California Cancer Registry Volume I

Data Standards and Data Dictionary

Cancer Reporting in California:
Abstracting and Coding Procedures for Hospitals

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PREFACE TO THE NINTH EDITION

REVISED JUNE, 2009

The staff of the Data Standards and Quality Control (DSQC) Unit of the California Cancer Registry would like to present the ninth edition, of *Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, Volume I*, revised June 2009. In 2006, the CCR switched to a new format for producing Volume I. Two versions are now available for users. One version is in HTML and is interactive and fully searchable. The other version is a printable, PDF version for downloading. Changes to this document are identified through the use of ***italicized, bolded, maroon-colored font***.

Instructions on current abstracting and coding rules are listed first in each section. Instructions on historical rules follow.

In addition to changes in requirements from national standard setting agencies for 2009, feedback from hospital registrars and regional registry staff has resulted in modifications and clarifications to this document.

A document titled Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, California Cancer Reporting System Standards, Volume I, Changes and Clarifications - 9th Edition, Revised June 2009, provides a detailed summary of the changes in Volume I, including those related to 2009 data changes. This document is posted to the CCR web site.

I want to acknowledge Dennis O'Neal and Alan Houser, MA, MPH, for their technical expertise and editorial assistance. Thanks also to all those who submitted recommendations and suggestions for Volume I. Lastly, thanks to the DSQC Quality Control Staff for their suggestions and assistance in revising this document.

For reporting facilities in California, please send corrections, comments, and suggestions regarding this document 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 download Volume I from the California Cancer Registry web site at http://ccrcal.org/cv1manualpdf/cv1manualpdf.pdf.

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.

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

Part 1. Introduction

I.1 Reporting Cancer Statistics

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

I.1.1 Role of the Cancer Registry

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

I.1.2 The California Cancer Registry

Information from hospital registries and other sources is gathered by the California Cancer Registry (CCR) primarily for use in epidemiological research and for monitoring the occurrence of cancer in the state. A unit in the Chronic Disease Surveillance and Research Branch of the California Department of Public Health, the CCR was established in 1947 as a pilot study to determine the feasibility of basing a central registry on data reported by hospitals. The study was successful and the registry gradually expanded its coverage from nine hospitals to thirty six, most of which were located in the San Francisco Bay area and Los Angeles County. As a result, valuable statistics were developed about the survival of cancer patients. But since the data did not apply to a defined segment of the population, it was not possible to calculate the incidence of cancer. A section covering the population of Alameda County was therefore added to the registry in 1960. When the National Cancer Institute (NCI) undertook its Third National Cancer Survey in 1969, the population based registration was extended to the entire San Francisco Oakland Standard Metropolitan Statistical Area (SF-O SMSA) consisting of Alameda, Contra Costa, Marin, San Francisco, and San Mateo counties. Support for the SF-O SMSA registration was subsequently provided by the NCI's Surveillance, Epidemiology and End Results (SEER) Program. Established in 1973, SEER is among the largest

population based registries in the Western world, covering approximately 36 million people in eleven designated regions of the United States.

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

I.1.3 State Cancer Reporting Requirements

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

January 1, 2001 Forward

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

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

I.1.4 Confidentiality

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

> All records of interviews, written reports and statements procured by the state Department of Public Health or by any other person, agency

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

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

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

For more information regarding the CCR's confidentiality policy, please go to the CCR web site:

http://www.ccrcal.org/PDF/CCRDataAccessDisclo_v04.4.pdf

I.1.5 Casefinding

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

I.1.5.1 Sources

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

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

I.1.5.2 Follow-Up

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

I.1.6 Reporting

The hospital must report every case of cancer first seen as an inpatient or outpatient, either with evidence of cancer or for cancer directed treatment, on or after the date that mandatory reporting was declared for the region (the region's reference date).

For cases seen in 2007 and forward, the CCR requires that reporting facilities must notify the regional registry of the following cases:

- Patients receiving transient care to avoid interrupting therapy initiated elsewhere (equipment failure at the reporting facility or while vacationing).
- Patients with active cancer who are admitted for other medical conditions.
- Patients seen at a facility for catheter placement for cancer therapy.
- Patients who are receiving long term therapy (such as hormone therapy). with a history of cancer but with no current evidence of cancer. Do not report cases with only a history of cancer. The patient must be receiving long term therapy AND have a history of cancer to be reportable via notification to the CCR.

The CCR minimum requirement is that these cases be reported via Confidential Morbidity Report (CMR) or similar mechanism as designated by the regional registry. If your regional registry requires a full abstract on one or more of these scenarios, please continue with this practice. Consult your regional registry for reporting requirements.

If the case is not found in the CCR database, the reporting facility may be asked to submit a full abstract for the case for incidence reporting, if they haven't already done so. These cases are all considered to be Class 3 cases for the reporting facility.

Although a reporting facility must notify the regional registry of cases fitting the scenarios listed and comply with regional reporting requirements, a reporting facility may choose to submit a full abstract for any of these type of cases seen at their facility.

Historically, 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 were no longer to be

reported to the California Cancer Registry. (Note: Some regional registries had elected not to implement this change. Contact your regional registry with questions about their reporting requirements.) In January 2006, for those who were required to report a full abstract for cases in which there is no evidence of disease or there is a history of cancer, but the patient is still receiving long term therapy (such as hormone therapy), submit a Confidential Morbidity Report (CMR) form only. A full abstract is no longer required for these cases. If these cases were never reported within your region, continue with this practice. This practice changed in 2007.

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

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.

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.

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.

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.

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.

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

January 1, 2001 and Forward

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

January 1, 1996 and Forward

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

For rules on reportability of neoplasms, review Section II.

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. (Refer to Appendix U -- Data Items and Their Required Status). If in doubt about how certain fields should be completed, the regional registry should be contacted.

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

I.1.6.3 Coding

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

I.1.6.4 Entering Dates

Enter the number of the month, then the day, then the four-digit year. Usually, the abstracting software will provide separators such as slashes, dashes, or even separate fields for each part of the date. 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 99 in all the fields (99/99/9999).

Examples

January 1, 2000	=	01/01/2000
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 Manual and Coding Instructions	Collaborative Staging Task Force of the American Joint Committee on Cancer. Version 01.04 Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004, NIH Publication Number 04-5496.
International Classification of Diseases for Oncology (ICD-O)	Fritz, A., Percy, C. et al, eds. 3rd ed. Geneva; World Health Organization, 2000.
International Classification of Diseases for Oncology (ICD-O)	Percy, C., VanHolten, V., and Muir, C., eds. 2d ed. Geneva: World Health Organization, 1990.
Multiple Primary and Histology Coding Rules Manual	SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: National Institutes of Health, National Cancer Institute, January 01,

	2007.
SEER Extent of Disease—1988 Codes and Coding Instructions	SEER (Surveillance, Epidemiology, and End Results Program). 3rd ed. [Bethesda]: National Institutes of Health, National Cancer Institute, 1998. NIH Pub. No. 98-1999.
Summary Staging Guide for the Cancer Surveillance, Epidemiology and End Results Reporting (SEER) Program	SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, April 1977, reprinted July 1986.
*SEER*Rx Version 1.20. The Cancer Registrar's Interactive Antineoplastic Drug Database*	SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, 2007 (applicable for cases diagnosed January 1, 2005 forward).
Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs	SEER (Surveillance, Epidemiology, and End Results Program). 3d ed. [Bethesda]: U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, 1994 (applicable for cases diagnosed prior to January 1, 2005).
Manual for Staging of Cancer	AJCC (American Joint Committee on Cancer). 6th ed. New York: Springer-Verlag, 2002.
CNExT User Manual	C/NET Solutions. [Berkeley]: Public Health Institute, CNExT Project.
Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data Standards (FORDS)	ACoS (American College of Surgeons Commission on Cancer). Chicago: American College of Surgeons Commission on Cancer, January 2003, revised 2007.
Helpful references, although not necessary for abstracting and coding, include the following:	
California Cancer Registry Inquiry System	California Cancer Registry, California Public Health Institute
SEER Inquiry System (SINQ): Resolved Questions	SEER (Surveillance, Epidemiology, and End Results Program)
SEER Program: Comparative Staging Guide for Cancer	SEER (Surveillance, Epidemiology, and End Results Program). [Bethesda]: National Institutes of Health, National Cancer Institute, 1993. NIH Pub. No. 93-3640.
The SEER Program Coding and Staging Manual 2007	SEER (Surveillance, Epidemiology, and End Results Program). 4th ed [Bethesda]: National Institutes of

	Health, National Cancer Institute, 2007. NIH Pub. No. 07-5581
SEER Program: Self-Instructional Manual for Cancer Registrars Shambaugh, E., ed-in-chief. [Bethesda]: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, various years. *Book One-Objectives and Functions of a Tumor Registry* 2d ed, 1980. [New edition is in preparation.] *Book Two-Cancer Characteristics and Selection of Cases* 3d ed, 1992. NIH Pub. No. 92-993 *Book Three-Tumor Registrar Vocabulary: The Composition of Medical Terms* 2d ed, 1993. NIH Pub. No. 93-1078. *Book Four-Human Anatomy as Related to Tumor Formation* 2d ed, 1993. NIH Pub. No. 93-2161. *Book Five-Abstracting a Medical Record: Patient Identification, History, and Examinations* 2d ed, 1993. NIH Pub. No. 93-1263 *Book Seven-Statistics and Epidemiology for Tumor Registrars* 1994	
International Classification of Diseases for Oncology (ICD-O)	World Health Organization. Geneva: World Health Organization, 1976.
International Classification of Diseases for Oncology(ICD-O)	Percy, C., and VanHolten, V.. Field Trial Edition. Geneva: World Health Organization, 1988.
U.S. Postal Service National Zip Code & Post Office Directory.	

I.1.7 Reporting by Non-hospital Treatment Centers

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

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

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

I.1.8 Abstracting Requirements for Non-analytic Cases

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

Therefore, the CCR requires that non-analytic cases — classes 3, 4, 5, 7, 8, and 9 — be abstracted and submitted. For definitions of non-analytic and analytic cases and class of case, see Section III.3.5.

I.1.8.1 Autopsy Only Cases

Abstracting requirements for Autopsy Only (Class 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 limited to a brief statement of the patient's history and the reason for the present admission must be included. Enter the statement in the Physical Exam text area.

Examples

Leukemia diagnosed 5/87 in San Francisco, in remission since 6/87, now admitted for treatment of relapse.

Colon cancer diagnosed 1 year PTA. Now has widespread mets. Admitted for terminal care.

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

I.2 CNExT

This section was software specific and deleted in 2008.

Part II. Reportable Neoplasms

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

II.1 Determining Reportability

Every 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 continues to require reporting them. Other benign neoplasms are not reportable. For a list of reportable and non-reportable neoplasms, refer to the morphology section of ICD-O-3.

II.1.1 Criterion for Reportability

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

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

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

See Section II.1.9.1 Reportability.

II.1.2.1 Metastasis

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

reference will be found in examinations of the lymph nodes. Occurrence of a lesion in a lymph node ordinarily indicates metastasis.

II.1.2.2 Abstracting Each Primary

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

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

January 1, 2007 and Forward

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

These are large files and take one to two minutes to load into your PC.

http://seer.cancer.gov/tools/mphrules/2007_mphrules_manual_04302008.pdf

http://seer.cancer.gov/tools/codingmanuals/index.html

January 1, 2005 through December 31, 2006

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

II.1.2 Identifying the Primary Neoplasm

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

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

II.1.2.1 Metastasis

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

II.1.2.2 Abstracting Each Primary

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

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

January 1, 2007 and Forward

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

January 1, 2005 through December 31, 2006

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

II.1.3 Single and Multiple Primaries

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

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

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

January 1, 2007 and Forward

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

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

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

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

January 1, 2005 through December 31, 2006

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

Prior to January 1, 2005

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

II.1.3.1 Single Primaries

January 1, 2007 and Forward

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

January 1, 02005 through December 31, 2006

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

Prior to January 1, 02005

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

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

II.1.3.2 Multiple Primaries

January 1, 2007 Forward

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

January 1, 2005 through December 31, 2006

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

Prior to January 1, 2005

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

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

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

  Exception #2: If there is an in situ followed by an invasive cancer in the same site more than two months apart, report as two primaries even if noted to be a recurrence. The invasive case must be diagnosed 1/1/95 or later. Effective with cases diagnosed January 1, 1998, and later, this also applies to bladder and prostate sites. For these two sites, the first invasive case must be diagnosed 1/1/98 and later. The purpose of this guideline is to ensure that a case is counted as an incidence case, *i.e.*, invasive, when data are analyzed by the regional and central registry.

1. 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.)
2. Multiple lesions of different histologic types in different sites.

See also:

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

II.1.3.3 Paired Sites

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

Prior to January 1, 2007
For cases diagnosed prior to January 1, 2007, apply the following rules:

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.
- If the record shows two independent primaries, submit two abstracts, one for each side.
- If the record contains no information about the number of primaries, submit two independent abstracts, one for each side. Prepare a single abstract for the following bilateral primaries:
    - Bilateral ovarian primaries of the same histologic type, diagnosed within two months of each other.
    - Bilateral retinoblastomas.
    - Bilateral Wilms' tumors.

For additional discussion of laterality, see topics in Section V.2.

II.1.3.4 Breast Ductal and Lobular Carcinomas

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

Prior to January 1, 2007
For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

Prior to January 1, 2005
For cases diagnosed prior to January 1, 2005, apply the following rules:

Prepare a single abstract for certain combinations of ductal and lobular carcinomas occurring in the same breast within two months of each other. ICD-O-2 has assigned morphology 8522 to this combination.

Code as follows:

Infiltrating duct carcinoma (8500/3) and lobular carcinom	(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.

In addition, you can review each topic in Section V.1.

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

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

Prior to January 1, 2007

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

II.1.3.6 Lymphatic and Hematopoietic Diseases - Subsequent Diagnoses

The CCR is concerned with identifying lymphomas and leukemias that are or might be treatment induced, usually as a result of chemotherapy plus radiotherapy or chemotherapy with alkylating agents.

The ICD-O-3 version of the hematopoietic primaries table is very different from the ICD-O-2 version in both format and medical understanding of these diseases. As a result, it is not possible to use the tables interchangeably. The first link indicated below, Definitions of Single and Subsequent Primaries for Hematologic Malignancies Based on ICD-O-3 Reportable Malignancies, Effective with Diagnoses 01/01/2001 and After, explains the reasoning that underlies the ICD-O-3 table.

From January 1, 2001 Forward

Use the ICD-O-3 table found in
http://seer.cancer.gov/icd-o-3/hematopoietic_primaries.d03152001.pdf,
if both diseases are diagnosed after January 1, 2001 or if a first diagnosis was prior to 2001, but a second diagnosis was after January 1, 2001.

Also review the following errata files.

http://seer.cancer.gov/icd-o-3/errata.d05222001.pdf

http://seer.cancer.gov/icd-o-3/errata.d05062003.pdf

Prior to January 1, 2001

Use the ICD-O-2 rules that follow:

(1) Hodgkin's disease (9650-9667).

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) Malignant lymphoma, NOS[2] (9590).

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) Non-Hodgkin's lymphoma[2] (9591-9595, 9670-9686, 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) Burkitt's lymphoma (9687).

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) Cutaneous and peripheral T-cell lymphomas (9700 9709).

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) Malignant histiocytosis or Letterer-Siwe's disease or true histiocytic lymphoma (9720, 9722, 9723).

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) Plasmacytoma or multiple myeloma (9731, 9732).

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) Mast cell tumor (9740, 9741).

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) Immunoproliferative disease, NOS (9760) or Waldenstrom's macroglobulinemia (9761).

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 (980).0

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) Plasma cell leukemia (9830).

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) Lymphosarcoma cell leukemia (9850).

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) Non-lymphocytic leukemias (9840-9842, 9860-9894, 9910-9932).

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) Mast cell leukemia (9900).

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 Single and Multiple Primaries, Kaposi's Sarcoma

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

II.1.4 Skin Carcinomas

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

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

II.1.4.1 Skin Carcinoma Exceptions

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

II.1.4.2 Reportable Skin Tumors

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

II.1.5 Cervix

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

II.1.6 Ambiguous Diagnostic Terms

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

II.1.6.1 Reportable Terms

Apparently (malignant)

Appears to*

Comparable with*

Compatible with (a malignancy)*

Consistent with (a malignancy)

Favor (a malignancy)

Malignant appearing*

Most likely (malignant)

Presumed (malignant)

Probable (malignancy)

Suspect or suspected (malignancy)

Suspicious (of malignancy)

Typical (of/for malignancy)

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

II.1.6.2 Non-Reportable Terms *

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

Approaching (malignancy)

Cannot be ruled out

Equivocal (for malignancy)

Possible (malignancy)

Potentially malignant

Questionable (malignancy)

Rule out (malignancy)

Suggests (malignancy)

Very close to (malignancy)

Worrisome (for malignancy)

* Without additional information

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 topics in 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 ***must*** be notified of the case using one or both of the following methods:

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

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

II.1.8 Newly Reportable Hematopoietic Diseases (NRHD)

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.

Newly Reportable Hematopoietic Diseases 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, seem Section VI.8.

II.1.9 Intracranial/CNS Tumors

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

The CCR requires that follow up be performed on these cases. Due to this national implementation, several elements of reporting these entities have changed. Refer to topics II_1_9_1 through II_1_9_8 for specifics.

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)

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

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

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

Reportable Terminology

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

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

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

II.1.9.2 Determining Multiple Primaries

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

- Site(s)
- Histologies
- Timing
- Laterality

Site

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

Examples

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

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

Histology

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

Histologic Group	ICD-O-3 Histology Code
Choroid plexus neoplasms	9390/0, 9390/1
Ependymomas	9383, 9394, 9444
Neuronal and neuronal-glial neoplasms	9384, 9412, 9413, 9442, 9505/1, 9506
Neurofibromas	9540/0, 9540/1, 9541, 9550, 9560/0
Neurinomatosis	9560/1
Neurothekeoma	9562
Neuroma	9570
Perineuroma, NOS	9571/0

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

Example

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

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

Example

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

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

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

Example

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

4. If the histologies are listed in different groupings in the table, they are different histologies.

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

Timing

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

Laterality

- Beginning with malignant and benign/borderline CNS tumors diagnosed January 1, 2004 forward, the following sites require a laterality code of 1-4, 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 code single primary
- If same site and same histology and laterality is both sides, then code 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

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

January 1, 2004 and Forward

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

Example

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

January 1, 2001 to December 31, 2003

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

Example

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

II.1.9.4 Sequence Number

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

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

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

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

Example

First tumor, benign meningioma, sequence 60.

Second tumor, astrocytoma, sequence 00.

II.1.9.5 Malignant Transformation

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 brain and CNS 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.

References:

http://www.cdc.gov/cancer/npcr/training/pdfs/braintumorguide.pdf (<--This document takes about 30-seconds to download.)

http://www.cancerstaging.org/cstage/index.html

II.1.9.8 Staging

January 1, 2004 and Forward

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

January 1, 2001 to December 31, 2003

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

II.1.10 Borderline Ovarian Tumors

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

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

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

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

II.2 Abstracting: Preliminary Procedures

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

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

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

II.2.1 Year First Seen

Certain abstracting software applications, request Year First Seen.

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

Example

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

Assign 1993 as the year first seen for this primary.

II.2.2 CNExT Generated Accession Numbers

This section was software specific and deleted in 2008.

II.2.3 Accession Number

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

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

Examples

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

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

II.2.4 Sequence Number

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

Sequence Codes for Tumors with Invasive and In Situ Behavior:

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

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

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

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

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

NOTE: Alphabetic sequence codes are no longer allowed.

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 you can review the following topics (or entire topic area).

Section V.5 , Stage at Diagnosis

Section V.3.5 , Grade and Differentiation.

Section V.4 , Extent of Disease. If these sections do not reveal the worst prognosis, assign sequence numbers in the order in which the abstracts are prepared.

Example

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

II.2.4.2 Updating

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

II.2.5 Other Tumors

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

Part III. Identification

III.1 Registry Information

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

III.1.1 Abstractor

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

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

III.1.2 Suspense Flag

This section was software specific and deleted in 2008.

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

This section was software specific and deleted in 2008.

III.1.4 Reporting Hospital

Enter the reporting hospital's CCR assigned code or the hospital's name.

Reporting facilities by code or alphabetic listing can be found on the CCR web site at:

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-1.7.0.17-Code.pdf

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-1.7.0.17-Alpha.pdf

January 1, 2007 and Forward
Beginning with cases diagnosed January 1, 2007, if available, enter the NPI (National Provider Identifier) code that identifies the reporting hospital. See Appendix X for details.

III.1.5 CNExT Automatic Entries

This section was software specific and deleted in 2008.

III.1.6 ACoS Approved Flag

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

1	CANCER PROGRAM APPROVED
2	CANCER PROGRAM NOT APPROVED

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

III.2 Patient Information

III.2.1 Name

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

Guidelines for Entering Patient Name:

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

III.2.1.1 Last Name

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

- Enter the patient's entire last name.
- Include the hyphen in a hyphenated name, but do not enter any other non-alphabetic characters.

- If the last name contains more than 25 characters, enter only the first 25.
- If the patient has no last name or the name cannot be determined, enter NLN.
- If a patient's last name has changed, enter the current last name in the Last Name field and move the original name to the Alias field.

III.2.1.2 First Name

For the first name enter no more than the first 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.

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

III.2.1.3 Middle Name

Enter the middle name, up to 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

Enter up to 15 characters in the Alias Last Name field.

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

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III.2.1.6 Alias First Name

In the Alias First Name Field enter up to 15 characters. Including:

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

III.2.1.7 Religious Names

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

Examples

1. Religious name: Sister Mary Anthony

    Secular name: Jane Smith

    Report as: (last name) Smith

        (first name) Jane

        (alias) Anthony

Religious name: Sister Mary Anthony

    Secular name: Smith (first name unknown)

    Report as: (last name) Smith

        (first name) Sister

        (alias) Anthony

Religious name: Sister Mary Anthony

    Secular name: unknown

    Report as: (last name) Anthony

        (first name) Sister

        (middle name) Mary

III.2.1.8 Name Suffix

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

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

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

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

III.2.1.9 Mother's First Name

Enter the patient's mother's first name in this field. This is to be entered for all patients, not just children. It is 14 characters in length. If this name is not available, this field may be left blank.

III.2.2 Medical Record Number

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

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

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

III.2.3 Social Security Number

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

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

effort to ascertain the patient's own number. Enter it and its suffix in the fields provided.

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

The following values are not allowed:

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

Examples

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

Medicare claim number: 123-45-6789B

Enter 111-22-3333.

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

No other numbers recorded in chart.

Enter 222-33-4444D5.

3. Social security number from face sheet: not recorded

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

Enter 999-99-9999.

III.2.4 Phone Number (Patient)

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

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

Leave blank, if the phone number is unknown.

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

III.2.5 Address at Diagnosis

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

Every effort should be made to determine the correct address.

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

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

III.2.5.1 Rules

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.

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III.2.5.2 Data Entry, Number and Street

When entering number and street, not the following requirements:

- 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."
- The field, **Patient Address at Diagnosis Supplemental**, provides the ability to record additional address information such as the name of a place or facility (i.e., a nursing home or name of an apartment complex) at the time of diagnosis. Use up to 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.

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III.2.5.3 Data Entry, 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").

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

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

III.2.5.4 Data Entry, State

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

California is CA.

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

III.2.5.5 Data Entry, ZIP

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

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

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

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

III.2.5.6 Data Entry, County

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

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

For California residents, enter the code for the county of residence at the time of diagnosis. Some abstracting software will automatically enter the code if the county name is entered. Consult maps or reference works as needed to determine the correct county. Enter code 998 if the county of residence is not known or if it is a state and is other than California and its name is known.

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

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

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

Canadian province codes are listed in Appendix C.

III.2.5.7 Address Dx City, USPS (NEW)

This data item identifies the city in which the patient resides at the time the reportable tumor is diagnosed. Currently, the data item, City at Diagnosis, allows for up to 20 characters. The data item, Address Dx City, USPS, using the USPS file listing, allows for up to 28 characters. No data entry is required, as it is a generated field.

III.2.6 Marital Status

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

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

1 SINGLE (never married, including only marriage annulled)

2 MARRIED (including common law)

3 SEPARATED

4 DIVORCED

5 WIDOWED

9 UNKNOWN

III.2.7 Sex

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

1 MALE

2 FEMALE

3 HERMAPHRODITE/INTERSEXED (persons with sex chromosome abnormalities)

4 TRANSSEXUAL/TRANSGENDERED (persons who desire or plan to undergo or have undergone sex change surgery)

9 UNKNOWN

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

III.2.8 Religion

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

Use code 99 if the religion is not stated.

01	NONE
02	AGNOSTIC
03	ATHEIST
04	NONE, AGNOSTIC, ATHEIST (OLD)
05	CATHOLIC; ROMAN CATHOLIC
06	CHRISTIAN, NOS; PROTESTANT, NOS
PROTESTANT DENOMINATIONS:	
07	AFRICAN METHODIST EPISCOPAL (AME)
08	ANGLICAN; CHURCH OF ENGLAND
09	BAPTIST
10	COMMUNITY
11	CONGREGATIONAL
12	EPISCOPALIAN
13	LUTHERAN
14	METHODIST
15	PREBYTERIAN
16	UNITARIAN
17	PROTESTANT DENOMINATION, OTHER
18	CHRISTIAN REFORMED
19	DISCIPLES OF CHRIST
20	DUTCH REFORMED
21	FIRST CHRISTIAN
22	INTERDENOMINATIONAL
23	MORAVIAN
24	NON-DENOMINATIONAL
25	SEAMAN'S CHURCH
26	TRINITY

27	UNIVERSAL
28	PROTESTANT, OTHER
ORTHODOX:	
29	ARMENIAN ORTHODOX
30	COPTIC
31	GREEK ORTHODOX
32	RUSSIAN ORTHODOX
33	SERBIAN ORTHODOX
34	LEBANESE MARONITE; MARONITE; ORTHODOX, CHRISTIAN, OTHER; ORTHODOX, CHRISTIAN, NOS
CHRISTIAN SECTS:	
35	JEHOVAH'S WITNESSES
36	CHRISTIAN SCIENCE
37	MORMON; LATTER DAY SAINTS
38	SEVENTH-DAY ADVENTIST
39	FRIENDS; QUAKER
CHRISTIAN SECTS-OTHER:	
40	AMISH
41	MENNONITES
42	APOSTOLIC
43	ARMENIAN APOSTOLIC
44	ASSEMBLIES OF GOD
45	BRETHREN; BROTHERS
46	CHRISTIAN APOSTOLIC
47	CHURCH OF ARMEDIAN
48	CHURCH OF CHRIST
49	CHURCH OF GOD
50	CHURCH OF MESSIANITY
51	CHURCH OF THE DIVINE
52	CHURCH OF THE OPEN DOOR
53	CONGREGATIONAL HOLY; HOLY

	CONGREGATIONAL
54	COVENANT
55	DIVINE SCIENCE
56	EVANGELICAL
57	FUNDAMENTAL
58	FOURSQUARE
59	FULL GOSPEL
60	HOLINESS
61	HOLY INNOCENTS
62	NAZARENE
63	NEW APOSTOLIC
64	PENTECOSTAL
65	RELIGIOUS SCIENCE
66	SALVATION ARMY
67	SCIENCE OF MIND
68	UNITY
69	CHRISTIAN SECTS, OTHER
70	JEWISH
71	JEWISH ORTHODOX; ORTHODOX JEWISH
WESTERN OTHER:	
72	BAHA'I
73	CRICKORIAN; ETHICAL CULTURE; GREGORIAN; LAWSONIAN; MASON; METAPHYSICS; OCCULT; PEACE OF MIND; PEOPLE'S; SELF-REALIZATION; SOCIETY OF LIFE; SPIRITUALIST; THEOSOPHY; TRUTH SEAKER
74	MOLIKAN; MOLOKAN
75	WESTERN RELIGION OR CREED, OTHER; WESTERN RELIGION OR CREED, NOS
76	KO
EASTERN RELIGIONS:	
77	BUDDHIST; ZEN; ZEN BUDDHISM
78	DROUZE

79	CONFUCIANISM; TOAISM
80	JAIN
81	NATION OF ISLAM
82	MOSLEM; MUSLIM; MOHAMMEDAN
83	HINDU
84	ISLAM
85	PARSEE; ZOROASTRIAN
86	SHINTO
87	SIKH
88	VEDANTA
89	ORIENTAL PHILOSOPHY; EASTERN RELIGION, OTHER; EASTERN RELIGION, NOS
90	AMERICAN INDIAN RELIGIONS; NATIVE AMERICAN TRADITIONAL RELIGIONS
91	HAITIAN/AFRICAN/BRAZILIAN RELIGIONS, OTHER; SANTORIA; VOODOO
92	SHAMANISM
93	OTHER TRADITIONAL OR NATIVE RELIGION
94	***Scientology***
98	OTHER
99	UNSPECIFIED; UNKNOWN

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

III.2.9 Race and Ethnicity

Race and ethnicity are two of the most important data items to epidemiologists who investigate cancer. Differences in incidence rates among ethnic groups generate hypotheses for research. The National Cancer institute has recognized the need to better explain the cancer burden in racial/ethnic minorities and is concerned with research on the full diversity of the U.S. population. The CCR recognizes the importance of these data items and relies on quality data to assist researchers in identifying and reducing disparities due to race and ethnicity.

The CCR requires that race code documentation must be supported by text documentation for those cases where there is conflicting information. Outlined below are examples of when text documentation would be required. A text

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

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

Scenarios Demonstrating Conflicting Race Information:

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

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

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

Race and ethnicity are defined by specific physical, heredity and cultural traditions, not by birthplace or place of residence. Beginning with cases diagnosed January 1, 2000, four race fields were added to the data set in addition to the existing race field. These fields were added so that patients who belong to more than one racial

category can be coded with multiple races, consistent with the 2000 Census. The codes for all five fields are identical with the exception of Code 88 - No further race documented. Code 88 is not to be used for coding the first race field.

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

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

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

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

a. If a person's race is a combination of Hawaiian and any other race(s), code Race 1 as 07 Hawaiian and code the other races in Race 2, Race 3, Race 4, and Race 5 as appropriate.

Example

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

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

Example

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

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

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.

Examples

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

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

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

Example

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

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

Examples

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

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

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

d. If race is unknown or not stated in the medical record and birth place is recorded, in some cases race may be inferred from the nationality. Refer to Appendix W "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" to identify nationalities from which race codes may be inferred.

Examples

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

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

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

Examples

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

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

e. Use of patient name in determining race

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

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

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

Examples

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

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

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

Example

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

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

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.

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

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

III.2.9.1 Codes For Race Field

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

01	WHITE
02	BLACK
03	AMERICAN INDIAN, ALEUTIAN, OR ESKIMO
04	CHINESE
05	JAPANESE
06	FILIPINO
07	HAWAIIAN
08	KOREAN
09	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 new SEER 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

Albanian

Algerian

Arabian

Armenian

Australian

Austrian

Bulgarian

Caucasian

Central American*

Cuban**

Cypriot

Czechoslovakian

Dominican**

Eqyptian

Greek

Gypsy

Hungarian

Iranian

Iraqi

Israeli

Italian

Jordanian

Latino

Lebanese

Mexican*

Moroccan

Palestinian

Polish

Portuguese

Puerto Rican**

Rumanian

Russian

Saudi Arabian

Slavic

Slovene

South American*

Spanish

Syrian

Tunisian

Turkish

Yugoslavian

III.2.9.2 Spanish/Hispanic *Origin

The Spanish/Hispanic Origin field is for identifying patients of Spanish or Hispanic origin or descent. The field corresponds to a question asked in the U.S. census. Included are people whose native tongue is Spanish, who are nationals of a Spanish speaking Latin American country or Spain, and/or who identify with Spanish or Hispanic culture (such as Chicanos living in the American Southwest). Coding is independent of the Race field, since persons of Hispanic origin might be described as white, black, or some other race in the medical record. Spanish origin is not the same as birth in a Spanish language country. Birthplace might provide guidance in determining the correct code, but do not rely on it exclusively. Information about birthplace is entered separately. See Section III.2.12. In the Spanish/Hispanic Origin field, enter one of the following codes:

0	NON-SPANISH, NON-HISPANIC
1	MEXICAN (including Chicano, NOS)
2	PUERTO RICAN

3	CUBAN
4	SOUTH OR CENTRAL AMERICAN (except Brazilian)
5	OTHER SPECIFIED SPANISH ORIGIN (includes European; excludes DOMINICAN REPUBLIC for cases diagnosed January 1, 2005 forward)
6	SPANISH, NOS; HISPANIC, NOS; LATINO, NOS (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1-5.)
7	SPANISH SURNAME ONLY (only evidence of person's Hispanic origin is surname or maiden name, and there is no contrary evidence that the person is not Hispanic.)**
8	DOMINICAN REPUBLIC (for cases diagnosed on or after January 1, 2005)
9	UNKNOWN WHETHER SPANISH OR NOT

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

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

If the patient has a Spanish surname, but the record contains information that he or she is not of His panic 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 or 8 and there is evidence other than surname that the person is Hispanic, use code 6, Spanish, NOS.

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

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

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

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

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

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

Examples

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

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

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

* 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 note the following:

- Enter the month first, then the day, then the year. See Section I.1.6.4.
- Use two digits for the month and day, and four digits for the year. (mmddccyy)
- Enter 0 before the number, if the month or day has one digit.
- The year is divided into two parts, the century (18-20) and the year.
    - Enter 99 for a month or day that is not known.
    - Enter 9999 and also code the month and day as unknown, if the year is not known.
    - Calculate the year by subtracting the age from the diagnosis date, if the record only states the patient's age. The codes are:

MONTH	01-12 (January-December)
	99 (unknown)
DAY	01-31
	99 (unknown)

CENTURY	18-20
	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 a required field. Usually, the Age at First Diagnosis is calculated and generated by the abstracting software. If the Age at First Diagnosis is calculated and generated by the abstracting software, calculate the age and enter it into this field.

III.2.12 Birthplace

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

SEER Program Manual entry available

COC Facility Oncology Registry Data Standards (FORDS manual) entry available

NAACCR Data Standards and Data Dictionary entry available

III.2.13 Occupation and Industry

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

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

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

III.2.13.1 Occupation

Enter any available information about the kind of work performed (e.g., television repairman, chemistry teacher, bookkeeper, construction worker), up to 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. Complete the Occupational and Industry fields as follows:

Occupation: Child—MO: biology professor

Industry: MO: University

III.2.14 Patient, No Research Contact Flag

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

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

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

Code 1 - Hospital First Notified - would be entered.

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

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

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

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

III.3 Case Identification

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

III.3.1 Date of First Contact

Enter the date the patient was first seen at the reporting hospital with a reportable neoplasm, according to the following.

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 out patient for the reportable neoplasm.

See Section I.1.6.4 for entering dates.

III.3.2 Dates of Inpatient Admission and Inpatient Discharge

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

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

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

See Section I.1.6.4 for entering dates.

III.3.3.1 Coding

When entering dates of "Inpatient Admission and Inpatient Discharge", apply the following guidelines:

- Enter the Month, then the Day, then the Year.
- Enter "99" for any unknown part of the date (with the exception of the year, which requires 4 digits).
- Enter Day as unknown, if the month is unknown.
- Enter "99999999" if the year is not known.

III.3.3.2 Vague Dates

Following are coding procedures for vague dates regarding "Inpatient Admission and Inpatient Discharge".

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, enter an approximate date for "Inpatient Admission and Inpatient Discharge" when the exact date cannot be determined. It is preferable to use an approximate month or year rather than enter "unknown."

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

III.3.3 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.

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

Examples

6/4/06. Chest X-ray shows mass in right upper lobe. 6/6/06 Bronchial washings are positive for carcinoma.

The diagnosis date is 6/6/2006, because the term "mass" does not

constitute a diagnosis of cancer.

5/20/05. Mammogram-suspicious for carcinoma, left breast, upper outer quadrant. 6/3/05. Fine needle aspiration, left breast—positive for carcinoma.

The date of diagnosis is 5/20/2005, because the term "suspicious" constitutes a presumptive diagnosis of cancer. See Section II.1.6 for vague or ambiguous terms.

7/9/04 Cervical lymph node biopsy shows papillary carcinoma. Review of slides from a thyroidectomy performed in April 2002 reveals foci of papillary carcinoma not diagnosed at the time and now thought to be the primary tumor.

Backdate the diagnosis date to 04/99/2002, the date of the earliest evidence.

III.3.4 Place of Diagnosis

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

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

III.3.5 Class of Case

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, codes "7-Pathology Report Only" and "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 ELSE WHERE, (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 per formed 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. Code this field in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. The codes are:

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

* Codes 4, 5, and 7 are not used by hospitals.

** Before 1988, code 2 was used for CLINIC (hospital outpatient or private) before 1988, and thus appears in some older cases.

*** Codes 2 and 8 are to be applied to cases diagnosed 1/1/2006 forward.

****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 type(s) of admission at the reporting hospital during the four months after the patient was seen there for the first time.

1	INPATIENT ONLY
2	OUTPATIENT ONLY
3*	TUMOR BOARD ONLY
4*	PATHOLOGY SPECIMEN ONLY
5	INPATIENT AND OUTPATIENT
6	INPATIENT AND TUMOR BOARD

7	OUTPATIENT AND TUMOR BOARD
8	INPATIENT, OUTPATIENT, AND TUMOR BOARD
9	UNKNOWN (may appear in archival files but is not entered by hospitals)

*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.

Case first identified at cancer reporting facility:

10 REPORTING HOSPITAL, NOS

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

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

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

23 RADIATION THERAPY DEPARTMENT/CENTER

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

25 OUTPATIENT CHEMOTHERAPY

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

27 TUMOR BOARD

28 HOSPITAL REHABILITATION SERVICE OR CLINIC

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

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

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

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

50 PRIVATE PATHOLOGY LABORATORY REPORT

60 NURSING HOME INITIATED CASE

70 CORONER'S OFFICE RECORDS REVIEW

75 MANAGED CARE ORGANIZATION (MCO) OR INSURANCE RECORDS

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

85 OUT-OF-STATE CASE SHARING

90 OTHER NON REPORTING HOSPITAL SOURCE

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

99 UNKNOWN

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

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

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

The primary payment source and text fields are required and may not be left blank.

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

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

01 NOT INSURED

02 NOT INSURED, SELF PAY

10 INSURANCE, NOS

20 MANAGED CARE

21 PRIVATE INSURANCE: FEE-FOR SERVICE

28 HMO

29 PPO

31 MEDICAID

35 MEDICAID ADMINISTERED THROUGH A MANAGED CARE PLAN

60 MEDICARE/MEDICARE, NOS

61 MEDICARE WITH SUPPLEMENT, NOS

62 MEDICARE - ADMINISTERED THROUGH A MANAGED CARE PLAN

63 MEDICARE WITH PRIVATE SUPPLEMENT

64 MEDICARE WITH MEDICAID ELIGIBILITY

65 TRICARE

66 MILITARY

67 VETERANS AFFAIRS

68 INDIAN/PUBLIC HEALTH SERVICES

89 COUNTY FUNDED, NOS

99 INSURANCE STATUS UNKNOWN

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

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

III.3.10 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.

January 1, 2007 and Forward
Beginning with cases diagnosed January 1, 2007, if available, enter the NPI (National Provider Identifier) code that identifies the facility that referred the patient to the reporting facility. See Appendix X for details.

The following links on CCR web site list the code numbers of all facilities in California and some out of state facilities:

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-Vers-1.8.0.8,5-14-08-Code.pdf

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-Vers-1.8.0.8,5-14-08-Alpha.pdf

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 zeros.

If it is not known where the patient was diagnosed or most recently seen, enter 999999, Unknown Hospital.

Ten-digit codes for VA facilities are accepted. The 10-digit field is not restricted to 6 digits with 4 leading 0's.

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.

January 1, 2007 and Forward
Beginning with cases diagnosed January 1, 2007, if NPI codes are available, enter the NPI (National Provider Identifier) code that identifies the facility to which the patient was referred for further care after discharge from the reporting facility. See Appendix X for details.

The following links on CCR web site list the code numbers of all facilities in California and some out of state facilities:

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-Vers-1.8.0.8,5-14-08-Code.pdf

http://www.ccrcal.org/PDF-DSQC/CAHospLabels-Vers-1.8.0.8,5-14-08-Alpha.pdf

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 zeros.

Ten-digit codes for VA facilities are accepted. The 10-digit field is not restricted to 6 digits with 4 leading 0's.

III.3.12 Physicians

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

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

III.3.12.1 License Numbers

State physician's license numbers are nine characters.

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

For dentists, the same instructions apply.

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

Examples

Physician - A23456 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

January 1, 2007 Forward

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

First Field 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 the attending physician cannot be determined, 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.

Second Field The second field is to be used to enter the referring physician.

Third Field The third field is to be used for coding the surgeon.

Fourth Field The fourth field is to be used for coding the medical oncologist.

Fifth Field The fifth field is to be used for coding the radiation oncologist.

Last Fields The last two fields may be used to code any other physician.

The following physician has his or her own designated field.

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

Surgeon

00000000 No surgery and no surgical consultation performed

88888888 Non - surgeon performed procedure

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

Radiation Oncologist

00000000 No radiation therapy or radiation therapy consult performed

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

Medical Oncologist

00000000 No chemotherapy or chemotherapy consult was performed

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

III.3.13 Comorbidity/Complications

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

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

III.3.14 ICD Revision, Comorbidities and Complications

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

ICD Revision Comorbidity and Complications codes are as follows:

0 No secondary diagnosis reported

1 ICD - 10

9 ICD - 9

Blank Comorbidities and Complications not collected

III.3.15 Discovered By Screening

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

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

This item is not required by the CCR.

Codes:

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

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

2 Hospital screening program (targeted to a particular cancer)

3 State-sponsored screening program

4 Nationally-sponsored screening program

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

9 Unknown if via screening (default)

Part IV. Diagnostic Procedures

IV.1 Diagnostic Procedures Performed

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

Report the results of physical examinations and diagnostic procedures for all analytic cases and for autopsy only (class 5) cases.

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

IV.1.1 General Instructions

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

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

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

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

It is acceptable to continue into another text field with free space available, if text limits have been reached. However, it is essential to note into which field the text is continued.

Only use the unique non-alpha numeric symbol *, **, ***, etc as the last entry in the originating text field. The same symbol should be the first entry in the new text field to indicate that the text is a continuation from another field. Do not use other symbols to indicate a continuation.

IV.1.1.2 Size

January 1, 2004 and Forward

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

Prior to January 1, 2004
For cases diagnosed prior to January 1, 2004, apply the following rules for documenting tumor size:

When recording size as the results of diagnostic examinations, code the total tumor size when a pathology report describes tumor size as invasive with a minor component of in situ.

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 less than 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 and is coded 999.

Examples

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

SEER EOD rules state to always code the size of the tumor, not the size of the polyp, ulcer, or cyst. However, 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

January 1, 2008 and Forward

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

Prior to January 1, 2004

For cases diagnosed prior to January 1, 2004, apply the following rules for documenting tumor extension:

When recording extension as the results of diagnostic examinations, 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

January 1, 2008 and Forward

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

Prior to January 1, 2004
For cases diagnosed prior to January 1, 2004, apply the following rules for documenting lymph node involvement:

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

IV.1.3 X-Ray/Scans

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

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

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

IV.1.4 Scopes

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

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

Record size of an observed lesion, if given.

Enter "none" if no endoscopic examination was performed.

IV.1.5 Laboratory Tests

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

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

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

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

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

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

IV.1.6 Operative Findings

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

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

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

Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, Ninth Edition, June 2009

IV.1.7 Pathology

January 1, 2008 and Forward
Beginning in 2008 and forward, record the text for each pathology report type (see the DxRx Report Type listing, IV_3_4 DxRx Report Type 1-5) in the Path Text field. If additional space is necessary, continue the text documentation in the Text - Staging field. Each DxRx report must be identified in the text field as R1 - R5 with R1 referencing DxRx Report 1, R2 referencing Report 2, etc.

Examples for documenting DxRx Reports in the pathology text field:

R1 - Colon bx: Adenoca

R2 - Colon resection: Adenoca, extramural extension into serosa, 2/10 LN's

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

Describe the location of the primary site or sub-site and laterality of the primary tumor. See Section V.1 and Section V.2 for discussions of site and laterality.

Record the histologic diagnosis and identify the appropriate ICD-O-3 code. See Section V.3.2 and Section V.3.3).

Describe multiple tumors and multiple sites of origin.

Document the extent of disease (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.

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. If additional space is needed, continue the pathology text in the Staging Text field.

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

For grade and differentiation, see Section V.3.5.

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

Enter the facility ID number, dates, report types, and pathology numbers in the DxRx Reports (1-5) fields. See section IV_3 DxRx Reports

IV.1.7.1 Pathology Report Number - Biopsy/FNA

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

See section IV_3_4 DxRx Report Type 1-5.

IV.1.7.2 Pathology Report Number - Surgery

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

See section IV.3.2 DxRx Report Number1-5.

IV.2 Diagnostic Confirmation

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

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

Medical records must be studied to determine what methods were used to confirm the diagnosis of cancer. The most conclusive method should be coded in the confirmation field. As the confirmation field covers the patient's entire medical history in regard to the primary tumor, follow up data (see Section VII.1) might change the coding. The codes, in the order of their conclusiveness, are:

Microscopic Confirmation

1 POSITIVE HISTOLOGY

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

Code 1 also includes microscopic examination of frozen section specimens and surgically removed tumor tissue, whether taken from the primary or a

metastatic site. In addition, positive hematologic findings regarding leukemia and NRHD are coded 1. Cancers first diagnosed as a result of an autopsy or previously suspected and confirmed in an autopsy are coded 1 if microscopic examination is performed on the autopsy specimens.

2 POSITIVE CYTOLOGY, NO POSITIVE HISTOLOGY

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

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

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

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

4 POSITIVE MICROSCOPIC CONFIRMATION, METHOD NOT SPECIFIED

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

No Microscopic Confirmation

5 POSITIVE LABORATORY TEST OR MARKER STUDY

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

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

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

6 DIRECT VISUALIZATION WITHOUT MICROSCOPIC CONFIRMATION

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

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

7 RADIOGRAPHY WITHOUT MICROSCOPIC CONFIRMATION

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

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

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

microscopically.

9 UNKNOWN WHETHER OR NOT MICROSCOPICALLY CONFIRMED

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

IV.3 DxRx Report Identifier Data Items

In order for the CCR's central data base system (Eureka) to integrate pathology report processing with new case abstract processing, the system needs a way to easily match abstracts to path reports. Five sets of path report identifier data items have been added to the CCR's required data set to allow the documentation of up to five pathology reports that were used as reference reports. These new items include "DxRx" in their names because they are intended to allow documentation of diagnostic and treatment reports. Initially, they will be used to document the types of pathology reports used in abstracting that are listed under DxRx Report Type.

For any existing cases in the database, the fields: DxRx Report Number (1-5) and the DxRx Report Type (1-5) will be filled with data converted from the following fields: Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery. The fields Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery, become obsolete with the implementation of the DxRx Report Identifier fields.

January 1, 2008 and Forward

These data items are required by the CCR, effective January 1, 2008. If there is no report, leave the field blank. Additional report types that include report numbers, dates, and facility may be added later as they become available.

Record the text for each pathology report type (see the DxRx Report Type listing, IV_3_4_DxRx Report Type 1-5) in the Path Text field. If additional space is necessary, continue the text documentation in the Text - Staging field. Each DxRx report must be identified in the text field as R1 - R5 with R1 referencing DxRx Report 1, R2 referencing Report 2, etc.

Examples for documenting DxRx Reports in the text field:

R1 - Colon bx: Adenoca

R2 - Colon resection: Adenoca, extramural extension into serosa, 2/10 LN's

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

IV.3.1 DxRx Report Facility ID (1-5)

Identifies the facility that produced the reference report, using the CCR reporting source number. Allows for the documentation of up to five facility ID numbers that were used as reference reports. *If your facility does not have its own path lab and utilizes an independent pathology lab record the number for the path lab and not your hospital number. If you do not have the number for the path lab, use the following numbers:*

996001 UNSPEC LAB CALIF

996002 UNSPEC LAB NONCALIF

This is in order for Eureka to integrate pathology report processing with new case abstract processing.

This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report.

Note: Eventually, this may become the NPI number for the facility, but for now we will use the CCR reporting source numbers.

IV.3.2 DxRx Report Number (1-5)

January 1, 2008 and Forward

Enter the filler order number/lab accession number associated with the pathology report specimen or other report type's number uniquely identifying the report for that facility. This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report.

Prior to January 1, 2008

For cases diagnosed prior to 1/1/2008 and any existing cases in the database, this field will be filled with data converted from the following fields: Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery. This is a 20 character field, that accommodates the documentation of up to five filler order number/lab accession numbers.

IV.3.3 DxRx Report Date (1-5)

January 1, 2008 and Forward

This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report. This 8 character field accommodates the documentation of up to five dates. It identifies the date the specimen associated with a pathology report was collected from the patient, or the most distinguishing report date for other document types.

IV.3.4 DxRx Report Type (1-5)

January 1, 2008 and Forward

This data item is required by the CCR, effective January 1, 2008. Leave this field blank if there is no report. It identifies the type of report entered as a reference report in the other DxRx fields of the set. This two character field allows for the documentation of up to five report types that were used as reference reports. If a biopsy, surgical resection or bone marrow biopsy report also includes results of report types 05-10, code to biopsy, surgical resection or bone marrow biopsy. Use codes 05-10 only if that is the single item result in the report, not as part of the biopsy or resection specimen.

Prior to January 1, 2008
For cases diagnosed prior to 1/1/2008 and for any existing cases in the database, DxRx Report Type (1-5) will be filled with data converted from the following fields: Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery.

Codes:

01 Biopsy

02 Surgical resection

03 Bone marrow biopsy

04 Autopsy

05 Cytology

06 Flow Cytometry/Immunophenotype

07 Tumor Marker (p53, CD's Ki, CEA, HER2-neu)

08 Cytogenetics

09 Immunohistochemical stains

10 Molecular studies

88 Other, NOS

IV.3.5 Text - Staging

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

As a reminder, record the text for each pathology report type (see the DxRx Report Type listing, IV_3_4 DxRx Report Type 1-5) in the Path Text field. If additional space is necessary, continue the text documentation in the Text - Staging field. DxRx Reports other than Each DxRx report must be identified in the text field as R1 - R5 with R1 referencing DxRx Report 1, R2 referencing Report 2, etc.

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

Part V. Tumor Data

V.1 Primary Site

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

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

V.1.1 ICD-O Coding

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

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

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

January 1, 2001 Forward

*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. ICD-O-2 codes will not be allowed for cases diagnosed January 1, 2001 forward.

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

Examples

(1) All entries under lung have the first three characters C34, followed by a final digit indicating the subsite:

C34 BRONCHUS AND LUNG

C34.0 Main bronchus
Carina
Hilus of lung

C34.1 Upper lobe, lung
Lingula of lung

Upper lobe, bronchus

C34.2 Middle lobe, lung

Middle lobe, bronchus

C34.3 Lower lobe, lung

Lower lobe, bronchus

C34.8 Overlapping lesion of lung or bronchus

C34.9 Lung, NOS (not otherwise specified)

Bronchus, NOS

Bronchiole

Bronchogenic

Pulmonary, NOS

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

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

Code the last digit of the primary site code to '8' when a single tumor overlaps an adjacent subsite(s) of an organ and the point of origin cannot be determined.

Examples

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

Code the primary site to C028 (overlapping lesion of tongue).

Code the last digit of the primary site code to '9' for single primaries, when multiple tumors arise in different subsites of the same anatomic site, unless the subsite is defined in one of the site groups listed in the SEER Site Grouping Table. Refer to the SEER Site Grouping Table in the section entitled "How to Determine Same vs Different Primary Site" to determine the primary site code for specified site groups.

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

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

See also the following topics for coding rules for Primary Site:

V.1.2 Identification of Separate Sites

V.1.3 Indefinite and Metastatic Sites

V.1.4 Special Conditions

V.1.5 Site-Specific Morphology

V.1.6 Uncertain Diagnoses

V.1.2 Identification of Separate Sites

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

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

For Cases Diagnosed Prior to January 1, 2005
A principal way of determining how many primary tumors a patient has is the identification of separate sites. For further discussion of primaries, see Section II.1.2 and Section 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.

With cases diagnosed prior to January 1, 2007, 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.

Examples

> 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

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

Codes C76.0 - C76.8

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

Code C80.9

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

V.1.4 Special Conditions

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.1.3.5 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, re ticuloendothelial 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 in 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)
- Appears to
- Comparable with
- Compatible with (a malignancy)
- Consistent with (a malignancy)
- Favor (a malignancy)
- Malignant appearing
- Most likely (malignant)
- Presumed (malignant)
- Probable (malignancy)
- Suspect or suspected (malignancy)
- Suspicious (of malignancy)
- Typical (of/for malignancy)

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

- Approaching (malignancy)

Cannot be ruled out

Equivocal (for malignancy)

Possible (malignancy)

Potentially malignant

Questionable (malignancy)

Rule out (malignancy)

Suggests (malignancy)

Very close to (malignancy)

Worrisome (for malignancy)

V.1.7 Multiple Primaries Related Data Items

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

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

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

Also, you can review the following related sections:

- V.1.7.1 Ambiguous Terminology Diagnosis
- V.1.7.2 Date of Conclusive Diagnosis
- V.1.7.3 Multiplicity Counter
- V.1.7.4 Date of Multiple Tumors
- V.1.7.5 Type of Multiple Tumors Reported as a Single Primary

V.1.7.1 Ambiguous Terminology Diagnosis

January 1, 2007 Forward

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

Apparent(ly)

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

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

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

Consistent with

Favor(s)

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

Most likely

Presumed

Probable

Suspect(ed)

Suspicious (for)

Typical (of)

Definitions

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

Examples

Clinical: a physician's statement that the patient most likely has lung cancer.

Laboratory tests: A CBC suspicious for leukemia.

Pathology: A prostate biopsy compatible with adenocarcinoma.

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

Code	Description	Timeframe
0	**Conclusive term.** There was a conclusive diagnosis within 60 days of the original diagnosis. Case was accessioned based on conclusive terminology. Includes all diagnostic methods such as clinical diagnosis, cytology, pathology, etc.	Within 60 days of the date of initial diagnosis.
1	**Ambiguous term only.** The case was accessioned based only on ambiguous terminology. There was no conclusive terminology during the first 60 days following the initial diagnosis. Includes all diagnostic methods except cytology.Note: Cytology is excluded because registrars are not required to collect cases with ambiguous terms describing a cytology diagnosis.	Not Applicable
2	**Ambiguous term followed by conclusive term.** The	60 days or more

	case was originally assigned a code 1 (was accessioned based only on ambiguous terminology). More than 60 days after the initial diagnosis the information is being updated to show that a conclusive diagnosis was made by any diagnostic method including clinical diagnosis, cytology, pathology, autopsy, etc.	after the date of diagnosis
9	**Unknown term**. There is no information about ambiguous terminology.	Not Applicable

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

Note: Usually the patient undergoes a diagnostic work-up because there is a suspicion of cancer (ambiguous terminology). For example, a mammogram may show calcifications suspicious for intraductal carcinoma; the date of the mammogram is the date of initial diagnosis. When there is a clear and definite diagnosis within 60 days of that mammogram (date of initial diagnosis) such as the pathology from an excisional biopsy showing intraductal carcinoma, assign a code 0.

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

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

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

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

V.1.7.2 Date of Conclusive Diagnosis
Enter the date a definite statement of malignancy is made following an initial diagnosis based on ambiguous terminology only.

Record the date of Conclusive Terminology in the month, day, century, year format (MMDDCCYY) with 99 for unknown month or day and 9999 for unknown year.

Leave this field blank for cases diagnosed prior to 01/01/2007.

The date of conclusive diagnosis must be greater than 60 days following the initial (ambiguous terminology only) diagnosis. If the date of conclusive diagnosis is within 60 days of the initial diagnosis, the case does not meet the criteria for ambiguous terminology only, use code 88888888.

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

Codes (in addition to valid dates):

00000000NO CONCLUSIVE DIAGNOSIS MADE

88888888NOT APPLICABLE, INITIAL DIAGNOSIS MADE BY UNAMBIGUOUS TERMINOLOGY

99999999UNKNOWN DATE, UNKNOWN IF DIAGNOSIS BASED ON AMBIGUOUS TERMINOLOGY

See 2007 SEER Multiple Primary and Histology Coding Rules.

V.1.7.3 Multiplicity Counter

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

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

Use code 01 when:

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

Use code 88 for:

- Leukemia
- Lymphoma
- Immunoproliferative disease
- Unknown primary

Use code 99 when:

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

Multiplicity Counter Codes:

01 ONE TUMOR ONLY

02 TWO TUMORS PRESENT

03 THREE TUMORS PRESENT

"

"

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

99 MULTIPLE TUMORS PRESENT, UNKNOWN HOW MANY

V.1.7.4 Date of Multiple Tumors

Enter the date used to identify the month, day and year the patient is diagnosed with multiple tumors reported as a single primary using the 2007 SEER Multiple Primary and Histology Coding Rules.

Enter the date in month, day, century, year format (MMDDCCYY) with 99 for unknown month or day and 9999 for unknown year.

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

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

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

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

Codes (in addition to valid dates):

00000000SINGLE TUMOR

88888888INFORMATION ON MULTIPLE TUMOR NOT COLLECTED/NOT APPLICABLE FOR THIS SITE

99999999UNKNOWN DATE

See 2007 SEER Multiple Primary and Histology Coding Rules.

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

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

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

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

Prior to January 1, 2007
Leave this field blank for cases diagnosed prior to January 1, 2007.

Codes for Type of Multiple Tumors Reported as a Single Primary are as follows:

00 **ALL SINGLE TUMORS.** INCLUDES SINGLE TUMORS WITH BOTH IN SITU AND INVASIVE COMPONENTS

10 **MULTIPLE BENIGN.** AT LEAST TWO BENIGN TUMORS IN SAME ORGAN/PRIMARY SITE. USE THIS CODE FOR REPORTABLE TUMORS IN INTRACRANIAL AND CNS SITES ONLY MAY BE USED FOR REPORTABLE BY AGREEMENT CASES.

11 **MULTIPLE BORDERLINE.** AT LEAST TWO BORDERLINE TUMORS IN THE SAME ORGAN/PRIMARY SITE USE THIS CODE FOR REPORTABLE TUMORS IN INTRACRANIAL AND CNS SITES AND REPORTABLE BORDERLINE OVARIAN TUMORS ONLY MAY BE USED FOR REPORTABLE BY AGREEMENT CASES.

12 **BENIGN AND BORDERLINE.** AT LEAST ONE BENIGN AND AT LEAST ONE BORDERLINE TUMORS IN THE SAME ORGAN/ PRIMARY SITE USE THIS CODE FOR REPORTABLE TUMORS IN INTRACRANIAL AND CNS SITES ONLYMAY BE USED FOR REPORTABLE BY AGREEMENT CASES.

20 **MULTIPLE IN SITU.** AT LEAST TWO IN SITU TUMORS IN THE SAME ORGAN/PRIMARY SITE.

30 **IN SITU AND INVASIVE.** ONE OR MORE IN SITU TUMOR(S)AND ONE OR MORE INVASIVE TUMORS IN THE SAME ORGAN/PRIMARY SITE.

31 **POLYP AND ADENOCARCINOMA.** ONE OR MORE POLYPS WITH EITHER· IN SITU CARCINOMA OR · INVASIVE CARCINOMA AND ONE OR MORE FRANK ADENOCARCINOMA(S) IN THE SAME SEGMENT OF COLON, RECTOSIGMOID, AND/OR RECTUM

32 **FAP WITH CARCINOMA**. DIAGNOSIS OF FAMILIAL POLYPOSIS (FAP) AND CARCINOMA (IN SITU OR INVASIVE) IS PRESENT IN AT LEAST ONE OF THE POLYPS

40 **MULTIPLE INVASIVE.** AT LEAST TWO INVASIVE TUMORS IN THE SAME ORGAN

80 **UNK IN SITU OR INVASIVE.** MULTIPLE TUMORS PRESENT IN THE SAME ORGAN/PRIMARY SITE, UNKNOWN IF IN SITU OR INVASIVE.

88 **NOT APPLICABLE.** INFORMATION ON MULTIPLE TUMORS NOT COLLECTED/NOT APPLICABLE FOR THIS SITE.

99 UNKNOWN

For more details and examples, consult the 2007 SEER Multiple Primary and Histology Coding Rules.

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
- V.2.2 Principal Paired Sites
- V.2.3 Site Coding Restriction

V.2.1 Coding (Laterality)

Code numbers for recording laterality are:

0 NOT A PAIRED SITE

1 RIGHT SIDE ORIGIN OF PRIMARY

2 LEFT SIDE ORIGIN OF PRIMARY

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

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

9 PAIRED SITE, BUT NO INFORMATION AVAILABLE CONCERNING LATERALITY

Never use code 4 for bilateral primaries for which separate abstracts are prepared or when the side of origin is known and the tumor has spread to the other side.

Example

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

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

From January 1/1/2004 and Forward

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

Prior to January 1, 2004

Prior to 1/1/2004, completion of this field was optional for sites not listed in Section V.2.2.

V.3.3 Histologic Type

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

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

Prior to January 1, 2007
For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

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

V.3 Histology, Behavior, and Differentiation

The five digit histology field consists of two parts:

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

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

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

V.3.1 ICD-O

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

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

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

V.3.2 ICD-O Coding

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

Example

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

9040/3 Synovial sarcoma, NOS

9041/3 Synovial sarcoma, spindle cell

9042/3 Synovial sarcoma, epithelioid cell

9043/3 Synovial sarcoma, biphasic

9044/3 Clear cell sarcoma, except of kidney

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

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

V.3.3.1 Sources for Determining Histology

January 1, 2007 and Forward

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

Prior to January 1, 2007
For cases or tumors diagnosed prior to January 1, 2007, apply the following guidelines:

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, in a text field, every source of information used.

V.3.3.2 Basic Rule

January 1, 2007 and Forward
Before attempting to code histology, determine whether the case involves a single primary or multiple primaries.

For cases diagnosed January 1, 2007 and forward, apply the SEER Multiple Primary and Histology Coding Rules. See Section II.1.3.

Prior to January 1, 2007
For cases diagnosed prior to January 1, 2007, apply the following guidelines:

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.

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 hematopoietic 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

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

January 1, 2005 through December 31, 2006
For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004, pages 7-19 and 84-87.

Prior to January 1, 2007
For cases diagnosed prior to January 1, 2005, apply the following guidelines:

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

Predominantly lobular with a ductal component.

Use the combination code for lobular and ductal carcinoma.

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

Adenocarcinoma (8140/3) of the sigmoid colon with mucin-producing features.

Code as mucin-producing adenocarcinoma (8481/3).

Invasive carcinoma, probably squamous cell type.

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

Adenocarcinoma of 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 than 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.

Examples

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.

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, apply the rules that follow. See Section II.1.3 for criteria.

- 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

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

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

See also Section IV.2.

V.3.3.5 Metastatic Site

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

Prior to January 1, 2007
For cases diagnosed prior to January 1, 2007, apply the following guideline:

> 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

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

Prior to January 1, 2007
For cases diagnosed January 1, 2005 through December 31, 2006, apply the SEER Multiple Primary and Histology Rules as written in the SEER Program Coding and Staging Manual, 2004.

Prior to January 1, 2005
For cases diagnosed prior to January 1, 2005, apply the following guidelines:

Lymphomas present some unique coding difficulties because of the complexity of the classification and the variety of terminologies in use. cell lymphoma

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.
- 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 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.
  - If there are specific diagnoses that can be coded, avoid using non specific or unclassified lymphoma terms.
- 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

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

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

Prior to January 1, 2005
For cases diagnosed prior to January 1, 2005, apply the following guidelines:

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 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.

Adenocarcinoma with Mucin

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 requires 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.

Codes are listed below:

/0* BENIGN

/1* UNCERTAIN WHETHER BENIGN OR MALIGNANT

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

LOW MALIGNANT POTENTIAL

/2 CARCINOMA IN SITU

Intraepithelial

Non-infiltrating

Non-invasive

/3 MALIGNANT, PRIMARY SITE

/6**MALIGNANT, METASTATIC SITE

MALIGNANT, SECONDARY SITE

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

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

** Reportable behavior, but enter code 3.

V.3.4.1 ICD-O/Pathology Conflicts

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

V.3.4.2 In Situ Coding

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

"In situ" behavior can be determined only by pathologic examination and not by clinical evidence alone. If a tumor is classifiable as "in situ" according to the time period rules for stage at diagnosis (see Section V.5), code the tumor as "in situ". In other words, a behavior code of 2, "in situ", corresponds to a stage code of 0, "in situ" and vice versa. Computer and visual edits will verify that the codes in

these two fields correspond. Do not interpret terms like "approaching in situ" or "very close to in situ" as "in situ".

Reportable terms indicating "in situ"behavior include:

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

Bowen's Disease

DCIS (ductal carcinoma in situ)

DIN 3 (ductal intraepithelial neoplasia 3)**

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

Confined to epithelium

Hutchinson's melanotic freckle

Intracystic, non-infiltrating

Intraductal

Intraepidermal

Intraepithelial

Intrasquamous

Involvement up to but not including the basement membrane

LCIS (lobular carcinoma in situ)

Lentigo maligna

LIN (laryngeal intraepithelial neoplasia)**

Lobular neoplasia, Grade III

No stromal invasion

Non-infiltrating

Non-invasive

Precancerous melanosis

Preinvasive

Queyrat's erythroplasia

Stage 0

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

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

* Effective with cases diagnosed 1/1/1992 and later
** Effective with cases diagnosed 1/1/2001 and later
All other terms have been reportable since the region’s reference date.
Not Reportable (Reminder)

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

V.3.4.3 Microinvasion

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

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

V.3.5 Grade and Differentiation

Also see:

- V.3.5.6 Gleason's Score
- V.3.5.7 Lymphomas and Leukemias
- V3.5.8 Bloom-Richardson Grade for Breast Cancer
- V.3.5.9 Grading Astrocytomas

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

Do not code as "not stated" if there is a relevant statement in the microscopic description. If there is a difference in grade between two pathologic specimens, code a known grade over an unknown grade.

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

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

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

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

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 neoplasm. This could include different degrees of differentiation between the biopsy and resection specimens.

Example

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

Code as grade III.

V.3.5.2 Microscopic Description

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

Examples

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

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

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

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

V.3.5.3 Variation in Terms for Degree of Differentiation
Use the higher grade when different terms are used for the degree of differentiation as follows:

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

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

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

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

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

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

V.3.5.4 In Situ

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

V.3.5.5 Brain Tumors

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

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

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

V.3.5.6 Gleason's Score

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

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

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

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

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

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

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

January 1, 2003 and Forward

* For cases diagnosed January 1, 2003 forward, code Gleason's 7 to grade 3.

Prior to January 1, 2003

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

Facility Oncology Registry Data Standards (FORDS manual) entry available

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 should be used, if available.

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

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

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

Tumor tubule formation	Score
>75% of tumor cells arranged in tubules	1
>10% and <75%	2
<10%	3
Number of mitoses	
(low power scanning (X100), find most mitotically tumor area, proceed to high power (x400)	
<10 mitoses in 10 high-power fields	1
>10 and <20 mitoses	2
>20 mitoses per 10 high power fields	3

Nuclear pleomorphism (nuclear grade)	
Cell nuclei are uniform in size and shape, relatively small, have dispersed chromatin patterns, and are without prominent nucleoli	1
Cell nuclei are somewhat pleomorphic, have nucleoli, and are intermediate size	2
Cell nuclei are relatively large, have prominent nucleoli or multiple nucleoli, coarse chromatin patterns, and vary in size and shape	3

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

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

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

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

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

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

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

V.3.5.9 Grading Astrocytomas

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

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

V.3.5.10 Fuhrman's Grade for Renal Cell Carcinoma

January 1, 2004 and Forward

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

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

Fuhrman's grade is based on 3 parameters:

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

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

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

V.3.6 Edits of Primary Site / Histology Codes

Certain combinations of histology and primary site codes indicate errors in coding. The CCR data management system (Eureka) edit data and reject false combinations. False combinations (edit errors) must be corrected before the data management system can store the data and make it available for research.

Disallowed combinations are of two types:

- Those involving the first four digits of the histology field (morphology code).
- Those involving the behavior code (fifth digit of the histology field).

V.3.6.1 Morphology / Site Codes

Some combinations of morphology and site codes are rejected because another site code more accurately reflects the tissue of origin. For example, a liposarcoma (8850/3) arising in the abdominal wall should be coded as site C49.4, soft tissues of abdomen, instead of C76.2, abdomen, NOS. Contact the regional registry for coding assistance, if required. Following are combinations of morphology and site codes that are rejected:

Morphology / Site Code

1. 8090-8096, Basal cell carcinomas, with

    C00._ Lip

    C19.9 Rectosigmoid

    C20.9-C21.8 Rectum and anus

2. 8720-8790, Melanoma, with

    C48.0 C48.8 Retroperitoneum/ peritoneum

    C38.1 C38.8 Pleura and Mediastinum

    C40.0-C41.9 Bone

    C76._ Other and ill-defined sites

3. 8010-8671 Epithelial & with

C38.1-C38.8 Pleura and Mediastinum

specialized gonadal

C40.0-C41.9* Bone tumors

C47.0-C47.9 Peripheral Nerves

C49.0-C49.9 Soft Tissues

C70.0-C72.9 Brain and Other Nervous System

4. 8940–8941, Mixed tumors, with

C38.1 C38.8 Pleura and Mediastinum

C40.0-C41.9* Bone

C47.0-C47.9 Peripheral Nerves

C49.0-C49.9 Soft tissues

C70.0-C71.9 Brain

C72._ Other nervous system

C76._ Other and ill defined sites

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

5. 9250 9340, Bone tumors, with

C30.0-C31.9 Nasal cavity, sinuses

6. 8800-8811, 8813-8831, 8840-8920, 8990-8991, 9040-9044, 9120-9170, 9240-9251, 9540-9560, 9580-9581, Sarcomas and other soft-tissue tumors, with

76._ Other and ill defined sites

V.3.6.2 Behavior / Site Codes

Do not code in situ behavior with a primary site that is unknown or ill defined. Therefore, if the behavior code is 2 (in situ), the following primary site codes are rejected as errors:

C26.9 Gastrointestinal tract, NOS

Alimentary tract, NOS

Digestive organs, NOS

C39.9 Ill defined sites within respiratory system
Respiratory tract, NOS

C55.9 Uterus, NOS
Uterine, NOS

C57.9 Female genital tract, NOS
Female genital organs, NOS
Female genitourinary tract, NOS
Urethrovaginal septum
Vesicocervical tissue
Vesicovaginal septum

C63.9 Male genital organs, NOS
Male genital tract, NOS
Male genitourinary tract, NOS

C68.9 Urinary system, NOS

C72.9 Nervous system, NOS
Central nervous system
Epidural
Extradural
Parasellar

C75.9 Endocrine gland, NOS

C76._ Other and ill-defined sites

C80.9 Unknown primary site

V.4 Coding Systems

V.4.1 Extent of Disease

Prior to January 1, 2004
Extent of Disease (EOD) coding applies to cases diagnosed prior to January 1, 2004. EOD staging was replaced by Collaborative Staging for cases diagnosed January 1, 2004 and forward.

Concerning EOD staging...

The ten-digit EOD code has five components:

- Size of the tumor (three digits)
- Extent to which the primary tumor has spread (two digits)
- Lymph node involvement (one digit)
- Number of nodes found positive in a pathological examination of regional lymph nodes (two digits)
- 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).

Extent of Disease coding is required for all California reporting facilities and all EOD fields are to be coded. Blanks will not be allowed. (Beginning with cases diagnosed January 1, 1994.)

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 are 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.

For cases diagnosed prior to January 1, 1995, the prostate EOD Path Extension field must be left blank.

Tumor Size, number of Regional Nodes Positive, and number of Regional Nodes Examined are required items for hospitals with ACoS approved programs. Refer to the ACoS Facility Oncology Registry Data Standards (FORDS) manual for codes and coding instructions.

Beginning with cases diagnosed January 1, 1998, new codes, new site-specific coding schemes and a new time-frame for assigning codes were added. In addition, rules for coding have been revised. 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 were effective through the December 31, 2003 diagnosis year.

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. The new codes are as follows:

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

January 1, 2008 and Forward
Although Collaborative Staging has been required by the CCR since 2004, effective with cases diagnosed January 1, 2008 and forward, SEER (and thus the CCR) expanded the requirement to also include the CS Evaluation fields. Thus the following CS fields are required effective with cases diagnosed January 1, 2008 and forward:

- CS Extension
- CS Lymph Nodes
- Regional Nodes Positive*
- Regional Nodes Examined
- CS Mets at Diagnosis
- CS Site Specific Factor 1
- CS Site Specific Factor 2
- CS Site Specific Factor 3
- CS Site Specific Factor 4
- CS Site Specific Factor 5
- CS Site Specific Factor 6
- CS Tumor Size/Extension Evaluation
- CS Lymph Node Evaluation
- CS Metastasis Evaluation
- Derived AJCC T Descriptor
- Derived AJCC N Descriptor
- Derived AJCC M Descriptor

Prior to January 1, 2008
The following Collaborative Staging data items are not required by the CCR, but must be submitted 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

Refer to the Collaborative Staging Manual for coding instructions.

January 1, 2004 and Forward
The CCR has required the collection of the Collaborative Staging fields 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 Extension
- CS Lymph Nodes
- Regional Nodes Positive*
- Regional Nodes Examined
- CS Mets at Diagnosis
- CS Site Specific Factor 1
- CS Site Specific Factor 2
- CS Site Specific Factor 3
- CS Site Specific Factor 4
- CS Site Specific Factor 5
- CS Site Specific Factor 6
- CS Tumor Size/Extension Evaluation
- CS Lymph Node Evaluation
- CS Metastasis Evaluation
- Derived AJCC T Descriptor
- Derived AJCC N Descriptor
- Derived AJCC M Descriptor

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

Prior to January 1, 2004
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 Stage at Diagnosis

Stage at Diagnosis is a grouping of cases into broad categories, for example, localized, regional, and distant. This is different than Extent of Disease which is a detailed description of the spread of the disease from the site of origin.

January 1, 2004 and Forward
Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, Stage Group, Summary Stage 1977, and Summary Stage 2000.

Prior to January 1, 2004
For cases seen prior to January 1, 2004, apply the following guidelines:

In the Stage at Diagnosis field, enter the code that represents the farthest tumor involvement as indicated by all the evidence obtained from diagnostic and therapeutic procedures performed during the first course of treatment or within four months after the date of diagnosis, whichever is earlier. (See Section VI.1 for definitions of first course of treatment and definitive treatment.) Coding must be supported by textual information entered under Diagnostic Procedures (see Section IV.1).

Stage at Diagnosis is not required beginning with cases diagnosed January 1, 1994. Hospitals wishing to do so may continue its use.

Prior to January 1, 1994
Cases diagnosed prior to January 1, 1994 must continue to be staged using SEER Summary Staging Guide 1977. this document is available from SEER.

Rules for Summary State 19778 and SEER Summary State 2000

Although Summary Stage is not required by the CCR, it is required by NAACCR and NPCR. The rules for using SEER Summary Stage 1977 and SEER Summary Stage 2000 are as follows:

- Cancer cases diagnosed before January 1, 2001 should be assigned a summary stage according to SEER Summary Stage Guide 1977.
- Cases diagnosed on or after January 1, 2001 should be assigned a stage according to SEER Summary Stage 2000.

V.5.1 Codes

Always base coding on the site-specific schemes presented in the *Summary Staging Guide for the Cancer Surveillance, Epidemiology and End Results Reporting (SEER) Program*, which is available as a separate publication or as Book 6 of the *Self Instructional Manual for Tumor Registrars* (see Section I.1.6.5).

Instructions in sections V.5.8, V.5.9, V.5.10, and V.5.11 are provided for guidance only. The codes are:

0	IN SITU
1	LOCALIZED
2	REGIONAL, DIRECT EXTENSION ONLY

3	REGIONAL, LYMPH NODES ONLY
4	REGIONAL, DIRECT EXTENSION AND LYMPH NODES
5	REGIONAL, NOS
7	DISTANT METASTASES OR SYSTEMIC DISEASE (REMOTE)
9	UNSTAGEABLE (stage cannot be determined from available information)
Blank	NOT DONE

V.5.2 Definitions

Terms commonly used to describe stage include:

Invasion

Local spread of a neoplasm by infiltration into or destruction of adjacent tissue.

Microinvasive

The earliest invasive stage. Applied to cervical cancer, describes a small cancer that has invaded the stroma to a limited extent. The FIGO stage is IA. See Section V.3.4.3 and Section V.5.9.4.

Direct Extension

A continuous infiltration or growth from the primary site into other tissue or organs (compare to metastasis).

Metastasis

Dissemination of tumor cells in a discontinuous fashion from the primary site to other parts of the body—for example, by way of the circulatory system or a lymphatic system.

Regional

Organs or tissues related to a site by physical proximity. Also applies to the first chain of lymph nodes draining the area of the site.

V.5.3 Ambiguous Terms

Physicians sometimes use ambiguous terms to indicate the involvement of tissue or an organ by a tumor. Refer to the Collaborative Staging Manual, 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 earlier. This time limitation ensures that the stage recorded is based on the same information that was used to plan the patient's treatment. Exclude progression of the disease since the time of the original diagnosis. See Section VI.1.1 for the analogous rule concerning first course of treatment.

Example

A patient with lung cancer is staged "regional lymph nodes" by the physician on the basis of positive mediastinal lymph nodes and radiation therapy is instituted. Four weeks into the treatment course the patient develops neurological symptoms, and further work–up reveals previously unsuspected brain metastases. The treatment plan is changed to take this new manifestation into account. Since the disease has progressed since the time of original diagnosis, the stage would not be changed to distant

V.5.5 Autopsy Reports

Include pertinent findings from autopsy reports if the patient dies within four months of the diagnosis of the cancer. However, as with other types of information, exclude data about progression of the disease since the time of the original diagnosis.

V.5.6 Staging by Physician

When a physician has assigned a stage using the TNM, FIGO, Dukes', or any other system, use the information as a guide for coding stage, especially when information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread. For a discussion of TNM, see Section V.7. However, take certain precautions:

- Physicians might use different versions of a staging system at the same time, and a specific designation of stage might have different meanings. To determine the corresponding summary stage code, it is essential to know exactly which version a physician is using.
- Some staging systems (FIGO for example) use clinical information only, whereas CCR's Stage at Diagnosis includes all information, clinical, surgical, and pathological, that falls into the time period. Use the physician's clinical stage if no pathological information is available.

V.5.7 Contradictory Reports

Sometimes the stage is stated incorrectly in the medical record due to a typographical, transcription, or similar error. If the stage recorded in one report is clearly contradicted in another, query the physician or the registry's medical consultant. Do not code stage based on information that appears to be inaccurate.

V.5.8 In situ (Code 0)

A diagnosis of in situ, which must be based on microscopic examination of tissue or cells, means that a tumor has all the characteristics of malignancy except invasion, that is, the basement membrane has not been penetrated. A tumor that displays any degree of invasion is not classified as in situ.

For example, even if a report states *carcinoma in situ of the cervix showing microinvasion of one area*, the tumor is not in situ and code 0 is incorrect. However, a primary tumor might involve more than one site (for example, cervix and vagina, labial mucosa and gingiva) and still be in situ, as long as it does not show any invasion.

V.5.8.1 Terms Indicating In Situ

Certain terms indicate an in situ stage. Also see Section V.3.4.2.

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

Bowen's Disease

DCIS (ductal carcinoma in situ)

DIN 3 (ductal intraepithelial neoplasia 3)**

CIN III (cervical intraepithelial neoplasia, grade III)*

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

Confined to epithelium

Hutchinson's melanotic freckle, nos

Intracystic, non infiltrating

Intraductal

Intraepidermal

Intraepithelial

Intrasquamous

Involvement up to but not including the basement membrane

LCIS (lobular carcinoma in situ)

Lentigo maligna

LIN (laryngeal intraepithelial neoplasia)**

Lobular neoplasia, Grade III

No stromal invasion

Non infiltrating

Non invasive

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

Precancerous melanosis

Preinvasive

Queyrat's erythroplasia

Stage 0

Vaginal intraepithelial neoplasia, Grade III (VAIN III)*

Vulvar intraepithelial neoplasia, Grade III (VIN III)*

* Cases diagnosed January 1992 and later.

** Cases diagnosed January 2001 and later.

***Cases diagnosed January 2004 and later.

V.5.8.2 Behavior Code

If a tumor is staged in situ, the behavior code is 2. See Section V.3.4.

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

January 1, 2004 and Forward

For cases diagnosed January 1, 2004 and forward, apply the Collaborative Staging rules for inaccessible sites. Refer to the Collaborative Staging Manual for coding instructions.

Prior to January 1, 2004

The following Collaborative Staging data items are not required by the CCR, but must be submitted 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

For cases diagnosed prior to January 1, 2004, apply the following guidelines:

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).

Physicians sometimes use ambiguous terms to indicate the involvement of tissue or an organ by a tumor. Refer to the Collaborative Staging Manual, for a list of ambiguous terms.

Code a case as stage 1, localized, 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.

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" nodule, that is, lesions secondary to the primary one, might not be localized. Refer to the *Collaborative Staging Manual* 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 Stage (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)

At times a cancer spreads to surrounding organs or tissue with no involvement of regional lymph nodes. Before assigning code 2 to such a case, make sure that tissue adjacent to the original organ is actually involved. The terms "penetrating" and "extension" are sometimes used to describe spreading within an organ, such as the large intestine or bladder, in which case the stage might still be localized (code 1). The Summary Staging Guide lists organs and structures considered to be

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

Diagnoses such as "carcinoma of the stomach with involvement of the local lymph nodes" should, lacking further evidence, be considered regional and staged as code 3.

Statements like "carcinoma of the breast with auxiliary lymph node metastasis" and "carcinoma of the stomach with metastasis to perigastric nodes" indicate metastasis to regional nodes and should be staged as code 3.

V.5.10.3 Bilateral Involvement

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 region al 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 which is sometimes stated in the record as Stage II. See Section V.5.6 and Section 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 Guide.
- Metastasis to distant lymph nodes.
- Development of discontinuous secondary or metastatic tumors. (These often develop in the liver or lungs, because all venous blood flows through these

organs and the veins are invaded more easily than the thicker walled arteries.)

Code 7 also includes contralateral or bilateral lymph node metastases, if the primary site is not located along the midline of the body (for example, in the breast, lung, bronchus, ovary, testis, 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, any 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 note 2 of the CS Lymph Nodes instructions in the CS Manual, assume those lymph nodes are involved.

Prior to January 1, 2004

- For EOD coding (cases diagnosed prior to January 1, 2004), mediastinal lymph nodes greater than 1 cm are considered enlarged.

V.6 Tumor Markers

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

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

Historical Information

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 required 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 dehydrogenase (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.

V.6.1 Tumor Marker 1

January 1, 2004 and Forward

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

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

Historical Information

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: less than 1,000 NG/ML (S1)
5	RANGE 2: 1,000 - 10,000 NG/ML (S2)
6	RANGE 3: greater than 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, for colorectal and ovarian cancers before January 1, 2000, and for all other sites, enter:

9	NOT APPLICABLE

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

Use codes 0, 2, 4, 5, 6, 8, and 9 for testicular cancer. ***Do not use code 1 for testicular cancers.***

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.

V.6.2 Tumor Marker 2

January 1, 2004 and Forward

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

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

Historical Information

Use the following codes for the status of 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 for 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: less than 5,000 mIU/ml (S1)
5	RANGE 2: 5,000 - 50,000 mIU/ml (S2)
6	RANGE 3: greater than 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. Do not use code 1 for testicular cancers.

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.

V.6.3 Tumor Marker 3

January 1, 2004 and Forward

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

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

Historical Information

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

Do not use code 1 for testicular cancers.

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).

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

There are currently two FDA-approved tests to determine HER2 status: IHC and FISH

IHC stands for ImmunoHistoChemistry

- The IHC test is used to measure HER2 protein (also called HER2 receptor) overexpression in the tumor sample.
- Interpretation of IHC relies on a qualitative scoring system on a scale of 0 - 3+
- The results can be reported as 0, 1+, 2+, or 3+. If the result is 3+, the cancer is considered HER2 positive.

Using IHC, a tumor biopsy is scored as:

- 0 (negative)
- 1+ (negative)
- 2+ (borderline)
- 3+ (positive) on an IHC test based on the reviewer's interpretation of staining intensity and completeness of membrane staining

FISH stands for Fluorescence in Situ Hybridization

- FISH uses fluorescent probes to "paint" the HER2 genes in a tumor cell, to see if the number of gene copies is normal or not. A normal cell has 2 copies of the HER2 gene.
- If a FISH test detects more than 2 copies of the HER2 gene, it means that the cell is abnormal and is HER2-positive.
- With FISH testing, the results are quantitative instead of qualitative; tumors are interpreted as HER2 "negative" or "positive" by enumerating the HER2/neu gene copy number.

If both the IHC and FISH tests are performed, use the FISH results for coding this field. Document the type of test performed.

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	TEST ORDERED, RESULTS NOT IN CHART
9	UNKNOWN IF TEST DONE OR ORDERED; NO INFORMATION (includes death-certificate-only cases)

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

9	NOT APPLICABLE

V.7 AJCC Staging and Other ACoS Items

January 1, 2008 and Forward
Effective with cases diagnosed January 1, 2008 forward, physician-assigned pathologic AJCC staging will no longer be required to be collected by ACoS approved facilities.

January 1, 2004 and Forward
Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, and Stage Group.

Prior to January 1, 2004
For cases diagnosed prior to January 1, 2004, 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. Other TNM staging is part of their supplementary data set.

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 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

January 1, 2004 and Forward
Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, and Stage Group.

As the AJCC *Manual for Staging of Cancer* explains, the TNM system "is based on the premise that cancers of similar histology or site of origin share similar patterns of growth and extension. The size of the untreated cancer or tumor (T) increases progressively and at some point in time regional lymph node involvement (N) and finally, distant metastases (M) occur."

Because classifications are different for each primary site, and coding for extension depends on precise anatomical identification, the AJCC manual must be referred to for data entry unless the coding is provided by physicians in the medical records. But fundamentally the system consists of assigning appropriate numbers or letters to the three fields:

- T (primary tumor)
- N (nodal involvement)
- M (distant metastasis)

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

California Cancer Registry Volume I: Data Standards and Data Dictionary

Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, Ninth Edition, June 2009

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.

California Cancer Registry Volume I: Data Standards and Data Dictionary

Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, Ninth Edition, June 2009

V.7.3 TNM Stage Basis

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

The codes are as follows:

S*	Surgical evaluative
R	Retreatment
A	Autopsy

* Not used in the 3rd or 4th edition of the AJCC manual.

V.7.4 TNM Staging Elements (Clinical and Pathological)

January 1, 2004 and Forward
Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, and Stage Group.

Prior to January 1, 2004
For cases diagnosed prior to January 1, 2004, 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		T1A2	A2		T3	3
T0	0		T1B	1B		T3A	3A
Ta	A		T1B1	B1		T3B	3B
Tis	IS		T1B2	B2		T3C	3C
Tispu	SU		T1C	1C		T4	4
Tispd	SD		T2	2		T4A	4A
T1mic	1M		T2A	2A		T4B	4B
T1	1		T2B	2B		T4C	4C
T1A	1A		T2C	2C		T4D	4D

T1A1	A1				Not applicable	88

N Codes

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

M Codes

MX	X		M1A	1A
M0	0		M1B	1B
M1	1		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
M1a	Skin or subcutaneous tissue or lymph node(s) beyond the regional lymph nodes

M1c	Visceral metastasis at any site associated with an elevated serum lactic dehydrogenase (LDH).

V.7.5 AJCC Stage Group (Clinical and Pathological)

When entering a stage summary code, be sure to include any letter used for the tumor, for example; 3A, 2C. If there is no letter, leave the second digit in the field blank. The codes are:

STAGE 0	0	STAGE IIC	2C
STAGE 0A	0A	STAGE III	3
STAGE 0IS	0S	STAGE IIIA	3A
STAGE I	1	STAGE IIIB	3B
STAGE IA	1A	STAGE IIIC	3C
STAGE IA1	A1	STAGE IV	4
STAGE IA2	A2	STAGE IVA	4A
STAGE IB	1B	STAGE IVB	4B
STAGE IB1	B1	STAGE IVC	4C
STAGE IB2	B2	OCCULT	OC
STAGE IC	1C	NOT APPLICABLE	88
STAGE IS	1S		
STAGE II	2	RECURRENT, UNKNOWN, STAGE X	99
STAGE IIA	2A		
STAGE IIB	2B		

January 1, 2004 and Forward
Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, Stage Group.

Prior to January 1, 2004
For cases diagnosed prior to January 1, 2004, the AJCC manual contains instructions for coding summaries of TNM staging.

V.7.6 TNM Coder (Clinical, Pathological, and Other)

Record the responsible person for performing the TNM staging on the case.

The TNM Coder (Clinical) and TNM Coder (Pathological) are to be used in conjunction with clinical and pathological TNM staging.

These fields will be transmitted to the state registry.

The codes are as follows:

0 NOT STAGED

1 MANAGING PHYSICIAN

2 PATHOLOGIST

3 PATHOLOGIST AND MANAGING PHYSICIAN

4 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

The TNM Edition field may be left blank.

V.7.8 Pediatric Stage

This scheme is to be used for the purpose of entering the stage for pediatric patients only.

January 1, 1996 and Forward
Pediatric Stage includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 or later.

Use Code 88 - not applicable, for patients twenty years of age and older.

Use code 99 for pediatric leukemia cases.

For cases diagnosed prior to 1996, both pediatric and non-pediatric, this field may be left blank.

Record the stage assigned by the Managing Physician.

The codes are as follows:

1	STAGE I
1A	STAGE IA (rhabdomyosarcomas & related sarcomas)
1B	STAGE IB (rhabdomyosarcomas & related sarcomas)
2	STAGE II
2A	STAGE IIA (rhabdomyosarcomas & related sarcomas)
2B	STAGE IIB (rhabdomyosarcomas & related sarcomas)
2C	STAGE IIC (rhabdomyosarcomas & related sarcomas)
3	STAGE III
3A	STAGE IIIA (liver, rhabdo. & related sarcomas, Wilms')
3B	STAGE IIIB (liver, rhabdo. & related sarcomas, Wilms')
3C	STAGE IIIC (Wilms' tumor)
3D	STAGE IIID (Wilms' tumor)
3E	STAGE IIIE (Wilms' tumor)
4	STAGE IV
4A	STAGE IVA (bone)
4B	STAGE IVB (bone)
4S	STAGE IVS (neuroblastoma)
5	STAGE V (Wilms' tumor/retinoblastoma)
A	STAGE A (neuroblastoma)
B	STAGE B (neuroblastoma)
C	STAGE C (neuroblastoma)
D	STAGE D (neuroblastoma)

DS	STAGE DS (neuroblastoma)
88	NOT APPLICABLE (not a pediatric case)
99	UNSTAGED, UNKNOWN

V.7.9 Pediatric Stage System

This scheme is to be used for pediatric patients only.

January 1, 1996 and Forward
Beginning with cases diagnosed January 1, 2004 and forward, the CCR requires the collection of Collaborative Staging (CS) data items necessary to derive AJCC T, N, M, Stage Group.

Prior to January 1, 2004
For cases diagnosed prior to January 1, 2004, the AJCC manual contains instructions for coding summaries of TNM staging.

Pediatric Stage includes patients who are younger than twenty (20) years of age and diagnosed January 1, 1996 or later.

Use Code 88 - not applicable, for patients twenty years of age and older.

For cases diagnosed prior to 1996, both pediatric and non-pediatric, this field may be left blank.

Record in this field the staging system used by the Managing Physician.

The codes are as follows:

00	NONE
01	AMERICAN JOINT COMMITTEE ON CANCER (AJCC)
02	ANN ARBOR
03	CHILDREN'S CANCER GROUP (CCG)
04	EVANS
05	GENERAL SUMMARY
06	INTERGROUP EWINGS
07	INTERGROUP HEPATOBLASTOMA
08	INTERGROUP RHABDOMYOSARCOMA
09	INTERNATIONAL SYSTEM

10	MURPHY
11	NATIONAL CANCER INSTITUTE (Pediatric Oncology)
12	NATIONAL WILMS' TUMOR STUDY
13	PEDIATRIC ONCOLOGY GROUP (POG)
14	REESE-ELLSWORTH
15	SEER EXTENT OF DISEASE
16	CHILDREN'S ONCOLOGY GROUP (COG)
88	NOT APPLICABLE
97	OTHER
99	UNKNOWN

V.7.10 Pediatric Stage Coder

This data item is to be used for pediatric cases only diagnosed January 1, 1996 and later. It identifies the person who staged the case.

The ACoS states that the managing physician is responsible for staging analytical cases. The CCR concurs and feels that this applies to non-analytic cases, also.

If the staging has not been done by the physician, the registrar does not have to stage the case. Enter 0 for not staged.

For patients older than twenty (20), enter 0.For cases diagnosed prior to 1996, this field may be left blank. The codes are as follows:

0	NOT STAGED
1	MANAGING PHYSICIAN
2	PATHOLOGIST
3	OTHER PHYSICIAN
4	ANY COMBINATION OF 1, 2 OR 3
5	REGISTRAR
6	ANY COMBINATION OF 5 WITH 1, 2 OR 3
7	OTHER
8	STAGED, INDIVIDUAL NOT SPECIFIED
9	UNKNOWN IF STAGED

Part VI Treatment

VI.1 First Course of Treatment: General Instructions

In the treatment section, record all cancer directed therapy administered as part of the first course of treatment. It includes any therapeutic procedure directed at cancer tissue, whether in a primary or metastatic site, whatever the mode of treatment, and regardless of the sequence and degree of completion of any component part.

Effective with cases diagnosed January 1, 1998, a new definition for first course therapy was to be followed. In addition, note the definition for leukemias in see Section VI.1.1). Use the older definition for cases diagnosed prior to January 1, 1998.

The following rules are to be followed for first course therapy, and they are in the order of precedence:

1. If there is a documented, planned first course of therapy, first course ends at the completion of this treatment plan, regardless of the duration of the treatment plan.
2. If the patient is treated according to a facility's standards of practice, first course ends at the completion of the treatment.
3. 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.

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 intended therapy was actually performed, record

that it was recommended but it is not known whether the procedure was administered. (For example, Enter "Radiation therapy, recommended; unknown if given.") 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.

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. Reminder: Referral does not equal a recommendation.

VI.1.1 Special Situations

In Utero Diagnoses and Treatment

Beginning in 2009, the dates of diagnosis and treatment for tumors developed while in utero should reflect the dates on which they occur. In the past, these dates were assigned to the date the baby was born.

Treatment Performed Elsewhere (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 procedure that is directed toward symptoms only, the therapy is not considered to be treatment (e.g., colostomy, removal of fluid—even if cancer cells are present—to ease pressure, neurosurgery to relieve pain).

Antineoplastic Drugs

Applies to medications that prevent the development, maturation, or spread of cancer cells. Included are drugs for chemotherapy (see Section VI.4), hormonal treatment (see Section VI.5), and immunotherapy (see Section VI.6). For cases diagnosed 1/1/2005 forward, registrars must use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy). SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.

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 , code a summary of the entire first course of treatment. See Section VI.2 for coding each surgery field.

In the field provided, assign a separate code to that portion of the treatment administered at the reporting 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.

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. However, if a type of treatment is known to have been given but the date is not known, enter 9's.

From 1/1/2009 and Forward

In Utero Diagnoses and Treatment

Beginning in 2009, the dates of diagnosis and treatment for tumors developed while in utero should reflect the dates on which they occur. In the past, these dates were assigned to the date the baby was born.

From 1/1/03 Forward

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. The text field may be left blank when the type of treatment was not provided. But if no cancer-directed surgery is performed, record the reason in the text field for surgery.

NOTE: There is no text field for bone marrow transplant and endocrine procedures. Record text information regarding bone marrow transplants and endocrine procedures in the immunotherapy text field.

VI.1.3.4 Treatment Refused

If the patient or patient's guardian refuses surgery to the primary site, enter code 7 in the Reason for No Surgery field. Use code 87 in the respective treatment field if the patient or patient's guardian refuses that modality and record the fact in the text field. However, if a treatment that was originally refused was subsequently performed as part of the first course of treatment, enter the appropriate code for the procedure.

VI.1.3.5 No 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).

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. Reminder: Referral does not equal a recommendation.

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 a 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.

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. Reminder: Referral does not equal a recommendation.

VI.2 First Course of Treatment: Surgery Introduction

In abstracting surgical treatment, the total or partial removal (except an incisional biopsy) of tumor tissue must be recorded in the text field, whether from a primary or metastatic site. Also record procedures that remove normal tissue--for example, dissection of non-cancerous lymph nodes--if they are part of the first course of treatment. (Brushings, washings, aspiration of cells and peripheral blood smears are not considered surgical procedures, but they might have to be recorded as diagnostic procedures. See Section IV.1.

January 1, 2003 and Forward
Beginning with cases diagnosed January 1, 2003, the surgery codes, definitions, and fields were reformulated.

Surgical Approach, Number of Regional Lymph Nodes Examined, and Reconstructive Surgery were dropped and all remaining fields except Surgery of the Primary Site were given a simplified coding scheme;

Surgery of the Primary Site was assigned new site-specific codes

Reconstructive Surgery was folded into the Surgery to the Primary Site codes.

January 1, 1998 and Forward
Beginning with cases diagnosed January 1, 1998, new surgery codes, definitions, and fields from the American College of Surgeons were 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.

January 1, 1996 and Forward
For cases diagnosed January 1, 1996 forward, the surgery field was separated into three fields:

- Surgery of the primary site
- Diagnostic, staging or palliative procedures
- Reconstructive surgery

VI.2.1 Surgery of the Primary Site

See Appendix Q for Site-Specific Surgery Codes

Generally, cancer-directed surgery includes most procedures that involve removal of a structure (those with the suffix "ectomy") and such procedures as:

- Biopsy, excisional (which has microscopic residual disease or no residual disease)
- Biopsy, NOS, that removes all tumor tissue

- Chemosurgery (Moh's technique)
- Conization
- Cryosurgery
- Dessication and Curettage for bladder and skin tumors
- Electrocautery
- Fulguration for bladder, skin, and rectal neoplasms
- Laser therapy
- Local excision with removal of cancer tissue (including excisional biopsy but excluding incisional biopsy)
- Photocoagulation
- Splenectomy for lymphoma or leukemia
- Surgery removing metastatic malignant tissue
- Transurethral resection (TUR) with removal of tumor tissue of bladder or prostatic tumors

Do not code pre-surgical embolization of hypervascular tumors with particles, coils or alcohol. These pre-surgical embolizations are typically performed to make the resection of the primary tumor easier. Examples where pre-surgical embolization is used include meningiomas, hemangiomas, paragangliomas, and renal cell metastases in the brain.

For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is unavailable. Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix Q.

Refer to Appendix Q-1 for cases diagnosed prior to January 1, 2003. Refer to Appendix Q-2 for cases diagnosed on or after January 1, 2003.

Enter the procedures in chronological order. If more than three surgical procedures are performed on a patient, the earliest surgery and the most definitive surgery must be included.

Surgery of the Primary Site consists of three two-character fields which are to be used to record surgeries of the primary site only. If an en bloc resection is performed which removes regional tissue or organs with the primary site(s) part of a specific code definition, it should be coded. An en bloc resection is the removal of organs in one piece at one time.

Examples

> Patient undergoes a modified radical mastectomy. The breast and auxiliary contents are removed in one piece (en bloc).
>
> Surgery would be coded 50 for modified radical mastectomy regardless of whether nodes were found by pathology in the specimen.

For non-en bloc resections, record the resection of a secondary or metastatic site in the Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s).

Refer to Appendix Q for the site-specific surgery codes. They are hierarchical with less specific (NOS) terms followed by more specific terms. See the example.

Examples

50 Gastrectomy, NOS WITH removal of a portion of esophagus
51 Partial or subtotal gastrectomy
52 Near total or total gastrectomy

NOTE: Codes 10-90 have priority over code 99.
Codes 10-84 have priority over codes 90 and 99.
Codes 10-79 have priority over codes 80, 90 and 99, where 80 is site-specific surgery, not otherwise specified.

NOTE: If surgery removes the remaining portion of an organ, code the total removal of the organ.

NOTE: Biopsies that remove all gross tumor or leave only microscopic margins should be coded to surgery of the primary site.

The patient had a resection of a stomach remnant and portion of the esophagus at the time of their second procedure.

The first procedure was a partial gastrectomy, NOS - code 30.

The second procedure would be code 52 for a total gastrectomy.

A patient had a lobectomy--code 31--for cancer in August 1998. The remainder of the lung was surgically removed in November 1998.

The second procedure would be code 40--resection of whole lung..

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. Reminder: Referral does not equal a recommendation.

VI.2.2 Scope of Regional Lymph Node Surgery

These three one-character fields are to be used to record surgeries performed on regional lymph nodes. Record the farthest regional lymph node removed regardless of involvement with disease. There is no minimum number of nodes that must be removed. If a regional lymph node was aspirated or biopsied, code regional lymph node(s) removed, NOS (1).

January 1, 2003 and Forward
Starting with cases diagnosed January 1, 2003 forward, RX Summ, Scope of Reg LN Surg is not be coded according to site. It is coded using a single scheme for all sites. The three procedure fields must continue to be coded for 2003 forward cases. The codes for Scope of Regional LN's are as follows:

0	NONE No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	BIOPSY OR ASPIRATION OF REGIONAL LYMPH NODE, NOS Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease.
2	SENTINEL LYMPH NODE BIOPSY Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	NUMBER OF REGIONAL NODES REMOVED UNKNOWN OR NOT STATED; REGIONAL LYMPH NODE REMOVED, NOS Sampling or dissection of regional lymph node(s) and the number of nodes is unknown or not stated. The procedure is not specified as sentinel node biopsy.
4	1-3 REGIONAL LYMPH NODES REMOVED Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 OR MORE REGIONAL LYMPH NODES REMOVED Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
6	SENTINEL NODE BIOPSY AND CODE 3,4, OR 5 AT SAME TIME, OR TIMING OUT NOT STATED Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 was performed, but timing was not stated in patient record.
7	SENTINEL NODE BIOPSY AND CODE 3,4, OR 5 AT DIFFERENT TIMES Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.
9	UNKNOWN OR NOT APPLICABLE It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary;primaries of the brain and central nervous system, or for

	hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

For Unknown Primary, Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease Primaries, Lymphoma, Brain, Meninges, Spinal cord, Cranial Nerves and other part of the CNS (including the Pituitary Gland) and Primaries of Ill-Defined Sites, use code 9.

Cases diagnosed prior to January 1, 2003 must be coded in a new field, Scope of Regional LN 98-02. Refer to Appendix Q-1 for these codes.

Each site contains a list of nodes which are regional. Any nodes not contained on these lists are distant and should be coded in Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

In Appendix Q-1 for head and neck primaries diagnosed prior to January 1, 2003, the fields are to be used for neck dissections. Codes 2-5 indicate only that a neck dissection procedure was performed. They do not imply that nodes were found during the pathologic examination of the surgical specimen. Code the neck dissection even if no nodes were found in the specimen.

VI.2.3 Number of Regional Lymph Nodes Examined

Record the number of lymph nodes identified in the pathology report during each surgical procedure of the regional lymph nodes. The codes are the same for all sites. Refer to Appendix Q-1 for these codes, which are to be entered in chronological order. If no regional lymph nodes were identified in the pathology report, leave the field blank even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or if the operative report documents removal of the nodes.

Note: This field is not cumulative. It does not replace or duplicate the "Regional Lymph Nodes Examined" field used in Extent of Disease coding.

Effective with cases diagnosed on or after January 1, 2003, the fields for Rx Summ-Reg LN Examined and Rx Hosp-Reg LN Examined are no longer required by the CCR and the CoC. Information regarding the number of lymph nodes has been incorporated into the scope fields. However, the summary field for cases diagnosed prior to January 1, 2003 must continue to be coded.

Use code 99 for an Unknown Primary Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease Primaries, Lymphoma, Brain (including the pituitary gland) and Primaries of Ill-Defined Sites.

VI.2.4 Surgery of Other Regional Sites, Distant Sites, or Distant Lymph Nodes

There are three one-character fields to be used to record removal of tissue other than the primary tumor or organ of origin. This would not be an en bloc resection. See example #1. Code the removal of non-primary site tissue which the surgeon may have suspected to be involved with malignancy even if the pathology was

negative. Do not code the incidental removal of tissue for reasons other than malignancy. See example #2. These procedures are to be entered in chronological order. If no surgery was performed of other regional or distant sites or distant lymph nodes, leave the fields blank.

Starting with cases diagnosed January 1, 2003 forward, RX Summ - Surg Oth Reg/Dis and its corresponding procedure fields are not coded according to site. Rather, they are coded using a single scheme for all sites. The new codes are as follows:

0	NONE No surgical procedure of nonprimary site
1	NONPRIMARY SURGICAL PROCEDURE PERFORMED Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	NONPRIMARY SURGICAL PROCEDURE TO OTHER REGIONAL SITES Resection of regional site.
3	NONPRIMARY SURGICAL PROCEDURE TO DISTANT LYMPH NODE(S) Resection of distant lymph node(s).
4	NONPRIMARY SURGICAL PROCEDURE TO DISTANT SITE Resection of distant site.
5	COMBINATION OF CODES Any combination of surgical procedures 2, 3, or 4.
9	UNKNOWN It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.

NOTE: Use code 1 if any surgery is performed to treat tumors of Unknown or Ill-defined Primary sites (C76.0-76.8, C80.9) or for Hematopoietic/Reticuloendothelial/Immunoproliferative disease (C42.0, C42.1, C42.3, C42.4, or 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 (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.

January 1, 2003 and Forward
Beginning with cases diagnosed 1/1/2003, 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 used in conjunction with each surgical procedure performed. If the procedure was performed at the reporting facility, the reporting hospital number should be entered. Use NPI facility number if available.

The fields are to be left blank if no cancer-directed surgery was performed.

VI.2.7 Surgical Margins of the Primary Site

This field is not required by the CCR effective with cases diagnosed January 1, 2000, but it is required by the ACoS. It describes the status of the surgical margins after each resection of the primary tumor.

For cases diagnosed after January 1, 2003, please refer to the FORDS Manual.

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

VI.2.8 Reconstructive Surgery - Immediate

January 1, 2003 and Forward
Beginning with cases diagnosed, January 1, 2003, this field is no longer required by the CCR or the CoC. Information with regards to reconstruction is incorporated into the Surgery of the Primary Site field.

Prior to January 1, 2003

The old field was retained and cases diagnosed prior to January 1, 2003 must continue to be coded.

For these cases, refer to Appendix Q-1.

Record the procedure in both the *Reconstructive Summary* and *At This Hospital* fields and in the surgery text field if it was performed subsequent to surgery as part of the planned first course of therapy. This procedure improves the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies.

VI.2.9 Reason for No Surgery of the Primary Site

If surgery of the primary site was performed, enter 0.

Reason for No Surgery only applies to the Surgery of the Primary Site field, not Scope of Regional Lymph Node Surgery or Surgery Other Regional/Distant Sites.

For sites where "Surgery of the Primary Site" is coded to 00 or 98 (hematopoietic included) use code 1.

Effective with cases diagnosed 1/1/2003, Code 5, *surgery not performed because patient died* was added. Definitions for codes 1, 2, and 6 were modified.

0	SURGERY OF THE PRIMARY SITE PERFORMED
1	SURGERY OF THE PRIMARY SITE NOT PERFORMED BECAUSE IT WAS NOT PART OF THE PLANNED FIRST COURSE TREATMENT
2	SURGERY OF THE PRIMARY SITE NOT PERFORMED BECAUSE OF CONTRAINDICATIONS DUE TO PATIENT RISK FACTORS (COMORBID CONDITIONS, ADVANCED AGE, ETC.)
5	SURGERY OF THE PRIMARY SITE WAS NOT PERFORMED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED SURGERY (code added in 2003)
6	SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT NOT PERFORMED. NO REASON WAS NOTED IN THE PATIENT'S RECORD
7	SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT REFUSED BY THE PATIENT, FAMILY MEMBER OR GUARDIAN. THE REFUSAL IS NOTED IN THE PATIENT'S RECORD.
8	SURGERY OF THE PRIMARY SITE WAS RECOMMENDED BUT UNKNOWN IF PERFORMED
9	NOT KNOWN IF SURGERY OF THE PRIMARY SITE WAS RECOMMENDED OR PERFORMED; DEATH CERTIFICATE ONLY AND AUTOPSY ONLY CASES

VI.2.10 Diagnostic or Staging Procedures

Record surgical procedures performed solely for establishing a diagnosis and or determining stage of disease. If there is more than one surgical diagnostic or

staging procedure, record the first one performed. Some of the procedures should be recorded in the Operative Findings field.

Beginning with cases diagnosed January 1, 2003 forward, this field does not include palliative treatment/procedures. Palliative treatment/procedures are recorded in a separate field. The CCR does not require that palliative treatment/procedures be recorded but the CoC does require this field. Please consult the *FORDS Manual* for instructions regarding the palliative procedure field.

Surgical diagnostic or staging procedures include:

- Biopsy, incisional or NOS (if a specimen is less than or equal to 1 cm, assume the biopsy to have been incisional unless otherwise specified)
- 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:

- Brushings, washings, cell aspirations and hematologic findings (peripheral smears), as they are NOT considered surgical procedures and should not be coded in the Diagnostic or Staging Procedures field. Code positive brushings, washings and cell aspirations, and hematologic findings (peripheral smears) as cytologic diagnostic confirmation in the Diagnostic Confirmation field.
- Surgical procedures which aspirate, biopsy, or remove regional lymph nodes in effort to diagnose and/or stage disease in this data item. Use the data item Scope of Regional Lymph Node Surgery to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item Date of Surgical Diagnostic and Staging Procedure.
- Excisional biopsies with clear or microscopic margins in this data item. Use the data item Surgical Procedure of Primary Site to code these procedures.
- Palliative surgical procedures in this data item.

VI.2.10.1 Diagnostic or Staging Procedure Codes

00	NO SURGICAL DIAGNOSTIC OR STAGING PROCEDURE
01	INCISIONAL, NEEDLE, OR ASPIRATION BIOPSY OF OTHER THAN PRIMARY SITE (Code microscopic residual disease or no residual disease as Surgery of Other Regional Site[s], Distant Site[s], or Distant Lymph Nodes[s])
02	INCISIONAL, NEEDLE, OR ASPIRATION BIOPSY OF PRIMARY SITE (Code Microscopic residual disease or no residual disease as Surgery of Primary Site)
03	EXPLORATORY SURGERY ONLY (no biopsy)
04	BYPASS SURGERY OR OSTOMY ONLY (no biopsy)
05	COMBINATION OF 03 PLUS 01 OR 02
06	COMBINATION OF 04 PLUS 01 OR 02
07	DIAGNOSTIC OR STAGING PROCEDURE, NOS
09	UNKNOWN IF DIAGNOSTIC OR STAGING PROCEDURE DONE

NOTE: Give priority to:

Codes 01-07 over code 09.

Codes 01-06 over code 07.

The highest code in the range 01-06

VI.2.11 Date of Diagnostic or Staging Surgical Procedures

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	Unknown if any surgical diagnostic or staging procedure performed; date unknown, or death certificate only case

VI.2.12 Sources for Information (Surgery)

To ascertain exactly what procedures were performed, read the operative and pathology reports thoroughly. Do not depend on the title of an operative report, because it might be incomplete. If the operative report is unclear about what tissue was excised, or the operative and pathology reports contain different information, use the pathology report unless there is reason to doubt its accuracy.

VI.2.13 Special Rules for Coding Ambiguous Cases (Surgery)

There are specific rules for coding certain ambiguous situations:

Excision Of Multiple Primaries

If multiple primaries are excised at the same time, enter the appropriate code for each site.

Examples

A total abdominal hysterectomy was performed for a patient with two primaries, one of the cervix and one of the endometrium.

Code each site as having had a total abdominal hysterectomy.

A total colectomy was performed on a patient with multiple primaries in several segments of the colon.

Code total colectomy for each of the primary segments.

Excisional Biopsy

Record an excisional biopsy as first surgical treatment, whether followed by further definitive surgery or not and whether or not residual tumor was found in a later resection. If there is no statement that the initial biopsy was excisional, yet no residual tumor was found at a later resection, assume that the biopsy was excisional.

Extranodal Lymphomas

When coding surgery for extranodal lymphomas, use the appropriate code for the extranodal site. For example, use a code for the stomach to code a lymphoma of the stomach.

VI.2.14 Systemic Therapy With Surgery Sequence

January 1, 2006 and Forward

For cases diagnosed 1/1/2006 forward, code the sequence in which systemic therapy and surgical procedures were performed as part of the first course of treatment.

Use the following codes:

0	No systemic therapy and /or surgical procedures
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before or after surgery
9	Sequence unknown

If first course of treatment includes (codes 10-90 in Surgery of the Primary Site fields, codes 1-7 in the Scope of Regional Lymph Node Surgery fields, and codes 1-8 in the Surgery of Other Regional(s), Distant Site(s), or Distant Lymph Node(s) fields) and systemic therapy, use codes 2-9. For all other cases, use code 0.

VI.3 First Course of Treatment: Radiation Therapy

The name or chemical symbol and method of administration of any radiation therapy that is directed toward tumor tissue or given prophylactically must be documented in the text field.

Do not include radiation for hormonal effect, such as irradiation of non-cancerous endocrine glands.

Do not include irradiation of the male breast to prevent gynecomastia.

January 1, 2008 and Forward
For cases diagnosed 1/1/2008 forward, the data item, Radiation Location Treatment is required by the CCR. This data item identifies the location of the facility in which radiation treatment was administered during first course of treatment.

January 1, 2003 and Forward
For cases diagnosed 1/1/2003 forward, *Radiation - Regional RX Modality and Radiation - Boost RX Modality*, are required to code first course radiation therapy. Software conversions of these two fields generate the Radiation Therapy Summary field.

Additional Note

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

VI.3.1 Types of Radiation

The principal types of radiation therapy are the external administration of radioactive beams, implantation of radioactive material, and the internal administration of radioisotopes by other than implantation. Radioactive materials include the following:

Au^{198} gold

Co^{60} cobalt

$Cr^{32}PO_4$ phosphocol

$CrPO_4$ chromic phosphate

Cs cesium

I^{125} iodine

I^{131} iodine

Ir^{192} iridium

P^{32} phosphorus

Pb^{210} lead

Ra^{226} radium

Rn^{222} radon

Ru^{106} ruthenium

Sr^{90} strontium

Y^{90} yttrium

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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

Brachytron

Cobalt

Cyclotron

Grenz ray

Helium ion or other heavy particle beam

Linear accelerator (LINAC)

MeV

Neutron beam

Spray radiation

Stereotactic radiosurgery, such as gamma knife and proton beam

X-ray

VI.3.1.2 Radioactive Implants

Record the name or chemical symbol and method of administration of any radioactive material administered by implants, molds, seeds, needles, or intracavity applicators. (Heyman capsules, Fletcher suit, and Fletcher after loader are methods of isotope application. Interpret these terms as radioactive implants.)

Record High Dose Rate (HDR) and Low Dose Rate (LDR) Brachytherapy as radioactive implants - Code 2.

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.

VI.3.2 Radiation Therapy Summary Codes

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

January 1, 2003 and Forward
Beginning with cases diagnosed 1/1/2003, *Radiation - Regional RX Modality* and *Radiation - Boost RX Modality*, are required to code first course radiation therapy. Also, radiation to the brain and CNS for lung and leukemia cases are to be coded in the *Radiation – Regional RX Modality* and *Radiation – Boost RX Modality* fields.

0	NONE
1	BEAM RADIATION
2	RADIOACTIVE IMPLANTS
3	RADIOISOTOPES
4	COMBINATION OF 1 WITH 2 OR 3
5	RADIATION, NOS (method or source not specified)
9	UNKNOWN IF RADIATION THERAPY RECOMMENDED OR GIVEN

Additional Note

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

January 1, 1998 and Forward
Beginning with cases diagnosed January 1, 1998, radiation to the brain and central nervous system for lung cancers and leukemias only is to be recorded in the Radiation Summary and Radiation At This Hospital fields. Include prophylactic treatment and treatment of known spread to the CNS.

VI.3.3 Radiation - Regional RX Modality

Record the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment. The CCR requires the collection of this field. This data item and Radiation-Boost RX Modality are converted to generate the RX Summ-Radiation.

Radioembolization is embolization combined with injection of small radioactive beads or coils into an organ or tumor. Code Radiation Modality as brachytherapy, code 50, when tumor embolization is performed using a radioactive agent or radioactive seeds.

The codes for Radiation-Regional RX Modality are as follows:

00	NO RADIATION TREATMENT; DIAGNOSED AT AUTOPSY
20	EXTERNAL BEAM, NOS
21	ORTHOVOLTAGE
22	COBALT-60, CESIUM-137
23	PHOTONS (2-5 MV)
24	PHOTONS (6-10 MV)
25	PHOTONS (11-19 MV)
26	PHOTONS (>19 MV)
27	PHOTONS (MIXED ENERGIES)
28	ELECTRONS
29	PHOTONS AND ELECTRONS MIXED
30	NEUTRONS, WITH OR WITHOUT PHOTONS/ELECTRONS
31	IMRT
32	CONFORMAL OR 3-D THERAPY
40	PROTONS
41	STEREOTACTIC RADIOSURGERY, NOS
42	LINAC RADIOSURGERY
43	GAMMA KNIFE
50	BRACHYTHERAPY, NOS
51	BRACHYTHERAPY, 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
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.

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. Reminder: Referral does not equal a recommendation.

VI.3.4 Radiation - Boost RX Modality

Record the dominant modality of radiation therapy used to deliver the most clinically significant boost dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or IMRT. External beam boosts may consist of two or more successive phases with progressively smaller fields generally coded as a single entity.

The CCR requires the collection of this data item. This data item and Radiation-Regional RX Modality are converted to generate the RX Summ-Radiation.

Radioembolization is embolization combined with injection of small radioactive beads or coils into an organ or tumor. Code Radiation Modality as brachytherapy, code 50, when tumor embolization is performed using a radioactive agent or radioactive seeds.

The codes are as follows:

00	NO BOOST TREATMENT; DIAGNOSED AT AUTOPSY
20	EXTERNAL BEAM, NOS
21	ORTHOVOLTAGE
22	COBALT-60, CESIUM-137
23	PHOTONS (2-5 MV)
24	PHOTONS (6-10 MV)

25	PHOTONS (11-19 MV)
26	PHOTONS (>19 MV)
27	PHOTONS (MIXED ENERGIES)
28	ELECTRONS
29	PHOTONS AND ELECTRONS MIXED
30	NEUTRONS, WITH OR WITHOUT PHOTONS/ELECTRONS
31	IMRT
32	CONFORMAL OR3-D THERAPY
40	PROTONS
41	STEREOTACTIC RADIOSURGERY, NOS
42	LINAC RADIOSURGERY
43	GAMMA KNIFE
50	BRACHYTHERAPY, NOS
51	BRACHYTHERAPY, 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
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.

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. Reminder: Referral does not equal a recommendation.

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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.

Codes (in addition to valid dates)

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	WHEN IT IS UNKNOWN WHETHER ANY RADIATION THERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY

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VI.3.6 Reason for No Radiation

The following codes are to be used to record the reason the patient did not undergo radiation treatment:

0	RADIATION TREATMENT PERFORMED
1	RADIATION TREATMENT NOT PERFORMED BECAUSE IT WAS NOT A PART OF THE PLANNED FIRST COURSE TREATMENT
2	RADIATION CONTRAINDICATED BECAUSE OF OTHER CONDITIONS OR OTHER PATIENT RISK FACTORS (CO-MORBID CONDITIONS, ADVANCED AGE, ETC)
5	RADIATION TREATMENT NOT PERFORMED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED TREATMENT
6	RADIATION TREATMENT WAS RECOMMENDED BUT NOT PERFORMED. NO REASON WAS NOTED IN THE PATIENT'S RECORD.

7	RADIATION TREATMENT WAS RECOMMENDED BUT REFUSED BY THE PATIENT, FAMILY MEMBER OR GUARDIAN. THE REFUSAL IS NOTED IN THE PATIENT'S RECORD.
8	RADIATION RECOMMENDED, UNKNOWN IF DONE
9	UNKNOWN IF RADIATION RECOMMENDED OR PERFORMED; DEATH CERTIFICATE AND AUTOPSY ONLY CASES

NOTE: Include radiation to the brain and central nervous system when coding this field.

January 1, 2003 and Forward

NOTE: Beginning with cases diagnosed 1/1/2003, Code 5 - radiation not performed because patient died was added. Definitions for codes 1, 2, and 6 were also modified.

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VI.3.8 Location of Radiation Treatment

January 1, 2008 and Forward

Beginning January 1, 2008, code the location of the facility in which radiation treatment was administered during first course of treatment. Use the following codes:

0	NO RADIATION TREATMENT
1	ALL RADIATION TREATMENT AT THIS FACILITY
2	REGIONAL TREATMENT AT THIS FACILITY, BOOST ELSEWHERE
3	BOOST RADIATION AT THIS FACILITY, REGIONAL ELSEWHERE
4	ALL RADIATION TREATMENT ELSEWHERE
8	OTHER, NOS
9	UNKNOWN

VI.4 First Course of Treatment: Chemotherapy

Chemotherapy includes the use of any chemical to attack or treat cancer tissue, unless the chemical achieves its effect through change of the hormone balance or by affecting the patient's immune system. In coding consider only the agent, not the method of administering it, although the method of administration may be recorded. Chemotherapy typically is administered orally, intravenously, or 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, the generic or trade names of the drugs used for chemotherapy must be recorded. Include agents that are in the investigative or clinical trial phase.

January 1, 2005 and Forward
For cases diagnosed 1/1/2005 forward, registrars must use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy). SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.

VI.4.2 Chemotherapy Codes

Use the following codes for recording chemotherapy in the Summary field.

Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.

Use codes 00-87 for recording chemotherapy in the At This Hospital field.

00	NONE, CHEMOTHERAPY WAS NOT PART OF THE PLANNED FIRST COURSE OF THERAPY. DIAGNOSED AT AUTOPSY
01	CHEMOTHERAPY, NOS.
02	SINGLE-AGENT CHEMOTHERAPY.
03	MULTIAGENT CHEMOTHERAPY ADMINISTERED AS FIRST COURSE THERAPY.
82	CHEMOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (i.e., COMORBID CONDITIONS, ADVANCED AGE).
85	CHEMOTHERAPY NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.
86	CHEMOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST

	COURSE OF THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
87	CHEMOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WaS NOTED IN PATIENT RECORD.
88	CHEMOTHERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
99	IT IS UNKNOWN WHETHER A CHEMOTHERAPEUTIC AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 0 or 3.

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. Reminder: Referral does not equal a recommendation.

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.

Codes (in addition to valid dates)

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	WHEN IT IS UNKNOWN WHETHER ANY CHEMOTHERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY

VI.5 First Course of Treatment: Hormone (Endocrine) 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

Cancer-directed treatment with hormones and antihormones must be documented in the text field for all sites.

Report cancer directed use of adenocorticotrophic hormones for treatment of leukemias, lymphomas, multiple myelomas, and breast and prostate cancers. But report as hormone therapy any hormonal agent that is given in combination with chemotherapy (e.g., MOPP or COPP) for cancer of any site whether it affects the cancer cells or not.

January 1, 2005 Forward
For cases diagnosed 1/1/2005 forward, registrars must use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy). SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.

VI.5.1.1 Agents for Endometrial and Kidney Tumors

Agents commonly used in the treatment of endometrial cancer and cancer of the kidney include:

Delalutin

Depo Provera

Hydroxyprogesterone

Medroxyprogesterone

Megace

Megestrol acetate

Methyl progesterone

Norethindrone

Norlutate

Norlutin

Progestone

Progesterone

Progestin

Progestoral

Proluton

Provera

VI.5.1.2 Agents For Thyroid Cancer

Agents commonly used in the treatment of thyroid cancer include:

Cytomel

Levothyroxine

Liothyronine

Proloid

Synthroid

Triiothyronine

Thyroglobulin

Thyroid (extract)

Thyrolar

Thyroxine

TRIT

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 desiccated 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.
01	HORMONE THERAPY ADMINISTERED AS FIRST COURSE THERAPY.
82	HORMONE THERAPY WAS NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (IE, COMORBID CONDITIONS, ADVANCED AGE).
85	HORMONE THERAPY WAS NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.
86	HORMONE THERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
87	HORMONE THERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN THE PATIENT RECORD.
88	HORMONE THERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
99	IT IS UNKNOWN WHETHER A HORMONAL AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 0 or 3.

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. Reminder: Referral does not equal a recommendation.

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.

Codes (in addition to valid dates)

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 Timeliness Section IX.2.3.
99999999	WHEN IT IS UNKNOWN WHETHER ANY HORMONE THERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY

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

Immunotherapy agents must be recorded in the text field.

January 1, 2005 and Forward

For cases diagnosed 1/1/2005 forward, registrars must use SEER*Rx, for coding systemic treatment (i.e. chemotherapy, hormone therapy, and immunotherapy). SEER*Rx is the downloadable, interactive antineoplastic drug database that replaces SEER Self-Instructional Manual Book 8, Antineoplastic Drugs. The software can be downloaded from the SEER*Rx Web Site.

Report the following as immunotherapy:

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

*Some monoclonal antibodies are used to deliver chemotherapy or radiation agents to the tumor, not to kill the tumor immunologically. Consult SEER*RX to determine how to appropriately code monoclonal antibodies.

VI.6.2 Immunotherapy Codes

January 1, 2003 and Forward

Effective with cases diagnosed 1/1/2003, this data item was modified. Codes for transplants and endocrine procedures were removed and were coded in a separate field called RX Summ - Transplnt/Endocr . The length of this field was changed from 1 to 2 characters. The codes for reason for no immunotherapy (BRM) given were incorporated into this scheme.

Use codes 00-87 for recording immunotherapy in the At This Hospital field.

Use the following codes for recording immunotherapy in the Summary field.

00	NONE, IMMUNOTHERAPY WAS NOT PART OF THE PLANNED FIRST COURSE OF THERAPY
01	IMMUNOTHERAPY ADMINISTERED AS FIRST COURSE THERAPY
82	IMMUNOTHERAPY WAS NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (i.e. COMORBID CONDITIONS, ADVANCED AGE).
85	IMMUNOTHERAPY WAS NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.
86	IMMUNOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE OF THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
87	IMMUNOTHERAPY WAS NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN THE PATIENT RECORD.
88	IMMUNOTHERAPY WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
99	IT IS UNKNOWN WHETHER AN IMMUNOTHERAPEUTIC AGENT(S) WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 0 or 3.

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. Reminder: Referral does not equal a recommendation.

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 (zeros).

If immunotherapy is known to have been given but the date in 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. THE DATE SHOULD BE REVISED AT THE NEXT FOLLOW-UP.
99999999	WHEN IT IS UNKNOWN WHETHER ANY IMMUNOTHERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY

VI.7 First Course of Treatment: Transplant/Endocrine Procedures

Record systemic therapeutic procedures administered as part of first course of treatment. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. Information on transplants and endocrine procedures was removed from the Rx Summ-BRM (Immunotherapy) field and moved to this field. Bone marrow and stem cell procedures are now coded in this field along with endocrine surgery or radiation.

For cases prior to January 1, 2003, a conversion was required using both the Rx Summ - BRM (Immunotherapy) and Rx Summ - Hormone fields. Although the CoC did not add a corresponding "At this Hospital" field, the CCR required this field in order to provide consistency, since all of the other treatment fields except radiation have a hospital-level field during this time period.

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
10	A BONE MARROW TRANSPLANT PROCEDURE WAS ADMINISTERED, BUT THE TYPE WAS NOT SPECIFIED
11	BONE MARROW TRANSPLANT - AUTOLOGOUS
12	BONE MARROW TRANSPLANT - ALLOGENEIC
20	STEM CELL HARVEST
30	ENDOCRINE SURGERY AND/OR ENDOCRINE RADIATION THERAPY
40	COMBINATION OF ENDOCRINE SURGERY AND/OR RADIATION WITH A TRANSPLANT PROCEDURE. (COMBINATION OF CODES 30 AND 10, 11, 12, OR 20.)
82	HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WERE NOT RECOMMENDED/ADMINISTERED BECAUSE IT WAS CONTRAINDICATED DUE TO PATIENT RISK FACTORS (i.e., COMORBID CONDITIONS, ADVANCED AGE).
85	HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WERE NOT ADMINISTERED BECAUSE THE PATIENT DIED PRIOR TO PLANNED OR RECOMMENDED THERAPY.

86	HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WERE NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT WAS NOT ADMINISTERED AS PART OF THE FIRST COURSE THERAPY. NO REASON WAS STATED IN PATIENT RECORD.
87	HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WERE NOT ADMINISTERED. IT WAS RECOMMENDED BY THE PATIENT'S PHYSICIAN, BUT THIS TREATMENT WAS REFUSED BY THE PATIENT, A PATIENT'S FAMILY MEMBER, OR THE PATIENT'S GUARDIAN. THE REFUSAL WAS NOTED IN PATIENT RECORD.
88	HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WAS RECOMMENDED, BUT IT IS UNKNOWN IF IT WAS ADMINISTERED.
99	IT IS UNKNOWN WHETHER HEMATOLOGIC TRANSPLANT AND/OR ENDOCRINE SURGERY/RADIATION WAS RECOMMENDED OR ADMINISTERED BECAUSE IT IS NOT STATED IN PATIENT RECORD. DEATH CERTIFICATE ONLY.

Note: For recording Therapy at this Hospital, do not use code 99 if Class of Case is coded to 0 or 3.

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. Reminder: Referral does not equal a recommendation.

VI.7.2 Date of Transplant/Endocrine Procedure

Record the date on which the transplant/endocrine procedure took place at any facility as part of the first course treatment.

If transplant/endocrine procedures were not performed leave the date field blank.

If a transplant/endocrine procedure is known to have been performed but the date is not known, enter 9's.

Codes (in addition to valid dates)

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	WHEN IT IS UNKNOWN WHETHER ANY TRANSPLANT/ENDOCRINE THERAPY WAS PERFORMED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY

VI.8 First Course of Treatment: Other Therapy

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

- Hyperbaric oxygen (as adjunct to definitive treatment).
- Hyperthermia (given alone or in combination with chemotherapy, as in isolated heated limb perfusion for melanoma).
- 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.

Apply code 1, Other Cancer Directed Therapy, to the following:

- ***Embolization using alcohol as an embolizing agent.***

Or

- ***Embolization to a site other than the liver where the embolizing agent is unknown.***

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 PATIENT'S GUARDIAN REFUSED THERAPY WHICH WOULD HAVE BEEN CODED 1–3 ABOVE
8	OTHER CANCER DIRECTED THERAPY RECOMMENDED, UNKNOWN IF ADMINISTERED
9	UNKNOWN IF OTHER THERAPY RECOMMENDED OR ADMINISTERED. DEATH CERTIFICATE ONLY.

Note: For recording Therapy at this Hospital, do not use code 9 if Class of Case is coded to 0 or 3.

If the only information available is that the patient was referred to a surgeon, medical oncologist or radiation oncologist, with no confirmation that treatment was administered, code no treatment given. **Reminder**: A referral does not equal a recommendation.

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	UNKNOWN IF ANY OTHER THERAPY WAS ADMINISTERED; THE DATE IS UNKNOWN, OR THE CASE WAS IDENTIFIED BY DEATH CERTIFICATE ONLY.

VI.9 Protocol Participation

January 1, 2001 and Forward

Beginning with cases diagnosed January 1, 2001, the CCR requires that this field be collected and transmitted to the CCR. The codes are as follows:

00	Not Applicable

National Protocols

01	NSABP
02	GOG
03	RTOG
04	SWOG
05	ECOG
06	POG
07	CCG
08	CALGB
09	NCI
10	ACS
11	National Protocol, NOS
12	ACOS-OG
13	VA [Veterans Administration]
14	COG [Children's Oncology Group]
15	CTSU [Clinical Trials Support Unit]
16-50	National Trials

Locally Defined

51-79	Locally Defined
80	Pharmaceutical
81-84	Locally Defined
85	In-House Trial
86-88	Locally Defined

89	Other
90-98	Locally Defined
99	Unknown

Part VII. Follow-Up

VII.1 Follow-Up Information

An function of the California cancer reporting system is annual monitoring of patients to ascertain survival rates.

Therefore, if follow-up information is available before an abstract is submitted, include the follow-up information in the abstract.

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), or from the patient's physician, contact letters, and telephone calls.

If follow-up information is located, it must be reported to the CCR.

The CCR also requires follow-up on all benign and borderline CNS tumors as well as borderline ovarian tumors from ACoS approved facilities.

The CCR does not require follow-up for class 0 cases, diagnosed January 1, 2006 and forward.

The CCR does require follow-up for class 0 cases diagnosed prior to 2006.

Annual follow-up is not required for a hospital that does not have a tumor registry and is submitting an abstract only to meet state reporting requirements. The CCR does not impose follow-up requirements beyond what a hospital chooses to do for its own purposes. For example, if a hospital elects not to follow non analytic cases, the CCR will not expect to receive follow-up information for such cases.

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 contact with the patient in one of the following forms:

- Direct response to a letter or phone call to the patient or other contact person
- A report by the patient's physician
- Re-admission to the hospital as an inpatient or outpatient
- Death certificate

It might be necessary to trace the patient through such agencies and organizations as the registrar of voters, welfare agencies, labor unions, religious groups, or the Office of the State Registrar for a death certificate.

VII.1.3 Currency of Information

Currency is defined as contact with the patient within 15 months of the date the follow up is reported.

Although current information is preferred, updated information that is not current should still be reported.

VII.1.4 Shared Follow-Up

In those cases where a patient is being followed by more than one 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.

Follow-up may be shared without a signed agreement as long as the source is not disclosed.

This does not preclude a hospital registry's submission of more current information about its patients. Shared follow up is instituted only by agreement among participating hospitals in a region.

VII.2 Follow-Up Data Items

Follow-up data items provide information about the outcome of cancers and the results of treatment. A patient's survival time is calculated on the basis of Date of Diagnosis and Date of Last Contact.

VII.2.1 Date of Last Contact

Enter the date the patient was last seen or heard from or the date of death. Do not enter the date the information was forwarded or received.

If no follow up information has been received, enter the date of discharge from the hospital. 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

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

VII.2.4 Tumor Status

Summarize the best available information about the status of the tumor on the date of last contact. The field applies only to the tumor for which the abstract is submitted, regardless of any other tumors the patient might have.

The codes are:

1 FREE—NO EVIDENCE OF THIS CANCER

2 NOT FREE—EVIDENCE STILL EXISTS OF THIS CANCER

9 UNKNOWN—STATUS OF THIS CANCER UNKNOWN

VII.2.5 Quality of Survival

Enter the code that best characterizes the patient's quality of survival. This item is not required by the CCR.

Codes

0 NORMAL ACTIVITY

1 SYMPTOMATIC AND AMBULATORY

2 AMBULATORY MORE THAN 50%, OCCASIONALLY NEEDS ASSISTANCE

3 AMBULATORY LESS THAN 50%, NURSING CARE NEEDED

4 BEDRIDDEN, MAY REQUIRE HOSPITALIZATION

8 NOT APPLICABLE, DEAD

9 UNKNOWN/UNSPECIFIED

Reporting hospitals may use another coding system or scale adopted by the hospital's cancer committee.

VII.2.6 Last Type of Follow-Up

There are two fields which are to be used to enter the source of the most recent follow-up information about the patient:

- Last Type of Tumor Follow-Up
- Last Type of Patient Follow-Up

VII.2.6.1 Last Type of Tumor Follow-Up

This field is to be used to enter information representing the source of the most recent information on the tumor being followed. Reporting 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 obtained by regional registry from:

20 LETTER TO A PHYSICIAN

22 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE

23 COMPUTER MATCH WITH HMO FILE

25 NATIONAL DEATH INDEX

26 COMPUTER MATCH WITH STATE DEATH TAPE

29 COMPUTER MATCH, OTHER OR NOS

30 OTHER SOURCE

31 TELEPHONE CALL TO ANY SOURCE

32 SPECIAL STUDIES

34 ARS (AIDS REGISTRY SYSTEM)

35 COMPUTER MATCH WITH DISCHARGE DATA

36 OBITUARY

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

40 LETTER TO A PHYSICIAN

41 TELEPHONE CALL TO ANY SOURCE

52 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE

53 COMPUTER MATCH WITH HMO FILE

55 NATIONAL DEATH INDEX

56 COMPUTER MATCH WITH STATE DEATH TAPE

59 COMPUTER MATCH, OTHER OR NOS

60 OTHER SOURCE

Follow-up obtained by hospitals or facilities usually done by the regional/central registry:

73 COMPUTER MATCH WITH HMO FILE

76 COMPUTER MATCH WITH STATE DEATH TAPE

Additional Codes:

99 SOURCE UNKNOWN

VII.2.6.2 Last Type of Patient Follow-Up

This field is to be used to enter the code representing the source of the most recent information about the patient being followed. Reporting hospitals ordinarily use codes from the first of the three following groups, i.e., 00-15.

Follow-up obtained by hospital from:

00 ADMISSION BEING REPORTED

01 READMISSION TO REPORTING 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
16 SSDI MATCH

Follow-up obtained by regional registry from:

20 LETTER TO A PHYSICIAN
21 COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES FILE
22 COMPUTER MATCH WITH MEDICARE OR MEDICAID FILE
23 COMPUTER MATCH WITH HMO FILE
24 COMPUTER MATCH WITH VOTER REGISTRATION FILE
25 NATIONAL DEATH INDEX
26 COMPUTER MATCH WITH STATE DEATH TAPE
27 DEATH MASTER FILE (SOCIAL SECURITY)
29 COMPUTER MATCH, OTHER OR NOS
30 OTHER SOURCE
31 TELEPHONE CALL TO ANY SOURCE
32 SPECIAL STUDIES
33 EQUIFAX
34 ARS (AIDS REGISTRY SYSTEM)
35 COMPUTER MATCH WITH DISCHARGE DATA
36 OBITUARY
37 COMPUTER MATCH WITH CHANGE OF ADDRESS SERVICE
38 TRW
39 REGIONAL REGISTRY FOLLOW-UP LIST

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

40 LETTER TO A PHYSICIAN

41 TELEPHONE CALL TO ANY SOURCE
48 Research Study Follow Up
50 CMS (CENTER FOR MEDICARE & MEDICAID SERVICES)
51 COMPUTER MATCH WITH DEPARTMENT OF MOTOR VEHICLES FILE
52 CALIFORNIA MEDICAL REVIEW INC
53 COMPUTER MATCH WITH HMO FILE
54 COMPUTER MATCH WITH VOTER REGISTRATION FILE
55 NATIONAL DEATH INDEX
56 COMPUTER MATCH WITH STATE DEATH TAPE
57 COMPUTER MATCH WITH MEDI-CAL
58 COMPUTER MATCH WITH SOCIAL SECURITY DEATH FILE
59 COMPUTER MATCH, OTHER OR NOS
60 OTHER SOURCE
61 SOCIAL SECURITY - SSN
62 SPECIAL STUDIES
65 COMPUTER MATCH WITH OSHPD HOSPITAL DISCHARGE DATA BASE
66 COMPUTER MATCH WITH NATIONAL CHANGE OF ADDRESS FILE
67 SSA - EPIDEMIOLOGICAL VITAL STATUS
68 PROPERTY TAX LINKAGE
69 STATE DEATH TAPE (INCREMENTAL)

Follow-up obtained by hospitals or facilities usually done by the regional/central registry:

73 COMPUTER MATCH WITH HMO FILE
76 COMPUTER MATCH WITH STATE DEATH TAPE

Regional Registry (Additional Codes)

80 SOCIAL SECURITY ADMINISTRATION
81 PROPERTY TAX LINKAGE
82 PROBE360
83 SSDI - INTERNET
84 E-PATH
85 PATH LABS
86 PATIENT
87 RELATIVE

Unknown Source

99 SOURCE UNKNOWN

VII.2.7 Last Follow-Up Hospital

Enter the ten-digit code (beginning with 4 leading zeros), NPI number or name of the hospital, facility, or agency that provided the most recent follow-up information. To view NPI numbers, click one of the links that follow:

Code Numbers (Sorted by Code in Ascending Numeric Order)
http://www.ccrcal.org/PDF-DSQC/CAHospLabels-Vers-1.8.0.8,5-14-08-Code.pdf

Code Numbers (Sorted by Facility in Ascending Alphabetic Order)
http://www.ccrcal.org/PDF-DSQC/CAHospLabels-Vers-1.8.0.8,5-14-08-Alpha.pdf

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

7 * PATIENT PRESUMED LOST, STOP PRINTING FOLLOW-UP LETTERS

8 * FOREIGN RESIDENT, FOLLOW-UP DISCONTINUED OR NOT INITIATED

9 * DO NOT FOLLOW UP (except code 8)

VII.2.9 Next Follow-Up Hospital

Enter the ten-digit code or NPI number if available or name of the hospital, facility, or agency responsible for the next follow-up of the patient. To view NPI numbers, click one of the links that follow:

Code Numbers (Sorted by Code in Ascending Numeric Order)
http://www.ccrcal.org/PDF-DSQC/CAHospLabels-Vers-1.8.0.8,5-14-08-Code.pdf

Code Numbers (Sorted by Facility in Ascending Alphabetic Order)
http://www.ccrcal.org/PDF-DSQC/CAHospLabels-Vers-1.8.0.8,5-14-08-Alpha.pdf

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.)

January 1, 2007 and Forward

Beginning with cases diagnosed January 1, 2007, enter the physician NPI code in

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 transmitted to the CCR.

VII.2.12 Recurrence Information

If a patient's primary tumor recurred after a period of complete remission, the Date of First Recurrence and Type of First Recurrence must be coded by American College of Surgeons-approved registries. The data are optional for reporting to the California Cancer Registry. Code only the first recurrence and do not update the fields except to correct data entry errors.

VII.2.12.1 Date of First Recurrence

Enter the date of first recurrence of a primary tumor that recurred after a period of complete remission. See Section I.1.6.4 for entering dates. If the exact date is not known, enter an estimate based on the best available information. If the patient was never free of the primary tumor or did not experience a recurrence, leave the field as zeros.

VII.2.12.2 Type of First Recurrence

Enter one of the following codes to indicate the type of first recurrence:

00	NONE, DISEASE FREE
01	IN SITU
06	RECURRENCE FOLLOWING DIAGNOSIS OF AN IN SITU LESION OF THE SAME SITE
10	LOCAL
11	TROCAR SITE
15	COMBINATION OF 10 AND 11
16	LOCAL RECURRENCE FOLLOWING AN IN SITU LESION OF THE SAME SITE
17	COMBINATION OF 16 WITH 10, 11 AND/OR 15
20	REGIONAL, NOS
21	REGIONAL TISSUE
22	REGIONAL LYMPH NODES
25	COMBINATION OF 21 AND 22
26	REGIONAL RECURRENCE FOLLOWING AN IN SITU LESION OF THE SAME SITE
27	COMBINATION OF 26 WITH 21, 22, AND/OR 25
30	ANY COMBINATION OF 10, 11, AND 20, 21 OR 22
36	ANY COMBINATION OF RECURRENCE FOLLOWING AN IN SITU LESION OF THE SAME SITE WITH 10, 11, 20, 21 OR 22
40	DISTANT RECURRENCE, AND THERE IS INSUFFICIENT INFORMATION AVAILABLE TO CODE TO 46-62
46	DISTANT RECURRENCE OF AN IN SITU TUMOR
51	DISTANT RECURRENCE OF INVASIVE TUMOR IN THE PERITONEUM ONLY. PERITONEUM INCLUDES PERITONEAL SURFACES OF ALL STRUCTURES WITHIN THE ABDOMINAL CAVITY AND/OR POSITIVE ASCITIC FLUID.
52	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE LUNG ONLY. LUNG INCLUDES THE VISCERAL PLEURA.
53	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE PLEURA ONLY. PLEURA INCLUDES THE PLEURAL SURFACE OF ALL STRUCTURES WITHIN THE THORACIC CAVITY AND/OR POSITIVE PLEURAL FLUID.
54	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE LIVER ONLY.
55	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN BONE ONLY. THIS

	INCLUDES BONES OTHER THAN THE PRIMARY SITE.
56	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE CNS ONLY. THIS INCLUDES THE BRAIN AND SPINAL CORD, BUT NOT THE EXTERNAL EYE.
57	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN THE SKIN ONLY. THIS INCLUDES SKIN OTHER THAN THE PRIMARY SITE.
58	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN LYMPH NODE ONLY. REFER TO THE STAGING SCHEME FOR A DESCRIPTION OF LYMPH NODES THAT ARE DISTANT FOR A PARTICULAR SITE.
59	DISTANT SYSTEMIC RECURRENCE OF AN INVASIVE TUMOR ONLY. THIS INCLUDES LEUKEMIA, BONE MARROW METASTASIS, CARCINOMATOSIS, GENERALIZED DISEASE.
60	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN A SINGLE DISTANT SITE (51-58) AND LOCAL, TROCAR AND/OR REGIONAL RECURRENCE (10-15, 20-25, OR 30).
62	DISTANT RECURRENCE OF AN INVASIVE TUMOR IN MULTIPLE SITES (RECURRENCES THAT CAN BE CODED TO MORE THAN ONE CATEGORY 51-59).
70	SINCE DIAGNOSIS, PATIENT HAS NEVER BEEN DISEASE-FREE. THIS INCLUDES CASES WITH DISTANT METASTASIS AT DIAGNOSIS, SYSTEMIC DISEASE, UNKNOWN PRIMARY, OR MINIMAL DISEASE THAT IS NOT TREATED.
88	DISEASE HAS RECURRED, BUT THE TYPE OF RECURRENCE IS UNKNOWN
99	IT IS UNKNOWN WHETHER THE DISEASE HAS RECURRED OR IF THE PATIENT WAS EVER DISEASE-FREE

NOTE: The Distant Recurrence Sites field has been removed and incorporated into the Type of First Recurrence field.

VII.2.13 Death Information

If the patient has died, enter the code for the state or country where the death occurred in the Place of Death field. (The code for California is 097. See Appendix C and Appendix D1 for other codes.) If the patient is still alive, enter 997. Hospitals are not required to complete the *Cause of Death* field or *DC (Death Certificate) File No*. field.

To report that a patient has died, make every attempt to find the month and year of death. Approximations are acceptable when all attempts to find the date of death have failed.

VII.2.14 Follow-Up Remarks

This section was software specific and deleted in 2008. The information entered here was not transmitted to the CCR.

VII.3 Contact Name/Address File

The Contact Name/Address File is for generating follow up letters to the patient or designated contact(s). Space is provided for the name and address of the patient and up to five contacts for information about the patient. Enter names and addresses exactly as they are to appear in the heading of the letter, using capital and lower case letters, punctuation, and special characters like # for number. But in the Phone field, enter the area code and number without spaces, dashes, or other marks.

A supplemental field has been added which provides the ability to record additional address information such as the name of a place or facility (i.e., a nursing home or name of an apartment complex). This supplemental field is limited to 40 characters.

VII.3.1 Follow-Up Resources

This section was software specific and deleted in 2008.

VII.3.2 Contact

In the Contact #1 fields enter the following:

- The patient's name preceded by Mr., Mrs., Ms., or followed by Jr. or Sr. (up to 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
- The zip code (up to ten characters and spaces

If the patient is under 18, enter a parent's name and address.

Addresses in foreign countries may be entered, including foreign postal codes.

Entry of a telephone number is required for all patients alive at the time the case is abstracted. Include the area code.

If the telephone number changes at the time of follow up, it needs to be changed in this field. If there is no phone, enter all 0's.

In the Patient Address Current--Supplemental field, record the place or facility (i.e., nursing home or name of an apartment complex) of the patient's current usual residence. If the patient has multiple tumors, the address may be different for subsequent primaries. Update this data item if a patient's address changes. This supplemental field is limited to 40 characters.

VII.3.3 Contacts #2 through #6

If available in the abstracting software, enter the names, addresses, and phone numbers of up to six people designated as contacts for the case.

A supplemental follow-up contact field has been added. This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex. It can be used to generate a follow-up inquiry, and must correspond to the other fields in the follow-up contact address. If the patient has multiple tumors, Follow-Up Contact--Suppl should be the same. This supplemental field is limited to 40 characters.

Part VIII. Remarks and Extra Hospital Information

VIII.1 Remarks and Final Diagnosis

Textual information that does not fit into its designated field can be recorded in the Remarks area. Indicate the name of the field being extended and enter the overflow information. Also record other pertinent information for which there is no designated field.

The last two lines of this section are available for recording the final cancer diagnosis (FDX) as determined by a recognized medical practitioner. This information is ideally found in the discharge summary or progress notes. Record the date of the notation and the final diagnosis, including stage if given. If there is no final diagnosis in the medical record, please state FDX: NR; do not leave this field blank.

VIII.1.1 Required Data Items

Certain required data must be recorded in the Remarks section:

Other tumors See Section II.2.5.

Race of patient, when coded as "Other" or if there is conflicting race information. See Section III.2.9.

Parent or guardian of a child whose case is being reported. (Information about the parent is also entered in the Contact #1 area. Section VII.3.2.

VIII.1.2 Confidential Remarks

January 1, 2009
This section was software specific and was removed at the conclusion of 2008.

VIII.1.3 More Remarks

January 1, 2009
This section was software specific and was removed at the conclusion of 2008.

VIII.2 Regional Data

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

VIII.3 Extra 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 CCR.

VIII.4 Clinical Indicators

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

VIII.5 Tumor History

These fields are available for recording the tumor history of the patient for each tumor.

Part IX. Transmittal of Case Information and Quality Control

IX.1 Transmittal of Case Information

All cases must be transmitted electronically and must be encrypted and password protected.

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

IX.1.1 Timeliness

Submit all reports to the regional 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

Address At Diagnosis City USPS

Alias First Name

Alias Last Name

Ambiguous Terminology Diagnosis

Behavior Code ICD-O-3

Birth Date

Birthplace
Casefinding Source
Chemotherapy at This Hospital
Chemotherapy Summary
Class of Case
Comorbidity/Complication 1
Comorbidity/Complication 2
Comorbidity/Complication 3
Comorbidity/Complication 4
Comorbidity/Complication 5
Comorbidity/Complication 6
Comorbidity/Complication 7
Comorbidity/Complication 8
Comorbidity/Complication 9
Comorbidity/Complication 10
County of Residence at Diagnosis
CS Tumor Size
CS Tumor Size/Extension Evaluation
CS Extension
CS Lymph Nodes
CS Lymph Node Evaluation
CS Metastasis at Diagnosis
CS Mets at Diagnosis Evaluation
CS Site Specific Factor 1
CS Site Specific Factor 2
CS Site Specific Factor 3
CS Site Specific Factor 4
CS Site Specific Factor 5
CS Site Specific Factor 6
CS Tumor Size/Ext Evaluation
CS Reg Nodes Evaluation
Mets Evaluation
Date of Chemotherapy

Date of Conclusive Diagnosis
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 Multiple Tumors
Date of Other Therapy
Date of Radiation Therapy
Date of Surgery
Date of Surgery - Procedure 1
Date of Surgery - Procedure 2
Date of Surgery - Procedure 3
Date of Systemic Therapy
Date of Transplant/Endocrine Procedures
Derived AJCC T
Derived AJCC N
Derived AJCC M
Derived AJCC Stage Group
Derived SS2000
Derived SS1977
Diagnostic Confirmation
Diagnostic or Staging Procedures at This Hospital
Diagnostic or Staging Procedure Summary
Discovered by Screening
DxRx Report Facility (1-5)
DxRx Report Number (1-5)
DxRx Report Date (1-5)
DxRx Report Type (1-5)
Extent of Disease - Extension

Extent of Disease - Extension (Path)
Extent of Disease - Lymph Node Involvement
First Name
Histology - Behavior - (ICD-O-2)
Histology - Type - (ICD-O-3)
Histology - Grade/Differentiation
Histology - Type - (ICD-O-2)
Hormone Therapy at This Hospital
Hormone Therapy Summary
Hospital Number (Reporting)
Hospital Referred From
Hospital Referred To
ICD Revision Comorbidities
Immunotherapy at This Hospital
Immunotherapy Summary
Industry - Text
Last Name
Laterality
Maiden Name
Marital Status
Medical Record Number
Middle Name
Mother's First Name
Multiple Tumors Reported as One Primary
Multiplicity Counter
Name Suffix
Number of Regional Lymph Nodes
NPI Hospital Referred From
NPI Hospital Referred To
NPI Following Registry
NPI Physician Managing
NPI Physician Follow-up
NPI Physician Primary Surgeon

NPI Physician Radiation Oncologist
NPI Physician Medical Oncologist
NPI Reporting Facility
Examined - Summary
Occupation - Text
Other Therapy at This Hospital
Other Therapy Summary
Pathology Report Number - Biopsy/FNA
Pathology Report Number - Surgery
Patient No Research Contact Flag
Payment Source (Primary & Secondary)
Payment Source Text (Primary)
Pediatric Stage
Pediatric Stage Coder
Pediatric Stage System
Physicians
Protocol Participation
Race 1
Race 2
Race 3
Race 4
Race 5
Radiation Summary
Radiation - Regional Rx Modality
Radiation - Boost Treatment Modality
Radiation - Location of RX
Radiation/Surgery Sequence
Reason No Radiation
Reason for No Surgery
Regional Data
Regional Nodes Examined (Number)
Regional Nodes Positive (Number)
Religion

Scope of Regional Lymph Node Surgery at This Hospital
Scope of Regional Lymph Node Surgery - Procedure 1
Scope of Regional Lymph Node Surgery - Procedure 2
Scope of Regional Lymph Node Surgery - Procedure 3
Scope of Regional Lymph Node Surgery - Summary
Scope of Regional Lymph Node Surgery 98-02
Sequence Number - Hospital
Sex
Site - Primary (ICD-O-2)
Social Security Number
Social Security Number Suffix
Spanish/Hispanic Origin
Summary Stage 1977
Summary Stage 2000
Surgical Procedure/Other Site at This Hospital
Surgical Procedure/Other Site - Procedure 1
Surgical Procedure/Other Site - Procedure 2
Surgical Procedure/Other Site - Procedure 3
Surgical Procedure/Other Site - Summary
Surgical Procedure/Other Site 98-02
Surgery of Primary Site at This Hospital
Surgery of the Primary Site - Procedure 1
Surgery of the Primary Site - Procedure 2
Surgery of the Primary Site - Procedure 3
Surgery of Primary Site - Summary
Surgery of Primary Site 98-02
Surgery Summary - Reconstructive
Systemic/Surgery Sequence
Text-Diagnostic Procedures - Physical Examination
Text-Diagnostic Procedures - X-ray
Text-Diagnostic Procedures - Scopes
Text-Diagnostic Procedures - Tests
Text-Diagnostic Procedures - Operative

Text-Diagnostic Procedures - Pathological
Text-Site
Text-Histology
Text-Staging
Text Rx-Surgery
Text Rx-Radiation (Beam)
Text Rx-Radiation (Other)
Text Rx-Chemotherapy
Text Rx-Hormone Therapy
Text Rx-Immunotherapy
Text Rx-Other Therapy
Text-Remarks
Text-Final Diagnosis
TNM Coder (Clinical)
TNM Coder (Path)
TNM Edition
TNM M Code (Clinical)
TNM M Code (Path)
TNM N Code (Clinical)
TNM N Code (Path)
TNM Stage (Clinical)
TNM Stage (Path)
TNM T Code (Clinical)
TNM T Code (Path)
Transplant/Endocrine Procedures at This Hospital
Transplant/Endocrine Procedures- Summary
Treatment Hospital Number - Procedure 1
Treatment Hospital Number - Procedure 2
Treatment Hospital Number - Procedure 3
Tumor Marker 1
Tumor Marker 2
Tumor Marker 3
Tumor Marker-CA-1

Tumor Size

Type of Admission

Type of Reporting Source

Year First Seen

In the text field displayed on the screen, enter an explanation of why the changes are being made. If the only reason is that the regional registry notified the hospital of the change or correction, simply enter the word "REGION" (use capital letters), beginning in the first space of the first line in the field.

Example

A case has been transmitted as an Primary Unknown (site code C80.9), Carcinoma, NOS (histology 8010/3), and Stage Unknown (code 9), based on a biopsy of the brain. Four months later, the patient dies and an autopsy reveals that, in fact, the cancer was an oat cell carcinoma of the right upper lobe of the lung that had metastasized widely at diagnosis. Change the site code to C34.1, laterality to code 1, histology to 8042/3, and stage to Distant Metastases, code 7. When the request for the reason for the changes appears, enter a statement such as "Autopsy final DX: oat cell CA, RUL lung, mets to left lung, hilar and mediastinal lymph nodes, brain, and liver."

IX.1.3 DELETIONS

Delete any duplicate records if a case is found to have been abstracted and sent to the regional registry more than once.

Delete a previously reported case if subsequent evidence disproves the presence of cancer, or if what was thought to be a new primary cancer is later found to be a manifestation of an earlier primary cancer.

All deletions must be reported to the regional registry.

IX.2 Quality Control

The CCR and regional registries have procedures for assuring the quality of the data produced by the reporting system. Staff from both the regional registry and the CCR visit cancer reporting facilities to perform quality control audits. The CCR has established uniform standards of quality for 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 the 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.

Accuracy is evaluated using various methods:

- Visual editing
- Computer edits
- Reabstracting audits

The CCR's regional registries perform visual editing on a percentage of the abstracts submitted by hospital registries. Feedback is provided to hospitals on the results of visual editing.

A visual editing accuracy rate was established at 97% in January 2000. This rate applies to cancer reporting facilities and not to individual cancer registry abstractors. The reporting facility is responsible for cancer reporting requirements, not specific individuals; therefore, an accuracy rate reflects the facility's compliance with regulations. Please refer to the CCR web site at www.ccrcal.org for the current list of visually edited data items.

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

Computer edits are also used to assess the quality of data submitted. The CCR provides a standard set of edits for abstracting software. These edits are performed on data at the time of abstracting. The measure used to evaluate accuracy is the percent of a hospital's cases that fail an edit. CCR's cases must pass the interfield edits specified in Cancer Reporting in California: Data Standards for Regional Registries and California Cancer Registry (California Cancer Reporting System Standards, Volume III).

The CCR's edit set contains a number of edits that require review . After review and confirmation that the abstracted information is correct, a flag must be set so that repeated review is not necessary and a case can be set to complete. See Appendix T for a list of these over-rides. Please follow the instructions provided by your hospital abstracting software vendor for using these flags.

Another method of assessing accuracy is to reabstract cases in the hospitals. A sample of cases from each facility is reabstracted by speciality 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.

APPENDIX A

HISTOLOGY CODES FOR LYMPHOMAS AND LEUKEMIAS

January 1, 1998 and Forward

LEUKEMIA TERMS. *Effective for cases diagnosed January 1, 1998, and after.*

The following rules are to be used. They are in priority order:

1. Code the FAB (French-American-British) classification. FAB is implied if the description includes "L" or "M" with a number such as "L2" or M5". If more than one FAB classification is listed, use the NOS code. Example:

   Path: "Acute myelogenous leukemia, probably M1 or M2...."

   Code to 9861/3, Acute myeloid leukemia, NOS

2. If the diagnostic statement lists a specific acute leukemia cell type, code that term. If more than one term is listed, use rules in ICD-O-2.

In addition to these rules, the following information will assist in assigning codes:

- "Maturation" and "differentiation" are synonymous.
- Code "acute non-lymphocytic leukemia" as 9861/3, acute myelogenous leukemia, NOS.
- Code "acute biphenotypic leukemia" or "mixed lineage leukemias" to 9801/3, acute leukemia, NOS.
- Terms equivalent to granulocytic are: myeloblastic, myelocytic, myelogenous, myeloid, non-lymphocytic.
- Terms equivalent to lymphocytic are: lymphoblastic, lymphoid, lymphatic.

ICD-O Code	Term
9821/3	Acute lymphoblastic leukemia, L1 type (*) Acute lymphocytic leukemia, L1 type (*) Acute lymphoid leukemia, L1 type (*) Acute lymphatic leukemia, L1 type (*) Lymphoblastic leukemia, L1 type (*) FAB L1 (*)
9826/3	FAB L3 (*)
9828/3	Acute lymphoblastic leukemia, L2 type Acute lymphocytic leukemia, L2 type Acute lymphoid leukemia, L2 type

	Acute lymphatic leukemia, L2 type Lymphoblastic leukemia, L2 type FAB L2
9840/3	FAB M6 (*)
9861/3	Acute myeloid leukemia, NOS (*) Acute myeloblastic leukemia, NOS (*) Acute granulocytic leukemia, NOS (*) Acute myelogenous leukemia, NOS (*) Acute myelocytic leukemia, NOS (*)
9866/3	FAB M3 (*)
9867/3	Acute myelomonocytic leukemia, NOS (*) FAB M4 (*)
9871/3	Acute myelomonocytic leukemia with eosinophils FAB M4E
9872/3	Acute myeloid leukemia, minimal differentiation Acute myeloblastic leukemia, minimal differentiation Acute granulocytic leukemia, minimal differentiation Acute myelogenous leukemia, minimal differentiation Acute myelocytic leukemia, minimal differentiation FAB M0
9873/3	Acute myeloid leukemia without maturation Acute myeloblastic leukemia without maturation Acute granulocytic leukemia, without maturation Acute myelogenous leukemia, without maturation Acute myelocytic leukemia, without maturation FAB M1
9874/3	Acute myeloid leukemia with maturation Acute myeloblastic leukemia with maturation Acute granulocytic leukemia, with maturation Acute myelogenous leukemia, with maturation Acute myelocytic leukemia, with maturation FAB M2
9891/3	FAB M5 (*) FAB M5A (*) FAB M5B (*)
9910/3	Megakaryoblastic leukemia, NOS (C42.1) FAB M7

(*) New terms for existing numbers

January 1, 1998 and Forward

LYMPHOMA TERMS. *Effective for cases diagnosed January 1, 1995, and after.*

ICD-O Code	Term

9673/3	Mantle cell lymphoma (*)
9688/3	T-cell rich B-cell lymphoma
9708/3	Subcutaneous panniculitic T-cell lymphoma
9710/3	Marginal zone lymphoma, NOS
9714/3	Anaplastic large cell lymphoma (ALCL), CD30+ (*)
9715/3	Mucosal-Associated Lymphoid Tissue (MALT) lymphoma
9716/3	Hepatosplenic γδ (gamma - delta) cell lymphoma
9717/3	Intestinal T-cell lymphoma Enteropathy associated T-cell lymphoma

(*) New terms for existing numbers

APPENDIX B

POSTAL ABBREVIATIONS FOR STATES AND TERRITORIES OF THE UNITED STATES

AL	ALABAMA	NH	NEW HAMPSHIRE
AK	ALASKA	NJ	NEW JERSEY
AS	AMERICAN SAMOA	NM	NEW MEXICO
AZ	ARIZONA	NY	NEW YORK
AR	ARKANSAS	NC	NORTH CAROLINA
CA	CALIFORNIA	ND	NORTH DAKOTA
CO	COLORADO	MP	NORTHERN MARIANA ISLANDS
CT	CONNECTICUT	OH	OHIO
DE	DELAWARE	OK	OKLAHOMA
DC	DISTRICT OF COLUMBIA	OR	OREGON
FL	FLORIDA	PW	PALAU
GA	GEORGIA	PA	PENNSYLVANIA
GU	GUAM	PR	PUERTO RICO
HI	HAWAII	RI	RHODE ISLAND
ID	IDAHO	SC	SOUTH CAROLINA
IL	ILLINOIS	SD	SOUTH DAKOTA
IN	INDIANA	TN	TENNESSEE
IA	IOWA	TX	TEXAS
KS	KANSAS	TT	TRUST TERRITORIES
KY	KENTUCKY	UM	US MINOR OUTLYING ISLANDS
LA	LOUISIANA	US	RESIDENT OF UNITED STATES, NOS

ME	MAINE	UT	UTAH
MD	MARYLAND	VT	VERMONT
MH	MARSHALL ISLANDS	VA	VIRGINIA
MA	MASSACHUSETTS	VI	VIRGIN ISLANDS
MI	MICHIGAN	DC	WASHINGTON, DISTRICT OF
FM	MICRONESIA, FEDERATED STATE OF	WA	WASHINGTON, STATE OF
MN	MINNESOTA	WV	WEST VIRGINIA
MS	MISSISSIPPI	WI	WISCONSIN
MO	MISSOURI	WY	WYOMING
MT	MONTANA	XX	NOT U.S., U.S. TERRITORY, NOT CANADA, AND COUNTRY IS KNOWN
NE	NEBRASKA	YY	NOT U.S., U.S. TERRITORY, NOT CANADA, AND COUNTRY IS UNKNOWN
NV	NEVADA	ZZ	RESIDENCE IS UNKNOWN

UNITED STATES MILITARY PERSONNEL SERVING ABROAD

AA	American Territories-US Military abroad
AE	Europe-US Military abroad
AP	Pacific-US Military abroad

CANADIAN PROVINCE/ TERRITORY

AB	ALBERTA	NS	NOVA SCOTIA
BC	BRITISH COLUMBIA	NU	NUNAVUT
CD	CANADA, NOS	ON	ONTARIO

MB	MANITOBA	PE	PRINCE EDWARD ISLAND
NB	NEW BRUNSWICK	QB	QUEBEC
NL	NEWFOUNDLAND AND LABRADOR	SK	SASKATCHEWAN
NT	NORTHWEST TERRITORIES	YT	YUKON TERRITORIES

APPENDIX C

CODES FOR STATES AND TERRITORIES OF THE UNITED STATES AND PROVINCES AND TERRITORIES OF CANADA

US States / Territories

ALABAMA	037
ALASKA	091
AMERICAN SAMOA	121
ARIZONA	087
ARKANSAS	071
CALIFORNIA	097
COLORADO	083
CONNECTICUT	007
DELAWARE	017
DISTRICT OF COLUMBIA	022
FLORIDA	035
GEORGIA	033
GUAM	126
HAWAII	099
IDAHO	081
ILLINOIS	061
INDIANA	045
IOWA	053
KANSAS	065
KENTUCKY	047
LOUISIANA	073
MAINE	002
MARSHALL ISLANDS	131
MARYLAND	021
MASSACHUSETTS	005

MICRONESIA, FEDERATED STATES OF	123
MICHIGAN	041
MINNESOTA	052
MISSISSIPPI	039
MISSOURI	063
MONTANA	056
NEBRASKA	067
NEVADA	085
NEW HAMPSHIRE	003
NEW JERSEY	008
NEW MEXICO	086
NEW YORK	011
NORTH CAROLINA	025
NORTH DAKOTA	054
NORTHERN MARIANA ISLANDS	129
OHIO	043
OKLAHOMA	075
OREGON	095
PALAU	139
PENNSYLVANIA	014
PUERTO RICO	101
RHODE ISLAND	006
SOUTH CAROLINA	026
SOUTH DAKOTA	055
TENNESSEE	031
TEXAS	077
UTAH	084
VERMONT	004
VIRGINIA	023
VIRGIN ISLANDS	102
WASHINGTON, DISTRICT OF	022
WASHINGTON, STATE OF	093
WEST VIRGINIA	024

WISCONSIN	051
WYOMING	082
U.S.A., STATE UNKNOWN	000

CANADIAN PROVINCE/ TERRITORY

ALBERTA	224
BRITISH COLUMBIA	226
CANADA, NOS	220
MANITOBA	224
NEW BRUNSWICK	221
NEWFOUNDLAND AND LABRADOR	221
NORTHWEST TERRITORIES	225
NOVA SCOTIA	221
NUNAVUT	227
ONTARIO	223
PRINCE EDWARD ISLAND	221
QUEBEC	222
SASKATCHEWAN	224
YUKON TERRITORIES	225

APPENDIX D.1

CODES FOR COUNTRIES

In alphabetical order.

You can also view the codes in numerical 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 MINOR, NOS	610
ASIA, NOS	600
ASIA-ARAB COUNTRIES, NOS	620
ASIA-EAST, NOS	680
ASIA-MID-EAST, NOS	640
ASIA-NEAR EAST, NOS	610
ASIA-SOUTHEAST, NOS	650
ASIAN REPUBLICS OF FORMER USSR	634
ATLAN/CARIB US OTHER	109
ATLANTIC/CARIBBEAN AREA, U.S. POSSESSIONS	100
AUSTRALIA/AUST NEW GUINEA	711
AUSTRIA	436
AZERBAIDZHAN SSR	633
AZERBAIJAN	633
AZORES	445
BAHAMAS	247
BAHRAIN	629

BALEARIC ISL 443
BALTIC REPUBLIC, NOS 463
BALTIC STATES, NOS 463
BANGLADESH 645
BARBADOS 245
BARBUDA 245
BASUTOLAND 545
BAVARIA 431
BECHUANALAND 545
BELARUS 457
BELGIUM 433
BELIZE 252
BENIN 539
BERMUDA 246
BESSARABIA 456
BHUTAN 643
BIOKO 539
BOHEMIA 452
BOLIVIA 355
BOPHUTHATSWANA 545
BORNEO 673
BOSNIA-HERZOGOVINA 453
BOTSWANA 545
BRAZIL 341
BRITISH COLUMBIA 226
BRITISH GUIANA 331
BRITISH HONDURAS 252
BRUNEI 671

BULGARIA	454
BURKINA FASO	520
BURMA	649
BURUNDI	579
BYELORUSSIA	457
CABINDA	543
CAICOS ISLANDS	245
CALIFORNIA	097
CAMBODIA	663
CAMEROON	539
CANADA, NOS	220
CANADA-MARITIME PROVINCE	221
CANADA-NUNAVUT	227
CANADA-NW TERR/YUKON	225
CANADA-PRAIRIE PROVIINCE	224
CANAL ZONE	110
CANARY ISL	443
CANTON/ENDERBURY ISL	122
CAPE COLONY	545
CAPE VERDE ISL	445
CARIBBEAN ISL NEC	245
CARIBBEAN, NOS	245
CAROLINE ISL (MICRONESA, FEDERATED STATES OF)	123
CARTIER ISLANDS	711
CAUCASIAN REPUBLICS OF FORMER USSR	633
CAYMAN ISLANDS	245
CENTRAL AFRICA, NOS	500
CENTRAL AFRICAN REPUBLIC	539

CENTRAL AMERICA, NOS	250
CEYLON	647
CHAD	520
CHANNEL ISL	401
CHILE	361
CHINA, NOS	681
CHINA, PEOPLE'S REPUBLIC	682
CHINA, REPUBLIC OF	684
CHRISTMAS ISLAND	723
CISKEL	545
COCHIN CHINA	665
COCOS ISLANDS	711
COLOMBIA	311
COLORADO	083
COMOROS	580
CONGO BELGIAN	541
CONGO BRAZZAVILLE	539
CONGO FRENCH	539
CONGO LEOPOLDVILLE	541
CONNECTICUT	007
COOK ISL (NEW ZEALAND)	124
CORSICA	441
COSTA RICA	256
COTE D'IVOIRE	539
CRETE	471
CROATIA	453
CUBA	241
CURACAO	245

CYPRUS 495
CYRENAICA 517
CZECH REPUBLIC 452
CZECHOSLOVAKIA 452
DAHOMEY 539
DALMATIA 453
DELAWARE 017
DENMARK 425
DJIBOUTI 583
DOBRUJA 449
DOMINICA 245
DOMINICAN REPUBLIC 243
DUTCH EAST INDIES 673
DUTCH GUIANA 332
EAST AFRICA, NOS 570
EAST GERMANY 431
ECUADOR 345
EGYPT 519
EIRE 410
EL SALVADOR 254
ELLICE ISL 125
ENDERBURY ISL 122
ENGLAND 401
EQUATORIAL AFRICA 500
EQUATORIAL GUINEA 539
ERITREA 585
ESTONIA 458
ESTONIAN S.S.R. 458

ETHIOPIA	585
EUROPE, NOS	499
EUROPE-CENTRAL, NOS	499
EUROPE-EASTERN, NOS	499
EUROPE-GERMANIC, NOS	430
EUROPE-MEDITER ILS NEC	490
EUROPE-OTHER MAINLAND, NOS	470
EUROPE-ROMANCE LANG, NOS	440
EUROPE-SLAVIC, NOS	450
FALKLAND ISLANDS	381
FAROE ISLANDS	425
FERNANDO PO	539
FIJI	721
FINLAND	429
FLORIDA	035
FORMOSA	684
FOTUNA	721
FRANCE/MONACO	441
FREE STATE	545
FRENCH GUIANA	333
FUTUNA ISLANDS	721
GABON	539
GALAPAGOS ISLANDS	345
GAMBIA	539
GAZA STRIP	631
GEORGIA	033
GEORGIA (USSR)	633
GERMAN DEMOCRATIC REPUBLIC	431

GERMANIC COUNTRIES 430
GERMANY 431
GERMANY, EAST 431
GERMANY, FEDERAL REPUBLIC OF 431
GERMANY, WEST 431
GHANA 539
GIBRALTAR 485
GILBERT ISLANDS 122
GREAT BRITAIN, NOS 400
GREECE 471
GREENLAND 210
GRENADA 245
GRENADINES 245
GUADALOUPE 245
GUAM 126
GUATAMALA 251
GUERNSEY 401
GUIANA BRITISH 331
GUIANA DUTCH 332
GUIANA FRENCH 333
GUINEA 539
GUINEA PORTUGUESE 539
GUINEA-BISSAU 539
GUYANA 331
HAITI 242
HAWAII 099
HOLLAND 432
HONDURAS 253

HONG KONG	683
HUNGARY	475
ICELAND	421
IDAHO	081
ILLINOIS	061
INDIA	641
INDIANA	045
INDO-CHINA, NOS	660
INDONESIA	673
IOWA	053
IRAN	637
IRAQ	627
IRAQ-SAUDI ARABIAN NEUTRAL ZONE	620
IRELAND	410
ISLE OF MAN	401
ISRAEL	631
ISSAS	583
ITALY/SAN MARINO	447
IVORY COAST (COTE D'IVOIRE)	539
JAMAICA	244
JAN MAYEN	423
JAPAN	693
JAVA	673
JERSEY	401
JOHNSTON ATOLL	127
JORDAN	625
KAMEROON	539
KAMPUCHEA	663

KANSAS	065
KAZAKH SSR	634
KAZAKHSTAN	634
KENTUCKY	047
KENYA	575
KIRGHIZ SSR	634
KIRIBATI	122
KOREA	695
KOREA, NORTH	695
KOREA, SOUTH	695
KUWAIT	629
KYRGYSTAN	634
KYRGYZ	634
LABRADOR	221
LAOS	661
LAPLAND, NOS	420
LATIN AMERICA, NOS	265
LATVIA	459
LATVIAN S.S.R.	459
LEBANON	623
LEEWARD ISL	245
LESOTHO	545
LIBERIA	539
LIBYA	517
LIECHTENSTEIN	437
LINE ISL SOUTHERN	122
LITHUANIA	461
LITHUANIAN S.S.R.	461

LOUISIANA	073
LUXEMBOURG	434
MACAO	686
MACAU	686
MACEDONIA	453
MADAGASCAR	555
MADEIRA ISL	445
MAINE	002
MALAGASY REPUBLIC	555
MALAWI	551
MALAY PENINSULA	671
MALAYSIA/SINGAPORE/BRUNEI	671
MALDIVES	640
MALI	520
MALTA	491
MANITOBA	224
MARSHALL ISL	131
MARTINIQUE	245
MARYLAND	021
MASSACHUSETTS	005
MAURITANIA	520
MAURITIUS	580
MAYOTTE	580
MEDITERRANEAN ISLANDS, OTHER	490
MELANESIA (MELANESIAN ISL)	721
MESOPOTAMIA	610
MEXICO	230
MICHIGAN	041

MICRONESIA	723
MICRONESIAN ISL	723
MIDWAY ISL	132
MINNESOTA	052
MIQUELON	249
MISSISSIPPI	039
MISSOURI	063
MOLDAVIA	456
MOLDAVIAN S.S.R.	456
MOLDOVA	456
MONACO	441
MONGOLIA	691
MONTANA	056
MONTENEGRO	453
MONTSERRAT	245
MORAVIA	452
MOROCCO	511
MOZAMBIQUE	553
MYANMAR	649
NAMIBIA	545
NAMPO SHOTO SOUTHERN	133
NATAL	545
NAURU	723
NEBRASKA	067
NEPAL/BHUTAN/SIKKIM	643
NETHERLANDS	432
NETHERLANDS ANTILLES	245
NEVADA	085

NEVIS	245
NEW BRUNSWICK	221
NEW CALEDONIA	725
NEW ENGLAND	001
NEW GUINEA AUSTRALIAN	711
NEW GUINEA NORTHEAST	711
NEW GUINEA PAPUA	711
NEW GUINEA, NOS	673
NEW HAMPSHIRE	003
NEW HEBRIDES	721
NEW JERSEY	008
NEW MEXICO	086
NEW YORK	011
NEW ZEALAND	715
NEWFOUNDLAND	221
NICARAGUA	255
NIGER	520
NIGERIA	531
NIUE	715
NORFOLK ISLANDS	711
NORTH AFRICA, NOS	510
NORTH AMERICA	260
NORTH AMERICAN ISL, NOS	240
NORTH CAROLINA	025
NORTH DAKOTA	054
NORTHERN IRELAND	404
NORTHWEST TERRITORY	225
NORWAY	423

NOT US, NOS	998
NOVA SCOTIA	221
NYASALAND	551
OCEANA, NOS	720
OHIO	043
OKINAWA	693
OKLAHOMA	075
OMAN AND MUSCAT	629
ONTARIO	223
ORANGE FREE STATE	545
OREGON	095
ORKNEY ISLANDS	403
PACIFIC ISL, NOS	720
PACIFIC ISLANDS, TRUST TERRITORY	123
PAKISTAN EAST	645
PAKISTAN WEST	639
PAKISTAN, NOS	639
PALAU	139
PALESTINE ARAB	625
PALESTINE JEWISH	631
PALESTINIAN NATIONAL AUTHORITY-PNA	631
PANAMA	257
PAPUA	711
PARAGUAY	371
PENNSYLVANIA	014
PERSIA	637
PERSIAN GULF STATES, NOS	629
PERU	351

PHILIPPINES 675
PHOENIX ISLANDS 122
PITCAIRN 725
POLAND 451
POLYNESIA 725
POLYNESIA, NOS 720
POLYNESIAN ISL 725
PORTUGAL 445
PORTUGUESE GUINEA 539
PRINCE EDWARD ISL 221
PRINCIPE 543
PUERTO RICO 101
QATAR 629
QUATAR 629
QUEBEC 222
REPUBLIC OF CHINA 684
REPUBLIC OF IRELAND 410
REPUBLIC OF SOUTH AFRICA 545
REUNION 580
RHODE ISLAND 006
RHODESIA 547
RHODESIA NORTHERN 549
RHODESIA SOUTHERN 547
RIO MUNI 539
ROMANIA 449
RUANDA 577
RUMANIA 449
RUSSIA, NOS 455

RUSSIAN FEDERATION (FORMER U.S.S.R.) 455
RUSSIAN S.F.S.R. 455
RWANDA 577
RYUKYU ISL (JAPAN) 134
SAHARA 520
SAMOA AMERICAN 121
SAMOA, WESTERN 725
SAN MARINO 447
SAO TOME 543
SARDINIA 447
SASKATCHEWAN 224
SAUDI ARABIA 629
SCANDANAVIA NOS 420
SCOTLAND 403
SENEGAL 539
SERBIA 453
SEYCHELLES 580
SHETLAND ISLANDS 403
SIAM 651
SICILY 447
SIERRA LEONE 539
SIKKIM 643
SINGAPORE 671
SLAVIC COUNTRIES 450
SLAVONIA 453
SLOVAK REPUBLIC 452
SLOVAKIA 452
SLOVENIA 453

SOLOMON ISLANDS	721
SOMALI REPUBLIC	581
SOMALIA	581
SOMALILAND FRENCH	583
SOMALILAND, NOS	581
SOUTH AFRICA, NOS	540
SOUTH AMERICA, NOS	300
SOUTH AMERICAN ISLANDS	380
SOUTH CAROLINA	026
SOUTH DAKOTA	055
SOUTH WEST AFRICA	545
SOUTHERN EUROPE, NOS	499
SOUTHERN LINE ISLANDS	122
SPAIN/ANDORRA	443
SPANISH SAHARA	520
SRI LANKA	647
ST. CHRISTOPHER-NEVIS	245
ST. HELENA	580
ST. KITTS	245
ST. LUCIA	249
ST. PIERRE	249
ST. VINCENT	245
SUDAN	520
SUMATRA	673
SURINAM	332
SVALBARD	423
SWAN ISL	135
SWAZILAND	545

SWEDEN 427
SWITZERLAND 435
SYRIA 621
TADZHIK SSR 634
TAIWAN 684
TAJIKISTAN 634
TANGANYIKA 571
TANZANIA 571
TANZANYIKA 571
TENNESSEE 031
TEXAS 077
THAILAND 651
TIBET 685
TOBAGO 245
TOGO 539
TOKELAU ISL (NEW ZEALAND) 136
TONGA 725
TONKIN 665
TRANS-JORDAN 625
TRANSKEI 545
TRANSVAAL 545
TRANSYLVANIA 449
TRINIDAD 245
TRIPOLI 517
TRIPOLITANIA 517
TRUCIAL STATES 629
TUNISIA 515
TURKEY 611

TURKMEN SSR	634
TURKMENISTAN	634
TURKS ISLANDS	245
TUVALU ISLANDS	125
UGANDA	573
UKRAINE/MOLDAVIA	456
UKRANIAN S.S.R.	456
ULSTER	404
UNION OF SOUTH AFRICA	545
UNITED ARAB EMIRATES	629
UNITED ARAB REPUBLIC	519
UNITED KINGDOM, NOS	400
UNITED STATES, NOS	000
UNKNOWN	999
UPPER VOLTA	520
URUGUAY	375
URUNDI	579
US POSS-ATL/CARIB, NOS	100
US POSS-PACIFIC	120
US, NOS	000
US-CENTRAL MIDWEST, NOS	060
US-MOUNTAIN STATES, NOS	080
US-NEW ENGLAND, NOS	001
US-NORTH ATLANTIC, NOS	010
US-NORTH CENTRAL, NOS	040
US-NORTH MIDWEST, NOS	050
US-PACIFIC STATES, NOS	090
US-SOUTH MID ATLANTIC, NOS	020

US-SOUTH MIDWEST, NOS	070
US-SOUTHEASTERN, NOS	030
USSR, NOS	455
UTAH	084
UZBECK SSR	634
UZBEKISTAN	634
VANUATU	721
VATICAN CITY	447
VENDA	545
VENEZUELA	321
VERMONT	004
VIET NAM	665
VIETNAM	665
VIRGIN ISL - US	102
VIRGIN ISLANDS, BRITISH	245
VIRGINIA	023
WAKE ISLAND	137
WALES	402
WALLACHIA	449
WALLIS ISLANDS	721
WASHINGTON	093
WASHINGTON DC	022
WEST AFRICA, FRENCH	530
WEST AFRICAN COUNTRIES, OTHER	539
WEST BANK	631
WEST GERMANY	431
WEST INDIES	245
WEST INDIES, NOS	245

WEST VIRGINIA	024
WESTERN SAHARA	520
WESTERN SAMOA	725
WHITE RUSSIA	457
WINDWARD ISLANDS	245
WISCONSIN	051
WYOMING	082
YEMEN	629
YEMEN, PEOPLE'S DEMOCRATIC REPUBLIC	629
YEMEN, SOUTHERN	629
YUGOSLAVIA	453
YUKON	225
ZAIRE	541
ZAMBIA	549
ZANZIBAR	571
ZIMBABWE	547

APPENDIX D.2

CODES FOR COUNTRIES

In numerical order.

You can also view codes in alphabetical order.

Includes codes for U.S. states and territories.

000	UNITED STATES, NOS
000	US NOS
001	NEW ENGLAND
001	US-NEW ENGLAND, NOS
002	MAINE
003	NEW HAMPSHIRE
004	VERMONT
005	MASSACHUSETTS
006	RHODE ISLAND
007	CONNECTICUT
008	NEW JERSEY
010	US-NORTH ATLANTIC, NOS
011	NEW YORK
014	PENNSYLVANIA
017	DELAWARE
020	US-SOUTH MID ATLANTIC, NOS
021	MARYLAND
022	WASHINGTON DC
023	VIRGINIA
024	WEST VIRGINIA
025	NORTH CAROLINA

026	SOUTH CAROLINA
030	US-SOUTHEASTERN, NOS
031	TENNESSEE
033	GEORGIA
035	FLORIDA
037	ALABAMA
039	MISSISSIPPI
040	US-NORTH CENTRAL, NOS
041	MICHIGAN
043	OHIO
045	INDIANA
047	KENTUCKY
050	US-NORTH MIDWEST, NOS
051	WISCONSIN
052	MINNESOTA
053	IOWA
054	NORTH DAKOTA
055	SOUTH DAKOTA
056	MONTANA
060	US-CENTRAL MIDWEST, NOS
061	ILLINOIS
063	MISSOURI
065	KANSAS
067	NEBRASKA
070	US-SOUTH MIDWEST, NOS
071	ARKANSAS
073	LOUISIANA
075	OKLAHOMA

077	TEXAS
080	US-MOUNTAIN STATES, NOS
081	IDAHO
082	WYOMING
083	COLORADO
084	UTAH
085	NEVADA
086	NEW MEXICO
087	ARIZONA
090	US-PACIFIC STATES, NOS
091	ALASKA
093	WASHINGTON
095	OREGON
097	CALIFORNIA
099	HAWAII
100	US POSS-ATL/CARIB, NOS
101	PUERTO RICO
102	VIRGIN ISL - US
109	ATLAN/CARIB US OTHER
110	CANAL ZONE
120	US POSS-PACIFIC
121	AMERICAN SAMOA
121	SAMOA AMERICAN
122	CANTON/ENDERBURY ISL
122	ENDERBURY ISL
122	GILBERT ISLANDS
122	LINE ISLANDS, SOUTHERN
122	PHOENIX ISLANDS

122	SOUTHERN LINE ISLANDS
123	CAROLINE ISL, MICRONESIA (FEDERAL STATES OF)
124	COOK ISLAND (NEW ZEALAND)
125	TUVALU (ELLICE ISLANDS)
126	GUAM
127	JOHNSTON ATOLL
129	MARIANA ISL
131	MARSHALL ISL
132	MIDWAY ISL
133	NAMPO SHOTO SOUTHERN
134	RYUKYU ISLAND (JAPAN)
135	SWAN ISL
136	TOKELAU ISLAND (NEW ZEALAND)
137	WAKE ISLAND
139	PALAU
200	WESTERN HEMISPHERE, NOS
210	GREENLAND
220	CANADA, NOS
221	CANADA-MARITIME PROVINCE
221	LABRADOR
221	NEW BRUNSWICK
221	NEWFOUNDLAND
221	NOVA SCOTIA
221	PRINCE EDWARD ISL
222	QUEBEC
223	ONTARIO
224	ALBERTA
224	CANADA-PRAIRIE PROVINCE

224	MANITOBA
224	SASKATCHEWAN
225	CANADA-NW TERR/YUKON
225	NORTHWEST TERRITORY
225	YUKON
226	BRITISH COLUMBIA
227	CANADA- NUNAVUT
230	MEXICO
240	NORTH AMERICAN ISL, NOS
241	CUBA
242	HAITI
243	DOMINICAN REPUBLIC
244	JAMAICA
245	ANGUILLA
245	ANTIGUA
245	ANTILLES
245	ARUBA
245	BARBADOS
245	BARBUDA
245	CAICOS ISLANDS
245	CARIBBEAN ISL NEC
245	CAYMAN ISLANDS
245	CURACAO
245	DOMINICA
245	GRENADINES
245	GRENADA
245	GUADALOUPE
245	LEEWARD ISLANDS

245	MARTINIQUE
245	MONTSERRAT
245	NETHERLANDS ANTILLES
245	ST. CHRISTOPHER-NEVIS
245	ST. KITTS
245	ST. LUCIA
245	ST. VINCENT
245	TOBAGO
245	TRINIDAD
245	TURKS ISLANDS
245	VIRGIN ISLANDS, BRITISH
245	WEST INDIES, BRITISH
245	WEST INDIES, NOS
245	WINDWARD ISLANDS
246	BERMUDA
247	BAHAMAS
249	ST. PIERRE AND MIQUELON
250	CENTRAL AMERICA, NOS
251	GUATAMALA
252	BELIZE
252	BRITISH HONDURAS
253	HONDURAS
254	EL SALVADOR
255	NICARAGUA
256	COSTA RICA
257	PANAMA
260	AMERICA, NORTH
260	NORTH AMERICA, NOS

265	LATIN AMERICA, NOS
300	SOUTH AMERICA, NOS
311	COLOMBIA
321	VENEZUELA
331	BRITISH GUIANA
331	GUIANA BRITISH
331	GUYANA
332	DUTCH GUIANA
332	GUIANA DUTCH
332	SURINAM
333	FRENCH GUIANA
333	GUIANA FRENCH
341	BRAZIL
345	ECUADOR
345	GALAPAGOS ISLANDS
351	PERU
355	BOLIVIA
361	CHILE
365	ARGENTINA
371	PARAGUAY
375	URUGUAY
380	SOUTH AMERICAN ISLANDS
381	FALKLAND ISLANDS
400	GREAT BRITAIN, NOS
400	UNITED KINGDOM, NOS
401	CHANNEL ISL
401	ENGLAND
401	GUERNSEY

401	ISLE OF MAN
401	JERSEY
402	WALES
403	ORKNEY ISLANDS
403	SCOTLAND
403	SHETLAND ISLANDS
404	NORTHERN IRELAND
404	ULSTER
410	EIRE
410	IRELAND
410	REPUBLIC OF IRELAND
420	LAPLAND, NOS
420	SCANDANAVIA, NOS
421	ICELAND
423	JAN MAYEN
423	NORWAY
423	SVALBARD
425	DENMARK
425	FAROE ISLANDS
427	SWEDEN
429	FINLAND
430	EUROPE-GERMANIC, NOS
431	BAVARIA
431	GERMANY
432	HOLLAND
432	NETHERLANDS
433	BELGIUM
434	LUXEMBOURG

435	SWITZERLAND
436	AUSTRIA
437	LIECHTENSTEIN
440	EUROPE-ROMANCE LANG, NOS
441	CORSICA
441	FRANCE/MONACO
441	MONACO
443	ANDORRA
443	BALEARIC ISL
443	CANARY ISL
443	SPAIN/ANDORRA
445	AZORES
445	CAPE VERDE ISL
445	MADEIRA ISL
445	PORTUGAL
447	ITALY/SAN MARINO
447	SAN MARINO
447	SARDINIA
447	SICILY
447	VATICAN CITY
449	DOBRUJA
449	MOLDAVIA RUMANIA
449	ROMANIA
449	RUMANIA
449	TRANSYLVANIA
449	WALLACHIA
450	EUROPE-SLAVIC, NOS
451	POLAND

452	BOHEMIA
452	CZECH REPUBLIC
452	CZECHOSLOVAKIA
452	MORAVIA
452	SLOVAKIA
452	SLOVAK REPUBLIC
453	BOSNIA-HERZOGOVINA
453	CROATIA
453	DALMATIA
453	MACEDONIA
453	MONTENEGRO
453	SERBIA
453	SLAVONIA
453	SLOVENIA
453	YUGOSLAVIA (FORMER)
454	BULGARIA
455	RUSSIA, NOS (RUSSIAN S.F.S.R.)
455	RUSSIAN FEDERATION (FORMER) U.S.S.R
455	RUSSIA
455	USSR, NOS
456	BESSARABIA
456	MOLDAVIA
456	MOLDAVIAN SSR
456	UKRAINE/MOLDOVA
456	UKRANIAN SSR
457	BELARUS
457	BYELORUSSIA
457	WHITE RUSSIA

458	ESTONIA (ESTONIAN SSR)
459	LATVIA (LATVIAN SSR)
461	LITHUANIA (LITHUANIAN SSR)
463	BALTIC REPUBLIC(S), NOS
470	EUROPE-OTHER MAINLAND, NOS
471	CRETE
471	GREECE
475	HUNGARY
481	ALBANIA
485	GIBRALTAR
490	EUROPE-MEDITER ILS NEC
491	MALTA
495	CYPRUS
499	CENTRAL EUROPE, NOS
499	EASTERN EUROPE, NOS
499	EUROPE, NOS
499	NORTHERN EUROPE, NOS
499	SOUTHERN EUROPE, NOS
499	WESTERN EUROPE, NOS
500	EQUATORIAL AFRICA, NOS
500	AFRICA, NOS
500	CENTRAL AFRICA, NOS
510	NORTH AFRICA NOS
511	MOROCCO
513	ALGERIA
515	TUNISIA
517	CYRENAICA
517	LIBYA

517	TRIPOLITANIA
517	TRIPOLI
519	EGYPT
519	UNITED ARAB REPUBLIC
520	AFRICA-SUDANESE COUNTRIES
520	BURKINA FASO (UPPER VOLTA)
520	CHAD
520	MALI
520	MAURITANIA
520	NIGER
520	SAHARA
520	SUDAN
520	WESTERN (SPANISH) SAHARA
530	FRENCH WEST AFRICA, NOS
530	WEST AFRICA
531	NIGERIA
539	AFRICA-CENTRAL (OTHER WEST)
539	BENIN
539	CAMEROON
539	CENTRAL AFRICAN REPUBLIC
539	CONGO
539	CONGO FRENCH
539	CONGO BRAZZAVILLE
539	COTE D'IVOIRE (IVORY COAST)
539	DAHOMEY
539	EQUATORIAL GUINEA
539	FERNANDO PO
539	GABON

539	GAMBIA
539	GHANA
539	GUIANA BISSAU
539	GUIANA PORTUGUESE
539	GUINEA
539	KAMEROON
539	LIBERIA
539	PORTUGUESE GUINEA
539	RIO MUNI
539	SENEGAL
539	SIERRA LEONE
539	TOGO
540	SOUTH AFRICA, NOS
541	CONGO BELGIAN
541	CONGO LEOPOLDVILLE
541	CONGO/KINSHASA
541	ZAIRE
543	ANGOLA
543	CABINDA
543	PRINCIPE
543	SAO TOME
545	BASUTOLAND
545	BECHUANALAND
545	BOPHUTHATSWANA
545	BOTSWANA
545	CAPE COLONY
545	CISKEL
545	FREE STATE (ORANGE FREE STATE)

545	LESOTHO
545	NAMIBIA
545	NATAL
545	REPUBLIC OF SOUTH AFRICA
545	SOUTH WEST AFRICA
545	SWAZILAND
545	TRANSKEI
545	TRANSVAAL
545	UNION OF SOUTH AFRICA
545	VENDA
547	RHODESIA SOUTHERN
547	RHODESIA
547	ZIMBABWE
549	RHODESIA NORTHERN
549	ZAMBIA
551	MALAWI
551	NYASALAND
553	MOZAMBIQUE
555	MADAGASCAR
555	MALAGASY REPUBLIC
570	EAST AFRICA, NOS
571	TANGANYIKA
571	TANZANIA
571	TANZANYIKA
571	ZANZIBAR
573	UGANDA
575	KENYA
577	RUANDA

577	RWANDA
579	BURUNDI
579	URUNDI
580	AFRICAN COASTAL ISLANDS
580	COMOROS
580	MAURITIUS
580	MAYOTTE
580	REUNION
580	SEYCHELLES
580	ST. HELENA
581	SOMALIA
581	SOMALILAND, NOS
581	SOMALI REPUBLIC
583	AFARS/ISSAS
583	DJIBOUTI
583	ISSAS
583	SOMALILAND FRENCH
585	ABYSSINIA
585	ERITREA
585	ETHIOPIA
600	ASIA, NOS
610	ASIA-NEAR EAST, NOS
610	MESOPOTAMIA
611	ANATOLIA
611	ASIA MINOR, NOS
611	TURKEY
620	ASIA-ARAB COUNTRIES, NOS
620	IRAQ-SAUDI ARABIA NEUTRAL ZONE

621	SYRIA
623	LEBANON
625	JORDAN
625	PALESTINE ARAB
625	TRANS-JORDAN
627	IRAQ
629	ADEN
629	ARABIAN PENINSULA
629	ARABIA
629	BAHRAIN
629	KUWAIT
629	OMAN AND MUSCAT
629	PERSIAN GULF STATES, NOS
629	QATAR
629	QUATAR
629	SAUDI ARABIA
629	TRUCIAL STATES
629	UNITED ARAB EMIRATES
629	YEMEN
631	GAZA
631	ISRAEL
631	PALESTINE (PALESTINIAN NATIONAL AUTHORITY-PNA)
631	WEST BANK
633	ARMENIA
633	AZERBAIDZHAN SSR
633	AZERBAIJAN
633	CAUCASIAN REPUBLICS OF FORMER USSR
633	GEORGIA (USSR)

634	KAZAKHSTAN
634	KAZAKH SSR
634	KIRGHIZ SSR
634	KYRGYSTAN
634	OTHER ASIAN REPUBLICS OF FORMER USSR
634	TADZHIK SSR
634	TAJIKISTAN
634	TURKMEN SSR
634	TURMENISTAN
634	UZBECK SSR
634	UZBEKISTAN
637	IRAN
637	PERSIA
638	AFGHANISTAN
639	PAKISTAN NOS
639	PAKISTAN WEST
640	ASIA-MID-EAST, NOS
640	MALDIVES
641	ANDAMAN ISLANDS
641	INDIA
643	BHUTAN
643	NEPAL/BHUTAN/SIKKIM
643	SIKKIM
645	BANGLADESH
645	PAKISTAN EAST
647	CEYLON
647	SRI LANKA
649	BURMA

649	MYANMAR
650	ASIA-SOUTHEAST, NOS
651	SIAM
651	THAILAND
660	INDO-CHINA, NOS
661	LAOS
663	CAMBODIA
663	KAMPUCHEA
665	ANNAM
665	COCHIN CHINA
665	TONKIN
665	VIET NAM
665	VIETNAM
671	BRUNEI
671	MALAY PENINSULA
671	MALAYSIA/SINGAPORE/BRUNEI
671	SINGAPORE
673	BORNEO
673	DUTCH EAST INDIES
673	INDONESIA
673	JAVA
673	NEW GUINEA, NOS
673	SUMATRA
675	PHILIPPINES
680	ASIA-EAST, NOS
681	CHINA, NOS
682	CHINA, PEOPLE'S REPUBLIC
683	HONG KONG

684	CHINA, REPUBLIC OF
684	FORMOSA
684	REPUBLIC OF CHINA
684	TAIWAN
685	TIBET
686	MACAO
686	MACAU
691	MONGOLIA
693	JAPAN
693	OKINAWA
695	KOREA
695	NORTH KOREA
695	SOUTH KOREA
711	AUSTRALIA/AUST NEW GUINEA
711	CARTIER ISLANDS
711	COCOS ISLANDS
711	NEW GUINEA AUSTRALIAN
711	NEW GUINEA NORTHEAST
711	NEW GUINEA PAPUA
711	NORFOLK ISLANDS
711	PAPUA
715	NEW ZEALAND
715	NIUE
720	OCEANA, NOS
720	PACIFIC ISL, NOS
720	POLYNESIA, NOS
721	FIJI
721	FOTUNA

721	FUTUNA ISLANDS
721	MELANESIA (MELANESIA ISLANDS)
721	NEW HEBRIDES
721	SOLOMON ISLANDS
721	VANUATA
721	WALLIS ISLANDS
723	CHRISTMAS ISLAND
723	MICRONESIA (MICRONESIAN ISLANDS)
723	NAURU
725	NEW CALEDONIA
725	PITCAIRN
725	POLYNESIA (POLYNESIAN ISLANDS)
725	SAMOA, WESTERN
725	TONGA
725	WESTERN SAMOA
750	ANTARCTICA
998	NOT US NOS
999	UNKNOWN

APPENDIX E

RULES FOR DETERMINING RESIDENCY OF MILITARY PERSONNEL ASSIGNED TO SHIPS AND CREWS OF MERCHANT VESSELS

Cancer reporting facilities that serve patients in the U.S. Navy or Merchant Marine need detailed rules for determining whether their patients are residents of their region for purposes of cancer reporting. The rules for determining residency are the same as those used by the Census Bureau. The guidelines that follow were adapted from U.S. Department of Commerce publications.

Note: Also see Appendix B - Postal Code Abbreviations, for military personnel serving abroad.

NAVY PERSONNEL

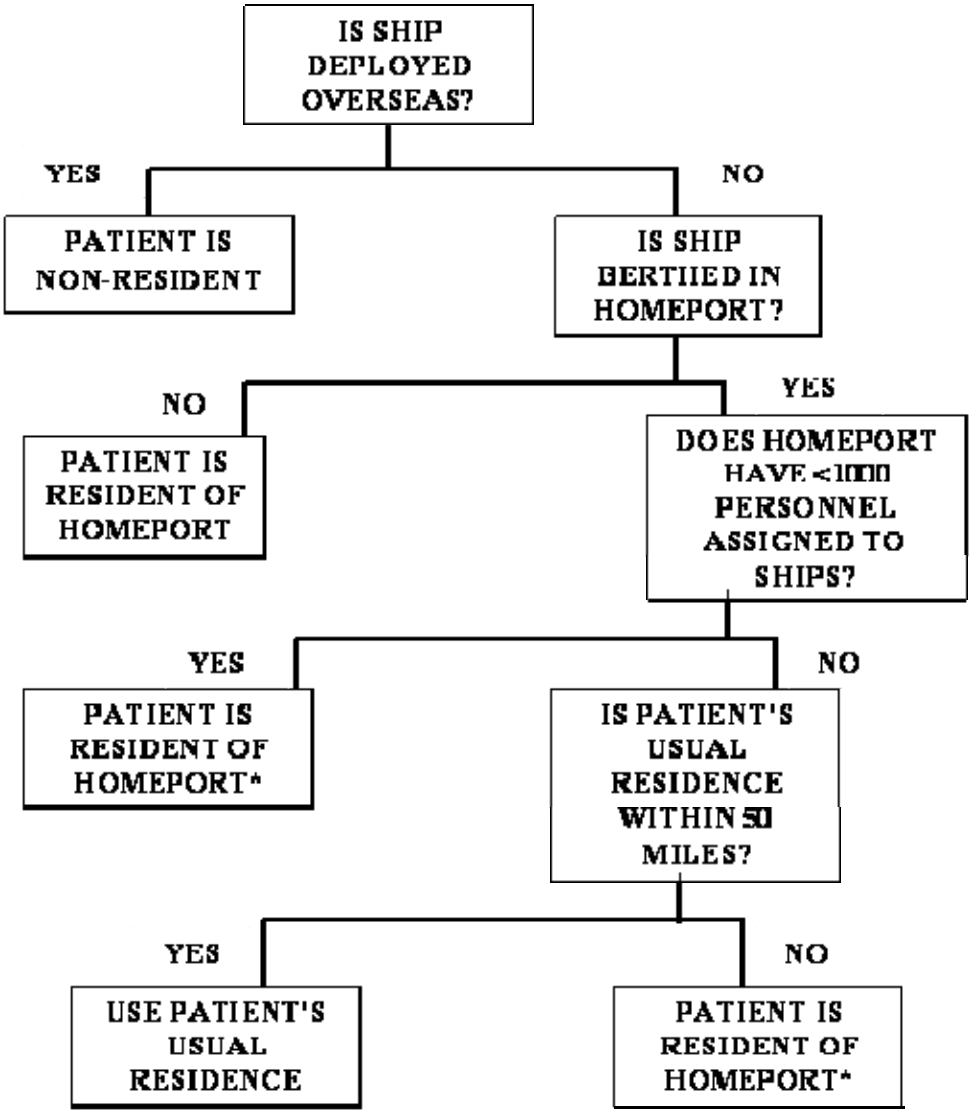
Patients diagnosed with cancer while their ships are deployed overseas are considered overseas residents for cancer-reporting purposes. For ships not deployed overseas, specific rules (shown in the chart below) apply. The Navy assigns a home port to each of its ships. If a ship that is not deployed overseas is not berthed in its home port, any crew member diagnosed with cancer is considered a resident of the home port. If the ship is berthed in its home port, and the home port has fewer than 1000 naval personnel assigned to ships, a crew member diagnosed with cancer is considered a resident of the ship. If, however, the home port has more than 1000 naval personnel assigned to ships and the cancer patient has a usual residence within 50 miles of the home port, the person's residence is the home, not the ship itself. If the patient's usual residence is more than 50 miles from the home port, he or she is considered to be a resident of the ship. For patients who are considered residents of a ship, code residence as the ship's home port unless the home port is contained in more than one municipality. In that case, code the patient's residence as the municipality immediately adjacent to the dock or pier where the ship is berthed.

CREWS OF MERCHANT VESSELS

Crews of U.S. vessels outside the U.S., or crews of vessels flying a foreign flag, are considered non-residents. If a U.S. vessel is not berthed in a U.S. port but is in territorial waters, and the port of destination is inside the U.S., a crew member diagnosed with cancer is considered a resident of the port of destination. If the destination is outside the U.S., the home port of the ship is considered the patient's residence. If a U.S. vessel is berthed in a U.S. port at the time of diagnosis, the patient is a resident of that port.

CHART

Summary of Rules for Determining Residency of Navy Personnel Assigned to Ships



* If home port is maintained in more than municipality, code patient as resident of the municipality immediately adjacent to the dock or pier where the ship is berthed.

CALIFORNIA HOSPITAL CODE NUMBERS

Appendix F1 and F2 have been deleted from Volume I. California Hospital lists by facility code or facility name are now posted on the CCR web site at the following links:

Code Numbers (Sorted by Code in Ascending Numeric Order) 5/20/09

http://www.ccrcal.org/PDF-DSQC/Vers-1.9.2.00-Code-Order.pdf

Code Numbers (Sorted by Facility in Ascending Alphabetic Order) 5/20/09

http://www.ccrcal.org/PDF-DSQC/Vers-1.9.2.00-Alpha-Order.pdf

APPENDIX G.1

CODES FOR RELIGIONS

(in numerical order) (Or see alphabetical order)

01	NONE
02	AGNOSTIC
03	ATHEIST
04	*NONE, AGNOSTIC, ATHEIST (OLD)
05	*ROMAN CATHOLIC
05	CATHOLIC
06	CHRISTIAN, NOS
06	PROTESTANT, NOS

PROTESTANT DENOMINATIONS:

07	*AFRICAN METHODIST EPISCOPAL (AME)
08	ANGLICAN
08	CHURCH OF ENGLAND
09	BAPTIST
10	COMMUNITY
11	CONGREGATIONAL
12	EPISCOPALIAN
13	LUTHERAN
14	METHODIST
15	PRESBYTERIAN
16	UNITARIAN

17	*PROTESTANT DENOMINATION, OTHER
18	CHRISTIAN REFORMED
19	DISCIPLES OF CHRIST
20	*DUTCH REFORMED
21	FIRST CHRISTIAN
22	INTERDENOMINATIONAL
23	MORAVIAN
24	NON-DENOMINATIONAL
25	SEAMAN'S CHURCH
26	TRINITY
27	UNIVERSAL
28	PROTESTANT, OTHER

ORTHODOX:

29	ARMENIAN ORTHODOX
29	ORTHODOX, ARMENIAN
30	*COPTIC
31	GREEK ORTHODOX
31	ORTHODOX, GREEK
32	ORTHODOX, RUSSIAN
32	RUSSIAN ORTHODOX
33	SERBIAN ORTHODOX
33	ORTHODOX, SERBIAN
34	*LEBANESE MARONITE
34	*MARONITE
34	*ORTHODOX, CHRISTIAN, OTHER
34	*ORTHODOX, CHRISTIAN, NOS

CHRISTIAN SECTS:

35 JEHOVAH'S WITNESSES
36 CHRISTIAN SCIENCE
37 MORMON
37 LATTER DAY SAINTS
38 SEVENTH-DAY ADVENTIST
39 FRIENDS
39 QUAKER

CHRISTIAN SECTS-OTHER:

40 AMISH
41 MENNONITES
42 APOSTOLIC
43 ARMENIAN APOSTOLIC
44 ASSEMBLIES OF GOD
45 BRETHREN
45 BROTHERS
46 CHRISTIAN APOSTOLIC
47 CHURCH OF ARMEDIAN
48 CHURCH OF CHRIST
49 CHURCH OF GOD
50 CHURCH OF MESSIANITY
51 CHURCH OF THE DIVINE
52 CHURCH OF THE OPEN DOOR
53 CONGREGATIONAL HOLY
53 HOLY CONGREGATIONAL
54 COVENANT
55 DIVINE SCIENCE

56	EVANGELICAL
57	FUNDAMENTAL
58	FOURSQUARE
59	FULL GOSPEL
60	HOLINESS
61	HOLY INNOCENTS
62	NAZARENE
63	NEW APOSTOLIC
64	PENTECOSTAL
65	RELIGIOUS SCIENCE
66	SALVATION ARMY
67	SCIENCE OF MIND
68	UNITY
69	*CHRISTIAN SECTS, OTHER
70	JEWISH
71	*ORTHODOX JEWISH
71	*JEWISH ORTHODOX

WESTERN OTHER:

72	BAHA'I
73	CRICKORIAN
73	ETHICAL CULTURE
73	GREGORIAN
73	LAWSONIAN
73	MASON
73	METAPHYSICS
73	OCCULT
73	PEACE OF MIND

73	PEOPLE'S
73	SELF-REALIZATION
73	SOCIETY OF LIFE
73	SPIRITUALIST
73	THEOSOPHY
73	TRUTH SEEKER
74	MOLIKAN
74	MOLOKAN
75	*WESTERN RELIGION OR CREED, OTHER
75	*WESTERN RELIGION OR CREED, NOS
76	KO

EASTERN RELIGIONS:

77	BUDDHIST
77	*ZEN
77	*ZEN BUDDHISM
78	DROUZE
79	*CONFUCIANISM
79	*TAOISM
80	*JAIN
81	*NATION OF ISLAM
82	MOSLEM
82	MUSLIM
82	MOHAMMEDAN
83	HINDU
84	ISLAM
85	*PARSEE
85	ZOROASTRIAN

86	SHINTO
87	*SIKH
88	VEDANTA
89	ORIENTAL PHILOSOPHY
89	*EASTERN REGLIGION, OTHER
89	*EASTERN RELIGION, NOS
90	*AMERICAN INDIAN RELIGIONS
90	*NATIVE AMERICAN TRADITIONAL RELIGIONS
91	*HAITIAN/AFRICAN/BRAZILIAN RELIGIONS, OTHER
91	*SANTORIA
91	*VOODOO
92	*SHAMANISM
93	*OTHER TRADITIONAL OR NATIVE RELIGION
94	***Scientology***
98	*OTHER
99	UNSPECIFIED, UNKNOWN

APPENDIX G.1

CODES FOR RELIGIONS

(in numerical order) (Or see alphabetical order)

01	NONE
02	AGNOSTIC
03	ATHEIST
04	*NONE, AGNOSTIC, ATHEIST (OLD)
05	*ROMAN CATHOLIC
05	CATHOLIC
06	CHRISTIAN, NOS
06	PROTESTANT, NOS

PROTESTANT DENOMINATIONS:

07	*AFRICAN METHODIST EPISCOPAL (AME)
08	ANGLICAN
08	CHURCH OF ENGLAND
09	BAPTIST
10	COMMUNITY
11	CONGREGATIONAL
12	EPISCOPALIAN
13	LUTHERAN
14	METHODIST
15	PRESBYTERIAN
16	UNITARIAN

17	*PROTESTANT DENOMINATION, OTHER
18	CHRISTIAN REFORMED
19	DISCIPLES OF CHRIST
20	*DUTCH REFORMED
21	FIRST CHRISTIAN
22	INTERDENOMINATIONAL
23	MORAVIAN
24	NON-DENOMINATIONAL
25	SEAMAN'S CHURCH
26	TRINITY
27	UNIVERSAL
28	PROTESTANT, OTHER

ORTHODOX:

29	ARMENIAN ORTHODOX
29	ORTHODOX, ARMENIAN
30	*COPTIC
31	GREEK ORTHODOX
31	ORTHODOX, GREEK
32	ORTHODOX, RUSSIAN
32	RUSSIAN ORTHODOX
33	SERBIAN ORTHODOX
33	ORTHODOX, SERBIAN
34	*LEBANESE MARONITE
34	*MARONITE
34	*ORTHODOX, CHRISTIAN, OTHER
34	*ORTHODOX, CHRISTIAN, NOS

CHRISTIAN SECTS:

35	JEHOVAH'S WITNESSES
36	CHRISTIAN SCIENCE
37	MORMON
37	LATTER DAY SAINTS
38	SEVENTH-DAY ADVENTIST
39	FRIENDS
39	QUAKER

CHRISTIAN SECTS-OTHER:

40	AMISH
41	MENNONITES
42	APOSTOLIC
43	ARMENIAN APOSTOLIC
44	ASSEMBLIES OF GOD
45	BRETHREN
45	BROTHERS
46	CHRISTIAN APOSTOLIC
47	CHURCH OF ARMEDIAN
48	CHURCH OF CHRIST
49	CHURCH OF GOD
50	CHURCH OF MESSIANITY
51	CHURCH OF THE DIVINE
52	CHURCH OF THE OPEN DOOR
53	CONGREGATIONAL HOLY
53	HOLY CONGREGATIONAL
54	COVENANT
55	DIVINE SCIENCE

56	EVANGELICAL
57	FUNDAMENTAL
58	FOURSQUARE
59	FULL GOSPEL
60	HOLINESS
61	HOLY INNOCENTS
62	NAZARENE
63	NEW APOSTOLIC
64	PENTECOSTAL
65	RELIGIOUS SCIENCE
66	SALVATION ARMY
67	SCIENCE OF MIND
68	UNITY
69	*CHRISTIAN SECTS, OTHER
70	JEWISH
71	*ORTHODOX JEWISH
71	*JEWISH ORTHODOX

WESTERN OTHER:

72	BAHA'I
73	CRICKORIAN
73	ETHICAL CULTURE
73	GREGORIAN
73	LAWSONIAN
73	MASON
73	METAPHYSICS
73	OCCULT
73	PEACE OF MIND

73	PEOPLE'S
73	SELF-REALIZATION
73	SOCIETY OF LIFE
73	SPIRITUALIST
73	THEOSOPHY
73	TRUTH SEEKER
74	MOLIKAN
74	MOLOKAN
75	*WESTERN RELIGION OR CREED, OTHER
75	*WESTERN RELIGION OR CREED, NOS
76	KO

EASTERN RELIGIONS:

77	BUDDHIST
77	*ZEN
77	*ZEN BUDDHISM
78	DROUZE
79	*CONFUCIANISM
79	*TAOISM
80	*JAIN
81	*NATION OF ISLAM
82	MOSLEM
82	MUSLIM
82	MOHAMMEDAN
83	HINDU
84	ISLAM
85	*PARSEE
85	ZOROASTRIAN

86	SHINTO
87	*SIKH
88	VEDANTA
89	ORIENTAL PHILOSOPHY
89	*EASTERN REGLIGION, OTHER
89	*EASTERN RELIGION, NOS
90	*AMERICAN INDIAN RELIGIONS
90	*NATIVE AMERICAN TRADITIONAL RELIGIONS
91	*HAITIAN/AFRICAN/BRAZILIAN RELIGIONS, OTHER
91	*SANTORIA
91	*VOODOO
92	*SHAMANISM
93	*OTHER TRADITIONAL OR NATIVE RELIGION
94	***Scientology***
98	*OTHER
99	UNSPECIFIED, UNKNOWN

*NEW OR REVISED LABEL

APPENDIX J

PATIENT INFORMATION SHEET

CCR suggests the following statement be used by hospitals and physicians in notifying their patients that cancer and other specific benign and borderline tumors are reportable entities:

CALIFORNIA CANCER REPORTING SYSTEM

PATIENT INFORMATION SHEET

California Department of Health Services (CDHS) is mandated under state law (Health and Safety Code, Section 103885) to gather information on the amount and type of cancer occurring throughout the state. Beginning January 1, 2001 and forward, diagnoses of borderline and benign primary intracranial and central nervous system (CNS) tumors are also reportable, as well as borderline ovarian cancer and Newly Reportable Hematopoietic Diseases (NRHD) listed below. The purpose of the law is to help identify preventable causes of cancer and specific borderline and benign tumors.

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

The information collected is confidential under California Health and Safety Code Sections 100330 and 103885, Civil Code, Sections 56.05 and 1798, Government Code, Sections 6250-62-65, and Federal Law PL 104-191. CDHS has more than 50 years' experience in handling confidential records. Laws, regulations and programmatic safeguards are in place throughout the system to assure that the identities of patients are not revealed. Some cancer patients may, however, be contacted later by CDHS or the regional cancer registries as part of their ongoing investigations into the causes of cancer.

NRHD include the following :

Chronic Myeloproliferative Diseases

- Polycythemia vera
- Chronic myeloproliferative disease
- Myelosclerosis with myeloid metaplasia
- Essential thrombocythemia
- Chronic neutrophilic leukemia

- Hypereosinophilic syndrome

Myelodysplastic Syndromes

- Refractory anemia
- Refractory anemia with sideroblasts
- Refractory anemia with excess blasts
- Refractory anemia with excess blasts
- in Transformation
- Refractory cytopenia with multilineage

Dysplasia

- Myelodysplastic syndrome with 5q-syndrome
- Therapy-related myelodysplastic syndrome
- Other New Diagnoses
- Langerhans cell histiocytosis, disseminated
- Acute biphenotypic leukemia
- Precursor lymphoblastic leukemia
- Aggressive NK cell leukemia
- Chronic neutrophilic leukemia
- Hypereosinophilic syndrome
- Leukemias with cytogenetic abnormalities
- Dendritic cell sarcoma.

APPENDIX K-1 Codes for Casefinding (Prior to 2007)

Screening List of OF ICD-9-CM Codes for Casefinding

Certain ICD-9-CM* codes used by medical records departments for discharge diagnoses identify cases of malignant neoplasms that are reportable to the California Cancer Registry. Case finding procedures must include the review of medical records coded with the following numbers. Newly reportable diseases are followed by the ICD-O-3 morphology and behavior code in parentheses.

See Appendix K.2 for Codes between January 1, 2007 and September 30, 2008.

See Appendix K.3 for Codes for October 1, 2008 and later.

For Casefinding prior to January 1, 2007, use the following screening list:

ICD-9-CM* CODE	
042	AIDS (review cases for AIDS-related malignancies)
140.0-208.9	Malignant neoplasms (primary and secondary)
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
225.0-227.4	Benign central nervous system neoplasms
230.0–234.9	Carcinoma in situ (exclude skin codes 232.0-232.9, and cervix code 233.1)
235.0–238.9	Neoplasms of uncertain behavior
236.2	Ovarian neoplasms of uncertain behavior (8442/1, 8451/1, 8462/1, 8472/1, 8473/1)
237.0–237.9	Central nervous system neoplasms of uncertain behavior
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.7	Chronic myeloproliferative disease (9960/3)
238.7	Myelosclerosis with myeloid metaplasia (9961/3)
238.7	Essential thrombocythemia (9962/3)
238.7	Refractory cytopenia with multilineage dysplasia (9985/3)
238.7	Myelodysplastic syndrome with 5q-syndrome (9986/3)
238.7	Therapy-related myelodysplastic syndrome (9987/3)
239.0–239.9	Neoplasms of unspecified nature
273.2	Gamma heavy chain disease Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
284.9	Refractory anemia (9980/3)

285.0	Refractory anemia with ringed sideroblasts (9982/3)
285.0	Refractory anemia with excess blasts (9983/3)
285.0	Refractory anemia with excess blasts in transformation (9984/3)
288.3	Hypereosinophilic syndrome (9964/3)
289.8	Acute myelofibrosis (9932/3)
V07.3	Other prophylactic chemotherapy
V07.8	Other specified prophylactic measures
V10.0-V10.9	Personal history of malignant neoplasms
V58.0	Radiotherapy session
V58.1	Maintenance chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Follow-up exam following radiotherapy
V67.2	Follow-up exam following chemotherapy
V71.1	Observation for suspected malignant neoplasm
V76.0–V76.9	Special screening for malignant neoplasms

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

APPENDIX K-2 Codes for Casefinding (Prior to 2007)

Screening List of OF ICD-9-CM Codes for Casefinding

Certain ICD-9-CM* codes used by medical records departments for discharge diagnoses identify cases of malignant neoplasms that are reportable to the California Cancer Registry. Case finding procedures must include the review of medical records coded with the following numbers. Newly reportable diseases are followed by the ICD-O-3 morphology and behavior code in parentheses.

See Appendix K.1 for Codes prior to January 1, 2007.

See Appendix K.3 for Codes for October 1, 2008 and later.

For Casefinding between January 1, 2007 to September 30, 2008, use the following screening list:

ICD-9-CM* CODE	
042	AIDS (review cases for AIDS-related malignancies)
140.0-208.9	Malignant neoplasms (primary and secondary)
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
225.0-227.4	Benign central nervous system neoplasms
230.0–234.9	Carcinoma in situ (exclude skin codes 232.0-232.9, and cervix code 233.1)
235.0–238.9	Neoplasms of uncertain behavior
236.2	Ovarian neoplasms of uncertain behavior (8442/1, 8451/1, 8462/1, 8472/1, 8473/1)
237.0–237.9	Central nervous system neoplasms of uncertain behavior
238.4	Polycythemia vera (9950/3)

238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.71	Essential thrombocythemia (was 238.7; 9962/3) Essential (hemorrhagic) thrombocythemia Essential thrombocytosis Idiopathic (hemorrhagic) thrombocythemia Primary thrombocytosis
238.72	Low grade myelodysplastic syndrome lesions Refractory anemia (was 284.9; 9980/3) Refractory anemia with ringed sideroblasts (RARS) (was 285.0; 9982/3) Refractory cytopenia with multilineage dysplasia (RCMD) (was 238.7; 9985/3) Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) was 238.7; 9985/3)
238.73	High grade myelodysplastic syndrome lesions Refractory anemia with excess blasts-1 (RAEB-1) (was 285.0; 9983/3) Refractory anemia with excess blasts-2 (RAEB-2) (was 285.0; 9983/3)
238.74	Myelodysplastic syndrome with 5q deletion (was 238.7; 9986/3) 5q minus syndrome NOS Excludes: constitutional 5q deletion (758.39) (not reportable) high grade myelodysplastic syndrome with 5q deletion (238.73)
238.75	Myelodysplastic syndrome, unspecified (was 238.7; 9985/3, 9989/3)
238.76	Myelosclerosis with myeloid metaplasia (9961/3) Agnogenic myeloid metaplasia Idiopathic myelofibrosis (chronic) Myelosclerosis with myeloid metaplasia Primary myelofibrosis Excludes: myelofibrosis NOS (289.83) myelophthisic anemia (284.2) (not reportable)

	myelophthisis (284.2) (not reportable) secondary myelofibrosis (289.83)
238.79	Other lymphatic and hematopoietic tissues Lymphoproliferative disease (chronic) NOS (was 238.7; 9970/1) Megakaryocytic myelosclerosis (was 238.7; 9961/3) Myeloproliferative disease (chronic) NOS (was 238.7; 9960/3) Panmyelosis (acute) (was 238.7; 9931/3)
239.0–239.9	Neoplasms of unspecified nature
273.2	Gamma heavy chain disease Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
288.3	Hypereosinophilic syndrome (9964/3)
289.83	Myelofibrosis (9932/3) Myelofibrosis, NOS Secondary myelofibrosis Code first underlying disorder, such as: malignant neoplasm of breast (174.0-174.9, 175.0-175.9) Excludes: Idiopathic myelofibrosis (238.76) leukoerythroblastic anemia (238.2) (not reportable) myelofibrosis with myeloid metaplasia (238.76) myelophthisic anemia (284.2) (not reportable)

	myelophthisis (284.2) (not reportable) primary myelofibrosis (238.76)
289.89	Other specified diseases of blood and blood-forming organs
V07.3	Other prophylactic chemotherapy
V07.8	Other specified prophylactic measures
V10.0- V10.9	Personal history of malignant neoplasms
V58.0	Radiotherapy session
V58.1	Maintenance chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Follow-up exam following radiotherapy
V67.2	Follow-up exam following chemotherapy
V71.1	Observation for suspected malignant neoplasm
V76.0– V76.9	Special screening for malignant neoplasms
V86	Estrogen receptor status

Please Note:

- Code 042 is not a combination code of AIDS with specified malignancies.
- Prostatic Intraepithelial Neoplasia (PIN III), morphology code 8148/2 is not reportable to the CCR.
- Pilocytic/juvenile astrocytoma, morphology code 9421, is reportable as a /3 behavior code and is assigned a regular tumor sequence number per SEER requirements, effective with cases diagnosed 1/1/2001 and forward.
- Ovarian borderline cystadenomas, morphology codes 8442/1, 8451/1, 8462/1, 8472/1 and 8473/1, which changed behavior codes from /3 to /1 will continue to be reportable to the CCR. These tumors are to be sequenced following the American College of Surgeons guideline for benign tumors.

APPENDIX K-3 Codes for Casefinding (For Cases Diagnosed January 1, 2009 and Later)

Screening List of OF ICD-9-CM Codes for Casefinding

Certain ICD-9-CM* codes used by medical records departments for discharge diagnoses identify cases of malignant neoplasms that are reportable to the California Cancer Registry. Case finding procedures must include the review of medical records coded with the following numbers. Newly reportable diseases are followed by the ICD-O-3 morphology and behavior code in parentheses.

See Appendix K.1 for Casefinding Codes for Cases Diagnosed prior to January 1, 2007.

See Appendix K.2 for Casefinding Codes for Cases Diagnosed between Jan 1, 2007 and December 31, 2008.

The following information is taken directly from the SEER web site:

Fiscal Year 2009 Casefinding List

The Fiscal Year 2009 Comprehensive ICD-9-CM Casefinding and Supplementary ICD-9-CM Code Lists are to be used to identify cases diagnosed January 1, 2009 and later. The revised tables include new and expanded ICD-9-CM codes. The revised tables also now include paraneoplastic syndromes indicated by * in Explanation of Code.

The 2009 Comprehensive ICD-9-CM Casefinding Code List is designed to assist in casefinding activities that are performed to identify reportable neoplasms, including benign brain and CNS tumors which became reportable in 2004, among a variety of casefinding sources that use ICD-9-CM* codes (modified October 2008) to characterize a diagnosis.

For Cases Diagnosed January 1, 2009 and later, use the following screening list for casefinding:

Comprehensive ICD-9-CM Casefinding Code List for Reportable Tumors (Effective Date: 1/1/2009 forward)

ICD-9-CM Code^	Explanation of Code
140.0 – 208.9	Malignant Neoplasms
209.0 – 209.3	Neuroendocrine tumors (Effective date: 1/1/09)
225.0 – 225.9	Benign neoplasm of brain and spinal cord neoplasm

227.3 – 227.4	Benign neoplasm of pituitary gland, pineal body, and other intracranial endocrine-related structures
227.9	Benign neoplasm; endocrine gland, site unspecified
228.02	Hemangioma; of intracranial structures
228.1	Lymphangioma, any site
230.0 – 234.9	Carcinoma in situ
236.0	Endometrial stroma, low grade (8931/1)
237.0 – 237.9	Neoplasm of uncertain behavior [borderline] of endocrine glands and nervous system
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)Extramedullary plasmacytoma (9734/3)
238.7	Other lymphatic and hematopoietic tissues (This code was discontinued as of 10/2006 but should be included in extract programs for quality control purposes)
238.71	Essential thrombocythemia (9962/3)
238.72	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9985/3)
238.73	High grade myelodysplastic syndrome lesions (includes 9983/3)
238.74	Myelodysplastic syndrome with 5q deletion (9986/3)
238.75	Myelodysplastic syndrome, unspecified (9985/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3)
238.77	Post transplant lymphoproliferative disorder (9987/3)
238.79	Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3)
239.6	Neoplasms of unspecified nature, brain
239.7	Neoplasms of unspecified nature; endocrine glands and other parts of nervous system
259.2	Carcinoid Syndrome
259.8	Other specified endocrine disorders
273.2	Gamma heavy chain disease (9762/3); Franklin's disease (9762/3)
273.3	Waldenstrom macroglobulinemia (9761/3)
285.22	Anemia in neoplastic disease
288.3	Hypereosinophilic syndrome (9964/3)
289.83	Myelofibrosis (NOS) (9961/3)

289.89	Other specified diseases of blood and blood-forming
511.81	Malignant pleural effusion (code first malignant neoplasm if known)
789.51	Malignant ascites (code first malignant neoplasm if known)
795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy
795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy
795.76	Papanicolaou smear of anus with cytologic evidence of malignancy
V10.0 – V10.9	Personal history of malignancy (screen for recurrences, subsequent primaries, and/or subsequent treatment)

Many new codes and conditions have been added to the Supplementary ICD-9-CM Code List. It is recommended that each registry screen cases using the supplementary list as time permits. Experience among the SEER registries has proven that using the supplementary list significantly improves casefinding outcomes for benign brain and CNS tumors, hematopoietic and lymphoid neoplasms, and other reportable diseases.

NOTE: Cases with these codes should be screened only as registry time allows. Some codes represent neoplasm-related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm. Complete casefinding would include investigation of patient records with diagnoses represented on either list.

Supplementary ICD-9-CM Code List to Screen for Cancer Cases Not Identified by Other Codes (Effective Date: 1/1/09)

ICD-9-CM Code^	Explanation of Code
042	Acquired Immunodeficiency Syndrome (AIDS) (This is not a malignancy. Medical coders are instructed to add codes for AIDS-associated malignancies. Screen 042 for history of cancers that might not be coded.)
079.4	Human papillomavirus
079.50 – 079.59	Retrovirus (HTLV, types I, II and 2)
210.0 – 229.9	Benign neoplasms (screen for incorrectly coded malignancies or reportable by agreement tumors)
235.0 – 236.6	Neoplasms of uncertain behavior (screen for incorrectly coded malignancies or reportable by agreement tumors)

238.0 – 239.9	Neoplasms of uncertain behavior (screen for incorrectly coded malignancies or reportable by agreement tumors)
253.6	Syndrome of inappropriate secretion of antidiuretic hormone*
258.02 – 258.03	Multiple endocrine neoplasia (MEN) type IIA and IIB (rare familial cancer syndrome)
273.0	Polyclonal hypergammaglobulinemia (Waldenstrom) review for miscodes
273.1	Monoclonal gammopathy of undetermined significance (9765/1) (screen for incorrectly coded Waldenstrom macroglobulinemia or progression)
273.9	Unspecified disorder of plasma protein metabolism (screen for incorrectly coded Waldenstrom's macroglobulinemia)
275.42	Hypercalcemia*
279.00	Hypogammaglobulinemia (predisposed to lymphoma or stomach cancer)
279.02 – 279.06	Selective IgM immunodeficiency (associated with lymphoproliferative disorders)
279.10	Immunodeficiency with predominant T-cell defect, NOS
279.12	Wiskott-Aldrich Syndrome
279.13	Nezelof's Syndrome
279.2 – 279.9	Combined immunity deficiency – Unspecified disorder of immune mechanism
284.81	Red cell aplasia (acquired, adult, with thymoma)
284.89	Other specified aplastic anemias due to drugs (chemotherapy or immunotherapy), infection, radiation
288.03	Drug induced neutropenia
323.81	Encephalomyelitis; specified cause NEC*
338.3	Neoplasm related pain (acute, chronic); Cancer associated pain; Pain due to malignancy (primary/secondary); Tumor associated pain
379.59	Opsoclonia*
528.01	Mucositis due to antineoplastic therapy

686.01	Pyoderma gangrenosum*
695.89	Sweet's syndrome*
701.2	Acanthosis nigricans*
710.3	Dermatomyositis*
710.4	Polymyositis*
790.93	Elevated prostate specific antigen [PSA]
795.8	Abnormal tumor markers; Elevated tumor associated antigens [TAA]; Elevated tumor specific antigens [TSA]; Excludes: elevated prostate specific antigen [PSA] (790.93)
795.81	Elevated carcinoembryonic antigen [CEA]
795.82	Elevated cancer antigen 125 [CA 125]
795.89	Other abnormal tumor markers
999.31	Infection due to central venous catheter (porta-cath) (Effective Date: 1/1/2009)
999.81	Extravasation of vesicant chemotherapy (Effective Date: 1/1/2009)
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E933.1	Adverse effect of immunosuppressive drugs
V07.3	Other prophylactic chemotherapy (screen for incorrectly coded malignancies)
V07.8	Other specified prophylactic measure
V15.3	Irradiation: previous exposure to therapeutic or ionizing radiation
V42.81	Organ or tissue replaced by transplant, Bone marrow transplant
V42.82	Transplant; Peripheral stem cells
V51.0	Encounter for breast reconstruction following mastectomy (Effective Date: 1/1/2009)
V52.4	Breast prosthesis and implant (Effective Date: 1/1/2009)

V58.0	Encounter for radiation therapy
V58.1	Encounter for antineoplastic chemotherapy and immunotherapy (This code was discontinued as of 10/2006 but should be included in extract programs for quality control purposes)
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy
V58.42	Aftercare following surgery for neoplasm
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow up
V67.2	Chemotherapy follow up
V76.0 – V76.9	Special screening for malignant neoplasm
V78.0 – V78.9	Special screening for disorders of blood and blood-forming organs
V82.71	Screening for genetic disease carrier status
V82.79	Other genetic screening
V82.89	Genetic screening for other specified conditions
V82.9	Genetic screening for unspecified condition
V84.01 – V84.09	Genetic susceptibility to malignant neoplasm
V86.0	Estrogen receptor positive status [ER+]
V86.1	Estrogen receptor negative status [ER-]
V87.41	Personal history of antineoplastic chemotherapy

NOTES:

Prostatic Intraepithelial Neoplasia (PIN III) M-8148/2 will NOT be collected by SEER registries.

Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will

CONTINUE to report these cases and code behavior a /3 (malignant). Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER registries.

The World Health Organization (WHO) diagnosis "B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma" is coded as 9823/3, and cross-referenced to 9670/3, malignant lymphoma, small B lymphocytic, NOS. If this WHO term is used to describe malignancy in blood or bone marrow, code 9823/3; if the term is used to describe malignance in tissue, lymph nodes or any organ in combination with blood or bone marrow, code 9670/3.

^ *International Classification of Diseases, Ninth Revision, Clinical Modification, 2009.*

APPENDIX L.1

CODES FOR CALIFORNIA COUNTIES

(in alphabetical order)

(Or see numerical order)

Name	US FIPS Code	California County Code	Name	*US FIPS Code*	California County Code
ALAMEDA	001	001	ORANGE	059	030
ALPINE	003	002	PLACER	061	031
AMADOR	005	003	PLUMAS	063	032
BUTTE	007	004	RIVERSIDE	065	033
CALAVERAS	009	005	SACRAMENTO	067	034
CALIFORNIA NOS	998	000	SAN BENITO	069	035
COLUSA	011	006	SAN BERNARDINO	071	036
CONTRA COSTA	013	007	SAN DIEGO	073	037
DEL NORTE	015	008	SAN FRANCISCO	075	038
EL DORADO	017	009	SAN JOAQUIN	077	039
FRESNO	019	010	SAN LUIS OBISPO	079	040
GLENN	021	011	SAN MATEO	081	041
HUMBOLDT	023	012	SANTA BARBARA	083	042
IMPERIAL	025	013	SANTA CLARA	085	043
INYO	027	014	SANTA CRUZ	087	044
KERN	029	015	SHASTA	089	045
KINGS	031	016	SIERRA	091	046

LAKE	033	017	SISKIYOU	093	047
LASSEN	035	018	SOLANO	095	048
LOS ANGELES	037	019	SONOMA	097	049
MADERA	039	020	STANISLAUS	099	050
MARIN	041	021	SUTTER	101	051
MARIPOSA	043	022	TEHAMA	103	052
MENDOCINO	045	023	TRINITY	105	053
MERCED	047	024	TULARE	107	054
MODOC	049	025	TUOLUMNE	109	055
MONO	051	026	US NOT CALIF	998	000
MONTEREY	053	027	VENTURA	111	056
NAPA	055	028	YOLO	113	057
NEVADA	057	029	YUBA	115	058

APPENDIX L.2

CODES FOR CALIFORNIA COUNTIES

(in numerical order) (Or see alphabetical order)

US FIPS Code	California County Code	Name	*US FIPS Code*	California County Code	Name
998	000	CALIFORNIA NOS	***057***	029	NEVADA
998	000	US NOT CALIF	***059***	030	ORANGE
001	001	ALAMEDA	***061***	031	PLACER
003	002	ALPINE	***063***	032	PLUMAS
005	003	AMADOR	***065***	033	RIVERSIDE
007	004	BUTTE	***067***	034	SACRAMENTO
009	005	CALAVERAS	***069***	035	SAN BENITO
011	006	COLUSA	***071***	036	SAN BERNARDINO
013	007	CONTRA COSTA	***073***	037	SAN DIEGO
015	008	DEL NORTE	***075***	038	SAN FRANCISCO
017	009	EL DORADO	***077***	039	SAN JOAQUIN
019	010	FRESNO	***079***	040	SAN LUIS OBISPO
021	011	GLENN	***081***	041	SAN MATEO
023	012	HUMBOLDT	***083***	042	SANTA BARBARA
025	013	IMPERIAL	***085***	043	SANTA CLARA
027	014	INYO	***087***	044	SANTA CRUZ
029	015	KERN	***089***	045	SHASTA
031	016	KINGS	***091***	046	SIERRA
033	017	LAKE	***093***	047	SISKIYOU

035	018	LASSEN	***095***	048	SOLANO
037	019	LOS ANGELES	***097***	049	SONOMA
039	020	MADERA	***099***	050	STANISLAUS
041	021	MARIN	***101***	051	SUTTER
043	022	MARIPOSA	***103***	052	TEHAMA
045	023	MENDOCINO	***105***	053	TRINITY
047	024	MERCED	***107***	054	TULARE
049	025	MODOC	***109***	055	TUOLUMNE
051	026	MONO	***111***	056	VENTURA
053	027	MONTEREY	***113***	057	YOLO
055	028	NAPA	***115***	058	YUBA

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 Rx. 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
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
Dermatology	DERM
Diagnosis	DX
Diameter	DIAM
Differentiated	DIFF
Dilatation and Curettage	D&C
Discharge	DIS, DISCH, DS
Discontinued	DC
Disease	DZ, DIS
Doctor	PMD
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 >)
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
Lymph Node(s)	LN, LN'S, LNS
Lymphadenopathy	LAD/LAN
Lymphadenopathy-Associated Virus	LAV
Magnetic Resonance Imaging	MRI
Malignant	MALIG, MAL
Mandible	MAND
Mastectomy	MAST
Maxilla(ry)	MAX
Maximum	MAX
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
No Significant Findings	NSF
Normal	NL
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 Medical Doctor	DR, MD
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
Sentinel Lymph Node	SLN
Sequential Multiple Analysis (Biochem Profile)	SMA
Serum Glutamic Oxaloacetic Transaminase	SGOT
Serum Glutamic Pyruvic	SGPT
Shortness of Breath	SOB
Skilled Nursing Facility	SNF
Small	SM, SML
Small Bowel	SB, SML BWL
Specimen	SPEC
Spine	
Cervical	C-SPINE
Lumbar	L-SPINE
Sacral	S-SPINE
Thoracic	T-SPINE
Split Thickness Skin Graft	STSG
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 Bladder (Tumor)	TURB(T)
Transurethral Resection	TUR
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
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)

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 Rx. Other accepted abbreviations are:

A&P	Auscultation & Percussion
A-COLON	Ascending Colon
ABD	Abdomen
ACID PHOS	Acid Phosphatase
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
APPROX	Approximately
APP	Appendix
AP	Abdominal Perineal
AP	Anteroposterior
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	Bowel Movement
BM	Bone Marrow
BPH	Benign Prostatic Hypertrophy/Hyperplasia
BRB(PR)	Bright Red Blood (per Rectum)
BRM	Biological Response Modifier
BS, BRS	Breath Sounds
BSC	Bone Scan
BSO	Bilateral Salpingo-oophorectomy
BS	Bowel Sounds
BUN	Blood Urea Nitrogen
BUS	Bartholin's, Urethral, & Skene's Glands
BX	Biopsy
C-SPINE	Cervical Spine
C/O	Complaining of
C/W	Consistent with
C1-C7	Cervical Vertebra
CA	Carcinoma
CA	Calcium
CBC	Complete Blood Count
CBD	Common Bile Duct
CC	Cubic Centimeter
CC	Chief Complaint
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
CML	Chronic Myeloid Leukemia

CMV	Cytomegalovirus
CM	Costal Margin
CM	Centimeter
CNS	Central Nervous System
CONT	Continue
CSF	Cerebrospinal Fluid
CS	Cesium
CT, CT SC	Computerized Axial Tomography Scan, CAT Scan
CXR	Chest Xray
CX	Cervix
CYSTO	Cystoscopy
CYTO	Cytology
C	With
D&C	Dilatation and Curettage
D-COLON	Descending Colon
DCIS	Ductal Carcinoma In Situ
DC	Discontinued
DECR (or <)	Decreased
DERM	Dermatology
DIAM	Diameter
DIFF	Differentiated
DIN	Ductal Intraepithelial Neoplasia
DIS, DISCH	Discharge
DIS	Disease
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(A)	Estrogen Receptor (Assay)
ERCP	Endoscopic Retrograde Cholangiopancreatography

ER	Emergency Room
ETOH	Alcohol
EUA	Examination under Anesthesia
EVAL	Evaluation
EXAM	Examination
EXC	Excision
EXP LAP	Exploratory Laparotomy
EXT	Extension
EXT	Extremity
EXT	External
EXT	Extend
F(M)H	Family (Medical) History
FB	Fingerbreadth
FOM	Floor of Mouth
FS	Frozen Section
FUO	Fever Unknown Origin
FU	Follow-up
FX	Fracture
GB	Gallbladder
GE	Gastroenterostomy
GE	Gastroesophageal
GI	Gastrointestinal
GM	Gram
GR	Grade
GU	Genitourinary
GYN	Gynecology
H&P	History and Physical
HCG	Human Chorionic Gonadotropin
HCT	Hematocrit
HEENT	Head, Eyes, Ears, Nose, Throat
HGB	Hemoglobin
HIV	Human Immunodeficiency Virus
HORM	Hormone
HOSP	Hospital
HO	History of
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
ICM	Intercostal Margin
IG	Immunoglobulin
IMA	Internal Mammary Artery
IMP	Impression
INCL	Includes, Including
INCR (or >)	Increase
INFILT	Infiltrating
IP	Inpatient
IT	Intrathecal
IVC	Inferior Vena Cava
IVP	Intravenous Pyelogram
IV	Intravenous
I	Iodine
JVD	Jugular Venous Distention
KG	Kilogram
KUB	Kidneys, Ureters, Bladder
KV	Kilovolt
L-SPINE	Lumbar Spine
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
LSO	Left Salpingo-oophorectomy
LS	Lumbosacral
LT	Left
LUE	Left Upper Extremity
LUL	Left Upper Lobe
LUQ	Left Upper Quadrant
L	Liter
L	Left
MAL, MALIG	Malignant
MAND	Mandible
MAST	Mastectomy
MAX	Maxilla(ry)
MAX	Maximum
MC(H)	Millicurie(hours)
MCL	Midclavicular Line
MD	Moderately Differentiated
MD	Medical Doctor
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 DIFF	Moderately Differentiated
MOD	Moderate
MRI	Magnetic Resonance Imaging
MRM	Modified Radical Mastectomy
N&V	Nausea and Vomiting
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
NVD	Neck Vein Distention
OBST	Obstructed (-ing, -ion)
OP REPORT	Operative Report
OP	Outpatient
OP	Operation
OR	Operating Room
OZ	Ounce
P&A	Percussion and Auscultation
PALP	Palpated (-able)
PAP	Papanicolaou Smear
PAP	Papillary
PATH	Pathology
PA	Pulmonary Artery
PA	Posteroanterior
PD	Poorly Differentiated
PERC	Percutaneous
PET	Positron Emission Tomography
PE	Physical Examination
PID	Pelvic Inflammatory Disease
PIN	Prostatic Intraepithelial Neoplasia
PI	Present Illness
PLT	Platelets
PMD	Personal (Primary) Medical Doctor
PMH	Past Medical History
POD	Postoperative Day
POOR DIFF	Poorly Differentiated
POS (or +)	Positive
POSS	Possible
POSTOP	Postoperative (-ly)
POST	Postmortem Examination
POST	Posterior
PO	Postoperative (-ly)
PPD	Packs per Day
PR(A)	Progesterone Receptor (Assay)
PREOP	Preoperative (-ly)
PROB	Probable (-ly)
PTA	Prior to Admission
PT	Patient

PULM	Pulmonary
RAD	Radiation Absorbed Dose
RAD	Radiation
RAD	Radical
RA	Radium
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
R	Right
S-COLON	Sigmoid Colon
S-SPINE	Sacral Spine
S/P	Status Post
S1-S5	Sacral Vertebra
SB	Small Bowel
SCC	Squamous Cell Carcinoma
SGOT	Serum Glutamic Oxaloacetic Transaminase
SGPT	Serum Glutamic Pyruvic Transaminase
SIL	Squamous Intraepithelial Lesion
SLN	Sentinel Lymph Node
SMA	Sequential Multiple Analysis (Biochem Profile)
SML BWL	Small Bowel
SML	Small

SM	Small
SNF	Skilled Nursing Facility
SOB	Shortness of Breath
SO	Salpingo-oophorectomy
SPEC	Specimen
SQ, SQUAM	Squamous
SQ	Subcutaneous
STSG	Split Thickness Skin Graft
SUB-Q, SUBQ	Subcutaneous
SURG	Surgery, Surgical
SVC	Superior Vena Cava
SX	Symptoms
T-COLON	Transverse Colon
T-SPINE	Thoracic Spine
T1-T12	Thoracic Vertebra
TAH-BSO	Total Abdominal HysterectomyBilateral Salpingo-oophorectomy
TCC	Transitional Cell Carcinoma
TPN	Total Parenteral Nutrition
TS	Tumor Size
TURB(T)	Transurethral Resection Bladder (Tumor)
TURP	Transurethral Resection Prostate
TUR	Transurethral Resection
TVH	Total Vaginal Hysterectomy
TX	Treatment
T	Thoracic
UE	Upper Extremity
UGI	Upper Gastrointestinal
UIQ	Upper Inner Quadrant
UNDIFF	Undifferentiated
UOQ	Upper Outer Quadrant
VAG HYST	Vaginal Hysterectomy
VAG	Vagina, Vaginal
VAIN	Vaginal Intraepithelial Neoplasia
VASC	Vascular
VIN	Vulvar Intraepithelial Neoplasia
W/	With
W/O	Without
W/U	Work-up
WBC	White Blood Cells

WD, WELL DIFF	Well Differentiated
WNL	Within Normal Limits
XRT	Radiation Therapy
XR	Xray
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	Base of tongue
C02	Other and unspecified parts of tongue
C05	Palate
C06	Other and unspecified parts of mouth
C07	Parotid gland
C08	Other and unspecified major salivary glands
C09	Tonsil
C10	Oropharynx
C12	Pyriform sinus
C13	Hypopharynx
C19	Rectosigmoid junction
C20	Rectum
C23	Gallbladder
C24	Other and unspecified parts of biliary tract

C30	Nasal cavity and middle ear
C31	Accessory sinuses
C33	Trachea
C34	Bronchus and lung
C37	Thymus
C38.0-.3	Heart and mediastinum
C38.8	Overlapping lesion of heart, mediastinum, and pleura
C40	Bones, joints and articular cartilage of limbs
C41	Bones, joints and articular cartilage of other and unspec. sites
C51	Vulva
C52	Vagina
C57.7	Other specified female genital organs
C57.8-.9	Overlapping lesion and female genital tract, NOS
C60	Penis
C63	Other and unspecified male genital organs
C64	Kidney
C65	Renal pelvis
C66	Ureter
C68	Other and unspecified urinary organs
C74	Adrenal gland
C75	Other endocrine glands and related structures

Instructions for Using 1980 Census List of Spanish Surnames

Quick lookup: ABA-AZU BAB-BUZ CAA-CUZ DAB-DUR ECH-EZR FAB-FUS GAB-GUZ HAC-HYS IAN-JUV LAB-LUZ MAC-MUZ NAB-OZU PAB-PUY QUA-RUZ SAA-SWA TAB-UZU VAC-VUE XIM-ZUZ

This list can be used to code last names in most areas of the United States.

- 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."
- 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" with an accent (’) and "Nuñez" with a tilde (~) are listed as "MARTINEZ" and "NUNEZ."
- If a surname consists of two names, separated by a dash or a space, code the person as Spanish if either 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.
- If the surname is of the form "Lopez R.," ignore the initial and look up the name, "LOPEZ."
- 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."

- 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.

APPENDIX O

Instructions for Using 1980 Census List of Spanish Surnames

Quick lookup: ABA-AZU BAB-BUZ CAA-CUZ DAB-DUR ECH-EZR FAB-FUS GAB-GUZ HAC-HYS IAN-JUV LAB-LUZ MAC-MUZ NAB-OZU PAB-PUY QUA-RUZ SAA-SWA TAB-UZU VAC-VUE XIM-ZUZ

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- 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."
- 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" with an accent (’) and "Nuñez" with a tilde (~) are listed as "MARTINEZ" and "NUNEZ."
- If a surname consists of two names, separated by a dash or a space, code the person as Spanish if either 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.
- If the surname is of the form "Lopez R.," ignore the initial and look up the name, "LOPEZ."
- 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."

- 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.

Appendix Q: Surgery Codes

Appendix Q1 ROADS Surgery Codes

Appendix Q2 FORDS Surgery Codes

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery (NAACCR Item #1292) or Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672).

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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

Clarification: Use code 16 if local tumor destruction occurs via the use of BCG and more extensive surgery is not performed. When BCG is administered via Intravesical Therapy, also use code 16. In addition, also code the item under "Immunotherapy" as code 01.

No specimen sent to pathology from surgical events 10-16.

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

Any combination of 20 or 26-27 WITH
[SEER Guideline: the following codes INCLUDE local tumor excision, polypectomy or excisional biopsy]

21 Photodynamic therapy (PDT)

22 Electrocautery

23 Cryosurgery

24 Laser ablation

25 Laser excision

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 without urethrectomy. The procedure is also called cystoprostatectomy. If a radical cystectomy is the procedure for a woman, use code 71.]

61 Radical cystectomy PLUS ileal conduit

62 Radical cystectomy PLUS continent reservoir or pouch, NOS

63 Radical cystectomy PLUS abdominal pouch (cutaneous)

64 Radical cystectomy PLUS in situ pouch (orthotopic)

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 Regional Lymph Node Surgery (NAACCR Item #1292) or Scope of Regional Lymph Node Surgery at This Facility (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

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

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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 lesion or mass. ***Excision (removal) of the primary tumor, or "debulking" (less than full removal of the tumor). Most primary brain surgery is code 20.***
Specimen sent to pathology from surgical event 20.

40 Partial resection [NOS], ***partial resection of a lobe.***

55 Gross total resection [formerly SEER codes 31, 32, 50, 60], ***gross total resection of a lobe. This is a less common form of surgical treatment.***

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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 total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.

For single primaries only, code removal of involved contralateral breast under the data item Surgical Procedure/Other Site (NAACCR Item #1294) or Surgical Procedure/Other Site at This Facility (NAACCR Item #674).

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.

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) or Surgical Procedure/Other Site at This Facility (NAACCR Item #674).

60 Radical mastectomy, NOS

61 WITHOUT removal of uninvolved contralateral breast

64 Reconstruction, NOS

65 Tissue

66 Implant

67 Combined (Tissue and Implant)

62 WITH removal of uninvolved contralateral breast

68 Reconstruction, NOS

69 Tissue

73 Implant

74 Combined (Tissue and Implant)

[SEER Guideline: Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes en bloc axillary dissection. For single primaries only, code removal of involved contralateral breast under the data item "Surgery of other regional sites, distant sites, or distant lymph nodes."]

70 Extended radical mastectomy

71 WITHOUT removal of uninvolved contralateral breast

72 WITH removal of uninvolved contralateral breast

[SEER Guideline: Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes removal of internal mammary nodes and en bloc axillary dissection. For single primaries only, code removal of involved contralateral breast under the data item "Surgery of other regional sites, distant sites, or distant lymph nodes."]

80 Mastectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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

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

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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 30-32 include but are not limited to: appendectomy (for an appendix primary only), enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures, segmental resection, e.g., cecectomy, sigmoidectomy]

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)

41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)

51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
[SEER Guideline: commonly used for familial polyposis or polyposis coli]

61 Plus resection of contiguous organ; example: small bowel, bladder

70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Colectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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.]

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy

61 Modified radical hysterectomy

62 Extended hysterectomy

63 Radical hysterectomy; Wertheim procedure

64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies) [formerly SEER code 70]

66 WITHOUT removal of tube(s) and ovary(ies) [formerly SEER code 71]

67 WITH removal of tube(s) and ovary(ies) [formerly SEER code 72]

75 Pelvic exenteration [formerly SEER code 80]

76 Anterior exenteration [formerly SEER code 81]

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

77 Posterior exenteration [formerly SEER code 82]

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

78 Total exenteration [formerly SEER code 83]

Includes removal of all pelvic contents and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

79 Extended exenteration [formerly SEER code 84]
Includes pelvic blood vessels or bony pelvis.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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 5254

80 Esophagectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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

Codes

9 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative
8 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) ***or Surgical Procedure/Other Site at This Facility (NAACCR Item #674)*****.**

9 Death certificate only
9

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.

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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 nephrectomyfor kidney parenchyma
Nephroureterectomy
Includes bladder cuff for renal pelvis or ureter.

50 Radical nephrectomy
May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter.

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)
The other organs, such as colon or bladder, may be partially or totally removed.
[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Nephrectomy, NOS
Ureterectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 LIVER AND INTROHEPATIC 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.

1/2008: Chemoembolization should only be coded in the Chemotherapy field. Do not code this in the surgery fields.

20 Wedge or segmental resection, NOS

- 21 Wedge resection
- 22 Segmental resection, NOS
  - 23 One
  - 24 Two
  - 25 Three
  - 26 Segmental resection AND local tumor destruction

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

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery (NAACCR Item #1292) or Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672).

45 Lobe or bilobectomy extended, NOS

46 WITH chest wall

47 WITH pericardium

48 WITH diaphragm

55 Pneumonectomy, NOS [formerly SEER codes 40, 50, 51, 52, 53, 54]

56 WITH mediastinal lymph node dissection (radical pneumonectomy)

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery (NAACCR Item #1292) or Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672).

NOTE: Peribronchial or hilar lymph nodes are not included in any of the lung surgery codes. If peribronchial or hilar nodes are dissected as part of a surgical procedure which involves the destruction, excision or resection of the primary tumor then the extent of the nodal dissection is recorded in the item

"Scope of Regional Lymph Node Surgery" and the number of nodes dissected is recorded as part of the cumulative Regional Lymph Nodes Examined."

65 Extended pneumonectomy

66 Extended pneumonectomy plus pleura or diaphragm

70 Extended radical pneumonectomy
[SEER Guideline: an extended radical pneumonectomy is a radical pneumonectomy (including removal of mediastinal nodes) and the removal of other tissues or nodes]

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery (NAACCR Item #1292) or Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672).

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

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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 an *excisional biopsy of a single lymph node*.

30 Lymph node dissection, NOS

31 One chain

32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy

41 One chain

42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)

51 One chain

52 Two or more chains

60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy (Includes staging laparotomy for lymphoma.)

61 One chain

62 Two or more chains

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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]

Codes 40-43 include:
Total glossectomy
Radical glossectomy

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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/Other Site.

72 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

NOTE: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

80 (Salpingo-)oophorectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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

Appendix Q-2 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)

80 Parotidectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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

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

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 PROSTATE

C61.9

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 TURPcancer is incidental finding during surgery for benign disease [formerly SEER code 12]
- 23 TURPpatient has suspected/known cancer [SEER code 13]

Any combination of 20-23 WITH

- 24 Cryosurgery
- 25 Laser
- 26 Hyperthermia

Specimen sent to pathology from surgical events 20-26.

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS; total prostatectomy, NOS [formerly SEER code 30 or 40]
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.
[SEER Guideline: in continuity with or en bloc means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Prostatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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

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 Wedge or segmental resection; partial proctosigmoidectomy, NOS

- 31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:

Anterior resection
Hartmann operation
Low anterior resection (LAR)
Partial colectomy, NOS
Rectosigmoidectomy, NOS
Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)
[SEER Guideline: Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation.]

50 Total proctectomy
[SEER Guideline: Procedures coded 50 include but are not limited to: abdominoperineal resection (A & P resection), anterior/posterior resection (A/P resection)/Mile's operation, Rankin's operation]

51 Total colectomy [SEER Guideline: removal of the colon from cecum to rectosigmoid or portion of rectum]

55 Total colectomy WITH ileostomy, NOS

56 Ileorectal reconstruction

57 Total colectomy WITH other pouch; example: Koch pouch

60 Total proctocolectomy, NOS [SEER Guideline: combination of 50 and 51]

65 Total proctocolectomy WITH ileostomy, NOS

66 Total proctocolectomy WITH ileostomy and pouch

Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.

70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration
[SEER Guideline: Procedures that may be part of an en bloc resection include, but are not limited to: an oophorectomy and a rectal mucosectomy. Code 70 includes any colectomy (partial, hemicolectomy or total) with an en bloc resection of any other organs. There may be partial or total removal of other organs in continuity with the primary.]
[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Colectomy, NOS; Proctectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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
Hartmanns operation
Low anterior resection (LAR)
Transsacral rectosigmoidectomy

40 Pull through WITH sphincter preservation (coloanal anastomosis)
[SEER Guideline: Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbul'ls operation.]

50 Total proctectomy
Procedure coded 50 includes, but is not limited to:
Abdominoperineal resection (Miles Procedure)
[SEER Guideline: also called anterior/posterior (A/P) resection/Mile's operation, Rankin's operation]

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration
[SEER Guideline: in continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Proctectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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 or equal to 2 cm

47 WITH margins greater than 2 cm

If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code, 20-36.

60 Major amputation [NOS]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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 or excision, NOS
[formerly SEER code 10 = local excision, destruction, NOS]
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

21 Partial splenectomy

22 Total splenectomy

80 Splenectomy, NOS [formerly SEER code 20]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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.

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

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 TESTIS

C62.0-C62.9
(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

12 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 12.

20 Local or partial excision of testicle [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

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 OTHER SITES

C14.1-C14.8, C17.0-C17.9, C23.9, C24.0-C24.9, C26.0-C26.9, C30.0-C 30.1, C31.0-C31.9, C33.9, C37.9, C38.0-C38.8, C39.0-C39.9, C48.0-C48.8, C51.0-C51.9, C52.9, C57.0-C57.9, C58.9, C60.0-C 60.9, C63.0-C63.9, C68.0-C68.9, C69.0-C69.9, C74.0-C74.9, C75.0-C75.9
(Except for M-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

For Cases Diagnosed on or after January 1, 2003

Appendix Q-2 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.

[99 **Death certific**

Appendix Q-1 Surgery Codes - ANUS

(For Cases Diagnosed prior to January 1, 2003)

C21.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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 cancer-directed 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.

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 cancer-directed 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 documented

8 No cancer-directed 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 nodes 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 removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

2 Other regional sites

3 Distant lymph nodes

4 Distant sites

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**

Appendix Q-1 Surgery Codes - BLADDER

(For Cases Diagnosed prior to January 1, 2003)

C67.0-C67.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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 cancer-directed 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.

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 cancer-directed 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 documented

8 No cancer-directed 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 nodes 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 removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph nodes
- 4 Distant sites
- 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 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**

Appendix Q-1 Surgery Codes - BONES,PERIPHERAL NERVES, & SOFT TISSUES

(For Cases Diagnosed prior to January 1, 2003)

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 cancer-directed 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 cancer-directed 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 cancer-directed 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 documented

8 No cancer-directed 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 nodes removed, NOS

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 5 Distant lymph nodes
- 6 Distant sites
- 7 Combination of 6 **with** 2 or 5

9 Unknown; not stated; death certificate **only**

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**

Appendix Q-1 Surgery Codes - BRAIN & OTHER PARTS of the CENTRAL NERVOUS SYSTEM

(For Cases Diagnosed prior to January 1, 2003)

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 cancer-directed surgery of primary site

4 Open

9 Unknown; not stated; death certificate **only**

SURGERY OF PRIMARY SITE

Codes

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction

20 Excision of tumor, lesion, or mass

- 21 Subtotal resection, NOS
- 22 Partial resection

23 Debulking

30 Excision of tumor, lesion, or mass, NOS

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

90 Surgery, NOS

99 Unknown if cancer-directed 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 documented

8 No cancer-directed 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 nodes removed, NOS

9 Unknown; not stated; death certificate **only**

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 removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or

distant

2 Other regional sites

5 Distant lymph nodes

6 Distant sites

7 Combination of 6 **with** 2 or 5

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

9 Not applicable (There are no known reconstructive procedures for this site.)

Appendix Q-1 Surgery Codes - BREAST

(For Cases Diagnosed prior to January 1, 2003)

C50.0-C50.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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

Codes

00 None; no cancer-directed 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 Reexcision of the biopsy site (usually 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**.

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).

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 cancer-directed surgery performed; death certificate **only**

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.

Codes

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 documented

8 No cancer-directed 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 Sentinel lymph nodes 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

2 Regional lymph nodes 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

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 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 sites or nodes, NOS; unknown if regional or distant

2 Other regional sites

3 Distant lymph nodes

4 Distant sites

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**

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 Abdominus recti flap
  - 6 Flap, NOS + implant
  - 7 Latissimus dorsi flap + implant
  - 8 Abdominus recti + implant

9 Unknown; not stated; death certificate **only**

Appendix Q-1 Surgery Codes - CERVIX UTERI

(For Cases Diagnosed prior to January 1, 2003)
C53.0-C53.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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

0 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.

Code

00 None; no cancer-directed 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.

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).

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 cancer-directed 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 documented

8 No cancer-directed 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 nodes removed, NOS

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 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 sites or nodes, NOS; unknown if regional or distant

2 Other regional sites

3 Distant lymph nodes, NOS

4 Periaortic lymph nodes

5 Distant sites

6 Combinations of 5 with 4

7 Combination of 5 **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**

Appendix Q-1 Surgery Codes - COLON

(For Cases Diagnosed prior to January 1, 2003)

C18.0-C18.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS

Endoscopy procedures include: Colonoscopy; Laparoscopy; Sigmoidoscopy

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 cancer-directed 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.

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.

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 cancer-directed 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 documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

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)

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 nodes removed, NOS

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 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 sites or nodes, NOS; unknown if regional or distant

- 2 Removal of other regional sites, **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 2 and 4
- 6 Removal of other distant sites or distant lymph nodes, **only**
- 7 Combination of code 6 **with** 3 or 5
- 8 Combination of code 6 **with** 4

9 Unknown; not stated; death certificate **only**

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**

Appendix Q-1 Surgery Codes - CORPUS UTERI

(For Cases Diagnosed prior to January 1, 2003)

C

Corpus uteri C54.0-C54.9, Uterus NOS C55.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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 cancer-directed 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.

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).

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 cancer-directed 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 documented

8 No cancer-directed 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 and external iliac Hypogastric (obturator) Para aortic Parametrial Sacral

Codes

0 No regional lymph nodes removed

1 Regional lymph nodes removed, NOS

2 Pariaortic with or without other regional lymph nodes

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 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 sites or nodes, NOS; unknown if regional or distant

2 Other regional sites

3 Distant lymph nodes, NOS

4 Periaortic lymph nodes

5 Distant sites

6 Combinations of 5 with 4

7 Combination of 5 **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**

Appendix Q-1 Surgery Codes - ESOPHAGUS

(For Cases Diagnosed prior to January 1, 2003)
C15.0-C15.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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 cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)

- 11 Photodynamic therapy (PDT)

  PDT: Exposing photo-sensitive drugs to specific wave lengths of light in the presence of oxygen causing drug to become cytotoxic.

- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery

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.

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 cancer-directed 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 documented

8 No cancer-directed 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 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 nodes 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).

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph nodes
- 4 Distant sites
- 5 Combination of 4 with 2 or 3

9 Unknown; not stated; death certificate only

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**

Appendix Q-1 Surgery Codes - KIDNEY, RENAL PELVIS & URETER

(For Cases Diagnosed prior to January 1, 2003)
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

SURGICAL APPROACH

Codes

0 None; no cancer directed 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 cancer-directed 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.

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 cancer-directed 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 documented

8 No cancer-directed 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

Codes

0 No regional lymph nodes removed

1 Regional lymph nodes 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 removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 ribs during the operative approach.

Codes

0 None; no surgery to other regional or distant sites

1 Surgery to other sites or nodes, NOS; unknown if regional or distant

2 Other regional sites

3 Distant lymph nodes

4 Distant sites

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**

Appendix Q-1 Surgery Codes - LARYNX

(For Cases Diagnosed prior to January 1, 2003)

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; no cancer-directed surgery of primary site

4 Open

9 Death certificate **only**

SURGERY OF PRIMARY SITE

Codes

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)

11 Photodynamic therapy (PDT)

PDT: Exposing photo-sensitive drugs to specific wave lengths of light in the presence of oxygen causing drug to become

cytotoxic.

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.

30 Less than total parotidectomy, 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

41 Facial nerve spared

42 Facial nerve sacrificed

50 Radical parotidectomy, NOS

51 **without** removal of temporal bone

52 **with** removal of temporal bone

80 Parotidectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed 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 documented

8 No cancer-directed 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:
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 nodes 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 nonlymphatic structures are preserved. A selective neck dissection preserves one or more lymph node groups routinely removed in radical neck dissection.

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph nodes
- 4 Distant sites
- 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**

Appendix Q-1 Surgery Codes - LIVER INTRATRAHEPATIC BILE DUCTS

(For Cases Diagnosed prior to January 1, 2003)

C22.0-C22.1

SURGICAL APPROACH

Codes

0 None; no cancer-directed surgery of primary site

1 Endoscopy **only**, NOS (laparoscopy)

- 2 Not image guided
- 3 Image guided

4 Open, NOS

- Not assisted by endoscopy
- Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

SURGERY OF PRIMARY SITE

Codes

00 None; no cancer-directed 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)

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 cancer-directed 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 documented

8 No cancer directed 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 nodes removed, NOS

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

2 Other regional sites

3 Distant lymph nodes (includes inferior phrenic lymph nodes)

4 Distant sites

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 Rioux en Y; hepatojejunostomy including stent

2 Liver transplant

9 Unknown; not stated; death certificate **only**

Appendix Q-1 Surgery Codes - LUNG

(For Cases Diagnosed prior to January 1, 2003)

C34.0-C34.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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 cancer-directed 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

Procedures coded 40 include, but are not limited to: 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 Lymph 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 Lymph Nodes Removed.

80 Resection of lung, NOS

90 Surgery, NOS

99 Unknown if cancer-directed 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 documented

8 No cancer-directed 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

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS

  2 Microscopic involvement

  5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites, distant sites or distant lymph nodes

1 Surgery to other sitesor nodes, 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 sites 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 sites

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**

Appendix Q-1 Surgery Codes - ORAL

(For Cases Diagnosed prior to January 1, 2003)

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,

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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 cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)

11 Photodynamic therapy (PDT)

PDT: Exposing photo-sensitive drugs to specific wave lengths of light in the presence of oxygen causing drug to become cytotoxic.

12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

13 Cryosurgery

14 Laser

No specimen sent to pathology from this surgical event.

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 cancer-directed 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 documented

8 No cancer-directed 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

Codes

0 No regional lymph nodes removed

1 Regional lymph nodes 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 preserves one or more lymph node groups routinely removed in radical neck dissection.

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

2 Other regional sites

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 **is** a part of an en bloc resection of the primary tumor, code under Surgery of Primary Site.

5 Distant lymph nodes

6 Distant sites

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**

Appendix Q-1 Surgery Codes - OVARY

(For Cases Diagnosed prior to January 1, 2003)

C56.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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 endosopy

9 Unknown; not stated; death certificate **only**

SURGERY OF PRIMARY SITE

Codes

00 None; no cancer-directed 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

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 cancer-directed surgery performed; death certificate **only**

SURGICAL MARGINS

For this site only, this field will describe the residual tumor burden 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 cancer directed 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 nodes removed, NOS

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional

lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph nodes
- 4 Distant sites
- 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 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**

Appendix Q-1 Surgery Codes - PANCREAS

(For Cases Diagnosed prior to January 1, 2003)

C25.0-25.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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 cancer-directed 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 cancer-directed 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 documented

8 No cancer-directed 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 nodes 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 removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Removal of other regional sites, **only**
- 3 Removal of distant nodes
- 4 Removal of distant site
- 5 Combination of 2 **with** 3 and/or 4

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

9 Not applicable (There are no known reconstructive procedures for this site.)

Appendix Q-1 Surgery Codes - PAROTID

(For Cases Diagnosed prior to January 1, 2003)
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed surgery of primary site

4 Open

9 Death certificate **only**

SURGERY OF PRIMARY SITE

Codes

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)

- 11 Photodynamic therapy (PDT)

  PDT: Exposing photo-sensitive drugs to specific wave lengths of light in the presence of oxygen causing drug to become cytotoxic.

- 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.

30 Less than total parotidectomy, 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

41 Facial nerve spared

42 Facial nerve sacrificed

50 Radical parotidectomy, NOS

51 **without** removal of temporal bone

52 **with** removal of temporal bone

80 Parotidectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed 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 documented

8 No cancer-directed 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:
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 nodes 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 nonlymphatic structures are preserved. A selective neck dissection preserves one or more lymph node groups routinely removed in radical neck dissection.

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

2 Other regional sites

3 Distant lymph nodes

4 Distant sites

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**

Appendix Q-1 Surgery Codes - PHARYNX

(For Cases Diagnosed prior to January 1, 2003)

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; no cancer-directed surgery of primary site

4 Open

9 Death certificate **only**

SURGERY OF PRIMARY SITE

Codes

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)

11 Photodynamic therapy (PDT)

PDT: Exposing photo-sensitive drugs to specific wave lengths of light in the presence of oxygen causing drug to become cytotoxic.

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.

30 Less than total parotidectomy, 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

41 Facial nerve spared

42 Facial nerve sacrificed

50 Radical parotidectomy, NOS

51 **without** removal of temporal bone

52 **with** removal of temporal bone

80 Parotidectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed 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 documented

8 No cancer-directed 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:
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 nodes 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 nonlymphatic structures are preserved. A selective neck dissection preserves one or more lymph node groups routinely removed in radical neck dissection.

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph nodes
- 4 Distant sites
- 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**

Appendix Q-1 Surgery Codes - PROSTATE

(For Cases Diagnosed prior to January 1, 2003)
C61.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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

Codes

00 None; no cancer-directed 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.

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 cancer-directed surgery performed; death certificate **only**

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 documented (TURP)

8 No cancer-directed 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)

Codes

0 No regional lymph nodes removed

1 Regional lymph nodes removed, NOS

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 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 sites or nodes, NOS; unknown if regional or distant

2 Other regional sites

3 Distant lymph nodes

4 Distant sites

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**

Appendix Q-1 Surgery Codes - RECTOSIGMOID

(For Cases Diagnosed prior to January 1, 2003)

C19.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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

Codes

00 None; no cancer-directed 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.

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 the 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 (colo-anal 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

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

Codes

0 All margins grossly and microscopically negative

1 Margins involved, NOS

2 Microscopic involvement

5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

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 nodes removed, NOS

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 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 sites or nodes, NOS; unknown if regional or distant

- 2 Removal of other regional sites, **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 2 and 4
- 6 Removal of other distant sites or distant lymph nodes, **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**

Appendix Q-1 Surgery Codes - RECTUM

(For Cases Diagnosed prior to January 1, 2003)

C20.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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; no cancer-directed 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
- 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: Altemeier's operation; Duhamel's operation; Soave's submucosal resection; Swenson's operation; Turnbull's

operation.

40 Pull through **with** sphincter preservation (colo-anal 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

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 cancer-directed 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 documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

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 (Gerotas) 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 nodes removed, NOS

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 style="font-weight: normal;">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 sites or nodes, NOS; unknown if regional or distant

- 2 Removal of other regional sites, **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 2 with 4
- 6 Removal of other distant sites or distant lymph nodes, **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**

Appendix Q-1 Surgery Codes - SKIN

(For Cases Diagnosed prior to January 1, 2003)

C44.0-C44.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed surgery of primary site

4 Open approach

9 Death certificate **only**

SURGERY OF PRIMARY SITE

Codes

00 None; no cancer-directed 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

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.

40 Wide excision or reexcision 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 tumor free. The margins may be microscopically involved.

60 Major amputation, NOS

90 Surgery, NOS

99 Unknown if cancer-directed 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 documented

8 No cancer-directed 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 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

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 removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph nodes
- 4 Distant sites
- 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**

Appendix Q-1 Surgery Codes - SPLEEN & LYMPH NODES

(For Cases Diagnosed prior to January 1, 2003)

Spleen C42.2
Lymph Nodes C77.0-C77.9

SURGICAL APPROACH

Codes

0 None; no cancer directed 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 cancer-directed surgery of primary site

10 Local excision, destruction, NOS

20 Splenectomy, NOS

- 21 Partial splenectomy
- 22 Total splenectomy

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

- 61 One chain
- 62 Two or more chains

90 Surgery, NOS

99 Unknown if cancer-directed 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 documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

SCOPE OF REGIONAL LYMPH NODE SURGERY

Note: For primary sites C77.0-C77.9, code this field as 9.

Codes

0 No regional lymph nodes removed

1 Regional lymph nodes removed, NOS

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Note: Spleen only. For lymphomas, code this field to 99.

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 5 Distant lymph nodes
- 6 Distant sites
- 7 Combination of 6 **with** 2 or 5

9 Unknown; not stated; death certificate **only**

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 cancer-directed surgery of primary site

4 Open approach

9 Death certificate **only**

SURGERY OF PRIMARY SITE

Codes

00 None; no cancer-directed 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

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.

40 Wide excision or reexcision 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 tumor free. The margins may be microscopically involved.

60 Major amputation, NOS

90 Surgery, NOS

99 Unknown if cancer-directed 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 documented

8 No cancer-directed 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 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	Leg	Groin-trochanter-gluteal sulcus

buttock AND		
Right AND	Left	Midline

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 removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph nodes
- 4 Distant sites
- 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**

California Cancer Registry Volume I: Data Standards and Data Dictionary

Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, Ninth Edition, June 2009

Appendix Q-1 Surgery Codes - STOMACH

(For Cases Diagnosed prior to January 1, 2003)

C16.0-C16.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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

Codes

00 None; no cancer-directed 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.

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 (near total = 80% 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

90 Surgery, NOS

99 Unknown if cancer-directed 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 documented

8 No cancer-directed 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:	
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 nodes removed, NOS

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

  2 Removal of other regional sites, **only**

  3 Removal of distant nodes

  4 Removal of distant site

  5 Combination of 2 **with** 3 and/or 4

9 Unknown; not stated; death certificate **only**

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**

Appendix Q-1 Surgery Codes - THYROID

(For Cases Diagnosed prior to January 1, 2003)
C73.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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 cancer-directed 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 cancer-directed 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 documented

8 No cancer-directed 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.

Codes

0 No regional lymph nodes removed

1 Regional lymph nodes 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 removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph nodes
- 4 Distant sites
- 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.)

Appendix Q-1 Surgery Codes - TESTIS

(For Cases Diagnosed prior to January 1, 2003)

C62.0-C62.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed surgery of primary site

4 Open, NOS

- 5 Scrotal
- 6 Inguinal

9 Death certificate **only**

SURGERY OF PRIMARY SITE

Codes

00 None; no cancer-directed 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 cancer-directed 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 documented

8 No cancer directed 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 nodes 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 removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph nodes
- 4 Distant sites
- 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 Testicular implant

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Appendix Q-1 Surgery Codes - ALL OTHER SITES

(For Cases Diagnosed prior to January 1, 2003)

ALL OTHER SITES

C14.1-C14.8, C17.0-C17.9, C23.9, C24.0-C24.9, C26.0-C26.9, C30.0-C30.1, 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-C60.9, C63.0-C63.9, C68.0-C69.9, C74.0-C76.8, C80.9

SURGICAL APPROACH

Codes

0 None; no cancer-directed 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 cancer-directed 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.

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

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 cancer-directed 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 documented

8 No cancer-directed 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 nodes removed, NOS

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph nodes removed but aspiration of regional lymph nodes 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 sites or nodes, NOS; unknown if regional or distant

- 2 Other regional sites
- 3 Distant lymph nodes
- 4 Distant sites
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION / RESTORATION - FIRST COURSE

Codes

9 At this time, reconstructive procedures are not being collected for these sites

Appendix R: ICD-O-3 Lymphatic and Hematopoietic Diseases - Subsequent Diagnoses

The CCR is concerned with identifying lymphomas and leukemias that are or might be treatment induced, usually as a result of chemotherapy plus radiotherapy or chemotherapy with alkylating agents.

The ICD-O-3 version of the hematopoietic primaries table is very different from the ICD-O-2 version in both format and medical understanding of these diseases. As a result, it is not possible to use the tables interchangeably. The first link indicated below, Definitions of Single and Subsequent Primaries for Hematologic Malignancies Based on ICD-O-3 Reportable Malignancies, Effective with Diagnoses 01/01/2001 and After, explains the reasoning that underlies the ICD-O-3 table.

From January 1, 2001 Forward
Use the ICD-O-3 table found in
http://seer.cancer.gov/icd-o-3/hematopoietic_primaries.d03152001.pdf,
if both diseases are diagnosed after January 1, 2001 or if a first diagnosis was prior to 2001, but a second diagnosis was after January 1, 2001.

Also review the following errata files.

http://seer.cancer.gov/icd-o-3/errata.d05222001.pdf

http://seer.cancer.gov/icd-o-3/errata.d05062003.pdf

Prior to January 1, 2001
See Section II_1_3_6

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	ED2017	Override, Seq/Dx Confirm

IF23)		
		Override, Seq/Site
		Override, Site/Lat/SeqNum
		Override, Site/TNM Stage
Summary Stage 2000, Site Dist Met 1 (CNET)	ED2029	Override, Stage/Dist Mets
Summary Stage 2000, Regional Nodes Pos (CNET)	ED2028	Override, Stage/Nodes Pos
Summary Stage 2000, TNM M (CNET)	ED2050	Override, Stage/TNM-M
Summary Stage 2000, TNM N (CNET)	ED2051	Override, Stage/TNM-N
Seq Num-Hosp, Primary Site, Morphology	ED2514	Override, Hosp Seq/Site

APPENDIX U

TABLE OF DATA ITEMS AND THEIR REQUIRED STATUS

Reporting requirements are not uniform for all cancer reporting facilities. Consult the following table to determine which data items must be reported:

Key to Symbols

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
C/N	DESIGNATES THE CNExT DATA SET
Hosp> Regn	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 Volume I *Abstracting and Coding Procedures for Hospitals)*; VOL. 2 (California Cancer Reporting System Standards, Volume Two: *Standards for Automated Reporting)*; OR C/N USER *(CNExT User Manual)*

See the NAACCR *Data Standards and Data Dictionary (Volume II, Eleventh Edition, Record Layout Version 11.1*) for Data Items Required by SEER and the Commission on Cancer.

http://www.naaccr.org/filesystem/pdf/2007_Required_Status_Table_11.1.pdf

Data Items and Their Required Status

Item Name	Manual	C/N	RX Ctr	Hosp> Regn
Abstractor	III.1.1	yes	yes	yes
Accession Number (Hosp)	II.2.3	yes	yes	yes
ACoS Approved Flag	III.1.6	yes	yes	yes
Address at Diagnosis City	III.2.5	yes	yes	yes
Address at Diagnosis City USPS	III.2.5.7	yes	yes	
Address at Diagnosis No. & Street	III.2.5	yes	yes	yes
Address at Diagnosis No. & Street - Supplemental	III.2.5	yes*	yes*	yes*
Address at Diagnosis - State	III.2.5	yes	yes	yes
Address at Diagnosis - Zip Code	III.2.5	yes	yes	yes
Age at Diagnosis	III.2.11	gen	gen	gen
Alias First Name	III.2.1.6	yes*	yes*	yes*
Alias Last Name	III.2.1.5	yes*	yes*	yes*
Ambiguous Terminology Dx	II.1.6.3	yes	yes	yes
Birth Date	III.2.10	yes	yes	yes
Birthplace	III.2.12	yes	yes	yes
Casefinding Source	III.3.8	yes	yes	yes
Cause of Death	VII.2.14	may	no	no
Chemotherapy at This Hospital	VI.4	yes	yes	yes
Chemotherapy Summary	VI.4	yes	yes	yes
Class of Case	III.3.5	yes	yes	yes
Coding Procedure	III.1.5	gen	gen	yes
Comorbidity Complications 1	III.3.13	yes*	yes*	yes*
Comorbidity Complications 2	III.3.13	yes*	yes*	yes*
Comorbidity Complications 3	III.3.13	yes*	yes*	yes*
Comorbidity Complications 4	III.3.13	yes*	yes*	yes*
Comorbidity Complications 5	III.3.13	yes*	yes*	yes*
Comorbidity Complications 6	III.3.13	yes*	yes*	yes*
Comorbidity Complications 7	III.3.13	yes*	yes*	yes*
Comorbidity Complications 8	III.3.13	yes*	yes*	yes*

Comorbidity Complications 9	III.3.13	yes*	yes*	yes*
Comorbidity Complications 10	III.3.13	yes*	yes*	yes*
Contact City	VII.3	yes*	yes*	yes*
Contact Country	VII.3	may	may	may
Contact Name	VII.3	yes*	yes*	yes*
Contact State	VII.3	yes*	yes*	yes*
Contact Street	VII.3	yes*	yes*	yes*
Contact Street - Supplemental	VII.3	yes*	yes*	yes*
Contact Zip	VII.3	yes*	yes*	yes*
County of Residence at Diagnosis	III.2.5	yes	yes	yes
CS Tumor Size	V.4.2	yes	yes	yes
CS Extension	V.4.2	yes	yes	yes
CS Tumor Size/Extension Evaluation	V.4.2	yes	yes	>yes
CS Lymph Nodes	V.4.2	yes	yes	yes
CS Lymph Nodes Evaluation	V.4.2	yes	yes	yes
CS Metastasis at Diagnosis	V.4.2	yes	yes	yes
CS Metastasis Evaluation	V.4.2	yes	yes	yes
CS Site Specific Factor 1	V.4.2	yes	yes	yes
CS Site Specific Factor 2	V.4.2	yes	yes	yes
CS Site Specific Factor 3	V.4.2	yes	yes	yes
CS Site Specific Factor 4	V.4.2	yes	yes	yes
CS Site Specific Factor 5	V.4.2	yes	yes	yes
CS Site Specific Factor 6	V.4.2	yes	yes	yes
CS Version 1st	V.4.2	yes	yes	yes
CS Version Latest	V.4.2	yes	yes	yes
Date of Conclusive Dx	II.1.6.4	yes	yes	yes
Date of Chemotherapy	VI.1.3.2	sel	sel	yes*
Date of Diagnosis	III.3.3	yes	yes	yes
Date of First Admission	III.3.1	yes	yes	yes
Date of Inpatient Admission	III.3.2	yes*	no	yes*
Date of Inpatient Discharge	III.3.2	yes*	no	yes*
Date of Hormone Therapy	VI.1.3.2	sel	sel	yes*

Date of Immunotherapy	VI.1.3.2	sel	sel	yes*
Date of Last Patient Contact or Death	VII.2.1	yes	yes	yes
Date of Last Tumor Status	VII.2.3	yes	yes	yes
Date of Most Definitive Surgery of the Primary Site	VI.2.5	gen	gen	yes*
Date of Multiple Tumors	II.1.3.9.2	yes	yes	yes
Date of Other Therapy	VI.1.3.2	sel	sel	yes*
Date of Radiation	VI.1.3.2	sel	sel	yes*
Date of Systemic Therapy	VI.1.3.2	gen	gen	yes*
Date of Surgery	VI.1.3.2	gen	gen	yes*
Date of Surgery Diagnostic or Staging Procedures	VI.2.12	sel	sel	yes*
Date of Surgery Procedures 1-3	VI.2.5	sel	sel	yes
Date of Therapy	Vol III	no	no	no
Date of Transplant/Endocrine Procedures	VI.7.2	sel	sel	yes*
Death File Number	VII.2.14	may	no	no
Derived AJCC T	V.4.2	yes	yes	yes
Derived AJCC T Descriptor	V.4.2	yes*	yes*	yes*
Derived AJCC N	V.4.2	yes	yes	yes
Derived AJCC N Descriptor	V.4.2	yes*	yes*	yes*
Derived AJCC M	V.4.2	yes	yes	yes
Derived AJCC M Descriptor	V.4.2	yes*	yes*	yes*
Derived AJCC Stage Group	V.4.2	yes	yes	yes
Derived SS2000	V.4.2	yes	yes	yes
Derived SS1977	V.4.2	yes	yes	yes
Derived AJCC - Flag	V.4.2	yes	yes	yes
Derived SS2000 - Flag	V.4.2	yes	yes	yes
Derived SS1977 - Flag	V.4.2	yes	yes	yes
Diagnostic Confirmation	IV.2	yes	yes	yes
Discovered by Screening	III.3.15	yes	no	may
DxRx Report Facility ID (1-5)	IV.3.1	yes	yes	yes
DxRx Report Number (1-5)	IV.3.2	yes	yes	yes

DxRx Report Date (1-5)	IV.3.3	yes	yes	yes
DxRx Report Type (1-5)	IV.3.4	yes	yes	yes
EOD Extension	V.4	yes	yes	yes
EOD Extension (Path)	V.4	yes	yes	yes
EOD - Lymph Node Involvement	V.4	yes	yes	yes
First Name	III.2.1.2	yes	yes	yes
Follow up Contact Address Other	VII.3	yes*	yes*	yes
Follow up Contact Address Other - Supplemental	VII.3	yes*	yes*	yes*
Follow up Contact City Other	VII.3	yes*	yes*	yes
Follow up Contact Name Other	VII.3	yes*	yes*	yes
Follow up Contact State Other	VII.3	yes*	yes*	yes
Follow up Contact Zip Other	VII.3	yes*	yes*	yes
Follow up Last Type (Patient)	VII.2.6.2	yes	yes	yes
Follow up Last Type (Tumor)	VII.2.6.1	yes	yes	yes
Follow up Next Type	VII.2.8	yes*	yes*	yes*
Follow up Hospital (Next)	VII.2.9	yes*	no	no
Follow up Hospital (Last)	VII.2.7	yes	yes	yes
Histology Text	IV.1.7	yes	yes	yes
Histology Behavior (ICD-O-2)	V.3.4	yes	yes	yes
Histology Behavior (ICD-O-3)	V.3.4	yes	yes	yes
Histology Grade/ Differentiation	V.3.5	yes	yes	yes
Histology Type (ICD-O-2)	V.3	yes	yes	yes
Histology Type (ICD-O-3)	V.3	yes	yes	yes
Hormone Therapy at This Hospital	VI.5	yes	yes	yes
Hormone Therapy Summary	VI.5	yes	yes	yes
Hospital Number (Reporting)	III.1.4	yes	yes	yes
Hospital Patient Number	Vol. 2	gen	gen	yes
Hospital Referred From	III.3.10	yes	yes	yes
Hospital Referred To	III.3.11	yes	yes	yes
ICD Revision Comorbidities	III.3.14	yes	yes	yes
ICD-O-3 Conversion Flag	Vol. 2	gen	gen	yes
Immunotherapy at This Hospital	VI.6	yes	yes	yes

Immunotherapy Summary	VI.6	yes	yes	yes
Industry Text	III.2.13.2	yes	no	yes
Last Name	III.2.1.1	yes	yes	yes
Laterality	V.2	yes	yes	yes
Maiden Name	III.2.1.4	yes*	yes*	yes*
Marital Status	III.2.6	yes	yes	yes
Medical Record Number	III.2.2	yes*	yes*	yes*
Middle Name	III.2.1.3	yes*	yes*	yes*
Mothers First Name	III.2.1.9	yes*	yes*	yes*
Multiple Tumors Reported as One Primary	II.1.3.9.3	yes	yes	yes
Multiplicity Counter	II.1.3.9.1	yes	yes	yes
Name Suffix	III.2.1.8	yes*	yes*	yes*
Number of Regional Lymph Nodes Examined Surgery Summary	VI.2.2	gen	gen	sel
Number of Regional Lymph Nodes Examined Procedures 1-3	VI.2.3	yes	yes	no
NPI Reporting Facility	III.1.4	yes*	yes*	yes*
NPI Hospital Referred From	III.3.10	yes*	yes*	yes*
NPI Hospital Referred To	III.3.11	yes*	yes*	yes*
NPI Following Registry	Appendix X	yes*	yes*	yes*
NPI Physician-Managing	III.3.12	yes*	yes*	yes*
NPI Physician-Primary Surgeon	III.3.12	yes*	yes*	yes*
NPI Physician-Follow-up	VII.2.10	yes*	yes*	yes*
NPI Physician 3	III.3.12	yes*	yes*	yes*
NPI Physician 4	III.3.12	yes*	yes*	yes*
NPI Physician Other 1	III.3.12	yes*	yes*	yes*
NPI Physician Other 2	III.3.12	yes*	yes*	yes*
NPI Archive FIN	Appendix X	no	no	no
Occupation Text	III.2.13.1	yes	no	yes
Other Therapy at This Hospital	VI.7	yes	yes	yes
Other Therapy Summary	VI.7	yes	yes	yes
Over-ride Flags	Appendix T	yes	yes	yes
Patient No Research Contact Flag	III.2.14	yes	yes	yes

Payment Source (Primary)	III.3.9	yes	yes	yes
Payment Source (Secondary)	III.3.9	yes*	yes*	yes*
Payment Source Text	III.3.9	yes	yes	yes
Pediatric Stage	V.7.8	sel	sel	sel
Pediatric Stage Coder	V.7.10	sel	sel	sel
Pediatric Stage System	V.7.9	sel	sel	sel
Phone Number (Patient)	III.2.4	yes*	yes*	yes*
Physician (Attending)	III.3.12	yes	yes	yes
Physician (Following)	VII.2.10	yes*	yes*	yes*
Physician (Medical Oncologist)	III.3.12	yes*	yes*	yes*
Physician (Other)	III.3.12	yes*	yes*	yes*
Physician (Other)	III.3.12	yes*	yes*	yes*
Physician (Radiation Oncologist)	III.3.12	yes*	yes*	yes*
Physician (Referring)	III.3.12	yes*	yes*	yes*
Physician (Surgeon)	III.3.12	yes*	yes*	yes*
Place of Death	VII.2.14	sel	yes*	yes*
Place of Diagnosis	III.3.4	may	may	yes*
Protocol Participation	VI.9	sel	sel	sel
Quality of Survival	VII.2.5	may	no	no
Race 1	III.2.9	yes	yes	yes
Race 2	III.2.9	yes	yes	yes
Race 3	III.2.9	yes	yes	yes
Race 4	III.2.9	yes	yes	yes
Race 5	III.2.9	yes	yes	yes
Radiation at This Hospital	VI.3	yes	no	no
Radiation - Boost RX Modality	VI.3.4	yes	yes	yes
Radiation - Location of Treatment	VI.3.8	yes	yes	yes
Radiation - Regional RX Modality	VI.3.3	yes	yes	yes
Radiation Summary	VI.3	yes	yes	yes
Radiation/Surgery Sequence	VI.3.4	yes	yes	yes
Reason for No Radiation	VI.3.3	yes	yes	yes
Reason for No Surgery	VI.2.10	yes	yes	yes
Recurrence Date	VII.2.13.1	may	may	may

Recurrence Sites	VII.2.13.3	may	may	may
Recurrence Type	VII.2.12.2	may	may	may
Regional Data	-	may	may	yes*
EOD- Regional Nodes Examined	V.4	yes	yes	yes
EOD- Regional Nodes Positive	V.4	yes	yes	yes
Religion	III.2.8	yes	yes	yes
Scope of Regional Lymph Node Surgery 98-02 Summary	VI.2.2	gen	gen	sel
Scope of Regional Lymph Node Surgery Summary	VI.2.2	gen	gen	yes
Scope of Regional Lymph Node Surgery Procedures 1-3	V.7.12	yes	yes	yes
Sequence Number	II.2.4	yes	yes	yes
Sex	III.2.7	yes	yes	yes
Site Text	IV.1	yes	yes	yes
Site, Primary	V.1.1	yes	yes	yes
Social Security Number	III.2.3	yes*	yes*	yes*
Social Security Number Suffix	III.2.3	yes*	yes*	yes*
Spanish/Hispanic Origin	III.2.9.2	yes	yes	yes
Stage-Alternate	V.5.6	may	may	may
Staging Text	IV.3.5	yes	yes	yes
Summary Stage 1977	V.5	sel	sel	sel
Summary Stage 2000	V.5	sel	sel	sel
Surgery at This Hospital Diagnostic or Staging Procedure	VI.2.11	yes	yes	yes
Surgery at This Hospital Reconstructive	VI.2.8	yes	no	no
Surgery at This Hospital	VI.2.1	gen	gen	no
Surgery of Primary Site 9802 Summary	VI.2.1	gen	gen	sel
Surgery of Primary SiteSummary	VI.2.1	gen	gen	yes
Surgery of Primary Site Procedures 1-3	VI.2.1	yes	yes	yes
Surgery of Other Site Summary 98-02	VI.2.4	gen	gen	sel

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)Summary	VI.2.4	gen	gen	yes
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)Procedures 1-3	VI.2.4	yes	yes	yes
Surgery Summary Diagnostic or Staging Procedure	VI.2.11	yes	yes	yes
Surgery Summary Reconstructive	VI.2.8	yes	yes	yes
Surgical Margins Procedures 1-3	VI.2.7	yes	no	no
Surgical Margins Summary	VI.2.7	gen	gen	no
Systemic/Surgery Sequence	VI.2.14	yes	yes	yes
Text RX Chemotherapy	VI.4	sel	sel	sel
Text RX Hormone Therapy	VI.5	sel	sel	sel
Text RX Immunotherapy	VI.6	sel	sel	sel
Text RX Other Therapy	VI.7	sel	sel	sel
Text RX Radiation (Beam)	VI.3	sel	sel	sel
Text RX Radiation (Other)	VI.3	sel	sel	sel
Text RX Radiation Boost RX Modality	VI.3	sel	sel	sel
Text RX Radiation Regional RX Modality	VI.3	sel	sel	sel
Text RX Surgery	VI.2	sel	sel	sel
Text DxProc Lab Tests	IV.1.5	yes*	yes*	yes*
Text DxProc Operative	IV.1.6	yes*	yes*	yes*
Text DxProc Pathological	IV.1.7	yes*	yes*	yes*
Text DxProc PE	IV.1.2	yes*	yes*	yes*
Text DxProc Scopes	IV.1.4	yes*	yes*	yes*
Text DxProc Xray	IV.1.3	yes*	yes*	yes*
Text Remarks	VIII.1	yes*	yes*	yes*
TNM Coder (Clinical)	V.7.6	yes*	yes*	yes*
TNM Coder (Path)	V.7.6	yes*	yes*	yes*
TNM Edition	V.7.7	yes*	yes*	yes*
TNM Stage (Clinical)	V.7.5	yes*	yes*	yes*

TNM Stage (Path)	V.7.5	yes*	yes*	yes*
TNM M Code (Clinical)	V.7.4	yes*	yes*	yes*
TNM M Code (Path)	V.7.4	yes*	yes*	yes*
TNM N Code (Clinical)	V.7.4	yes*	yes*	yes*
TNM N Code (Path)	V.7.4	yes*	yes*	yes*
TNM T Code (Clinical)	V.7.4	yes*	yes*	yes*
TNM T Code (Path)	V.7.4	yes*	yes*	yes*
Transplant/Endocrine Procedures At This Hospital	VI.7.1	yes	yes	yes
Transplant/Endocrine Procedures Summary	VI.7.1	yes	yes	yes
Treatment Hospital Number-Procedure 1-3	VI.2.6	yes	yes	yes
Tumor Markers 1-3	V.6	sel	sel	sel
Tumor Marker-CA-1	V.6.4	sel	sel	sel
Tumor Size	V.4	yes	yes	yes
Tumor Status	VII.2.4	yes	yes	yes
Type of Admission	III.3.7	yes	yes	yes
Type of Reporting Source	III.3.6	yes	yes	yes
Vendor Version		gen	yes	gen
Vital Status	VII.2.2	yes	yes	yes
Year First Seen	II.2.1	yes	no	yes

Note: As of 1/1/2008, data items Pathology Report Number Biopsy/FNA and Pathology Report Number - Surgery became obsolete. For cases diagnosed prior to 1/1/2008, the data in these fields were converted to the DxRx Report Number 1 and 2 fields.

Appendix V: Brain and CNS Site/Histology Listing

Based on ICD-O-3 SEER Site/Histology Validation list
Reviewed by Neuropathologists: Drs. Roger McLendon, Janet Bruner, Steven Moore
SEER: Lynn Ries
CBTRUS: Dr. Bridget McCarthy, Carol Kruchko

Underlined bold type indicates histology codes with a benign or uncertain behavior code that have been added by CBTRUS and are not contained in the ICD-O-3 SEER Site/Histology Validation List.

Bold type indicates histology codes with a malignant behavior code that have been added by CBTRUS and are not contained in the ICD-O-3 SEER Site/Histology Validation List.

Meninges - Brain/Spinal Cord/Cranial Nerves - Ventricle - Cerebellum - Other Nervous System - Pituitary - Pineal

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

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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	967	

LYMPHOCYTIC		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 plexus papilloma
		9390/3 Choroid plexus papilloma, malignant
		9391/3 Ependymoma, NOS
		9392/3 Ependymoma, anaplastic
		9393/3 Papillary ependymoma
ASTROCYTOMA, NOS	940	
		9400/3 Astrocytoma, NOS
		9401/3 Astrocytoma, anaplastic

PROTOPLASMIC ASTROCYTOMA	941	
		9410/3 Protoplasmic astrocytoma
		9411/3 Gemistocytic astrocytoma
FIBRILLARY ASTROCYTOMA	942	
		9420/3 Fibrillary astrocytoma
		9421/1 Pilocytic astrocytoma
		9423/3 Polar spongioblastoma
		9424/3 Pleomorphic xanthoastrocytoma
ASTROBLASTOMA	943	
		9430/3 Astroblastoma
GLIOBLASTOMA, NOS	944	
		9440/3 Glioblastoma, NOS
		9441/3 Giant cell glioblastoma
		9442/3 Gliosarcoma
		9444/1 Chordoid glioma
OLIGODENDROGLIOMA, NOS	945	
		9450/3 Oligodendroglioma, NOS
		9451/3 Oligodendroglioma, anaplastic
PRIMITIVE NEUROECTODERMAL	947	
		9473/3 Primitive neuroectodermal tumor (PNET)
GANGLIONEUROBLASTOMA	949	
		9490/0 Ganglioneuroma
		9490/3 Ganglioneuroblastoma

9492/0 Gangliocytoma

NEUROBLASTOMA, NOS 950

9500/3 Neuroblastoma, NOS

9501/3 Medulloepithelioma, NOS

9502/3 Teratoid medulloepithelioma

9503/3 Neuroepithelioma, NOS

9505/1 Ganglioglioma, NOS

9505/3 Ganglioglioma, anaplastic

9506/1 Central neurocytoma

9508/3 Atypical teratoid/rhabdoid tumor

MENINGIOMAS 953

9530/0 Meningioma, NOS

9530/1 Meningiomatosis, NOS

9530/3 Meningioma, malignant

9531/0 Meningotheliomatous meningioma

9532/0 Fibrous meningioma

9533/0 Psammomatosis meningioma

9534/0 Angiomatous meningioma

9537/0 Transitional meningioma

9538/1 Clear cell meningioma

9538/3 Papillary meningioma

MALIGNANT LYMPHOMA, NOS 959

9590/3 Malignant lymphoma, NOS

9591/3 Malignant lymphoma, non-Hodgkin

9596/3 Composite Hodgkin and non-Hodgkin lymphoma

ML, SMALL B-CELL LYMPHOCYTIC	967	
		9670/3 ML, small B lymphocytic, NOS
		9671/3 ML, lymphoplasmacytic
		9673/3 Mantle cell lymphoma
		9675/3 ML, mixed sm. and lg. cell, diffuse
ML, LARGE B-CELL, DIFFUSE	968	
		9680/3 ML, large B-cell, diffuse
		9684/3 ML, large B-cell, diffuse, immunoblastic, NOS
		9687/3 Burkitt lymphoma, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9690/3 Follicular lymphoma, NOS
		9691/3 Follicular lymphoma, grade 2
		9695/3 Follicular lymphoma, grade 1
		9698/3 Follicular lymphoma, grade 3
		9699/3 Marginal zone B-cell lymphoma, NOS
T-CELL LYMPHOMAS	970	
		9701/3 Sezary syndrome
		9702/3 Mature T-cell lymphoma, NOS
		9705/3 Angioimmunoblastic T-cell lymphoma
OTHER SPEC. NON-HODGKIN LYMPHOMA	971	
		9714/3 Anaplastic large cell lymphoma, T-cell and Null cell type
		9719/3 NK/T-cell lymphoma, nasal and nasal-type

PRECURS. CELL LYMPHOBLASTIC LYMPH.	972	
		9727/3 Precursor cell lymphoblastic lymphoma, NOS
		9728/3 Precursor B-cell lymphoblastic lymphoma
		9729/3 Precursor T-cell lymphoblastic lymphoma
PLASMA CELL TUMORS	973	
		9731/3 Plasmacytoma, NOS
		9734/3 Plasmacytoma, extramedullary
NEOPLASMS OF HISTIOCYTES AND ACCESSORY LYMPHOID CELLS	975	
		9750/3 Malignant histiocytosis
		9754/3 Langerhans cell histiocytosis, disseminated
		9755/3 Histiocytic sarcoma
		9756/3 Langerhans cell sarcoma
		9757/3 Interdigitating dendritic cell sarcoma
		9758/3 Follicular dendritic cell sarcoma

CEREBELLUM C716

NEOPLASM	800	
		8000/0 Neoplasm, benign
		8000/1 Neoplasm, uncertain whether benign or malignant
		8000/3 Neoplasm, malignant
		8001/0 Tumor cells, benign
		8001/1 Tumor cells, uncertain whether benign or malignant
		8001/3 Tumor cells, malignant

		8005/3 Malignant tumor, clear cell type
SARCOMA, NOS	880	
		8800/0 Soft tissue tumor, benign
		8800/3 Sarcoma, NOS
		8805/3 Undifferentiated sarcoma
		8806/3 Desmoplastic small round cell tumor
FIBROMATOUS NEOPLASMS	881	
		8810/3 Fibrosarcoma, NOS
		8815/0 Solitary fibrous tumor
LIPOMATOUS NEOPLASMS	885	
		8850/0 Lipoma, NOS
GERM CELL NOEPLASMS	908	
		9080/0 Teratoma, benign
		9080/1 Teratoma, NOS
		9080/3 Teratoma, malignant, NOS
		9084/0 Dermoid cyst, NOS
BLOOD VESSEL TUMORS	912	
		9120/0 Hemangioma, NOS
HEMANGIOENDOTHELIOMA	913	
		9131/0 Capillary hemangioma
HEMANGIOPERICYTOMA	915	
		9150/1 Hemangiopericytoma, NOS

HEMANGIOBLASTOMA	916	
		9161/1 Hemangioblastoma
CHORDOMA	937	
		9370/3 Chordoma, NOS
		9371/3 Chondroid chordoma
		9372/3 Dedifferentiated chordoma
GLIOMA	938	
		9380/3 Glioma, malignant
		9381/3 Gliomatosis cerebri
		9382/3 Mixed glioma
		9383/1 Subependymoma
EPENDYMOMA, NOS	939	
		9391/3 Ependymoma, NOS
		9392/3 Ependymoma, anaplastic
		9393/3 Papillary ependymoma
ASTROCYTOMA, NOS	940	
		9400/3 Astrocytoma, NOS
		9401/3 Astrocytoma, anaplastic
PROTOPLASMIC ASTROCYTOMA	941	
		9410/3 Protoplasmic astrocytoma
		9411/3 Gemistocytic astrocytoma
FIBRILLARY	942	

ASTROCYTOMA		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	967	

LYMPHOCYTIC		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	972	

LYMPHOBLASTIC LYMPH.		9727/3 Precursor cell lymphoblastic lymphoma, NOS
		9728/3 Precursor B-cell lymphoblastic lymphoma
		9729/3 Precursor T-cell lymphoblastic lymphoma
PLASMA CELL TUMORS	973	
		9731/3 Plasmacytoma, NOS
		9734/3 Plasmacytoma, extramedullary
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 code 90 for Other South Asian. Please note that code 90 is not included in Appendix W because it is a code added by the CCR.

Refer to Section III.2.9 for more detailed race coding information.

Races to be coded as 90 include:

Bangladeshi
Bhutanese
Nepalese
Sikkimese
Sri Lankan

Do not use code 96 as Appendix W indicates for the races listed above.

Appendix W.1

RACE AND NATIONALITY DESCRIPTIONS 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.

See **ALPHABETIC INDEX**

References:

1. *Race and Ethnicity Code Set, Version 1.0, Centers for Disease Control and Prevention, March 2000.*
2. *Instruction manual, part 4: Classification And Coding Instructions For Death Records, 1999-2001, Division of Vital Statistics, National Center for Health Statistics, undated*

Key

Use this code unless patient is stated to be Native American (Indian) or other race

* *Terms listed in reference 2, above.*

! *Description of religious affiliation rather than stated nationality or ethnicity; should be used with caution when determining appropriate race code.*

CODE 01 WHITE

Afghan, Afghanistani
Afrikaner
Albanian
Algerian*
Amish*
Anglo-Saxon*
Arab, Arabian
Argentinian*
Armenian
Assyrian
Australian*
Austrian*

Azores*
Basque*
Bavarian*
Bolivian*
Bozniak/Bosnian
Brava/Bravo*
Brazilian
Bulgarian
Cajun
Californio
Canadian*
Caucasian*
Central American
Chechnyan
Chicano*
Chilean
Colombian*
Costa Rican*
Croat/Croatian
Crucian*
Cuban (*unless specified as Black*)*
Cypriot
Czechoslovakian*
Eastern European
Ebian*
Ecuadorian*
Egyptian
English
English-French*
English-Irish*
European*
Finnish*
French
French Canadian*
Georgian*
German
Greek*
Guatemalan
Gypsy*
Hebrew*!
Herzegovenian
Hispanic*
Honduran
Hungarian*
Iranian, Iran
Iraqi
Irish
Islamic*!

Israeli
Italian
Jordanian*
Kurd/Kurdish
Kuwaitian*
Ladina/Ladino*
Latin American*
Latino
Latvian*
Lebanese
Libyan*
Lithuanian*
Maltese*
Marshenese*
Mauritian*
Moroccan*
Mediterranean*
Mexican
Middle Eastern
Moroccan*
Moslem*!
Muslim*
Near Easterner
Nicaraguan
Nordic*
North African
Norwegian*
Other Arab
Palestinian
Panamanian
Paraguayan
Parsi*
Persian*
Peruvian*
Polish
Portuguese*
Puerto Rican (*unless specified as Black*)
Romanian*
Rumanian
Russian*
Salvadoran
Saudi Arabian*
Scandanavian*
Scottish, Scotch
Semitic*!
Serbian*
Servian*
Shiite!

Sicilian*
Slavic, Slovakian*
South American
Spanish*, Spaniard
Sunni*!
Swedish*
Syrian
Tunisian*
Turkish, Turk*
Ukranian*
United Arab Emirati
Uruguayan
Venezuelan*
Welsh*
White
Yemenite*
Yugoslavian*
Zoroastrian*

CODE 02 BLACK OR AFRICAN AMERICAN
African
African American
Afro-American
Bahamian
Barbadian
Bilalian*
Black
Botswana
Cape Verdean*
Dominica Islander (*unless specified as White*)
Dominican/Dominican Republic (*unless specified as White*)
Eritrean*
Ethiopian
Ghanian*
Haitian
Hamitic*
Jamaican
Kenyan*
Liberian
Malawian*
Mugandan*
Namibian
Nassau*
Negro
Nigerian
Nigritian
Nubian*

Other African
Santo Domingo*
Seychelloise*
Sudanese*
Tanzanian*
Tobagoan
Togolese*
Trinidadian
West Indian
Zairean

CODE 03 AMERICAN INDIAN AND ALASKA NATIVE
(see separate list of tribes 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

Appendix W.2

RACE AND NATIONALITY DESCRIPTIONS FROM THE 2000 CENSUS AND BUREAU OF VITAL STATISTICS

ALPHABETIC INDEX

Note: Use these lists only when race is not stated but other information is provided in the medical record.

See CODE LIST

References:

1. *"Race and Ethnicity Code Set, Version 1.0," Centers for Disease Control and Prevention, March 2000.*
2. *"Instruction manual, part 4: Classification And Coding Instructions For Death Records, 1999-2001," Division of Vital Statistics, National Center for Health Statistics, undated*

Key

Use this code unless patient is stated to be Native American (Indian) or other race

* *Terms listed in reference 2, above.*

! *Description of religious affiliation rather than stated nationality or ethnicity; should be used with caution when determining appropriate race code.*

A

03	Abnaki
03	Absentee-Shawnee
03	Acoma
01	Afghan, Afghanistani
02	African
02	African American
01	Afrikaner
02	Afro-American
03	Ak Chin
03	Alabama-Coushatt Tribes of Texas

03 Alaska Native
01 Albanian
03 Aleut
01 Algerian*
03 Alsea
96 Amerasian
03 American Indian
01 Amish*
01 Anglo-Saxon*
03 Apache
01 Arab, Arabian
03 Arapaho
01 Argentinian*
03 Arikara
01 Armenian
96 Asian
09 Asian Indian
96 Asiatic
03 Assiniboin
01 Assyrian
03 Atacapa
03 Athapaskan
03 Atsina
01 Australian*
01 Austrian*
01 Azores*
03 Aztec

B

02 Bahamian
96 Bangladeshi
02 Barbadian
01 Basque*
01 Bavarian*
03 Bear River
03 Beaver
03 Bella Coola
03 Beothuk
96 Bhutanese
20 Bikinian
02 Bilalian*
02 Black
03 Blackfoot
03 Blue Lake
01 Bolivian*
03 Boold Piegan
96 Bornean
02 Botswana

01 Bozniak/Bosnian
01 Brava/Bravo*
01 Brazilian
03 Brotherton
96 Bruneian
01 Bulgarian
96 Burmese

C

03 Caddo
01 Cajun
03 Cakchiquel-lenca
03 Calapooya
01 Californio
13 Cambodian
01 Canadian*
02 Cape Verdean*
20 Carolinian
03 Carrier
03 Catawba
03 Cattaraugus
01 Caucasian*
03 Cayuga
03 Cayuse
96 Celebesian
01 Central American
03 Central American Indian
96 Ceram
96 Ceylonese
21 Chamorro
03 Chasta Costa
01 Chechnyan
03 Chehalis
03 Chemehuevi
03 Cherokee
03 Chetco
03 Cheyenne
03 Cheyenne River Sioux
01 Chicano*
03 Chickahominy
03 Chickasaw
01 Chilean
04 Chinese
03 Chinook
03 Chipewyan
03 Chippewa
03 Chippewa-Ojibwa
03 Chiricahua Apache

03 Chitimacha
03 Choctaw
03 Chol
03 Chontal
03 Chorti
03 Chuckchansi
03 Chumash
20 Chuukese
03 Clackamus
03 Clallam
03 Clatsop
03 Clear Lake
03 Coast Salish
03 Cochimi
03 Cochiti
03 Cocopa
03 Cocopah
03 Coeur D'Alene Tribe of Idaho
01 Colombian*
03 Columbia
03 Colville
03 Comanche
03 Comox
03 Concow
03 Conquille
25 Cook Islander
01 Costa Rican*
03 Coushatta
03 Covelo
03 Cow Creek
03 Cowichan
03 Cowlitz
03 Coyotero Apache
03 Cree
03 Creek
01 Croat/Croatian
03 Crow
03 Crow Creek Sioux
01 Crucian*
01 Cuban (*unless specified as Black*)*
01 Cypriot
01 Czechoslovakian*

D

03 Dakota
03 Delaware
03 Diegueno
03 Digger

03 Dog Rib
02 Dominica Islander (*unless specified as White*)
02 Dominican/Dominican Republic (*unless specified as White*)
03 Duckwater

E

01 Eastern European
01 Ebian*
01 Ecuadorian*
01 Egyptian
01 English
01 English-French*
01 English-Irish*
20 Eniwetok, Enewetak
02 Eritrean*
03 Eskimo
02 Ethiopian
03 Euchi
96 Eurasian
01 European*
03 Eyak

F

31 Fijian
06 Filipino
01 Finnish*
03 Flathead
03 Fort Hall Res. Tribe of Idaho
01 French
01 French Canadian*
03 French Indian

G

03 Gabrieleno
03 Galice Creek
03 Gay Head
01 Georgian*
01 German
02 Ghanian*
03 Gosiute
01 Greek*
03 Gros Ventre
22 Guamanian
01 Guatemalan
01 Gypsy*

H

03 Haida

02 Haitian
02 Hamitic*
03 Han
03 Hare
03 Hat Creek
07 Hawaiian
03 Hawasupai
01 Hebrew*!
01 Herzegovenian
03 Hidatsa
01 Hispanic*
12 Hmong
03 Hoh
01 Honduran
03 Hoopa
03 Hopi
03 Houma
03 Hualapai
03 Huastec
03 Humboldt Bay
01 Hungarian*
03 Hupa
03 Huron

I

03 Illinois
09 Indian (*from India*)
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

APPENDIX X

NATIONAL PROVIDER IDENTIFIER (NPI) CODES

The National Provider Identifier (NPI) is a unique identification number for health care providers. It is scheduled for 2007 implementation by the Centers for Medicare and Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health care providers have started the process of obtaining NPI codes, and hospitals have until May 2007 to meet the HIPAA deadline. NPI numbers are being distributed by CMS to all health care providers in the United States. CMS has mandated use of the assigned NPI in all administrative and financial transactions between "large" health plans and CMS starting in May 2007. For billing purposes, these providers will be required to use NPI codes by May 2007, but indications are that some health care facilities will start using these codes in advance of this deadline. If a facility starts to use the NPI codes, that information should be available from the provider's billing department.

NPI numbers are only assigned to health care providers who meet the definition of a "covered entity, " and this only includes individuals and entities licensed to provide health care. NPI's are not being issued to physicians who have opted out of government programs; entities that bill or are paid for health care services furnished by other health care providers; or clearing houses, vendors, administrative, and billing services (*Federal Register* [Friday, January 23, 2004]).

Registries should be able to record the NPI for their hospital or individual physicians with January 1, 2007, diagnoses. It is necessary, however, to be aware that NPI's may not have been assigned to all eligible parties by January 1, 2007. Historic facilities or physicians may no longer be in business or licensed and therefore, may not have an NPI assigned.

The NPI is a 10 byte numeric data item. The NPI consists of 9 numeric digits followed by one numeric check digit. The NPI will not have embedded intelligence. The NPI format and check digit calculation will be compatible with the card issuer identifier on a standard health identification card. The card standard was developed by the National Committee for Information Technology Standards (NCITS), which is accredited by the American National Standards Institute. NPI's will be issued initially with the first digit equal to 1 or 2. NPIs with the first digit equal to 1 are assigned to individual health care providers (i.e., physicians); hospitals or other entities that provide health care services will be assigned the first digit of NPI equal to 2. These digits will not be used as the first digits for other card issuer identifiers. NPI numbers will be generated using a scattering algorithm that has the capability to use all possible numeric combinations beginning with 1 or 2. Each NPI generated will be unique, without requiring database access for verification.

When a facility starts to use the NPI codes, that information should be entered and transmitted in the appropriate NPI data item fields. It is anticipated that the implementation of the NPI will vary by facility, provider, and data collection reporting software. Hospital registries should become aware of how the NPI will be implemented in their specific software.

The following data items are all components of the NPI implementation effort.

NPI--Registry ID (NAACCR #45)
The National Provider Identifier (NPI) code that represents the data transmission source. This item stores the NPI of the facility registry that transmits the record.

NPI--Reporting Facility (NAACCR #545)
The NPI code for the facility submitting the data in the record.

NPI--Inst Referred From (NAACCR #2415)
The NPI code that identifies the facility that referred the patient to the reporting facility.

NPI--Inst Referred To (NAACCR #2425)
The NPI code that identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

NPI--Following Registry (NAACCR # 2445)
The NPI code that records the registry responsible for following the patient.

NPI--Physician—Managing (NAACCR # 2465)
The NPI code that identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

NPI--Physician--Follow-Up (NAACCR # 2475)
The NPI code for the physician currently responsible for the patient's medical care.

NPI--Physician--Primary Surg (NAACCR # 2485)
The NPI code for physician who performed the most definitive surgical procedure.

NPI--Physician 3 (NAACCR # 2495)
The NPI code for another physician involved in the care of the patient.

NPI--Physician 4 (NAACCR # 2505)
The NPI code for another physician involved in the care of the patient.