCURIETHER MEDCORP	010745
CAL INST FOR MEN	369993
CAL MENS COLONY	409990
CALEXICO	130666
CALIF MED CTR LA	190125
CALIF MED FAC VACAVILLE	485000
CALIF MEDICAL FACILITY	485000
CALIFORNIA PACIFIC MEDCTR	380920
CALVOTER REGISTRATION	000454
CAMARILLO STATE	560681
CAMINO MED GRP	438800
CANCER/BLOOD KERN (OLD)	159991
CANOGA PARK	190130
CAREUNIT LA (OLD)	190827
CASA COLINA REHAB	190137
CASTLE AFB (OLD)	249990
CCR	000001
CEDARS COMP CA CTR	190553
CEDARS-SINAI MED	190555
CENTINELA MAMMOTH	260011
CENTINELA MED CTR	190148
CENTRAL VALLEY GENERAL	160787
CENTURY CITY	190155
CENTURY COMMUNITY (OLD)	190108
CHABOYA CLINIC	430884
CHANNEL ISLANDS (OLD)	560502
CHANNEL ISLANDS SURGICTR	560475
CHAPMAN GENERAL	301140
CHAPMAN MED CTR	301140
CHARTER COMMUNITY	190159
CHARTER PACIFIC	190655
CHARTER SUBURBAN	190599
CHICO COMMUNITY (OLD)	040828
CHICO SURGERY CENTER	044153
CHILDRENS HOSP AT MISSION	301150
CHILDRENS LA	190170
CHILDRENS OAKLAND	010776
CHILDRENS ORANGE	300032
CHILDRENS SAN DIEGO	370673
CHILDRENS SF (OLD)	380777
CHILDRENS STANFORD	430741
CHINESE	382715
CHINO COMMUNITY	361144
CHOPE	410782
CHOWCHILLA DIST	200692
CHRISTIAN MED CTR (OLD)	332172
CIGNA CLINICS LA	190665
CIGNA HOSP LA (OLD)	190661
CIRCLE CITY	331145
CITRUS VALLEY MED CTR	190413
CITY OF ANGELS MED CTR	190175
CITY OF HOPE	190176
CITY VIEW (OLD)	190178
CLAIREMONT COMMUN (OLD)	370674
CLOVIS COMMUNITY	100005
CMRI	000452
CMS	000450
COALINGA DISTRICT	100697
COAST PLAZA MED CTR	190766
COASTAL CITIES MRI & ROC	560480
COASTAL COMMUNITIES	301258
COASTAL RAD ONC MED GROUP	560485
COLDWATER CANYON	190199
COLLEGE COSTA MESA	301155
COLLEGE PARK (OLD)	370683
COLORADO CENTRAL CA REG	989083
COLUMBIA GOOD SAM SN JOSE	430779
COLUMBIA HUNTINGTON BEACH	301209
COLUMBIA SAN CLEMENTE MED	301325
COLUMBIA SAN JOSE MED CTR	430879
COLUMBIA SAN LEANDRO HOSP	013619
COLUMBIA SOUTH VALLEY	430924
COLUMBIA VALLEY HOSP	361144
COLUMBIA WEST ANAHEIM MED	301379
COLUMBIA WEST HILLS	190859
COLUSA COMMUNITY	060870
COMMUN CHULA VISTA	370875
COMMUNITY HOSP LONG BEACH	190180
COMMUNITY MED CTR CLOVIS	100005
COMMUNITY MED CTR FRESNO	100717
COMMUNITY MEMORIAL	560473
COMMUNITY RAD ONC CTR	362045
COMMUNITY SALINAS (OLD)	270706
CONNECTICUT SEER	800007
CONNECTICUT STATE REG	989007
CONTRA COSTA COUNTY	070924
CONTRA COSTA REG MED CTR	070924
CONVALESCENT HOSPITAL	000804
CORCORAN DISTRICT	160702
CORCORAN STATE PRISON	169996
CORNING MEMORIAL (OLD)	520837
CORONA COMMUNITY (OLD)	331152
CORONA RAD ONC MED CLINIC	331158
CORONA REGIONAL MED CTR	331145
CORONADO	370689
CORONER	000802
COSTA MESA MED CTR	301155
COTTAGE HOSPITAL	420514
COVINA VALLEY COMM	190458
COWELL BERKELEY (OLD)	010799
COWELL DAVIS (OLD)	571139
CRENSHAW CENTER	190216
CRYSTAL SPRINGS	410752
DAMERON	390846
DANIEL FREEMAN MAR	190500
DANIEL FREEMAN MEM	190230
DAVID GRANT USAF	489990
DAVIES MED CTR	380933
DC ONLY	000801
DEATH CERTIFICATE (STAT)	000456

DEATH CLEARENCE (INCR)	000469
DEL AMO DX CTR	190420
DEL PUEBLO (OLD)	190065
DEL PUERTO (OLD)	500850
DELANO REGIONAL MED	150706
DELAWARE STATE REG	989017
DELTA MEMORIAL	070934
DESERT	331164
DESERT RAD ONCOLOGY	361150
DESERT RADIATION ONCOLOGY	361150
DESERT VALLEY	361155
DETROIT SEER	800041
DIGESTIVE DISEASE CENTER	302000
DISTRICT OF COLUMBIA REG	989022
DMV	000451
DOCTORS BELLFLOWER	190066
DOCTORS EAST LA	190256
DOCTORS HAWTHORNE (OLD)	190406
DOCTORS LA	190854
DOCTORS LAKEWOOD	190240
DOCTORS LAKEWOOD C (OLD)	190453
DOCTORS LODI	390922
DOCTORS LONG BEACH	190477
DOCTORS LONG BEACH (OLD)	190478
DOCTORS MANTECA	392287
DOCTORS MEDICAL CENTER	070904
DOCTORS MODESTO	500852
DOCTORS MONTCLAIR	361166
DOCTORS OAKLAND (OLD)	019996
DOCTORS PINOLE (OLD)	073449
DOCTORS SAN PABLO	070904
DOCTORS SANTA ANA OLD	301167
DOCTORS' SURGERY CENTER	450900
DOMINGUEZ VALLEY	190242
DOMINICAN ST CRUZ	440755
DOS PALOS MEMORIAL (OLD)	240853
DOWNEY COMMUNITY	190243
DOWNEY RAD ONC MED CLINIC	193020
DRS EAST LA	190256
DRS HAWTHORNE (OLD)	190406
DRS LA	190854
DRS LAKEWOOD	190240
DRS LAKEWOOD CLARK (OLD)	190453
DRS LODI	390922
DRS LONG BEACH	190477
DRS LONG BEACH (OLD)	190478
DRS MANTECA	392287
DRS MODESTO	500852
DRS MONTCLAIR	361166
DRS OAKLAND (OLD)	019996
DRS PINOLE (OLD)	073449
DRS SANTA ANA OLD	301167
E DOHENEY EYE FND	199995
EAST BAY (OLD)	071053
EAST VALLEY CLINIC	430885
EAST VALLEY MED GRP	190285
EAST VALLEY PAVILLION	430886
EASTERN PLUMAS	320859
EDEN	010805
EDWARDS AFB	159990
EISENHOWER MED CTR	331168
EL CAJON VALLEY OLD	370697
EL CAMINO	430763
EL CENTRO COMMUN	130699
EL MONTE COMMUNITY	190352
EMANUEL MED CTR	500867
ENCINO (OLD)	190280
ENCINO-TARZANA REG MED CT	190517
ENDOSCOPY CENTER	514009
ENLOE MEDICAL CENTER	040962
ENLOE MEMORIAL	040962
ESCONDIDO SURGICAL CTR	370688
ESKATON AMER RIV	340869
ESTUDILLO CORP	010809
EXETER MEMORIAL	540755
FAIRCHILD MED CTR	471031
FAIRMONT (OLD)	010811
FAIRVIEW STATE	301781
FALLBROOK DISTRICT	370705
FEATHER RIVER	040875
FEATHER RIVER SURG CENTER	514010
FED CORRECT SN PDRO	199993
FHP FOUNTAIN VLY	300225
FHP LA COUNTY MED CTRS	190161
FHP NOS	999980
FHP ORANGE COUNTY MEDCTRS	300227
FHP PHYSICIANS ONLY	999985
FLORIDA STATE REG	989035
FOOTHILL PRESBYTERIAN	190298
FORT IRWIN	369990
FORT ORD	279990
FORT YUMA IND HOSP	139990
FOUNTAIN VALLEY COMM	301175
FOUNTAIN VALLEY OP SURG	301170
FOUNTAIN VALLEY REG HOSP	301175
FOWLER MUNICIPAL (OLD)	100714
FRANK HOWARD MEM	230949
FRANKLIN	380933
FRED HUTCHINSON	989992
FREMONT	510882
FRENCH LA	190307
FRENCH SF (OLD)	380816
FRENCH SN LUIS OBS	400480
FRESNO COMMUNITY	100717
FRESNO SURGERY CENTER	100720
FRIENDLY HILLS REG OLD	301232
FROST ST SURG CTR	370710
FULLERTON COMMUN (OLD)	301180
G BAKERSFIELD MEM	150722
GARDEN GROVE MED	301283
GARDEN SULLIVAN (OLD)	382684
GARDENA COMMUNITY	190196
GARDENA MEMORIAL	190521
GARFIELD MED CTR	190315
GENERAL EUREKA	120981
GEORGE AFB	369991
GEORGE L MEE MEM	270777
GEORGIA STATE REG	989033
GLENDALE ADV CC (OLD)	190326
GLENDALE ADVENTIST	190323
GLENDALE MEMORIAL	190522
GLENDORA COMMUNITY	190328

GLENN GENERAL	110889
GLENN MED CTR	110889
GOLETA VALLEY	420483
GOOD SAM BAKERSFIELD	150775
GOOD SAM SAN JOSE	430779
GOOD SAM SN CLARA VLY	430779
GOOD SAMARITAN LA	190392
GRANADA HILLS COMM	190348
GREATER EL MONTE COMMUN	190352
GREATER SACRAMENTO SURG	341088
GROSSMONT DIST	370714
HAHNEMANN (OLD)	380826
HAMILTON AFB (OLD)	219998
HANFORD COMMUNITY	160725
HARBOR GENERAL	191227
HARBOR VIEW MED OLD	370672
HAROLD D CHOPE	410782
HAWAII SEER	800099
HAWAII STATE REG	989099
HAWKINS MEMORIAL	350784
HAWTHORNE MEMORIAL	190523
HAYWARD (OLD)	013637
HAZEL HAWKINS MEM	350784
HEALDSBURG GENERAL	490964
HEALTHCARE TUSTIN	301357
HEALTHSOUTH SURG ALHAMBRA	344066
HEALTHSOUTH SURG FORT SUT	344015
HEMET VALLEY MED CTR	331194
HENRY MAYO NEWHALL	190949
HERITAGE	361168
HERMOSA BEACH (OLD)	191002
HERRICK (OLD)	010844
HI DESERT MED CTR	362041
HIGHLAND GENERAL (OLD)	010846
HILLSIDE (OLD)	370721
HOAG MEM PRESBYTER	301205
HOLDERMAN MEMORIAL	281297
HOLLYWD PRES/QUEEN ANGELS	190490
HOLLYWOOD COMMUN	190380
HOLLYWOOD PRESBY (OLD)	190382
HOLY CROSS	190385
HOME HEALTH	999991
HOSP DISCHARGE DATA-OSHPD	000465
HOSPICE	999990
HOWARD MEMORIAL	230949
HUMANA HUNTINGTON	301209
HUMANA NOS	999981
HUMANA SAN LEANDRO	013619
HUMANA W ANAHEIM	301379
HUMANA WEST HILLS	190859
HUMANA WESTMINSTER (OLD)	301380
HUMBOLDT COMMUNITY	121031
HUNTINGTON BEACH MED CTR	301209
HUNTINGTON E VALLEY MED	190328
HUNTINGTON MEM	190400
HUNTINGTON PARK	190197
IDAHO STATE REG	989081
ILLINOIS STATE CA REG	989061
IMPERIAL VALLEY CANCER CT	130710
INDIAN VALLEY DIST	320874
INDIANA STATE REG	989045
INGLEWOOD WOMENS (OLD)	190412
INLAND RAD THERAPY	361170
INLAND RADIATION THERAPY	361170
INLAND VALLEY REG MED CTR	331239
INTERCOMM COVINA	190413
IOWA SEER	800053
IOWA STATE REG	989053
IRVINE MED CTR	300125
IRVINE REGIONAL HOSPITAL	300125
JEROLD R PHELPS COMMUNITY	121031
JERRY PETTIS MEM	369992
JOHN C FREMONT	220733
JOHN F KENNEDY MEM	331216
JOHN MUIR MED CTR	070988
JOHN MUIR MEMORIAL	070988
KAISER ANAHEIM	301132
KAISER BAKERSFIELD	150770
KAISER BALDWIN PARK	190425
KAISER BELLFLOWER	190430
KAISER CARSON	190135
KAISER EL CAJON OLD	370716
KAISER FONTANA	361223
KAISER FREMONT	014132
KAISER FRESNO	100500
KAISER HARBOR CITY	190431
KAISER HAYWARD	010858
KAISER INGLEWOOD	190433
KAISER LA	190429
KAISER MARTINEZ	071010
KAISER NORWALK	190428
KAISER NOS	999982
KAISER OAKLAND	010856
KAISER PANORAMA	190432
KAISER REDWOOD CITY	410804
KAISER RICHMOND	070991
KAISER RIVERSIDE	331230
KAISER ROSEVILLE	311015
KAISER RWC	410804
KAISER SACRAMENTO	340913
KAISER SAN DIEGO	370730
KAISER SAN RAFAEL	210992
KAISER SANTA ROSA	491400
KAISER SANTA TERESA	431506
KAISER SF	380857
KAISER SN CLARA	430805
KAISER SO SACTO	340920
KAISER SO SF	410806
KAISER SSF	410806
KAISER STOCKTON CLINIC	391020
KAISER SUNSET	190429
KAISER VALLEJO	480989
KAISER WALNUT CRK	070990
KAISER WEST LA	190434
KAISER WOODLAND HILLS	190435
KANSAS STATE REG	989065
KAWEAH DELTA DIST	540734
KENNETH NORRIS USC	191216
KENTFIELD MED	210993
KENTUCKY STATE REG	989047
KERN MEDICAL CTR	150736
KERN REGIONAL CANCER CTR	150740
KERN VALLEY	150737
KINDRED SACRAMENTO	341040

KING-DREW	191230
KINGSBURG GENERAL (OLD)	100745
KLAMATH TRINITY (OLD)	120982
KPC GLOBAL MED CTR	361166
KRANS MEDICAL PARTNERS	193055
LA CO HIGH DESERT	191261
LA CO JAIL HOSP	199996
LA CO KING-DREW MED	191230
LA CO OLIVE VIEW	191231
LA CO RANCHO AMIGOS	191306
LA CO USC MED	191228
LA COMMUNITY	190198
LA HABRA COMMUNITY	301232
LA MIRADA MED CTR	190449
LA PALMA INTERCOMM	301234
LA VINA FOR RESP	190451
LAGUNA HONDA REHAB	380865
LAKE VIEW MED CTR (OLD)	190592
LAKESIDE CLINIC	171300
LAKESIDE COMMUNITY	171395
LAKESIDE HOSPITAL	331233
LAKEWOOD REGIONAL MED CTR	190240
LANCASTER COMMUN	190455
LANTERMAN STATE	190588
LAS ENCINAS	190462
LASSEN COMMUNITY	180919
LAUREL GROVE (OLD)	010869
LAWRENCE BERK LAB	019989
LETTERMAN ARMY (OLD)	389995
LINCOLN MED CTR	190468
LINDA VISTA COMMUNITY	190684
LINDSAY MED CTR	540746
LITTLE CO MARY	190470
LIVINGSTON MED CTR	370735
LIVINGSTON WHEELER	370735
LODI COMMUNITY	390922
LODI MEMORIAL	390923
LODI OUTPATIENT SURG CTR	394004
LOMA LINDA COMMUN	361246
LOMA LINDA COMMUN (OLD)	361245
LOMA LINDA UNIV	361246
LOMPOC DISTRICT	420491
LOMPOC PENITENTARY	429991
LONG BEACH	190477
LONG BEACH COMMUN (OLD)	190475
LONG BEACH DOCTORS	190477
LONG BEACH MEM MED	190525
LOS ALAMITOS MED	301248
LOS ALTOS (OLD)	190482
LOS AMIGOS	191306
LOS ANGELES COMMUN	190198
LOS BANOS COMMUN	240924
LOS GATOS COMMUN	430743
LOS MEDANOS COMMUN	073638
LOS ROBLES REGIONAL	560492
LOS ROBLES SURGICENTER	560495
LOUISIANA STATE REG	989073
MAD RIVER COMMUN	121002
MADERA COMMUNITY	201281
MAINE STATE REG	989002
MAMMOTH	260011
MANTECA	392287
MARCH AFB	339990
MARIAN MEDICAL CTR	420493
MARIN GENERAL	211006
MARK TWAIN	050932
MARSHAL HALE (OLD)	380826
MARSHALL	090933
MARSHALL HOSP RAD ONC CTR	090935
MARTIN LUTHER KING	191230
MARTIN LUTHER MED (OLD)	301761
MARYLAND STATE REG	989021
MARYS HELP	410817
MASSACHUSETTS STATE REG	989005
MATHER AFB	349990
MAXICARE MED CTRS	190305
MAYERS MEMORIAL	450936
MAYO CLINIC	989990
MD ANDERSON	989991
MD ONLY	999996
MEDI-CAL ELIGIBILITY	000457
MEE MEMORIAL	270777
MEM SLOAN KETTERNG	989993
MEMORIAL CERES	500938
MEMORIAL LOS BANOS	240924
MEMORIAL MODESTO	500939
MEMORIAL SAN LEANDRO	010887
MENDOCINO COAST	231013
MENDOCINO COMMUN	231014
MENIFEE VALLEY	331235
MERCED COMMUNITY	240942
MERCY AMERICAN RIVER	340869
MERCY BAKERSFIELD	150761
MERCY FOLSOM	341065
MERCY GEN SACTO	340947
MERCY GEN SANTA ANA	301258
MERCY MERCED	240948
MERCY MERCED COMMUNITY	240942
MERCY MERCED DOMINICAN	240948
MERCY MT SHASTA	470871
MERCY REDDING	450949
MERCY SACRAMENTO	340947
MERCY SACRAMENTO ROC	340948
MERCY SAN DIEGO	370744
MERCY SAN JUAN	340950
MERCY SAN JUAN ROC	340955
MERRITHEW MEMORIAL	070924
MERRITT	010937
MERRITT PERALTA MED CTR	010937
METHODIST SACTO	340951
METHODIST SO CALIF	190529
METROPOLITAN	190530
MICHAEL J FAZIO MD SURG	344118
MICHIGAN CANCER REG	989041
MIDVALLEY	191231
MIDWAY MED CTR	190534
MIDWOOD COMMUNITY (OLD)	301345
MILLS MEMORIAL	410742
MILLS-PENINSULA	410772
MINERS (OLD)	290952
MINNESOTA STATE REG	989052
MISSION	190538

MISSION BAY MEM (OLD)	370746
MISSION COMMUNITY	301262
MISSION COMMUNITY HOSP	190524
MISSION HOSP REG MED CTR	301262
MISSION MED ASSOCIATES	400500
MISSION OAKS (OLD)	430915
MISSION VALLEY MED CTR	331239
MISSION VIEJO RAD ONC GRP	301785
MISSISSIPPI STATE REG	989039
MISSOURI STATE REG	989063
MODESTO CITY (OLD)	500954
MODOC MED ALTURAS	250956
MOJAVE RADIATION ONC CTR	361250
MONO GENERAL	261263
MONROVIA COMMUNITY	190541
MONTANA STATE REG	989056
MONTEREY PARK	190547
MONTEREY PEN COMM	270744
MONTEREY PENINSULA (OLD)	271118
MONTEREY PENINSULA SURG	270740
MOORE J E LAB (OLD)	019998
MORENO VALLEY MED CTR	331245
MORRIS JOHNSTON MEM	190298
MOTION PICTURE TV	190552
MOUNTAINS COMM	361266
MT DIABLO MED CTR	071018
MT SHASTA COMMUNITY	470871
MT ZION	380895
MULLIKIN MED CTR	191320
NAPA STATE	281266
NATIONAL DEATH INDEX	000455
NATIVIDAD MEM CTR	270831
NAVAL LEMOORE	169990
NAVAL LONG BEACH	199990
NAVAL OAKLAND	019990
NAVAL PENDLETON	379990
NAVAL SAN DIEGO	379991
NCOA	000466
NEBRASKA STATE REG	989067
NEEDLES DESERT COMM	361458
NEVADA STATEWIDE CA REG	989085
NEVADA, STATE REGISTRY OF	989085
NEW HAMPSHIRE STATE REG	989003
NEW JERSEY STATE REG	989008
NEW MEXICO SEER	800086
NEW MEXICO STATE REG	989086
NEW YORK STATE REG	989011
NEWHALL COMMUNITY	190559
NO HOLLYWOOD MED	190654
NON-HOSPITAL NOS	999995
NORTH CAROLINA STATE REG	989025
NORTH COAST HEALTHCARE	490907
NORTH COAST REHAB	490907
NORTH DAKOTA STATE REG	989054
NORTH KERN (OLD)	150769
NORTHBAY MED CTR	481357
NORTHERN INYO	141273
NORTHRIDGE MED CTR	190568
NORTHRIDGE SHERMAN WAY	190810
NORWALK COMMUNITY	190570
NOVATO COMMUNITY	212637
NU-MED REGIONAL MED CTR	190860
OAK KNOLL NAVAL	019990
OAK VALLEY DIST	500967
OAKLAND (OLD)	010902
OCONNOR CAMPBELL (OLD)	431722
OCONNOR SAN JOSE	430837
OHIO STATE REG	989043
OJAI VALLEY COMMUN	560501
OKLAHOMA STATE REG	989075
ONCOLOGY INSTITUTES	560470
ONCOLOGY THERAPIES INC	370790
ONTARIO COMMUNITY	361274
ORANGE COAST MEM MED CTR	300225
ORANGE CO INST GE&ENDO	302005
ORANGE GROVE HOSP (OLD)	190600
OREGON STATE CANCER REG	989095
OROVILLE MED CTR	040937
ORTHOPEDIC	190581
OXNARD COMMUNITY (OLD)	560502
PACIFIC ALLIANCE MED CTR	190307
PACIFIC LONG BEACH	190587
PACIFIC MED CTR (OLD)	380929
PACIFIC PRESBYTER (OLD)	380929
PACIFIC RAD ONCOL	309990
PACIFICA COMMUNITY OLD	301282
PACIFICA OF THE VALLEY	190696
PALM DRIVE	491338
PALM IMAGING	362046
PALM TUMOR CLINIC	193080
PALMDALE MED CTR	190595
PALO ALTO MED FND	439998
PALO VERDE	331288
PALOMAR MEMORIAL	370755
PAMC	439998
PANORAMA COMMUNITY	190524
PARADISE VALLEY	370759
PARK VIEW (OLD)	190603
PARKVIEW COMMUN	331293
PASADENA MED CTR (OLD)	190608
PATIENTS HOSP OF REDDING	450950
PATTON STATE	361315
PENINSULA MED CTR	410852
PENNSYLVANIA STATE REG	989014
PERALTA (OLD)	010919
PETALUMA VALLEY	490001
PETERSON MED CLINIC (OLD)	560505
PHS WINTERHAVEN	139990
PHYSICIAN	000803
PHYSICIAN ONLY	999996
PHYSICIANS COMMUN (OLD)	010887
PICO RIVERA COMMUN	190616
PINECREST (OLD)	420506
PIONEER	190619
PIONEERS MEMORIAL	130760
PLACENTIA-LINDA	301297
PLASTIC SURG CTR MED GRP	342259
PLEASANT VALLEY	560508
PLUMAS DISTRICT	320986
POMERADO	370977
POMONA VALLEY	190630
PORT HUENEME ADVENT (OLD)	560468
PORTERVILLE DEVELOP CTR	541123
PORTERVILLE STATE	541123

PRESB INTERCOMMUN	190631
PRESBYTERIAN MED (OLD)	380929
PRESIDIO SAN FRAN (OLD)	389995
PROPERTY TAX	000468
PROVIDENCE (OLD)	013626
QUEEN ANGELS/HOLLYWD PRES	190490
QUEEN OF ANGELS LA (OLD)	190635
QUEEN VALLY NAPA	281047
QUEEN VALLEY W COV	190636
RAD ONC CONSULT MED GRP	193086
RAD ONC CTR HAYWARD (OLD)	010859
RAD ONC MED GRP SO CALIF	301782
RAD ONC MED SPECIALISTS	370760
RAD THERAPY MED GROUP	331155
RADIATION MED GRP	370760
RADIATION ONC ASSOCIATES	193085
RADIATION THERAPY MED GRP	331155
RADIOLOGY MED GRP	370760
RALPH K DAVIES	380933
RANCHO ENCINO	190862
RANCHO LOS AMIGOS	191306
RANCHO SPRINGS MED CTR	331350
RECOVERY INN LOS GATOS	430750
RECOVERY INN MENLO PARK	410820
RED BLUFF TUMOR INSTITUTE	522052
REDBUD COMMUNITY	171049
REDDING CANCER RX CTR	450938
REDDING MED CTR	450940
REDDING SURGERY CENTER	452000
REDLANDS COMMUNITY	361308
REDWOOD MEMORIAL	121051
REG MED CTR OF SAN JOSE	432002
REGION 1	000101
REGION 10	000110
REGION 2	000102
REGION 3	000103
REGION 3 OVARIAN STUDY	000303
REGION 4	000104
REGION 5	000105
REGION 6	000106
REGION 7	000107
REGION 8	000108
REGION 9	000109
REHAB INST SANTA BARBARA	421167
RHODE ISLAND STATE REG	989006
RIDEOUT MEMORIAL	580996
RIDGECREST COMMUN	150782
RIO HONDO MEMORIAL	190651
RIVERSIDE COMMUN	331312
RIVERSIDE COUNTY REG MED	331313
RIVERSIDE GEN UNIV	331313
RIVERSIDE KNOLLWD (OLD)	331226
RK DAVIES	380933
ROBERT F. KENNEDY	190366
ROGUE VALLEY MED CTR	989195
ROSEVILLE COMM	311000
ROSEVILLE RAD ONC CTR	311005
ROSS GENERAL (OLD)	211056
ROSS LOOS MEDICAL (OLD)	190661
SACRAMENTO COMMUN (OLD)	342097
SACRAMENTO MIDTOWN ENDOSC	344005

SACRED HEART	160787
SADDLEBACK COMMUNITY	301317
SADDLEBACK MEM MED CTR	301317
SALINAS VALLEY MEM	270875
SAMARITAN MED CTR	301325
SAMUEL MERRITT NO (OLD)	010782
SAN ANTONIO COMMUN	361318
SAN BENITO DIST	350784
SAN BERNARDINO CANCER CTR	362045
SAN BERNARDINO CM	361323
SAN BERNARDINO CO	361320
SAN BERNARDINO MT	361266
SAN BUENAVENTURA	560473
SAN CLEMENTE GEN	301325
SAN DIEGO AMB SURG CTR	370765
SAN DIEGO GENERAL (OLD)	370686
SAN DIEGO PHYSICNS (OLD)	370686
SAN DIMAS COMMUN	190673
SAN FERNANDO COMM	190676
SAN FRANCISCO GEN	380939
SAN GABRIEL COMMUN	190200
SAN GABRIEL VALLEY MEDCTR	190200
SAN GORGONIO MEM HOSP	331326
SAN GORGONIO PASS	331326
SAN JOAQUIN COMMUN	150788
SAN JOAQUIN GEN	391010
SAN JOAQUIN LASER & SURG	394023
SAN JOSE HEALTH	430879
SAN JOSE MED CTR	430879
SAN LEANDRO HOSPITAL	013619
SAN LUIS MED CLINIC	400500
SAN LUIS OBISPO GEN	400511
SAN MATEO COUNTY GENERAL	410782
SAN PEDRO PENINSULA	190680
SAN QUENTIN PR	211167
SAN RAMON REGIONAL MEDCTR	075100
SAN VICENTE (OLD)	190681
SANDLEWOOD (OLD)	190379
SANGER	100791
SANSUM MED CLINIC (OLD)	420540
SANTA ANA MED	301314
SANTA BARBARA BREAST (OLD)	420545
SANTA BARBARA MED FDN-OLD	420550
SANTA BARBARA MEM	421167
SANTA CLARA VALLEY	430883
SANTA CRUZ COMMUN (OLD)	441807
SANTA CRUZ GENERAL	440886
SANTA CRUZ MED CLINIC	440890
SANTA CRUZ RAD ONC MED GR	440894
SANTA FE COMMUNITY	190684
SANTA MARTA CLINIC	190685
SANTA MONICA MED	190687
SANTA MONICA CANCER RX	193090
SANTA MONICA MED	190687
SANTA PAULA MEM	560521
SANTA ROSA COMMUN	490919
SANTA ROSA GENERAL (OLD)	491012
SANTA ROSA MEM	491064
SANTA TERESA COMM	431506
SANTA TERESITA	190691
SANTA YNEZ VALLEY	420522

SCENIC GENERAL (OLD)	501015
SCRIPPS CHULA VISTA	370658
SCRIPPS EAST COUNTY OLD	370697
SCRIPPS ENCINITAS	371394
SCRIPPS GREEN	371256
SCRIPPS LA JOLLA	370771
SEASIDE MED CLINIC	081066
SEATTLE SEER	800093
SELMA COMMUNITY	100793
SELMA DISTRICT	100793
SENECA DISTRICT	321016
SEQUOIA	410891
SERRA MEMORIAL	190696
SETON MED CTR COASTSIDE	410828
SETON MEDICAL CTR	410817
SF GENERAL	380939
SHARP CABRILLO	370693
SHARP CHULA VISTA MED CTR	370875
SHARP HEALTHCARE MURRIETA	331350
SHARP MARY BIRCH	370690
SHARP MEMORIAL	370694
SHARP REES STEALY	370695
SHASTA GENERAL (OLD)	451018
SHERMAN OAKS COMM	190708
SHRINERS LA	190712
SHRINERS SF	380954
SIERRA COMM FRESNO	100796
SIERRA KINGS	100797
SIERRA MADRE COMM (OLD)	190714
SIERRA NEVADA MEM	291023
SIERRA SONORA	552209
SIERRA SURGICENTER	070950
SIERRA VALLEY DIST	461024
SIERRA VIEW DIST	540798
SIERRA VISTA	400524
SILAS B HAYS ARMY	279990
SIMI VALLEY ADVENT	560525
SIMI VALLEY COMMUN (OLD)	560526
SISKIYOU GENERAL	471031
SKILLED NURSING FACILITY	999992
SMITH HANNA OLD	370775
SN BARBARA BREAST CA (OLD)	420545
SN BARBARA COTTAGE	420514
SO HUMBOLDT COMMUN	121031
SOCIAL SECURITY- DEATHS	000458
SOCIAL SECURITY-SSN	000461
SOLANO SURGERY CENTER	484003
SONOMA COUNTY REDWOOD REG	491070
SONOMA STATE	491267
SONOMA VALLEY	491076
SONORA COMMUNITY	551034
SOUTH BAY	190734
SOUTH CAROLINA STATE REG	989026
SOUTH COAST MED	301337
SOUTH VALLEY CLINIC	430887
SOUTH VALLEY HOSP	430924
SOUTHCOAST TUMOR INS (OLD)	370776
SOUTHERN INYO	141338
SOUTHWEST CANCER CARE	370777
SPECIALIST SURGEY CTR	484021
SSA-EVS	000467
ST AGNES MED CTR	100899
ST BERNARDINE	361339
ST CATHERINE	410828
ST DOMINICS	390850
ST ELIZABETH COMM	521041
ST FRANCIS LYNWOOD	190754
ST FRANCIS SF	380960
ST FRANCIS SN BARB	420528
ST HELENA HEALTH	281078
ST JOHNS OXNARD	560529
ST JOHNS SN MONICA	190756
ST JOSEPH BURBANK	190758
ST JOSEPH EUREKA	121080
ST JOSEPH OAK PARK (OLD)	392232
ST JOSEPH ORANGE	301340
ST JOSEPH'S SF (OLD)	389994
ST JOSEPHS STOCKTN	391042
ST JUDE FULLERTON	301342
ST JUDE YORBA LINDA OLD	301169
ST LOUISE (OLD)	430850
ST LOUISE CANCER CARE CTR	431500
ST LOUISE REG HOSP (OLD)	430924
ST LOUISE REG MED CTR	432001
ST LUKE PASADENA	190759
ST LUKES SF	380964
ST MARY DESERT VLY	361343
ST MARY LONG BEACH	190053
ST MARY REG MED CTR	361343
ST MARYS SF	380965
ST PAULS (OLD)	019999
ST ROSE	010967
ST TERESA RADIATION	391050
ST VINCENT MED	190762
STAFF PHYSICIAN	999993
STANFORD UNIV	430905
STANISLAUS MED CTR	501015
STUDEBAKER COMMUN	190766
SUMMIT MED CTR	010937
SUN CITY CA CLIN	339991
SURGERY CENTER	192070
SURPRISE VALLEY	250955
SUTTER AMADOR	030786
SUTTER AUBURN FAITH	310791
SUTTER COAST	081066
SUTTER COAST (OLD)	081070
SUTTER COM YUBA CY (OLD)	511049
SUTTER COMMUN HOSPITALS	341052
SUTTER DAVIS	571215
SUTTER GEN SACTO (OLD)	341051
SUTTER LAKESIDE	171395
SUTTER MATERN & SURG CTR	440905
SUTTER MED CTR	490919
SUTTER MED CTR SACRAMENTO	341052
SUTTER MEM SACTO	341052
SUTTER MERCED	240942
SUTTER NORTH PROCEDURE	514021
SUTTER RAD ONCOLOGY CTR	341055
SUTTER ROSEVILLE COMM	311000
SUTTER SOLANO MED CTR	481094
SUTTER SURG CTR J ST	344062
SUTTER SURGERY CENTER	341068
SUTTER TRACY COMMUNITY	391056
TAHOE FOREST	291053

TALBERT DESERT SIERRA	710585
TALBERT LA CO MED CTRS	190161
TALBERT MED GRP NOS	999980
TALBERT ORANGE CO MEDCTRS	300227
TALBERT PHYSICIANS ONLY	999985
TARZANA MED CTR	190517
TEHACHAPI	150808
TEMECULA CANCER CTR	331355
TEMPLE COMMUNITY	190784
TENNESSEE STATE REG	989031
TERMINAL ISLAND	199993
TERRACE PLAZA MED	190049
TEXAS STATE REG	989077
THOMPSON MEMORIAL MED CTR	190114
TORRANCE MEMORIAL	190422
TRACY COMMUNITY	391056
TRAVIS AFB	489990
TREATMENT FOLLOW BACK	970000
TRI-CITY	370780
TRI-CITY REGIONAL MED CTR	190790
TRI-CITY WEST (OLD)	370753
TRI-VALLEY CASTRO VALLEY	010969
TRI-VALLEY PLEASANTON	010970
TRINITY GENERAL	531059
TULARE DISTRICT	540816
TUOLUMNE GENERAL	551061
TUSTIN HOSP MED CTR	301357
TWIN CITIES COMMUN	400548
TWIN CITIES SURGICENTER	584003
U PACIFIC DENTAL	389990
UC DAVIS	341006
UC IRVINE	301279
UC SAN DIEGO	370782
UC SF MED CENTER	381154
UCD	341006
UCI	301279
UCLA	190796
UCLA HARBOR	191227
UCMC SAN FRANCISCO	381154
UCSD	370782
UCSF FRESNO	109998
UCSF MED CENTER	381154
UCSF STANFORD HEALTH CARE	381160
UKIAH ADVENTIST	231396
UKIAH GENERAL (OLD)	231339
UKIAH SURGERY CENTER	231350
UKIAH VALLEY MED	231396
UNIVERSITY MED CTR	100822
UNKNOWN HOSP	999999
UNREFERRED PATIENT	000000
UNSPEC BAY AREA H	999997
UNSPEC CALIF HOSP	999998
UNSPEC CENTRAL CA HOSP	999987
UNSPEC NONCAL HOSP	999994
UNSPEC NORTHERN CA HOSP	999988
UNSPEC SOUTHERN CA HOSP	999989
US FAMILY CARE MED CTR	361166
USC MEDICAL CENTER	191228
USC UNIVERSITY HOSPITAL	191210
UTAH SEER	800084
UTAH STATE REG	989084
VA BRENTWOOD	199992
VA FRESNO	109999
VA LIVERMORE (OLD)	019995
VA LOMA LINDA	369992
VA LONG BEACH	199991
VA MARTINEZ	079997
VA MATHER	341085
VA PALO ALTO (OLD)	439999
VA PALO ALTO (VAPAHCS)	439995
VA RENO (OLD)	989999
VA SACRAMENTO	341085
VA SAN DIEGO	379992
VA SAN FRANCISCO	389992
VA SEPULVEDA	199994
VA W LOS ANGELES	199992
VA WADSWORTH	199992
VACA VALLEY HOSP	481070
VALLEJO GENERAL	481094
VALLEY CANCER INSTITUTE	193100
VALLEY CANOG PK (OLD)	190605
VALLEY CHILDRENS	201819
VALLEY CHILDRENS (OLD)	100819
VALLEY COMMUNITY	420535
VALLEY HEALTH CTR	430888
VALLEY LIVERMORE	010983
VALLEY MED EL CAJON	370697
VALLEY MED FRESNO	100822
VALLEY PLAZA DOCTORS HOSP	331233
VALLEY POMONA (OLD)	190314
VALLEY PRESB MEM	190812
VALLEY REG ONC CTR	332173
VALLEY TUMOR MED GRP	193104
VALLEY VAN NUYS	190810
VALLEY VISTA (OLD)	190678
VALLEY WEST GEN (OLD)	430915
VAN NUYS COMMUNITY (OLD)	190814
VANDENBERG AFB	429990
VAPA HEALTH CARE SYSTEM	439995
VENCOR	190305
VENCOR ONTARIO	361274
VENCOR SACRAMENTO	341040
VENTURA CO MED CTR	560481
VENTURA CO RAD ONC CTR	560482
VERDUGO HILLS	190818
VERMONT STATE REG	989004
VESPER SL	010887
VICTOR VALLEY	361370
VILLA VIEW COMMUN	370787
VIRGINIA STATE REG	989023
VISALIA COMMUNITY	540827
VISTA RADIATION	370790
WALNUT CRK RAD GRP	079996
WARRACK MED CTR	491103
WASHINGTON CULVER	190847
WASHINGTON D.C. REG	989022
WASHINGTON FREMONT	010987
WASHINGTON STATE REG	989093
WATSONVILLE COMMUN	440920
WEED ARMY	369990
WEST ANAHEIM MED CTR	301379
WEST COVINA	190857

WEST HILLS REG MED CTR	190859
WEST HOLLYWOOD	190384
WEST PARK	190860
WEST SIDE	150830
WEST SIDE COMMUN (OLD)	241082
WEST VALLEY HOSP & HEALTH	190860
WEST VIRGINIA STATE REG	989024
WESTERN ANAHEIM	301188
WESTERN MED SN ANA	301566
WESTERN TUMOR MED GRP	193110
WESTLAKE COMMUN	190867
WESTSIDE LA	190873
WHEELER	430924
WHILSHIRE ONC MED GRP	193117
WHITE MEMORIAL	190878
WHITTIER MED CTR	190883
WHITTIER ONCOLOGY CLINIC	193113
WISCONSIN CA REPORTING	989051
WOMENS BREAST CTR	301570
WOODLAND MEMORIAL	571086
WOODRUFF COMMUNITY	190891
WOODRUFF GABLES (OLD)	190893
WYOMING STATE REG	989082
X-RAY MED GROUP LA MESA	372000
YOLO GENERAL	571093
YUBA SUTTER RAD ONC CTR	511060

APPENDIX F.2
CALIFORNIA HOSPITAL CODE NUMBERS
(In numerical order)

The first two digits of the hospital code number represent the California county code (minus the leading 0) where the hospital or reporting facility is located. Mercy General Sacramento (340947) is in Sacramento County (034).

Hospitals with similar names can be differentiated by the county code. Mission Community Hospital (190524) is in Los Angeles County (019), whereas Mission Community (301262) is in Orange County (030).

There are facilities, which have general names, such as Radiation Therapy Med Grp, but have a specific hospital code number (331155). Therefore, this hospital code number should not be used for another facility with the same name located in a different county.

"OLD" after the hospital name indicates that the hospital number is an inactive reporting source, e.g., hospital closed or merged.

000000	UNREFERRED PATIENT
000001	CCR
000101	REGION 1
000102	REGION 2
000103	REGION 3
000104	REGION 4
000105	REGION 5
000106	REGION 6
000107	REGION 7
000108	REGION 8
000109	REGION 9
000110	REGION 10
000203	AIM 1 COLORECTAL STUDY
000303	REGION 3 OVARIAN STUDY
000450	CMS
000451	DMV
000452	CMRI
000454	CALVOTER REG
000455	NATIONAL DEATH INDEX
000456	DEATH CERTIFICATE (STAT)
000457	MEDI-CAL ELIGIBILITY
000458	SOCIAL SECURITY-DEATHS
000461	SOCIAL SECURITY-SSN
000465	HOSP DISCHARGE DATA-OSHPD
000466	NOCA
000467	SSA-EVS
000468	PROPERTY TAX
000469	DEATH CLEARENCE (INCR)
000801	DC ONLY
000802	CORONER
000803	PHYSICIAN
000804	CONVALESCENT HOSPITAL
010735	ALAMEDA HOSPITAL
010737	ALAMEDA COUNTY MED CTR
010738	ALAMEDA RAD ONCOLOGY
010739	ALTA BATES/HERRICK
010745	CAL ENDOCURIETHER MED CORP
010776	CHILDRENS OAKLAND
010782	SAMUEL MERRITT NO (OLD)
010799	COWELL BERKELEY (OLD)
010805	EDEN
010809	ESTUDILLO CORP
010811	FAIRMONT (OLD)
010844	HERRICK (OLD)
010846	HIGHLAND GENERAL (OLD)
010856	KAISER OAKLAND
010858	KAISER HAYWARD
010859	RAD ONC CTR HAYWARD (OLD)
010869	LAUREL GROVE (OLD)
010887	PHYSICIANS COMMUN (OLD)
010887	VESPER SL
010887	MEMORIAL SAN LEANDRO
010902	OAKLAND (OLD)
010919	PERALTA (OLD)
010937	SUMMIT MED CTR
010937	MERRITT
010937	MERRITT PERALTA MED CTR
010967	ST ROSE
010969	TRI-VALLEY CASTRO VALLEY
010970	TRI-VALLEY PLEASANTON
010983	VALLEY LIVERMORE
010987	WASHINGTON FREMONT
013619	SAN LEANDRO HOSPITAL
013619	COLUMBIA SAN LEANDRO HOSP

013619	HUMANA SAN LEANDRO
013626	PROVIDENCE (OLD)
013636	ALTA BATES ALBANY (OLD)
013637	HAYWARD (OLD)
014132	KAISER FREMONT
019989	LAWRENCE BERK LAB
019990	NAVAL OAKLAND
019990	OAK KNOLL NAVAL
019995	VA LIVERMORE (OLD)
019996	DOCTORS OAKLAND (OLD)
019996	DRS OAKLAND (OLD)
019997	BROOKDALE (OLD)
019998	MOORE J E LAB (OLD)
019999	ST PAULS (OLD)
030786	SUTTER AMADOR
030786	AMADOR
040802	BIGGS GRIDLEY MEM
040828	CHICO COMMUNITY (OLD)
040875	FEATHER RIVER
040937	OROVILLE MED CTR
040962	ENLOE MEDICAL CENTER
040962	ENLOE MEMORIAL
044153	CHICO SURGERY CENTER
050932	MARK TWAIN
060870	COLUSA COMMUNITY
070650	BAY AREA REG CANCER CTR
070904	DOCTORS MEDICAL CENTER
070904	DOCTORS SAN PABLO
070904	BROOKSIDE
070924	CONTRA COSTA REG MED CTR
070924	CONTRA COSTA COUNTY
070924	MERRITHEW MEMORIAL
070934	DELTA MEMORIAL
070950	SIERRA SURGICENTER
070988	JOHN MUIR MED CTR
070988	JOHN MUIR MEMORIAL
070990	KAISER WALNUT CRK
070991	KAISER RICHMOND
071010	KAISER MARTINEZ
071018	MT DIABLO MED CTR
071053	EAST BAY (OLD)
073449	DOCTORS PINOLE (OLD)
073449	DRS PINOLE (OLD)
073638	LOS MEDANOS COMMUN
075100	SAN RAMON REG MEDCTR
079996	WALNUT CRK RAD GRP
079997	VA MARTINEZ
081066	SUTTER COAST
081066	SEASIDE MED CLINIC
081070	SUTTER COAST (OLD)
090793	BARTON MEMORIAL
090933	MARSHALL
090935	MARSHALL HOSP RAD ONC CTR
100005	COMMUNITY MED CTR CLOVIS
100005	CLOVIS COMMUNITY
100500	KAISER FRESNO
100697	COALINGA DISTRICT
100714	FOWLER MUNICIPAL (OLD)
100717	COMMUNITY MED CTR FRESNO
100717	FRESNO COMMUNITY
100720	FRESNO SURGERY CENTER
100745	KINGSBURG GENERAL (OLD)
100791	SANGER
100793	SELMA COMMUNITY
100793	SELMA DISTRICT
100796	SIERRA COMM FRESNO
100797	SIERRA KINGS
100819	VALLEY CHILDRENS (OLD)
100822	UNIVERSITY MED CTR
100822	VALLEY MED FRESNO
100899	ST AGNES MED CTR
109998	UCSF FRESNO
109999	VA FRESNO
110889	GLENN MED CTR
110889	GLENN GENERAL
120981	GENERAL EUREKA
120982	KLAMATH TRINITY (OLD)
121002	MAD RIVER COMMUN
121031	JEROLD R PHELPS COMMUNITY
121031	SO HUMBOLDT COMMUN
121031	HUMBOLDT COMMUNITY
121051	REDWOOD MEMORIAL
121080	ST JOSEPH EUREKA
130666	CALEXICO
130699	EL CENTRO COMMUN
130710	IMPERIAL VALLEY CANCER CT
130760	PIONEERS MEMORIAL
139990	FORT YUMA IND HOSP
139990	PHS WINTERHAVEN
141273	NORTHERN INYO
141338	SOUTHERN INYO
150050	BAKERSFIELD HEART HOSP
150706	DELANO REGIONAL MED
150722	G BAKERSFIELD MEM
150722	BAKERSFIELD MEM
150736	KERN MEDICAL CTR
150737	KERN VALLEY
150740	KERN REGIONAL CANCER CTR
150761	MERCY BAKERSFIELD
150769	NORTH KERN (OLD)
150770	KAISER BAKERSFIELD
150775	GOOD SAM BAKERSFIELD
150775	BAKERSFIELD COMMUNITY
150775	ALLIANCE COMMUNITY
150778	BAKERSFIELD COMM RAD (OLD)
150782	RIDGECREST COMMUN
150788	SAN JOAQUIN COMMUN
150808	TEHACHAPI
150830	WEST SIDE
159990	EDWARDS AFB
159991	CANCER/BLOOD KERN (OLD)
160681	AVENAL DISTRICT (OLD)
160702	CORCORAN DISTRICT
160725	HANFORD COMMUNITY
160787	CENTRAL VALLEY GENERAL
160787	SACRED HEART
169990	NAVAL LEMOORE
169996	CORCORAN STATE PRISON
171049	REDBUD COMMUNITY
171300	LAKESIDE CLINIC
171395	SUTTER LAKESIDE
171395	LAKESIDE COMMUNITY

180919	LASSEN COMMUNITY
190017	ALHAMBRA COMMUNITY
190034	ANTELOPE VALLEY
190044	AVALON MEMORIAL (OLD)
190045	AVALON MUNICIPAL
190049	TERRACE PLAZA MED
190052	BARLOW
190053	ST MARY LONG BEACH
190057	BAY HARBOR
190065	DEL PUEBLO (OLD)
190066	BELLFLOWER DOCTORS
190066	DOCTORS BELLFLOWER
190069	BELLWOOD GENERAL
190078	BEVERLY GLEN (OLD)
190080	BEVERLY HILLS (OLD)
190081	BEVERLY HOSPITAL
190108	CENTURY COMMUNITY (OLD)
190110	BROTMAN MED CTR
190114	THOMPSON MEMORIAL MED CTR
190114	BURBANK COMMUNITY
190125	CALIF MED CTR LA
190130	CANOGA PARK
190135	KAISER CARSON
190137	CASA COLINA REHAB
190148	CENTINELA MED CTR
190155	CENTURY CITY
190159	CHARTER COMMUNITY
190161	TALBERT LA CO MED CTRS
190161	FHP LA COUNTY MED CTRS
190170	CHILDRENS LA
190175	CITY OF ANGELS MED CTR
190176	CITY OF HOPE
190178	CITY VIEW (OLD)
190180	COMMUNITY HOSP LONG BEACH
190196	GARDENA COMMUNITY
190197	HUNTINGTON PARK
190198	LOS ANGELES COMMUN
190198	LA COMMUNITY
190199	COLDWATER CANYON
190200	SAN GABRIEL VALLEY MEDCTR
190200	SAN GABRIEL COMMUN
190216	CRENSHAW CENTER
190230	DANIEL FREEMAN MEM
190240	DOCTORS LAKEWOOD
190240	LAKEWOOD REGIONAL MED CTR
190240	DRS LAKEWOOD
190242	DOMINGUEZ VALLEY
190243	DOWNEY COMMUNITY
190256	DOCTORS EAST LA
190256	DRS EAST LA
190280	ENCINO (OLD)
190285	EAST VALLEY MED GRP
190298	FOOTHILL PRESBYTERIAN
190298	MORRIS JOHNSTON MEM
190305	VENCOR
190305	MAXICARE MED CTRS
190307	PACIFIC ALLIANCE MED CTR
190307	FRENCH LA
190312	CA GARDENA (OLD)
190314	VALLEY POMONA (OLD)
190315	GARFIELD MED CTR
190323	GLENDALE ADVENTIST
190326	GLENDALE ADV CC (OLD)
190328	HUNTINGTON E VALLEY MED
190328	GLENDORA COMMUNITY
190348	GRANADA HILLS COMM
190352	GREATER EL MONTE COMMUN
190352	EL MONTE COMMUNITY
190366	ROBERT F. KENNEDY
190379	SANDLEWOOD (OLD)
190380	HOLLYWOOD COMMUN
190382	HOLLYWOOD PRESBY (OLD)
190384	WEST HOLLYWOOD
190385	HOLY CROSS
190392	GOOD SAMARITAN LA
190400	HUNTINGTON MEM
190406	DOCTORS HAWTHORNE (OLD)
190406	DRS HAWTHORNE (OLD)
190412	INGLEWOOD WOMENS (OLD)
190413	CITRUS VALLEY MED CTR
190413	INTERCOMM COVINA
190420	DEL AMO DX CTR
190422	TORRANCE MEMORIAL
190425	KAISER BALDWIN PARK
190428	KAISER NORWALK
190429	KAISER SUNSET
190429	KAISER LA
190430	KAISER BELLFLOWER
190431	KAISER HARBOR CITY
190432	KAISER PANORAMA
190433	KAISER INGLEWOOD
190434	KAISER WEST LA
190435	KAISER WOODLAND HILLS
190449	LA MIRADA MED CTR
190451	LA VINA FOR RESP
190453	DOCTORS LAKEWOOD C (OLD)
190453	DRS LAKEWOOD CLARK (OLD)
190455	LANCASTER COMMUN
190458	COVINA VALLEY COMM
190462	LAS ENCINAS
190468	LINCOLN MED CTR
190470	LITTLE CO MARY
190475	LONG BEACH COMMUN (OLD)
190477	LONG BEACH DOCTORS
190477	LONG BEACH
190477	DOCTORS LONG BEACH
190477	DRS LONG BEACH
190478	DRS LONG BEACH (OLD)
190478	DOCTORS LONG BEACH (OLD)
190482	LOS ALTOS (OLD)
190488	BEVERLY HILLS MED (OLD)
190490	QUEEN ANGELS/HOLLYWD PRES
190490	HOLLYWD PRES/QUEEN ANGELS
190500	DANIEL FREEMAN MAR
190517	ENCINO-TARZANA REG MED CT
190517	TARZANA MED CTR
190521	GARDENA MEMORIAL
190522	GLENDALE MEMORIAL
190523	HAWTHORNE MEMORIAL
190524	MISSION COMMUNITY HOSP
190524	PANORAMA COMMUNITY
190525	LONG BEACH MEM MED

190529	METHODIST SO CALIF
190529	ARCADIA METHODIST
190530	METROPOLITAN
190534	MIDWAY MED CTR
190538	MISSION
190541	MONROVIA COMMUNITY
190547	MONTEREY PARK
190552	MOTION PICTURE TV
190553	CEDARS COMP CA CTR
190555	CEDARS-SINAI MED
190559	NEWHALL COMMUNITY
190568	NORTHRIDGE MED CTR
190570	NORWALK COMMUNITY
190581	ORTHOPEDIC
190587	PACIFIC LONG BEACH
190588	LANTERMAN STATE
190592	LAKE VIEW MED CTR (OLD)
190595	PALMDALE MED CTR
190599	CHARTER SUBURBAN
190600	ORANGE GROVE HOSP (OLD)
190603	PARK VIEW (OLD)
190605	VALLEY CANOG PK (OLD)
190608	PASADENA MED CTR (OLD)
190616	PICO RIVERA COMMUN
190619	PIONEER
190630	POMONA VALLEY
190631	PRESB INTERCOMMUN
190635	QUEEN OF ANGELS LA (OLD)
190636	QUEEN VALLEY W COV
190651	RIO HONDO MEMORIAL
190654	NO HOLLYWOOD MED
190655	CHARTER PACIFIC
190661	ROSS LOOS MEDICAL (OLD)
190661	CIGNA HOSP LA (OLD)
190665	CIGNA CLINICS LA
190673	SAN DIMAS COMMUN
190676	SAN FERNANDO COMM
190678	VALLEY VISTA (OLD)
190680	SAN PEDRO PENINSULA
190681	SAN VICENTE (OLD)
190684	LINDA VISTA COMMUNITY
190684	SANTA FE COMMUNITY
190685	SANTA MARTA CLINIC
190687	SANTA MONICA MED
190691	SANTA TERESITA
190696	PACIFICA OF THE VALLEY
190696	SERRA MEMORIAL
190708	SHERMAN OAKS COMM
190712	SHRINERS LA
190714	SIERRA MADRE COMM (OLD)
190734	SOUTH BAY
190754	ST FRANCIS LYNWOOD
190756	ST JOHNS SN MONICA
190758	ST JOSEPH BURBANK
190759	ST LUKE PASADENA
190762	ST VINCENT MED
190766	STUDEBAKER COMMUN
190766	COAST PLAZA MED CTR
190784	TEMPLE COMMUNITY
190790	TRI-CITY REGIONAL MED CTR
190796	UCLA
190810	NORTHRIDGE SHERMAN WAY
190810	VALLEY VAN NUYS
190812	VALLEY PRESB MEM
190814	VAN NUYS COMMUNITY (OLD)
190818	VERDUGO HILLS
190827	CAREUNIT LA (OLD)
190847	WASHINGTON CULVER
190854	DOCTORS LA
190854	DRS LA
190857	WEST COVINA
190859	COLUMBIA WEST HILLS
190859	WEST HILLS REG MED CTR
190859	HUMANA WEST HILLS
190860	NU-MED REGIONAL MED CTR
190860	WEST VALLEY HOSP & HEALTH
190860	WEST PARK
190862	RANCHO ENCINO
190867	WESTLAKE COMMUN
190873	WESTSIDE LA
190878	WHITE MEMORIAL
190883	WHITTIER MED CTR
190891	WOODRUFF COMMUNITY
190893	WOODRUFF GABLES (OLD)
190949	HENRY MAYO NEWHALL
191002	HERMOSA BEACH (OLD)
191210	USC UNIVERSITY HOSPITAL
191216	KENNETH NORRIS USC
191227	UCLA HARBOR
191227	HARBOR GENERAL
191228	LA CO USC MED
191228	USC MEDICAL CENTER
191230	KING-DREW
191230	MARTIN LUTHER KING
191230	LA CO KING-DREW MED
191231	LA CO OLIVE VIEW
191231	MIDVALLEY
191261	LA CO HIGH DESERT
191306	LA CO RANCHO AMIGOS
191306	RANCHO LOS AMIGOS
191306	LOS AMIGOS
191320	MULLIKIN MED CTR
192070	SURGERY CENTER
193005	ANTELOPE VALLEY RAD ONC
193010	BEVERLY ONC & IMAGING CTR
193020	DOWNEY RAD ONC MED CLINIC
193055	KRANS MEDICAL PARTNERS
193080	PALM TUMOR CLINIC
193085	RADIATION ONC ASSOCIATES
193086	RAD ONC CONSULT MED GRP
193090	SANTA MONICA CANCER RX
193100	VALLEY CANCER INSTITUTE
193104	VALLEY TUMOR MED GRP
193110	WESTERN TUMOR MED GRP
193113	WHITTIER ONCOLOGY CLINIC
193117	WHILSHIRE ONC MED GRP
199990	NAVAL LONG BEACH
199991	VA LONG BEACH
199992	VA W LOS ANGELES
199992	VA WADSWORTH
199992	VA BRENTWOOD
199993	FED CORRECT SN PDRO

199993	TERMINAL ISLAND
199994	VA SEPULVEDA
199995	E DOHENEY EYE FND
199996	LA CO JAIL HOSP
199997	BREAST CENTER, THE
200692	CHOWCHILLA DIST
201281	MADERA COMMUNITY
201819	CHILDRENS HOSP CENTRAL CA
201819	VALLEY CHILDRENS
210992	KAISER SAN RAFAEL
210993	KENTFIELD MED
211006	MARIN GENERAL
211056	ROSS GENERAL (OLD)
211167	SAN QUENTIN PR
212637	NOVATO COMMUNITY
219998	HAMILTON AFB (OLD)
220733	JOHN C FREMONT
230949	FRANK HOWARD MEM
230949	HOWARD MEMORIAL
231013	MENDOCINO COAST
231014	MENDOCINO COMMUN
231339	UKIAH GENERAL (OLD)
231350	UKIAH SURGERY CENTER
231396	UKIAH VALLEY MED
231396	UKIAH ADVENTIST
240803	BLOSS MEM DISTRICT (OLD)
240853	DOS PALOS MEMORIAL (OLD)
240924	MEMORIAL LOS BANOS
240924	LOS BANOS COMMUN
240942	MERCY MERCED COMMUNITY
240942	SUTTER MERCED
240942	MERCED COMMUNITY
024948	MERCY MERCED DOMINICAN
240948	MERCY MERCED
241082	WEST SIDE COMMUN (OLD)
249990	CASTLE AFB (OLD)
250955	SURPRISE VALLEY
250956	MODOC MED ALTURAS
260011	MAMMOTH
260011	CENTINELA MAMMOTH
261263	MONO GENERAL
270706	ALISAL COMMUNITY (OLD)
270706	COMMUNITY SALINAS (OLD)
270740	MONTEREY PENINSULA SURG
270744	MONTEREY PEN COMM
270777	GEORGE L MEE MEM
270777	MEE MEMORIAL
270831	NATIVIDAD MEM CTR
270875	SALINAS VALLEY MEM
271118	MONTEREY PENINSULA (OLD)
279990	SILAS B HAYS ARMY
279990	FORT ORD
281047	QUEEN VALLEY NAPA
281078	ST HELENA HEALTH
281266	NAPA STATE
281297	HOLDERMAN MEMORIAL
290952	MINERS (OLD)
291023	SIERRA NEVADA MEM
291053	TAHOE FOREST
300032	CHILDRENS ORANGE
300125	IRVINE REGIONAL HOSPITAL
300125	IRVINE MED CTR
300225	ORANGE COAST MEM MED CTR
300225	FHP FOUNTAIN VLY
300227	TALBERT ORANGE CO MEDCTRS
300227	FHP ORANGE COUNTY MEDCTRS
301097	ANAHEIM GENERAL
301098	ANAHEIM MEMORIAL
301098	ANAHEIM MEMORIAL EAST
301109	BUENA PARK DOCTORS OLD
301109	BEACH COMMUNITY OLD
301126	BREA COMMUNITY
301132	KAISER ANAHEIM
301140	CHAPMAN MED CTR
301140	CHAPMAN GENERAL
301150	CHILDRENS HOSP AT MISSION
301155	COLLEGE COSTA MESA
301155	COSTA MESA MED CTR
301167	DOCTORS SANTA ANA
301167	DRS SANTA ANA OLD
301169	ST JUDE YORBA LINDA OLD
301170	FOUNTAIN VALLEY OP SURG
301175	FOUNTAIN VALLEY REG HOSP
301175	FOUNTAIN VALLEY COMM
301180	FULLERTON COMMUN (OLD)
301188	WESTERN ANAHEIM
301205	HOAG MEM PRESBYTER
301209	HUNTINGTON BEACH MED CTR
301209	COLUMBIA HUNTINGTON BEACH
301209	HUMANA HUNTINGTON
301232	FRIENDLY HILLS REG OLD
301232	LA HABRA COMMUNITY OLD
301234	LA PALMA INTERCOMM
301242	BUENA PARK COMMUN (OLD)
301248	LOS ALAMITOS MED
301258	COASTAL COMMUNITIES
301258	MERCY GEN SANTA ANA
301262	MISSION HOSP REG MED CTR
301262	MISSION COMMUNITY
301279	UC IRVINE
301279	UCI
301282	PACIFICA COMMUNITY OLD
301283	GARDEN GROVE MED
301297	PLACENTIA-LINDA
301314	SANTA ANA MED
301317	SADDLEBACK MEM MED CTR
301317	SADDLEBACK COMMUNITY
301325	SAN CLEMENTE GEN
301325	COLUMBIA SAN CLEMENTE MED
301325	SAMARITAN MED CTR
301337	SOUTH COAST MED
301340	ST JOSEPH ORANGE
301342	ST JUDE FULLERTON
301345	MIDWOOD COMMUNITY (OLD)
301357	TUSTIN HOSPITAL MED CTR
301357	HEALTHCARE TUSTIN
301379	WEST ANAHEIM MED CTR
301379	COLUMBIA WEST ANAHEIM MED
301379	HUMANA W ANAHEIM
301380	HUMANA WESTMINSTER (OLD)
301566	WESTERN MED SN ANA
301570	WOMENS BREAST CTR

301761	ANAHEIM MEM OUTPT (OLD)
301761	ANAHEIM MEM WEST (OLD)
301761	MARTIN LUTHER MED (OLD)
301781	FAIRVIEW STATE
301782	RAD ONC MED GRP SO CALIF
301785	MISSION VIEJO RAD ONC GRP
302000	DIGESTIVE DISEASE CENTER
302005	ORANGE CO INST GE & ENDO
309990	PACIFIC RAD ONCOL
310791	SUTTER AUBURN FAITH
310791	AUBURN FAITH COMM
311000	SUTTER ROSEVILE COMM
311000	ROSEVILLE COMM
311005	ROSEVILLE RAD ONC CTR
311010	AUBURN RAD ONC CTR
311015	KAISER ROSEVILLE
314010	AUBURN SURGERY CENTER
320859	EASTERN PLUMAS
320874	INDIAN VALLEY DIST
320986	PLUMAS DISTRICT
321016	SENECA DISTRICT
331145	CORONA REGIONAL MED CTR
331145	CIRCLE CITY
331152	CORONA COMMUNITY (OLD)
331155	RADIATION THERAPY MED GROUP
331155	RAD THERAPY MED GROUP
331158	CORONA RAD ONC MED CLINIC
331164	DESERT
331168	EISENHOWER MED CTR
331194	HEMET VALLEY MED CTR
331216	JOHN F KENNEDY MEM
331226	RIVERSIDE KNOLLWD (OLD)
331230	KAISER RIVERSIDE
331233	VALLEY PLAZA DOCTORS HOSP
331233	LAKESIDE HOSPITAL
331235	MENIFEE VALLEY
331239	INLAND VALLEY REG MED CTR
331239	MISSION VALLEY MED CTR
331245	MORENO VALLEY MED CTR
331288	PALO VERDE
331293	PARKVIEW COMMUN
331312	RIVERSIDE COMMUN
331313	RIVERSIDE COUNTY REG MED
331313	RIVERSIDE GEN UNIV
331326	SAN GORGONIO MEM HOSP
331326	SAN GORGONIO PASS
311350	RANCHO SPRINGS MED CTR
331350	SHARP HEALTHCARE MURRIETA
331355	TEMECULA CANCER CTR
332172	CHRISTIAN MED CTR (OLD)
332173	VALLEY REG ONC CTR
339990	MARCH AFB
339991	SUN CITY CA CLIN
340869	MERCY AMERICAN RIVER
340869	ESKATON AMER RIV
340913	KAISER SACRAMENTO
340920	KAISER SO SACTO
340947	MERCY GEN SACTO
340947	MERCY SACRAMENTO
340948	MERCY SACRAMENTO ROC
340950	MERCY SAN JUAN
340951	METHODIST SACTO
340955	MERCY SAN JUAN ROC
341006	UC DAVIS
341006	UCD
341040	VENCOR SACRAMENTO
341051	SUTTER GEN SACTO (OLD)
341052	SUTTER MED CTR SACRAMENTO
341052	SUTTER COMMUN HOSPITALS
341052	SUTTER MEM SACTO
341055	SUTTER RAD ONCOLOGY CTR
341065	MERCY FOLSOM
341085	VA SACRAMENTO
341088	GREATER SACRAMENTO SURG
341608	SUTTER SURGERY CENTER
342097	SACRAMENTO COMMUN (OLD)
342259	PLASTIC SURG CTR MED GRP
344005	SACRAMENTO MIDTOWN ENDOSC
344015	HEALTHSOUTH SURG FORT SUT
344062	SUTTER SURGICAL CTR J STREET
344066	HEALTHSOUTH SURG ALHAMBRA
344118	MICHAEL J FAZIO MD SURG
349990	MATHER AFB
350784	HAZEL HAWKINS MEM
350784	HAWKINS MEMORIAL
350784	SAN BENITO DIST
361105	BARSTOW COMMUNITY
361110	BEAR VALLEY COMMUN
361144	COLUMBIA VALLEY HOSP
361144	CHINO COMMUNITY
361150	DESERT RADIATION ONCOLOGY
361150	DESERT RAD ONCOLOGY
361155	DESERT VALLEY
361166	KPC GLOBAL MED CTR
361166	US FAMILY CARE MED CTR
361166	DOCTORS MONTCLAIR
361166	DRS MONTCLAIR
361168	ANGELS
361168	HERITAGE
361170	INLAND RADIATION THERAPY
361170	INLAND RAD THERAPY
361223	KAISER FONTANA
361245	LOMA LINDA COMMUN (OLD)
361246	LOMA LINDA UNIV
361246	LOMA LINDA COMMUN
361250	MOJAVE RADIATION ONC CTR
361266	MOUNTAINS COMM
361266	SAN BERNARDINO MT
361274	VENCOR ONTARIO
361274	ONTARIO COMMUNITY
361308	REDLANDS COMMUNITY
361315	PATTON STATE
361318	SAN ANTONIO COMMUN
361320	ARROWHEAD REG MED CTR
361320	SAN BERNARDINO CO
361323	SAN BERNARDINO CM
361330	APPLE VALLEY RAD ONC
361339	ST BERNARDINE
361343	ST MARY REG MED CTR
361343	ST MARY DESERT VLY
361370	VICTOR VALLEY
361458	NEEDLES DESERT COMM

362041	HI DESERT MED CTR
362045	SAN BERNARDINO CANCER CTR
362045	COMMUNITY RAD ONC CTR
362046	PALM IMAGING
369990	WEED ARMY
369990	FORT IRWIN
369991	GEORGE AFB
369992	VA LOMA LINDA
369992	JERRY PETTIS MEM
369993	CAL INST FOR MEN
370000	BOYD, DAVID, MD
370652	ALVARADO MED CTR
370652	ALVARADO COMMUNITY
370658	SCRIPPS CHULA VISTA
370658	BAY MEDICAL CENTER
370660	BAY RADIOLOGY MED GRP OLD
370672	HARBOR VIEW MED OLD
370673	CHILDRENS SAN DIEGO
370674	CLAIREMONT COMMUN (OLD)
370683	COLLEGE PARK (OLD)
370686	SAN DIEGO GENERAL (OLD)
370686	SAN DIEGO PHYSICNS (OLD)
370688	ESCONDIDO SURGICAL CTR
370689	CORONADO
370690	SHARP MARY BIRCH
370693	SHARP CABRILLO
370694	SHARP MEMORIAL
370695	SHARP REES STEALY
370697	SCRIPPS EAST COUNTY OLD
370697	VALLEY MED EL CAJON OLD
370697	AMI VALLEY MED CTR OLD
370697	EL CAJON VALLEY OLD
370705	FALLBROOK DISTRICT
370710	FROST ST SURG CTR
370714	GROSSMONT DIST
370716	KAISER EL CAJON OLD
370721	HILLSIDE (OLD)
370730	KAISER SAN DIEGO
370735	LIVINGSTON MED CTR
370735	LIVINGSTON WHEELER
370744	MERCY SAN DIEGO
370746	MISSION BAY MEM (OLD)
370749	ALVARADO EAST (OLD)
370753	TRI-CITY WEST (OLD)
370755	PALOMAR MEMORIAL
370759	PARADISE VALLEY
370760	RAD ONC MED SPECIALISTS
370760	RADIATION MED GRP
370760	RADIOLOGY MED GRP
370765	SAN DIEGO AMB SURG CTR
370771	SCRIPPS LA JOLLA
370775	SMITH HANNA OLD
370776	SOUTHCOAST TUMOR INS (OLD)
370777	SOUTHWEST CANCER CARE
370780	TRI-CITY
370782	UC SAN DIEGO
370782	UCSD
370787	VILLA VIEW COMMUN
370790	ONCOLOGY THERAPIES INC
370790	VISTA RADIATION
370875	SHARP CHULA VISTA MED CTR
370875	COMMUN CHULA VISTA
370977	POMERADO
371256	SCRIPPS GREEN
371394	SCRIPPS ENCINITAS
372000	X-RAY MED GROUP LA MESA OLD
379990	NAVAL PENDLETON
379991	NAVAL SAN DIEGO
379992	VA SAN DIEGO
380769	CA PODIATRY (OLD)
380777	CHILDRENS SF (OLD)
380816	FRENCH SF (OLD)
380826	MARSHAL HALE (OLD)
380826	HAHNEMANN (OLD)
380857	KAISER SF
380865	LAGUNA HONDA REHAB
380895	MT ZION
380920	CALIFORNIA PACIFIC MEDCTR
380929	PACIFIC MED CTR (OLD)
380929	PRESBYTERIAN MED (OLD)
380929	PACIFIC PRESBYTER (OLD)
380933	DAVIES MED CTR
380933	RK DAVIES
380933	FRANKLIN
380933	RALPH K DAVIES
380939	SAN FRANCISCO GEN
380939	SF GENERAL
380954	SHRINERS SF
380960	ST FRANCIS SF
380964	ST LUKES SF
380965	ST MARYS SF
381154	UC SF MED CENTER
381154	UCSF MED CENTER
381154	UCMC SAN FRANCISCO
381160	UCSF STANFORD HEALTH CARE
382684	GARDEN SULLIVAN (OLD)
382715	CHINESE
389990	U PACIFIC DENTAL
389992	VA SAN FRANCISCO
389994	ST JOSEPH'S SF (OLD)
389995	LETTERMAN ARMY (OLD)
389995	PRESIDIO SAN FRAN (OLD)
390820	BEN SCHAFFER CA INST
390846	DAMERON
390850	ST DOMINICS
390922	DRS LODI
390922	LODI COMMUNITY
390922	DOCTORS LODI
390923	LODI MEMORIAL
391010	SAN JOAQUIN GEN
391020	KAISER STOCKTON CLINIC
391042	ST JOSEPHS STOCKTN
391050	ST TERESA RADIATION
391056	SUTTER TRACY COMMUNITY
391056	TRACY COMMUNITY
392232	ST JOSEPH OAK PARK (OLD)
392287	MANTECA
392287	DOCTORS MANTECA
392287	DRS MANTECA
394004	LODI OUTPATIENT SURG CTR
394023	SAN JOAQUIN LASER & SURG
400466	ARROYO GRANDE COMM

400480	FRENCH SN LUIS OBS
400500	MISSION MED ASSOCIATES
400500	SAN LUIS MED CLINIC
400511	SAN LUIS OBISPO GEN
400524	SIERRA VISTA
400548	TWIN CITIES COMMUN
400683	ATASCADERO STATE
409990	CAL MENS COLONY
410742	MILLS MEMORIAL
410752	CRYSTAL SPRINGS
410772	MILLS-PENNINSULA
410782	SAN MATEO COUNTY GENERAL
410782	HAROLD D CHOPE
410782	CHOPE
410804	KAISER REDWOOD CITY
410804	KAISER RWC
410806	KAISER SO SF
410806	KAISER SSF
410817	SETON MEDICAL CTR
410817	MARYS HELP
410820	RECOVERY INN MENLO PARK
410828	SETON MED CTR COASTSIDE
410828	ST CATHERINE
410852	PENINSULA MED CTR
410891	SEQUOIA
420483	GOLETA VALLEY
420491	LOMPOC DISTRICT
420493	MARIAN MEDICAL CTR
420506	PINECREST (OLD)
420514	SN BARBARA COTTAGE
420514	COTTAGE HOSPITAL
420522	SANTA YNEZ VALLEY
420528	ST FRANCIS SN BARB
420530	CA FOUNDATION SN BARBARA
420530	CA FDN SN BARBARA RAD CTR
420535	VALLEY COMMUNITY
420540	SANSUM MED CLINIC (OLD)
420544	SANSUM SANTA BARBARA MED
420545	SANTA BARBARA BREAST (OLD)
420545	SN BARBARA BREAST CA (OLD)
420550	SANTA BARBARA MED FDN (OLD)
421167	REHAB INST SANTA BARBARA
421167	SANTA BARBARA MEM
429990	VANDENBERG AFB
429991	LOMPOC PENITENTARY
430700	AGNEWS DEVEL CTR
430705	ALEXIAN BROTHERS (OLD)
430741	CHILDRENS STANFORD
430743	LOS GATOS COMMUN
430750	RECOVERY INN LOS GATOS
430763	EL CAMINO
430779	COLUMBIA GOOD SAM SN JOSE
430779	GOOD SAM SN CLARA VLY
430779	GOOD SAM SAN JOSE
430805	KAISER SN CLARA
430837	OCONNOR SAN JOSE
430850	ST LOUISE (OLD)
430879	COLUMBIA SAN JOSE MED CTR
430879	SAN JOSE MED CTR
430879	SAN JOSE HEALTH
430883	SANTA CLARA VALLEY
430884	CHABOYA CLINIC
430885	EAST VALLEY CLINIC
430886	EAST VALLEY PAVILLION
430887	SOUTH VALLEY CLINIC
430888	VALLEY HEALTH CTR
430905	STANFORD UNIV
430915	VALLEY WEST GEN (OLD)
430915	MISSION OAKS (OLD)
430924	ST LOUISE REG HOSP (OLD)
430924	COLUMBIA SOUTH VALLEY
430924	SOUTH VALLEY HOSP
430924	WHEELER
431500	ST LOUISE CANCER CARE CTR
431506	KAISER SANTA TERESA
431506	SANTA TERESA COMM
431722	OCONNOR CAMPBELL (OLD)
432001	ST LOUISE REG MED CTR
432002	REG MED CTR OF SAN JOSE
438800	CAMINO MED GRP
439995	VA PALO ALTO (VAPAHCS)
439995	VAPA HEALTH CARE SYSTEM
439998	PALO ALTO MED FND
439998	PAMC
439999	VA PALO ALTO (OLD)
440755	DOMINICAN ST CRUZ
440886	SANTA CRUZ GENERAL
440890	SANTA CRUZ MED CLINIC
440894	SANTA CRUZ RAD ONC MED GR
440905	SUTTER MATERN & SURG CTR
440920	WATSONVILLE COMMUN
441807	SANTA CRUZ COMMUN (OLD)
450900	DOCTORS' SURGERY CENTER
450936	MAYERS MEMORIAL
450938	REDDING CANCER RX CTR
450940	REDDING MED CTR
452005	REDDING ENDOSCOPY CENTER
450949	MERCY REDDING
450950	PATIENTS HOSP OF REDDING
451018	SHASTA GENERAL (OLD)
452000	REDDING SURGERY CENTER
461024	SIERRA VALLEY DIST
470871	MERCY MT SHASTA
470871	MT SHASTA COMMUNITY
471031	FAIRCHILD MED CTR
471031	SISKIYOU GENERAL
480989	KAISER VALLEJO
481015	BROADWAY VALLEJO (OLD)
481070	VACA VALLEY HOSP
481094	SUTTER SOLANO MED CTR
481094	VALLEJO GENERAL
481357	NORTHBAY MED CTR
484003	SOLANO SURGERY CENTER
484021	SPECIALISTS SURGERY CTR
485000	CALIF MEDICAL FACILITY
485000	CALIF MED FAC VACAVILLE
489990	TRAVIS AFB
489990	DAVID GRANT USAF
490001	PETALUMA VALLEY
490907	NORTH COAST HEALTHCARE
490907	NORTH COAST REHAB
490907	BROOKWOOD

490919	SUTTER MED CTR
490919	SANTA ROSA COMMUN
490964	HEALDSBURG GENERAL
491012	SANTA ROSA GENERAL (OLD)
491064	SANTA ROSA MEM
491070	SONOMA COUNTY REDWOOD REG
491076	SONOMA VALLEY
491103	WARRACK MED CTR
491267	SONOMA STATE
491338	PALM DRIVE
491400	KAISER SANTA ROSA
500850	DEL PUERTO (OLD)
500852	DOCTORS MODESTO
500852	DRS MODESTO
500867	EMANUEL MED CTR
500938	MEMORIAL CERES
500939	MEMORIAL MODESTO
500954	MODESTO CITY (OLD)
500967	OAK VALLEY DIST
501015	STANISLAUS MED CTR
501015	SCENIC GENERAL (OLD)
510882	FREMONT
511049	SUTTER COM YUBA CY (OLD)
511060	YUBA SUTTER RAD ONC CTR
514009	ENDOSCOPY CENTER
514010	FEATHER RIVER SURG CTR
514021	SUTTER NORTH PROCEDURE
520837	CORNING MEMORIAL (OLD)
521041	ST ELIZABETH COMM
522052	RED BLUFF TUMOR INSTITUTE
531059	TRINITY GENERAL
540680	ALTA HOSPITAL DIST
540734	KAWEAH DELTA DIST
540740	SEQUOIA REG CANCER CTR
540746	LINDSAY MED CTR
540755	EXETER MEMORIAL
540798	SIERRA VIEW DIST
540816	TULARE DISTRICT
540827	VISALIA COMMUNITY
541123	PORTERVILLE DEVELOP CTR
541123	PORTERVILLE STATE
551034	SONORA COMMUNITY
551061	TUOLUMNE GENERAL
552209	SIERRA SONORA
560468	ANACAPA ADVENTIST (OLD)
560468	PORT HUENEME ADVENT (OLD)
560470	ONCOLOGY INSTITUTES
560473	COMMUNITY MEMORIAL
560473	SAN BUENAVENTURA
560475	CHANNEL ISLANDS SURGI CTR
560476	BUENAVENTURA MED CTR
560480	COASTAL CITIES MRI & ROC
560481	VENTURA CO MED CTR
560482	VENTURA CO RAD ONC CTR
560485	COASTAL RAD ONC MED GROUP
560492	LOS ROBLES REGIONAL
560495	LOS ROBLES SURGICENTER
560501	OJAI VALLEY COMMUN
560502	CHANNEL ISLANDS (OLD)
560502	OXNARD COMMUNITY (OLD)
560505	PETERSON MED CLINIC (OLD)
560508	PLEASANT VALLEY
560521	SANTA PAULA MEM
560525	SIMI VALLEY ADVENT
560526	SIMI VALLEY COMMUN (OLD)
560529	ST JOHNS OXNARD
560681	CAMARILLO STATE
571086	WOODLAND MEMORIAL
571093	YOLO GENERAL
571139	COWELL DAVIS (OLD)
571215	SUTTER DAVIS
580996	RIDEOUT MEMORIAL
584003	TWIN CITIES SURGICENTER
589990	BEALE AFB
710585	TALBERT DESERT SIERRA
800007	CONNECTICUT SEER
800033	ATLANTA SEER
800041	DETROIT SEER
800053	IOWA SEER
800084	UTAH SEER
800086	NEW MEXICO SEER
800093	SEATTLE SEER
800099	HAWAII SEER
970000	TREATMENT FOLLOW BACK
989002	MAINE STATE REG
989003	NEW HAMPSHIRE STATE REG
989004	VERMONT STATE REG
989005	MASSACHUSETTS STATE REG
989006	RHODE ISLAND STATE REG
989007	CONNECTICUT STATE REG
989008	NEW JERSEY STATE REG
989011	NEW YORK STATE REG
989014	PENNSYLVANIA STATE REG
989017	DELAWARE STATE REG
989021	MARYLAND STATE REG
989022	DISTRICT OF COLUMBIA REG
989022	WASHINGTON D.C. REG
989023	VIRGINIA STATE REG
989024	WEST VIRGINIA STATE REG
989025	NORTH CAROLINA STATE REG
989026	SOUTH CAROLINA STATE REG
989031	TENNESSEE STATE REG
989033	GEORGIA STATE REG
989035	FLORIDA STATE REG
989037	ALABAMA STATE REG
989039	MISSISSIPPI STATE REG
989041	MICHIGAN CANCER REG
989043	OHIO STATE REG
989045	INDIANA STATE REG
989047	KENTUCKY STATE REG
989051	WISCONSIN CA REPORTING
989052	MINNESOTA STATE REG
989053	IOWA STATE REG
989054	NORTH DAKOTA STATE REG
989056	MONTANA STATE REG
989061	ILLINOIS STATE CA REG
989063	MISSOURI STATE REG
989065	KANSAS STATE REG
989067	NEBRASKA STATE REG
989071	ARKANSAS STATE REG
989073	LOUISIANA STATE REG
989075	OKLAHOMA STATE REG

989077	TEXAS STATE REG
989081	IDAHO STATE REG
989082	WYOMING STATE REG
989083	COLORADO CENTRAL CA REG
989084	UTAH STATE REG
989085	NEVADA, STATE REGISTRY OF
989085	NEVADA STATEWIDE CA REG
989086	NEW MEXICO STATE REG
989087	ARIZONA CANCER REGISTRY
989091	ALASKA STATE REG
989093	WASHINGTON STATE REG
989095	OREGON STATE REG
989099	HAWAII STATE REG
989195	ROGUE VALLEY MED CTR
989990	MAYO CLINIC
989991	MD ANDERSON
989992	FRED HUTCHINSON
989993	MEM SLOAN KETTERNG
989999	VA RENO (OLD)
999980	TALBERT MED GRP NOS
999980	FHP NOS
999981	HUMANA NOS
999982	KAISER NOS
999985	TALBERT PHYSICIANS ONLY
999985	FHP PHYSICIANS ONLY
999987	UNSPEC CENTRAL CA HOSP
999988	UNSPEC NORTHERN CA HOSP
999989	UNSPEC SOUTHERN CA HOSP
999990	HOSPICE
999991	HOME HEALTH
999992	SKILLED NURSING FACILITY
999993	STAFF PHYSICIAN
999994	UNSPEC NONCAL HOSP
999995	NON-HOSPITAL NOS
999996	PHYSICIAN ONLY
999996	MD ONLY
999997	UNSPEC BAY AREA H
999998	UNSPEC CALIF HOSP
999999	UNKNOWN HOSP

APPENDIX G.1
CODES FOR RELIGIONS
(in numerical order)

01	NONE
02	AGNOSTIC
03	ATHEIST
04	*NONE, AGNOSTIC, ATHEIST (OLD)
05	CATHOLIC
05	*ROMAN CATHOLIC
06	CHRISTIAN, NOS
06	PROTESTANT, NOS
	PROTESTANT DENOMINATIONS:
07	*AFRICAN METHODIST EPISCOPAL (AME)
08	ANGLICAN
09	BAPTIST
08	CHURCH OF ENGLAND
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
34	*LEBANESE MARONITE
34	*MARONITE
29	ORTHODOX, ARMENIAN
31	ORTHODOX, GREEK
32	ORTHODOX, RUSSIAN
33	ORTHODOX, SERBIAN
32	RUSSIAN ORTHODOX
33	SERBIAN ORTHODOX
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
54	COVENANT
55	DIVINE SCIENCE
56	EVANGELICAL
57	FUNDAMENTAL
58	FOURSQUARE
59	FULL GOSPEL
60	HOLINESS
53	HOLY CONGREGATIONAL
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
74	MOLIKAN
74	MOLOKAN
73	OCCULT
73	PEACE OF MIND
73	PEOPLE'S
73	SELF-REALIZATION
73	SOCIETY OF LIFE
73	SPIRITUALIST
73	THEOSOPHY
73	TRUTH SEEKER
75	*WESTERN RELIGION OR CREED, OTHER
75	*WESTERN RELIGION OR CREED, NOS
76	KO
	EASTERN RELIGIONS:
77	BUDDHIST
78	DROUZE
79	*CONFUCIANISM
80	*JAIN
81	*NATION OF ISLAM
82	MOSLEM
82	MUSLIM
82	MOHAMMEDAN
83	HINDU
84	ISLAM
89	ORIENTAL PHILOSOPHY
85	*PARSEE
86	SHINTO
87	*SIKH
79	*TAOISM
88	VEDANTA
77	*ZEN
77	*ZEN BUDDHISM
85	ZOROASTRIAN
89	*EASTERN REGLIGION, OTHER
89	*EASTERN RELIGION, NOS
90	*AMERICAN INDIAN RELIGIONS
91	*HAITIAN/AFRICAN/BRAZILIAN RELIGIONS, OTHER
90	*NATIVE AMERICAN TRADITIONAL RELIGIONS
91	*SANTORIA
92	*SHAMANISM
91	*VOODOO
93	*OTHER TRADITIONAL OR NATIVE RELIGION
98	*OTHER
99	UNSPECIFIED, UNKNOWN

*NEW OR REVISED LABEL

APPENDIX G.2
CODES FOR RELIGIONS
(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, NOS	06
CHRISTIAN REFORMED	18
CHRISTIAN SCIENCE	36
CHRISTIAN SECTS, OTHER	69
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	11
CONGREGATIONAL HOLY	53
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	70
JEWISH ORTHODOX	71
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	01
NONE, AGNOSTIC, ATHEIST (OLD)	04
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	98
OTHER TRADITIONAL OR NATIVE RELIGION	93
PARSEE	85
PEACE OF MIND	73
PENTACOSTAL	64
PEOPLE'S	73

Codes for Religions (in alphabetical order)

PRESBYTERIAN	15	OTHER
PROTESTANT DENOMINATION,	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	
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	77	
ZEN BUDDHISM	77	
ZOROASTRIAN	85	

APPENDIX H
SUMMARY OF CODES

The codes used for reporting cancer data to the CCR are summarized below. For explanations of the codes and status of data item reportability to the CCR, refer to the sections indicated. Only coded items, not text fields, are listed here.

SECTION	ITEM	CODE
REGISTRY INFORMATION		
III.1.1	Abstractor	Three initials of abstractor; flush left, no spaces between initials XXX = unknown
II.2.3	Accession Number	Nine-digit number assigned to patient by hospital tumor registry
II.2.4	Sequence Number	00 ONE PRIMARY MALIGNANCY 01 FIRST OF TWO OR MORE PRIMARIES 02 SECOND OF TWO OR MORE PRIMARIES 10 TENTH OF TEN OR MORE PRIMARIES 11 ELEVENTH OF ELEVEN OR MORE PRIMARIES 99 SEQUENCE UNKNOWN
II.2.1	Year First Seen	Four–digit number assigned by the hospital tumor registry to each registered case
III.1.4	Reporting Hospital	Six-digit number assigned by CCR (see Appendix F); blank if none assigned
III.1.6	ACoS Approved Flag	1 CANCER PROGRAM APPROVED 2 CANCER PROGRAM NOT APPROVED Blank CASES DIAGNOSED BEFORE 1999
PATIENT IDENTIFICATION		
III.2.1	Patient's Name	Uppercase alpha, except single hyphen allowed within last name; maximum of 25 characters for last name, 14 letters for first name, and 14 letters for middle name/initial; no spaces within name; middle name may be blank

III.2.1.4	Maiden Name	Uppercase alpha, except hyphen; first 15 characters of maiden surname; no spaces within name; blank if not applicable
III.2.1.5	Alias Last Name	Uppercase alpha, except hyphen; first 15 characters of alias surname; no spaces within name; blank if not applicable
III.2.1.6	Alias First Name	Uppercase alpha, except hyphen, 15 characters, no spaces within name; blank if not applicable
III.2.1.8	Name Suffix	Alpha; 3 characters; may be left blank
III.2.1.9	Mother's First Name	Alpha; 14 characters; may be left blank
III.2.2	Medical Record No.	Maximum of 12 letters or numbers assigned to patient/admission by reporting hospital, flush left, without special characters or spaces within number; blank if none assigned
III.2.3	Social Security No. and Suffix	Nine-digit number; up to two-character suffix; flush left; blank if unknown; valid suffixes determined by Social Security Administration
III.2.5.2	Number & Street	Maximum of 40 letters, numbers, spaces, and the special characters (#), (/), (-), (,), and (.), flush left; if unknown enter "UNKNOWN"
III.2.5.2	City	Maximum of 20 letters and spaces only; if unknown enter "UNKNOWN"
III.2.5.2	State	Two–letter postal abbreviation (see Appendix B) *XX = Resident of country other than the US or Canada and the country is known* *YY = Resident of country other than the US or Canada, and country is unknown* *ZZ = Resident of the US, NOS; Canada, NOS; residence unknown*
III.2.5.2	Zip	Nine-character field for five- or nine-digit postal code, flush left 8's = NON-USA, NON-CANADIAN RESIDENT 9's = UNKNOWN
III.2.5.2	County of Residence	Three-digit code for county at DX in California (see Appendix L); for non-USA or non-Canadian residents, three-digit code for country (see Appendix D) 000 NON-CALIFORNIA RESIDENT; USA, NOS; CALIFORNIA RESIDENT, COUNTY UNKNOWN 999 COUNTRY UNKNOWN

III.2.4 & VII.3.2	Phone	Ten-digit telephone number, including area code; no hyphens; may be blank; enter 0's for no phone
III.2.6	Marital Status	1 SINGLE 2 MARRIED 3 SEPARATED 4 DIVORCED 5 WIDOWED 9 UNKNOWN
III.2.7	Sex	1 MALE 2 FEMALE 3 HERMAPHRODITE 4 TRANSSEXUAL 9 UNKNOWN
III.2.8	Religion	Two-digit code (see Appendix G)
III.2.9.1	Race 1	01 WHITE 02 BLACK 03 AMERICAN INDIAN, ALEUTIAN, OR ESKIMO 04 CHINESE 05 JAPANESE 06 FILIPINO 07 HAWAIIAN 08 KOREAN 09 ASIAN INDIAN, PAKISTANI 10 VIETNAMESE 11 LAOTIAN 12 HMONG 13 KAMPUCHEAN (CAMBODIAN) 14 THAI 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 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

III.2.9.1 Race 2-5

01	WHITE
02	BLACK
03	AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
04	CHINESE
05	JAPANESE
06	FILIPINO
07	HAWAIIAN
08	KOREAN
09	ASIAN INDIAN, PAKISTANI
10	VIETNAMESE
11	LAOTIAN
12	HMONG
13	KAMPUCHEAN (CAMBODIAN)
14	THAI
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
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

*Note: these races were previously coded 09 - Asian Indian. Per the 2004 SEER Race Code Guideline, these cases are coded as 96 Other Asian. For consistency in these codes over time, the CCR created a new code, code 90 for Other South Asian. These cases will be converted from 90 to 96 for calls for data.

III.2.9.2 Spanish Hispanic/Origin

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 on or after January 1, 2005 forward)*
6	SPANISH, NOS; HISPANIC, NOS, LATINO, NOS (evidence that Hispanic cannot be assigned to codes 1-5)
7	SPANISH SURNAME ONLY (only evidence is surname or maiden name)*
8	*DOMINICAN REPUBLIC (for cases diagnosed on or after January 1, 2005)*
9	UNKNOWN WHETHER SPANISH OR NOT

*Use Appendix O to code this field.

III.2.10	Birth Date Month	01-12 for January - December 99 = UNKNOWN
	Day	01-31 99 = UNKNOWN
	Year	Four-digit year of birth 9999 = UNKNOWN
III.2.11	Age at Diagnosis	Three-digit age at diagnosis 000 LESS THAN ONE YEAR OLD 999 UNKNOWN AGE
III.2.12	Birthplace	Three-digit code (see Appendix D)
III.2.13	Occupation	Four-digit code, U.S. Bureau of the Census 1990 occupation and industry classification; leave blank because entered by regional or central registry
III.2.13	Industry	Four-digit code (see Occupation, above); leave blank
III.2.14	Patient No Research Contact Flag	0 NO FLAG 1 HOSPITAL FIRST NOTIFIED 2 REGION FIRST NOTIFIED 3 CCR FIRST NOTIFIED 4 OUT OF STATE CASE, NOT FOR RESEARCH

CASE IDENTIFICATION

III.3.1	Date of Admission	MMDDYYYY (unknown = 99 or 9999 for unknown year)
III.3.2	Dates of Inpatient Admission and Inpatient Discharge	MMDDYYYY (unknown = 99 or 9999 for unknown year); may be blank
III.3.3	Date of Diagnosis	MMDDYYYY (unknown = 99 or 9999 for unknown year)

III.3.5 Class of Case

ANALYTIC–CODES 0, 1, and 2

0 FIRST DIAGNOSED AT REPORTING HOSPITAL SINCE ITS REFERENCE DATE, BUT ENTIRE FIRST COURSE OF THERAPY GIVEN ELSEWHERE
1 FIRST DIAGNOSED AT REPORTING HOSPITAL SINCE ITS REFERENCE DATE, AND EITHER (a) RECEIVED ALL OR PART OF FIRST COURSE OF THERAPY AT THE HOSPITAL, OR (b) WAS NEVER TREATED
2 FIRST DIAGNOSED AT ANOTHER HOSPITAL AND EITHER (a) RECEIVED ALL OR PART OF THE FIRST COURSE OF THERAPY AT THE REPORTING HOSPITAL AFTER ITS REFERENCE DATE, OR (b) PLANNING OF THE FIRST COURSE OF THERAPY WAS DONE PRIMARILY AT THE REPORTING HOSPITAL

NON-ANALYTIC Codes 3–9

3 FIRST DIAGNOSED AT ANOTHER HOSPITAL AND EITHER (a) ENTIRE FIRST COURSE OF THERAPY* WAS GIVEN ELSEWHERE, (b) WAS NEVER TREATED, or (c) UNKNOWN IF TREATED
4 FIRST DIAGNOSED AT REPORTING HOSPITAL BEFORE ITS REFERENCE DATE
5 FIRST DIAGNOSED AT AUTOPSY
6 DIAGNOSED AND RECEIVED ALL OF THE FIRST COURSE OF TREATMENT IN A STAFF PHYSICIAN'S OFFICE. (PER THE AMERICAN COLLEGE OF SURGEONS, THESE CASES ARE NON-ANALYTIC AND REPORTABILITY IS OPTIONAL.)
7 PATHOLOGY REPORT ONLY. PATIENT DOES NOT ENTER THE REPORTING FACILITY AT ANY TIME FOR DIAGNOSIS OR TREATMENT. THIS CATEGORY EXCLUDES CASES DIAGNOSED AT AUTOPSY
8 DIAGNOSIS WAS ESTABLISHED BY DEATH CERTIFICATE ONLY. USED BY CENTRAL REGISTRIES ONLY.
9 PATIENT TREATED AT REPORTING HOSPITAL BUT DATE OF DIAGNOSIS IS UNKNOWN AND CANNOT BE REASONABLY ESTIMATED

III.3.6 Type of Reporting Source

1 HOSPITAL INPATIENT/OUTPATIENT OR CLINIC
3 LABORATORY
*4 PRIVATE MEDICAL PRACTITIONER
*5 NURSING HOME, CONVALESCENT HOSPITAL, OR HOSPICE
6 AUTOPSY ONLY
*7 DEATH CERTIFICATE ONLY

NOTE: Code 2 (Clinic) will still be accepted.
*Codes 4, 5, and 7 are not used by hospitals.

III.3.7 Type of Admission

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)

III.3.8 Casefinding Source

Case first identified in cancer-reporting facility:

10 REPORTING HOSPITAL, NOS
20 PATHOLOGY DEPARTMENT REVIEWS
21 DAILY DISCHARGE REVIEW
22 DISEASE INDEX REVIEW
23 RADIATION THERAPY DEPARTMENT/CENTER
24 LABORATORY REPORTS
25 OUTPATIENT CHEMOTHERAPY
26 DIAGNOSTIC IMAGING/RADIOLOGY
27 TUMOR BOARD
28 HOSPITAL REHABILITATION SERVICE OR CLINIC
29 OTHER HOSPITAL SOURCE, INCL. CLINIC, NOS OR OPD, NOS

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

30 PHYSICIAN-INITIATED CASE
40 CONSULTATION-ONLY OR PATHOLOGY-ONLY REPORT
50 PRIVATE PATHOLOGY LABORATORY REPORT
60 NURSING-HOME-INITIATED CASE
70 CORONER'S-OFFICE RECORDS REVIEW
80 DEATH CERTIFICATE FOLLOW-BACK
85 OUT OF STATE CASE SHARING
90 OTHER NON-REPORTING HOSPITAL SOURCE
95 QUALITY CONTROL REVIEW
99 UNKNOWN

III.3.9 Payment Source Primary and Secondary

01 NOT INSURED
02 NOT INSURED, SELF-PAY
10 INSURANCE, NOS
20 MANAGED CAR*E*
28 HMO
29 PPO
31 MEDICAID
35 MEDICAID ADMINISTERED THROUGH A MANAGED CARE PLAN
36 MEDICAID WITH MEDICARE SUPPLEMENT
50 MEDICARE
51 MEDICARE WITH SUPPLEMENT
52 MEDICARE WITH MEDICAID SUPPLEMENT
53 TRICARE
54 MILITARY
55 VETERANS AFFAIRS
56 INDIAN/PUBLIC HEALTH SERVICE
60 COUNTY FUNDED, NOS
99 INSURANCE STATUS UNKNOWN

III.3.10	Hospital Referred From	Six-digit number assigned by CCR (see Appendix F); 0's if not referred
III.3.11	Hospital Referred To	Six-digit number assigned by CCR (see Appendix F); 0's if not referred
III.3.12	Physicians	Eight-digit code based on physician's state license number (7 fields); may enter dentist's and osteopath's license number; may enter out-of-state license but first character must be an X; blank if not applicable; Attending Physician may not be blank. If there is no attending physician, or if it cannot be determined who the attending physician is, the code for unknown physician or license number not assigned (99999999) must be entered.

TUMOR DATA

IV.1.7.1	Pathology Report Number-Biopsy/FNA	Ten-digit, alpha numeric, left justified. Special characters allowed. May be left blank.
IV.1.7.2	Pathology Report Number-Surgery	Ten-digit, alpha numeric, left justified. Special characters allowed. May be left blank.

IV.2	Diagnostic Confirmation	1	POSITIVE HISTOLOGY
		2	POSITIVE CYTOLOGY, NO POSITIVE HISTOLOGY
		4	POSITIVE MICROSCOPIC CONFIRMATION, METHOD NOT SPECIFIED
		5	POSITIVE LABORATORY TEST OR MARKER STUDY
		6	DIRECT VISUALIZATION WITHOUT MICROSCOPIC CONFIRMATION
		7	RADIOGRAPHY WITHOUT MICROSCOPIC CONFIRMATION
		8	CLINICAL DIAGNOSIS ONLY
		9	UNKNOWN WHETHER OR NOT MICROSCOPICALLY CONFIRMED
V.1	Primary Site	Four-digit ICD-O-3 code	
V.2	Laterality	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
		9	PAIRED SITE, BUT NO INFORMATION AVAILABLE CONCERNING LATERALITY
V.3	Histology–Type and Behavior	Five-digit ICD-O-3 code	
V.3.5	Histology– Grade/Diff.	One-digit ICD-O-3 code	

V.4.1 Extent of Disease

EOD items may be blank if not abstracted prior to January 1, 1994. For cases diagnosed 1/1/94 and after, these fields must be coded. For SEER regions, the date is earlier (1/1/88 for Region 8, and 1/1/92 for Region 1 and Region 9). Please refer to SEER Extent of Disease - 1988 Codes and Coding Instructions - for codes. *With the implementation of Collaborative Staging the Regional Nodes Positive and Examined fields are the same fields for CS and for EOD. However, effective with cases diagnosed January 1, 2004 forward, the codes for Regional Nodes Positive have changed. Cases diagnosed prior to January 1, 2004 will be converted.*

NOTE: Any cases entered after the conversion process should apply the new codes regardless of date of diagnosis. The new codes are as follows:

00	*ALL NODES EXAMINED ARE NEGATIVE.*
01-89	*1-89 NODES ARE POSITIVE. (CODE EXACT NUMBER OF NODES POSITIVE)*
90	*90 OR MORE NODES ARE POSITIVE*
95	*POSITIVE ASPIRATION OF LYMPH NODE(S) WAS PERFORMED*
97	*POSITIVE NODES ARE DOCUMENTED, BUT THE NUMBER IS UNSPECIFIED*
98	*NO NODES EXAMINED*
99	*IT IS UNKNOWN WHETHER NODES ARE POSITIVE; NOT APPLICABLE; NOT STATED IN PATIENT RECORD*

V.4.2 Collaborative Staging

Beginning with cases diagnosed January 1, 2004 forward and for cases with an unknown date of diagnosis first seen at your facility after January 1, 2004, 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 (Derived AJCC T, Derived AJCC N, Derived AJCC M, Derived AJCC Stage Group, Derived SS1977, and Derived SS2000) for all cases. These required data items include:

CS Tumor Size
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

**Definition changes were made to codes 90-97. See Section V.4.1 for the table of new codes for Regional Nodes Positive.*

The following Collaborative Staging data items are not required by the CCR, but are to be sent from CoC approved facilities:

CS Tumor Size/Extension Evaluation
CS Lymph Node Evaluation
CS Metastasis Evaluation
Derived AJCC T Descriptor
Derived AJCC N Descriptor
Derived AJCC M Descriptor

Please refer to the Collaborative Staging Manual for coding instructions. Cases diagnosed prior to January 1, 2004 should continue to use the EOD fields with the exception of the Regional Nodes Positive field.

V.5.1 Stage at Diagnosis

Stage at Diagnosis is not required with cases diagnosed on or after January 1, 1994. Hospitals wishing to do so may continue its use. Cases diagnosed prior to January 1, 1994 must continue to be staged using SEER Summary Staging.

0 IN SITU
1 LOCALIZED
2 REGIONAL, DIRECT EXTENSIONS ONLY
3 REGIONAL, NODES ONLY
4 REGIONAL, DIRECT EXTENSION AND NODES

		5 REGIONAL, NOS 7 DISTANT METASTASES OR SYSTEMIC DISEASE (REMOTE) 8 NOT APPLICABLE (for coding benign brain tumors, effective with cases diagnosed 1/1/2004 forward) 9 UNSTAGEABLE; UNKNOWN Blank NOT DONE
V.6.1	Tumor Marker 1	For breast cancer cases (C50.0-C50.9) diagnosed on or after 1/1/90 and prostate (C61.9) and testicular (C62.0-C62.9) cancer cases diagnosed on or after 1/1/98. For colorectal cancer cases - Carcinoembryonic Antigen (CEA). For ovarian cancer cases - Carbohydrate Antigen 125 (CA-125). *For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields. Refer to Section V.6.1 for codes.*
V.6.2	Tumor Marker 2	For breast cancer cases (C50.0-C50.9) diagnosed on or after 1/1/90 and prostate (C61.9) and testicular (62.0-62.9) cancer cases diagnosed on or after 1/1/98. *For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields. Refer to Section V.6.2 for codes.*
V.6.3	Tumor Marker 3	For testicular cancer cases diagnosed on or after 1/1/98. *For cases diagnosed January 1, 2004 forward, Tumor Markers 1-3 will be collected in the Collaborative Staging Site Specific Factor fields. Refer to Section V.6.3 for codes.*
V.6.4	Tumor Marker-CA-1	Her 2/neu tumor marker for breast cancer. Refer to Section V.6.4 for codes.
ACoS Items		
V.7.4	TNM-T Code Clinical	Site-specific code, one, two, or three characters (ACoS), flush left
V.7.4	TNM-N Code Clinical	Site-specific code, one, two, or three characters (ACoS), flush left
V.7.4	TNM-M Code Clinical	Site-specific code, two characters (ACoS)
V.7.4	TNM-T Code Pathological	Site-specific code, one, two, or three characters (ACoS), flush left

V.7.4	TNM-N Code Pathological	Site-specific code, one, two, or three characters (ACoS), flush left
V.7.4	TNM-M Code Pathological	Site-specific code, two characters (ACoS)
V.7.5	TNM Stage-(Clinical & Pathological)	Site-specific code, one or two characters (ACoS), entered as Arabic (not Roman) numerals; flush left
V.7.6	TNM Coder (Clinical) (Pathological), and (Other) (ACoS)	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
V.7.7	TNM Edition (ACoS)	00 NOT STAGED 01 FIRST EDITION 02 SECOND EDITION 03 THIRD EDITION 04 FOURTH EDITION 05 FIFTH EDITION 06 SIXTH EDITION 88 NOT APPLICABLE (cases that do not have an AJCC staging scheme and staging was not done) 99 UNKNOWN May be left blank

V.7.8	Pediatric Stage	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	00	NONE
		01	AMERICAN JOINT COMMITTEE ON CANCER
		02	ANN ARBOR
		03	CHILDREN'S CANCER GROUP
		04	EVANS
		05	GENERAL SUMMARY
		06	INTERGROUP EWINGS
		07	INTERGROUP HEPATOBLASTOMA
		08	INTERGROUP RHABDOMYSARCOMA
		09	INTERNATIONAL SYSTEM
		10	MURPHY
		11	NATIONAL CANCER INSTITUTE
		12	NATIONAL WILM'S TUMOR SURGERY
		13	PEDIATRIC ONCOLOGY GROUP (POG)
		14	REESE-ELLSWORTH
		15	SEER EXTENT OF DISEASE
		16	CHILDREN'S ONCOLOGY GROUP
		88	NOT APPLICABLE
		97	OTHER
		99	UNKNOWN

V.7.10	Pediatric Stage Coder	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

FIRST COURSE OF TREATMENT--SUMMARY

VI.1.3.2	RX Date (start date for each of six treatment types)	MMDDYYYY (blank if none; unknown = 99 or 9999 for unknown year) for each of seven types: surgery, radiation, chemotherapy, hormone/steroid, immunotherapy, transplant/endocrine procedure, and other
VI.2.1	Surgery of the Primary Site–Procedures 1-3	See Appendix Q-1 for site-specific codes for cases diagnosed prior to January 1, 2003. For cases diagnosed on or after January 1, 2003, see Appendix Q-2.
VI.2.2	Scope of Regional Lymph Node Surgery–Procedures 1-3	Cases diagnosed prior to January 1, 2003 are to be coded in a new field, Scope of Regional LN 98-02. Refer to Appendix Q-1 for these codes. For cases diagnosed on or after January 1, 2003, use the following codes: 0 None 1 Biopsy or aspiration of regional lymph node, NOS 2 Sentinel lymph node biopsy 3 Number of regional nodes removed unknown or not stated; regional lymph node removed, NOS 4 1-3 regional lymph nodes removed 5 4 or more regional lymph nodes removed 6 Sentinel node biopsy and code 3,4, or 5 at same time, or timing out not stated 7 Sentinel node biopsy and code 3,4, or 5 at different times 9 Unknown or not applicable

VI.2.3	Number of Regional Lymph Nodes Examined–Procedures 1-3	See Appendix Q-1 for site-specific codes
VI.2 .4	Surgery of Other Regional Site(s), Distant to Site(s), or Distant Lymph Nodes–Procedures 1-3	Cases diagnosed prior to January 1, 2003 are to be coded in a new field, Surgery Other 98-02. Refer Appendix Q-1 for these codes. For cases diagnosed on or after January 1, 2003, use the following codes: 0 None 1 Nonprimary surgical procedure performed 2 Nonprimary surgical procedure to other regional sites 3 Nonprimary surgical procedure to distant lymph node(s) 4 Nonprimary surgical procedure to distant site 5 Combination of codes 9 Unknown This field is for all procedures that do not meet the definitions of Surgery of Primary Site or Scope of Regional Lymph Nodes.
VI.2.5	Date of Surgery–Procedures 1-3	MMDDYYYY (blank if none; unknown = 99 or 9999 for unknown year)
VI.2.6	Treatment Hospital Number–Procedures 1-3	Six-digit number assigned by CCR (See Appendix F; blank if none assigned)
VI.2.7	Surgical Margins	See Appendix Q-1 for site-specific codes for cases diagnosed prior to January 1, 2003. For cases diagnosed on or after January 1, 2003, refer to the FORDS Manual
VI.2.8	Reconstructive Surgery–Immediate	See Appendix Q-1 for site-specific codes for cases diagnosed prior to January 1, 2003. This field is no longer required by the CCR or the CoC beginning with cases diagnosed January 1, 2003. Information with regards to reconstruction has been incorporated into the Surgery of the Primary Site field. The old field has been retained and cases diagnosed prior to January 1, 2003 must continue to be coded. For these older cases, refer to Appendix Q-1.

VI.2.9	Reason for No Surgery Of The Primary Site	*For sites where "Surgery of the Primary Site" is coded to 00 or 98 (hematopoietic included) use code 1.*

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
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
9 NOT KNOWN IF SURGERY OF THE PRIMARY SITE WAS RECOMMENDED OR PERFORMED; DEATH CERTIFICATE ONLY AND AUTOPSY ONLY CASES

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
02 INCISIONAL, NEEDLE, OR ASPIRATION BIOPSY 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

VI.2.10	Date Diagnostic and/or Staging Procedure	MMDDYYYY (blank if none; unknown = 99 or 9999 for unknown year)

VI.3.2	Radiation (Generated field for cases diagnosed on or after January 1, 2003)	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 NOTE: Code 6 may appear in converted cases.
VI.3.3	Radiation- Regional RX Modality	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, NOS 43 GAMMA KNIFE 50 BRACHYTHERAPY, NOS 51 BRACHYTHERAPY, INTRACAVIATARY, LDR 52 BRACHYTHERAPY, INTRACAVIATARY, HDR 53 BRACHYTHERAPY, INTERSTITIAL, LDR 54 BRACHYTHERAPY, INTERSTITIAL, HDR 55 RADIUM 60 RADIOISOTOPES, NOS 61 STRONTIUM-89 62 STRONTIUM-90 80 COMBINATION MODALITY, SPECIFIED* 85 COMBINATION MODALITY, NOS 98 OTHER, NOS 99 UNKNOWN; *DEATH CERTIFICATE ONLY*
VI.3.4	Radiation –Boost RX Modality	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 MRT
32 CONFORMAL OR 3-D THERAPY

40 PROTONS
41 STEREOTACTIC RADIOSURGERY, NOS
42 LINAC RADIOSURGERY, NOS
43 GAMMA KNIFE

50 BACHYTHERAPY, NOS
51 BRACHYTHERAPY, INTRACAVIATARY, LDR
52 BRACHYTHERAPY, INTRACAVIATARY, HDR
53 BRACHYTHERAPY, INTERSTITIAL, LDR
54 BRACHYTHERAPY, INTERSTITIAL, HDR
55 RADIUM

60 RADIOISOTOPES, NOS
61 STONTIUM-89
62 STONTIUM-90

98 OTHER, NOS
99 UNKNOWN; *DEATH CERTIFICATE ONLY*

VI. 3.5 Date of Radiation Therapy

00000000 NO RADIATION THERAPY ADMINISTERED; AUTOPSY-ONLY CASE

88888888 WHEN RADIATION THERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP. THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW-UP.

99999999 THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

VI.3.6 Reason for No Radiation

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

VI.3.7 Radiation Sequence With Surgery

0	NOT APPLICABLE; *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

VI.4 Chemotherapy

00	NONE, CHEMOTHERAPY WAS NOT PART OF THE PLANNED FIRST COURSE OF THERAPY; *DIAGNOSED AT AUTOPSY*
01	CHEMOTHERAPY, NOS.
02	SINGLE AGENT CHEMOTHERAPY
03	MULTIAGENT CHEMOTHERAPY ADMINISTERED AS FIRST COURSE THERAPY
82	CHEMOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED DUE TO CONTRAINDICATIONS.
85	CHEMOTHERAPY NOT ADMINISTERED BECAUSE THE PATIENT DIED.
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.

VI.4.3 Date of Chemotherapy

00000000	NO CHEMOTHERAPY ADMINISTERED; AUTOPSY ONLY CASE
88888888	WHEN CHEMOTHERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP, THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW UP.
99999999	THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

VI.5.4 Hormone Therapy

00	NONE, HORMONE THERAPY WAS NOT PART OF THE PLANNED FIRST COURSE THERAPY; *DIAGNOSED AT AUTOPSY.*
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. 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.

VI.5.5 Date Of Hormone Therapy

00000000	NO HORMONE THERAPY ADMINISTERED; AUTOPSY-ONLY
88888888	WHEN HORMONE THERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP, THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW UP.
99999999	THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

VI.6 Immunotherapy (Biological Response Modifier)

00	NONE, IMMUNOTHERAPY WAS NOT PART OF PART OF THE PLANNED FIRST COURSE OF THERAPY; *DIAGNOSED AT AUTOPSY.*
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.

VI.6.3 Date of Immunotherapy

00000000	NO IMMUNOTHERAPY ADMINISTERED; AUTOPSY-ONLY CASE
88888888	WHEN IMMUNOTHERAPY ISPLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP, THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW UP.
99999999	THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

VI.7 Transplant/ Endocrine Procedures

00	NO TRANSPLANT PROCEDURE OR ENDOCRINE THERAPY WAS ADMINISTERED AS PART OF THE FIRST COURSE THERAPY; *DIAGNOSED AT AUTOPSY.*
10	A BONE MARROW TRANSPLANT PROCEDURE WAS ADMINISTERED, BUT THE TYPE WAS NOT SPECIFIED
11	BONE MARROW TRANSPLANT - AUTOLOGOUS
12	BONE MARROW TRANSPLANT - ALLOGENEIC
20	STEM CELL HARVEST *AND INFUSION*
30	ENDOCRINE SURGERY AND/OR ENDOCRINE RADIATION THERAPY
40	COMBINATION OF ENDOCRINE SURGERY AND/OR RADIATION WITH A TRANSPLANT PROCEDURE. (COMBINATION OF CODES 30 AND 10, 11, 12, OR 20.)
82	HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WERE NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (i.e., COMORBID CONDITIONS, ADVANCED AGE).
85	HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WERE NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.
86	HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION 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.

VI.7.2 Date of Transplant/Endocrine Procedure

00000000	NO TRANSPLANT OR ENDOCRINE THERAPY WAS PERFORMED; AUTOPSY-ONLY CASE
88888888	WHEN TRANSPLANT/ENDOCRINE THERAPY IS PLANNED AS PART OF THE FIRST COURSE OF TREATMENT, BUT HAD NOT BEEN STARTED AT THE TIME OF THE MOST RECENT FOLLOW-UP, THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW UP.
99999999	THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

VI.8 Other Therapy

0	NO OTHER CANCER DIRECTED THERAPY EXCEPT AS CODED ELSEWHERE; *DIAGNOSED AT AUTOPSY.*
1	OTHER CANCER DIRECTED THERAPY
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*

VI.8.2 Date of Other Therapy

00000000	NO OTHER THERAPY ADMINISTERED; AUTOPSY ONLY CASE
99999999	UNKNOWN IF ANY OTHER THERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

VI.9 Protocol Participation.

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
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

FIRST COURSE OF TREATMENT GIVEN AT REPORTING HOSPITAL
Fields and codes are the same as for First Course of Treatment–Summary.

FOLLOW-UP

VII.2.1	Date of Last Contact	MMDDYYYY (do not leave blank or code year as unknown)
VII.2.2	Vital Status	0 DEAD 1 ALIVE
VII.2.3	Date of Last Tumor Status	MMDDYYYY (do not leave blank if patient alive; do not code year as unknown)
VII.2.4	Tumor Status	1 FREE-NO EVIDENCE OF THIS PRIMARY CANCER 2 NOT FREE-THIS PRIMARY CANCER STILL EXISTS 9 UNKNOWN

VII.2.5	Quality of Survival	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
VII.2.6.1	Last Type of Tumor Follow-Up	Follow-up obtained by hospital from: 00 ADMISSION BEING REPORTED 01 READMISSION TO REPORTING HOSPITAL 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 HOSPITAL 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 *21 COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES* 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 SOCIAL SECURITY, DEATH MASTER FILE 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-MATCHING USING ADDRESS SERVICE* *38 TRW CREDIT* *39 REGIONAL REGISTRY FOLLOW-UP LISTING* Follow-up obtained by central (state) registry from: 40 LETTER TO A PHYSICIAN 41 TELEPHONE CALL TO ANY SOURCE

50 CMS (CENTER FOR MEDICARE AND MEDICAID SERVICES)
51 DEPARTMENT OF MOTOR VEHICLES
52 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
53 COMPUTER MATCH WITH HMO FILE
54 CALVOTER REGISTRATION
55 NATIONAL DEATH INDEX
56 STATE DEATH TAPE-DEATH
57 MEDI-CAL ELIGIBILITY
58 SOCIAL SECURITY - DEATHS
59 COMPUTER MATCH, OTHER OR NOS
60 OTHER SOURCE
61 SOCIAL SECURITY - SSN
62 SPECIAL STUDIES
65 HOSPITAL DISCHARGE DATA - OSHPD
66 NATIONAL CHANGE OF ADDRESS (NCOA)
67 SOCIAL SECURITY ADMINISTRATION – EPIDEMIOLOGICAL VITAL STATUS
68 PROPERTY TAX LINKAGE
69 STATE DEATH TAPE – DEATH CLEARANCE (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

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

99 SOURCE UNKNOWN

VII.2.6.2 Last Type of Patient Follow-Up

Follow-up obtained by hospital from:
00 ADMISSION BEING REPORTED
01 READMISSION TO REPORTING HOSPITAL
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 HOSPITAL
09 OTHER SOURCE
11 TELEPHONE CALL TO ANY SOURCE
12 SPECIAL STUDIES
13 EQUIFAX
14 ARS (AIDS REGISTRY SYSTEM)

Follow-Up Data Items

15 COMPUTER MATCH WITH DISCHARGE DATA

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
50 CMS (CENTER FOR MEDICARE AND MEDICAID SERVICES)
51 COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES FILE
52 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
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 DATABASE
66 COMPUTER MATCH WITH NATIONAL CHANGE OF ADDRESS FILE
67 SOCIAL SECURITY ADMINISTRATION – EPIDEMIOLOGICAL VITAL STATUS
68 PROPERTY TAX LINKAGE

69 STATE DEATH TAPE – DEATH CLEARANCE (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

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

99 SOURCE UNKNOWN

VII.2.7	Last Follow-Up Hospital	A six-digit number assigned by CCR (see Appendix F); blank if unknown
VII.2.8	Next Type of Follow-Up	0 SUBMIT A REQUEST FOR THE PATIENT'S CHART TO THE REPORTING HOSPITAL'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 HOSPITAL 5 FOLLOW-UP BY A METHOD NOT DESCRIBED ABOVE 6 SEND A FOLLOW-UP LETTER TO THE PATIENT May be blank
VII.2.9	Next Follow-Up Hosp.	A six-digit number assigned by CCR (see Appendix F); blank if unknown

Recurrence Information

The fields may be blank if recurrence information is not collected.

VII.2.12.1	Recurrence Date	MMDDYY (99 = unknown 9999 for unknown year); leave blank if no recurrence or patient never free

VII.2.12.2 Recurrence Type

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.

Death Information

VII.2.13	Place of Death	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 Appendices C and D for other codes.) *If the patient is still alive, use code 997.*
VII.2.13	Cause of Death	Four-digit ICD code; not coded by hospitals
VII.2.13	DC State File Number	Six-digit number; not entered by hospital

APPENDIX J
PATIENT INFORMATION SHEET

CCR suggests the following statement be used by hospitals and physicians in notifying their patients that cancer is a reportable disease:

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. The purpose of the law is to help identify preventable causes of cancer.

For the system to be useful, it must obtain complete and accurate counts of all new cancers that occur. Therefore the new law requires hospitals and physicians to notify the appropriate regional registry of each new case of cancer.

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 programmiatic 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.

APPENDIX K
SCREENING LIST 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 should 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.

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
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 sideoblasts (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

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.

** International Classification of Diseases, 9th Revision, Clinical Modification, 4th ed.*

APPENDIX L.1
CODES FOR CALIFORNIA COUNTIES
(in alphabetical order)

ALAMEDA CO.	001	PLACER CO.	031
ALPINE CO.	002	PLUMAS CO.	032
AMADOR CO.	003	RIVERSIDE CO.	033
BUTTE CO.	004	SACRAMENTO CO.	034
CALAVERAS CO.	005	SAN BENITO CO.	035
CALIFORNIA NOS	000	SAN BERNARDINO	036
COLUSA CO.	006	SAN DIEGO CO.	037
CONTRA COSTA CO.	007	SAN FRANCISCO CO.	038
DEL NORTE CO.	008	SAN JOAQUIN CO.	039
EL DORADO CO.	009	SAN LUIS OBISPO	040
FRESNO CO.	010	SAN MATEO CO.	041
GLENN CO.	011	SANTA BARBARA CO.	042
HUMBOLDT CO.	012	SANTA CLARA CO.	043
IMPERIAL CO.	013	SANTA CRUZ CO.	044
INYO CO.	014	SHASTA CO.	045
KERN CO.	015	SIERRA CO.	046
KINGS CO.	016	SISKIYOU CO.	047
LAKE CO.	017	SOLANO CO.	048
LASSEN CO.	018	SONOMA CO.	049
LOS ANGELES CO.	019	STANISLAUS CO.	050
MADERA CO.	020	SUTTER CO.	051
MARIN CO.	021	TEHAMA CO.	052
MARIPOSA CO.	022	TRINITY CO.	053
MENDOCINO CO.	023	TULARE CO.	054
MERCED CO.	024	TUOLUMNE CO.	055
MODOC CO.	025	US NOT CALIF.	000
MONO CO.	026	VENTURA CO.	056
MONTEREY CO.	027	YOLO CO.	057
NAPA CO.	028	YUBA CO.	058
NEVADA CO.	029		
ORANGE CO.	030		

APPENDIX L.2
CODES FOR CALIFORNIA COUNTIES
(in numerical order)

000	CALIFORNIA NOS
000	US NOT CALIF.
001	ALAMEDA CO.
002	ALPINE CO.
003	AMADOR CO.
004	BUTTE CO.
005	CALAVERAS CO.
006	COLUSA CO.
007	CONTRA COSTA CO.
008	DEL NORTE CO.
009	EL DORADO CO.
010	FRESNO CO.
011	GLENN CO.
012	HUMBOLDT CO.
013	IMPERIAL CO.
014	INYO CO.
015	KERN CO.
016	KINGS CO.
017	LAKE CO.
018	LASSEN CO.
019	LOS ANGELES CO.
020	MADERA CO.
021	MARIN CO.
022	MARIPOSA CO.
023	MENDOCINO CO.
024	MERCED CO.
025	MODOC CO.
026	MONO CO.
027	MONTEREY CO.
028	NAPA CO.
029	NEVADA CO.
030	ORANGE CO.
031	PLACER CO.
032	PLUMAS CO.
033	RIVERSIDE CO.
034	SACRAMENTO CO.
035	SAN BENITO CO.
036	SAN BERNARDINO
037	SAN DIEGO CO.
038	SAN FRANCISCO CO.
039	SAN JOAQUIN CO.
040	SAN LUIS OBISPO
041	SAN MATEO CO.
042	SANTA BARBARA CO.
043	SANTA CLARA CO.
044	SANTA CRUZ CO.
045	SHASTA CO.
046	SIERRA CO.
047	SISKIYOU CO.
048	SOLANO CO.
049	SONOMA CO.
050	STANISLAUS CO.
051	SUTTER CO.
052	TEHAMA CO.
053	TRINITY CO.
054	TULARE CO.
055	TUOLUMNE CO.
056	VENTURA CO.
057	YOLO CO.
058	YUBA CO.

APPENDIX M.1
COMMON ACCEPTABLE ABBREVIATIONS
(in order of terms)

Do not use non-standard abbreviations in abstracts. When abbreviating words in an address, refer to the Address Abbreviations section of the *National Zip Code and Post Office Directory*, published by the U.S. Postal Service. For short names of antineoplastic drugs, consult the SEER Program *Self Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs, 3rd Edition*. Other accepted abbreviations are:

Abdomen	ABD
Abdominal Perineal	AP
Above Knee (Amputation)	AK(A)
Acid Phosphatase	ACID PHOS
Acquired Immunodeficiency Syndrome	AIDS
Acute Granulocytic Leukemia	AGL
Acute Lymphocytic Leukemia	ALL
Acute Myelogenous Leukemia	AML
Adenocarcinoma	ADENOCA
Adjacent	ADJ
Admission; Admit	ADM
Against Medical Advice	AMA
Aids Related Complex	ARC
Alcohol	ETOH
Alkaline Phosphatase	ALK PHOS
Alpha-fetoprotein	AFP
Also Known As	AKA
Ambulatory	AMB
Anal Intraepithelial Neoplasia	AIN
Anaplastic	ANAP
Angiography	ANGIO
Anterior	ANT
Anteroposterior	AP
Appendix	APP
Approximately	APPROX
Arteriovenous	AV
Aspiration	ASP
Auscultation & Percussion	A&P
Autopsy	AUT
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium Enema	BE
Bartholin's, Urethral, & Skene's Glands	BUS
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
Blood Urea Nitrogen	BUN
Bone Marrow	BM
Bone Scan	BSC
Bowel Movement	BM
Bowel Sounds	BS
Breath Sounds	BS, BRS
Bright Red Blood (per Rectum)	BRB(PR)
Calcium	CA
Carcinoembryonic Antigen	CEA
Carcinoma	CA
Carcinoma In Situ	CIS
CAT Scan	CT, CT SC
Centimeter	CM
Central Nervous System	CNS
Cerebrospinal Fluid	CSF
Cervical Intraepithelial Neoplasia	CIN
Cervical Vertebra	C1-C7
Cervix	CX
Cesium	CS
Chemotherapy	CHEMO
Chest Xray	CXR
Chief Complaint	CC
Chronic Granulocytic Leukemia	CGL
Chronic Lymphocytic Leukemia	CLL

Common Acceptable Abbreviations
(in order of terms)

Chronic Myeloid Leukemia	CML
Cigarettes	CIG
Clear	CLR
Colon	
Ascending	A-COLON
Descending	D-COLON
Sigmoid	S-COLON
Transverse	T-COLON
Common Bile Duct	CBD
Complaining of	C/O
Complete Blood Count	CBC
Computerized Axial Tomography Scan	CT, CAT SCAN
Consistent with	C/W
Continue	CONT
Costal Margin	CM
Cubic Centimeter	CC
Cystoscopy	CYSTO
Cytology	CYTO
Cytomegalovirus	CMV
Date of Birth	DOB
Dead on Arrival	DOA
Decreased	DECR (or <)
Dermatology	DERM
Diagnosis	DX
Diameter	DIAM
Differentiated	DIFF
Dilatation and Curettage	D&C
Discharge	DIS, DISCH, DS
Discontinued	DC
Disease	DZ, DIS
Doctor	DR, MD
Ductal Carcinoma In Situ	DCIS
Ductal Intraepithelial Neoplasia	DIN
Ears, Nose, and Throat	ENT
Electroencephalogram	EEG
Electromyogram	EMG
Emergency Room	ER
Endoscopic Retrograde Cholangiopancreatography	ERCP
Enlarged	ENL
Esophagogastroduodenoscopy	EGD
Estrogen Receptor (Assay)	ER(A)
Evaluation	EVAL
Examination	EXAM
Examination under Anesthesia	EUA
Excision	EXC
Exploratory Laparotomy	EXP LAP
Extend	EXT
Extended Care Facility	ECF
Extension	EXT
External	EXT
Extremity	EXT
Eyes, Ears, Nose, and Throat	EENT
Family (Medical) History	F(M)H
Fever Unknown Origin	FUO
Fingerbreadth	FB
Floor of Mouth	FOM
Follow-up	FU
Fracture	FX
Frozen Section	FS
Gallbladder	GB
Gastroenterostomy	GE
Gastroesophageal	GE
Gastrointestinal	GI
Genitourinary	GU
Grade	GR
Gram	GM
Gynecology	GYN
Head, Eyes, Ears, Nose, Throat	HEENT
Hematocrit	HCT
Hemoglobin	HGB
Hepatosplenomegaly	HSM
History	HX
History and Physical	H&P
History of	HO
History of Present Illness	HPI
Hormone	HORM
Hospital	HOSP
Hour, Hours	HR, HRS
Human Chorionic Gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus Type III	HTLV-III
Hysterectomy	HYST
Immunoglobulin	IG
Impression	IMP
Includes, Including	INCL
Increase	INCR (or >)

Common Acceptable Abbreviations
(in order of terms)

Inferior Vena Cava	IVC
Infiltrating	INFILT
Inpatient	IP
Intercostal Margin	ICM
Internal Mammary Artery	IMA
Intrathecal	IT
Intravenous	IV
Intravenous Pyelogram	IVP
Iodine	I
Jugular Venous Distention	JVD
Kidneys, Ureters, Bladder	KUB
Kilogram	KG
Kilovolt	KV
Laparotomy	LAP
Large	LG
Laryngeal Intraepithelial Neoplasia	LIN
Last Menstrual Period	LMP
Lateral	LAT
Left	L, LT
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 Quadrant	LUQ
Liter	L
Liver, Kidney, Spleen (Bladder)	LKS(B)
Lobular Carcinoma In Situ	LCIS
Local M.D.	LMD
Lower Extremity	LE
Lower Inner Quadrant	LIQ
Lower Outer Quadrant	LOQ
Lumbar Puncture	LP
Lumbar Vertebra	L1-L5
Lumbosacral	LS
Lymphadenopathy	LAD/LAN
Lymphadenopathy-Associated Virus	LAV
Lymph Node(s)	LN, LN'S, LNS
Magnetic Resonance Imaging	MRI
Malignant	MALIG, MAL
Mandible	MAND
Mastectomy	MAST
Maxilla(ry)	MAX
Maximum	MAX
Medical Doctor	DR, MD
Medicine	MED
Metastatic, Metastases	MET, METS
Microscopic	MICRO
Midclavicular Line	MCL
Middle Lobe	ML
Millicurie (hours)	MC(H)
Milligram (hours)	MG(H)
Milliliter	ML
Millimeter	MM
Million Electron Volts	MEV
Minimum	MIN
Moderate	MOD
Moderately Differentiated	MD, MOD DIFF
Modified Radical Mastectomy	MRM
Nausea and Vomiting	N&V
Neck Vein Distention	NVD
Negative	NEG (or –)
Neurology	NEURO
No Evidence of Disease	NED
Normal	NL
No Significant Findings	NSF
Not Applicable	NA
Not Otherwise Specified	NOS
Not Recorded	NR
Obstructed (-ing, -ion)	OBST
Operating Room	OR
Operation	OP
Operative Report	OP REPORT
Ounce	OZ
Outpatient	OP
Packs per Day	PPD
Palpated (-able)	PALP
Papanicolaou Smear	PAP
Papillary	PAP
Past Medical History	PMH
Pathology	PATH
Patient	PT
Pelvic Inflammatory Disease	PID
Percussion and Auscultation	P&A
Percutaneous	PERC
Personal (Primary) Medical Doctor	PMD

Common Acceptable Abbreviations
(in order of terms)

Physical Examination	PE
Platelets	PLT
Poorly Differentiated	PD, POOR DIFF
Positive	POS (or +)
Positron Emission Tomography	PET
Possible	POSS
Posterior	POST
Posteroanterior	PA
Postmortem Examination	POST
Postoperative (-ly)	PO, POSTOP
Postoperative Day	POD
Preoperative (-ly)	PREOP
Present Illness	PI
Prior to Admission	PTA
Probable (-ly)	PROB
Progesterone Receptor (Assay)	PR(A)
Prostatic Intraepithelial Neoplasia	PIN
Pulmonary	PULM
Pulmonary Artery	PA
Radiation	RAD
Radiation Absorbed Dose	RAD
Radiation Therapy	RT/XRT
Radical	RAD
Radioimmunoassay	RIA
Radium	RA
Red Blood Cells	RBC
Resection	RESEC
Respiratory	RESPIR
Review of Outside Films	ROF
Review of Outside Slides	ROS
Review of Systems	ROS
Right	R, RT
Right Costal Margin	RCM
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ
Right Middle Lobe	RML
Right Salpingo-oophorectomy	RSO
Right Upper Extremity	RUE
Right Upper Lobe	RUL
Right Upper Quadrant	RUQ
Rule Out	RO, R/O
Sacral Vertebra	S1-S5
Salpingo-oophorectomy	SO
Sentinal Lymph Node	SLN
Sequential Multiple Analysis (Biochem Profile)	SMA
Serum Glutamic Oxaloacetic Transaminase	SGOT
Serum Glutamic Pyruvic Transaminase	SGPT
Shortness of Breath	SOB
Skilled Nursing Facility	SNF
Specimen	SPEC
Split Thickness Skin Graft	STSG
Small	SM, SML
Small Bowel	SB, SML BWL
Spine	
Cervical	C-SPINE
Lumbar	L-SPINE
Sacral	S-SPINE
Thoracic	T-SPINE
Squamous	SQ, SQUAM
Squamous Cell Carcinoma	SCC
Squamous Intraepithelial Lesion	SIL
Status Post	S/P
Subcutaneous	SUB-Q, SUBQ, SQ
Superior Vena Cava	SVC
Surgery, Surgical	SURG
Symptoms	SX
Thoracic	T
Thoracic Vertebra	T1-T12
Total Abdominal Hysterectomy-Bilateral Salpingo-oophorectomy	TAH-BSO
Total Parenteral Nutrition	TPN
Total Vaginal Hysterectomy	TVH
Transitional Cell Carcinoma	TCC
Transurethral Resection	TUR
Transurethral Resection Bladder (Tumor)	TURB(T)
Transurethral Resection Prostate	TURP
Treatment	RX, TX
Tumor Size	TS
Undifferentiated	UNDIFF
Upper Extremity	UE
Upper Gastrointestinal	UGI
Upper Inner Quadrant	UIQ
Upper Outer Quadrant	UOQ
Vagina, Vaginal	VAG

Common Acceptable Abbreviations
(in order of terms)

Vaginal Hysterectomy	VAG HYST
Vaginal Intraepithelial Neoplasia	VAIN
Vascular	VASC
Vulvar Intraepithelial Neoplasia	VIN
Well Differentiated	WD, WELL DIFF
White Blood Cells	WBC
With	W/ or C
Within Normal Limits	WNL
Without	W/O
Work-up	W/U
Xray	XR
Year	YR

Symbols	
At	@
Comparison	/
Decrease, less than	<
Equals	=
Increase, more than	>
Negative	–
Number*	#
Positive	+
Pounds**	#
Times	x

*If it appears before a numeral.
**If it appears after a numeral.

APPENDIX M.2
COMMON ACCEPTABLE ABBREVIATIONS
(in order of abbreviations)

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ABD	Abdomen
ACID PHOS	Acid Phosphatase
A-COLON	Ascending Colon
ADENOCA	Adenocarcinoma
ADJ	Adjacent
ADM	Admission; Admit
AFP	Alpha-fetoprotein
AGL	Acute Granulocytic Leukemia
AIDS	Acquired Immunodeficiency Syndrome
AIN	Anal Intraepithelial Neoplasia
AK(A)	Above Knee (Amputation)
AKA	Also Known As
ALK PHOS	Alkaline Phosphatase
ALL	Acute Lymphocytic Leukemia
AMA	Against Medical Advice
AMB	Ambulatory
AML	Acute Myelogenous Leukemia
ANAP	Anaplastic
ANGIO	Angiography
ANT	Anterior
A&P	Auscultation & Percussion
AP	Abdominal Perineal
AP	Anteroposterior
APP	Appendix
APPROX	Approximately
ARC	Aids Related Complex
ASP	Aspiration
AUT	Autopsy
AV	Arteriovenous
AX	Axilla(ry)
BA	Barium
BCG	Bacillus Calmette-Guerin
BD	Bile Duct
BE	Barium Enema
BIL	Bilateral
BK(A)	Below Knee (Amputation)
BM	Bone Marrow
BM	Bowel Movement
BPH	Benign Prostatic Hypertrophy/Hyperplasia
BRB(PR)	Bright Red Blood (per Rectum)
BRM	Biological Response Modifier
BS, BRS	Breath Sounds
BS	Bowel Sounds
BSC	Bone Scan
BSO	Bilateral Salpingo-oophorectomy
BUN	Blood Urea Nitrogen
BUS	Bartholin's, Urethral, & Skene's Glands
BX	Biopsy
C	With
C1-C7	Cervical Vertebra
CA	Calcium
CA	Carcinoma
CBC	Complete Blood Count
CBD	Common Bile Duct
CC	Chief Complaint
CC	Cubic Centimeter
CEA	Carcinoembryonic Antigen
CGL	Chronic Granulocytic Leukemia
CHEMO	Chemotherapy
CIG	Cigarettes
CIN	Cervical Intraepithelial Neoplasia
CIS	Carcinoma In Situ
CLL	Chronic Lymphocytic Leukemia
CLR	Clear

Common Acceptable Abbreviations
(in order of abbreviations)

CM	Centimeter
CM	Costal Margin
CML	Chronic Myeloid Leukemia
CMV	Cytomegalovirus
CNS	Central Nervous System
C/O	Complaining of
CONT	Continue
CS	Cesium
CSF	Cerebrospinal Fluid
C-SPINE	Cervical Spine
CT, CT SC	Computerized Axial Tomography Scan, CAT Scan
C/W	Consistent with
CX	Cervix
CXR	Chest Xray
CYSTO	Cystoscopy
CYTO	Cytology
D&C	Dilatation and Curettage
DC	Discontinued
DCIS	Ductal Carcinoma In Situ
D-COLON	Descending Colon
DECR (or <)	Decreased
DERM	Dermatology
DIAM	Diameter
DIFF	Differentiated
DIN	Ductal Intraepithelial Neoplasia
DIS	Disease
DIS, DISCH	Discharge
DOA	Dead on Arrival
DOB	Date of Birth
DR	(Medical) Doctor
DS	Discharge
DX	Diagnosis
DZ	Disease
ECF	Extended Care Facility
EEG	Electroencephalogram
EENT	Eyes, Ears, Nose, and Throat
EGD	Esophagogastroduodenoscopy
EMG	Electromyogram
ENL	Enlarged
ENT	Ears, Nose, and Throat
ER	Emergency Room
ER(A)	Estrogen Receptor (Assay)
ERCP	Endoscopic Retrograde Cholangiopancreatography
ETOH	Alcohol
EUA	Examination under Anesthesia
EVAL	Evaluation
EXAM	Examination
EXC	Excision
EXP LAP	Exploratory Laparotomy
EXT	Extend
EXT	Extension
EXT	External
EXT	Extremity
FB	Fingerbreadth
F(M)H	Family (Medical) History
FOM	Floor of Mouth
FS	Frozen Section
FU	Follow-up
FUO	Fever Unknown Origin
FX	Fracture
GB	Gallbladder
GE	Gastroenterostomy
GE	Gastroesophageal
GI	Gastrointestinal
GM	Gram
GR	Grade
GU	Genitourinary
GYN	Gynecology
HCG	Human Chorionic Gonadotropin
HCT	Hematocrit
HEENT	Head, Eyes, Ears, Nose, Throat
HGB	Hemoglobin
HIV	Human Immunodeficiency Virus
HO	History of
HORM	Hormone
HOSP	Hospital
H&P	History and Physical
HPI	History of Present Illness
HPV	Human Papilloma Virus
HR, HRS	Hour, Hours
HSM	Hepatosplenomegaly
HTLV-III	Human T-Lymphotrophic Virus Type III
HX	History
HYST	Hysterectomy
I	Iodine
ICM	Intercostal Margin
IG	Immunoglobulin

Common Acceptable Abbreviations
(in order of abbreviations)

IMA	Internal Mammary Artery
IMP	Impression
INCL	Includes, Including
INCR (or >)	Increase
INFILT	Infiltrating
IP	Inpatient
IT	Intrathecal
IV	Intravenous
IVC	Inferior Vena Cava
IVP	Intravenous Pyelogram
JVD	Jugular Venous Distention
KG	Kilogram
KUB	Kidneys, Ureters, Bladder
KV	Kilovolt
L	Left
L	Liter
L1-L5	Lumbar Vertebra
LAD/LAN	Lymphadenopathy
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-Associated Virus
LCIS	Laryngeal Intraepithelial Neoplasia
LCM	Left Costal Margin
LE	Lower Extremity
LG	Large
LIQ	Lower Inner Quadrant
LKS(B)	Liver, Kidney, Spleen (Bladder)
LLE	Left Lower Extremity
LLL	Left Lower Lobe
LLQ	Left Lower Quadrant
LMD	Local M.D.
LMP	Last Menstrual Period
LN, LN'S, LNS	Lymph Node(s)
LOQ	Lower Outer Quadrant
LP	Lumbar Puncture
LS	Lumbosacral
LSO	Left Salpingo-oophorectomy
L-SPINE	Lumbar Spine
LT	Left
LUE	Left Upper Extremity
LUL	Left Upper Lobe
LUQ	Left Upper Quadrant
MAL, MALIG	Malignant
MAND	Mandible
MAST	Mastectomy
MAX	Maxilla(ry)
MAX	Maximum
MC(H)	Millicurie(hours)
MCL	Midclavicular Line
MD	Medical Doctor
MD	Moderately Differentiated
MED	Medicine
MET, METS	Metastatic, Metastases
MEV	Million Electron Volts
MG(H)	Milligram (hours)
MICRO	Microscopic
MIN	Minimum
ML	Middle Lobe
ML	Milliliter
MM	Millimeter
MOD	Moderate
MOD DIFF	Moderately Differentiated
MRI	Magnetic Resonance Imaging
MRM	Modified Radical Mastectomy
NA	Not Applicable
NED	No Evidence of Disease
NEG (or –)	Negative
NEURO	Neurology
NL	Normal
NOS	Not Otherwise Specified
NR	Not Recorded
NSF	No Significant Findings
N&V	Nausea and Vomiting
NVD	Neck Vein Distention
OBST	Obstructed (-ing, -ion)
OP	Operation
OP	Outpatient
OP REPORT	Operative Report
OR	Operating Room
OZ	Ounce
P&A	Percussion and Auscultation
PA	Posteroanterior
PA	Pulmonary Artery
PALP	Palpated (-able)
PAP	Papanicolaou Smear
PAP	Papillary
PATH	Pathology
PD	Poorly Differentiated
PE	Physical Examination

Common Acceptable Abbreviations
(in order of abbreviations)

PERC	Percutaneous
PET	Positron Emission Tomography
PI	Present Illness
PID	Pelvic Inflammatory Disease
PIN	Prostatic Intraepithelial Neoplasia
PLT	Platelets
PMD	Personal (Primary) Medical Doctor
PMH	Past Medical History
PO	Postoperative (-ly)
POD	Postoperative Day
POOR DIFF	Poorly Differentiated
POS (or +)	Positive
POSS	Possible
POST	Posterior
POST	Postmortem Examination
POSTOP	Postoperative (-ly)
PPD	Packs per Day
PR(A)	Progesterone Receptor (Assay)
PREOP	Preoperative (-ly)
PROB	Probable (-ly)
PT	Patient
PTA	Prior to Admission
PULM	Pulmonary
R	Right
RA	Radium
RAD	Radiation
RAD	Radiation Absorbed Dose
RAD	Radical
RBC	Red Blood Cells
RCM	Right Costal Margin
RESEC	Resection
RESPIR	Respiratory
RIA	Radioimmunoassay
RLE	Right Lower Extremity
RLL	Right Lower Lobe
RLQ	Right Lower Quadrant
RML	Right Middle Lobe
RO, R/O	Rule Out
ROF	Review of Outside Films
ROS	Review of Outside Slides
ROS	Review of Systems
RSO	Right Salpingo-oophorectomy
RT	Radiation Therapy
RT	Right
RUE	Right Upper Extremity
RUL	Right Upper Lobe
RUQ	Right Upper Quadrant
RX	Treatment
S1-S5	Sacral Vertebra
SB	Small Bowel
SCC	Squamous Cell Carcinoma
S-COLON	Sigmoid Colon
SGOT	Serum Glutamic Oxaloacetic Transaminase
SGPT	Serum Glutamic Pyruvic Transaminase
SIL	Squamous Intraepithelial Lesion
SLN	Sentinal Lymph Node
SM	Small
SMA	Sequential Multiple Analysis (Biochem Profile)
SML	Small
SML BWL	Small Bowel
SNF	Skilled Nursing Facility
SO	Salpingo-oophorectomy
SOB	Shortness of Breath
S/P	Status Post
SPEC	Specimen
SQ	Subcutaneous
SQ, SQUAM	Squamous
S-SPINE	Sacral Spine
STSG	Split Thickness Skin Graft
SUB-Q, SUBQ	Subcutaneous
SURG	Surgery, Surgical
SVC	Superior Vena Cava
SX	Symptoms
T	Thoracic
T1-T12	Thoracic Vertebra
TAH-BSO	Total Abdominal Hysterectomy–Bilateral Salpingo-oophorectomy
TCC	Transitional Cell Carcinoma
T-COLON	Transverse Colon
TPN	Total Parenteral Nutrition
TS	Tumor Size
T-SPINE	Thoracic Spine
TUR	Transurethral Resection
TURB(T)	Transurethral Resection Bladder (Tumor)
TURP	Transurethral Resection Prostate

Common Acceptable Abbreviations
(in order of abbreviations)

TVH	Total Vaginal Hysterectomy
TX	Treatment
UE	Upper Extremity
UGI	Upper Gastrointestinal
UIQ	Upper Inner Quadrant
UNDIFF	Undifferentiated
UOQ	Upper Outer Quadrant
VAG	Vagina, Vaginal
VAG HYST	Vaginal Hysterectomy
VAIN	Vaginal Intraepithelial Neoplasia
VASC	Vascular
VIN	Vulvar Intraepithelial Neoplasia
W/	With
WBC	White Blood Cells
WD, WELL DIFF	Well Differentiated
WNL	Within Normal Limits
W/O	Without
W/U	Work-up
XR	Xray
XRT	Radiation Therapy
YR	Year

Symbols

@	At
/	Comparison
<	Decrease, less than
=	Equals
>	Increase, more than
–	Negative
#	Number*
	Pounds**
+	Positive
x	Times

* If it appears before a numeral
** If it appears after a numeral

APPENDIX N

ICD-0-3 CODES TO BE CONSIDERED ONE PRIMARY SITE WHEN DETERMINING MULTIPLE PRIMARIES

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

ICD-0-3 CODES TO BE CONSIDERED ONE PRIMARY SITE WHEN DETERMINING MULTIPLE PRIMARIES

ICD-0-3 Codes	Site Groupings
C64	Kidney
C65	Renal pelvis
C66	Ureter
C68	Other and unspecified urinary organs
C74	Adrenal gland
C75	Other endocrine glands and related structures

APPENDIX O

1980 CENSUS LIST OF SPANISH SURNAMES

INSTRUCTIONS FOR USING 1980 CENSUS LIST OF SPANISH SURNAMES

Attached is the 1980 Census List of Spanish Surnames. This list can be used to code last names in most areas of the United States.

1. All names are listed alphabetically in upper-case letters without any blanks or spaces. For example, names such as "De Leon", "De la Torre", or "La Luz" are shown as "DELEON", "DELATORRE", or "LALUZ".

2. Spanish surnames often have accent marks (`) or a tilde (~) over the n (ñ). Disregard accent marks or tildes as these marks have been omitted from the list. For example, the names "Martínez" and "Núñez" are listed as "MARTINEZ" and "NUNEZ".

3. If a surname consists of two names, separated by a dash or a space, code the person as Spanish if <u>either</u> name appears on the list. For example, for "Collins-Garcia", check "COLLINS" on the list. Since it does not appear, check for "GARCIA". If the name appeared as "Garcia-Collins", then "GARCIA" would be checked first.

4. If the surname is of the form "Lopez R.", ignore the initial and look up the name, "LOPEZ".

5. If the surname consists of two surnames separated by "de" such as "Perez de Seda", first look up the name written first, i.e., "PEREZ"; if it is not on the list, look up the final name including the word "de", i.e., "DESEDA"; if it is still not on the list, look up the final name without the word "de", i.e., "SEDA".

   a. Surnames written with spaces which begin "de", "de la", or "del", such as "de la Cruz", should be looked up with and without the prefix words, i.e., "CRUZ", "LACRUZ", and "DELACRUZ". If any of the combinations is listed, the surname should be considered Spanish.

A

ABAD
ABADIA
ABADIANO
ABADIAS
ABADILLA
ABADIN
ABAIGAR
ABAJO
ABALLE
ABALO
ABALOS
ABAONZA
ABARCA
ABARCO
ABAROA
ABARQUEZ
ABARTA
ABARZUA
ABASCAL
ABASTA
ABASTAS
ABASTO
ABAUNZA
ABAURREA
ABAY
ABAYA
ABBADIE
ABDALA
ABEA
ABEITA
ABEJA
ABELAIRAS
ABELAR
ABELDANO
ABELEDO
ABELLA
ABELLAN
ABELLEIRA
ABELLERA
ABENDANO
ABERASTURI
ABERASTURIA
ABERGEL
ABESADA
ABETE
ABEYTA
ABEYTIA
ABIEGA
ABILA
ABILES
ABILEZ
ABIN
ABINA
ABIO

1980 CENSUS LIST OF SPANISH SURNAMES

ABIOL
ABISLAIMAN
ABITIA
ABITU
ABITUA
ABLANEDO
ABOGADO
ABOITE
ABOITES
ABOLILA
ABONCE
ABORLLEILE
ABOY
ABOYTES
ABRAHANTE
ABRAHANTES
ABRAJAN
ABRANTE
ABREA
ABREGO
ABREO
ABREU
ABREUS
ABREUT
ABREV
ABREW
ABREYO
ABRICA
ABRIGO
ABRIL
ABRIOL
ABUIN
ABUNDES
ABUNDEZ
ABUNDIS
ABUNDIZ
ABUNDO
ABURTO
ABUTIN
ACABA
ACABEO
ACARON
ACASTA
ACCOSTA
ACCUAR
ACEBAL
ACEBEDO
ACEBO
ACED
ACEDO
ACEITUNO
ACENCIO
ACENEDO
ACERA
ACEREDO
ACERETO
ACERO
ACETY
ACEUEDO
ACEVDO
ACEVEDA
ACEVEDO
ACEVES
ACEVEZ
ACEVIDO
ACHA
ACHEZ
ACHON
ACIDO
ACIN
ACOBE
ACOSTA
ACOYA
ACUESTA
ACUNA
ACUSTA
ADAME
ADAMES
ADAMEZ
ADAN
ADANZA
ADARGO
ADAROS
ADAUTO
ADELO
ADONA
ADORNO
ADRIASOLA
ADROVER
ADROVET
ADUNA
ADVINCULA
AEDO
AFAN
AFANADOR
AFRE
AGADO
AGALA
AGANZA
AGAPITO
AGEITOS
AGIRRE
AGON
AGOSTO
AGRA
AGRAIT
AGRAMONTE
AGRAS
AGRAZ
AGREDA
AGREDANO
AGREGADO
AGRONT
AGUABELLA
AGUADO
AGUALLO
AGUANO
AGUARISTI
AGUAS
AGUASVIVAS
AGUAYA
AGUAYO
AGUDELO
AGUDO
AGUEDA
AGUELAR
AGUERA
AGUERO
AGUEROS
AGUERRE
AGUERREBERE
AGUERRIA
AGUET
AGUIGUI
AGUILA
AGUILAR
AGUILER
AGUILERA
AGUILES
AGUILLAR
AGUILLEN
AGUILLERA
AGUILLON
AGUILO
AGUILON
AGUILOR
AGUILOS
AGUILU
AGUILUZ
AGUINAGA
AGUINIGA
AGUINO
AGUINS
AGUIRE
AGUIRRA
AGUIRRE
AGUIRRECHU
AGUIRREGAVIRIA
AGUIRRES
AGUIRREZABAL
AGULAR
AGULIAR
AGULLES
AGULLO
AGUNDES
AGUNDEZ
AGUNDIS
AGUNDIZ
AGUON
AGURRIES
AGURTO
AGUSTI
AGVILAR
AHEDO
AHIN
AHUERO
AHUMADA
AIBAR
AINSA
AINZ
AINZA
AIRA
AISA
AISO
AISPURO
AIZPURU
AJUNTAS
AJURIA
ALABADO
ALACAN
ALACAR
ALADRO
ALAEZ
ALAFA
ALAFFA
ALAGA
ALAGO
ALAMAN
ALAMANO
ALAMANZA

ALAMARES
ALAMBAR
ALAMEDA
ALAMIA
ALAMILLA
ALAMILLO
ALAMO
ALAMOS
ALANIS
ALANIZ
ALANSO
ALANZO
ALAQUINES
ALAQUINEZ
ALARCO
ALARCON
ALARD
ALARDE
ALARDIN
ALARI
ALARICO
ALARID
ALARY
ALAS
ALATORRE
ALATRISTE
ALAVA
ALAVARADO
ALAVARDO
ALAYA
ALAYETO
ALAYO
ALAYON
ALBA
ALBACETE
ALBALADEJO
ALBALATE
ALBALOS
ALBANA
ALBANDOZ
ALBANEZ
ALBAREDA
ALBARENGA
ALBAREZ
ALBARICO
ALBARRACIN
ALBARRAN
ALBEAR
ALBELO
ALBERCA
ALBERIO
ALBERRO
ALBERTORIO
ALBERU
ALBEZ
ALBIAR
ALBIDRES
ALBIDREZ
ALBILLAR
ALBINES
ALBIOL
ALBISO
ALBITRE
ALBIZO
ALBIZU
ALBO
ALBONIGA
ALBOR
ALBORNOZ
ALBORS
ALBUERNE
ALBUJAR
ALBURQUERQUE
ALCADE
ALCAIDA
ALCAIDE
ALCALA
ALCALAN
ALCALDE
ALCANIZ
ALCANTA
ALCANTAR
ALCANTARA
ALCANTARO
ALCANTOR
ALCARAS
ALCARAZ
ALCAREZ
ALCASAS
ALCAYDE
ALCAZAR
ALCE
ALCEDO
ALCERRECA
ALCIBAR
ALCIVAR
ALCOBER
ALCOCER
ALCOCES
ALCOLA
ALCOLEA
ALCON
ALCONTAR
ALCORTA
ALCOSER
ALCOSET
ALCOVER
ALCOZAR
ALCOZER
ALCUDIA
ALDABA
ALDABE
ALDACO
ALDAHONDO
ALDAMA
ALDANA
ALDAPA
ALDAPE
ALDARONDO
ALDAS
ALDASORO
ALDAVA
ALDAVE
ALDAYA
ALDAZ
ALDAZABAL
ALDEBOT
ALDECOA
ALDECOCEA
ALDEIS
ALDEREGUIA
ALDERETE
ALDERETTE
ALDERTE
ALDRETE
ALDUEN
ALDUENDA
ALEANTAR
ALEBIS
ALEDO
ALEGADO
ALEGRE
ALEGRET
ALEGRIA
ALEJANDRE
ALEJANDRES
ALEJANDREZ
ALEJANDRO
ALEJO
ALEJOS
ALELUNAS
ALEMAN
ALEMANIA
ALEMANY
ALEMAR
ALEN
ALENCASTRO
ALEQUIN
ALERS
ALERTE
ALEVEDO
ALEXANDRINO
ALFALLA
ALFARA
ALFARD
ALFARO
ALFASSA
ALFAU
ALFEREZ
ALFONSECA
ALFONSO
ALFONZO
ALFRIDO
ALGARA
ALGARIN
ALGARRA
ALGAVA
ALGEA
ALGECIRAS
ALGORA
ALGORRI
ALGORTA
ALGUACIL
ALGUESEVA
ALIAGA
ALICANTE
ALICCA
ALICEA
ALICIA
ALIJA
ALINAYA
ALIPAZ
ALIRE
ALIRES
ALIREZ
ALLADICE
ALLADO
ALLALA
ALLANDE
ALLARID

ALLEGRANZA
ALLEGUE
ALLEGUEZ
ALLENDE
ALLENEGUI
ALLESANDRO
ALLONGO
ALLOZA
ALMA
ALMADA
ALMADO
ALMADOVA
ALMAGER
ALMAGNER
ALMAGRO
ALMAGUER
ALMANCE
ALMANDOZ
ALMANSA
ALMANZA
ALMANZAN
ALMANZAR
ALMANZO
ALMAQUER
ALMARAS
ALMARAZ
ALMARES
ALMAREZ
ALMARZA
ALMAZAN
ALMEDA
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ALMEJO
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ALMENAR
ALMENARA
ALMENARES
ALMENDARES
ALMENDAREZ
ALMENDARIZ
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ALMENDRAS
ALMENGER
ALMENGOR
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ALMERAZ
ALMERIA
ALMESTICA
ALMEYDA
ALMEZQUITA
ALMIRALL
ALMIRUDIS
ALMODOBAR
ALMODOUAR
ALMODOVA
ALMODOVAR
ALMOGABAR
ALMOGUERA
ALMOINA
ALMONACID
ALMONDOVAR
ALMONTE
ALMONTES
ALMORA
ALMUINA
ALOMA
ALOMAR
ALONA
ALONSO
ALONZO
ALOY
ALOYO
ALPIZAR
ALPUCHE
ALPUIN
ALQUICIRA
ALSINA
ALTAGRACIA
ALTAMIRA
ALTAMIRANO
ALTARRIBA
ALTENES
ALTIMIRANO
ALTONAGA
ALTOSINO
ALTRECHE
ALTUBE
ALTUNA
ALTUR
ALTURET
ALTUZARRA
ALUAREZ
ALUIZO
ALUSTIZA
ALUYON
ALVA
ALVANADO
ALVARA
ALVARADA
ALVARADO
ALVARAZ
ALVARDEZ
ALVARDO
ALVAREDO
ALVARENGA
ALVARES
ALVAREZ
ALVARIDO
ALVARINO
ALVARODO
ALVARRAN
ALVARY
ALVEAR
ALVELAIS
ALVELO
ALVERADO
ALVERANGA
ALVERES
ALVEREZ
ALVERIO
ALVERO
ALVEZ
ALVIAR
ALVIDRES
ALVIDREZ
ALVILLAR
ALVIRA
ALVIRDE
ALVIREZ
ALVISO
ALVITRE
ALVIZAR
ALVIZO
ALVIZU
ALVO
ALVORADO
ALZA
ALZAGA
ALZALDE
ALZATE
ALZINA
ALZOLA
ALZUGARAY
ALZURI
AMABISCA
AMADOR
AMAGO
AMALBERT
AMALLA
AMARGOS
AMARILLA
AMARILLAS
AMARO
AMAVISCA
AMAVIZCA
AMAYA
AMBE
AMBEGUIA
AMBERT
AMBIA
AMBRIS
AMBRIZ
AMEJORADO
AMELY
AMENABAR
AMENEDO
AMENGUAL
AMESCUA
AMESGUITA
AMESOLA
AMESQUA
AMESQUITA
AMESTI
AMESTOY
AMEZAGA
AMEZCUA
AMEZOLA
AMEZQUITA
AMEZUA
AMIAL
AMIEIRO
AMIEVA
AMIGO
AMILL
AMIRA
AMIRES
AMOR
AMORES
AMOROS
AMOROZ
AMOSTEGUI
AMOZURRUTIA
AMPARAN
AMPARANO
AMPARO
AMPUDIA
AMPUERO
ANADON
ANALCO
ANALLA

ANAMOSA
ANASAGASTI
ANAYA
ANAZAGASTY
ANCHANDO
ANCHIA
ANCHIETA
ANCHONDO
ANCHUNDIA
ANCIRA
ANCISO
ANDA
ANDABLO
ANDALON
ANDALUZ
ANDASOLA
ANDAVAZO
ANDAVERDE
ANDAZOLA
ANDEREZ
ANDIARENA
ANDINA
ANDINO
ANDOLLO
ANDRACA
ANDRADA
ANDRADE
ANDRADES
ANDRADO
ANDREOLAS
ANDREU
ANDREZ
ANDRIAL
ANDRINO
ANDUAGA
ANDUEZA
ANDUIZA
ANDUJA
ANDUJAL
ANDUJAR
ANDUJO
ANDUYO
ANDUZE
ANEIRO
ANEIROS
ANEL
ANERO
ANGELES
ANGLADA
ANGLADE
ANGLERO
ANGOCO
ANGON
ANGUEIRA
ANGUERA
ANGUIANO
ANGUINO
ANGUITA
ANGULO
ANIAS
ANIBARRO
ANILLO
ANIZ
ANORGA
ANQUIANO
ANSALDUA
ANSALMO
ANSISO
ANSOATEGUI
ANSOLABEHERE
ANSURES
ANTA
ANTABLIN
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YTURBE
YTURRALDE
YTURRI
YTURRIA
YTURRIAGA
YUBETA
YUCUPICIO
YUDESIS
YUDICE
YUDICO
YULAN
YULFO
YURIAR
YUSTE
YVANEZ
YVARRA
YZABAL
YZAGUIRRE
YZNAGA
YZQUIERDO

Z

ZABAL
ZABALA
ZABALETA
ZABALLA
ZABALO
ZABALZA
ZACARIAS
ZACUTO
ZADRIMA
ZAERA
ZAFEREO
ZAFRA
ZAGALA
ZAGALES
ZAGONA
ZALACAIN
ZALACE
ZALAMEA
ZALAPA
ZALAZAR
ZALDANA
ZALDIVAR
ZALDUA
ZALDUMBIDE
ZALDUONDO
ZALVIDEA
ZAMACONA
ZAMAGO
ZAMANIEGO
ZAMANILLO
ZAMANO
ZAMAR
ZAMARIPA
ZAMARIPPA
ZAMARO
ZAMARRI
ZAMARRIPA
ZAMARRIPAS
ZAMARRON
ZAMAYOA
ZAMAZAL
ZAMBADA
ZAMBRANA
ZAMBRANO
ZAMILPA
ZAMORA
ZAMORANO
ZAMORES
ZAMOREZ
ZAMOT
ZAMUDIO
ZANABRIA
ZANDATE
ZANDONA
ZANGRONIZ
ZANUDO
ZAPARA
ZAPATA
ZAPATER
ZAPATERO
ZAPEDA
ZAPIAIN
ZAPIEN
ZARABOZO
ZARAGOSA
ZARAGOZ
ZARAGOZA
ZARAGOZI
ZARATE
ZARAZUA
ZARCO
ZARCOS
ZARDENETA
ZARDENETTA
ZARDO
ZARDON
ZARDOYA
ZAROGOZA
ZARRAGA
ZARRAGOITIA
ZARRAGOZA
ZARRIA
ZARUBICA
ZARZANA
ZARZOSA
ZARZOZA
ZARZUELA
ZASUETA
ZATARAIN
ZATARAY
ZATARIAN
ZATOREN
ZAUALA
ZAUL
ZAUZA
ZAVALA
ZAVALETA
ZAVALETTA
ZAVALLA
ZAVALZA
ZAVAT
ZAYAS
ZAYASBAZAN
ZAYAZ
ZAZUETA
ZAZUETTA
ZEAS
ZEBALLOS
ZEDENO
ZEDILLO
ZEGARRA
ZELADA
ZELAYA
ZELEDON
ZEMEN
ZENDEJAS
ZENGOTITA
ZENIZO
ZENOZ
ZENTELLA
ZENTENO
ZEPADA
ZEPEDA
ZEQUEIRA
ZERDA
ZERIN
ZERMENO
ZERPA
ZERQUERA
ZERTUCHE
ZERVIGON
ZETINA
ZETINO
ZEVALLOS
ZILBAR
ZILLAS
ZOLETA
ZOMORA
ZOROLA
ZORRILLA
ZOZAYA
ZUAZNABAR
ZUAZO
ZUAZUA
ZUBELDIA
ZUBIA
ZUBIATE
ZUBIETA
ZUBILLAGA
ZUBIRAN
ZUBIRI
ZUBIRIA
ZUBIZARRETA
ZUGASTI
ZULAICA
ZULETA
ZULOAGA
ZULUAGA
ZULUETA

ZUMARRAGA
ZUMAYA
ZUNIGA
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ZURITA
ZURRICA
ZUVIA
ZUVIETA
ZUZUARREGUI

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APPENDIX Q.1

SURGERY CODES
(For Cases Diagnosed Prior to January 1, 2003)

ORAL CAVITY
Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C09.9, 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

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- 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 this surgical event.

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

Procedures in codes 20-27 include, but are not limited to:
Shave Wedge resection

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Procedures in code 30 include, but are not limited to:
Hemiglossectomy Partial glossectomy

30 Wide excision, NOS

Procedures in codes 40-43 include, but are not limited to:
Radical glossectomy

40 Radical excision of tumor, NOS
- 41 Radical excision of tumor ONLY
- 42 Combination of 41 WITH en bloc mandibulectomy (marginal, segmental, hemi-, or total)
- 43 Combination of 41 WITH en bloc maxillectomy (partial, subtotal, total)

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

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

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional cervical lymph nodes are:
Caudal jugular (deep cervical) Cranial jugular (deep cervical) Dorsal cervical (superficial cervical) Medial jugular (deep cervical) Occipital Paratracheal (anterior cervical) Prelaryngeal (anterior cervical) Retroauricular (mastoid, posterior auricular) Submandibular (submaxillary) Submental Supraclavicular

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

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS
  2 Neck dissection, NOS
    3 Selective, limited; nodal sampling; "berry picking"
    4 Modified/modified radical
    5 Radical
9 Unknown; not stated; death certificate ONLY

> Terminology of neck dissection (Robbins et al. 1991):
> A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.
>
> In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more non lymphatic structures are preserved.
>
> A selective neck dissection is a neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

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

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional site(s)
  - 3 Mandibulectomy (marginal, segmental, hemi-, or total)
  - 4 Maxillectomy (partial, subtotal, or total)

> Code a mandibulectomy or a maxillectomy in this field only if the procedure is NOT a part of an en bloc resection of the primary tumor. If the mandibulectomy or maxillectomy ARE a part of an en bloc resection of the primary tumor, code under "Surgery of Primary Site."

- 5 Distant lymph node(s)
- 6 Distant site(s)
- 7 Combination of 6 WITH 2, 3, 4, or 5

9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Flaps, grafts, or any type of "plasty," NOS
- 2 WITHOUT implant/prosthesis
- 3 WITH implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

PAROTID AND OTHER UNSPECIFIED GLANDS
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

4 Open

9 Death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- 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 this surgical event.

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

PAROTID AND OTHER UNSPECIFIED GLANDS
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

30 Less than total parotidectomy, NOS; less than total removal 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 **(WITH or WITHOUT superficial lobe)**
  - 37 Facial nerve spared
  - 38 Facial nerve sacrificed

40 Total parotidectomy, NOS; Total removal major salivary gland, NOS
- 41 Facial nerve spared
- 42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; Radical removal major salivary gland, NOS
- 51 WITHOUT removal of temporal bone
- 52 WITH removal of temporal bone

80 Parotidectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

PAROTID AND OTHER UNSPECIFIED GLANDS
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional cervical lymph nodes are:
Buccal (facial) Caudal jugular (deep cervical) Cranial jugular (deep cervical) Dorsal cervical (superficial cervical) Medial jugular (deep cervical) Occipital Paratracheal (anterior cervical) Parotid Prelaryngeal (anterior cervical) Retroauricular (mastoid, posterior auricular) Retropharyngeal Submandibular (submaxillary) Submental Supraclavicular

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

- 2 Neck dissection, NOS
  - 3 Selective, limited; nodal sampling; “berry picking”
  - 4 Modified/modified radical
  - 5 Radical

9 Unknown; not stated; death certificate ONLY

PAROTID AND OTHER UNSPECIFIED GLANDS
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

Terminology of neck dissection (Robbins et al. 1991):

A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection, the same lymph nodes are removed as in a radical neck dissection; however, one or more non-lymphatic structures are preserved.

A selective neck dissection is a neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

PAROTID AND OTHER UNSPECIFIED GLANDS
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Flaps, grafts, or any type of "plasty," NOS
- 2 WITHOUT implant/prosthesis
- 3 WITH implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed
9 Unknown; not stated; death certificate ONLY

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

SURGICAL APPROACH

Codes

0 None; surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- 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 this surgical event.

Surgery 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

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

30 Pharyngectomy, NOS
- 31 Limited/partial pharyngectomy; Tonsillectomy, NOS
- 32 Total pharyngectomy

40 Pharyngectomy WITH mandibulectomy (marginal, segmental, hemi-), and/or laryngectomy, NOS
- 41 WITH laryngectomy (laryngopharyngectomy)
- 42 WITH mandibulectomy
- 43 WITH both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS
- 51 WITHOUT laryngectomy
- 52 WITH laryngectomy

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

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

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

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

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional cervical lymph nodes are:
Buccal (facial) Caudal jugular (deep cervical) Cranial jugular (deep cervical) Dorsal cervical (superficial cervical) Medial jugular (deep cervical) Occipital Paratracheal (anterior cervical) Parotid Prelaryngeal (anterior cervical) Retroauricular (mastoid, posterior auricular) Retropharyngeal Submandibular (submaxillary) Submental Supraclavicular

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

- 2 Neck dissection, NOS
  - 3 Selective, limited; nodal sampling; ‘berry picking’
  - 4 Modified/modified radical
  - 5 Radical

9 Unknown; not stated; death certificate ONLY

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

NUMBER OF REGIONAL LYMPH NODES EXAMINED
Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

2 Laryngectomy ONLY

3 Mandibulectomy ONLY (marginal, segmental, or hemi-)

4 Combination of 2 and 3

5 Removal of other regional sites

6 Combination of 5 with 2-4

7 Removal of other distant sites(s) or distant lymph node(s)

8 Combination of 7 WITH any of 2-6

9 Unknown; not stated; death certificate ONLY

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

RECONSTRUCTION/RESTORATION - FIRST COURSE

Code only the following reconstructive procedures:
Myocutaneous flaps (pectoralis major, trapezius) Reconstruction of mandible Regional flaps

Codes

0 No reconstruction/restoration

1 Reconstruction/restoration, NOS
  2 WITHOUT implant/prosthesis
  3 WITH implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

ESOPHAGUS
C15.0-C15.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

Endoscopy procedures include:
Esophagoscopy Mediastinoscopy Thoracoscopy

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Trans-hiatal
- 6 Thoracotomy (includes split sternum)
- 7 Laparotomy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- 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 this surgical event.

Surgery Codes

ESOPHAGUS
C15.0-C15.9

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

30 Partial esophagectomy

40 Total esophagectomy

50 Partial esophagectomy WITH laryngectomy and/or gastrectomy, NOS
- 51 WITH laryngectomy
- 52 WITH gastrectomy, NOS
  - 53 Partial gastrectomy
  - 54 Total gastrectomy
- 55 Combination of 51 WITH any of 52-54

60 Total esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
- 61 WITH laryngectomy
- 62 WITH gastrectomy, NOS
  - 63 Partial gastrectomy
  - 64 Total gastrectomy
- 65 Combination of 61 WITH any of 62-64

70 Esophagectomy, NOS WITH pharyngectomy and laryngectomy

80 Esophagectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ESOPHAGUS
C15.0-C15.9

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

ESOPHAGUS
C15.0-C15.9

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional lymph nodes are different for each anatomical subsite. The following list identifies nodes classified as regional for each subsite:	
Cervical esophagus:	Cervical, NOS Internal jugular Periesophageal Scalene Supraclavicular Upper cervical
Intrathoracic esophagus (upper, middle, lower):	Carinal Hilar (pulmonary roots) Internal jugular Mediastinal, NOS Paracardial Periesophageal Perigastric Peritracheal Superior mediastinal Tracheobronchial

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

Celiac nodes are distant for intrathoracic esophagus. Code removal of celiac nodes in the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

ESOPHAGUS
C15.0-C15.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

ESOPHAGUS
C15.0-C15.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

Code only the following procedures as reconstructive:
Endoluminal stents Endoprosthesis Esophageal stents Esophagogastric fundoplasty Esophagogastrostomy (cardioplasty) Esophagojejunostomy Esophagomyotomy Esophagoplasty (plastic repair or reconstruction) Esophagoplasty/WITH/WITHOUT repair of a tracheoesophageal fistula Esophagostomy Gastropharyngostomy Interposition of remaining esophagus with stomach using large or small bowel Self expanding metal vynal Stent placement in conjunction with cancer-directed surgery

0 No reconstruction/restoration

1 Reconstruction/restoration, NOS
  2 WITHOUT implant/prosthesis
  3 WITH implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

STOMACH
C16.0-C16.9

SURGICAL APPROACH

CODE

0 None; no surgery of primary site

Endoscopy procedures include:
Esophago-/gastro-/duodeno-/jejuno-/scopy Gastroscopy Laparoscopy

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

CODE

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- 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 this surgical event.

Surgery Codes

STOMACH
C16.0-C16.9

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Code 30, partial gastrectomy, includes a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

30 Gastrectomy, NOS (partial, subtotal, hemi-)
- 31 Antrectomy, lower (distal)

Resection of less than 40% of stomach

- 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

40 Near-total or 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

60 Gastrectomy WITH en bloc resection of other organs, NOS
- 61 Partial or subtotal gastrectomy WITH en bloc resection
- 62 Near total or total gastrectomy WITH en bloc resection
- 63 Radical gastrectomy WITH en bloc resection

EN BLOC RESECTION is the removal of organs in one piece at one time and may include an omentectomy.

80 Gastrectomy, NOS

Surgery Codes

STOMACH
C16.0-C16.9

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

CODE

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

STOMACH
C16.0-C16.9

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:	
Greater Curvature of Stomach	Gastroduodenal Gastroepiploic, left Gastroepiploic, right or NOS Greater omental Greater curvature Pancreaticoduodenal (anteriorly along the first part of duodenum) Pyloric, including subpyloric and infrapyloric
Pancreatic and Splenic Area:	Pancreaticolienal Peripancreatic Splenic hilum
Lesser Curvature of Stomach:	Cardioesophageal Celiac Common hepatic Hepatoduodenal Left gastric Lesser omental Lesser curvature Paracardial; cardial Perigastric, NOS

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

STOMACH
C16.0-C16.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of gallbladder, bile ducts, appendix, or vagus nerve. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Removal of other regional sites, ONLY
- 3 Removal of distant node(s)
- 4 Removal of distant site(s)
- 5 Combination of 2 WITH 3 and/or 4

9 Unknown; not stated; death certificate ONLY

STOMACH
C16.0-C16.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Gastrostomy
  2 WITHOUT reservoir/pouch
  3 WITH reservoir/pouch (abdominal)

9 Unknown; not stated; death certificate ONLY

COLON
C18.0 - C18.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

Endoscopy procedures include:
Colonoscopy Laparoscopy Sigmoidoscopy

1 Endoscopy, NOS
  2 Not image guided
  3 Image guided

4 Open, NOS
  5 Not assisted by endoscopy
  6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Code removal/surgical ablation of single or multiple liver metastases under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
  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 this surgical event.

Surgery Codes

COLON
C18.0 - C18.9

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Procedures coded 30-31 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

30 Partial colectomy, but less than hemicolectomy
- 31 Partial colectomy WITH permanent colostomy (Hartmann's operation)

ALSO CODE colostomy in the data item "Reconstruction/Restoration."

40 Hemicolectomy or greater (but less than total); right or left colectomy

A hemicolectomy is the removal of total right or left colon and a portion of transverse colon.
A right hemicolectomy routinely includes removal of a portion of the terminal ileum.

Surgery Codes

COLON
C18.0 - C18.9

50 Total colectomy

Removal of colon from cecum to the rectosigmoid or a portion of the rectum

60 Total proctocolectomy

Commonly used for familial polyposis or polyposis coli.

70 Colectomy or coloproctectomy WITH an en bloc resection of other organs; pelvic exenteration

CODE 70 includes any colectomy (partial, hemicolectomy, or total) WITH an en bloc resection of any other organs. The other organs may be partially or totally removed. Procedures that may be a **PART OF AN EN BLOC RESECTION** include, but are not limited to: oophorectomy, partial proctectomy, rectal mucosectomy

EN BLOC resection is the removal of organs in one piece at one time.

THE CREATION OF ILEAL RESERVOIR which is a part of a pelvic exenteration **MUST ALSO BE CODED** in the data item "Reconstruction/Restoration."

80 Colectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

COLON
C18.0 - C18.9

SCOPE OF REGIONAL LYMPH NODE SURGERY

The pathology report often describes regional lymph nodes by their anatomic location: colic nodes; mesenteric nodes; peri-\epi-\para-\ colic. Regional lymph nodes differ for each anatomical subsite. The following list identifies the regional lymph nodes for each subsite of the colon:	
Cecum and appendix	Anterior cecal Ileocolic Posterior cecal Right colic
Ascending colon	Ileocolic Middle colic Right colic
Hepatic flexure	Middle colic Right colic
Transverse colon	Middle colic
Splenic flexure	Inferior mesenteric Middle colic, left colic
Descending colon	Inferior mesenteric Left colic Sigmoid
Sigmoid colon	Inferior mesenteric Sigmoid mesenteric Sigmoidal Superior rectal(hemorrhoidal)

COLON
C18.0 - C18.9

Superior mesenteric, external iliac and common iliac nodes are distant lymph nodes. Code the removal of any of these nodes in the data item "Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)."

Codes

0 No regional lymph nodes removed
1 Regional lymph node(s) removed, NOS
9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

COLON
C18.0 - C18.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of appendix, gallbladder, bile ducts, or spleen. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Removal of other regional site(s), ONLY
- 3 Removal/surgical ablation of single liver metastasis
- 4 Removal/surgical ablation of multiple liver metastases
- 5 Combination of codes 2 and 3 or 4
- 6 Removal of other distant site(s) or distant lymph node(s), ONLY
- 7 Combination of code 6 WITH 3 or 5
- 8 Combination of code 6 WITH 4

9 Unknown; not stated; death certificate ONLY

COLON
C18.0 - C18.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Do not code anastomosis as reconstruction.

Codes

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS
- 3 WITHOUT a reservoir or pouch
- 4 WITH an abdominal reservoir or pouch
- 5 WITH an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate ONLY

RECTOSIGMOID
C19.9

SURGICAL APPROACH

CODE

0 None; no surgery of primary site

1 Endoscopy, NOS (includes laparoscopic)

4 Open, NOS
- 5 Transanal
- 6 Posterior; coccygeal; trans-sacral; abdominosacral
- 7 Low anterior (LAR)
- 8 Abdominal perineal (AP)

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

CODE removal/surgical ablation of single or multiple liver metastases under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Node(s)."

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- 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 this surgical event.

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

RECTOSIGMOID
C19.9

Procedures coded 30 include, but are not limited to:
Anterior resection Hartmann's operation Low anterior resection Partial colectomy, NOS Rectosigmoidectomy, NOS Sigmoidectomy

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS

Also code the colostomy in the data item "Reconstruction/Restoration."

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

40 Pull through WITH sphincter preservation (coloanal anastomosis)

Procedures coded 50 include but are not limited to:
Abdominoperineal resection (A & P resection) Anterior/posterior resection (A/P resection)/Miles' operation Rankin's operation

50 Total proctectomy
51 Total colectomy

Removal of the colon from cecum to the rectosigmoid or a portion of the rectum

60 Combination of 50 and 51

70 Colectomy or proctocolectomy WITH an en bloc resection of other organs; pelvic exenteration

RECTOSIGMOID
C19.9

EN BLOC RESECTION is the removal of organs in one piece at one time. Procedures that may be a 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. The other organs may be partially or totally removed.

An **ILEAL RESERVOIR**, which is part of a pelvic exenteration, should be coded in the data item "Reconstruction/Restoration".

80 Colectomy, NOS; Proctectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate ONLY

SURGICAL MARGINS

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

RECTOSIGMOID
C19.9

SCOPE OF REGIONAL LYMPH NODE SURGERY

The pathology report often identifies regional lymph nodes by their anatomic location: colic; mesenteric; peri-/para-/ colic; perirectal; rectal.

The specific regional lymph nodes are:

Inferior mesenteric
Left colic
Middle rectal (hemorrhoidal)
Perirectal
Sigmoid mesenteric
Sigmoidal
Superior rectal (superior hemorrhoidal)

Superior mesenteric, external iliac and common iliac nodes are distant nodes. Code removal of these nodes under the data item "Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)".

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

RECTOSIGMOID
C19.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

RECTOSIGMOID
C19.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of appendix, gallbladder, or bile ducts. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Removal of other regional site(s), ONLY
- 3 Removal/surgical ablation of single liver metastasis
- 4 Removal/surgical ablation of multiple liver metastases
- 5 Combination of codes 2 and 3 or 4
- 6 Removal of other distant site(s) or distant lymph node(s), ONLY
- 7 Combination of code 6 WITH 3, 4 or 5
- 8 Combination of code 6 WITH 3 or 5

9 Unknown; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS
- 3 WITHOUT a reservoir or pouch
- 4 WITH an abdominal reservoir or pouch
- 5 WITH an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate ONLY

RECTUM
C20.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS (includes laparoscopy)

4 Open, NOS
- 5 Transanal (Kraske, York-Mason)
- 6 Posterior; coccygeal; trans-sacral; abdominosacral
- 7 Low anterior (LAR)
- 8 Abdominal perineal (AP)

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

CODE removal/surgical ablation of single or multiple liver metastases under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

Codes

00 None; surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- 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 this surgical event.

Surgery Codes

RECTUM
C20.9

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy
- 28 Curette and fulguration

Specimen sent to pathology from this surgical event.

Procedures coded 30 include, but are not limited to:
Anterior resection Hartmann's operation Low anterior resection (LAR) Trans-sacral rectosigmoidectomy

30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 40 include but are not limited to:
Altimeter's operation Duhamel's operation Soave's submucosal resection Swenson's operation Turnbull's operation

40 Pull through WITH sphincter preservation (coloanal anastomosis)

Procedures coded 50 include but are not limited to:
Abdominoperineal resection (A & P resection) Anterior/Posterior (A/P) resection/Miles' operation Rankin's operation

50 Total proctectomy

RECTUM
C20.9

60 Total proctocolectomy, NOS
70 Proctectomy or proctocolectomy WITH an en bloc resection of other organs; pelvic exenteration

> **EN BLOC RESECTION** is the removal of organs in one piece at one time.
>
> The creation of an ileal reservoir, which is a part of a pelvic exenteration, should be coded in the data item "Reconstruction/Restoration".

80 Proctectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

RECTUM
C20.9

SCOPE OF REGIONAL LYMPH NODE SURGERY

The pathology report often identifies regional lymph nodes by their anatomic location: mesenteric nodes; perirectal nodes; rectal nodes.

The specific regional lymph nodes are:

Inferior rectal (hemorrhoidal)
Inferior mesenteric
Internal iliac
Lateral sacral
Middle rectal (hemorrhoidal)
Perirectal
Presacral
Sacral promontory (Gerota's)
Sigmoid mesenteric
Superior rectal (hemorrhoidal)

Superior mesenteric, external iliac and common iliac nodes are classified as distant lymph nodes. Code removal of these nodes under the data item "Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)."

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

RECTUM
C20.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

RECTUM
C20.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of appendix, gallbladder, bile ducts, or spleen. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Removal of other regional site(s), ONLY
- 3 Removal/surgical ablation of single liver metastasis
- 4 Removal/surgical ablation of multiple liver metastases
- 5 Combination of codes 2 with 3 or 4
- 6 Removal of other distant site(s) or distant lymph node(s), ONLY
- 7 Combination of code 6 WITH 3, 4 or 5
- 8 Combination of code 6 WITH 3 or 5

9 Unknown; death certificate ONLY

RECTUM
C20.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS
- 3 WITHOUT a reservoir or pouch
- 4 WITH an abdominal reservoir or pouch
- 5 WITH an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate ONLY

ANUS
C21.0-C21.8

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS
  2 Not image guided
  3 Image guided

4 Open, NOS
  5 Not assisted by endoscopy
  6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

Procedures for codes 10-14 include, but are not limited to:
Cryosurgery Electrocautery Excisional biopsy Laser Thermal ablation

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
  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 this surgical event.

Surgery Codes

ANUS
C21.0-C21.8

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

> Specimen sent to pathology from this surgical event.
>
> Margins of resection may have microscopic involvement.

60 Abdominal perineal resection, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

ANUS
C21.0-C21.8

SCOPE OF REGIONAL LYMPH NODE SURGERY

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

- 2 Perirectal, anorectal lymph nodes
- 3 Internal iliac lymph nodes (hypogastric), unilateral
- 4 Inguinal lymph nodes, unilateral
- 5 Combination of 2 and 4
- 6 Bilateral internal iliac and/or bilateral inguinal lymph nodes

9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 90 or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS
- 3 WITHOUT a reservoir or pouch
- 4 WITH an abdominal reservoir or pouch
- 5 WITH an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate ONLY

LIVER AND INTRAHEPATIC BILE DUCTS
C22.0-C22.1

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy ONLY, NOS (laparoscopy)
  2 Not image guided
  3 Image guided

4 Open, NOS
  5 Not assisted by endoscopy
  6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

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 (PEI)
  16 Heat
  17 Other (ultrasound, acetic acid)

20 Wedge resection, NOS; segmental resection

30 Lobectomy, NOS
  31 Simple
  32 Extended

Extended lobectomy: resection of a single lobe plus a segment of another lobe.

40 Excision of a bile duct (for an intrahepatic bile duct primary only)

LIVER AND INTRAHEPATIC BILE DUCTS
C22.0-C22.1

70 Total hepatectomy with transplant

Liver transplant must also be coded under the data item "Reconstruction/Restoration."

80 Hepatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional lymph nodes are the hilar nodes:
Along the portal vein Along the inferior vena cava Along the proper hepatic artery At the hepatic pedicle

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

LIVER AND INTRAHEPATIC BILE DUCTS
C22.0-C22.1

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

2 Other regional sites(s)

3 Distant lymph node(s) (includes inferior phrenic lymph nodes)

4 Distant site(s)

5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

LIVER AND INTRAHEPATIC BILE DUCTS
C22.0-C22.1

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Rioux-en-Y; hepatojejunostomy including stent

2 Liver transplant

9 Unknown; not stated; death certificate ONLY

PANCREAS
C25.0-C25.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS (laparoscopy)
  2 Not image guided
  3 Image guided

4 Open, NOS
  5 Not assisted by endoscopy
  6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local excision of tumor, NOS

20 Partial pancreatectomy, NOS

40 Total pancreatectomy

50 Local or partial pancreatectomy and duodenectomy
  51 Without subtotal gastrectomy
  52 With subtotal gastrectomy (Whipple)

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

PANCREAS
C25.0-C25.9

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Celiac (head only) Hepatic artery Infrapyloric (head only) Lateral aortic Pancreaticolienal (body and tail only) Peripancreatic (superior, inferior, anterior, posterior splenic) Retroperitoneal Splenic (body and tail only) Subpyloric (head only) Superior mesenteric

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

  2 Extended lymphadenectomy

An extended pancreaticoduodenectomy incorporates selected aspects of the Whipple procedure and regional pancreatectomy. A wide Kocher maneuver removes all lymphatic tissue over the medical aspect of the right kidney, inferior vena cava, and left renal vein.

9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

2 Removal of other regional sites, ONLY

3 Removal of distant node(s)

4 Removal of distant site(s)

5 Combination of 2 WITH 3 and/or 4

9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

9 Not applicable (There are no known reconstructive procedures for this site.)

LARYNX
C32.0-C32.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS
  2 Not image guided
  3 Image guided

4 Open, NOS
  5 Not assisted by endoscopy
  6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
  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 this surgical event.

Surgery Codes

LARYNX
C32.0-C32.9

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy
- 28 Stripping

Specimen sent to pathology from this surgical event.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LARYNX
C32.0-C32.9

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional cervical lymph nodes are:
Buccal (facial) Caudal jugular (deep cervical) Cranial jugular (deep cervical) Dorsal cervical (superficial cervical) Medial jugular (deep cervical) Occipital Paratracheal (anterior cervical) Parotid Prelaryngeal (anterior cervical) Retroauricular (mastoid, posterior auricular) Retropharyngeal Submandibular (submaxillary) Submental Supraclavicular

LARYNX
C32.0-C32.9

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

- 2 Neck dissection, NOS
  - 3 Selective, limited; nodal sampling; "berry picking"
  - 4 Modified/modified radical
  - 5 Radical

9 Unknown; not stated; death certificate ONLY

Terminology of neck dissection (Robbins et al. 1991):

A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more non lymphatic structures are preserved.

A selective neck dissection is a neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.

LARYNX
C32.0-C32.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

2 Other regional sites(s)

3 Distant lymph node(s)

4 Distant site(s)

5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

LARYNX
C32.0-C32.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Flaps, grafts, or any "plastys," NOS
  2 WITHOUT implant/prosthesis
  3 WITH implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

LUNG
C34.0 - C34.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS
  2 Bronchoscopy
  3 Mediastinoscopy
  4 Thoracoscopy

5 Open, NOS (thoracotomy, sternotomy)
  6 Not assisted by endoscopy
  7 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local tumor destruction or excision, NOS
  11 Excision
  12 Laser ablation or excision
  13 Cautery; fulguration
  14 Bronchial sleeve resection ONLY

20 Resection of less than one lobe
  21 Wedge resection
  22 Segmental resection, including lingulectomy

30 Resection of at least one lobe, but less than the whole lung (partial pneumonectomy, NOS)
  31 Lobectomy
  32 Bilobectomy

Surgery Codes

LUNG
C34.0 - C34.9

Complete pneumonectomy Pneumonectomy, NOS Sleeve pneumonectomy Standard pneumonectomy Total pneumonectomy

40 Resection of whole lung

50 Resection of lung **WITH an en bloc resection of other organs**
- 51 Wedge resection
- 52 Lobectomy
- 53 Bilobectomy
- 54 Pneumonectomy (less than a radical or extended pneumonectomy)

EN BLOC resection is the removal of organs in one piece at one time.

60 Radical pneumonectomy

Radical pneumonectomy is a complete pneumonectomy WITH removal of mediastinal lymph nodes. Removal of mediastinal nodes is also coded in the data fields "Scope of Regional Lymph Node Surgery" and "Number of Regional Nodes Removed."

70 Extended radical pneumonectomy

An extended radical pneumonectomy is a radical pneumonectomy (including removal of mediastinal nodes) and the removal of other tissues or nodes. Removal of mediastinal nodes is also coded in the data fields "Scope of Regional Lymph Node Surgery" and "Number of Regional Nodes Removed."

80 Resection of lung, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LUNG
C34.0 - C34.9

SURGICAL MARGINS

CODE

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

Mediastinal nodes are:
Aortic (includes subaortic, aorticopulmonary window, periaortic, including ascending aorta or including azygos) Periesophageal Peritracheal (including those that may be designated tracheobronchial, i.e., lower peritracheal, phrenic) Pre- and retrotracheal (includes precarinal) Pulmonary ligament Subcarinal

Surgery Codes

LUNG
C34.0 - C34.9

CODE

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

- 2 Intrapulmonary (includes interlobar, lobar, segmental), ipsilateral hilar and/or ipsilateral peribronchial nodes
- 3 Ipsilateral mediastinal and/or subcarinal nodes
- 4 Combination of 2 and 3
- 5 Contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene and/or supraclavicular nodes
- 6 Combination of 5 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

LUNG
C34.0 - C34.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of ribs. Ribs are removed to provide access to the lung.

Codes

0 None; no surgery to other regional sites, distant sites or distant lymph nodes

1 Surgery to other site(s)or node(s), NOS; unknown if regional or distant

2 Surgery to a regional site ONLY

3 Removal of a solitary lesion in the same lung (primary site), different (non-primary) lobe

> There is one primary. Patient has two tumors with the same histology in different lobes of the same lung.

4 Resection of metastasis in a distant site(s) or resection of distant lymph nodes(s), NOS

5 Removal of a solitary lesion in the contralateral lung

> Patient has one primary. There is a primary tumor or tumor(s) in one lung and a solitary metastatic lesion in the contralateral lung.

6 Removal of a solitary lesion in a distant site or a distant lymph node, NOS

> This includes, but is not limited to the removal of a solitary metastatic brain lesion.

7 Removal of multiple lesions in distant site(s)

9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Chest wall reconstruction/restoration, NOS

9 Unknown; not stated; death certificate ONLY

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

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS
  2 Not image guided
  3 Image guided

4 Open, NOS
  5 Not assisted by endoscopy
  6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local tumor destruction or excision

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

90 Surgery, NOS
99 Unknown if surgery performed; death certificate ONLY

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

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

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

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

  2 Other regional site(s)

  5 Distant lymph node(s)

  6 Distant site(s)

  7 Combination of 6 WITH 2, 3, 4, or 5

9 Unknown; not stated; death certificate ONLY

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

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Flap, graft, or any "plasty," NOS
  2 WITHOUT implant/prosthesis
  3 WITH implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

SPLEEN AND LYMPH NODES
Spleen C42.2, Lymph Nodes C77.0 - C77.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS
  2 Not image guided
  3 Image guided

4 Open, NOS
  5 Not assisted by endoscopy
  6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local excision, destruction, NOS
  For lymphoma, use 10 to code lymph node biopsy that is not an excision of the full chain of lymph nodes.

20 Splenectomy, NOS (for spleen primaries only)
  21 Partial splenectomy
  22 Total splenectomy

30 Lymph node dissection, NOS (for lymphomas only)
  31 One chain
  32 Two or more chains

40 Lymph node dissection, NOS plus splenectomy
  41 One chain
  42 Two or more chains

SPLEEN AND LYMPH NODES
Spleen C42.2, Lymph Nodes C77.0 - C77.9

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY (SPLEEN Only)
Note: For primary sites C77.0-C77.9, code this field as ‘ 9.’

Codes

0 No regional lymph nodes removed (Spleen primary only)

1 Regional lymph node(s) removed, NOS (Spleen primary only)

9 Unknown; not stated; death certificate ONLY (Use this code for lymphoma)

SPLEEN AND LYMPH NODES
Spleen C42.2, Lymph Nodes C77.0 - C77.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED (SPLEEN Only)
Note: For primary sites C77.0-C77.9, code this field as "99."

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional site(s)
- 5 Distant lymph node(s)
- 6 Distant site(s)
- 7 Combination of 6 WITH 2, 3, 4, or 5

9 Unknown; not stated; death certificate ONLY

SPLEEN AND LYMPH NODES
Spleen C42.2, Lymph Nodes C77.0 - C77.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

9 At this time, reconstructive procedures are not being collected for these sites

SKIN
C44.0 - C44.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

4 Open approach

9 Death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- 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 this surgical event.

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

30 Biopsy of primary tumor followed by a gross excision of the lesion
- 31 Shave biopsy followed by a gross excision of the lesion; MOHS surgery
- 32 Punch biopsy followed by a gross excision of the lesion
- 33 Incisional biopsy followed by a gross excision of the lesion

Less than a wide excision, less than 1 cm margin.

Surgery Codes

SKIN
C44.0 - C44.9

40 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.
>
> Local amputation is the surgical resection of digits, ear, eyelid, lip, or nose.

.50 Radical excision of a lesion, NOS

> Margins of excision are greater than 1 cm and grossly tumors free. The margins may be microscopically involved.

60 Major amputation, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SKIN
C44.0 - C44.9

SCOPE OF REGIONAL LYMPH NODE SURGERY

Regional lymph nodes are different for each anatomical subsite.

Head, neck	Cervical, ipsilateral preauricular, submandibular, and supraclavicular
Thorax	Ipsilateral axillary
Arm	Ipsilateral epitrochlear and axillary
Abdomen, loins, and buttocks	Ipsilateral inguinal
Anal margin and perianal skin	Ipsilateral inguinal
Leg	Ipsilateral inguinal and popliteal

There are boundary zones between the subsites (i.e., between the thorax and arm, the boundary zone is the shoulder and axilla). The boundary zones do not belong to either subsite. If a tumor originates in one of these 4 cm boundary zones, the nodes on either side of the bands are regional.

BETWEEN THE SUBSITES		**THE BOUNDARY ZONE IS**
Head and neck AND	Thorax	Clavicula-acromion-upper shoulder blade edge
Thorax AND	Arm	Shoulder-axilla-shoulder
Thorax AND	Abdomen, loins, and buttocks	Front: Middle between navel and costal arch Back: Lower border of thoracic vertebrae (midtransverse axis)
Abdomen, loins, and buttock AND	Leg	Groin-trochanter-gluteal sulcus
Right AND	Left	Midline

SKIN
C44.0 - C44.9

Iliac, other pelvic, abdominal or intrathoracic lymph nodes are distant. Code the removal of these nodes under the data item, "Surgery of Other Regional Site(s), Distant Site(s), or Distant Node(s)."

Codes

0 No regional lymph nodes removed

1 Sentinel node, NOS

A sentinel node is the first node to receive drainage from a primary tumor. It is identified by an injection of a dye or radio label at the site of the primary tumor

2 Regional lymph nodes removed, NOS

9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SKIN
C44.0 - C44.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional sites(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Pedicle flap, free flap, skin graft, NOS

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

BREAST
C50.0 - C50.9

SURGICAL APPROACH

CODE

0 None; no surgery of primary site

4 Open approach, NOS
- 5 WITHOUT dye or needle localization
- 6 WITH dye or needle localization

9 Death certificate ONLY

SURGERY OF PRIMARY SITE

CODE

00 None; no surgery of primary site

> Procedures coded as 10-17 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

10 Partial mastectomy, NOS; less than total mastectomy, NOS
- 11 Nipple resection
- 12 Lumpectomy or excisional biopsy
- 13 Re excision of the biopsy site for gross or microscopic residual disease.
- 14 Wedge resection
- 15 Quadrantectomy
- 16 Segmental mastectomy
- 17 Tylectomy

30 Subcutaneous mastectomy

> A subcutaneous mastectomy is the removal of breast tissue without the nipple and areolar complex or overlying skin. **THIS PROCEDURE IS RARELY PERFORMED TO TREAT MALIGNANCIES.**

BREAST
C50.0 - C50.9

40 Total (simple) mastectomy, NOS
- 41 WITHOUT removal of uninvolved contralateral breast
- 42 WITH removal of uninvolved contralateral breast

> A 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 "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
- 52 WITH removal of uninvolved contralateral breast

> Removes all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin. The procedure involves an en bloc resection of the axilla. The specimen may or may not include a portion of the pectoralis major muscle. Includes an en bloc axillary dissection.
>
> For single primaries only, code removal of involved contralateral breast under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
- 62 WITH removal of uninvolved contralateral breast

> Removal of breast tissue, nipple, areolar complex, a variable amount of skin, pectoralis minor, and pectoralis major. Includes an en bloc axillary dissection.
>
> For single primaries only, code removal of involved contralateral breast under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

Surgery Codes

BREAST
C50.0 - C50.9

70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

> Removal of breast tissue, nipple, areolar complex, variable amounts of skin, pectoralis minor, and pectoralis major. Includes removal of internal mammary nodes and an en bloc axillary dissection.
>
> For single primaries only, code removal of involved contralateral breast under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

80 Mastectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BREAST
C50.0 - C50.9

SURGICAL MARGINS

Since the codes are hierarchical, if more than one code is applicable, use the numerically higher code. For example, if multiple margins are microscopically and macroscopically involved, code the macroscopic involvement(s).

Multiple margins are two separate margins, both of which are microscopically involved with tumor. **DO NOT CODE** multiple margins (4) if ONE MARGIN has multiple foci of tumor.

0 All margins grossly and microscopically negative

1 Margins involved, NOS

- 2 Microscopic involvement
  - 3 Single margin
  - 4 Multiple margins
- 5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

0 No regional lymph nodes removed

1 Sentinel lymph node(s) removed

A sentinel node is the first node to receive drainage from a primary tumor. It is identified by an injection of a dye or radio label at the site of the primary tumor

BREAST
C50.0 - C50.9

2 Regional lymph node(s) removed, NOS; axillary, NOS (Levels I, II, or III lymph nodes) Intramammary, NOS

3 Combination of 1 and 2

4 Internal mammary

5 Combination of 4 WITH any of 1-3

9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

BREAST
C50.0 - C50.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE removal of fragments or tags of muscles; removal of the pectoralis minor; the resection of pectoralis muscles, NOS; or the resection of fascia with no mention of muscle.

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
  - 5 Removal of involved contralateral breast (single primary only)
- 6 Combination of 4 or 5 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

BREAST
C50.0 - C50.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

The insertion of a tissue expander is often the beginning of the reconstructive procedure.

Codes

0 No reconstruction/restoration

1 Reconstruction, NOS (unknown if flap)

2 Implant; reconstruction WITHOUT flap

3 Reconstruction WITH flap, NOS
- 4 Latissimus dorsi flap
- 5 Abdomminus recti flap
- 6 Flap, NOS + implant
- 7 Latissimus dorsi flap + implant
- 8 Abdominus recti + implant

9 Unknown; not stated; death certificate ONLY

CERVIX UTERI
C53.0 - C53.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Vaginal, NOS
- 2 Not assisted by endoscopy
- 3 Assisted by colposcopy
- 4 Assisted by laparoscopy

5 Open, NOS
- 6 Not assisted by endoscopy
- 7 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

FOR INVASIVE CANCERS, dilation and curettage is coded as an incisional biopsy (02) under the data item "Non Cancer-Directed Surgery."

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 LEEP

No specimen sent to pathology from this surgical event.

Surgery Codes

CERVIX UTERI
C53.0 - C53.9

20 Local tumor destruction or excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser
- 24 Cone biopsy WITH gross excision of lesion
- 25 Dilatation and curettage; endocervical curettage (cancer-directed for in situ only)
- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 28 LEEP
- 29 Trachelectomy; removal of cervical stump; cervicectomy

> Specimen sent to pathology from this surgical event.

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 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's 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. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

Surgery Codes

CERVIX UTERI
C53.0 - C53.9

72 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CERVIX UTERI
C53.0 - C53.9

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Common iliac External iliac Hypogastric (obturator) Internal iliac Paracervical Parametrial Presacral Sacral

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

CERVIX UTERI
C53.0 - C53.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

CERVIX UTERI
C53.0 - C53.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of an appendix. **DO NOT CODE** an omentectomy **IF** it was the only surgery performed in addition to hysterectomy. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional site(s)
- 3 Distant lymph node(s), NOS
  - 4 Periaortic lymph nodes
- 5 Distant site(s)
- 6 Combinations of 5 with 4
- 7 Combination of 5 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

CERVIX UTERI
C53.0 - C53.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Vaginal reconstruction

2 Urinary reconstruction

3 Bowel reconstruction/restoration

4 Combination of 3 with 1 or 2

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

CORPUS UTERI
C54.0 - C55.9

SURGICAL APPROACH

0 None; no surgery of primary site

1 Vaginal, NOS
- 2 Not assisted by endoscopy
- 3 Assisted by colposcopy
- 4 Assisted by laparoscopy

5 Open, NOS
- 6 Not assisted by endoscopy
- 7 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

FOR INVASIVE CANCERS, dilation and curettage is coded as an incisional biopsy (02) under the data item "Non Cancer-Directed Surgery."

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 LEEP

No specimen sent to pathology from this surgical event.

Procedures in code 20 include but are not limited to:
Cryosurgery Electrocautery Excisional biopsy Laser ablation Thermal ablation

CORPUS UTERI
C54.0 - C55.9

20 Local tumor destruction or excision, NOS; simple excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser
- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

> Specimen sent to pathology from this surgical event.
>
> Margins of resection may have microscopic involvement.

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)

> Cervix 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) 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's procedure
- 64 Extended radical hysterectomy

70 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
- 71 WITHOUT removal of tube(s) and ovary(ies)
- 72 WITH removal of tube(s) and ovary(ies)

80 Pelvic exenteration
- 81 Anterior exenteration

> Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

CORPUS UTERI
C54.0 - C55.9

82 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

83 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

84 Extended exenteration

Includes pelvic blood vessels or bony pelvis

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

CORPUS UTERI
C54.0 - C55.9

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Common iliac and external iliac Hypogastric (obturator) Para aortic Parametrial Sacral

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

2 Pariaortic with or without other regional lymph nodes

9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

CORPUS UTERI
C54.0 - C55.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of the appendix or an omentectomy **IF** it was the only surgery performed in addition to hysterectomy. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Vaginal reconstruction

2 Urinary reconstruction

3 Bowel reconstruction/restoration

4 Combination of 3 with 1 or 2

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

OVARY
C56.9

SURGICAL APPROACH

0 None; no surgery of primary site

1 Endoscopy, NOS (laparoscopy)
  2 Not image guided
  3 Image guided

Open approaches include, but are not limited to:
Low transverse abdominal incision Vertical abdominal incision

4 Open, NOS
  5 Not assisted by endoscopy
  6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

00 None; no surgery of primary site

10 Total removal of tumor or (single) ovary, NOS
  11 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
    12 WITHOUT hysterectomy
    13 WITH hysterectomy
  14 Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done
    15 WITHOUT hysterectomy
    16 WITH hysterectomy

20 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done
  21 WITHOUT hysterectomy
  22 WITH hysterectomy

30 Unilateral or bilateral (salpingo-) oophorectomy **WITH OMENTECTOMY**, NOS; partial or total; unknown if hysterectomy done
  31 WITHOUT hysterectomy
  32 WITH hysterectomy

Surgery Codes

OVARY
C56.9

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 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

> Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

- 72 Posterior

> Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

- 73 Total

> Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

- 74 Extended

> Includes pelvic blood vessels or bony pelvis.

80 (Salpingo-) oophorectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

OVARY
C56.9

SURGICAL MARGINS

For this site only, this field will describe the residual tumor after cancer-directed surgery.

Codes

0 No visible residual tumor

1 Visible residual tumor, NOS
  2 Visible residual tumor, cumulative maximum of less than 1 cm
  3 Visible residual tumor, cumulative maximum of at least 1 cm, not more than 2 cm
  4 Visible residual tumor, cumulative maximum of more than 2 cm

8 No surgery of primary site

9 Unknown whether visible residual tumor was present; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Common iliac External iliac Hypogastric (obturator) Inguinal Lateral sacral Paraaortic Pelvic, NOS Retroperitoneal, NOS

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

OVARY
C56.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE an incidental removal of the appendix. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

OVARY
C56.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Urinary reconstruction

2 Bowel reconstruction/restoration

3 Combination of 1 and 2

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

PROSTATE
C61.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS (transurethral)

2 Laparoscopic, NOS

3 Open, NOS
- 4 Suprapubic
- 5 Perineal
- 7 Trans-sacral
- 8 Retropubic

> Code the approach for radical prostatectomy as retropubic unless otherwise specified.

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the field "Hormone Therapy."

Codes

00 None; no surgery of primary site

10 Local tumor destruction or excision, NOS
- 11 Transurethral resection (TURP), NOS
  - 12 TURP - cancer is incidental finding during surgery for benign disease
  - 13 TURP - patient has suspected/known cancer
- 14 Cryoprostatectomy
- 15 Laser
- 16 Hyperthermia
- 17 Other method of local resection or destruction

30 Subtotal or simple prostatectomy, NOS

> A segmental resection or enucleation leaving the capsule intact.

Surgery Codes

PROSTATE
C61.9

40 Less than total prostatectomy, NOS

An enucleation using an instrument such as a Vapotrode which may leave all or part of the capsule intact.

50 Radical prostatectomy, NOS; total prostatectomy, NOS

Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy WITH en bloc resection of other organs; pelvic exenteration

Surgeries coded 70 are any prostatectomy WITH an en bloc resection of any other organs. The other organs may be partially or totally removed.

EN BLOC RESECTION is the removal of organs in one piece at one time. Procedures that may involve an en bloc resection include, but are not limited to: cystoprostatectomy, radical cystectomy and prostatectomy.

80 Prostatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PROSTATE
C61.9

SURGICAL MARGINS

The codes are hierarchical, if more than one code is applicable, use the numerically higher code. For example, if multiple margins are microscopically and macroscopically involved, code the macroscopic involvement (5).

Multiple margins are two separate margins, both of which are microscopically involved with tumor. DO NOT CODE multiple margins (4) if one margin has multiple foci of tumor.

Codes

0 All margins grossly and microscopically negative

1 Margin(s) involved, NOS

- 2 Microscopic involvement
  - 3 Single margin
  - 4 Multiple margins
- 5 Macroscopic involvement, NOS

7 Margins not evaluable (TURP)

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Hypogastric Iliac, NOS (internal and external) Obturator Pelvic, NOS Periprostatic Sacral, NOS (lateral presacral, promontory [Gerota's] or NOS)

Surgery Codes

PROSTATE
C61.9

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of nodes unknown /not stated and not documented as sampling or dissection
99 Unknown if regional lymph nodes removed; death certificate ONLY

PROSTATE
C61.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S)

DO NOT CODE orchiectomy. For prostate primaries, code orchiectomies under "Hormone Therapy."

The most commonly removed distant lymph nodes are: aortic (para-aortic, peri-aortic, lumbar), common iliac, inguinal, superficial inguinal (femoral), supraclavicular, cervical, and scalene.

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Reconstruction/restoration, NOS
- 2 Collagen injection for incontinence
- 3 Penile prosthesis
- 4 Artificial urinary sphincter
- 5 Combinations of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

TESTIS
C62.0-C62.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

4 Open, NOS
  5 Scrotal
  6 Inguinal

9 Death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local or partial excision of testicle

30 Excision of testicle, NOS WITHOUT cord

40 Excision of testicle, NOS WITH cord/or cord not mentioned

80 Orchiectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

TESTIS
C62.0-C62.9

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Interaortocaval Paraaortic (Periaortic) Paracaval Preaortic Precaval Retroaortic Retrocaval

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS; not stated if bilateral or unilateral
  2 Unilateral regional lymph nodes
  3 Bilateral regional lymph nodes

9 Unknown; not stated; death certificate ONLY

TESTIS
C62.0-C62.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

TESTIS
C62.0-C62.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Testicular implant

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS
  2 Not image guided
  3 Image guided

4 Open, NOS
  5 Not assisted by endoscopy
  6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
  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 this surgical event.

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
  21 Photodynamic therapy (PDT)
  22 Electrocautery
  23 Cryosurgery
  24 Laser ablation
  25 Laser excision
  26 Polypectomy
  27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Surgery Codes

KIDNEY, RENAL PELVIS, AND URETER
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

Procedures coded 30 include, but are not limited to:
Cryosurgery Electrocautery Excisional biopsy Laser Segmental resection Thermal ablation Wedge resection

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Margins of resection are grossly negative. There may be microscopic involvement

40 Complete/total/simple nephrectomy - for 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) **PLUS** an en bloc resection of other organ(s) (colon, bladder)

The other organs, such as colon or bladder, may be partially or totally removed.

80 Nephrectomy, NOS
Ureterectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are	
Kidney	Aortic (para-aortic, periaortic, lateral aortic) Paracaval Renal hilar Retroperitoneal, NOS
Renal pelvis	Aortic Paracaval Renal hilar Retroperitoneal, NOS
Ureter	Iliac (common, internal [hypogastric], external) Paracaval Pelvic, NOS Periureteral Renal hilar

KIDNEY, RENAL PELVIS, AND URETER
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS; not stated if bilateral or unilateral
  2 Unilateral regional lymph nodes
  3 Bilateral regional lymph nodes

9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of nodes unknown /not stated and not documented as sampling or dissection
99 Unknown if regional lymph nodes removed; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE the incidental removal of ribs during the operative approach.

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

  2 Other regional site(s)

  3 Distant lymph node(s)

  4 Distant site(s)

  5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Kidney transplant (primary site)

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

BLADDER
C67.0-C67.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS
  2 Cystoscopy (TURB)
  3 Laparoscopy

4 Open, NOS
  5 Not assisted by endoscopy (laparoscopy)
  6 Assisted by endoscopy (laparoscopy)

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
  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 this surgical event.

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
  21 Photodynamic therapy (PDT)
  22 Electrocautery
  23 Cryosurgery
  24 Laser ablation
  25 Laser excision
  26 Polypectomy
  27 Excisional biopsy (TURB)

Specimen sent to pathology from this surgical event.

Surgery Codes

BLADDER
C67.0-C67.9

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Radical cystectomy (male only)

> This code is used only for men. It involves the removal of bladder and prostate, with or without urethrectomy.
>
> If a radical cystectomy is the procedure name for a woman, use code 71.

70 Pelvic exenteration, NOS

71 Radical cystectomy (female only); anterior exenteration

> A radical cystectomy in a female includes removal of bladder, uterus, ovaries, entire vaginal wall and entire urethra.

72 Posterior exenteration

73 Total exenteration

> Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration

> Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BLADDER
C67.0-C67.9

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are:
Hypogastric Iliac (internal, external, NOS) Obturator Pelvic, NOS Perivesical Presacral Sacral (lateral, sacral promontory [Gerota's])

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS; not stated if bilateral or unilateral
  2 Unilateral regional lymph nodes
  3 Bilateral regional lymph nodes

9 Unknown; not stated; death certificate ONLY

BLADDER
C67.0-C67.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

DO NOT CODE the partial or total removal of a ureter during a cystectomy.

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

BLADDER
C67.0-C67.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Conduit diversion

2 Continent reservoir (a bladder substitute)

Types of continent reservoirs include, but are not limited to:
Hemi-Kock Ileal reservoir Ileocecal reservoir Indiana or Mainz pouch Koch Studer pouch W-shaped ileoneobladder by Hautmann

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate ONLY

BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM
Meninges C70.0 - C70.9, Brain C71.0 - C71.9
Other Parts of Central Nervous System C72.0 - C72.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

4 Open

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

DO NOT CODE laminectomies for spinal cord primaries.

Codes

00 None; no surgery of primary site

10 Local tumor destruction

20 Partial excision of tumor, lesion, or mass (> 5% and < 100%)
- 21 Subtotal resection, NOS (. 50% and < 100%)
- 22 Partial resection (> 50% and <100%)
- 23 Debulking (> 5% and < 50%)

30 Total excision of tumor, lesion, or mass, NOS (100%)
- 31 Total resection
- 32 Gross resection

40 Partial resection, NOS
- 41 Partial lobe
- 42 Partial meninges
- 43 Partial nerve(s)

50 Total resection (lobectomy of brain)

60 Radical resection

Resection of primary site plus partial or total removal of surrounding organs/tissue

BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM
Meninges C70.0 - C70.9, Brain C71.0 - C71.9
Other Parts of Central Nervous System C72.0 - C72.9

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

There are no regional lymph nodes for brain. Code no regional lymph nodes removed (0). Central nervous system sites, however have regional lymph nodes.

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM
Meninges C70.0 - C70.9, Brain C71.0 - C71.9
Other Parts of Central Nervous System C72.0 - C72.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

There are no regional lymph nodes for brain. Code no regional lymph nodes removed (00). Central nervous system tumors, however, have regional lymph nodes.

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional site(s)
- 5 Distant lymph node(s)
- 6 Distant site(s)
- 7 Combination of 6 WITH 2, 3, 4, or 5

9 Unknown; not stated; death certificate ONLY

BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM
Meninges C70.0 - C70.9, Brain C71.0 - C71.9
Other Parts of Central Nervous System C72.0 - C72.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

9 Not applicable (There are no known reconstructive procedures for this site.)

THYROID GLAND
C73.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS
  2 Not image guided
  3 Image guided

4 Open, NOS
  5 Not assisted by endoscopy
  6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Removal of less than a lobe, NOS
  11 Local surgical excision
  12 Removal of a partial lobe ONLY

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

THYROID GLAND
C73.9

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

The regional lymph nodes are the cervical and upper mediastinal lymph nodes.

Terminology of neck dissection (Robbins et al. 19):

A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more non lymphatic structures are preserved.

A selective neck dissection is a neck dissection with preservation of one or more lymph nodes group routinely removed in radical neck dissection.

THYROID GLAND
C73.9

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

- 2 Neck dissection, NOS
  - 3 Selective, limited; nodal sampling; "berry picking"
  - 4 Modified/modified radical
  - 5 Radical

9 Unknown; not stated; death certificate ONLY

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

THYROID GLAND
C73.9

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

9 Not applicable (There are no known reconstructive procedures for this site.)

ALL 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, C42.0 - C42.1, C42.3 - C42.4, C48.0 - C48.8, C51.0 - C51.9, C52.9, C57.0 - C57.9, C58.9, C60.0 - C 60.9, C63.0 - C 63.9, C68.0 - C68.9, C69.0 - C69.9, C74.0 - C76.8, C80.9

SURGICAL APPROACH

Codes

0 None; no surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate ONLY

SURGERY OF PRIMARY SITE

Codes

00 None; no surgery of primary site

10 Local tumor destruction, NOS **(WITHOUT PATHOLOGY SPECIMEN)**
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery' fulguration
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from this surgical event.

Surgery Codes

ALL 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, C42.0 - C42.1, C42.3 - C42.4, C48.0 - C48.8, C51.0 - C51.9, C52.9, C57.0 - C57.9, C58.9, C60.0 - C 60.9, C63.0 - C 63.9, C68.0 - C68.9, C69.0 - C69.9, C74.0 - C76.8, C80.9

20 Local tumor excision, NOS (**WITH PATHOLOGY SPECIMEN**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation

50 Surgery stated to be "debulking"

60 Radical surgery

Partial or total removal of the primary site WITH an en bloc resection (partial or total removal) of other organs.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ALL 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, C42.0 - C42.1, C42.3 - C42.4, C48.0 - C48.8, C51.0 - C51.9, C52.9, C57.0 - C57.9, C58.9, C60.0 - C 60.9, C63.0 - C 63.9, C68.0 - C68.9, C69.0 - C69.9, C74.0 - C76.8, C80.9

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS
  2 Microscopic involvement
  5 Macroscopic involvement

7 Margins not evaluable

8 No surgery of primary site

9 Unknown whether margins were involved or negative; death certificate ONLY

SCOPE OF REGIONAL LYMPH NODE SURGERY

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate ONLY

Surgery Codes

ALL 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, C42.0 - C42.1, C42.3 - C42.4, C48.0 - C48.8, C51.0 - C51.9, C52.9, C57.0 - C57.9, C58.9, C60.0 - C 60.9, C63.0 - C 63.9, C68.0 - C68.9, C69.0 - C69.9, C74.0 - C76.8, C80.9

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant

2 Other regional sites

3 Distant lymph node(s)

4 Distant site(s)

5 Combination of 4 WITH 2 or 3

9 Unknown; not stated; death certificate ONLY

Surgery Codes

ALL 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, C42.0 - C42.1, C42.3 - C42.4, C48.0 - C48.8, C51.0 - C51.9, C52.9, C57.0 - C57.9, C58.9, C60.0 - C 60.9, C63.0 - C 63.9, C68.0 - C68.9, C69.0 - C69.9, C74.0 - C76.8, C80.9

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

9 At this time, reconstructive procedures are not being collected for these sites

Appendix Q-2 Surgery Codes
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Parotid & Other Unspecified Glands……...3

Pharynx……5

Esophagus……7

Stomach……8

Colon……10

Rectosigmoid……..….12

Rectum……....14

Anus……....16

Liver & Intrahepatic Bile Ducts……..17

Pancreas……..18

Larynx…….19

Lung……..…20

Hematopoietic/ Reticuloendothelial/Immunoproliferative Disease…….22

Bones, Joints& Articular Cartilage/ Peripheral Nerves/ Connective & Soft Tissue……23

Spleen ……..24

Skin……...25

Breast……28

Cervix Uteri……..…29

Corpus Uteri……..…31

Ovary……33

Prostrate……..….35

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Brain & Other Parts of Central Nervous System……...…42

Thyroid Gland……..…43

Lymph Nodes……..…..44

All Other Sites……..……45

Unknown and Ill Defined Primary Sites……...…..46

APPENDIX Q.2
SURGERY CODES
(For Cases Diagnosed on or after January 1, 2003)

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-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

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

Specimen sent to pathology from surgical events 20–27.
[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]

Surgery 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-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Codes 40–43 include:
Total glossectomy
Radical glossectomy

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PAROTID AND OTHER UNSPECIFIED GLANDS
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

Specimen sent to pathology from surgical events 20-27.

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)

Surgery Codes

PAROTID AND OTHER UNSPECIFIED GLANDS
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

80 Parotidectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery 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-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

Specimens sent to pathology from surgical events 20-28.

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

Surgery 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-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

50 Radical pharyngectomy (includes total mandibular resection), NOS
- 51 WITHOUT laryngectomy
- 52 WITH laryngectomy

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

ESOPHAGUS

C15.0-C15.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

Specimen sent to pathology from surgical events 20-27.

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 52-54

80 Esophagectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

STOMACH

C16.0-C16.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

Specimen sent to pathology from surgical events 20-27.

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.

Surgery Codes

STOMACH

C16.0-C16.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

Surgery Codes

COLON

C18.0-C18.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

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

Specimen sent to pathology from surgical events 20-29.

30 Partial colectomy, segmental resection
- 32 Plus resection of contiguous organ; example: small bowel, bladder

[SEER Guideline: codes 30-31include 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., cecetomy, sigmoidectomy]

40 Subtotal colectomy/hemicolectomy [or greater (but less tha total); right or left colectomy] (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

Surgery Codes

COLON

C18.0-C18.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

RECTOSIGMOID

C19.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

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

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

Specimen sent to pathology from surgical events 20-27.

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

Surgery Codes

RECTOSIGMOID

C19.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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: abdominaoperineal resection (A & P resection), anterior/posterior resection (A/P resection)/Miles' operation, Rankin's operation]

51 Total colectomy [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
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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

RECTUM

C20.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

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

Specimen sent to pathology from surgical events 20-28.

30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 30 include but are not limited to:
- Anterior resection
- Hartmann's 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, Soace's submucosal resection, Swenson's operation, Turnbull's operation.]

Surgery Codes

RECTUM

C20.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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/Miles' 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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

ANUS

C21.0-C21.8

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

Specimen sent to pathology from surgical events 20-27.
[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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

LIVER AND INTRAHEPATIC BILE DUCTS

C22.0-C22.1

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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.

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

Specimen sent to pathology from surgical events 20-26.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

PANCREAS

C25.0-C25.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

Surgery Codes

LARYNX

C32.0-C32.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

Specimen sent to pathology from surgical events 20-28.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

LUNG

C34.0-C34.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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
Specimen sent to pathology from surgical events 20-25.

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

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 mediastinal lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292)

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."

Surgery Codes

LUNG

C34.0-C34.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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 mediastinal lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292)

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

HEMATOPOIETIC/RETICULOENDOTHELIAL/ IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE C42.0, C42.1, C42.3, C42.4 for all histologies Or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989 for all sites

Code

98 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* (NAACCR Item #1294).

99 Death certificate only.

NOTE: A hematopoietic case not otherwise specified in the list of 'standard exclusions' (M-9750, 9760-9764, 9800-9720, 9826, 9831-9920, 9931-9964, 9980-9989) in the surgery code appendix should be treated as an "Unknown And Ill-Defined Primary Site." Examples include solitary plasmacytoma and chloroma.

Surgery Codes

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-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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)]
Specimen sent to pathology from surgical events 25-26.

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)]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

SPLEEN

Spleen C42.2

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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, NOS[formerly SEER code 10 = local excision, destruction, NOS]
No 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]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

SKIN

C44.0-C44.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

Specimen sent to pathology from surgical events 20-27.

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 2 cm
- 47 WITH margins greater than 2 cm

60 Major amputation [NOS]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

BREAST

C50.0-C50.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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 is the removal of breast tissue without the nipple and areolar complex or overlying skin.
[SEER Guideline: this procedure is rarely used to treat, malignancies]

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 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* (NAACCR Item #1294).

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.

Surgery Codes

BREAST

C50.0-C50.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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* (NAACCR Item #1294).

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."]

Surgery Codes

BREAST

C50.0-C50.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CERVIX UTERI

C53.0-C53.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350)

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)

Specimen sent to pathology from surgical events 20-29.

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

CERVIX UTERI

C53.0-C53.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CORPUS UTERI

C54.0-C55.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

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

Specimen sent to pathology from surgical events 20-26.
[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]

CORPUS UTERI

C54.0-C55.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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]0
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.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

OVARY
C56.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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/OtherSite.*

OVARY
C56.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

72 Posterior *extenteration*
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
NOTE*: Do not code removal of pelvic lymph nodes Surgical Procedure/Other Site.*

73 Total *extenteration*
Includes removal of all pelvic contents and pelvic lymph nodes.
NOTE: *Do not code removal of pelvic lymph nodes Surgical Procedure/Other Site.*

74 Extended *extenteration*
Includes pelvic blood vessels or bony pelvis.
NOTE*: Do not code removal of pelvic lymph nodes Surgical Procedure/Other Site.*

80 (Salpingo-)oophorectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

PROSTATE

C61.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item "Hematologic Transplant and Endocrine Procedures" (NAACCR Item#3250).

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 TURP---cancer is incidental finding during surgery for benign disease [formerly SEER code 12]
- 23 TURP---patient 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 [formerly SEER code 30 or 40]

50 Radical prostatectomy, NOS; total prostatectomy, NOS
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]

Surgery Codes

PROSTATE

C61.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

80 Prostatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

TESTIS

C62.0-C62.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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 [formerly SEER code 10]
Specimen sent to pathology from surgical event 20.

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)

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

Specimen sent to pathology from surgical events 20-27.

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 nephrectomy---for 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.

Surgery Codes

KIDNEY, RENAL PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

BLADDER

C67.0-C67.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

No specimen sent to pathology from surgical events 10-16.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

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

Specimen sent to pathology from surgical events 20-27.

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 with 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)

BLADDER

C67.0-C67.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

70 Pelvic exenteration, NOS

71 Radical cystectomy (female only); anterior exenteration

A radical cystectomy in a female includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra.

72 Posterior exenteration

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

The lymph node dissection should also be coded under Scope of Lymph Node Surgery (NAACCR Item #1292) or Scope of Regional Lymph Node Surgery at This Hospital (NAACCR Item #672).

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

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-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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 as tumor destruction. It should be recorded in the radiation treatment item *Regional Treatment Modality* (NAACCR Item # 1570).

20 *Local excision (biopsy)* of tumor, lesion, or mass
Specimen sent to pathology from surgical event 20.

40 Partial resection [NOS]

55 Gross total resection [formerly SEER codes 31, 32, 50, 60]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Surgery Codes

THYROID GLAND

C73.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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]

Specimen sent to pathology from surgical events 25-27.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LYMPH NODES

Lymph Nodes C77.0-C77.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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 a lymph node biopsy.

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

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ALL OTHER SITES

***C14.2*-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-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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

Specimen sent to pathology from surgical events 20-27.

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]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

UNKNOWN AND ILL-DEFINED PRIMARY SITES

C76.0-C76.8, C80.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

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 (NAACCR Item #1294) *or Surgical Procedure/Other Site at This Hospital (NAACCR Item #647).*

[99 Death certificate only]

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

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

yes	REQUIRED ON ALL CASES (cannot be blank, but can be coded UNKNOWN)
yes*	REQUIRED ON ALL CASES, BUT IF INFORMATION IS NOT AVAILABLE OR NOT APPLICABLE CAN BE LEFT BLANK
sel	REQUIRED ON SELECTED IDENTIFIABLE CASES, SUCH AS CERTAIN SITES OR YEARS OF DIAGNOSIS (left blank or a specific entry is required on other cases, such as code 0, 9, or UNKNOWN)
no	NOT A PART OF THE DATA SET
may	PART OF THE DATA SET BUT NOT REQUIRED (may be left blank on any and all cases)
gen	GENERATED BY COMPUTER, BY THE REGIONAL REGISTRY, OR BY THE CALIFORNIA CANCER REGISTRY
res	RESERVED FIELD. LEAVE BLANK
SEER	DESIGNATES THE DATA SET OF THE NATIONAL CANCER INSTITUTE'S SEER PROGRAM
ACoS	DESIGNATES THE AMERICAN COLLEGE OF SURGEONS DATA SET
C/N	DESIGNATES THE CNExT DATA SET
Region	DESIGNATES THE DATA SET REQUIRED FOR REPORTING BY HOSPITALS TO REGIONAL REGISTRIES IN CALIFORNIA
RX CTR	DESIGNATES THE DATA SET REQUIRED FOR REPORTING BY NON-HOSPITAL TREATMENT CENTERS TO REGIONAL REGISTRIES IN CALIFORNIA
Manual	INDICATES WHERE INSTRUCTIONS FOR THE ITEM ARE FOUND: SECTION NUMBER (indicates section of *Abstracting and Coding Procedures for Hospitals)*; VOL. 2 (California Cancer Reporting System Standards, Volume Two: *Standards for Automated Reporting)*; OR C/N USER *(CNExT^2 User Manual)*
CCR	DESIGNATES THE DATA SET REQUIRED FOR REPORTING BY REGIONAL REGISTRIES TO THE CALIFORNIA CANCER REGISTRY.

Data Items and Their Required Status

Item Name	Manual	C/N	RX Ctr	Transmitted from Hospital to Region	SEER Collect	ACoS
Abstractor	III.1.1	yes	yes	yes	yes	yes
Accession Number (Hosp)	II.2.3	yes	yes	yes	yes	yes
ACoS Approved Flag	III.1.6	yes	yes	yes	no	no
Address at Diagnosis–City	III.2.5	yes	yes	yes	yes	yes
Address at Diagnosis –No. & Street	III.2.5	yes	yes	yes	yes	yes
Address at Diagnosis –No. & Street - Supplemental	III.2.5	yes*	yes*	yes*	yes	yes
Address at Diagnosis–State	III.2.5	yes	yes	yes	yes	yes
Address at Diagnosis–Zip Code	III.2.5	yes	yes	yes	yes	yes
Age at Diagnosis	III.2.11	gen	gen	gen	yes	yes
Alias First Name	III.2.1.6	yes*	yes*	yes*	no	no
Alias Last Name	III.2.1.5	yes*	yes*	yes*	no	no
Birth Date	III.2.10	yes	yes	yes	yes	yes
Birthplace	III.2.12	yes	yes	yes	yes	yes
Casefinding Source	III.3.8	yes	yes	yes	no	no
Cause of Death	VII.2.14	may	no	no	yes	no
Chemotherapy at This Hospital	VI.4	yes	yes	yes	yes	yes
Chemotherapy Summary	VI.4	yes	yes	yes	yes	yes
Class of Case	III.3.5	yes	yes	yes	no	no
Coding Procedure	III.1.5	gen	gen	yes	no	no
Contact City	VII.3	yes*	yes*	yes*	yes	no
Comorbidity/Complications 1	*III.3.13*	*yes**	*yes**	*yes**	*no*	*yes*
Comorbidity/Complications 2	*III.3.13*	*yes**	*yes**	*yes**	*no*	*yes*
Comorbidity/Complications 3	*III.3.13*	*yes**	*yes**	*yes**	*no*	*yes*
Comorbidity/Complications 4	*III.3.13*	*yes**	*yes**	*yes**	*no*	*yes*
Comorbidity/Complications 5	*III.3.13*	*yes**	*yes**	*yes**	*no*	*yes*
Comorbidity/Complications 6	*III.3.13*	*yes**	*yes**	*yes**	*no*	*yes*
Contact Country	VII.3	may	may	may	no	no
Contact Name	VII.3	yes*	yes*	yes*	yes	no
Contact State	VII.3	yes*	yes*	yes*	yes	no
Contact Street	VII.3	yes*	yes*	yes*	yes	no
Contact Street - Supplemental	VII.3	yes*	yes*	yes*	no	yes
Contact Zip	VII.3	yes*	yes*	yes*	yes	no
County of Residence at Diagnosis	III.2.5	yes	yes	yes	yes	no
CS Tumor Size	*V.4.2*	*yes*	*yes*	*yes*	*yes*	*yes*
CS Extension	*V.4.2*	*yes*	*yes*	*yes*	*yes*	*yes*
CS Tumor Size/Extension Evaluation	*V.4.2*	*yes**	*yes**	*yes**	*no*	*yes*
CS Lymph Nodes	*V.4.2*	*yes*	*yes*	*yes*	*yes*	*yes*
CS Lymph Nodes Evaluation	*V.4.2*	*yes**	*yes**	*yes**	*no*	*yes*

Data Items and Their Required Status

Item Name	Manual	C/N	RX Ctr	Transmitted from Hospital to Region	SEER Collect	ACoS
CS Metastasis at Diagnosis	V.4.2	yes	yes	yes	yes	yes
CS Metastasis Evaluation	V.4.2	yes*	yes*	yes*	no	yes
CS Site Specific Factor 1	V.4.2	yes	yes	yes	yes	yes
CS Site Specific Factor 2	V.4.2	yes	yes	yes	yes	yes
CS Site Specific Factor 3	V.4.2	yes	yes	yes	yes	yes
CS Site Specific Factor 4	V.4.2	yes	yes	yes	yes	yes
CS Site Specific Factor 5	V.4.2	yes	yes	yes	yes	yes
CS Site Specific Factor 6	V.4.2	yes	yes	yes	yes	yes
CS Version 1st	V.4.2	yes	yes	yes	yes	yes
CS Version Latest	V.4.2	yes	yes	yes	yes	yes
Date of Chemotherapy	VI.1.3.2	sel	sel	yes*	no	no
Date of Diagnosis	III.3.3	yes	yes	yes	yes	yes
Date of First Admission	III.3.1	yes	yes	yes	no	yes
Date of Inpatient Admission	III.3.2	yes*	no	yes*	no	no
Date of Inpatient Discharge	III.3.2	yes*	no	yes*	no	no
Date of Hormone Therapy	VI.1.3.2	sel	sel	yes*	no	no
Date of Immunotherapy	VI.1.3.2	sel	sel	yes*	no	no
Date of Last Patient Contact or Death	VII.2.1	yes	yes	yes	yes	yes
Date of Last Tumor Status	VII.2.3	yes	yes	yes	no	no
Derived AJCC T	V.4.2	yes	yes	yes	yes	yes
Derived AJCC T Descriptor	V.4.2	yes*	yes*	yes*	no	yes
Derived AJCC N	V.4.2	yes	yes	yes	yes	yes
Derived AJCC N Descriptor	V.4.2	yes*	yes*	yes*	no	yes
Derived AJCC M	V.4.2	yes	yes	yes	yes	yes
Derived AJCC M Descriptor	*V.4.2*	*yes**	*yes**	*yes**	*no*	*yes*
Derived AJCC Stage Group	V.4.2	yes	yes	yes	yes	yes
Derived SS2000	V.4.2	yes	yes	yes	yes	yes
Derived SS1977	V.4.2	yes	yes	yes	yes	yes
Derived AJCC - Flag	V.4.2	yes	yes	yes	yes	yes
Derived SS2000 - Flag	V.4.2	yes	yes	yes	yes	yes
Derived SS1977 - Flag	V.4.2	yes	yes	yes	yes	yes

Data Items and Their Required Status

Item Name	Manual	C/N	RX Ctr	Transmitted from Hospital to Region	SEER Collect	ACoS
Date of Most Definitive Surgery of the Primary Site	VI.2.5	gen	gen	yes*	no	yes
Date of Other Therapy	VI.1.3.2	sel	sel	yes*	no	yes
Date of Radiation	VI.1.3.2	sel	sel	yes*	no	yes
Date of Systemic Therapy	VI.1.3.2	gen	gen	yes*	no	yes
Date of Surgery	VI.1.3.2	gen	gen	yes*	no	yes
Date of Surgery– Diagnostic or Staging Procedures	VI.2.12	sel	sel	yes*	no	yes
Date of Surgery– Procedures 1-3	VI.2.5	sel	sel	yes	no	no
Date of Therapy	Vol III	no	no	no	yes	yes
Date of Transplant/Endocrine Procedures	VI.7.2	sel	sel	yes*	no	no
Death File Number	VII.2.14	may	no	no	no	no
Diagnostic Confirmation	IV.2	yes	yes	yes	yes	yes
EOD – Extension	V.4	yes	yes	yes	yes	no
EOD – Extension (Path)	V.4	yes	yes	yes	yes	no
EOD –- Lymph Node Involvement	V.4	yes	yes	yes	yes	no
First Name	III.2.1.2	yes	yes	yes	yes	yes
Follow up Contact Address–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact Address–Other - Supplemental	VII.3	yes*	yes*	yes*	no	no
Follow up Contact City–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact Name–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact State–Other	VII.3	yes*	yes*	yes	yes	no
Follow up Contact Zip–Other	VII.3	yes*	yes*	yes	yes	no
Follow up–Last Type (Patient)	VII.2.6.2	yes	yes	yes	no	no
Follow up–Last Type (Tumor)	VII.2.6.1	yes	yes	yes	no	no
Follow up–Next Type	VII.2.8	yes*	yes*	yes*	no	no
Follow up Hospital (Next)	VII.2.9	yes*	no	no	no	yes
Follow up Hospital (Last)	VII.2.7	yes	yes	yes	no	no
Histology Text	IV.1.7	yes	yes	yes	yes	no
Histology–Behavior (ICD-O-2)	V.3.4	yes	yes	yes	yes	no
Histology–-Behavior (ICD-O-3)	V.3.4	yes	yes	yes	yes	yes
Histology–Grade/ Differentiation	V.3.5	yes	yes	yes	yes	yes
Histology–Type (ICD-O-2)	V.3	yes	yes	yes	yes	no
Histology–-Type (ICD-O-3)	V.3	yes	yes	yes	yes	yes
Hormone Therapy at This Hospital	VI.5	yes	yes	yes	yes	yes
Hormone Therapy Summary	VI.5	yes	yes	yes	yes	yes

Data Items and Their Required Status

Item Name	Manual	C/N	RX Ctr	Transmitted from Hospital to Region	SEER Collect	ACoS
Hospital Number (Reporting)	III.1.4	yes	yes	yes	yes	yes
Hospital Patient Number	Vol. 2	gen	gen	yes	no	no
Hospital Referred From	III.3.10	yes	yes	yes	no	yes
Hospital Referred To	III.3.11	yes	yes	yes	no	no
ICD-O-3 Conversion Flag	Vol. 2	gen	gen	yes	yes	yes
Immunotherapy at This Hospital	VI.6	yes	yes	yes	yes	yes
Immunotherapy Summary	VI.6	yes	yes	yes	yes	yes
Industry–Text	III.2.13.2	yes	no	yes	no	no
Last Name	III.2.1.1	yes	yes	yes	yes	yes
Laterality	V.2	yes	yes	yes	yes	yes
Maiden Name	III.2.1.4	yes*	yes*	yes*	yes	no
Marital Status	III.2.6	yes	yes	yes	yes	no
Medical Record Number	III.2.2	yes*	yes*	yes*	yes	yes
Middle Name	III.2.1.3	yes*	yes*	yes*	yes	yes
Mother's First Name	III.2.1.9	yes*	yes*	yes*	no	no
Name Suffix	III.2.1.8	yes*	yes*	yes*	yes	no
Number of Regional Lymph Nodes Examined–Surgery Summary	VI.2.2	gen	gen	*sel*	no	no
Number of Regional Lymph Nodes Examined–Procedures 1-3	VI.2.3	yes	yes	no	no	no
Occupation–Text	III.2.13.1	yes	no	yes	no	no
Other Therapy at This Hospital	VI.7	yes	yes	yes	yes	yes
Other Therapy Summary	VI.7	yes	yes	yes	yes	yes
Over-ride Flags	Appendix T	yes	yes	yes	yes	yes
Pathology Report Number– Biopsy/FNA	IV.1.7.1	yes*	yes*	yes*	no	no
Pathology Report Number- Surgery	IV.1.7.2	yes*	yes*	yes*	no	no
Patient No Research Contact Flag	III.2.14	yes	yes	yes	no	no
Payment Source (Primary)	III.3.9	yes	yes	yes	no	yes
Payment Source (Secondary)	III.3.9	yes*	yes*	yes*	no	no
Payment Source Text	III.3.9	yes	yes	yes	no	no
Pediatric Stage	V.7.8	sel	sel	sel	no	no
Pediatric Stage Coder	V.7.10	sel	sel	sel	no	no
Pediatric Stage System	V.7.9	sel	sel	sel	no	no
Phone Number (Patient)	III.2.4	yes*	yes*	yes*	yes	yes
Physician (Attending)	III.3.12	yes	yes	yes	no	no
Physician (Following)	VII.2.10	yes*	yes*	yes*	yes	yes
Physician (Medical Oncologist)	III.3.12	yes*	yes*	yes*	no	yes
Physician (Other)	III.3.12	yes*	yes*	yes*	no	no
Physician (Other)	III.3.12	yes*	yes*	yes*	no	no

Data Items and Their Required Status

Item Name	Manual	C/N	RX Ctr	Transmitted from Hospital to Region	SEER Collect	ACoS
Physician (Radiation Oncologist)	III.3.12	yes*	yes*	yes*	no	yes
Physician (Referring)	III.3.12	yes*	yes*	yes*	no	no
Physician (Surgeon)	III.3.12	yes*	yes*	yes*	no	yes
Place of Death	VII.2.14	sel	yes*	yes*	no	no
Place of Diagnosis	III.3.4	may	may	yes*	no	no
Protocol Participation	VI.9	sel	sel	sel	no	no
Quality of Survival	VII.2.5	may	no	no	no	no
Race 1	III.2.9	yes	yes	yes	yes	yes
Race 2	III.2.9	yes	yes	yes	yes	yes
Race 3	III.2.9	yes	yes	yes	yes	yes
Race 4	III.2.9	yes	yes	yes	yes	yes
Race 5	III.2.9	yes	yes	yes	yes	yes
Radiation at This Hospital	VI.3	yes	no	no	yes	no
Radiation - Boost RX Modality	VI.3.4	yes	yes	yes	no	yes
Radiation - Regional RX Modality	VI.3.3	yes	yes	yes	no	yes
Radiation Summary	VI.3	yes	yes	yes	yes	no
Radiation/Surgery Sequence	VI.3.4	yes	yes	yes	yes	yes
Reason for No Radiation	VI.3.3	yes	yes	yes	no	yes
Reason for No Surgery	VI.2.10	yes	yes	yes	yes	yes
Recurrence Date	VII.2.13.1	may	may	may	no	yes
Recurrence Sites	VII.2.13.3	may	may	may	no	no
Recurrence Type	VII.2.12.2	may	may	may	no	yes
Regional Data	-	may	may	yes*	no	no
EOD- Regional Nodes Examined	V.4	yes	yes	yes	yes	yes
EOD- Regional Nodes Positive	V.4	yes	yes	yes	yes	yes
Religion	III.2.8	yes	yes	yes	no	no
Scope of Regional Lymph Node Surgery 98–02 Summary	VI.2.2	gen	gen	*sel*	no	no
Scope of Regional Lymph Node Surgery–Summary	VI.2.2	gen	gen	yes	yes	yes
Scope of Regional Lymph Node Surgery–Procedures 1-3	V.7.12	yes	yes	yes	no	no
Sequence Number	II.2.4	yes	yes	yes	yes	yes
Sex	III.2.7	yes	yes	yes	yes	yes
Site Text	IV.1	yes	yes	yes	yes	no
Site–Primary	V.1.1	yes	yes	yes	yes	R
Social Security Number	III.2.3	yes*	yes*	yes*	yes	yes
Social Security Number Suffix	III.2.3	yes*	yes*	yes*	no	no
Spanish/Hispanic Origin	III.2.9.2	yes	yes	yes	yes	yes

Data Items and Their Required Status

Item Name	Manual	C/N	RX Ctr	Transmitted from Hospital to Region	SEER Collect	ACoS
Stage-Alternate	V.5.6	may	may	may	no	no
Summary Stage 1977	V.5	sel	sel	sel	no	no
Summary Stage 2000	V.5	sel	sel	sel	no	yes
Surgery at This Hospital– Diagnostic or Staging Procedure	VI.2.11	yes	yes	yes	no	yes
Surgery at This Hospital–Reconstructive	VI.2.8	yes	no	no	no	no
Surgery at This Hospital	VI.2.1	gen	gen	no	no	yes
Surgery of Primary Site 98–02 Summary	VI.2.1	gen	gen	*sel*	no	no
Surgery of Primary Site–Summary	VI.2.1	gen	gen	yes	yes	yes
Surgery of Primary Site–Procedures 1-3	VI.2.1	yes	yes	yes	no	no
Surgery of Other Site – Summary – 98-02	VI.2.4	gen	gen	*sel*	no	no
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)–Summary	VI.2.4	gen	gen	yes	yes	yes
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)–Procedures 1-3	VI.2.4	yes	yes	yes	no	no
Surgery Summary– Diagnostic or Staging Procedure	VI.2.11	yes	yes	yes	no	yes
Surgery Summary– Reconstructive	VI.2.8	yes	yes	yes	no	no
Surgical Margins– Procedures 1-3	VI.2.7	yes	*no*	no	no	no
Surgical Margins– Summary	VI.2.7	gen	gen	no	no	yes
Text RX–Chemotherapy	VI.4	sel	sel	sel	no	no
Text RX –Hormone Therapy	VI.5	sel	sel	sel	no	no
Text RX–Immunotherapy	VI.6	sel	sel	sel	no	no
Text RX–Other Therapy	VI.7	sel	sel	sel	no	no
Text RX–Radiation (Beam)	VI.3	sel	sel	sel	no	no
Text RX –Radiation (Other)	VI.3	sel	sel	sel	no	no
Text RX- Radiation Boost RX Modality	VI.3	sel	sel	sel	no	no
Text RX- Radiation Regional RX Modality	VI.3	sel	sel	sel	no	no
Text RX–Surgery	VI.2	sel	sel	sel	no	no
Text–DxProc–Lab Tests	IV.1.5	yes*	yes*	yes*	no	no
Text–DxProc–Operative	IV.1.6	yes*	yes*	yes*	no	no
Text–DxProc– Pathological	IV.1.7	yes*	yes*	yes*	no	no
Text–DxProc–PE	IV.1.2	yes*	yes*	yes*	no	no
Text–DxProc–Scopes	IV.1.4	yes*	yes*	yes*	no	no
Text–DxProc–X–ray	IV.1.3	yes*	yes*	yes*	no	no
Text–Remarks	VIII.1	yes*	yes*	yes*	no	no

Data Items and Their Required Status

Item Name	Manual	C/N	RX Ctr	Transmitted from Hospital to Region	SEER Collect	ACoS
TNM Coder (Clinical)	V.7.6	yes*	yes*	yes*	no	yes
TNM Coder (Path)	V.7.6	yes*	yes*	yes*	no	yes
TNM Edition	V.7.7	yes*	yes*	yes*	no	yes
TNM Stage (Clinical)	V.7.5	yes*	yes*	yes*	no	yes
TNM Stage (Path)	V.7.5	yes*	yes*	yes*	no	yes
TNM–M Code (Clinical)	V.7.4	yes*	yes*	yes*	no	yes
TNM–M Code (Path)	V.7.4	yes*	yes*	yes*	no	yes
TNM–N Code (Clinical)	V.7.4	yes*	yes*	yes*	no	yes
TNM–N Code (Path)	V.7.4	yes*	yes*	yes*	no	yes
TNM–T Code (Clinical)	V.7.4	yes*	yes*	yes*	no	yes
TNM–T Code (Path)	V.7.4	yes*	yes*	yes*	no	yes
Transplant/Endocrine Procedures At This Hospital	VI.7.1	yes	yes	yes	no	no
Transplant/Endocrine Procedures Summary	VI.7.1	yes	yes	yes	yes	yes
Treatment Hospital Number-Procedure 1-3	VI.2.6	yes	yes	yes	no	no
Tumor Markers 1-3	V.6	sel	sel	sel	yes	no
Tumor Marker-CA-1	V.6.4	sel	sel	sel	no	no
Tumor Size	V.4	yes	yes	yes	yes	yes
Tumor Status	VII.2.4	yes	yes	yes	no	yes
Type of Admission	III.3.7	yes	yes	yes	no	no
Type of Reporting Source	III.3.6	yes	yes	yes	yes	no
Vendor Version	–	gen	yes	gen	no	no
Vital Status	VII.2.2	yes	yes	yes	yes	yes
Year First Seen	II.2.1	yes	no	yes	no	no

Appendix V

ICD-O-3 Primary 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 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 not contained in the ICD-O-3 SEER Site/Histology Validation List.
Red color indicates histology codes new to 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 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

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-HODGKIN LYMPHOMA	971	
		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 pl exus 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, NOS 945

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 RHABDOMYOSARCOMA	891	**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

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 a new code, 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.** Please refer Volume I, Section III.2.9 Race and Ethnicity 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
RACE AND NATIONALITY DESCRIPTIONS FROM THE 2000 CENSUS AND BUREAU OF VITAL STATISTICS

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

Code 01 White, continued

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

Code 01 White, continued

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*
Shi'ite‡
Sicilian*
Slavic, Slovakian*
South American†
Spanish*, Spaniard
Sunni*‡
Swedish*
Syrian
Tunisian*
Turkish, Turk*
Ukranian*
United Arab Emirati
Uruguayan†
Venezuelan*†

01 White, continued

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
09	Asian Indian
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)
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
09	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

ALPHABETIC INDEX TO RACE AND NATIONALITY DESCRIPTIONS FROM THE 2000 CENSUS AND BUREAU OF VITAL STATISTICS

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02	Afro-American
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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
09	Asian Indian
96	Asiatic
03	Assiniboin
01	Assyrian
03	Atacapa
03	Athapaskan
03	Atsina
01	Australian*
01	Austrian*
01	Azores*
03	Aztec
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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
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96	Bruneian
01	Bulgarian
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03	Carrier
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03	Cattaraugus
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96	Celebesian
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03	Chemehuevi
03	Cherokee
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03	Cheyenne River Sioux
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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
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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
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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
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31	Fijian
06	Filipino
01	Finnish*
03	Flathead
03	Fort Hall Res. Tribe of Idaho
01	French
01	French Canadian*
03	French Indian
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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)
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
09 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