CANCER REPORTING IN CALIFORNIA

Appendix

ABSTRACTING AND CODING PROCEDURES FOR HOSPITALS

California Cancer Reporting System Standards

VOLUME ONE

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STATE OF CALIFORNIA

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APPENDIX A

NEW HISTOLOGY CODES FOR LYMPHOMAS AND LEUKEMIAS

NEW LYMPHOMA TERMS. *Effective for cases diagnosed January 1, 1995, and after.*

ICD-O Code	Term
9673/3	Mantle cell lymphoma (*)
9688/3	T-cell rich B-cell lymphoma
9708/3	Subcutaneous panniculitic T-cell lymphoma
9710/3	Marginal zone lymphoma, NOS
9714/3	Anaplastic large cell lymphoma (ALCL), CD30+ (*)
9715/3	Mucosal-Associated Lymphoid Tissue (MALT) lymphoma
9716/3	Hepatosplenic γδ (gamma - delta) cell lymphoma
9717/3	Intestinal T-cell lymphoma Enteropathy associated T-cell lymphoma

(*) new term(s) for an existing number

NEW LEUKEMIA TERMS. *Effective for cases diagnosed January 1, 1998, and after.*

The following rules are to be used. They are in priority order:

1. Code the FAB (French-American-British) classification. FAB is implied if the description includes "L" or "M" with a number such as "L2" or M5". If more than one FAB classification is listed, use the NOS code. Example:

   Path: "Acute myelogenous leukemia, probably M1 or M2...."

   Code to 9861/3, Acute myeloid leukemia, NOS

   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 term(s) for an existing number

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

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

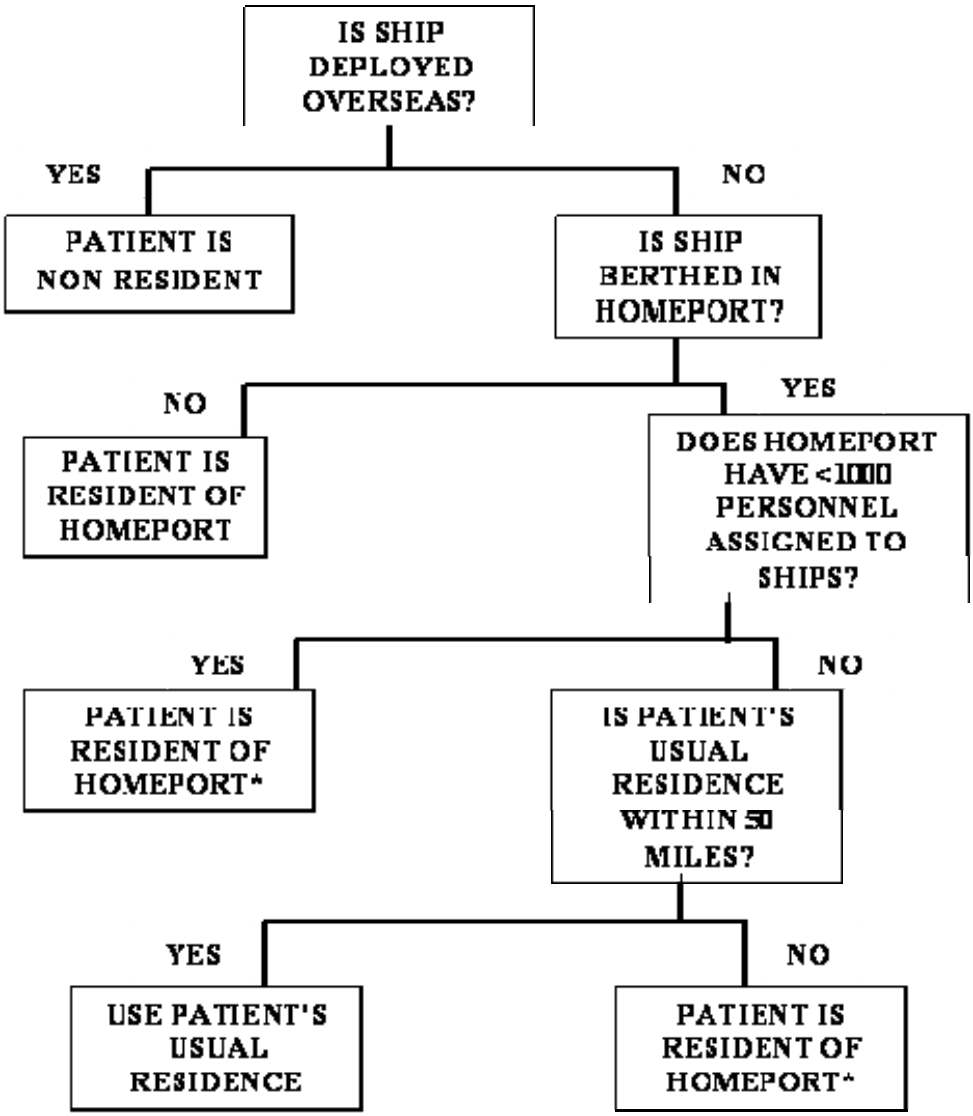
Patients diagnosed with cancer while their ships are deployed overseas are considered overseas residents for cancer-reporting purposes. For ships not deployed overseas, specific rules (shown in the chart below) apply. The Navy assigns a homeport to each of its ships. If a ship that is not deployed overseas is not berthed in its homeport, any crew member diagnosed with cancer is considered a resident of the homeport. If the ship is berthed in its homeport, and the homeport has fewer than 1000 naval personnel assigned to ships, a crew member diagnosed with cancer is considered a resident of the ship. If, however, the homeport has more than 1000 naval personnel assigned to ships and the cancer patient has a usual residence within 50 miles of the homeport, the person's residence is the home, not the ship itself. If the patient's usual residence is more than 50 miles from the homeport, he or she is considered to be a resident of the ship. For patients who are considered residents of a ship, code residence as the ship's homeport unless the homeport is contained in more than one municipality. In that case, code the patient's residence as the municipality immediately adjacent to the dock or pier where the ship is berthed.

CREWS OF MERCHANT VESSELS

Crews of U.S. vessels outside the U.S., or crews of vessels flying a foreign flag, are considered non-residents. If a U.S. vessel is not berthed in a U.S. port but is in territorial waters, and the port of destination is inside the U.S., a crew member diagnosed with cancer is considered a resident of the port of destination. If the destination is outside the U.S., the homeport of the ship is considered the patient's residence. If a U.S. vessel is berthed in a U.S. port at the time of diagnosis, the patient is a resident of that port.

CHART

Summary of Rules for Determining Residency of Navy Personnel Assigned to Ships



* If homeport is maintained in more than municipality, code patient as resident of the municipality immediately adjacent to the dock or pier where the ship is berthed.

APPENDIX F

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

Code Numbers (Sorted by Facility in Ascending Alphabetic Order)
http://www.ccrcal.org/PDF-DSQC/CAHospLabels-1.7.0.17-Alpha.pdf

APPENDIX G.1

CODES FOR RELIGIONS

(in numerical order) (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 G.2

CODES FOR RELIGIONS

(in alphabetical order)	(see numerical order)
AFRICAN METHODIST EPISCOPAL (AME)	07
AGNOSTIC	02
AMERICAN INDIAN RELIGIONS	90
AMISH	40
ANGLICAN	08
APOSTOLIC	42
ARMENIAN APOSTOLIC	43
ARMENIAN ORTHODOX	29
ASSEMBLIES OF GOD	44
ATHEIST	03
BAHA'I	72
BAPTIST	09
BRETHREN	45
BROTHERS	45
BUDDHIST	77
CATHOLIC	05
CHRISTIAN APOSTOLIC	46
CHRISTIAN REFORMED	18
CHRISTIAN SCIENCE	36
CHRISTIAN SECTS, OTHER	69
CHRISTIAN, NOS	06
CHURCH OF ARMEDIAN	47
CHURCH OF CHRIST	48
CHURCH OF ENGLAND	08
CHURCH OF GOD	49
CHURCH OF MESSIANITY	50
CHURCH OF THE DIVINE	51

CHURCH OF THE OPEN DOOR	52
COMMUNITY	10
CONFUCIANISM	79
CONGREGATIONAL HOLY	53
CONGREGATIONAL	11
COPTIC	30
COVENANT	54
CRICKORIAN	73
DISCIPLES OF CHRIST	19
DIVINE SCIENCE	55
DROUZE	78
DUTCH REFORMED	20
EASTERN RELIGION, NOS	89
EASTERN RELIGION, OTHER	89
EPISCOPALIAN	12
ETHICAL CULTURE	73
EVANGELICAL	56
FIRST CHRISTIAN	21
FOURSQUARE	58
FRIENDS	39
FULL GOSPEL	59
FUNDAMENTAL	57
GREEK ORTHODOX	31
GREGORIAN	73
HAITIAN/AFRICAN/BRAZILIAN RELIGIONS, OTHER	91
HINDU	83
HOLINESS	60
HOLY CONGREGATIONAL	53
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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

SCREENING LIST OF ICD-9-CM CODES FOR CASEFINDING

Certain ICD-9-CM* codes used by medical records departments for discharge diagnoses identify cases of malignant neoplasms that are reportable to the California Cancer Registry. Case finding procedures should include the review of medical records coded with the following numbers. Newly reportable diseases are followed by the ICD-O-3 morphology and behavior code in parentheses.

January 1, 2007 and Forward

For Casefinding starting January 1, 2007 and forward, 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.

Prior to January 1, 2007

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 L.1

CODES FOR CALIFORNIA COUNTIES

(in alphabetical order) (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) (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 C02	Base of tongue Other and unspecified parts of tongue
C05 C06	Palate Other and unspecified parts of mouth
C07 C08	Parotid gland Other and unspecified major salivary glands
C09 C10	Tonsil Oropharynx
C12 C13	Pyriform sinus Hypopharynx
C19 C20	Rectosigmoid junction Rectum
C23 C24	Gallbladder Other and unspecified parts of biliary tract
C30 C31	Nasal cavity and middle ear Accessory sinuses
C33 C34	Trachea Bronchus and lung

C37	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

APPENDIX O

1980 CENSUS LIST OF SPANISH SURNAMES

Instructions for Using 1980 Census List of Spanish Surnames

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

1980 CENSUS LIST OF SPANISH SURNAMES

ABA-AZU

See Index to Spanish Names

ABAD	ALCEDO	ANDUJAL	ARMADA
ABADIA	ALCERRECA	ANDUJAR	ARMADILLO
ABADIANO	ALCIBAR	ANDUJO	ARMADO
ABADIAS	ALCIVAR	ANDUYO	ARMAIZ

ABADILLA
ABADIN
ABAIGAR
ABAJO
ABALLE
ABALO
ABALOS
ABAONZA
ABARCA
ABARCO
ABAROA
ABARQUEZ
ABARTA
ABARZUA
ABASCAL
ABASTA
ABASTAS
ABASTO
ABAUNZA
ABAURREA
ABAY
ABAYA
ABBADIE
ABDALA
ABEA
ABEITA
ABEJA
ABELAIRAS
ABELAR
ABELDANO
ABELEDO
ABELLA
ABELLAN
ABELLEIRA
ABELLERA
ABENDANO
ABERASTURI
ABERASTURIA
ABERGEL
ABESADA
ABETE
ABEYTA
ABEYTIA
ABIEGA
ABILA
ABILES
ABILEZ
ABIN
ALCOBER
ALCOCER
ALCOCES
ALCOLA
ALCOLEA
ALCON
ALCONTAR
ALCORTA
ALCOSER
ALCOSET
ALCOVER
ALCOZAR
ALCOZER
ALCUDIA
ALDABA
ALDABE
ALDACO
ALDAHONDO
ALDAMA
ALDANA
ALDAPA
ALDAPE
ALDARONDO
ALDAS
ALDASORO
ALDAVA
ALDAVE
ALDAYA
ALDAZ
ALDAZABAL
ALDEBOT
ALDECOA
ALDECOCEA
ALDEIS
ALDEREGUIA
ALDERETE
ALDERETTE
ALDERTE
ALDRETE
ALDUEN
ALDUENDA
ALEANTAR
ALEBIS
ALEDO
ALEGADO
ALEGRE
ALEGRET
ALEGRIA
ANDUZE
ANEIRO
ANEIROS
ANEL
ANERO
ANGELES
ANGLADA
ANGLADE
ANGLERO
ANGOCO
ANGON
ANGUEIRA
ANGUERA
ANGUIANO
ANGUINO
ANGUITA
ANGULO
ANIAS
ANIBARRO
ANILLO
ANIZ
ANORGA
ANQUIANO
ANSALDUA
ANSALMO
ANSISO
ANSOATEGUI
ANSOLABEHERE
ANSURES
ANTA
ANTABLIN
ANTELO
ANTEQUERA
ANTIGUA
ANTILLON
ANTIMO
ANTOLIN
ANTOLINEZ
ANTOMARCHY
ANTONETTY
ANTOPIA
ANTRILLO
ANTU
ANTUNA
ANTUNANO
ANTUNEZ
ANZALDA
ANZALDO
ARMANDARIZ
ARMARIO
ARMAS
ARMENDA
ARMENDARES
ARMENDAREZ
ARMENDARIS
ARMENDARIZ
ARMENDEZ
ARMENDIA
ARMENGOL
ARMENTA
ARMENTERO
ARMENTEROS
ARMERO
ARMESTO
ARMIENTA
ARMIGO
ARMIJO
ARMIJOS
ARMINAN
ARMINANA
ARMITO
ARMO
ARMOLA
ARMORA
ARNADO
ARNAEZ
ARNAIZ
ARNALDO
ARNAVAT
ARNEDO
ARNERO
ARNIELLA
AROCENA
AROCHA
AROCHE
AROCHI
AROCHO
AROIZA
AROS
AROSEMENA
AROSTEGUI
AROYA
AROYO
AROZ
AROZENA
ARPON

ABINA
ABIO
ABIOL
ABISLAIMAN
ABITIA
ABITU
ABITUA
ABLANEDO
ABOGADO
ABOITE
ABOITES
ABOLILA
ABONCE
ABORLLEILE
ABOY
ABOYTES
ABRAHANTE
ABRAHANTES
ABRAJAN
ABRANTE
ABREA
ABREGO
ABREO
ABREU
ABREUS
ABREUT
ABREV
ABREW
ABREYO
ABRICA
ABRIGO
ABRIL
ABRIOL
ABUIN
ABUNDES
ABUNDEZ
ABUNDIS
ABUNDIZ
ABUNDO
ABURTO
ABUTIN
ACABA
ACABEO
ACARON
ACASTA
ACCOSTA
ACCUAR
ACEBAL

ALEJANDRE
ALEJANDRES
ALEJANDREZ
ALEJANDRO
ALEJO
ALEJOS
ALELUNAS
ALEMAN
ALEMANIA
ALEMANY
ALEMAR
ALEN
ALENCASTRO
ALEQUIN
ALERS
ALERTE
ALEVEDO
ALEXANDRINO
ALFALLA
ALFARA
ALFARD
ALFARO
ALFASSA
ALFAU
ALFEREZ
ALFONSECA
ALFONSO
ALFONZO
ALFRIDO
ALGARA
ALGARIN
ALGARRA
ALGAVA
ALGEA
ALGECIRAS
ALGORA
ALGORRI
ALGORTA
ALGUACIL
ALGUESEVA
ALIAGA
ALICANTE
ALICCA
ALICEA
ALICIA
ALIJA
ALINAYA
ALIPAZ

ANZALDUA
ANZAR
ANZARA
ANZARDO
ANZELDE
ANZORENA
ANZUA
ANZUALDA
ANZUETO
ANZULES
ANZURES
APABLASA
APADACA
APAEZ
APALATEGUI
APALATEQUI
APARICIO
APELLANIZ
APEZTEGUIA
APODACA
APODACO
APODOCA
APOLINAR
APONTE
APORTELA
APRATO
APRICIO
APUAN
AQUAYO
AQUERO
AQUEVEQUE
AQUIAR
AQUILAR
AQUILERA
AQUILES
AQUILLAR
AQUIN
AQUINAGA
AQUINES
AQUIRRE
ARA
ARABALO
ARABI
ARABITG
ARACENA
ARACHE
ARADILLAS
ARAGO

ARQUELLES
ARQUELLO
ARQUER
ARQUERO
ARQUES
ARQUETA
ARQUIMBAU
ARQUIZA
ARRABAL
ARRACHE
ARRAIGA
ARRAIZA
ARRAMBIDE
ARRANAGA
ARRASTIA
ARRATIA
ARRAYA
ARRAZCAETA
ARRAZOLA
ARREA
ARREAGA
ARREALA
ARREAZOLA
ARREBOLA
ARRECHE
ARRECHEA
ARREDENDO
ARREDONDA
ARREDONDO
ARREGUI
ARREGUIN
ARREGUY
ARRELLANO
ARRELLIN
ARRENDO
ARRENDONDO
ARRENQUIN
ARREOLA
ARREQUIBE
ARREQUIN
ARRESTOY
ARRETCHE
ARREY
ARREYGUE
ARREZOLA
ARRIAGA
ARRIAGO
ARRIARAN

ACEBEDO
ACEBO
ACED
ACEDO
ACEITUNO
ACENCIO
ACENEDO
ACERA
ACEREDO
ACERETO
ACERO
ACETY
ACEUEDO
ACEVDO
ACEVEDA
ACEVEDO
ACEVES
ACEVEZ
ACEVIDO
ACHA
ACHEZ
ACHON
ACIDO
ACIN
ACOBE
ACOSTA
ACOYA
ACUESTA
ACUNA
ACUSTA
ADAME
ADAMES
ADAMEZ
ADAN
ADANZA
ADARGO
ADAROS
ADAUTO
ADELO
ADONA
ADORNO
ADRIASOLA
ADROVER
ADROVET
ADUNA
ADVINCULA
AEDO
AFAN
ALIRE
ALIRES
ALIREZ
ALLADICE
ALLADO
ALLALA
ALLANDE
ALLARID
ALLEGRANZA
ALLEGUE
ALLEGUEZ
ALLENDE
ALLENEGUI
ALLESANDRO
ALLONGO
ALLOZA
ALMA
ALMADA
ALMADO
ALMADOVA
ALMAGER
ALMAGNER
ALMAGRO
ALMAGUER
ALMANCE
ALMANDOZ
ALMANSA
ALMANZA
ALMANZAN
ALMANZAR
ALMANZO
ALMAQUER
ALMARAS
ALMARAZ
ALMARES
ALMAREZ
ALMARZA
ALMAZAN
ALMEDA
ALMEDINA
ALMEJO
ALMENA
ALMENAR
ALMENARA
ALMENARES
ALMENDARES
ALMENDAREZ
ALMENDARIZ
ARAGON
ARAGONES
ARAGONEZ
ARAGUAS
ARAGUNDI
ARAGUS
ARAGUZ
ARAICA
ARAIN
ARAIZ
ARAIZA
ARAMAYO
ARAMBEL
ARAMBUL
ARAMBULA
ARAMBULO
ARAMBURO
ARAMBURU
ARAMENDIA
ARAN
ARANA
ARANALDE
ARANAS
ARANAZ
ARANCIBIA
ARANDA
ARANDIA
ARANDO
ARANDULES
ARANEGUI
ARANETA
ARANGO
ARANGUA
ARANGUIZ
ARANGURE
ARANGUREN
ARANIBAR
ARANJON
ARANO
ARANZA
ARANZAZU
ARANZUBIA
ARAOZ
ARAQUE
ARATER
ARAUGO
ARAUS
ARAUSA
ARRIASOLA
ARRIAZA
ARRIAZOLA
ARRIBA
ARRIBAS
ARRIERA
ARRIERO
ARRIETA
ARRIETE
ARRIETTA
ARRIGA
ARRILLAGA
ARRIOLA
ARRIQUIDEZ
ARRISOLA
ARRITOLA
ARRIVILLAGA
ARRIZOLA
ARRIZON
ARROCENA
ARROJAS
ARROJO
ARROLLADO
ARROLLO
ARRONA
ARRONDO
ARRONGE
ARRONIZ
ARRONTE
ARROYA
ARROYAS
ARROYAVE
ARROYO
ARROYOS
ARROZ
ARRUE
ARRUFAT
ARSATE
ARSOLA
ARSUAGA
ARTACHE
ARTALEJO
ARTAU
ARTAUD
ARTAVIA
ARTAZA
ARTEA
ARTEAGA

AFANADOR
AFRE
AGADO
AGALA
AGANZA
AGAPITO
AGEITOS
AGIRRE
AGON
AGOSTO
AGRA
AGRAIT
AGRAMONTE
AGRAS
AGRAZ
AGREDA
AGREDANO
AGREGADO
AGRONT
AGUABELLA
AGUADO
AGUALLO
AGUANO
AGUARISTI
AGUAS
AGUASVIVAS
AGUAYA
AGUAYO
AGUDELO
AGUDO
AGUEDA
AGUELAR
AGUERA
AGUERO
AGUEROS
AGUERRE
AGUERREBERE
AGUERRIA
AGUET
AGUIGUI
AGUILA
AGUILAR
AGUILER
AGUILERA
AGUILES
AGUILLAR
AGUILLEN
AGUILLERA

ALMENDRAL
ALMENDRAS
ALMENGER
ALMENGOR
ALMERA
ALMERAZ
ALMERIA
ALMESTICA
ALMEYDA
ALMEZQUITA
ALMIRALL
ALMIRUDIS
ALMODOBAR
ALMODOUAR
ALMODOVA
ALMODOVAR
ALMOGABAR
ALMOGUERA
ALMOINA
ALMONACID
ALMONDOVAR
ALMONTE
ALMONTES
ALMORA
ALMUINA
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APPENDIX O

1980 CENSUS LIST OF SPANISH SURNAMES

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APPENDIX O

1980 CENSUS LIST OF SPANISH SURNAMES

CAA-CUZ

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ECHAVARRIA	EMPERADOR	ESCARZAGA	ESQUILIN
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HERENA	HERROZ	HOLGUIN	HUICI
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LAB-LUZ

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LABASTIDA	LARRUBIA	LENERO	LLOSA
LABASTILLA	LARTUNDO	LENTE	LLOVERA
LABIO	LARZABAL	LEODORO	LLOVERAS
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LABISTE	LAPARRA	LEONES	LLOVIO
LABOCA	LAPAZ	LEONGUERRERO	LLUBERES
LABORDA	LAPENA	LEONIS	LLUCH
LABORI	LAPICA	LEONOR	LLUIS
LABORICO	LAPIZ	LEOS	LLURIA
LABORIN	LAPUERTA	LEOZ	LLUVERAS
LABOY	LAPUZ	LEPE	LOA
LABRA	LARA	LERA	LOAIZA
LABRADA	LARACUENTA	LERDO	LOARTE
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LABRADOR	LARALDE	LERET	LOBAINA
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LACHICA	LARRA	LETRIZ	LOGRONO
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LACOME	LARRAGOITE	LEVARIO	LOJA
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TACORONTE	TERRADO	TOYOS	ULLIVARRI
TADEO	TERRASA	TRABA	ULLOA
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TAFORO	TERRAZAS	TRACONIS	UMARAN
TAFOYA	TERRERO	TRANCOSA	UMPIERRE
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TAGANAS	TERRIGUEZ	TRAPAGA	UNAMUNO
TAGLE	TERRIQUEZ	TRASLAVINA	UNANUE
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VADIA	VEAS	VICIEDO	VILLARAN
VADILLO	VECIN	VICINAIZ	VILLARAOS
VADIZ	VECINO	VICIOSO	VILLARAUS
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VAEZ	VEGA	VICUNA	VILLARES
VAEZA	VEGARA	VIDACA	VILLARICO
VAIO	VEGATORRES	VIDAL	VILLARINO
VAISA	VEGAZO	VIDALES	VILLARINY
VAIZ	VEGERANO	VIDALEZ	VILLARIZA
VAIZA	VEGES	VIDANA	VILLAROEL
VAL	VEGO	VIDANO	VILLARONGA
VALADEZ	VEGOS	VIDAURE	VILLAROS
VALADON	VEGUE	VIDAURI	VILLARRE
VALAGUE	VEGUEZ	VIDAURRAZAGA	VILLARREAL
VALARDE	VEGUILLA	VIDAURRE	VILLARRIAL
VALAREZO	VEIGUELA	VIDAURRETA	VILLARROEL
VALASQUEZ	VEINTIDOS	VIDAURRI	VILLARRUBIA
VALAZQUEZ	VEITIA	VIDAURRY	VILLARRUEL
VALBUENA	VEJAR	VIDENA	VILLARRUZ
VALCARCE	VEJARA	VIDES	VILLARTA
VALCARCEL	VEJARANO	VIDOT	VILLARUBIA
VALCAZAR	VEJIL	VIDRIALES	VILLARUZ
VALDASO	VEJO	VIDRIO	VILLAS
VALDEMAR	VELA	VIDRIOS	VILLASAIZ
VALDENEGRO	VELAARCE	VIDUYA	VILLASANA
VALDEPENA	VELACUELLAR	VIEGO	VILLASANO
VALDERAMA	VELADO	VIEITES	VILLASANTE
VALDERAS	VELADOR	VIEJO	VILLASECA
VALDERAZ	VELAQUEZ	VIELMA	VILLASENOR
VALDEREZ	VELAR	VIELMAN	VILLASIS
VALDERRAIN	VELARDE	VIELMAS	VILLASTRIGO
VALDERRAMA	VELARDES	VIENTOS	VILLASUSO
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YBARA
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YBERA
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YPARRAGUIRRE
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YRACEBURU
YRACHETA
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YRIBARREN
YRIBE
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YRIGOLLEN
YRIGOYEN
YRINEO
YRIQUE
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YRISARRI
YRIZARRY
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YSAGUIRRE
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YSASAGA
YSASI
YSASSI
YSER
YSERN
YSET
YSLA
YSLAS
YSLAVA
YSQUIERDO
YTUARTE
YTURBE
YTURRALDE

ZALAZAR
ZALDANA
ZALDIVAR
ZALDUA
ZALDUMBIDE
ZALDUONDO
ZALVIDEA
ZAMACONA
ZAMAGO
ZAMANIEGO
ZAMANILLO
ZAMANO
ZAMAR
ZAMARIPA
ZAMARIPPA
ZAMARO
ZAMARRI
ZAMARRIPA
ZAMARRIPAS
ZAMARRON
ZAMAYOA
ZAMAZAL
ZAMBADA
ZAMBRANA
ZAMBRANO
ZAMILPA
ZAMORA
ZAMORANO
ZAMORES
ZAMOREZ
ZAMOT
ZAMUDIO
ZANABRIA
ZANDATE
ZANDONA
ZANGRONIZ
ZANUDO
ZAPARA
ZAPATA

ZAVALA
ZAVALETA
ZAVALETTA
ZAVALLA
ZAVALZA
ZAVAT
ZAYAS
ZAYASBAZAN
ZAYAZ
ZAZUETA
ZAZUETTA
ZEBALLOS
ZEDENO
ZEDILLO
ZEGARRA
ZELADA
ZELAYA
ZELEDON
ZEMEN
ZENDEJAS
ZENGOTITA
ZENIZO
ZENOZ
ZENTELLA
ZENTENO
ZEPADA
ZEPEDA
ZEQUEIRA
ZERDA
ZERIN
ZERMENO
ZERPA
ZERQUERA
ZERTUCHE
ZERVIGON
ZETINA
ZETINO
ZEVALLOS
ZILBAR

YEPEZ
YEPIS
YEPIZ
YERA
YERAS
YERENA
YERO
YESCAS
YESETA
YESTE
YEVERINO
YGLECIAS
YGLESIAS
YGNACIO
YGUADO
YGUERABIDE
YLARREGUI
YLIZALITURRI
YLLA
YLLADA
YLLANES
YLLESCAS
YNCERA
YNCLAN
YNDA
YNEGAS
YNEGES
YNFANTE
YNIGO
YNIGUEZ
YNIQUEZ
YNOA
YNOCENCIO
YNOSENCIO
YNOSTROSA
YNOSTROZA
YNZUNZA
YOGUEZ
YTURRI
YTURRIA
YTURRIAGA
YUBETA
YUCUPICIO
YUDESIS
YUDICE
YUDICO
YULAN
YULFO
YURIAR
YUSTE
YVANEZ
YVARRA
YZABAL
YZAGUIRRE
YZNAGA
YZQUIERDO

ZABAL
ZABALA
ZABALETA
ZABALLA
ZABALO
ZABALZA
ZACARIAS
ZACUTO
ZADRIMA
ZAERA
ZAFEREO
ZAFRA
ZAGALA
ZAGALES
ZAGONA
ZALACAIN
ZALACE
ZALAMEA
ZALAPA
ZAPATER
ZAPATERO
ZAPEDA
ZAPIAIN
ZAPIEN
ZARABOZO
ZARAGOSA
ZARAGOZ
ZARAGOZA
ZARAGOZI
ZARATE
ZARAZUA
ZARCO
ZARCOS
ZARDENETA
ZARDENETTA
ZARDO
ZARDON
ZARDOYA
ZAROGOZA
ZARRAGA
ZARRAGOITIA
ZARRAGOZA
ZARRIA
ZARUBICA
ZARZANA
ZARZOSA
ZARZOZA
ZARZUELA
ZASUETA
ZATARAIN
ZATARAY
ZATARIAN
ZATOREN
ZAUALA
ZAUL
ZAUZA
ZILLAS
ZOLETA
ZOMORA
ZOROLA
ZORRILLA
ZOZAYA
ZUAZNABAR
ZUAZO
ZUAZUA
ZUBELDIA
ZUBIA
ZUBIATE
ZUBIETA
ZUBILLAGA
ZUBIRAN
ZUBIRI
ZUBIRIA
ZUBIZARRETA
ZUGASTI
ZULAICA
ZULETA
ZULOAGA
ZULUAGA
ZULUETA
ZUMARRAGA
ZUMAYA
ZUNIGA
ZUNIZA
ZUNO
ZUNZUNEGUI
ZURBANO
ZURBARAN
ZURITA
ZURRICA
ZUVIA
ZUVIETA
ZUZUARREGUI

Appendix Q: Surgery Codes

Q1. See ROADS Surgery Codes*(For Cases Diagnosed Prior to January 1, 2003)*

Q2. See FORDS Surgery Codes*(For Cases Diagnosed on or after January 1, 2003)*

Appendix Q-1 Surgery Codes
(For Cases Diagnosed prior to January 1, 2003)

Index to Sites

Oral Cavity
Parotid & Other Unspecified Glands
Pharynx
Esophagus
Stomach
Colon
Rectosigmoid
Rectum
Anus
Liver & Intrahepatic Bile Ducts
Pancreas
Larynx
Lung
Bones, Joints & Articular Cartilage/ Peripheral Nerves/ Connective & Soft Tissue
Spleen and Lymph Nodes
Skin
Breast
Cervix Uteri
Corpus Uteri
Ovary
Prostate
Testis
Kidney, Renal Pelvis & Ureter
Bladder
Brain & Other Parts of Central Nervous System
Thyroid Gland
All Other Sites

ORAL CAVITY

Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C09.9,
Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9,

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 node(s) removed, NOS

2 Neck dissection, NOS

3 Selective, limited; nodal sampling; "berry picking"

4 Modified/modified radical

5 Radical

9 Unknown; not stated; death certificate **only**

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

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional site(s)
  - 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 node(s)
- 6 Distant site(s)
- 7 Combination of 6 **with** 2, 3, 4, or 5

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Flaps, grafts, or any type of "plasty," NOS

- 2 **without** implant/prosthesis
- 3 **with** implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

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

SURGICAL APPROACH

Codes

0 None; no 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 node(s) removed, NOS

- 2 Neck dissection, NOS
  - 3 Selective, limited; nodal sampling; "berry picking"

4 Modified/modified radical

5 Radical

9 Unknown; not stated; death certificate **only**

Terminology of neck dissection (Robbins et al. 1991): A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle. In a modified radical neck dissection, the same lymph nodes are removed as in a radical neck dissection; however, one or more 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Flaps, grafts, or any type of "plasty," NOS

- 2 **without** implant/prosthesis
- 3 **with** implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

PHARYNX
Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9, Pyriform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0

SURGICAL APPROACH

Codes

0 None; 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 node(s) removed, NOS

2 Neck dissection, NOS

3 Selective, limited; nodal sampling; "berry picking"

4 Modified/modified radical

5 Radical

9 Unknown; not stated; death certificate **only**

Terminology of neck dissection (Robbins et al. 1991): A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle. In a modified radical neck dissection, the same lymph nodes are removed as in a radical neck dissection; however, one or more 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 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**

ESOPHAGUS

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 node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Celiac nodes are distant for intrathoracic esophagus. Code removal of celiac nodes in the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

2 Other regional sites

3 Distant lymph node(s)

4 Distant site(s)

5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

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**

STOMACH
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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

DO NOT CODE the incidental removal of gallbladder, bile ducts, appendix, or vagus nerve. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Removal of other regional sites, **only**
- 3 Removal of distant node(s)
- 4 Removal of distant site
- 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**

COLON
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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

DO NOT CODE the incidental removal of appendix, gallbladder, bile ducts, or spleen. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Removal of other regional site(s), **only**
- 3 Removal/surgical ablation of single liver metastasis
- 4 Removal/surgical ablation of multiple liver metastases
- 5 Combination of codes 2 and 3 or 2 and 4
- 6 Removal of other distant site(s) or distant lymph node(s), **only**
- 7 Combination of code 6 **with** 3 or 5
- 8 Combination of code 6 **with** 4

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Do not code anastomosis as reconstruction.

Codes

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS

- 3 **without** a reservoir or pouch
- 4 **with** an abdominal reservoir or pouch
- 5 **with** an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate **only**

RECTOSIGMOID
C19.9

SURGICAL APPROACH

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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not

stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

DO NOT CODE the incidental removal of appendix, gallbladder, or bile ducts. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Removal of other regional site(s), **only**
- 3 Removal/surgical ablation of single liver metastasis
- 4 Removal/surgical ablation of multiple liver metastases
- 5 Combination of codes 2 and 3 or 2 and 4
- 6 Removal of other distant site(s) or distant lymph node(s), **only**
- 7 Combination of code 6 **with** 3, 4 or 5
- 8 Combination of code 6 **with** 3 or 5

9 Unknown; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS

- 3 **without** a reservoir or pouch
- 4 **with** an abdominal reservoir or pouch

5 **with** an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate **only**

RECTUM
C20.9

SURGICAL APPROACH

Codes

0 None; no 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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

DO NOT CODE 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 site(s) or node(s), NOS; unknown if regional or distant

2 Removal of other regional site(s), **only**

3 Removal/surgical ablation of single liver metastasis

4 Removal/surgical ablation of multiple liver

metastases

5 Combination of codes 2 with 3 or 2 with 4

6 Removal of other distant site(s) or distant lymph node(s), **only**

7 Combination of code 6 **with** 3, 4 or 5

8 Combination of code 6 **with** 3 or 5

9 Unknown; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS

3 **without** a reservoir or pouch

4 **with** an abdominal reservoir or pouch

5 **with** an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate **only**

ANUS
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 node(s) removed, NOS

- 2 Perirectal, anorectal lymph nodes
- 3 Internal iliac lymph nodes (hypogastric), unilateral
- 4 Inguinal lymph nodes, unilateral
- 5 Combination of 2 and 4
- 6 Bilateral internal iliac and/or bilateral inguinal lymph nodes

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS

- 3 **without** a reservoir or pouch

4 **with** an abdominal reservoir or pouch

5 **with** an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate **only**

LIVER AND INTRAHEPATIC BILE DUCTS
C22.0-C22.1

SURGICAL APPROACH

Codes

0 None; no 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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional sites
- 3 Distant lymph node(s) (includes inferior phrenic lymph nodes)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Rioux en Y; hepatojejunostomy including stent

2 Liver transplant

9 Unknown; not stated; death certificate **only**

PANCREAS
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 node(s) removed, NOS

2 Extended lymphadenectomy

An extended pancreaticoduodenectomy incorporates selected aspects of the Whipple procedure and regional pancreatectomy. A wide Kocher maneuver removes all lymphatic tissue over the medical aspect of the right kidney, inferior vena cava, and left renal vein.

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as

dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Removal of other regional sites, **only**
- 3 Removal of distant node(s)
- 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.)

LARYNX
C32.0-C32.9

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

15 Stripping

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 Stripping

Specimen sent to pathology from this surgical event.

30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS

- 31 Vertical laryngectomy
- 32 Anterior commissure laryngectomy
- 33 Supraglottic laryngectomy

40 Total or radical laryngectomy, NOS

- 41 Total laryngectomy **only**
- 42 Radical laryngectomy **only**

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

SURGICAL MARGINS

Codes

0 All margins grossly and microscopically negative

1 Margin 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 cervical lymph nodes are:
Buccal (facial) Caudal jugular (deep cervical)

Cranial jugular (deep cervical)
Dorsal cervical (superficial cervical)
Medial jugular (deep cervical)
Occipital
Paratracheal (anterior cervical)
Parotid
Prelaryngeal (anterior cervical)
Retroauricular (mastoid, posterior auricular)
Retropharyngeal
Submandibular (submaxillary)
Submental
Supraclavicular

Codes

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

2 Neck dissection, NOS

3 Selective, limited; nodal sampling; "berry picking"

4 Modified/modified radical

5 Radical

9 Unknown; not stated; death certificate **only**

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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Flaps, grafts, or any "plastys," NOS

- 2 without implant/prosthesis
- 3 with implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

LUNG
C34.0-C34.9

SURGICAL APPROACH

Codes

0 None; no 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional sites, distant sites or distant lymph nodes

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

2 Surgery to a regional site **only**

3 Removal of a solitary lesion in the same lung (primary site), different (non primary) lobe

There is one primary. Patient has two tumors with the same histology in different lobes of the same lung.

4 Resection of metastasis in a distant site(s) or resection of distant lymph nodes(s), NOS

5 Removal of a solitary lesion in the contralateral lung

Patient has one primary. There is a primary tumor or tumor(s) in one

lung and a solitary metastatic lesion in the contralateral lung.

6 Removal of a solitary lesion in a distant site or a distant lymph node, NOS

This includes, but is not limited to the removal of a solitary metastatic brain lesion.

7 Removal of multiple lesions in distant site(s)

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Chest wall reconstruction/restoration, NOS

9 Unknown; not stated; death certificate **only**

BONES, PERIPHERAL NERVES, & SOFT TISSUES

Bones, Joints, and Articular Cartilage C40.0-C41.9, Peripheral Nerves and Autonomic Nervous System C47.0-C47.9, Connective, Subcutaneous and Other Soft Tissues C49.0-C49.9

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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

2 Other regional site(s)

5 Distant lymph node(s)

- 6 Distant site(s)
- 7 Combination of 6 **with** 2 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**

SPLEEN AND LYMPH NODES

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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

2 Other regional site(s)

5 Distant lymph node(s)

6 Distant site(s)

7 Combination of 6 **with** 2 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

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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 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

2 Other regional sites

3 Distant lymph node(s)

4 Distant site(s)

5 >Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Pedicle flap, free flap, skin graft, NOS

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

BREAST
C50.0-C50.9

SURGICAL APPROACH

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 node(s) removed

A sentinel node is the first node to receive drainage from a primary tumor. It is identified by an injection of a dye or radio label at the site of the primary tumor

2 Regional lymph node(s) removed, NOS; axillary, NOS (Levels I, II, or III lymph nodes) Intramammary, NOS

3 Combination of 1 and 2

4 Internal mammary

5 Combination of 4 **with** any of 1-3

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Do not code removal of fragments or tags of muscles; removal of the pectoralis minor; the resection of pectoralis muscles, NOS; or the resection of fascia with no mention of muscle.

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
  - 5 Removal of involved contralateral breast (single primary only)
- 6 Combination of 4 or 5 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

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**

CERVIX UTERI
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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Do not code the incidental removal of an appendix. **Do not code** an omentectomy **if** it was the only surgery performed in addition to hysterectomy. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Codes

0 None; no surgery to other regional or distant sites

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

2 Other regional site(s)

3 Distant lymph node(s), NOS

4 Periaortic lymph nodes

5 Distant site(s)

6 Combinations of 5 with 4

7 Combination of 5 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Vaginal reconstruction

2 Urinary reconstruction

3 Bowel reconstruction/restoration

4 Combination of 3 with 1 or 2

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

CORPUS UTERI

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 node(s) removed, NOS

2 Pariaortic with or without other regional lymph nodes

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Do not code the incidental removal of an appendix. **Do not code** an omentectomy **if** it was the only surgery performed in addition to hysterectomy. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional site(s)
- 3 Distant lymph node(s), NOS
  - 4 Periaortic lymph nodes
- 5 Distant site(s)
- 6 Combinations of 5 with 4
- 7 Combination of 5 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Vaginal reconstruction

2 Urinary reconstruction

3 Bowel reconstruction/restoration

4 Combination of 3 with 1 or 2

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

OVARY
C56.9

SURGICAL APPROACH

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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Do not code an incidental removal of the appendix. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Urinary reconstruction

2 Bowel reconstruction/restoration

3 Combination of 1 and 2

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

PROSTATE
C61.9

SURGICAL APPROACH

Codes

0 None; no 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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

DO NOT CODE orchiectomy. For prostate primaries, code orchiectomies under Hormone Therapy.

The most commonly removed distant lymph nodes are: aortic (para-aortic, peri-aortic, lumbar), common iliac, inguinal, superficial inguinal (femoral), supraclavicular, cervical, and scalene.

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Reconstruction/restoration, NOS

- 2 Collagen injection for incontinence
- 3 Penile prosthesis
- 4 Artificial urinary sphincter
- 5 Combinations of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

TESTIS
C62.0-C62.9

SURGICAL APPROACH

Codes

0 None; no 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 node(s) removed, NOS; not stated if bilateral or unilateral

- 2 Unilateral regional lymph nodes
- 3 Bilateral regional lymph nodes

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Testicular implant

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

KIDNEY, RENAL PELVIS & URETER

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 node(s) removed, NOS; not stated if bilateral or unilateral

2 Unilateral regional lymph nodes

3 Bilateral regional lymph nodes

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

DO NOT CODE the incidental removal of ribs during the operative approach.

Codes

0 None; no surgery to other regional or distant sites

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

regional or distant

2 Other regional site(s)

3 Distant lymph node(s)

4 Distant site(s)

5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Kidney transplant (primary site)

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

BLADDER
C67.0-C67.9

SURGICAL APPROACH

Codes

0 None; no 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 node(s) removed, NOS; not stated if bilateral or unilateral

  2 Unilateral regional lymph nodes

  3 Bilateral regional lymph nodes

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

DO NOT CODE the partial or total removal of a ureter during a cystectomy.

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

0 No reconstruction/restoration

1 Conduit diversion

2 Continent reservoir (a bladder substitute)

Types of continent reservoirs include, but are not limited to: Hemi Kock; Ileal reservoir; Ileocecal reservoir; Indiana or Mainz pouch; Koch; Studer pouch; W shaped ileoneobladder by Hautmann.

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

BRAIN & OTHER PARTS OF CENTRAL NERVOUS SYSTEM
Meninges C70.0-C70.9, Brain C71.0-C71.9, Other Parts of Central Nervous System C72.0-C72.9

SURGICAL APPROACH

Codes

0 None; no 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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number

of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional site(s)
- 5 Distant lymph node(s)
- 6 Distant site(s)
- 7 Combination of 6 **with** 2 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.)

THYROID GLAND
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 node(s) removed, NOS

2 Neck dissection, NOS

- 3 Selective, limited; nodal sampling; "berry picking"
- 4 Modified/modified radical
- 5 Radical

9 Unknown; not stated; death certificate **only**

NUMBER OF REGIONAL LYMPH NODES EXAMINED

Codes

00 No regional lymph nodes 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a

sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

9 Not applicable (There are no known reconstructive procedures for this site.)

ALL OTHER SITES

C14.1-C14.8, C17.0-C17.9, C23.9, C24.0-C24.9, C26.0-C26.9, C30.0-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 node(s) 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 node(s) removed but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

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

Codes

0 None; no surgery to other regional or distant sites

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

2 Other regional sites

3 Distant lymph node(s)

4 Distant site(s)

5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

RECONSTRUCTION/RESTORATION - FIRST COURSE

Codes

9 At this time, reconstructive procedures are not being collected for these sites

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California Cancer Registry Volume I: Data Standards and Data Dic

Source: *Cancer Reporting in California: Abstracting and Coding Procedures for Hos Cancer Reporting System Standards, Vol. I)*, updated May 2008

Appendix Q-2 Surgery Codes
(For Cases Diagnosed on or after January 1, 2003)

Index to Sites

- Oral Cavity
- Parotid & Other Unspecified Glands
- Pharynx
- Esophagus
- Stomach
- Colon
- Rectosigmoid
- Rectum
- Anus
- Liver & Intrahepatic Bile Ducts
- Pancreas
- Larynx
- Lung
- Hematopoietic/ Reticuloendothelial/Immunoproliferative Disease
- Bones, Joints & Articular Cartilage/ Peripheral Nerves/ Connective & Soft Tissue
- Spleen
- Skin
- Breast
- Cervix Uteri
- Corpus Uteri
- Ovary
- Prostrate
- Testis
- Kidney, Renal Pelvis & Ureter
- Bladder
- Brain & Other Parts of Central Nervous System
- Thyroid Gland
- Lymph Nodes
- All Other Sites

Unknown and Ill Defined Primary Sites

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

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

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

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

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

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

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

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

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

LIVER AND INTRAHEPATIC BILE DUCTS
C22.0-C22.1
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS

- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Alcohol (Percutaneous Ethanol Injection-PEI)
- 16 Heat-Radio-frequency ablation (RFA)
- 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10-17.

Clarification from ACOS: Chemoembolization should be coded as 10 - Local Tumor Destruction and in addition, should also be

appropriately coded in the Chemotherapy field.

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

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

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

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

HEMATOPOIETIC/RETICULOENDOTHELIAL/IMMUNOPROLIFERATIVE /MYELOPROLIFERATIVE DISEASE

C42.0, C42.1, C42.3, C42.4 for all histologies
Or

M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989 for all sites
Code

98 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

Surgical procedures for hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative primaries are to be recorded using the data item Surgical Procedure/Other Site (NAACCR Item #1294) *or Surgical Procedure/Other Site at This Facility (NAACCR Item #674)*.

99 Death certificate only

NOTE: A hematopoietic case not otherwise specified in the list of standard exclusions (M-9750, 9760-9764, 9800-9720, 9826, 9831-9920, 9931-9964, 9980-9989) in the surgery code appendix should be treated as an Unknown And Ill-Defined Primary Site. Examples include solitary plasmacytoma and chloroma.

BONES, PERIPHERAL NERVES, AND SOFT TISSUES

BONES, JOINTS, AND ARTICULAR CARTILAGE C40.0-C41.9
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0-C47.9
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C49.0-C49.9
(Except for M-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

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

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

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

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

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

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

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

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

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

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

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

Specimen sent to pathology from surgical event 20.

40 Partial resection [NOS]

55 Gross total resection [formerly SEER codes 31, 32, 50, 60]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

THYROID GLAND
C73.9
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

13 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 13.

25 Removal of less than a lobe, NOS [formerly SEER code 10]

- 26 Local surgical excision [formerly SEER code 11]
- 27 Removal of a partial lobe ONLY [formerly SEER code 12]

Specimen sent to pathology from surgical events 25-27.

20 Lobectomy and/or isthmectomy

- 21 Lobectomy ONLY
- 22 Isthmectomy ONLY
- 23 Lobectomy WITH isthmus

30 Removal of a lobe and partial removal of the contralateral lobe

40 Subtotal or near total thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LYMPH NODES

Lymph Nodes C77.0-C77.9

(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS [formerly SEER code 10 under spleen and lymph nodes]
Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 15.

25 Local tumor excision, NOS
Less than a full chain, includes a lymph node biopsy.

30 Lymph node dissection, NOS

- 31 One chain
- 32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy

- 41 One chain
- 42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)

- 51 One chain
- 52 Two or more chains

60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy (Includes staging laparotomy for lymphoma.)

- 61 One chain
- 62 Two or more chains

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ALL OTHER SITES
C14.1-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

UNKNOWN AND ILL-DEFINED PRIMARY SITES
C76.0-C76.8, C80.9
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Code

98 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item Surgical Procedure/Other Site (NAACCR Item #1294) or Surgical Procedure/Other Site at This Facility (NAACCR Item #674).

[99 Death certificate only]

Memo Log

DSQC #2007-03 MPH Rules Training

DSQC #2007-04 Rescinding Memos 2007-01 and 2007-02

DSQC #2007-05 Reportable Benign Schwannomas

DSQC #2007-06 Benign Brain & CNS MPH Rules

DSQC #2006-01 **Rescind:** DSQC Memo 2002-08 - Coding Complex Morphologic Diagnoses, 3/3/06

DSQC #2006-02 Recording Tumor Markers in CS SSF Fields

DSQC #2006-03 Benign Brain Cases Unk Dx Year

DSQC #2006-04 Breast CS Lymph Nodes, SSF 3-5

DSQC #2005-01 2004 Data Changes Training Issues/FAQ: Benign Brain Tumors, 03/01/05

DSQC #2005-01 2004 Data Changes Training Issues/FAQ: Collaborative Staging, 03/01/05

DSQC #2005-02 Fine Needle Aspiration of Regional Lymph Nodes, 07/11/05

DSQC #2005-03 Unknown Social Security Number, 07/11/05

DSQC #2005-04 Melanoma Surgery Code Guidelines, 08/05/05

DSQC #2005-05 Use of SEER*Rx and Drugs Changing Categories, 11/25/05

DSQC #2003-01 Histology Code for Mucinous Adenocarcinoma in a Villoglandular Polyp, 03/31/03

DSQC #2003-02 Surgery of Primary Site - Breast, 09/01/03

DSQC #2003-03 Multiple Primaries - Breast, 12/08/03

DSQC #2003-04 ACoS Data Items, 12/08/03

DSQC #2003-05 SEER Coders & Abstractors Workshop Documents (May 2003), 12/08/03

DSQC #2002-01 Clarification: Reportable In Situ Terms, 1/28/02

DSQC #2002-02 Melanoma Surgery Codes, 1/28/02

DSQC #2002-03 SEER Prostate Guidelines

DSQC #2002-05 Revision of Extension Codes for Breast Cancer, 3/12/02

DSQC #2002-06 Race/Ethnicity Code Documentation, 07/23/02

DSQC #2002-07 SEER Coders & Abstractors Workshop Documents (May 2002), 8/1/02

DSQC #2002-08 Coding Complex Morphologic Diagnoses (revised 8/02)

DSQC #2001-01 Benign and Uncertain Behavior Brain and CNS Tumors, 03/27/01

DSQC #2001-02 Race and Ethnicity Code Documentation, 05/05/01

DSQC #2001-03 Anal Intraepithelial Neoplasia, Grade III, 05/04/01

DSQC #2001-04 Pilocytic/Juvenile Astrocytoma, 05/04/01

DSQC #2001-05 Rescind: Race & Ethnicity/pending, 08/13/01

DSQC #2001-06 ICD-O-2 to ICD-O-3 Conversion, 08/17/01

DSQC #2001-07 SEER Documents, 11/12/01

DSQC #2000-01 Prostate Extension Codes 33 And 34, 01/24/00

DSQC #2000-02 Guideline: Coding EOD for Non-Surgical Cases with Limited Or Ambiguous Information, 02/28/00

DSQC #2000-03 Guideline: General Visual Editing Guidelines, 02/28/00

DSQC #2000-04 Use of Colonoscopy Measurements for Assigning Colon Subsite Code, 03/08/00

DSQC #2000-05 Breslow Thickness and Clark Level of Invasion, 03/08/00

DSQC #2000-06 Focus, Focal and Foci, 03/08/00

DSQC #2000-07 Rescind: Coding Prostate Clinical EOD, 03/08/00

DSQC #2000-08 Type of Recurrence, 05/05/00

DSQC #2000-09 Coding Non-Hodgkin's Lymphoma Histology, 10/31/00

DSQC #2000-10 Errata and Corrections to the Third Edition of EOD 1988, 10/31/00

DSQC #2000-11 Tumor Size for Combined In Situ-Invasive Tumor, 12/18/00

DSQC #2000-12 Data Changes for 2001, 12/18/00

CATEGORY: CLARIFICATIONS
SUBJECT: 2007 Data Changes Training Questions
EFFECTIVE: Cases Diagnosed 1/1/2007 Forward

The attached questions and answer documents are a result of the 2007 Data Changes Training Sessions held throughout California, focusing on the SEER Multiple Primary and Histology (MPH) Coding Rules and the New Data Items. The question and answer documents are divided into the following categories:

- General Instructions for the Multiple Primary and Histology Coding Rules
- Breast – Multiple Primary and Histology Coding Rules
- Colon - Multiple Primary and Histology Coding Rules
- 2007 New Data Items

Some questions were submitted to the SEER SINQ. For those questions, the SEER SINQ identification number is included in the answer. Several MPH questions have also been added to the SEER SINQ, thus registrars are strongly encouraged to search the SINQ for MPH related questions, along with questions regarding the New Data Items. The SEER SINQ may be accessed at http://seer.cancer.gov/ The SEER Multiple Primary and Histology Coding Rules FAQ document and the referenced Breeze Sessions are also located on the SEER web site at http://seer.cancer.gov/tools/mphrules/ Registrars are encouraged to make use of these education and training resources.

General Multiple Primary and Histology Coding Questions

1. What is the date that visually edited discrepancies begin to be counted for the 2007 data changes?

A. You will receive feedback on the new data items and the new Multiple Primary and Histology rules for six months.

2. Are these rules going to be in Volume 1 or in the Multiple Primary and Histology Coding Rules Manual?

A. *Volume 1 will reference the Multiple Primary and Histology Coding Rules Manual. You will not see the rules in Volume 1. The new data items for 2007 will be documented and defined in Volume 1.*

3. Are the SEER Breeze sessions free?

A. *Yes.*

4. Regarding the statistics quoted to demonstrate the percentage of cases with regard to the timing rule, how does SEER know the number of cases that may have been counted as recurrence when the case should have been abstracted as another primary? SEER is an incidence registry. Was the COC database queried for the recurrence issue since the date and type of recurrence is documented there?

A. *SEER FAQ #3 states: The MPH Rules development team worked closely with epidemiologists and statisticians from NIH, Emory University, and NCI who carefully reviewed and compared outcomes from using the old rules versus new rules side-by-side and one at a time. We found nothing to indicate that we might expect a significant change in case counts or incidence rates. Most changes were measured in 100ths of one percent change. The technical documents describing the statistical review highlight differences and will be posted and made available for people who are interested in learning more about these details.*

5. If a registrar cannot use a clinician's statement to code histology what do you do for Class 2 or Class 3 cases when this is the only information available?

A. *If there is no pathology report or cytology report, the next two priorities in order are: a) references to pathology or cytology findings b) other mention of type of cancer (histology) in the medical record.*

6. Are the microscopic findings in a pathology report used in any other sites besides colon?

A. *No.*

7. Can any other pieces of information be ascertained from the microscopic section of the pathology report besides the mucin factor and the polyp factor, such as tumor behavior?

A. The MPH rules are not to be used to code other tumor data such as tumor behavior, stage, grade, etc.

8. When you apply the rule whether you can look in the microscopic area of the pathology report or not, is the CAP summary considered microscopic?

A. Yes

9. Does a recurrence have to be pathologically confirmed?

A. Yes

10. Is the statement "code the invasive component" even if the in situ component is more specific a rule for all sites?

A. *Yes, the invasive component is the tumor that will predict prognosis, drive the treatment plan and affect survival.*

11. Is there a priority order for the various types of scans if more than one is used in the workup, i.e. CT vs PET vs MRI?

A. Some sites have a priority order. If there is no site specific priority order, use the most specific histology documented in the scans.

12. If a pathologist states two TNM stages indicating two primary sites, do you ignore the multiple primary rules for that site?

A. *No. Use the Multiple Primary rules to determine how many cases to abstract.*

13. Regarding the 60 day rule when an invasive cancer is diagnosed after an in situ cancer, what is the rationale behind setting this at 60 days?

A. The 60 day rule is based on SEER historical rules and data.

14. Regarding the time period between the 60 days after diagnosis and the next 3-4 months before the case is abstracted. SEER FAQ # 17 address in situ and progressing to invasive during work-up. How to abstract new tumors that start to appear on the CT's between the time period of the 60 days and the time it was abstracted? They may not be documented as metastases?

A. *Any invasive tumor of the same histology diagnosed within 60 days of an in situ tumor in the same organ is considered a single primary. If you have an invasive tumor diagnosed more than 60 days following an in situ tumor, it should be abstracted as a new primary according to site specific rules even if the medical record/physician states it is recurrence or progression of disease.*

15. Please find out if "60 days" is the literal translation or approximation of two months.

A. *60 days is consecutive calendar days.*

16. Are you stating that any tumor recurrences noted after the site-specific timeframe allowed is to be counted as a new primary even if the clinician calls

this new tumor a recurrence from the original tumor? Hospital registrars are extremely concerned that they will not be able to document tumor recurrences with these new rules.

A. *The CoC clinical advisors were consulted and their suggestions were incorporated into these new rules. Contact the CoC if you and or your cancer committee have concerns regarding how these rules affect your facility's cancer program.*

17. How are other bilateral organs abstracted? For example, bilateral kidneys, ovaries, retinoblastomas?

A. *Kidney M4 states tumors in both right and left kidneys are multiple primaries unless the tumor in one kidney is documented to be metastatic from the other kidney. Other Sites M4 states to abstract bilateral retinoblastomas as a single primary. Other Sites M7 states to abstract bilateral epithelial ovarian tumors (8000-8799) diagnosed within 60 days of one another as a single primary.*

18. What happens if you make the wrong choice in the "Multiple Tumors" section of the rules?

A. *If the incorrect selection is made when assessing whether multiple tumors are abstracted as a Single Primary or as Multiple Primaries, you may end up generating the wrong number of abstracts for the case. It is very important to carefully read each rule to see if it applies to the case you are abstracting. If not, you continue down the rule hierarchy.*

Breast – Multiple Primary and Histology Coding Questions

General

1. Does neoadjuvant therapy affect the multiple primary rules?

A. Per SEER (4/25/07), neoadjuvant therapy has no affect on determining histology using the MPH rules.

2. Do these new rules overwrite the "Complex Morphology Coding Rules" ?

A. DSQC Statewide Memo 2006-01 replaced the Complex Morphology Coding Rules. These new rules apply for cases diagnosed January 1, 2007 forward.

3. If you only have the pathology report CAP protocol information and it does not include a final diagnosis, which fields of the protocol would be used to determine the histology and if there is carcinoma in situ present?

A. SINQ 20071048 states: If the CAP protocol is used in lieu of a final diagnosis, use all of the information in the CAP protocol.

4. Why can't we use the microscopic on breast cases?

A. SEER FAQ #1 states: Were your pathologists aware that you coded from the micro before? Pathologists were surprised when they learned that registrars have been incorrectly using the details described in the microscopic for coding and support the use of coding from the final diagnosis. The micro describes everything the pathologist sees (pieces of the puzzle) and not the overall impression of the tumor. When the pathologist dictates the final diagnosis they are describing their overall interpretation and using their expertise to make the diagnosis.

<u>Multiple Primaries</u>

5. M4. If the second digit of the ICD-0-3 code is different isn't that a different primary site?

A. Yes. This rules states if you have different primary sites, you have multiple primaries.

6. M6. Inflammatory carcinoma in one or both breasts. It does not state the inflammatory carcinoma must be from the final pathologic diagnosis. Can a clinical diagnosis of inflammatory carcinoma be used to determine multiple primaries?

A. M2 and M6 refer to pathologically confirmed inflammatory carcinoma only.

7. If there is an inflammatory carcinoma in one breast and a non-inflammatory in the other breast, is this a single or multiple primary?

A. M7 states these would be multiple primaries. If you get a case like this, submit it to the CCR Inquiry System. More factors may need to be considered.

8. When there is an invasive tumor following an in situ tumor within 60 days, is the behavior coded to invasive?

A. Yes, code the behavior to invasive.

Histology

9. H1. Can histology from radiology be used?

A. Apply the priority order for using documents to code histology when there is no cytology or pathology report available. Histology from radiology cannot be used for in situ tumors.

10. What is the difference between H3 and H6?

A. H3 states to code a more specific histologic term, if available. An example would be if the pathology report stated "intraductal carcinoma, cribriform type". This would be coded to ductal carcinoma in situ, cribriform type, 8201/2. ***H6 has a correction****. It should state that you would have an intraductal carcinoma and two or more specific intraductal types or two or more intraductal carcinomas. An example would be if the pathology report stated " in situ carcinoma, papillary and cribriform type." You would have already eliminated any comedocarcinoma combinations using H4 and the lobular and ductal combinations are eliminated in H5.*

11. H4. Is comedonecrosis the same as comedocarcinoma?

A. No, they are not the same. Comedonecrosis is defined as a type of necrosis occurring with glands in which there is central luminal inflammation with devitalized cells, usually occurring in the breast intraductal carcinoma. Comedocarcinoma is characterized by solid sheets of high grade malignant cells and central necrosis.

12. H6. Should it state "more than one specific type" rather than "one or more specific type"?

A. Yes, there is a correction to H6. It should state that a combination of intraductal carcinoma and two or more specific intraductal types or two or more intraductal carcinomas.

13. If the pathologist does not use terminology in Table 1 or Table 2 can you use it?

A. Only use the terminology in Table 1 or Table 2. Remember, the words "pattern" and "architecture" are not used for invasive tumors. If these terms are used with invasive tumors, consult the pathologist.

14. If a breast cancer has both invasive and in situ components, the in situ component is ignored?

A. Correct, code to the invasive, H9. The invasive component determines prognosis and survival.

15. Usually inflammatory carcinoma of the breast is a clinical diagnosis.

A. Correct. Inflammatory carcinoma is a clinical manifestation of ductal carcinoma. H13, Use the histology code for inflammatory carcinoma only if it is stated in the final diagnosis of the pathology report.

16. How is a ductal and lobular carcinoma combined with other subtypes coded? 8522 or 8523?

A. H16 states to include subtypes of ductal when selecting code 8522.

Cases

17. Case #2. This case has both DCIS with cribriform pattern.

A. Pattern is a descriptor that indicates a specific type of ductal carcinoma in situ (Table 1), therefore this case is coded to 8201/2 ductal carcinoma in situ, cribriform type.

18. Case #3. If at diagnosis the tumor was a single ductal carcinoma, and on day 61 during the work-up there is a lobular, how is this abstracted?

A. *This is would be reported as a single primary if the patient is still undergoing diagnostic work-up greater than 60 days. SEER FAQ#17 states: When the invasive component is discovered as part of the work-up phase leading to treatment decisions, the case would be abstracted as a single primary. In the rare instance when a patient has not been treated and is still having diagnostic work-up greater than 60 days after the malignancy is diagnosed, do not count the invasive diagnosis as a new primary.*

19. Case #5. Are the descriptors apocrine and metaplasia ignored?

A. *Yes.*

20. Case #9 It was noted that there was no documentation in the histology rules regarding needing a percentage of mucinous component, such as noted in the colon rules. Do we need a percentage in order to be able to code mucinous carcinoma of the breast? See Breast case #9.

A. Unlike colon, a percentage of mucin is not needed to code mucinous carcinoma of the breast. Code the histology from the final diagnosis. If the final pathology report states mucinous/colloid carcinoma, code it as such.

21. Case #9. Answer sheet states to code to colloid carcinoma. Please explain which rule was used to derive that code.

A. *In case #9, there are 2 tumors and Multiple Primary rule M12 applies, which states that "Histology codes are different at the first, second or third number," are multiple primaries. Tumor #1 is an invasive ductal carcinoma. Tumor #2 is invasive ductal carcinoma with extensive mucin production (colloid carcinoma). This is an example of when to apply rule H17, code 8523. Note: This answer is updated from the answer sheet provided at the 2007 Data Changes training. The SEER Breeze session dated 12/15/06 clarifies the answer. Unlike colon, colloid carcinoma in the breast does not need to have a percentage of mucin identified to code it as such.*

Colon – Multiple Primary and Histology Coding Questions

General

1. **Can we only use the final diagnosis and ignore the microscopic gross description?**

   A. *The general instructions indicate to only use the final diagnosis from the pathology report, unless there are site specific exceptions. The colon is one of the site-specific exceptions to this rule. Use the entire medical record to look for references to polyps associated with the malignancy. Use the microscopic description in the pathology report to determine the mucin/colloid and signet ring cell component status.*

2. **What does "frank" mean?**

   A. *Per the Terms and Definitions section for colon, this is adenocarcinoma arising from the colon wall. The malignancy did not originate in a polyp.*

3. **What code is used when the physician states malignancy, NOS?**

   A. *Unless the physician will state a more specific diagnosis, code to 8000/3. SINQ 20051115*

4. **A colon cancer patient receives adjuvant chemotherapy. After two cycles the chemotherapy is stopped due to complications. Seventeen months after the initial diagnosis, there is a recurrence at the anastomosis site at another facility. All of the physicians at the second facility make clear statements that this is a recurrence. Because this recurrence is over one year from the original diagnosis, this would be considered a new primary according to the MPH rules. We would lose the fact that the patient failed due to lack of adjuvant treatment.**

   A. *Include treatment text documentation why the chemotherapy was stopped. Yes, per the MPH rules, this would be considered a new primary, unless the pathologist states the tissue from anatomosis site is stated to be a recurrence from the original tumor.*

Multiple Primaries

5. **Does M5, diagnosed more than one year apart, apply unless the pathologist calls it a recurrence?**

   A. Yes

6. **Regarding M6, an invasive tumor following an in situ tumor more than 60 days after diagnosis - does this apply if the patient goes on a trip?**

   A. *SEER FAQ#17 and SINQ 20071023 state: When the invasive component is discovered as part of the work-up phase leading to treatment decisions, the case would be abstracted as a single primary. In the rare instance when a patient has not been treated and is still having diagnostic work-up greater than 60 days after the malignancy is diagnosed, do not count the invasive diagnosis as a new primary*.

7. **Regarding M6 - What if the invasive tumor was diagnosed 61 days later?**

A. Report as a new primary

Histology

8. **In H1, is it hierarchial within radiology?**

A. No, use the best information from the various radiology sources to determine histology.

9. **Sometimes the polyp information is not in the final diagnosis.**

A. Per the site-specific MPH rules for colon, registrars can use any reference or statement in the medical record indicating that this malignancy is related to a polyp. This includes the gross and microscopic sections of the pathology report. This is a site-specific exception to the General Instructions indicating that only the final diagnosis of the pathology report can be used to code histology.

10. **Sometimes a pathology report from a biopsy states that the carcinoma was arising in a polyp but the surgical resection did not mention anything regarding a polyp.**

A. *If there is any reference to a pre-existing polyp in relation to the colon malignancy in the medical record, use the appropriate polyp histology code.*

11. If the CAP protocol pathology report tumor configuration is described as "polypoid", would H4 be used? There is no further information in the medical record regarding polyps.

A. *Polypoid means like a polyp but this term* ***should not*** *be used to apply a polyp histology code, (confirmed by SEER, 4/26/07).*

12. Why is H4 used when there is no information that the pre-existing polyp(s) is malignant?

A. *It is important to capture the fact that the malignancy is associated with a polyp, regardless of whether the pre-existing polyp was malignant or not.*

13. If the tubulovillous adenoma is in situ and the other polyp(s) have an invasive component, does tubulovillous still have priority and should H18 be applied?

A. *SINQ 20071049 states: Always give precedence to coding the invasive. Rule H18 applies UNLESS the adenocarcinoma in the tubovillous adenoma is in situ and the others are invasive. In this case, code the histology of the invasive adenocarcinoma. This clarification will be added when the MP/H manual is revised.*

14. How do you want us to document "polyp" when we found this statement in the microscopic section of the pathology report?

A. *If the reference to a polyp was noted in the microscopic section of the pathology report, you can document it in the pathology section. The location of the documentation on the abstract is not as important as the fact that it is documented within the abstract where you found the reference to the polyp in the medical record.*

15. Are the MPH rules used to code tumor size in polyps?

A. *No, the MPH rules are to only be used for determining multiple primaries and coding histology. Do not use the rules to determine stage, reportability, tumor size, tumor grade, etc.*

16. Please clarify the difference between H5 and H6.

A. Apply H5 (code 8480 or 8490) if the final diagnosis in the pathology report states mucinous/colloid carcinoma or signet ring carcinoma or there is documentation in the microscopic description that 50% of the tumor is described as mucinous/colloid or signet ring cell. Apply H6 (code 8140) if the tumor is described as having less than 50% mucin/colloid or signet ring cell in the microscopic description or if the percentage of mucin/colloid or signet ring cell component is unknown.

17. Does the pathology report have to state the percentage of mucin 50%, 60%, etc., or can we use the statement "majority of the tumor" to code mucin?

A. No. There must be documentation that the tumor contains mucin elements of 50% or more in order to code the histology to mucin/colloid or signet ring. SEER FAQ #15 states: The new rules specifically instruct the registrar to code the histology to "adenocarcinoma, NOS" when the percentage of mucinous or signet ring cell carcinoma is unknown.

18. Do we have to have a percentage of the mucinous component in order to apply rule H7 (mucinous/colloid and signet ring)?

A. No, a percentage is not necessary, however, the final diagnosis on the pathology report must state "mucinous/colloid and signet ring carcinoma"

19. How do we code when there is no mention of the percentage of mucin/colloid or signet ring; H5.

A. Go to the next rule that applies. Rule H6 states that the percentage of mucinous or signet ring cell ca is unknown.

20. What are examples of "more specific terms" in H13?

A. Scirrhous carcinoma, 8141, and giant cell carcinoma, 8031 would be examples of more specific terms.

21. H8- How is "carcinoid tumor (Neuroendocrine)" coded?

A. Code 8240, carcinoid tumor

22. If the polyp contained a mucinous component is the histology coded to mucinous or polyp?

A. Apply H4, code to polyp.

23. Regarding H19 and H20- If there was less than 100 polyps and you were going through the "Multiple Tumors Abstracted as a Single Primary," you would stop at H19 and code 8221 and never get to H20 to code 8263 which may be the specific histology of those polyps.

B. That is correct, H19 has priority over H20. SEER clarification (4/26/07) carcinoma must be seen in at least 2 polyps to apply H19.

24. The note for H20 states "adenocarcinoma originated in a polyp" What if we do not have a note specifically stating the polyp is where the adenocarcinoma originated; what if the adenocarcinoma is a separate entity then the polyp?

C. If the procedure was done due to polyps and a malignancy was found, regardless of the polyp behavior, code the malignancy to the histology code with the polyp component.

Cases

25. In regards to colon case #2- Is this case coded to villous adenoma because it is villous polyps?

A. Yes.

26. Colon case # 4, if more than one subsite what is the subsite code?

A. C18.9

27. In regards to colon case #5 Please clarify if the tumor at 86 cm is invasive or not.

A. The tumor is non-invasive.

28. In regards to colon case #6- The first pathology report states ascending colon and the second pathology report states cecum. Why code cecum?

A. *The second pathology report came from the resection, which reflected that the tumor was in the cecum,*

29. Colon case #7, Item G states "metastatic adenocarcinoma involves at least four out of forty-one lymph nodes.

A. Code the histology from the primary site, final diagnosis from the pathology report, which in this case states adenocarcinoma, signet ring and mucinous types. We would apply rule H7, and code the case to 8255/3.

30. Colon case #7, do the proportions matter?

A. No, because adenocarcinoma, signet ring and mucinous types is in the final diagnosis.

2007 New Data Items

General

1. Will an update to any of these fields generate a correction record?

A. Yes, all the new data items will generate a correction record.

2. Will there be an impact to the state reporting facilities where they are not required to perform follow-up?

A. Yes, this means that every case has the potential to be reviewed and the case updated during the casefinding process.

3. Will there be consolidation of these data items at the central registry?

A. Yes

Multiplicity Counter

4. How will Multiplicity Counter effect the follow-up information? For example, now that 5 years is the time frame for counting recurrences, would another tumor and subsequent resection be considered as a recurrence? Would this be considered subsequent treatment or would you code this as the date of multiple tumors and the code the surgical resection as First Course of Treatment?

A. Code recurrences in the Multiplicity Counter using the site-specific MPH rules time frame paramenters. Once a date is entered in the Date of Multiple Tumor field, it does not change see #7. Treatment for recurrence is coded as subsequent treatment.

5. How much documentation is needed to document a change in these fields?

A. A brief statement of why the data item was changed, such as "subsequent tumor diagnosed" for a change in Multiplicity Counter.

6. Multiplicity Counter is changed only if number of tumors changes within one year from diagnosis date per the SEER FAQ or per site specific rules for breast, lung, etc. ?

A. Change the number of tumors reported as a single primary per the MPH site specific timeframes.

7. Is the Date of Multiple Tumor field changed when the Multiplicity Counter is changed?

A. No. Once a case has a date entered in the Date of Multiple Tumor field, do not change it. This data item captures the date the single tumor became a multiple tumor abstracted as a single primary. This can occur at the time of diagnosis or at a subsequent date. If the Date of Multiple Tumor field has a date entered, do not change this date with each change in the Multiplicity Counter.

8. Will the Date of Multiple Tumors and the Date of Conclusive Terminology fields be coded the same?

A. No, they are independent of each other. The Date of Multiple Tumors is related to the Multiplicity Counter. The Date of Conclusive Terminology is related to the Ambiguous Terminology data item.

9. A pathology report states "there are at least a certain number of lesions (for example: at least 5 lesions), is the actual number coded or is it coded 99?

A. Code 99

10. Does this data item include in situ polyps after an invasive diagnosis?

A. SINQ 20071043 states: If an in situ tumor following an invasive tumor is a single primary according to the multiple primary rules for that particular site, include the in situ and the invasive tumors in the multiplicity counter.

11. How do you code the Multiplicity Counter if you do not know if you have multiple tumors?

A. Per the multiple primary rules, if you do not know if you have single or multiple tumors, use the default and code the Multiplicity Counter to 99- It is unknown if there is a single tumor or multiple tumors . This is one of the corrections to the MPH Manual per the New Data Item Breeze session: **the coding instructions on page 340 of the Coding Manual under coding instruction 4c (we [SEER] will send a notice that this correction will be forthcoming) that instruction should be moved down under number 6. It inadvertently continued under number 4 and this is an indication of when to use code 99. Use code 99 when it is unknown whether there is a single tumor or multiple tumors.**

Date of Conclusive Terminology

12. Is there a timeframe for this field? How far beyond the 60 days can this field be coded?

A. SINQ 20071044 states: There is no strict timeframe for Date of Conclusive Terminology. The diagnosis using conclusive terminology could be made any time following the diagnostic work-up.
The date of conclusive terminology is related to code 2 [ambiguous term followed by conclusive term] in the data item "Ambiguous terminology." Assign code 2 when a conclusive diagnosis is made 60 days or more after a diagnosis using ambiguous terminology. Record the date of the conclusive diagnosis in "Date of Conclusive Terminology."

13. If several physicians use ambiguous terms and then one physician makes a conclusive statement, how is this coded?

A. Code the conclusive terminology statement. Depending on the timing, if it is within 60 days, use code 0- Conclusive Terminology. If the conclusive statement was made after 60 days, use code 2- Ambiguous Terminology followed by Conclusive Terminology. Reminder: Use all sources of information to look for a conclusive statement, such as lab tests, scan findings, path/cytology reports, in addition to statements from a physician.

14. For abstractors who do concurrent abstracting, this data might apply but for those who wait for four to six months this item may not need to change.

A. Correct.

Ambiguous Terminology

15. Is the Ambiguous Terminology field open-ended in terms of timeline?

A. Yes, Ambiguous Terminology is coded positive until such time, if ever, Conclusive Terminology is used for that primary.

16. It seems there is some confusion in the statement for the rules for Code 1 and Code 2. Should the definition for Code 2 be changed to match the Time Frame?

A. Per SINQ 20071045 Code 1 definition states: "within 60 days", *Code 2 definition states: "more than 60 days" but the Time Frame states "equal to or greater than 60 days". The definition for Code 2 should be "more than 60 days" after the date of diagnosis. Code 1 is 60 days or less, Code 2 is more than 60 days. This will be clarified in the first revision to the MP/H manual.*

17. Do pathologists know we will be using these Ambiguous Terms?

A. Registrars need to educate pathologists of these new coding rules and terms.

18. Why was 60 days chosen for ambiguous terminology?

A. SINQ 20071046 states: The Histology Task Force approved a 60 day time frame for ambiguous terminology. The majority of cases are first identified by ambiguous terminology; for example, a patient has a mammogram that shows a lesion suspicious for cancer. That first indication of cancer prompts a work-up to either confirm or rule-out the cancer diagnosis. The data item "Ambiguous terminology" is not intended to capture information on this routine method of detecting and diagnosing cancer. The 60 day time frame should keep these cases out of the ambiguous terminology data item.

The data item is intended to identify those cases where the cancer diagnosis is NOT confirmed during the work-up, but the case is still entered into the database. For example a patient who has a TRUS because of elevated PSA. The pathology from the TRUS says "Suspicious for adenocarcinoma of the prostate." The physician only documents that the patient is to return in 6 months for another PSA and TRUS. The registrar would enter this case into the data base because the word "suspicious" is on the ambiguous terminology list.

19. Why was the term "accessioned" used? Would the term "abstracted" be a better term for this data item?

A. SINQ 20071047 states: The purpose of the new data item "Ambiguous Terminology" is to identify cases that were put into the cancer registry database without a conclusive diagnosis. The decision to accession the case was influenced by ambiguous terminology. The emphasis is on accessioning the case rather than abstracting it.

20. Has ACOS taken this data item with regard to patient follow-up?

A. Yes, there are detailed instructions in the ACOS' FORDS Manual.

21. What do you do with a pathology report with ambiguous terminology, where the biopsy is "consistent with adenocarcinoma" and the physician states "showing adenocarcinoma". Is there a hierarchy?

A. There is no hierarchy but use the conclusive terminology. Remember that the registrar needs to provide text documentation to support codes.

DATA STANDARDS AND QUALITY CONTROL MEMORANDUM
DSQC #2007- 04

CATEGORY: RESCINDING PREVIOUS MEMOS
SUBJECT: DSQC Memos 2007-01 and 2007-02
EFFECTIVE: Immediately

As a response to the recent message from the Collaborative Staging Steering Committee with regards to the use of the list of EOD clinically apparent and inapparent terms for prostate cancer (see message below), the CCR has rescinded DSQC Memos 2007-01 and DSQC Memo 2007-02 and removed them from the CCR web site. This is effective immediately. DSQC Memo 2007-01 instructed registrars to use the list of clinically apparent and inapparent terms for prostate cancer and DSQC Memo 2007-02 reviewed the appropriate use of prostate CS Extension codes 15 and 30.

Registrars are not required to go back and review or recode cases already submitted to the regional registry.

Also effective immediately, discrepancies for prostate CS Extension codes within the range of 13-30 will not be counted. However, prostate cases submitted with CS Extension code 30 that should actually be coded to a higher code, will still be visually edited and if miscoded, be counted as a discrepancy.

Registrars should continue to follow the instructions in the Collaborative Staging Manual and on the Collaborative Staging web site (FAQ section): http://www.cancerstaging.org/cstage/faq.html

Questions regarding this data item should be sent to the Commission on Cancer's Inquiry & Response System: http://web.facs.org/coc/default.htm

The Commission on Cancer's Inquiry and Response System and SEER SINQ (http://seer.cancer.gov/seerinquiry/) should also be checked regularly for additional information on how to code cases without reference to the list of clinically apparent and inapparent terms for prostate cancer.

The statement issued on August 31, 2007, by the Collaborative Staging Steering Committee is as follows:

Clarification on the Use of Outside Resources for Coding Prostate Cancer

A great deal of confusion surrounds the interpretation of clinical reports with regard to whether the prostate cancer was apparent or inapparent. In 1998, SEER published an interpretation of "apparent" and "inapparent" terms for use in their Extent of Disease (EOD) Coding System for prostate cancer. This list was in effect for prostate EOD cases diagnosed in 1998-2003. There were several questions regarding whether this list could be used in Collaborative Staging (CS). After consultation with the AJCC curators for genitourinary disease, the CS Steering Committee has determined that the SEER list of terms for apparent and inapparent in the SEER Extent of Disease Manual is NOT to be used for interpreting reports for Collaborative Staging. While it was a convenient tool for registrars, the curators are of the opinion that the use of the list will lead to misinterpretation of reports. Rather, the curators recommend that registrars rely on a direct physician statement of apparent or inapparent disease for Collaborative Staging. It is not anticipated that prior cases will require review and recoding.

DATA STANDARDS AND QUALITY CONTROL
MEMORANDUM
DSQC #2007-05

CATEGORY: CLARIFICATION
SUBJECT: REPORTABLE BENIGN SCHWANNOMAS
EFFECTIVE: CASES DIAGNOSED 1/1/2004 FORWARD

As a clarification, only benign Schwannomas (9560/0) of the cranial nerves 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 cranial nerves are composed of twelve pairs of nerves that emanate from the nervous tissue of the brain. Cranial nerves are sometimes referred to by their number, such as the 8th cranial nerve, instead of the vestibulocochlear nerve.

To assist registrars with identifying reportable benign Schwannoma tumors, the cranial nerve numbers, names and their ICD-O-3 topography codes are listed below:

I Olfactory (C72.2)
II Optic (C72.3)
II Oculomotor (C72.5)
IV Trochlear (C72.5)
V Trigeminal (C72.5)
VI Abducens (C72.5)
VII Facial (C72.5)
VIII Vestibulocochlear (auditory and vestibular nerve) (C72.4)
IX Glossopharnygeal (C72.5)
X Vagus (C72.5)
XI Accessory (C72.5)
XII Hypoglossal (C72.5)

Example of a reportable Schwannoma:

- Vestibular Schwannoma, also known as acoustic neuroma (C72.4 M-9560/0)

Registrars are not expected to go back and review Schwannoma cases already submitted to the CCR.

References: DSQC Memo 2005-01
SINQ 20041097, 20051127
http://www.cdc.gov/cancer/npcr/training/btr/clarification.htm

DATA STANDARDS AND QUALITY CONTROL
MEMORANDUM
DSQC #2007-06

CATEGORY: REFERENCE DOCUMENT
SUBJECT: BENIGN BRAIN AND CNS MULTIPLE PRIMARY AND HISTOLOGY CODING RULES
EFFECTIVE: CASES DIAGNOSED 1/1/2004 FORWARD

Reformatted versions of the Benign Brain and CNS Rules have been developed by NCI SEER and approved by the Registry Operations Committee (ROC) of NAACCR. The rules have not been changed, only formatted to the Multiple Primary and Histology Coding Rules standard. The rules are available for downloading at http://seer.cancer.gov/tools/mphrules/benign_brain.html.

You will find a set of Equivalent Terms and Definitions as well as the rules in all three formats: text, matrix, and flowchart.

How to Use Prostate Extension Codes 33 and 34

Source: DSQC #2000-01 Guideline: Prostate Extension Codes 33 & 34, 01/24/00

The CCR realizes that medical record information is limited regarding tumors arising in or extending to the apex. In order for registrars to code extension consistently, the following operational rules apply. These rules apply to assigning both clinical and pathological extension codes.

Use code 33 when the apex is the only area identified as involved with tumor.

> *Example:* Biopsy of the apex is positive for adenocarcinoma. Biopsies of right and left lobes are negative for malignancy.

Use code 34 when the apex and any other sections of the prostate are positive for tumor.

> *Example:* Biopsies of left and right apex and left posterior lobe positive for adenocarcinoma.

Coding EOD for Non-Surgical Cases with Limited or Ambiguous Information

Source: DSQC #2000-02 Guideline: EOD for Non-Surgical Cases, 02/28/00

EOD coding works well for cases that are surgically treated such as colon and breast. EOD is not as accurate for cases that do not have a surgical resection. When EOD coding is based exclusively on clinical information

(physical exam, scans, and scopes), the results may be interpreted differently. When clinical information is limited, and there is no physician staging, use the following guidelines.

LIVER

Use available information.

> Example: Ultrasound of the liver showed a 2 cm. mass in the left lobe and a 3 cm. mass in the right lobe. Biopsy results stated hepatocellular carcinoma. No other work-up. Use code 65 rather than code 99.

LUNG

Lung primary with limited information and no MD staging.

If CT does not mention tumor outside lung, use extension code 10.

> Note: CXR may not be used to determine tumor extension outside the lung.
>
> Note: If there is no lung CT, tumor size can be coded from the CXR.

CT makes no mention of mediastinal adenopathy, follow the CCR 0 vs. 9 memo for the single digit lymph node code.

NODAL LYMPHOMA

Lymphoma primary with biopsy only, limited information, and no MD staging.

Physical exam must contain statement regarding all palpable lymph nodes or a statement such as "no other adenopathy", "examination within normal limits", or "remainder of exam within normal limits".

There must be a CT of chest <u>and</u> abdomen.

If the above two criteria are not in the medical record then use extension code 99.

> Example: Patient presents with cervical mass, which is biopsied and positive for lymphoma. No other information in medical record. Code 99.

PANCREAS

Obstruction, NOS.

Carcinoma of the head of pancreas causes obstruction of the common bile duct. When there is no information to determine if the obstruction is caused by direct extension into the common bile duct or extrinsic obstruction due to an enlarging mass localized in the head of pancreas and surrounding the common bile duct, use code 99.

General Visual Editing Guidelines

Source: DSQC #2000-03 Guideline: General Visual Editing Guidelines, 02/28/00

The visual editor will not change a code and count a discrepancy unless standard cancer registry reference materials can support the change. These reference materials include:

- Volume 1, California Cancer Registry
- SEER Extent of Disease Manual
- ICD-O
- CCR Inquiry System
- SEER Inquiry System
- CCR/Data Standards and Quality Control Unit memos and guidelines imprinted with "Statewide Distribution"
- Volume 2, ROADS
- ACOS Inquiry and Response System

Ambiguous/Inconsistent Information

The registrar is responsible for clarifying ambiguous information. If there is conflicting information in the medical record, it is the responsibility of the registrar to try to obtain physician staging or clarification and to document this information on the abstract prior to submitting the abstract. If no further information was obtainable/available prior to submitting the abstract, the registrar should document on the abstract that no further information was available prior to submitting the abstract.

> Example: When a CT mentions brain lesions, lytic lesions, adrenal masses, or other descriptions that may indicate metastases, and there is no physician statement to clarify the ambiguous description, the registrar must try to obtain physician staging or clarification and to document the outcome on the abstract before submitting the abstract.
>
> Example: The physical examination states there is a lesion in the right cervical area. Op report states the lesion is on the left. CT scan states the lesion is on the right. The pathology report does not state which side the biopsy was taken from. The registrar should state in the remarks section "no further information available to determine on which side of the neck the lesion was located." Therefore, the primary site [or extension, lymph node EOD, etc.] was coded as unknown [or NOS].

Query vs. Discrepancy

If a code is not supported by documentation on the abstract, then it will be counted as a discrepancy.

> Example: The abstract has the tumor size coded as 024, but there is no mention of the tumor size anywhere in the text of the abstract.

Tumor size will be changed to 999 and this will be counted as a discrepancy.

If the registrar does not clarify ambiguous information, then it will be counted as a discrepancy.

Example: The abstract has the following information submitted: patient name as Mei Ling Chang, race as white, Spanish as Cuban. The region will query the registrar for correct race and Spanish code. In addition, this will be counted as a discrepancy since the registrar did not clarify the ambiguous information in the original text of the abstract.

New Information/Guidelines

New information regarding abstracting standards is sent by the CCR to the regional registries for distribution to all registrars. Discrepancies resulting from this new information will not be counted for one month (30 days) after statewide distribution. The Date Completed on the abstract will be the date the visual editor will use to calculate the 30 day time frame.

Example: The Guideline for Prostate Codes 33 and 34 has a January 24, 2000, Statewide Distribution date. Information contained in the guideline will not be counted as a discrepancy unless the Date Completed on the abstract is later than February 24, 2000.

Extension Code Unknown (99)

If you know the extent of the tumor is at least regional but are not sure if it is more than that, and there is no physician TNM, code to regional.

Example: Chest CT: 4 cm pleural based mass RUL with mediastinal adenopathy. Questionable mass right adrenal gland. If querying the physician for more information regarding stage has no results: code as regional rather than unknown.

Ambiguous Terms Not Listed in Vol. 1

If a term or description used is not included in the ambiguous terms for diagnosis or involvement in Vol. 1, page 87 and 98 or SEER EOD Code Manual, page 2, but the language is commonly understood to mean diagnostic or involvement, then accept the term or description.

Example: CT showed an 8 cm. mass in the right kidney that "must be considered a hypernephroma until proven otherwise." Interpret as diagnostic.

If a physician states that an organ is malignant and the only abnormal findings on a scope, scan, or operative report describe a mass, nodule(s) or lesion(s) in that organ, it can be assumed that the mass, nodules or lesions represent the malignancy.

Similarly, if a physician states that an organ is involved with metastasis, and the scope, scan or operative report only describes a mass, nodule(s) or

lesion(s) in that organ, you can assume that the mass, nodules or lesions represent the metastasis.

> Example: Chest CT: right pleural effusion; 2 lesions, one in RUL and one just inferior to this; nodules left lung in mid lung and 3 densities in LLL. FDX: metastatic lung ca.

Discussion: Assume that the nodules and densities are metastases and code extension as 78, contralateral lung.

Ambiguous TNM

In order to use the guideline for TNM in the SEER EOD manual, 3rd Edition, General Instructions, the TNM coder must be the physician (codes 1-4). If the TNM coder is the physician and registrar (code 6), the abstractor must document which element (T,N,M) the physician coded. If no documentation is provided, the TNM information will be disregarded and the visual editor will code extent of disease from all of the submitted documentation.

Day of Month for Four Month Rule for Coding EOD

For coding EOD when the day of the month is unknown, use information up through the last day of the fourth month, or until the completion of first course of treatment.

> Example: Date of Diagnosis is 02/99/1999. Use information through 06/30/1999, or through first course of treatment.

CCR Statement Concerning Use of Colonoscopy Measurements for Assigning Colon Subsite Code

Source: DSQC #2000-04 Policy: Use of Colonoscopy Measurements, 03/08/00

There are numerous references and training guides available that provide approximate measurements of the segments of the large colon. These measurements can vary several centimeters per segment. 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.*

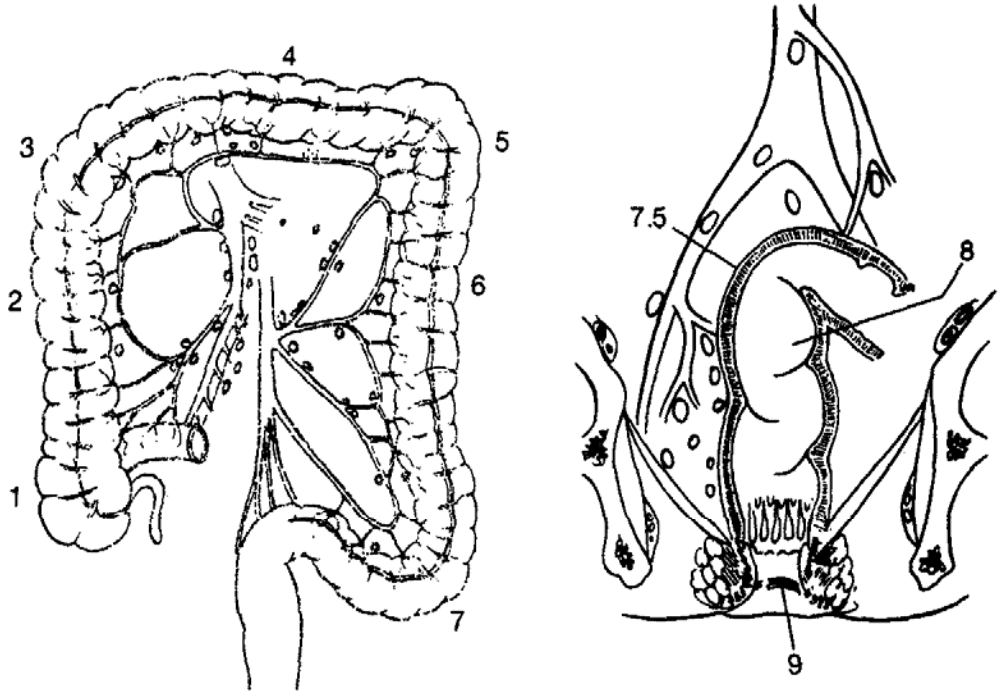
If there is conflicting information in the medical record with regard to subsite and there is no surgical resection, code the subsite as stated by the physician. If there is a surgical resection, code the subsite as stated in the operative report, or a combination of the operative report and pathology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

With regard to visual editing, if a case is coded to subsite .9 by the abstractor, the visual editor may change the code to a more specific subsite

based on the CCR's standard reference, but this will not be counted as a visual editing discrepancy. Conversely, if the abstractor uses the colonoscopy information to assign a more specific subsite to a .9, this will not be counted as a discrepancy.

From *AJCC Cancer Staging Manual, 5th Edition*, page 85.

Anatomic Areas of Colon and Rectum



A

	MEASUREMENT FROM ANAL VERGE	AVERAGE SEGMENT LENGTH	
		GRAY'S	TNM
Anus	0–4 cm	4 cm	4–5 cm
Rectum	4–16 cm	12 cm	12 cm
* Rectosigmoid	(at 15–17 cm)		
Sigmoid	17–57 cm	40 cm	n/a
Descending	57–82 cm	25 cm	10–15 cm
Transverse	82–132 cm	50 cm	n/a
Ascending	132–147 cm	15 cm	15–20 cm
Cecum	at 150 cm	6 cm	6 cm

(Total length of large intestine approximately 150 cm).
* The rectosigmoid is of anatomic and surgical importance because of the blood supply and the disappearance of the mesosigmoid. While the rectosigmoid is truly a junction, some authors include 1 inch of the sigmoid above and 1 inch of rectum below and refer to it as the rectosigmoid region.
These measurements are APPROXIMATIONS ONLY. Each person is different and these measurements should be used as GUIDELINES ONLY.

B

FIG. 12-1. The anatomic areas of the colon and rectum are: cecum *(1);* ascending colon *(2);* hepatic flexure *(3);* transverse colon *(4);* splenic flexure *(5);* descending colon *(6);* sigmoid *(7);* rectosigmoid *(7.5);* rectum *(8);* anal canal *(9).*

Breslow Thickness and Clark Level of Invasion

Source: DSQC #2000-05 Clarification: Breslow Thickness and Clark Level of Invasion, 03/08/00

Question: If only the thickness is given in the final diagnosis, can this be used to determine EOD extension along with the microscopic description?

Example: Can depth of invasion 1.7 mm (ulcerated) be converted to Clark's Level IV which equals extension 31?

Answer: No, depth of invasion cannot be converted to a "Clark" level and then to an EOD extension code. The correct answer for this question is TS 170 and EOD extension 41, involvement of the skin/dermis, NOS with ulceration. A researcher analyzing melanomas could include this case if studying "Breslow" measurements but not include it if studying "Clark" levels.

Per April Fritz and Carol Johnson, SEER, "Breslow" thickness and "Clark" level of invasion are completely separate measurements. There is not an exact correlation between the measured depth of the tumor and the invasion of the individual layers of the skin because measurements (depth) of the layers of skin vary from person to person and anatomic site to anatomic site. All you know about the case is that the melanoma measured 1.7 mm and was ulcerated. In a heavily calloused area, 1.7 mm could be above the papillary-reticular dermal interface or into the reticular dermis--you just don't know.

AJCC states to assign a T3 if a Breslow's thickness between 1.5 and 4 mm deep can be proven or Clark's level I, invasion of the reticular dermis, can be proven. It does not state that tumor between 1.5 and 4 mm is equivalent to Clark's level IV.

Focus, Focal and Foci

Source: DSQC #2000-06 Clarification: Focus, Focal and Foci, 03/08/00

Question: Does the term focal mean the same thing as focus and foci when coding tumor size?

Answer: No. Focus and foci are microscopic descriptions and are coded 001 when no other information is available. Focal refers to an area of involvement, focal should be coded 999.

The SEER Inquiry System Question and Answer #75 (4/94) states focus, focal and foci are variations of the same word. At the 5/99 SEER Coder and Abstractor Workshop, an answer was given which stated that focal does not equal focus and foci. Focal refers to an area of involvement. According to Carol Johnson, SEER, the 5/99 workshop response takes precedence over the SINQ question. It is a newer interpretation based on actual usage of the words in pathology reports.

Below are some examples of diagnoses from pathology reports followed by the correct tumor size.

1) focal adenocarcinoma - TS 999
2) microfocus of adenocarcinoma - TS 001
3) multiple foci of adenocarcinoma in specimen - TS 001
4) multifocal adenocarcinoma in specimen - TS 999
5) microscopic focus of adenocarcinoma in multiple fragements - TS 001
6) focal adenocarcinoma in chips - TS 999
7) focal adenocarcinoma in 5% of specimen - TS 999

Rescind Guidelines for Coding Prostate Clinical EOD

Source: DSQC #2000-07 Policy: Rescind Guidelines for Coding Prostate Clinical EOD, 03/08/00

As you are aware, the Data Standards and Quality Control Unit has performed two separate recoding audits on cancer of the prostate during the past year. The results of these audits showed that the use of Guidelines for Coding Prostate Clinical EOD, dated August 10, 1998, had resulted in cases being coded unknown (Code 90) when there was sufficient information on the abstract to assign a more specific code. In addition, it was apparent that not all registrars and regions were using this guideline. We have decided to rescind the use of Guidelines for Coding Prostate Clinical EOD. Please use the instructions in the SEER Extent of Disease Manual for assigning and visual editing codes. This change will be effective with cases diagnosed January 1, 2000.

Clarification on Type of First Recurrence and Other Type First Recurrence

Source: DSQC #2000-08 Clarification: Clarification on Type of Recurrence, 05/05/00

The California Cancer Registry received the attached memo to Software Vendors and State Cancer Registries dated, March 6, 2000, from the Commission on Cancer. It was also sent to hospital cancer registrars in January. This clarification refers to data items **1880 Type of First Recurrence** and **1890 Other Type First Recurrence** with regard to California Cancer Registry reporting requirements. Although the Commission recommends that software be changed to enable cancer registrars to use these two fields to report invasive cases initially diagnosed as in situ, the California Cancer Registry follows SEER reporting requirements for multiple primaries; therefore, these codes cannot be used to meet this requirement.

Also, while it was the Commission's intention to take the responsibility for abstracting these cases away from hospital cancer registrars, the mechanism recommended would place the responsibility of abstracting the invasive case on the regional registries. In order to do this, the regional registry would

have to contact the hospital cancer registrar for the medical record information. The hospital cancer registrar would still be involved with reporting these cases.

Because the addition of these codes will not result in less work for either hospital or regional cancer registries, we require that hospital cancer registrars continue to follow the CCR/SEER reporting requirements by abstracting both the in situ and invasive cancer case.

Clarification on Coding Non-Hodgkin's Lymphoma Histology

Source: DSQC #2000-09 Clarification: Clarification on Coding Non-Hodgkin's Lymphoma Histology, 10/31/00

The CCR has received a clarification from SEER regarding coding histology for Non-Hodgkin's Lymphoma. According to SEER, "Cases should be coded to the most current classification, either the Revised European-American Classification of Lymphoid Neoplasms (REAL) or the WHO, which is based on the REAL. The REAL, or WHO, classifies lymphomas according to the cell line (T or B or NK) from which the lymphoma arose. This reflects contemporary thinking in lymphomas." Therefore, the REAL, or WHO, classification has priority when coding Non-Hodgkin's Lymphoma. Ignore the SEER rule of coding to the highest morphology code number.

A document containing the REAL Classification of Lymphomas was distributed by the CCR in May 1998. Please refer to this document for the appropriate codes. If you do not have a copy of this document, contact your regional registry.

This change is effective October 31, 2000. It is not necessary to go back and recode cases that have already been abstracted or transmitted.

The CCR also wants to clarify how to code the term *malignant lymphoma, follicular center cell.* Code to 9690 - Follicular Lymphoma.

Errata and Corrections to the Third Edition of Extent of Disease 1988

Source: DSQC #2000-10 Clarification: Errata and Corrections to the Third Edition of EOD 1988, 10/31/00

The California Cancer Registry received "Errata and Corrections to the Third Edition of Extent of Disease 1988" at the SEER Abstractors and Coders Workshop in Albuquerque, New Mexico in May 2000. Since its distribution at this meeting, it has been updated (July 1, 2000).

Many of the changes in this errata are editorial corrections to the Extent of Disease manual. There are some changes, however, that will require review

and recoding. These are noted in bold in the "Change/addition" column. There are also changes that were not bolded for review in the errata, but need to be reviewed and recoded. These are Soft palate, p. 2 - delete code 50, add code 65 for "Hard palate" and Liver, p. 3 - delete code 75, add code 62 for "Gallbladder."

The CCR is in agreement with SEER and requires that all of the changes in this errata take place immediately and are retroactive to cases diagnosed January 1, 1998 and later.

Tumor Size for Combined *In Situ*-Invasive Tumor

Source: DSQC #2000-11 Clarification: Tumor Size for Combined In Situ-Invasive Tumor, 12/18/00

The CCR has received clarification from SEER regarding coding tumor size for *in situ*-invasive tumors when the *in situ* component is described as a minor component.

When a pathology report describes tumor size as invasive with a minor component of *in situ*, then code the total tumor size. Minor component is defined as: less than 5%, foci of tumor, or stated as "minor component."

Data Changes for 2001

Source: DSQC #2000-12 Guideline: Data Changes for 2001, 12/18/00

As you are aware there are a couple of significant changes that are effective with cases diagnosed January 1, 2001. The first of these changes is the implementation of the third edition of the *International Classification of Diseases for Oncology (ICD-O-3)* and the other is the change in reporting legislation that requires the reporting of benign and uncertain behavior intracranial and central nervous system (CNS) tumors. The following will assist you in coding and collecting these cases.

Intracranial and CNS Tumors

Benign and uncertain behavior intracranial and CNS tumors are required effective with January 1, 2001 cases, as noted above. Since you will need to begin casefinding in January, two lists are attached to assist you. The first list includes intracranial and CNS histologies that are now reportable. The second list includes ICD-9-CM codes to assist you in casefinding in medical records. These tumors are to be sequenced following the American College of Surgeons'Commission on Cancer guideline for tumor sequencing, *i.e.*, alpha characters - AA for the first tumor, BB for the second, etc. With regard to staging these tumors, the CCR is not requiring that they be staged at this time. We recommend that you code EOD Extension 99 (Unknown) for these cases. If your registry uses SEER Summary Stage, we recommend that you code them to Code 9. There may be registries that have been collecting benign brain tumors prior to this change in legislation. If you have been assigning codes/stages to them in the past, we recommend that you

continue this practice. The CCR requires that follow up be performed on these cases in hospitals that routinely perform follow up to meet Commission on Cancer requirements.

ICD-O-3

The histology for cases diagnosed January 1, 2001 is to be coded using ICD-O-3. The histology for cases diagnosed prior to this date is to be coded using ICD-O-2. There will be separate fields available in CNExT for coding these histologies. There are histologies that changed from malignant to borderline and vice versa in ICD-O-3. One of these is juvenile astrocytoma - Code 9421 (see updated instructions). ~~The NAACCR Uniform Data Standards Committee voted to continue to collect these tumors. The CCR will also require that these continue to be collected; however, behavior should be coded /1(uncertain behavior) instead of /3 (malignant). The reason for collecting these as /1 is because of the new legislation requiring the collection of benign and uncertain behavior intracranial tumors. It was felt that it would be less confusing to collect these under the correct behavior code.~~ Cases diagnosed prior to January 1, 2001 should continue to be coded /3.

Borderline ovarian tumors changed from malignant to borderline in ICD-O-3. The California Cancer Registry will require the continued collection of borderline ovarian tumors due to their potential to become malignant and because there are a number of studies underway in the state that include these tumors. They are also to be sequenced following American College of Surgeons guidelines for benign tumors. Behavior should be coded to /1 (borderline behavior). Although the behavior of these tumors has changed, follow up should be performed on these patients.

NAACCR formed an ICD-O-3 Working Group to address many of the questions that have been asked by both cancer registrars and cancer registry software vendors. A document entitled, *Guidelines for ICD-O-3 Implementation* was prepared to answer these questions. It was agreed that this document would be distributed widely by NAACCR, SEER and the American College of Surgeons' Commission on Cancer so you should be receiving it soon. It will also be available on the Web Sites of these organizations(SEER – *http://www.seer.cancer.gov*; NAACCR - *http://www.naaccr.org*; COC - *http://www.facs.org*). If you have not received a copy of this document, we would recommend that you download it and review it carefully. It contains an appendix with the list of histology changes in ICD-O-3 that can be used in conjunction with your ICD-O-2 manual until you are able to obtain an ICD-O-3 manual.

As many of you are aware, SEER has developed a training module on ICD-O-3 that is on its Web Site. In addition, a videoconference is planned for January 9, 2001. Your regional registries will be providing you with information as to sites for the videoconference. The CCR, in addition, will be developing a document that will include all of the available sites in the state for those of you who may not be able to get to the videoconference in your region. As with the Surgery Codes videoconference, the CCR will be making copies of the videoconference to be provided to your regional registries for

those of you who will be unable to participate that day. We recommend your participation in both of these activities.

We will continue to provide you additional information regarding ICD-O-3 and benign and uncertain behavior brain tumors through your regional registries.

Casefinding Benign and Uncertain Behavior Brain and CNS Tumors - ICD-O-3 Codes
Based on WHO Classification of CNS Tumors and Central Brain Tumor Registry of the United States

Source: DSQC #2001-01 Guideline: Casefinding Benign and Uncertain Behavior Brain and CNS Tumors, 03/27/01

ICD-O-3 HEADING	NAME	CODE
Adenomas and Adenocarcinomas 814-838	*Chromophobe adenoma* *Prolactinoma* Pituitary adenoma *Acidophil adenoma* *Mixed acidophil-basophil adenoma* *Basophil adenoma*	*8270/0* *8271/0* 8272/0 *8280/0* *8281/0* *8300/0*
Nevi and Melanomas 872-879	*Diffuse melanocytosis* *Meningeal melanocytoma*	*8728/0* *8728/1*
Germ Cell Neoplasms 906-909	Benign teratoma Teratoma, NOS	9080/0 9080/1
Miscellaneous 935-937	Craniopharyngioma *Adamantinomatous Craniopharyngioma* *Papillary Craniopharyngioma* Pinealoma Pineocytoma	9350/1 *9351/1* *9352/1* 9360/1 9361/1
Gliomas 938-948	Subependymoma Subependymal giant cell astrocytoma Choroid plexus papilloma, NOS Atypical chorioid plexus papilloma Myxopapillary ependymoma Desmoplastic astrocytoma of	*9383/1* 9384/1 9390/0 9390/1 9394/1 9412/1 9413/1 9421/1 9442/1 9444/1

	infancy Dysembryoplastic neuroepithelial tumor Pilocytic astrocytoma Gliofibroma Chordoid glioma	
Neuroepitheliomatous Neoplasms 949-952	Ganglioneuroma Ganglioneuromatosis Gangliocytoma Dysplastic gangliocytoma of cerebellum Ganglioglioma, NOS Central neurocytoma Pacinian tumor	9490/0 9491/0 9492/0 9493/0 *9505/1* 9506/1 9507/0
Meningiomas 953	Meningioma, NOS Meningiomatosis Meningothelial meningioma Fiborus meningioma Psammomatous meningioma Angiomatous meningioma Hemangioblastic meningioma Transitional meningioma *Clear cell meningioma* Atypical meningioma	9530/0 9530/1 9531/0 9532/0 9533/0 9534/0 9535/0 9537/0 *9538/1* 9539/1
Nerve Sheath Tumors 954-957	Neurofibroma *Neurofibromatosis* *Melanotic neurofibroma* Plexiform neurofibroma Schwannoma Acoustic Neuroma *Neurinomatosis* *Neurothekeoma* *Neuroma* Perineurioma	9540/0 *9540/1* *9541/0* 9550/0 9560/0 9560/0 *9560/1* *9562/0* *9570/0* 9571/0

Race and Ethnicity Code Documentation

Source: DSQC #2001-02 Guideline: Race and Ethnicity Documentation, 05/04/01

All race codes must be supported by text documentation. This information must be documented in the Remarks or Physical Examination field, with the exception of race code 88 (no further race documented). Documentation should include each race and ethnicity specified and the source of this information. Search beyond the face sheet for a more specific race and/or ethnicity.

Examples of statements in the Remarks or Physical Examination field are as follows:

> Pt is Filipino per the H&P.
>
> Pt is Hispanic, NOS, per consult.
>
> Pt is Cuban per physician notes.
>
> Race is White per face sheet.
>
> No race information available in chart.

Replaced by DSQC #2002-06.

Anal Intraepithelial Neoplasia, Grade III

Source: DSQC #2001-03 Clarification: AIN Grade III, 05/04/01

The CCR has received clarification from SEER regarding the reportability of Anal Intraepithelial Neoplasia (AIN), Grade III. In ICD-O-3, anal intraepithelial neoplasia, grade III, (C.21.1) is coded to 8077/2 and is reportable to the CCR beginning with cases diagnosed January 1, 2001 forward. Cases diagnosed AIN, Grade II-III, are also reportable beginning with cases diagnosed January 1, 2001 forward.

Change in Reporting Pilocytic/Juvenile Astrocytoma

Source: DSQC #2001-04 Clarification/Change: Pilocytic/Juvenile Astrocytoma, 05/04/01

Pilocytic/juvenile astrocytoma – morphology code 9421 must be reported to the CCR with a behavior code of /3. This is a change from the instructions in the Data Changes 2001 statewide memorandum dated December 18, 2000, that stated to code these to a behavior of /1. This will allow the CCR to be compatible with SEER reporting requirements. These tumors will be sequenced as any other reportable malignancy, using digits, not alpha

characters. This will continue to allow sequence numbers to reflect the chronological order of reportable malignancies.

Revised Guideline: Race and Ethnicity Code Documentation

Source: DSQC #2001-05 Rescind Guideline: Race & Ethnicity/pending, 08/13/01

Effective September 18, 2001, the attached race and ethnicity code documentation guideline (DSQC Memo #2001-02) has been revised to remove the requirement to document the source of race and ethnicity information. All race codes must be supported by text documentation to include each race and ethnicity specified. This information must be documented in the Remarks or Physical Examination field, with the exception of race code 88 (no further race documented). With 2002 data changes, a race and ethnicity text field will be added to the data set for documenting this information.

Replaced by DSQC #2002-06.

ICD-O-2 to ICD-O-3 Conversion

Source: DSQC #2001-06 Guideline: ICD-O-2 to ICD-O-3 Conversion, 08/17/01

With the transition from ICD-O-2 to ICD-O-3, a conversion program was developed by the SEER Program to be used by software vendors in cancer registries where it was elected to convert historical ICD-O-2 data to ICD-O-3 data. Please consult your software vendor instructions for this histology conversion review.

Although there are a large number of histologies flagged for review, the California Cancer Registry is only requiring hospital and regional registries to review the following:

ICD-O-2 Code	ICD-O-2 Histology
8580/3	Thymoma, malignant
8803/3	Small cell sarcoma
9731/3	Plasmacytoma, NOS

Source: DSQC #2001-07 Guideline: SEER Documents, 11/12/01

Three documents were distributed at the SEER Coders and Abstractors Workshop in May 2001:

- *Clarifications for Abstracting and Coding Hematopoietic Diseases* (see PDF document)
- *ICD-O-3 Errata and Clarifications* (see PDF document)
- **Coding and Abstracting Guide to the Hematopoietic Diseases**

  This item is obsolete and has been replaced with the SEER book, Abstracting and Coding Guide for the Hematopoietic Diseases (May 2002) [No. T-007] Pub. No. 02-5146. To order go to the SEER website.

Although *Coding and Abstracting Guide to the Hematopoietic Diseases* is a draft, please use it until a final version is available.

Please refer to these documents for assistance when abstracting these cancer sites. They are to be used for cases diagnosed January 1, 2001 and later.

For your convenience, this memorandum can be filed under Appendix S in the 6th Edition of Volume I.

A fourth document, *Clarification of Coding Rules for Prostate Cancer*, was distributed but is currently under review at the CCR. This will be distributed in the future.

[Note: the CNExT Labels files have been updated to reflect the *ICD-O-3 Errata and Clarifications* document.]

Reportable In Situ Terms

Source: DSQC #2002-01: Clarification: Reportable In Situ Terms, 1/28/02

The following is a revision of the list of reportable terms indicating in situ behavior (Volume I, Section V.3.4.2 In Situ Coding). Please note the addition of the terms AIN III, DIN 3 and LIN to this list for cases diagnosed 1/1/2001 forward. For AIN, DIN, LIN, VAIN and VIN, grade II-III is reportable. 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.

As a reminder, carcinoma in situ (including squamous cell and adenocarcinoma) of the cervix and Cervical Intraepithelial 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.

Surgical Margin Clarifications for Melanoma: Surgery Codes 40 and 50

Source: DSQC #2002-02: Clarification: Melanoma Surgery Codes, 1/28/02

Clarification of surgery codes 40 and 50 for surgical margins of melanoma has recently been provided by the Commission on Cancer. Please make the following changes as noted:

Code 40	Wide excision or re-excision of lesion or minor (local) amputation, NOS. Margins of excision are 1 cm or less. Margins may be microscopically involved. Local amputation is the surgical resection of digits, ear, eyelid, lip or nose.

Code 50	Radical excision of a lesion, 1 cm or more, NOS Margins of excision are greater than 1 cm and grossly tumor free. The margins may be microscopically involved.

DSQC #2002-03 GUIDELINE: SEER Prostate Guidelines

EFFECTIVE: Cases Diagnosed on or after 1/1/2001

The SEER Prostate Guidelines (see PDF document) are effective with cases diagnosed 1/1/01 and forward. Upon review of these guidelines, the CCR feels there are no major changes to the manner in which we have been coding extension for prostate cases. However, the CCR asks that you review all prostate cases diagnosed 1/1/01 forward for consistency in following these guidelines.

- Note on Page 4 - with SEER's permission, a CCR note has been added to clarify when to use PSA coding guidelines.
- Regarding date of diagnosis, please follow the rules in Volume I, III.3.3.
- Regarding Example 4 on page 2, April Fritz provides this clarification,

  > "For Example 4 on page 2, the pathologic code should be 20. We recognize that the first sentence under the PATHOLOGIC EOD section could be phrased more clearly (and it will be in the next iteration). The intent of the statement is to allow histologic information from clinical staging (i.e. needle biopsy or TURP tissue) to supplement information from the prostatectomy. The statement is a variation of Note 3, page 138 of the SEER EOD manual, 3 rd edition. The guidelines are intended to supplement the notes in the EOD book, not contradict them."

  As a reminder, clinical information that is disproven by the pathology of the prostatectomy specimen should NOT be used. April adds,

  > "In Example 3, the clinically identified hard nodule turned out to be an adenoma in the right apex. The remainder of the prostatectomy specimen reported only tumor involving the left lobe and was silent on anything else in the prostate, including the left apex. Had there been a bilateral positive biopsy of the apex or a needle biopsy of the left apex, we agree that the appropriate code should be 34. But without it, the best pathologic extension code to use is 20, involvement of one lobe."

DSQC #2002-04 Guideline Revision: EOD Lymph Node Summary Field: 0 vs 9 Guideline, 6/27/02

EFFECTIVE: Cases Diagnosed 1/1/2002 Forward

Attached please find the revised version (see PDF document) of the EOD Lymph Node Summary Field, 0 vs. 9 Guideline (original statewide distribution date of July 10, 1999). This version replaces the original document. The changes to the document are italicized for your convenience.

Along with providing more clarification, this revision contains:

- SEER Guidelines for lymph node involvement specific to prostate primaries
- Changes - Use code 0 for lymph nodes not mentioned at time of surgery or if radiologic studies are performed and lymph nodes are not mentioned
- Deletion - Use code 9 when there is lymphadenopathy mentioned on radiology studies and no clear documentation which indicates involvement by cancer

Revision of Extension Fields for Breast Cancer

Source: DSQC #2002-05: Guideline: Revision of Extension Fields for Breast Cancer, 3/12/2002

EFFECTIVE: June 12, 2002

The attached SEER document, Appendix 1, Revised Breast Cancer EOD Codes (Effective for cases diagnosed January 1, 1998 through December 31, 2002) is provided to supplement CNExT Version 1.2.3.

Due to the delay in implementing Collaborative Stage until 2004, these codes will be effective through December 31, 2003 diagnosis year. This effects extension code fields 10–30 and is meant to reduce the number of cases that are unstageable in the TNM conversion algorithm by capturing pathological information regarding both the in situ and invasive components of the tumor.

- The Regions have been instructed by the CCR to recode cases already submitted by the facilities.
- The online EOD manual has been updated for easy reference. This Appendix expands codes 10-30 and replaces all breast extension codes in the SEER EOD manual.
- The effective dates on Appendix 1 have been modified to read January 1, 1998 through December 31, 2003.

Reminder: Pathology text information must support SEER EOD codes.

Appendix 1

To: All SEER participants

From: April Fritz and Lynn Ries

Seer Memo on Revision of Extension Fields for Breast Cancer

The SEER Program will expand the choices of EOD Extension codes for breast cancer to document whether the tumor size recorded is other than for purely invasive cancers.

Purpose: To reduce the number of cases that are unstageable in the TNM conversion algorithm.

Background: In the 1999 breast cancer data, it became apparent that more and more path reports were only recording the size of the entire lesion and not the invasive component (resulting in 999 codes for breast tumor size). This has lead to many breast cancer cases being staged as unknown instead of stage I or II. The graph (Appendix 2) shows that the rate of unknown breast cancer has nearly doubled between 1998 and 1999 for women 50-64 and stage I has dropped dramatically. This shift is highly likely to be due to the tumor size rule rather than an actual shift in stage.

Cases affected: All breast cancer cases with Tumor Size code 999 and Extension code 10, 20 or 30.

Diagnosis date: *Current SEER registries*: diagnosed between January 1, 1998 and December 31, 2003

Expansion SEER Registries: diagnosed between January 1, 2000 and December 31, 2003.

Procedure: Select all breast cancer cases (non-lymphomas) with '10,' '20,' or '30' in the EOD extension and '999' for tumor size diagnosed after January 1, 1998. For each case, review the case and code size and EOD extension according to the attached documentation (Appendix 1). Changes should be recorded in the file that is submitted to NCI-SEER.

Completion date: Review of cases diagnosed January 1, 1998 hrough December 31, 2000 must be completed by and included with the Feb 1, 2003 submission. If possible, the cases diagnosed in 2001 should also be reviewed by February 1, 2003, but if this is a problem for 2001 cases, they may be submitted in the August 2003 submission.

SEER Edits: To accommodate the new codes, SEER*Edits will be revised and the changes will be distributed to participating regions as soon as possible.

Note 1: Several registries have asked whether they should also review cases with tumor size codes 009 and 019. The answer is that NCI-SEER is not requiring review of those cases. If an individual registry chooses to review them, they can. The

purpose of this review is to derive a tumor size that allows as many cases as possible to be converted to a TNM stage group. Codes 009 and 019 already indicate that the tumor, whether purely invasive or mixed invasive and in situ, is less than 2 cm, and therefore a TNM Tumor category of T1 can be inferred. Summary staging is not affected.

Note 2: A number of people asked about requiring software vendors to make changes in hospital registry software. The consensus is that, assuming that SEER changes over to the Collaborative Staging System with cases diagnosed January 1, 2003 and after, the ability to collect tumor size information will be captured in a different way. It is not feasible to require hospital software vendors to make the changes for the remainder of 2002 cases and then umentation

(Replaces DSQC #2001-02 & 2001-05)

EFFECTIVE: July 23, 2002

Race and ethnicity are two very important data items to epidemiologists who investigate cancer. 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.

1. Race code documentation must be supported by text documentation for those cases where there is conflicting information. Outlined below are examples of when text documentation would be required.

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

Scenarios Demonstrating Conflicting Race Information:

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

Birthplace:	Japanese
Marital Status:	California Married

2. A text statement indicating patient's race, i.e., "Pt is Japanese", is required for conflicting types of cases (see #1). This information must be entered in either the physical exam or remarks text fields.
3. Cases with conflicting information that lack supporting text documentation will be returned as queries and counted as discrepancies.
4. While race code documentation is only required when there is conflicting information, CCR recognizes the importance of race code documentation and strongly recommends that registrars continue to document race in the physical exam or remarks fields. Remember to search beyond the facesheet for the most definitive race and/or ethnicity information.
5. In version 1.2.3 of CNExT, the Remarks screen is now accessible near the demographic information in addition to where it was originally located for registrar's convenience in documenting race information.

DSQC #2002-07 GUIDELINE: SEER Coders & Abstractors Workshop Documents (May 2002), 8/1/02

The three attached documents were distributed at the SEER Abstractors & Coders Workshop in May 2002.

1. *Changes to SEER Data Set* (effective for cases diagnosed **1/1/03** & forward) (see PDF document)
2. *FDA Oncology Agents Not Listed in SEER Book 8* (effective for cases diagnosed **1/1/02** and forward) (see PDF document)
3. *Determining the Number of Primaries* (effective for cases diagnosed **1/1/02** and forward)

Please refer to these documents for assistance when abstracting. For your convenience, this memorandum can be filed under Appendix S in the 6th edition of Volume One.

The following documents were distributed at the workshop in May, however, they are currently being updated and/or under review by CCR. These documents will be distributed at a later date:

1. *SEER Summary Staging Manual Errata* -- An updated list is currently being developed and will be available in about 1 month. CCR will wait for the updated version for distribution.
2. *Coding Complex Morphologic Diagnoses* -- SEER is amending this information. CCR will distribute the revised version once it is available.
3. *Field & Code Changes* - DSQC staff will be meeting and discussing whether we need to retain any of these fields.

4. *NAACCR Standards* -- The table is being revised. CCR will wait for the revised document for distribution.

Trying to decide whether lesions are reportable as single or multiple primaries can be confusing. First, let's review the definition of separate sites.

1. For certain sites, a difference in the subsite indicates a separate primary. These sites are colon (C18), anus and anal canal (C21), bone (C40-C41), melanoma of skin (C44), nerves (C47), and connective tissue C49).

   For practical purposes, the only two sites where you are likely to encounter multiple primaries are colon and melanoma of the skin.

   For example, a melanoma of the skin of the arm (C44.6) and a melanoma of the skin of the leg (C44.7) are reported as two primaries.

2. For other sites, a difference in the main category (the two numbers after the C) of the site code is reported as a separate primary.

   For example, stomach (C16) and cecum (C18.0) are separate primaries and two abstracts would be prepared.

   Prepare a single abstract when there is a difference in subsite.

   For example, two separate squamous carcinomas, one of the true vocal cord (C32.0) and one of the posterior surface of the epiglottis (C32.1) are reported as a single primary because there is a difference only in subsite.

3. Table 24 in ICD-O-3 and pages 9-10 in the SEER Program Code Manual list site code groupings that are considered one primary site for reporting purposes. The groups that you are most likely to use are head and neck, genitalia and urinary system.

   Examples:

   A lesion on the soft palate (C05.1) and a lesion on the buccal mucosa (C06.0) would be reported as a single primary.

   Squamous carcinoma of the vulva (C51) and squamous carcinoma of the vagina (C52) would be reported as a single primary.

   Transitional cell carcinoma of the renal pelvis (C65) and a separate transitional cell carcinoma of the ureter (C66) would be reported as a single primary.

4. When there are multiple lesions, a difference in the first three digits of the histology code usually means different histologies.

   This means a difference in any of the first three digits of the histology code.

An angiosarcoma (9120) and an angiomyxosarcoma (8894) are different at the first digit. These are separate histologies.

A mucinous adenocarcinoma (8480) and a ductal carcinoma (8500) are different at the second digit. These are separate histologies.

An alveolar adenocarcinoma (8251) and a papillary adenocarcinoma (8260) are different at the third digit. These are separate histologies.

Oat cell carcinoma (8042) and small cell carcinoma (8041), because they are only different at the fourth digit, are the same histology for the purpose of determining the number of primaries to report.

Prepare a Single Abstract for:

1. A single lesion with one histologic type.
2. A single lesion with multiple histologic types. Code the histology in priority order: 1) a combination code if one exists; 2) a more specific code; 3) majority of the tumor; 4) higher ICD-O-3 code.

Examples:

A breast tumor with a mucinous component (8480/3) and a ductal component (8500/3) is reported as a single primary. (Code the combination histology, 8523/3.)

A colon cancer biopsy reported as adenocarcinoma, NOS (8140/3) and described as mucinous adenocarcinoma (8480/3) when resected. (Code the more specific diagnosis, 8480/3.)

A stomach carcinoma, predominantly signet ring type. (Code the majority term, 8490/3.)

A bladder tumor with transitional cell CA (8120/3) and squamous cell carcinoma (8070/3) is a single primary. (No combination code; code to higher ICD-O-3 code, 8120/3.)

3. Multiple lesions of the same histologic type, if diagnosed in the same site within two months.

For example, oat cell carcinoma (8042/3) of the LUL of the lung (C34.1) and small cell carcinoma (8041/3) of the LLL of the lung (C34.3) are a single primary.

4. An adenocarcinoma NOS and a more specific type of adenocarcinoma in the same site within two months are a single primary. This occurs most often in the colon.

For example, two separate tumors in the ascending colon, an adenocarcinoma (8140/3) and a mucin-producing adenocarcinoma (8481/3), are a single primary.

5. Multiple tumors of different cell types that commonly appear together in the same primary site diagnosed within two months are reported as a single primary.

Examples:

Ductal carcinoma in the UOQ and a lobular carcinoma in the LIQ are reported as a single primary (C50.9 -- 8522/3).

Separate nodules of follicular carcinoma and papillary carcinoma in the thyroid. (Use the combination code 8340/3)

Thanks to the Los Angeles SEER Registry for developing this overview.

Coding Complex Morphologic Diagnoses

Source: DSQC #2002-08 Guideline: Coding Complex Morphologic Diagnoses (revised 8/02)

EFFECTIVE: For cases diagnosed January 1, 2001 & forward

Per DSQC Memorandum 2006-01:

Effective immediately, DSQC Memorandum 2002-08 "Coding Complex Morphologic Diagnoses," is rescinded and the rules contained in the document **should no longer be applied**.

Source: DSQC #2003-01 Revised Clarification: Histology Code for Mucinous Adenocarcinoma in a Villoglandular Polyp

EFFECTIVE: March 31, 2003

The histology code for mucinous adenocarcinoma in a villoglandular polyp is code 8480/3.

NOTE: CCR Inquiry System #226 will be revised to reflect the correct code: 8480/3.

NOTE: CCR Inquiry System #498 is a similar question. That answer is correctly stated and remains unchanged.

Surgery of Primary Site - Breast

DSQC #2003-02 CLARIFICATION: Surgery of Primary Site - Breast

EFFECTIVE: September 1, 2003

The CCR has received a revised answer from the Commission on Cancer and SEER regarding cases treated with bilateral mastectomies with separate primaries.

If a patient is diagnosed with two separate right and left breast primaries and treated with right and left mastectomy(s), surgery code is 41 or 51 for each primary; two separate abstracts are reported, see examples below.

Codes 42/52 are used to capture prophylactic mastectomy of the opposite non-cancerous breast.

This is documented in Volume One, Seventh Edition, Appendix Q, SEER Program Code Manual, 3 rd . Edition, Revision 1, Appendix F, pages 23 and 24, and the FORDS manual, pages 269 and 270.

NOTE: CCR Inquiry System #447 will be revised to reflect the correct code: 41/51

NOTE: SINQ 20012002 reflects the correct code: 41/51

Example 1

Rt. & Lt. Breast CA (2 separate primaries)

Right Simple Mastectomy: Surgery Code

Left Simple Mastectomy: Surgery Code

Rt. Surgery Code = 41

Lt. Surgery Code = 41

Example 2

Rt. & Lt. Breast CA (2 separate primaries)

Right Modified Mastectomy

Left Modified Mastectomy

Rt. Surgery Code: 51

Lt. Surgery Code: 51

Example 3

Left Breast CA

Left Simple Mastectomy

Right Simple Mastectomy (Prophylactic)

Surgery Code =42

Example 4

Right Breast CA

Right Modified Mastectomy

Left Modified Mastectomy (Prophylactic)

Surgery Code =52

Multiple Primaries - Breast

DSQC #2003-03 CLARIFICATION: Multiple Primaries - Breast

EFFECTIVE: December 8, 2003

The CCR has received the following clarification from SEER regarding the use of the combination code for breast primaries.

When abstracting and coding breast cancer, determine if there is one tumor with complex morphologies or separate tumors with different histologies. Use the following guideline to determine number of abstracts:

- One tumor with complex morphologies; prepare one abstract
- Separate tumors with different histologies; prepare one abstract for each tumor

The use of combination codes for breast primaries with separate tumors in different locations are limited to the following scenarios and coded as one primary:

- Ductal and lobular ca (8522)
- Paget's Disease and intraductal ca (8543)
- Paget's Disease and infiltrating ductal ca (8541)

Other histologic type differences that occur as separate tumors in different parts of the same breast are coded as multiple primaries. ICD-O-3 histology code 8523 is NOT to be used to combine histologies from separate primaries; it is used for mixed histologies in a single primary.

CCR Inquiry System ID #540, 604 and 640 will be revised to reflect this clarification.

After the implementation date of this memo (30 days after effective date), breast cases incorrectly submitted as one primary will not be processed by the regions. These cases will be returned and need to be resubmitted as two primaries.

DSQC #2003-04 CLARIFICATION: ACoS Data Items

EFFECTIVE: Cases Diagnosed January 1, 2003 Forward

We have received numerous questions regarding surgery and treatment code fields, thus we have compiled a list of clarifications from the American College of Surgeons' Commission on Cancer (CoC) FORDS Manual as well as the CoC Inquiry and Response System. They are as follows:

Diagnostic and Staging Procedure Codes

This field describes incisional, needle or aspiration biopsies of the primary site or regional/distant tissue only. It *does not* describe incisional, needle or aspiration biopsies of regional lymph nodes; these are described in the "Scope of Regional Lymph Node Surgery".

Incisional biopsies and fine needle aspirations of the primary site performed for purposes of staging or diagnosing a cancer are coded as Surgical Diagnostic and Staging Procedures**02** when the procedure does not involve surgical treatment.

References: FORDS pages 16 and 109-110, ACoS I&R # 8996

Surgery Code: Bladder
Use code **27** for a transurethral resection bladder (TURB)

References: ACoS I&R #9486

Surgical Procedure/Other Site:
For the field Surgical Procedure/Other Site, apply code **1** - Nonprimary surgical procedure performed, if surgical treatment was performed for the following primary sites and morphologies:

- Unknown Primaries
- Ill-Defined Primaries
- Hematopoietic/Endoreticulothelial/Immunoproliferative or Myeloproliferative disease morphologies,

References: FORDS Manual, page 21, ACoS I&R #9404

DSQC #2003-05

GUIDELINES: SEER Workshop Documents (May 2003)

EFFECTIVE: See below

The attached documents were distributed at the SEER Abstractors & Coders Workshop in May 2003.

1. *The Brain Book, Abstracting & Coding Guidelines for Primary Central Nervous System Tumors*; Draft #2(9/4/2003). Effective for cases diagnosed 1/1/04 and forward.
2. *ICD-0-3 Errata and Clarifications Set #2*
3. Replacement page for *SEER Program Manual*, page 133 (Reason No Cancer Directed Surgery)
4. Replacement pages for *SEER Program Manual*, Appendix F (colon, breast & prostate)

These documents will also be posted to the CCR website in pdf format. Registrars may go to the CCR website to download "The Brain Book", draft #2. If unable to access the website, please request that your region provide you with a hardcopy. April Fritz has informed us that a finalized version of "The Brain Book" will be available at some time in the future. In the meantime, the CCR wants the draft #2 version available to registrars.

DSQC #2005-01
CLARIFICATION
EFFECTIVE: Cases Diagnosed January 1, 2004 Forward

The attached document includes clarifications in coding and abstracting instructions resulting from the 2004 Data Changes Training. Although this clarification is effective with cases diagnosed January 1, 2004 forward, it is not necessary to go back and recode cases that have already been abstracted or transmitted.

Please refer to this document for assistance when abstracting.

Benign Brain and CNS Tumors (BBT)

1. ***Question***: What diagnosis year is BBT reporting effective?

   Response: Statewide reporting of BBT commenced with diagnosis year 1/01/01.

   For cases diagnosed 1/01/04 forward, abstract using 2004 Data Changes rules (Vol. I, Sec. II.1.9.1 - II.1.9.7)

2. ***Question***: How are BBT staged?

   Response: For diagnosis years 2001-2003 the CCR does not require benign brain tumors to be staged; the default EOD codes are 999 99 9 99/99. If you have been assigning codes/stages to them in the past, we recommend you continue this practice.

   For cases diagnosed 1/01/04 forward, use the Collaborative Staging scheme for the appropriate site. There is a schema for Brain and Cerebral Meninges, Other parts of the CNS (includes the spinal meninges, and cranial nerves), and Thymus, Adrenal Gland and Other Endocrine Glands (includes pituitary and pineal glands and craniopharyngeal duct).

3. ***Question***: What sequence number is assigned to a second BBT?

   Response: The first BBT is assigned sequence #60. If another BBT primary tumor is subsequently diagnosed, the first BBT tumor sequence is changed to #61 and the second BBT is assigned sequence #62.

   Example: In 2004, a person was diagnosed with a BBT (sequence #60). In 2005, a second reportable BBT was diagnosed. The 2004 case changes to sequence #61 and the tumor diagnosed in 2005 is assigned sequence #62.

4. ***Question***: If a BBT case is diagnosed prior to 01/01/04 and recurs in 2004, is the recurrence reportable?

   Response: If the case was diagnosed prior to 1/01/01, it would not be reported. If the case was diagnosed 1/01/01 through 12/31/03, it would have been previously reported to the CCR using previous reporting rules.

5. ***Question***: How many primaries do you abstract in the scenario below?

A patient has a known BBT diagnosed after 1/01/04 and it is not treated. After time, the patient is diagnosed with a malignant brain tumor in the same site.

Response: Report as two primaries one benign (sequence number 60) and one malignant (sequence number 00). Once a tumor transforms from benign to malignant, another abstract for the malignant tumor is prepared.

Reference: Volume I, Section II.1.9.5

6. ***Question***: If there is one lesion in the midline of the brain, is this coded as one lesion?

   Response: Yes, code as one lesion and use the code where the midline structure is listed.

   Example: A midline lesion of the third ventricle would be coded to C71.5 third ventricle

7. ***Question***: If there is one lesion in the midline of the brain and one lesion elsewhere in the brain with the same histology diagnosed at the same time, is this one primary or two?

   Response: Compare the subsite code for the midline tumor to the subsite code for the other tumor. If they are different at the subsite level, abstract as two primaries. If the location of the midline tumor is in the same subsite, it would be considered one lesion.

   Example: There is one tumor in the midline of the third ventricle (C71.5) and a separate tumor with the same histology within the third ventricle (C71.5). Abstract as one primary.

   Example: There is one tumor in the midline of the temporal lobe (C71.2) and a separate midline tumor located in the right parietal lobe (C71.3). Abstract as two primaries.

8. ***Question***: How do you code laterality for a lesion in the midline of the brain?

   Response: Midline tumors of the CNS are sometimes coded 9 in laterality. If the lesion is midline in a single brain structure, then code 0. For example, laterality is coded 0 (not a paired organ) for C71.6, cerebellum, NOS.

9. ***Question***: For coding a single primary brain tumor with 2 histologies, (both histologies are listed in the same histologic group, Volume I, page 31), which histology do you code?

   Response: The table on page 31 of Volume I does not apply to single tumors. It only applies when there are multiple tumors. For single tumors with different histologies, follow rule 4 in Volume I, page 82, which states to use the numerically higher histology code.

10. ***Question***: Are non-malignant blood vessel tumors occurring in the CNS sites reportable?

Response: Yes, the ICD-O-3 Primary Brain and CNS Site/Histology Listing (Appendix V in Volume I) includes blood vessel tumors under several categories including meninges C70.0-C70.9, brain C71.0-C71.4 and C71.7-C71.9, (excluding ventricle), spinal cord C72.0, cauda equina C72.1, cranial nerves C72.2-C72.5, cerebellum C71.6 and other nervous system C72.8-C72.9.

These tumors include:

9120/0 Hemangioma, NOS

9121/0 Cavernous hemangioma

9150/0 Hemangiopericytoma, benign

9150/1 Hemangiopericytoma, NOS

9161/1 Hemanioblastoma

11. Question: Should blood vessel tumors occurring in CNS sites be coded to blood vessels or CNS?

Response: They should be coded to the CNS site in which they occur.

Example: Patient is diagnosed with a hemangioblastoma of the right temporal lobe of the brain. Site code: C71.2 (temporal lobe, brain), histology code: 9161/1, Laterality: Right only

12. *Question*: Is laterality coded for tumors of the meninges?

Response: Code laterality for cerebral meninges (C70.0) only. Spinal meninges (C70.1) is not listed as a lateral site, thus laterality for spinal meninges is coded to 0.

Reference: Volume I, Section II.1.9.2

13. *Question*: Is it possible for a benign schwannoma to arise on the spinal cord or do they always arise from nerve roots coming off the cord?

Response: Anatomically they must be derived from Schwann cells which are not a part of the CNS, so they must all come from peripheral nerves, therefore, they all come from nerve roots. Thus, benign schwannomas of the spinal cord/peripheral nerves are not reportable.

14. *Question*: If the surgeon states "resection of intradural extramedullary schwannoma" does this mean that the tumor is outside the cord but within the dura?

Response: Yes, but it also means it is on a peripheral nerve root and therefore not reportable.

DSQC #2005-01

CLARIFICATION

EFFECTIVE: Cases Diagnosed January 1, 2004 Forward

COLLABORATIVE STAGING

GENERAL INSTRUCTIONS

1. ***Question***: The General Instructions on page 25 of the Collaborative Staging Manual states, "Prostate needle biopsy shows 0.6 mm carcinoma, Code as 001." Page 27 states "For an incisional needle biopsy, code tumor size as 999. Do not code the tumor size from a needle biopsy unless no residual tumor is found on further resection." This is a contradiction. Which do we follow?

   Response from the CoC/CS Steering Committee:

   The General Instructions on page 25, which currently reads "Prostate needle biopsy shows 0.6 mm carcinoma Code as 001," will be edited and corrected to state "Prostate TURP shows 0.6 mm tumor size." The instruction on page 27 is correct.

2. ***Question***: If different metastatic sites are equally distant, how is the CS Distant Mets coded? Is this CS Mets Eval?

   Response: For the CS Distant Mets field, it doesn't matter how "distant" a metastatic site is for this field. The codes for CS Distant Mets are divided into the following categories:

   Code 10 - Distant lymph nodes (site specific)

   Code 40 - Distant metastasis (except code 10), distant metastasis, NOS, or carcinomatosis

   Code 50 – A combination of codes 10 and 40

   Code 99 – Unknown, cannot be assessed, not stated in patient record

   Assign the highest applicable code for CS Distant Mets, whether the determination was clinical or pathological and whether or not the patient had preoperative systemic therapy.

   For assessing CS Mets Eval, both the findings and distance from the primary site are factors in determining this field. If all workup is deemed negative, code the diagnostic method used to evaluate the site furthest from the primary site. If some of the workup is negative and some positive, code the diagnostic method used for the furthest positive finding. If all the workup is positive, code the diagnostic method used to evaluate the furthest metastatic site from the primary.

   Reminder: Select the CS Mets Eval code that documents the report or procedure from which the information was obtained about metastatic involvement farthest from the primary site. This may not be the numerically highest eval code.

3. ***Question***: Are there any CS fields that are not coded?

   Response: The CCR requires that all fields except the CS Evaluation fields be coded. CoC approved facilities are required to complete all CS data items, including the CS Evaluation fields.

4. ***Question***: How are the SSF coded when the only information is the MD TNM?

   Response: If the medical record does not contain information that can be coded in the SSF fields, use the appropriate code for "unknown" or "not applicable."

BREAST

5. ***Question***: What is the definition of H&E stain?

   Response: H&E stands for Hematoxylin and Eosin.

6. ***Question***: In the breast scheme, when would you use CS Lymph Node code 05?

   Response: Use code 05 when the regional lymph nodes are negative, but isolated tumor cells (ITC's) are detected on routine H&E stains. Reminder: Lymph nodes with ITC's only are not considered positive lymph nodes. See note 5 in this scheme.

7. ***Question***: How are SSF 4 and 5 coded for in situ breast cancer cases? When would you use code 888?

   Response: For Breast Site Specific Factor 4, use codes 000-009 only to report results of IHC on otherwise negative lymph nodes on routine H&E stain, i.e., only when CS Lymph Nodes is coded 00. The same applies to Site Specific Factor 5, relative to codes 000-002.

   Code 888 is for cases not coded to 00 for CS lymph Nodes. For instance, if you have a CS Lymph Node code 10, SSF 4 and 5 would be coded 888.

   References: CS Manual, page 464

   CoC I & R, # 12726

   Note 1: Please note the change on page 464 of the CS Manual, under Breast - Site Specific Factor 4, for code 888, CS Lymph Nodes code 05 has been deleted (revision 8/12/04).

   Note 2: Under the general CS Lymph Nodes rule, item 2 states to code CS Lymph Nodes to 00, when the CS Extension is coded as in situ, even if no lymph nodes were removed, since "in situ" by definition means noninvasive.

   Reference: CS Manual, page 34, item 2

8. ***Question***: How is Breast SSF 4 coded if the lymph node pathology is negative and no IHC was done?

   Response: Use Breast Site Specific Factor 4 code 000, regional lymph nodes negative on H&E, no IHC studies done. The same rule applies for SSF 5.

PROSTATE

9. ***Question***: Which EOD prostate guidelines can we apply for Collaborative Staging?

Response: Do not apply any of the EOD prostate guidelines. Prostate guidelines for Collaborative Staging are currently being developed by the CS Steering Committee.

LYMPHOMA

10. ***Question***: In the lymphoma scheme, what is the IPI Score?

Response: IPI Score stands for International Prognostic Index. An international cooperative study developed a prognostic index for patients with follicular lymphoma. Using 5 factors, the researchers were able to predict patients with a less than 50% 5-year survival who would be suitable candidates for more intensive therapy. The 5 risk factors include: Age 60 or over, Ann Arbor stage III-IV, hemoglobin level <120 g/L, elevated LDH and >4 nodal sites. This paper was published in the September 1, 2004 issue of Blood.

PAROTID GLAND

11. ***Question***: For Site Specific Factor 3, what lymph nodes are considered Level I-III for the parotid gland?

Response: Definitions of the levels and lymph node chains in each level for Head and Neck sites are listed on page 37 of the CS Manual.

Reference: CS Manual, page 37, and pages 192-193

DSQC #2005-02

CLARIFICATION

EFFECTIVE: Cases Diagnosed January 1, 2005 Forward

Fine needle aspirations (removal of cells or tissue) of regional lymph nodes are coded in the Scope of Regional Lymph Node Surgery field. Additionally, FNA biopsies of regional nodes are also included in the Number of Positive and Examined Regional Lymph Nodes fields. For Number of Positive Regional Lymph Nodes, if the total number of positive aspirated, biopsied, sampled, or dissected lymph nodes cannot be determined on the basis of cytology or histology, code the combination of lymph nodes to 97. For the Number of Examined Lymph Nodes, if it cannot be determined how many lymph nodes were aspirated, biopsied, sampled, or dissected, code the number of nodes to 98. If an FNA of regional nodes is the only procedure performed on lymph nodes, code Regional Lymph Nodes Positive/Examined to 95/95. Whether or not the lymph node aspiration resulted in cytology or histology does not affect the codes.

Example #1: Breast cancer patient had a biopsy of a sentinel axillary lymph node that was negative. An FNA of an axillary lymph node was performed on the same day and was positive. A month later, an axillary lymph node dissection was performed and the pathology report stated that 11/19 lymph nodes were positive.

Surgical Procedure #1: Code Scope of Regional Lymph Node Surgery to Code 2 - Sentinel lymph node biopsy.

Surgical Procedure #2: Code Scope of Regional Lymph Node Surgery to Code 7 – Sentinel lymph node biopsy & code 3, 4, or 5 at different times.

Rationale: Codes 0-7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.

Code CS Regional Lymph Nodes Positive/Examined: 12/21

Rationale: Positive: 0 sentinel node, 1 FNA of a node, 11 dissected nodes; Examined: 1 sentinel node, 1 FNA of a node, 19 dissected nodes.

Example # 2: Breast cancer patient had an FNA biopsy of an axillary lymph node that was positive for carcinoma. Subsequently, an axillary lymph node dissection was done elsewhere. Findings stated to be negative, but unknown how many lymph nodes were examined.

Surgical Procedure #1: Code Scope of Regional Lymph Node Surgery to Code 1 – Biopsy or aspiration of regional lymph nodes, NOS

Surgical Procedure #2: Code Scope of Regional Lymph Node Surgery to Code 3 – Number of regional lymph nodes removed unknown or not stated; regional lymph node removed, NOS

Code CS regional Lymph Nodes Positive/Examined: 01/97

Rationale: A single lymph node was positive on FNA, thus Regional Lymph Nodes Positive is coded to 01; regional lymph node removal was documented as a dissection, number of nodes is unknown/not stated, thus Regional Lymph Nodes Examined is coded to 97.

DSQC #2005-03

CLARIFICATION

EFFECTIVE: Immediately

It has come to the attention of the CCR that some facilities are submitting cases to the regional registries with social security numbers coded to 000-00-0001. Apparently the admitting departments at these facilities use this number when the patient's social security number is unknown. This is not a valid social security number according to the Social Security Administration. Do not submit cases to the regional registries using this invalid social security number.

Please follow the guideline in Volume I, section III.2.3 that states to code an unknown social security number to 999-99-9999.

Melanoma Surgery Code Guidelines

DSQC #2005-04

GUIDELINE

EFFECTIVE: Cases diagnosed January 1, 2005 Forward

Below please find the revised Melanoma Surgery Code Guidelines. Although this guideline is effective with cases diagnosed January 1, 2005 forward, registrars are not required to go back and apply these guidelines to 2005 cases already submitted to the regional registry.

In accordance with the CCR General Visual Editing Guidelines, discrepancies resulting from new information/guidelines will not be counted for one month (30 days) after statewide distribution. *DSQC Memo 2005-04 has a distribution date of August 5, 2005, thus regional registries will not count discrepancies using this guideline on cases with a Date Completed earlier than September 5, 2005.*

GENERAL GUIDELINES

1. Code a shave, punch bx or incisional biopsy or biopsy NOS as surgery, if it removes all of the melanoma (exc bx=27). Use the surgery date from this procedure.
2. Code a shave or punch biopsy, incisional biopsy or biopsy NOS as surgical, diagnostic and staging procedure (02), if it does not remove all of the melanoma. Also, if it is not known if all of the melanoma has been removed, code it as a surgical, diagnostic and staging procedure.
3. If the first procedure is labeled as an excisional bx (27) or an excision NOS (20) code them per the titles **unless surgical margins are > 1cm (then code in the applicable 40 range).**
4. Code the subsequent procedure based on the surgical margin measurements first. If this places the surgery code in the 30's range, then apply the code that corresponds to the first procedure (31=shave, punch=32, etc).
    a. If the surgical margins are **equal to or <1cm**, code 30-33 (as applicable).
    b. If the surgical margins are **>1cm**, code 45-47 (as applicable).
    c. If the surgical margins are NOS (**not documented or not known)**, code 30-33 (as applicable).
    d. If the subsequent procedure is a Mohs, use the appropriate 34-36 code.

NOTE 1: The biopsy NOS, shave, punch or incisional biopsy and the gross excision do not have to be done as a single procedure to code 30-33.

NOTE 2: Margins must be taken from the pathology report—following CAP (College of American Pathologists) protocol guidelines.

NOTE 3: To use the codes 45-47, the surgical margins must be > 1cm and microscopically negative.

NOTE 4: When there are no margins documented in the pathology report, do not guess/estimate the margin measurements from the specimen size.

NOTE 5: If there are margins for length, width and depth and they are different, code the smallest margin. The smallest margin dictates the surgery code, no matter where it comes from (width, length or depth).

NOTE: The CoC Technical Staff (ACoS) has reviewed this document for accuracy.

SURGERY CODE INSTRUCTIONS FOR MELANOMAS *(Two procedure scenarios listed with surgery codes)*		
1st Procedure=Shave/punch/inc/NOS biopsy & Residual Melanoma @ 2nd Procedure		
1st Procedure	Shave or punch biopsy, incisional biopsy or biopsy NOS	02
2nd Procedure	**Surg margins equal to or <1cm or NOS**=residual melanoma	30-33 (Mohs=34-35)
2nd Procedure	**Surg margins >1cm**=residual melanoma	45-47* (Mohs=36)
1st Procedure=Exc bx/Excision NOS & Residual Melanoma @ 2nd Procedure		
1st Procedure	Excisional biopsy or Excision NOS	27 or 20
2nd Procedure	**Surg margins equal to or <1cm or NOS**=residual melanoma	30 (Mohs=34-35)
2nd Procedure	**Surg margins >1cm**=residual melanoma	45-47* (Mohs=36)

NO RESIDUAL MELANOMA @ 2nd Procedure		
1st Procedure	Shave or punch biopsy, incisional biopsy, biopsy NOS, excisional bx (all preceding titles code 27) or excision NOS (20) (**unless surgical margins > 1cm**, then code in the 40 range)	27 or 20
2nd Procedure	**Surg margins equal to or <1cm or margins NOS**=no residual ***NOTE:*** *If the 1st procedure was an excisional bx, code the 2nd procedure 30.*	30-33 (Mohs=34-35)
2nd Procedure	**Surg margins > 1cm**=no residual	45-47* (Mohs=36)

***NOTE 1:** Margins must be microscopically negative and > 1cm to code in the 40 range.*

***NOTE 2:** Surgical margins must be taken from the path report.*

THREE SURGERY CODE EXAMPLES FOR MELANOMAS *(Three procedure scenarios listed with surgery codes)*		
Example 1		
1st Procedure	Punch biopsy: Atypical junctional melanocytic proliferation, present at bx margin.	02
2nd Procedure	Exc Skin: Malig melanoma, focally extending very close to peripheral margin.	32
3rd Procedure	Exc skin: No residual melanoma.	32
Example 2		
1st Procedure	Punch bx, skin: malignant melanoma, present at bx margin.	02
2nd Procedure	Exc, skin: malignant melanoma, focally extending very close to peripheral margin.	32
3rd Procedure	Exc, skin: No residual melanoma.	32
Example 3		
1st Procedure	Shave bx: Atypical junction nevus, no evidence of invasive disease.	02
2nd Procedure	Exc Lesion: Malig melanoma assoc w/compound nevus. Epidermal margin positive.	31
3rd Procedure	Moh's exc: Focal residual melanoma in situ, close to inked epidermal margin. Final surg margins clear.	34
Example 4		
1st Procedure	Shave bx: Melanoma in situ (lentigo maligna).	02
2nd Procedure	Skin punch bx: NED.	02
3rd Procedure	Moh's: Melanoma in situ, surgical margins: NED.	34

Use of SEER*Rx and Drugs Changing Categories

DSQC #2005-05

CLARIFICATION

EFFECTIVE: Cases Diagnosed 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. SEER*Rx can be downloaded from .

Since Book 8, the categories for a few drugs have changed from immunotherapy to cytostatic chemotherapy. Registrars will need to make appropriate corrections in their databases for any cases diagnosed 1/1/2005 forward in which a drug changed categories. To assist registrars in identifying these drugs, attached is a SEER SINQ entry, listing the drugs that changed categories from immunotherapy to cytostatic chemotherapy. There were no drugs that changed categories from chemotherapy to immunotherapy.

For cases diagnosed prior to 1/1/2005, registrars may use SEER*Rx if they wish. Registrars do not need to change or correct the drugs that switched categories for cases diagnosed prior to 1/1/2005.

In accordance with the Visual Editing Guidelines, discrepancies resulting from this new information will not be counted for one month (30 days) after statewide distribution. The Date Completed on the abstract will be the date the visual editor will use to calculate the 30-day time frame. Discrepancies will not be counted in which drugs shifted categories for cases with a Date Completed prior to December 31, 2005, or for any cases diagnosed prior to January 1, 2005.

ID : 20051111	Status : Final
1 of 1 GO	**Mark for Report**

References
SEER*Rx

Brief

Question
Chemotherapy/Immunotherapy: Which drugs changed categories when SEER*Rx came out?

Answer
Please refer to http://seer.cancer.gov/tools/seerrx/
SEER*Rx is effective for cases diagnosed 1-1-2005 and forward. It replaces all previous references. It is neither required nor recommended that cases treated prior to 2005 be recoded.

The following drugs in the 5/17/02 Book 8 update changed from immunotherapy to cytostatic chemotherapy in SEER*Rx:
alemtuzumab/Campath
bexarotene/Targretin
bevacizumab/Avastin
bortezomib/Velcade
pegaspargase/Oncaspar

rituximab/Rituxan
trastuzumab/Herceptin
asparaginase
The following drugs may have been coded as monoclonal antibodies but are radioisotopes in SEER*Rx:
epratuzumab/LymphoCide
ibrituzumab
tiuxetan/Zevalin
tositumomab/Bexxar
Any other monoclonal antibodies either remained as monoclonal antibodies or it was a local decision to code them as immunotherapy.
There were no drugs that changed from chemotherapy to immunotherapy.

RESCINDMENT - DSQC MEMORANDUM 2002-08 "Coding Complex Morphologic Diagnoses (revised 8/02)

SOURCE: DSQC #2006-01

CATEGORY: CLARIFICATION

EFFECTIVE: For Cases Diagnosed in 2005 and 2006

Statewide Distribution Date: March 3, 2006

Effective immediately, DSQC Memorandum 2002-08 "Coding Complex Morphologic Diagnoses," is rescinded and the rules contained in the document should no longer be applied.

SEER has informed the CCR that the document, "Coding Complex Morphologic Diagnoses" distributed by SEER, is no longer to be used in coding complex and difficult morphology combinations. Instead, SEER is directing registrars to use the SEER Multiple Primaries and Histology Rules from the *SEER Program Coding and Staging Manual 2004*, Fourth Edition. The pages from the *SEER Program Coding and Staging Manual 2004*, pertaining to histology coding are attached.

Please note that on page 2 of this attached document, the terms "architecture" and "pattern" may be used to designate the majority of tumor if written in the College of Pathology (CAP) protocol. Documentation in the pathology text is required indicating that the term originated from the CAP protocol (e.g. as per CAP protocol).

Please apply these multiple primaries and histology rules for all cases diagnosed in 2005 and 2006. Registrars are not expected to go back and apply these rules to cases already abstracted and submitted to the regional registry.

Note: in accordance with the CCR Visual Editing Standards, discrepancies resulting from this new information will not be counted for one month (30

days) after statewide distribution. The Date Completed on the abstract will be the date the visual editor will use to calculate the 30-day time frame.

DSQC Memo 2006-01 Attachment

Histologic Type ICD-O-3

The data item Histologic Type describes the microscopic composition of cells and/or tissue for a specific primary. In the rare instance where there is no tissue pathology, code the histology the medical practitioner uses to describe the tumor. The tumor type or histology is a basis for staging and determination of treatment options. It affects the prognosis and course of the disease.

The *International Classification of Diseases for Oncology*, Third Edition (ICD-O-3) is the standard reference for coding the histology for tumors diagnosed in 2001 and later. Do not record the 'M' that precedes the histology code. Refer to *ICD-O-3* for guidance in coding the histology. See sections *Coding Guidelines for Topography and Morphology*, and *Summary of Principal Rules for Using the ICD-O*, Third Edition.

The histology can be coded only after the determination of multiple primaries has been made.

Synonyms and Equivalent Terms

Mixed, combined, and **complex** are **usually** used as synonyms when describing histology.

Definitions

Cancer, NOS (8000) and **carcinoma,** NOS (8010) are not interchangeable.

Carcinoma, NOS (8010) and **adenocarcinoma** (8140) are interchangeable (See ICD-O-3).

Complex (mixed, combined) histology: The pathologist uses **multiple histologic terms** to describe a tumor. The histologic terms are frequently connected by the word "and" (for example ductal and lobular carcinoma).

Different histology: The first three digits of the ICD-O-3 histology code are different.

Different subtypes: The NOS cell types often have multiple subtypes; for example, scirrhous adenocarcinoma (8143), adenocarcinoma, intestinal type (8144), and linitis plastica (8141) are subtypes of adenocarcinoma, NOS (8140).

Majority of Tumor:

Terms that mean the majority of tumor	Terms that DO NOT mean the majority of tumor
Predominantly	With foci of

With features of	Focus of/focal
Major	Areas of
Type	Elements of
With…..Differentiation*	Component
Pattern (Only if written in College of American Pathologists (CAP) Protocol)**	
Architecture (Only if written in College of American Pathologists (CAP) Protocol)**	

Note: Examples of CAP protocols for specific primary sites may be found on the website – http://www.cap.org/cancerprotocols/protocols_intro.html

* Effective 1/1/1999 diagnosis

** Effective 1/1/2003 diagnosis

Mixed/combined histology: Different cell types in one tumor; terms used interchangeably. In most cases, the terms mixed and combined are used as synonyms; however the term mixed may designate a specific tumor.

Not Otherwise Specified (NOS): "Not Otherwise Specified."

Same histology: The first three digits of the ICD-O-3 histology code are identical.

Coding Instructions

Refer to "Determining Multiple Primaries" in the first section of this manual to determine the number of primaries. Use all of the information for a single primary to code the histology.

1. If there is no tumor specimen, code the histology described by the medical practitioner.

Example 1: The patient has a CT scan of the brain with a final diagnosis of glioblastoma multiforme (9440). The patient refuses all further workup or treatment. Code the histology to glioblastoma multiforme (9440).

Example 2: If the physician says that the patient has carcinoma, code carcinoma, NOS (8010).

2. Use the histology stated in the **final diagnosis** from the pathology report. Use the pathology from the procedure that resected the majority of the primary tumor.

If a more specific histologic type is definitely described in the microscopic portion of the pathology report or the comment, code the more specific diagnosis.

3. Lymphomas may be classified by the **WHO** Classification, **REAL** system, **Rappaport,** or **Working Formulation.** The WHO Classification is preferred. See page 13 in the ICD-O-3 for a discussion of hematologic malignancies.
4. Cases reported to SEER cannot have a metastatic (/6) behavior code. If the only pathology specimen is from a metastatic site, code the appropriate histology and the malignant behavior code /3. The primary site and its metastatic site(s) have the same basic histology.

Histology Coding Rules for Single Tumor

- The rules are in hierarchical order. Rule 1 has the highest priority.
- Use the rules in priority order.
- Use the first rule that applies to the case. (Do not apply any additional rules.)

1. Code the histology if only one type is mentioned in the pathology report.
2. Code the **invasive histology** when both invasive and in situ tumor are present.

Example: Pathology report reads infiltrating ductal carcinoma and cribriform ductal carcinoma in situ. Code the invasive histology 8500/3.

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

3. Use the **mixed** histology code if one exists

Examples of mixed codes: (This is not a complete list, these are examples only)

8490 Mixed tumor, NOS

9085 Mixed germ cell tumor

8855 Mixed liposarcoma

8990 Mixed mesenchymal sarcoma

8951 Mixed mesodermal tumor

8950 Mixed Mullerian tumor

9362 Mixed pineal tumor

8940 Mixed salivary gland tumor, NOS

9081 Teratocarcinoma, mixed embryonal carcinoma and teratoma

4. Use a **combination** histology code if one exists

Examples of combination codes: (This is not a complete list; these are examples only)

8255 Renal cell carcinoma, mixed clear cell and chromophobe types

8523 Infiltrating duct carcinoma mixed with other types of carcinoma

8524 Infiltrating lobular carcinoma mixed with other types of carcinoma

8560 Adenosquamous carcinoma

8045 Combined small cell carcinoma, combined small cell-large cell

5. Code the **more specific term** when one of the terms is 'NOS' and the other is a more specific description of the same histology.

Example 1: Pathology report reads poorly differentiated carcinoma, probably squamous in origin. Code the histology as squamous cell carcinoma rather than the non-specific term "carcinoma."

Example 2: The pathology report from a nephrectomy reads renal cell carcinoma (8312) (renal cell identifies the affected organ system rather than the histology cell type) in one portion of the report and clear cell carcinoma (8310) (a histologic cell type) in another section of the report. Code clear cell carcinoma (8310); renal cell carcinoma (8312) refers to the renal system rather than the cell type, so renal cell is the less specific code.

6. Code the **majority** of tumor.
   a. Based on the pathology report description of the tumor.
   b. Based on the use of majority terms. See definition for majority terms.
7. Code the **numerically higher** ICD-O-3 code. This is the rule with the lowest priority and should be used infrequently.

Histology Coding Rules for Multiple Tumors with Different Behaviors in the Same Organ Reported as a Single Primary

Code the histology of the invasive tumor when one lesion is in situ (/2) and the other is invasive (/3).

Example: At mastectomy for removal of a 2 cm invasive ductal carcinoma, an additional 5 cm area of intraductal carcinoma was noted. Code histology and behavior as invasive ductal carcinoma (8500/3).

Histology Coding Rules for Multiple Tumors in Same Organ Reported as a Single Primary

1. Code the histology when multiple tumors have the same histology.
2. Code the histology to adenocarcinoma (8140/_; in situ or invasive) when there is an adenocarcinoma and an adenocarcinoma in a polyp (8210/_, 8361/_, 8263/) in the same segment of the colon or rectum.

3. Code the histology to carcinoma (8010/_; in situ or invasive) when there is a carcinoma and carcinoma in a polyp (8210/_) in the same segment of the colon or rectum.
4. Use the **combination** code for the following:
    a. Bladder: Papillary and urothelial (transitional cell) carcinoma (8130)
    b. Breast: Paget Disease and duct carcinoma (8541)
    c. Breast: Duct carcinoma and lobular carcinoma (8522)
    d. Thyroid: Follicular and papillary carcinoma (8340)
5. Code the more specific term when one *SEER Program Coding and Staging Manual 2004*, Pages 84 – 87 of the terms is 'NOS' and the other is a more specific description of the same histology.
6. Code all other multiple tumors with different histologies as multiple primaries.

Recording Tumor Markers In Collaborative Staging System Site-Specific Factors

SOURCE: DSQC #2006-02

CATEGORY: Reference Document

EFFECTIVE DATE: Cases Diagnosed 1/1/2005 Forward

Statewide Distribution Date: June 29, 2006

Attached, please find a copy of the document "Recording Tumor Markers in Collaborative Staging System Site-Specific Factors." This resource, prepared by April Fritz, RHIT, CTR and approved by the CS Task Force and its medical consultants, is to be used to assist in the coding for those sites that collect tumor markers in the Collaborative Staging Site-Specific Factor fields.

As a reminder, the data item "Tumor Marker-California-1" (Her2/neu) is required by the CCR and is collected in its designated field.

Please apply these guidelines to all cases diagnosed 1/1/05 forward. Registrars are not expected to go back and apply these rules to cases already abstracted and submitted to the regional registry.

Note: In accordance with the CCR Visual Editing Standards, discrepancies resulting from this new information will not be counted for one month (30 days) after statewide distribution. The Date Completed on the abstract will be the date the visual editor will use to calculate the 30-day time frame.

ATTACHMENT

Reportability - Benign Brain Tumors with an Unknown Year of Diagnosis

SOURCE: DSQC Memo 2006-03,

CATEGORY: CLARIFICATION,
EFFECTIVE: Immediately
Statewide Distribution Date: June 29, 2006
Do not report benign brain tumor cases with an unknown (9999) year of diagnosis. Only benign brain tumor cases with a diagnosis year of 2001 forward are required to be reported to the CCR.

Use of document *"Coding Regional Lymph Nodes For Breast Cancers"*

SOURCE: DSQC 2006-04

CATEGORY: REFERENCE DOCUMENT

EFFECTIVE DATE: Immediately

Statewide Distribution Date: December 12, 2006

Attached, please find a copy of the document "*Coding Regional Lymph Nodes For Breast Cancers*." This resource was currently posted on the Collaborative Staging web site and is approved by the CS Task Force. It is also found in the front section of the Collaborative Staging Manual in Version 01.03.00.Here is the link:

http://www.cancerstaging.org/cstage/BreastNodesExplanation.doc

The purpose of the document is to clarify the reasons behind the codes in Breast CS Lymph Nodes and Site-Specific Factors 3-5 and to assist registrars in coding these fields correctly. Since this document serves to clarify coding instructions and does not change any of the fields, these guidelines can be used immediately.

Registrars are not expected to go back and apply these guidelines to cases already abstracted and submitted to the regional registry.

Note: In accordance with the CCR Visual Editing Standards, discrepancies resulting from this new information will not be counted for one month (30 days) after statewide distribution. The Date Completed on the abstract will be the date the visual editor will use to calculate the 30-day time frame.

CODING REGIONAL LYMPH NODES FOR BREAST

(Collaborative Staging Web Site – 11/2006)

Coding regional lymph node involvement for breast cancers is more complex than for many other sites, especially when dealing with isolated tumor cells (ITCs) and micrometastases. The following may help clarify the reasons behind the codes in CS Lymph Nodes and Site-Specific Factors 3-5. For a more detailed explanation, see the section in the breast chapter of the *AJCC Cancer Staging Manual*, 6th ed., called "Considerations for Evidence-Based Changes to the *AJCC Cancer Staging Manual*, 6th Edition" beginning on page 229.

Isolated Tumor Cells (ITCs). Pathologists can detect isolated tumor cells (ITCs) spread from a breast cancer into regional lymph nodes. These are

very small deposits of tumor cells, so small that they are **not** considered significant for assigning stage. They usually do not show evidence of malignant activity in the nodes, such as proliferation or stromal reaction. To be considered ITCs, they must be single tumor cells or small clusters not more than 0.2 mm. As more data are collected about these ITCs, their prognostic significance may be better understood. **At this time, nodes with only these ITCs are not considered positive nodes.** These ITCs are most often found using immunohistochemistry tests on sentinel lymph node specimens. The ITCs may sometimes also be seen on routine H&E-stained sections.

Hematoxylin and Eosin (H & E). (from " 'Hematoxylin & Eosin': (The Routine Stain)), by H. Skip Brown, BA, HT(ASCP), from:

http://www.sigmaaldrich.com/img/assets/7361/Primer-H&Emay04.pdf

> In histology, the standard or '**routine stain**' is the **hematoxylin and eosin** stain, better known as the '**H&E**' stain. With rare exceptions, every specimen being examined will first receive an H&E stain to give the laboratorian a visible look at the nucleus of the cells and their present state of activity. With most disease states there is abnormal growth and/or division in the nucleus of the cells. The hematoxylin and eosin stain uses two separate dyes, one staining the nucleus and the other staining the cytoplasm and connective tissue. Hematoxylin is a dark purplish dye that will stain the chromatin (nuclear material) within the nucleus, leaving it a deep purplish-blue color. Eosin is an orangish-pink to red dye that stains the cytoplasmic material including connective tissue and collagen, and leaves an orange-pink counterstain. This counterstain acts as a sharp contrast to the purplish-blue nuclear stain of the nucleus, and helps identify other entities in the tissues such as cell membrane (border), red blood cells, and fluid.

Immunohistochemistry (IHC). Immunohistochemistry (IHC) tests use antibodies to stain for proteins of interest in tissue specimens. The IHC test for metastatic breast cancer in lymph nodes uses antibodies to cytokeratin, so the test may be called "cytokeratin staining". Other IHC tests are used on the primary breast tumor, rather than the lymph nodes, to assess estrogen and progesterone receptors and HER-2 neu (human epidermal growth factor receptor). In SSF 4, code only IHC results for ITCs in LYMPH NODES.

Molecular Study: Reverse Transcriptase/Polymerase Chain Reaction (RT-PCR). An even more sensitive test used to detect ITCs in lymph nodes is RT-PCR, a molecular test looking for expression of genes of interest. This test is rarely done.

Micrometastasis. When the tumor deposits in the lymph nodes are larger than 0.2 mm but not larger than 2.0 mm, they are defined as micrometastasis. **Nodes with micrometastasis ARE considered positive for staging.**

In coding CS Lymph Nodes and Site-Specific Factors 3-5, the important things to abstract are the size of the tumor detected in the lymph nodes and the methods of detection. The table below may help in coding this

information. Note that the table includes codes for axillary nodes only, not internal mammary nodes. The table is followed by examples to illustrate likely coding situations.

To use the table, identify the group (numbered I-VI) of applicable rows based on the information in column 2 that best represents the information in the case. Within that group, find the row or rows that represent the information in the case, and read right to the last four columns to find the codes to use. The group numbers are for convenience in using this chart only, and do not correlate with any anatomic groups of nodes.

GIVEN THIS INFORMATION . . .			USE THESE CODES . . .			
	Row Num -ber	**IHC and/or Mol Studies Done, or Method of Detection/Verification**	**CS Lymph Nodes**	**SSF 3 (# pos ax)**	**SSF 4 (IHC)**	**SSF 5 (mol)**
I.	1.	None; does not apply	00	098	000	000
Clinical information only; no pathological information used to code CS Lymph Nodes; no nodes examined pathologically, nodes clinically NEGATIVE						
II. Clinical information only; no pathological information used to code CS Lymph Nodes; no nodes examined pathologically, nodes clinically POSITIVE	2.	None; does not apply	50, 60, or 99	098	888	888
Nodes examined pathologically, nodes negative; no Isolated Tumor Cells (ITCs)	3.	Immunohistochemistry (IHC) (cytokeratin staining) not done, **OR** unknown if done	00	000	000	
	4.	IHC done, neg for tumor	00	000	001	
NOTE: SSF 4 and 5 are coded independently of each other.						
	5.	Molecular studies not done, **OR** unknown if done	00	000		000
III.	6.	Molecular studies done, neg for tumor	00	000		001

Nodes examined pathologically, Isolated	7.	H&E (routine stained slides)	05	000	888	888
Tumor Cells (ITCs) ONLY;	8.	H&E neg, immunohistochemistry (IHC) (cytokeratin staining) not done, **OR** unknown if done	00	000	000	
Single tumor cells, or clusters < 0.2mm **OR** Immunohistochemistry (IHC) pos, NOS	9.	H&E neg, IHC done, neg for ITCs	00	000	001	
NOTE: SSF 4 and 5 are coded independently of each other.		10. H&E neg, IHC done, pos for ITCs	00	000	002	
		11. H&E neg, IHC done, pos but size of deposits not stated	00	000	009	
		12. H&E neg, molecular studies not done, or unknown if done	00	000		000
		13. H&E neg, molecular studies done, neg for tumor	00	000		001
IV.		14. H&E neg, molecular studies done, pos for ITCs	00	000		002

V. Nodes examined pathologically Tumor > 0.2mm, < 2.0mm (Micrometastasis)	15. H&E neg, micromets on IHC (cytokeratin staining) ONLY	13	001-097	888	888
	16. H&E pos for micromets	15	001-097	888	888
VI.Nodes examined pathologically Tumor > 2.0mm; positive lymph nodes	17. Does not apply	25 or higher	001-097	888	888

Examples for Each Group:

Group I Example

1. Nodes clinically negative, patient refused further workup. [Row number 1]

Group II Examples

1. Fixed and matted ipsilateral axillary nodes clinically, patient had pre-op chemotherapy. Subsequent modified radical mastectomy showed negative axillary nodes. (CS Reg Nodes Eval = 5 in this case.) [Row number 2]

2. Axillary nodes clinically positive, patient refused further workup. [Row number 2]

Group III Examples

1. Sentinel nodes neg on H&E. IHC (cytokeratin stain) performed, negative for ITCs. Molecular studies not done. [Rows 4 and 5]

2. Modified radical mastectomy, path report with 12 lymph nodes neg for tumor, no special stains, cytokeratin, IHC, or molecular studies performed on lymph nodes. [Rows 3 and 5]

3. Sentinel nodes neg on H&E. Unknown if IHC done. RT-PCR done, negative for ITCs. [Rows 3 and 6]

Group IV Examples

1. Sentinel nodes neg on H&E. IHC (cytokeratin stain) performed, positive for ITCs.

Unknown if molecular studies done. [Rows 10 and 12]

2. Sentinel nodes initially neg on H&E. IHC performed, positive for ITCs. No molecular studies done. ITCs then verified on H&E slides of the sentinel nodes. [Row 7 ONLY]

3. Class 3 case abstracted from clinical history. Sentinel nodes neg on H&E. IHC on sentinel nodes was positive, NOS. Molecular studies not mentioned. [Rows 11 and 12]

4. Sentinel nodes neg on H&E. Cytokeratin stain showed clusters of tumor cells in the node up to 0.15 mm. RT-PCR was pos for ITCs. [Rows 10 and 14]

5. Sentinel nodes neg on H&E. Unknown if IHC performed. RT-PCR study done, neg for ITCs. [Rows 8 and 13]

6. Sentinel nodes neg on H&E. IHC and RT-PCR negative for tumor. [Rows 9 and 13]

Group V Examples:

1. Path report, final diagnosis: “Lymph Nodes: one of three sentinel lymph nodes positive for capsular micrometastases.” Microscopic description: “Sections of the first submitted sentinel lymph node demonstrate normal nodal architecture, however, on cytokeratin stain, micrometastases are noted in the capsule.” [Row 15]

2. Path report, final diagnosis: "Lymph Nodes: one of three sentinel lymph nodes positive for capsular micrometastases." Microscopic description: "Sections of the first submitted sentinel lymph node demonstrate micrometastases in the capsule." No special studies are mentioned in the report. [Row 16]

Group VI Examples

1. Axilla neg on palpation. Modified radical mastectomy, 2/14 nodes positive. Largest metastasis 0.8 cm. [Row 17]

DATA STANDARDS AND QUALITY CONTROL MEMORANDUM
DSQC #2007- 04

CATEGORY: RESCINDING PREVIOUS MEMOS
SUBJECT: DSQC Memos 2007-01 and 2007-02
EFFECTIVE: Immediately

As a response to the recent message from the Collaborative Staging Steering Committee with regards to the use of the list of EOD clinically apparent and inapparent terms for prostate cancer (see message below), the CCR has rescinded DSQC Memos 2007-01 and DSQC Memo 2007-02 and removed them from the CCR web site. This is effective immediately. DSQC Memo 2007-01 instructed registrars to use the list of clinically apparent and inapparent terms for prostate cancer and DSQC Memo 2007-02 reviewed the appropriate use of prostate CS Extension codes 15 and 30.

Registrars are not required to go back and review or recode cases already submitted to the regional registry.

Also effective immediately, discrepancies for prostate CS Extension codes within the range of 13-30 will not be counted. However, prostate cases submitted with CS Extension code 30 that should actually be coded to a higher code, will still be visually edited and if miscoded, be counted as a discrepancy.

Registrars should continue to follow the instructions in the Collaborative Staging Manual and on the Collaborative Staging web site (FAQ section): http://www.cancerstaging.org/cstage/faq.html

Questions regarding this data item should be sent to the Commission on Cancer's Inquiry & Response System: http://web.facs.org/coc/default.htm

The Commission on Cancer's Inquiry and Response System and SEER SINQ (http://seer.cancer.gov/seerinquiry/) should also be checked regularly for additional information on how to code cases without reference to the list of clinically apparent and inapparent terms for prostate cancer.

The statement issued on August 31, 2007, by the Collaborative Staging Steering Committee is as follows:

Clarification on the Use of Outside Resources for Coding Prostate Cancer

A great deal of confusion surrounds the interpretation of clinical reports with regard to whether the prostate cancer was apparent or inapparent. In 1998, SEER published an interpretation of "apparent" and "inapparent" terms for use in their Extent of Disease (EOD) Coding System for prostate cancer. This list was in effect for prostate EOD cases diagnosed in 1998-2003. There were several questions regarding whether this list could be used in Collaborative Staging (CS). After consultation with the AJCC curators for genitourinary disease, the CS Steering Committee has determined that the SEER list of terms for apparent and inapparent in the SEER Extent of Disease Manual is NOT to be used for interpreting reports for Collaborative Staging. While it was a convenient tool for registrars, the curators are of the opinion that the use of the list will lead to misinterpretation of reports. Rather, the curators recommend that registrars rely on a direct physician statement of apparent or inapparent disease for Collaborative Staging. It is not anticipated that prior cases will require review and recoding.

APPENDIX T

CNExT OVER-RIDE FLAGS AND EDITS

Edit Name	CNExT Edit #	Flag Name
Date First Admission, Date Diagnosis (Calif)	ED1014	Override, DateDx/DateAdm
Primary Site, Behavior Code (C/NET IF39)	ED2000	Override, Site/Behavior
Morphology--Type & Behavior (C/NET MORPH)	ED2004	Override, Histology
Primary Site, Stage, EOD (Calif)	ED2010	Override, Site/Stage
Age, Primary Site, Morphology (C/NET IF15)	ED2015	Override, Age/Site/Morph
Diagnostic Confirm, Seq Num--Hospital (C/NET IF23)	ED2017	Override, SeqNo/DxConf
Diagnostic Confirmation, Behavior (C/NET IF31)	ED2018	Override, Histology
Diagnostic Confirmation, Histol Type (C/NET IF48)	ED2019	Override, Leuk, Lymphoma
Seq Num--Hosp, Primary Site, Morph (C/NET IF22)	ED2022	Override, Ill-defined Site
Primary Site, Morphology-Type Check (C/NET IF25)	ED2024	Override, Site/Type
Laterality, Primary Site, Morphology (C/NET IF42)	ED2030	Override, Site/Lat/Morph
Primary Site, Laterality, EOD (C/NET IF41)	ED2030	Override, Site/Lat/EOD
Date of Diagnosis, Primary Site, EOD (C/NET IF40)	ED2040	Override, Site/EOD/DX Date
RX Summ--Surgery Type, Diag Conf (C/NET IF46)	ED3011	Override, Surg/DxConf
Race - Spanish Origin - Birthplace (Calif)	ED6013	Override, Race/Spanish/Birthpl
Spanish Origin - Birthplace (Calif)	ED6014	Override, Spanish/Birthplace
Type of Report (DC), Seq Num--Hospital(C/NET IF04)	ED6015	Override, Report Source
First Name, Sex (Calif)	ED7004	Override, FirstName/Sex
Accession Number, Class of Case, Seq Number(C/NET)	ED7007	Override, Accession/Class/Seq
		Override, COC Site/Type
Diagnostic Confirm, Seq Num--Hospital (C/NET IF23)	ED2017	Override, Seq/Dx Confirm
		Override, Seq/Site
		Override, Site/Lat/SeqNum
		Override, Site/TNM Stage
Summary Stage 2000, Site Dist Met 1 (CNET)	ED2029	Override, Stage/Dist Mets
Summary Stage 2000, Regional Nodes Pos (CNET)	ED2028	Override, Stage/Nodes Pos
Summary Stage 2000, TNM M (CNET)	ED2050	Override, Stage/TNM-M
Summary Stage 2000, TNM N (CNET)	ED2051	Override, Stage/TNM-N
Seq Num-Hosp, Primary Site, Morphology	***ED2514***	***Override, Hosp Seq/Site***

APPENDIX U

TABLE OF DATA ITEMS AND THEIR REQUIRED STATUS

Reporting requirements are not uniform for all cancer reporting facilities. Consult the following table to determine which data items must be reported:

Key to Symbols

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***	***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
HistologyBehavior (ICD-O-2)	V.3.4	yes	yes	yes

Histology-Behavior (ICD-O-3)	V.3.4	yes	yes	yes
HistologyGrade/ Differentiation	V.3.5	yes	yes	yes
HistologyType (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	VI.2.4	gen	gen	yes

Distant Lymph Node(s)Summary				
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 not contained in the ICD-O-3 SEER Site/Histology Validation List.

Bold type indicates histology codes with a malignant behavior code that have been added by CBTRUS and not contained in the ICD-O-3 SEER Site/Histology Validation List.

Red color indicates histology codes new to the ICD-O-3 SEER Site/Histology Validation List.

Meninges - 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 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	969	

LYMPH, NOS		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	975	9750/3 Malignant histiocytosis

ACCESSORY LYMPHOID CELLS		9754/3 Langerhans cell histiocytosis, disseminated
		9755/3 Histiocytic sarcoma
		9756/3 Langerhans cell sarcoma
		9757/3 Interdigitating dendritic cell sarcoma
		9758/3 Follicular dendritic cell sarcoma

BRAIN, C710-C714 & C717-C719, (EXCL. VENTRICLE, CEREBELLUM) SPINAL CORD C720 , CAUDA EQUINA C721 & CRANIAL NERVES, C722-C725

NEOPLASM	800	
		8000/0 Neoplasm, benign
		8000/1 Neoplasm, uncertain whether benign or malignant
		8000/3 Neoplasm, malignant
		8001/0 Tumor cells, benign
		8001/1 Tumor cells, uncertain whether benign or malignant
		8001/3 Tumor cells, malignant
		8002/3 Malignant tumor, small cell type
		8003/3 Malignant tumor, giant cell type
		8004/3 Malignant tumor, spindle cell type
		8005/3 Malignant tumor, clear cell type
PARAGANGLIOMA	868	
		8680/1 Paraganglioma, NOS
NEVI & MELANOMAS	872	
		8720/3 Malignant melanoma
SARCOMA, NOS	880	
		8800/0 Soft tissue tumor,

		benign
		8800/3 Sarcoma, NOS
		8801/3 Spindle cell sarcoma
		8805/3 Undifferentiated sarcoma
		8806/3 Desmoplastic small round cell tumor
LIPOMATOUS NEOPLASMS	885	
		8850/0 Lipoma, NOS
		8851/0 Fibrolipoma
		8851/3 Liposarcoma
GERM CELL TUMORS	906	
		9060/3 Dysgerminoma
		9064/3 Germinoma
EMBRYONAL CARCINOMA	907	
		9070/3 Embryonal carcinoma, NOS
		9071/3 Yolk Sac Tumor
TERATOMA	908	
		9080/0 Teratoma, benign
		9080/1 Teratoma, NOS
		9080/3 Teratoma, malignant, NOS
		9081/3 Teratocarcinoma
		9085/3 Mixed germ cell tumor
TROPHOBLASTIC NEOPLASMS	910	
		9100/3 Choriocarcinoma, NOS
BLOOD VESSEL TUMORS	912	
		9120/0 Hemangioma, NOS
		9121/0 Cavernous

		hemangioma
		9122/0 Venous hemangioma
HEMANGIOENDOTHELIOMA	913	
		9131/0 Capillary hemangioma
HEMANGIOPERICYTOMA	915	
		9150/1 Hemangiopericytoma, NOS
HEMANGIOBLASTOMA	916	
		9161/1 Hemangioblastoma
CHORDOMA	937	
		9370/3 Chordoma,
		9371/3 Chondroid chordoma
		9372/3 Dedifferentiated chordoma
GLIOMA	938	
		9380/3 Glioma, malignant
		9381/3 Gliomatosis cerebri
		9382/3 Mixed glioma
		9383/1 Subependymoma
		9384/1 Subependymal giant cell astroctyoma
EPENDYMOMA, NOS	939	
		9391/3 Ependymoma, NOS
		9392/3 Ependymoma, anaplastic
		9393/3 Papillary Ependymoma
		9394/1 Myxopapillary ependymoma
ASTROCYTOMA, NOS	940	
		9400/3 Astrocytoma, NOS
		9401/3 Astrocytoma, anaplastic

PROTOPLASMIC ASTROCYTOMA	941	
		9410/3 Protoplasmic astrocytoma
		9411/3 Gemistocytic astrocytoma
		9412/1 Desmoplastic infantile astrocytoma
		9413/0 Dysembryoplastic neuroepithelial tumor
FIBRILLARY ASTROCYTOMA	942	
		9420/3 Fibrillary astrocytoma
		9421/1 Pilocytic astrocytoma
		9423/3 Polar spongioblastoma
		9424/3 Pleomorphic xanthoastrocytoma
ASTROBLASTOMA	943	
		9430/3 Astroblastoma
GLIOBLASTOMA, NOS	944	
		9440/3 Glioblastoma, NOS
		9441/3 Giant cell glioblastoma
		9442/1 Gliofibroma
		9442/3 Gliosarcoma
		9444/1 Chordoid glioma
OLIGODENDROGLIOMA, NOS	945	
		9450/3 Oligodendroglioma, NOS
		9451/3 Oligodendroglioma, anaplastic
OLIGODENDROBLASTOMA	946	
		9460/3 Oligodendroblastoma
PRIMITIVE NEUROECTODERMAL	947	
		9473/3 Primitive neuroectodermal tumor, NOS
GANGLIONEUROBLASTOMA	949	

		9490/0 Ganglioneuroma
		9490/3 Ganglioneuroblastoma
		9492/0 Gangliocytoma
NEUROBLASTOMA, NOS	950	
		9500/3 Neuroblastoma, NOS
		9501/3 Medulloepithelioma, NOS
		9502/3 Teratoid medulloepithelioma
		9503/3 Neuroepithelioma, NOS
		9505/1 Ganglioglioma, NOS
		9505/3 Ganglioglioma, anaplastic
		9508/3 Atypical teratoid/rhabdoid tumor
MENINGIOMA	953	
		9530/0 Meningioma, NOS
		9530/1 Mengiomatosis, NOS
		9530/3 Meningioma, malignant
		9531/0 Meningotheliomatous meningioma
		9532/0 Fibrous meningioma
		9533/0 Psammomatous meningioma
		9534/0 Angiomatous meningioma
		9537/0 Transitional meningioma
		9538/1 Clear cell meningioma
		9538/3 Papillary meningioma
		9539/1 Atypical meningioma
		9539/3 Meningeal sarcomatosis
NEUROFIBROSARCOMA	954	
		9540/0 Neurofibroma, NOS
		9540/1 Neurofibromatosis, NOS
		9540/3 Malignant peripheral nerve sheath tumor

		9541/0 Melanotic neurofibroma
PLEXIFORM NEUROFIBROMA	955	**9550/0 Plexiform neurofibroma**
NEURILEMOMA	956	**9560/0 Neurilemoma, NOS** **9560/1 Neurinomatosis** 9560/3 Neurilemoma, malignant 9561/3 Triton tumor, malignant **9562/0 Neurothekeoma**
NEUROMA	957	**9570/0 Neuroma, NOS** **9571/0 Perineurioma, NOS** 9571/3 Perineurioma, malignant
MALIGNANT LYMPHOMA, NOS	959	9590/3 Malignant lymphoma, NOS 9591/3 Malignant lymphoma, non-Hodgkin 9596/3 Composite Hodgkin and non-Hodgkin lymphoma
ML, SMALL B-CELL LYMPHOCYTIC	967	9670/3 ML, small B lymphocytic, NOS 9671/3 ML, lymphoplasmacytic 9673/3 Mantle cell lymphoma 9675/3 ML, mixed sm. and lg. cell, diffuse
ML, LARGE B-CELL, DIFFUSE	968	9680/3 ML, large B-cell, diffuse 9684/3 ML, large B-cell, diffuse, immunoblastic, NOS

		9687/3 Burkitt lymphoma, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9690/3 Follicular lymphoma, NOS
		9691/3 Follicular lymphoma, grade 2
		9695/3 Follicular lymphoma, grade 1
		9698/3 Follicular lymphoma, grade 3
		9699/3 Marginal zone B-cell lymphoma, NOS
T-CELL LYMPHOMAS	970	
		9701/3 Sezary syndrome
		9702/3 Mature T-cell lymphoma, NOS
		9705/3 Angioimmunoblastic T-cell lymphoma
OTHER SPEC. NON-HODGKIN LYMPHOMA	971	
		9714/3 Large cell lymphoma
		9719/3 NK/T-cell lymphoma, nasal and nasal-type
PRECURS. CELL LYMPHOBLASTIC LYMPH.	972	
		9727/3 Precursor cell lymphoblastic lymphoma, NOS
		9728/3 Precursor B-cell lymphoblastic lymphoma
		9729/3 Precursor T-cell lymphoblastic lymphoma
PLASMA CELL TUMORS	973	
		9731/3 Plasmacytoma, NOS
		9734/3 Plasmacytoma, extramedullary
NEOPLASMS OF HISTIOCYTES AND	975	
		9750/3 Malignant histiocytosis

ACCESSORY LYMPHOID CELLS		9754/3 Langerhans cell histiocytosis, disseminated
		9755/3 Histiocytic sarcoma
		9756/3 Langerhans cell sarcoma
		9757/3 Interdigitating dendritic cell sarcoma
		9758/3 Follicular dendritic cell sarcoma
LEUKEMIA	993	
		9930/3 Myeloid sarcoma

VENTRICLE C715

NEOPLASM	800	
		8000/0 Neoplasm, benign
		8000/1 Neoplasm, uncertain whether benign or malignant
		8000/3 Neoplasm, malignant
		8001/0 Tumor cells, benign
		8001/1 Tumor cells, uncertain whether benign or malignant
		8001/3 Tumor cells, malignant
		8005/3 Malignant tumor, clear cell type
TERATOMA	908	
		9085/3 Mixed germ cell tumor
MISCELLANEOUS TUMORS	937	
		9370/3 Chordoma, NOS
		9371/3 Chondroid chordoma
		9372/3 Dedifferentiated chordoma
GLIOMA	938	
		9380/3 Glioma, malignant
		9381/3 Gliomatosis cerebri

		9382/3 Mixed glioma
		9383/1 Gliomatosis cerebri
		9384/1 Subependymal giant cell astrocytoma
EPENDYMOMA, NOS	939	
		9390/0 Choroid plexus papilloma, NOS
		9390/1 Atypical choroid plexus papilloma
		9390/3 Choroid plexus papilloma, malignant
		9391/3 Ependymoma, NOS
		9392/3 Ependymoma, anaplastic
		9393/3 Papillary ependymoma
ASTROCYTOMA, NOS	940	
		9400/3 Astrocytoma, NOS
		9401/3 Astrocytoma, anaplastic
PROTOPLASMIC ASTROCYTOMA	941	
		9410/3 Protoplasmic astrocytoma
		9411/3 Gemistocytic astrocytoma
FIBRILLARY ASTROCYTOMA	942	
		9420/3 Fibrillary astrocytoma
		9421/1 Pilocytic astrocytoma
		9423/3 Polar spongioblastoma
		9424/3 Pleomorphic xanthoastrocytoma
ASTROBLASTOMA	943	
		9430/3 Astroblastoma
GLIOBLASTOMA, NOS	944	
		9440/3 Glioblastoma, NOS
		9441/3 Giant cell glioblastoma

		9442/3 Gliosarcoma
		9444/1 Chordoid glioma
OLIGODENDROGLIOMA, NOS	945	
		9450/3 Oligodendroglioma, NOS
		9451/3 Oligodendroglioma, anaplastic
PRIMITIVE NEUROECTODERMAL	947	
		9473/3 Primitive neuroectodermal tumor (PNET)
GANGLIONEUROBLASTOMA	949	
		9490/0 Ganglioneuroma
		9490/3 Ganglioneuroblastoma
		9492/0 Gangliocytoma
NEUROBLASTOMA, NOS	950	
		9500/3 Neuroblastoma, NOS
		9501/3 Medulloepithelioma, NOS
		9502/3 Teratoid medulloepithelioma
		9503/3 Neuroepithelioma, NOS
		9505/1 Ganglioglioma, NOS
		9505/3 Ganglioglioma, anaplastic
		9506/1 Central neurocytoma
		9508/3 Atypical teratoid/rhabdoid tumor
MENINGIOMAS	953	
		9530/0 Meningioma, NOS
		9530/1 Meningiomatosis, NOS
		9530/3 Meningioma, malignant
		9531/0 Meningotheliomatous meningioma
		9532/0 Fibrous meningioma
		9533/0 Psammomatosis meningioma
		9534/0 Angiomatous

		meningioma **9537/0 Transitional meningioma** **9538/1 Clear cell meningioma** **9538/3 Papillary meningioma**
MALIGNANT LYMPHOMA, NOS	959	
		9590/3 Malignant lymphoma, NOS 9591/3 Malignant lymphoma, non-Hodgkin 9596/3 Composite Hodgkin and non-Hodgkin lymphoma
ML, SMALL B-CELL LYMPHOCYTIC	967	
		9670/3 ML, small B lymphocytic, NOS 9671/3 ML, lymphoplasmacytic 9673/3 Mantle cell lymphoma 9675/3 ML, mixed sm. and lg. cell, diffuse
ML, LARGE B-CELL, DIFFUSE	968	
		9680/3 ML, large B-cell, diffuse 9684/3 ML, large B-cell, diffuse, immunoblastic, NOS 9687/3 Burkitt lymphoma, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9690/3 Follicular lymphoma, NOS 9691/3 Follicular lymphoma, grade 2 9695/3 Follicular lymphoma, grade 1 9698/3 Follicular lymphoma, grade 3 9699/3 Marginal zone B-cell lymphoma, NOS
T-CELL LYMPHOMAS	970	
		9701/3 Sezary syndrome 9702/3 Mature T-cell lymphoma,

		NOS
		9705/3 Angioimmunoblastic T-cell lymphoma
OTHER SPEC. NON-HODGKIN LYMPHOMA	971	
		9714/3 Anaplastic large cell lymphoma, T-cell and Null cell type
		9719/3 NK/T-cell lymphoma, nasal and nasal-type
PRECURS. CELL LYMPHOBLASTIC LYMPH.	972	
		9727/3 Precursor cell lymphoblastic lymphoma, NOS
		9728/3 Precursor B-cell lymphoblastic lymphoma
		9729/3 Precursor T-cell lymphoblastic lymphoma
PLASMA CELL TUMORS	973	
		9731/3 Plasmacytoma, NOS
		9734/3 Plasmacytoma, extramedullary
NEOPLASMS OF HISTIOCYTES AND ACCESSORY LYMPHOID CELLS	975	
		9750/3 Malignant histiocytosis
		9754/3 Langerhans cell histiocytosis, disseminated
		9755/3 Histiocytic sarcoma
		9756/3 Langerhans cell sarcoma
		9757/3 Interdigitating dendritic cell sarcoma
		9758/3 Follicular dendritic cell sarcoma

CEREBELLUM C716

NEOPLASM	800	
		8000/0 Neoplasm, benign
		8000/1 Neoplasm, uncertain

		whether benign or malignant
		8000/3 Neoplasm, malignant
		8001/0 Tumor cells, benign
		8001/1 Tumor cells, uncertain whether benign or malignant
		8001/3 Tumor cells, malignant
		8005/3 Malignant tumor, clear cell type
SARCOMA, NOS	880	
		8800/0 Soft tissue tumor, benign
		8800/3 Sarcoma, NOS
		8805/3 Undifferentiated sarcoma
		8806/3 Desmoplastic small round cell tumor
FIBROMATOUS NEOPLASMS	881	
		8810/3 Fibrosarcoma, NOS
		8815/0 Solitary fibrous tumor
LIPOMATOUS NEOPLASMS	885	
		8850/0 Lipoma, NOS
GERM CELL NOEPLASMS	908	
		9080/0 Teratoma, benign
		9080/1 Teratoma, NOS
		9080/3 Teratoma, malignant, NOS
		9084/0 Dermoid cyst, NOS
BLOOD VESSEL TUMORS	912	
		9120/0 Hemangioma, NOS
HEMANGIOENDOTHELIOMA	913	
		9131/0 Capillary hemangioma

HEMANGIOPERICYTOMA	915	**9150/1 Hemangiopericytoma, NOS**
HEMANGIOBLASTOMA	916	**9161/1 Hemangioblastoma**
CHORDOMA	937	9370/3 Chordoma, NOS 9371/3 Chondroid chordoma 9372/3 Dedifferentiated chordoma
GLIOMA	938	9380/3 Glioma, malignant 9381/3 Gliomatosis cerebri 9382/3 Mixed glioma **9383/1 Subependymoma**
EPENDYMOMA, NOS	939	9391/3 Ependymoma, NOS 9392/3 Ependymoma, anaplastic 9393/3 Papillary ependymoma
ASTROCYTOMA, NOS	940	9400/3 Astrocytoma, NOS 9401/3 Astrocytoma, anaplastic
PROTOPLASMIC ASTROCYTOMA	941	9410/3 Protoplasmic astrocytoma 9411/3 Gemistocytic astrocytoma
FIBRILLARY ASTROCYTOMA	942	9420/3 Fibrillary astrocytoma

		9421/1 Pilocytic astrocytoma
		9424/3 Pleomorphic xanthoastrocytoma
ASTROBLASTOMA	943	
		9430/3 Astroblastoma
GLIOBLASTOMA, NOS	944	
		9440/3 Glioblastoma, NOS
		9441/3 Giant cell glioblastoma
		9442/3 Gliosarcoma
OLIGODENDROGLIOMA, NOS	945	
		9450/3 Oligodendroglioma, NOS
		9451/3 Oligodendroglioma, anaplastic
MEDULLOBLASTOMA, NOS	947	
		9470/3 Medulloblastoma, NOS
		9471/3 Desmoplastic medulloblastoma
		9472/3 Medullomyoblastoma
		9473/3 Primitive neuroectodermal tumor
		9474/3 Large cell medulloblastoma
CEREBELLAR SARCOMA, NOS	948	
		9480/3 Cerebellar sarcoma, NOS
GANGLIONEUROBLASTOMA	949	
		9490/0 Ganglioneuroma
		9490/3 Ganglioneuroblastoma
		9492/0 Gangliocytoma
		9493/0 Dysplastic gangliocytoma of cerebellum (Lhermitte-Duclos)
NEUROBLASTOMA, NOS	950	
		9500/3 Neuroblastoma, NOS

		9501/3 Medulloepithelioma, NOS
		9502/3 Teratoid medulloepithelioma
		9503/3 Neuroepithelioma, NOS
		9505/1 Ganglioglioma, NOS
		9506/1 Central neurocytoma
		9508/3 Atypical teratoid/rhabdoid tumor
MENINGIOMAS	953	
		9530/0 Meningioma, NOS
		9530/1 Meningiomatosis, NOS
		9530/3 Meningioma, malignant
		9531/0 Meningotheliomatous meningioma
		9532/0 Fibrous meningioma
		9533/0 Psammomatous meningioma
		9534/0 Angiomatous meningioma
		9537/0 Transitional meningioma
		9538/1 Clear cell meningioma
		9538/3 Papillary meningioma
MALIGNANT LYMPHOMA, NOS	959	
		9590/3 Malignant lymphoma, NOS
		9591/3 Malignant lymphoma, non-Hodgkin
		9596/3 Composite Hodgkin and non-Hodgkin lymphoma
ML, SMALL B-CELL LYMPHOCYTIC	967	
		9670/3 ML, small B lymphocytic, NOS
		9671/3 ML, lymphoplasmacytic
		9673/3 Mantle cell lymphoma
		9675/3 ML, mixed sm. and lg. cell, diffuse

ML, LARGE B-CELL, DIFFUSE	968	
		9680/3 ML, large B-cell, diffuse
		9684/3 ML, large B-cell, diffuse, immunoblastic, NOS
		9687/3 Burkitt lymphoma, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9690/3 Follicular lymphoma, NOS
		9691/3 Follicular lymphoma, grade 2
		9695/3 Follicular lymphoma, grade 1
		9698/3 Follicular lymphoma, grade 3
		9699/3 Marginal zone B-cell lymphoma, NOS
T-CELL LYMPHOMAS	970	
		9701/3 Sezary syndrome
		9702/3 Peripheral T-cell lymphoma, NOS
		9705/3 Angioimmunoblastic T-cell lymphoma
OTHER SPEC. NON-HODGKIN LYMPHOMA	971	
		9714/3 Anaplastic large cell lymphoma, T-cell and Null cell type
		9719/3 NK/T-cell lymphoma, nasal and nasal-type
PRECURS. CELL LYMPHOBLASTIC LYMPH.	972	
		9727/3 Precursor cell lymphoblastic lymphoma, NOS
		9728/3 Precursor B-cell lymphoblastic lymphoma
		9729/3 Precursor T-cell lymphoblastic lymphoma
PLASMA CELL TUMORS	973	
		9731/3 Plasmacytoma, NOS

		9734/3 Plasmacytoma, extramedullary
NEOPLASMS OF HISTIOCYTES AND ACCESSORY LYMPHOID CELLS	975	
		9750/3 Malignant histiocytosis
		9754/3 Langerhans cell histiocytosis, disseminated
		9755/3 Histiocytic sarcoma
		9756/3 Langerhans cell sarcoma
		9757/3 Interdigitating dendritic cell sarcoma
		9758/3 Follicular dendritic cell sarcoma

OTHER NERVOUS SYSTEM C728-C729

NEOPLASM	800	
		8000/0 Neoplasm, benign
		8000/1 Neoplasm, uncertain whether benign or malignant
		8000/3 Neoplasm, malignant
		8001/0 Tumor cells, benign
		8001/1 Tumor cells, uncertain whether benign or malignant
		8001/3 Tumor cells, malignant
		8002/3 Malignant tumor, small cell type
		8003/3 Malignant tumor, giant cell type
		8004/3 Malignant tumor, spindle cell type
		8005/3 Malignant tumor, clear cell type
SARCOMA, NOS	880	
		8800/0 Soft tissue tumor, benign
		8800/3 Sarcoma, NOS
		8801/3 Spindle cell sarcoma

		8802/3 Giant cell sarcoma
		8803/3 Small cell sarcoma
		8804/3 Epithelioid sarcoma
		8805/3 Undifferentiated sarcoma
		8806/3 Desmoplastic small round cell tumor
LIPOMATOUS NEOPLASMS	885	
		8850/0 Lipoma, NOS
		8850/1 Atypical lipoma
		8850/3 Liposarcoma, NOS
ANGIOLIPOMA	886	
		8861/0 Angiolipoma
MYOMATOUS NEOPLASMS	889	
		8890/0 Leiomyoma, NOS
		8890/1 Leiomyomatosis, NOS
		8890/3 Leiomyosarcoma, NOS
		8897/1 Smooth muscle tumor, NOS
RHABDOMYOSARCOMA	890	
		8900/0 Rhabdomyoma, NOS
		8900/3 Rhabdomyosarcoma, NOS
EMBRYONAL RHABDOMYOSARCOMA	891	
		8910/3 Embryonal rhabdomyosarcoma, NOS
ALVEOLAR RHABDOMYOSARCOMA	892	
		8920/3 Alveolar rhabdomyosarcoma
GERM CELL TUMORS	906	
		9064/3 Germinoma

TERATOMA	908	
		9080/1 Teratoma, NOS
		9080/3 Teratoma, malignant, NOS
		9082/3 Malignant teratoma, undiff.
		9084/0 Dermoid cyst, NOS
		9084/3 Teratoma with malig. transformation
BLOOD VESSEL TUMORS	912	
		9120/0 Hemangioma, NOS
		9120/3 Hemangiosarcoma
		9121/0 Cavernous hemangioma
HEMANGIOENDOTHELIOMA	913	
		9130/0 Hemangioendothelioma, benign
		9130/1 Hemangioendothelioma, NOS
		9130/3 Hemangioendothelioma, malignant
KAPOSI SARCOMA	914	
		9140/3 Kaposi sarcoma
HEMANGIOPERICYTOMA	915	
		9150/0 Hemangiopericytoma, benign
		9150/1 Hemangiopericytoma, NOS
		9150/3 Hemangiopericytoma, malignant

HEMANGIOBLASTOMA	916	**9161/1 Hemangioblastoma**
MISCELLANEOUS BONE TUMORS	926	**9260/3 Ewing sarcoma**
CHORDOMA	937	9370/3 Chordoma, NOS 9371/3 Chondroid chordoma 9372/3 Dedifferentiated chordoma
NEUROBLASTOMA, NOS	950	9500/3 Neuroblastoma, NOS 9501/3 Medulloepithelioma, NOS 9502/3 Teratoid medulloepithelioma 9503/3 Neuroepithelioma, NOS 9508/3 Atypical teratoid/rhabdoid tumor
MENINGIOMA	953	**9530/0 Meningioma, NOS** **9530/1 Meningiomatosis, NOS** **9530/3 Meningioma, malignant** **9531/0 Meningotheliomatous meningioma** **9532/0 Fibrous meningioma** **9533/0 Psammomatous meningioma** **9534/0 Angiomatous meningioma** **9537/0 Transitional meningioma** **9538/1 Clear cell meningioma** **9538/3 Papillary meningioma**
NEUROFIBROSARCOMA	954	

		9540/0 Neurofibroma, NOS
		9540/1 Neurofibromatosis, NOS
		9540/3 Malignant peripheral nerve sheath tumor
		9541/0 Melanotic neurofibroma
PLEXIFORM NEUROFIBROMA	955	
		9550/0 Plexiform neurofibroma
NEURILEMOMA	956	
		9560/0 Neurilemmoma, NOS
		9560/3 Neurilemmoma, malignant
		9561/3 Triton tumor, malignant
		9562/0 Neurothekeoma
NEUROMA	957	
		9570/0 Neuroma, NOS
		9571/0 Perineurioma, NOS
		9571/3 Perineurioma, malignant
MALIGNANT LYMPHOMA, NOS	959	
		9590/3 Malignant lymphoma, NOS
		9591/3 Malignant lymphoma, non-Hodgkin
		9596/3 Composite Hodgkin and non-Hodgkin lymphoma
HODGKIN LYMPHOMA	965	
		9650/3 Hodgkin lymphoma, NOS
		9651/3 Hodgkin lymphoma, lymphocyte-rich
		9652/3 Hodgkin lymphoma, mixed cellularity, NOS
		9653/3 Hodgkin lymphoma, lymphocytic deplet., NOS
		9654/3 Hodgkin lymphoma,

		lymphocyt. deplet., diffuse fibrosis
		9655/3 Hodgkin lymphoma, lymphocyt. deplet., reticular
		9659/3 Hodgkin lymphoma, nodular lymphocyte predom.
HODGKIN LYMPHOMA, NOD. SCLER.	966	
		9661/3 Hodgkin granuloma
		9662/3 Hodgkin sarcoma
		9663/3 Hodgkin lymphoma, nodular sclerosis, NOS
		9664/3 Hodgkin lymphoma, nod. scler., cellular phase
		9665/3 Hodgkin lymphoma, nod. scler., grade 1
		9667/3 Hodgkin lymphoma, nod. scler., grade 2
ML, SMALL B-CELL LYMPHOCYTIC	967	
		9670/3 ML, small B lymphocytic, NOS
		9671/3 ML, lymphoplasmacytic
		9673/3 Mantle cell lymphoma
		9675/3 ML, mixed sm. and lg. cell, diffuse
ML, LARGE B-CELL, DIFFUSE	968	
		9680/3 ML, large B-cell, diffuse
		9684/3 ML, large B-cell, diffuse, immunoblastic, NOS
		9687/3 Burkitt lymphoma, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9690/3 Follicular lymphoma, NOS
		9691/3 Follicular lymphoma, grade 2
		9695/3 Follicular lymphoma, grade 1
		9698/3 Follicular lymphoma, grade 3
		9699/3 Marginal zone B-cell

		lymphoma, NOS
T-CELL LYMPHOMAS	970	
		9701/3 Sezary syndrome
		9702/3 Mature T-cell lymphoma, NOS
		9705/3 Angioimmunoblastic T-cell lymphoma
OTHER SPEC. NON-HODGKIN LYMPHOMA	971	
		9714/3 Anaplastic large cell lymphoma, T-cell and Null cell type
		9719/3 NK/T-cell lymphoma, nasal and nasal-type
PRECURS. CELL LYMPHOBLASTIC LYMPH.	972	
		9727/3 Precursor cell lymphoblastic lymphoma, NOS
		9728/3 Precursor B-cell lymphoblastic lymphoma
		9729/3 Precursor T-cell lymphoblastic lymphoma
PLASMA CELL TUMORS	973	
		9731/3 Plasmacytoma, NOS
		9734/3 Plasmacytoma, extramedullary
MAST CELL TUMORS	974	
		9740/3 Mast cell sarcoma
		9741/3 Malignant mastocytosis
NEOPLASMS OF HISTIOCYTES AND ACCESSORY LYMPHOID CELLS	975	
		9750/3 Malignant histiocytosis
		9754/3 Langerhans cell histiocytosis, disseminated
		9755/3 Histiocytic sarcoma
		9756/3 Langerhans cell sarcoma

9757/3 Interdigitating dendritic cell sarcoma

9758/3 Follicular dendritic cell sarcoma

LYMPHOID LEUKEMIAS 982

9827/3 Adult T-cell leukemia/lymphoma (HTLV-1 positive)

MYELOID LEUKEMIAS 986

9861/3 Acute myeloid leukemia, NOS

OTHER LEUKEMIAS 993

9930/3 Myeloid sarcoma

PITUITARY GLAND and CRANIOPHARYNGEAL DUCT C751-C752

NEOPLASM 800

8000/0 Neoplasm, benign

8000/1 Neoplasm, uncertain whether benign or malignant

8000/3 Neoplasm, malignant

8001/0 Tumor cells, benign

8001/1 Tumor cells, uncertain whether benign or malignant

8001/3 Tumor cells, malignant

8005/0 Clear cell tumor, NOS

8005/3 Malignant tumor, clear cell type

CARCINOMA, NOS 801

8010/0 Epithelial tumor, benign

8010/2 Carcinoma in situ, NOS

8010/3 Carcinoma, NOS

ADENOCARCINOMA, NOS 814

8140/0 Adenoma, NOS

		8140/2 Adenocarcinoma in situ 8140/3 Adenocarcinoma, NOS **8146/0 Monomorphic adenoma**
PAPILLARY ADENOMA, NOS	826	**8260/0 Papillary adenoma, NOS**
CHROMOPHOBE CARCINOMA	827	**8270/0 Chromophobe adenoma** 8270/3 Chromophobe carcinoma **8271/0 Prolactinoma** **8272/0 Pituitary adenoma, NOS** 8272/3 Pituitary carcinoma, NOS
ACIDOPHIL CARCINOMA	828	**8280/0 Acidophil adenoma** 8280/3 Acidophil carcinoma **8281/0 Mixed acidophil-basophil adenoma** 8281/3 Mixed acidophil-basophil carcinoma
OXYPHILIC ADENOCARCINOMA	829	**8290/0 Oxyphilic adenoma** 8290/3 Oxyphilic adenocarcinoma
BASOPHIL CARCINOMA	830	**8300/0 Basophil adenoma** 8300/3 Basophil carcinoma
CLEAR CELL ADENOCA., NOS	831	**8310/0 Clear cell adenoma**
GRANULAR CELL CARCINOMA	832	8320/3 Granular cell carcinoma **8323/0 Mixed cell adenoma**

		8323/3 Mixed cell adenocarcinoma
SOFT TISSUE TUMORS	880	
		8800/0 Soft tissue tumor, benign
		8800/3 Sarcoma, NOS
LIPOMATOUS NEOPLASMS	885	
		8850/0 Lipoma, NOS
DYSGERMINOMA	906	
		9060/3 Dysgerminoma
		9064/3 Germinoma
		9065/3 Germ cell tumor, nonseminomatous
EMBRYONAL CARCINOMA, NOS	907	
		9070/3 Embryonal carcinoma, NOS
		9071/3 Yolk sac tumor
		9072/3 Polyembryoma
TERATOMA, NOS	908	
		9080/0 Teratoma, benign
		9080/1 Teratoma, NOS
		9080/3 Teratoma, malignant, NOS
		9081/3 Teratocarcinoma
		9082/3 Malignant teratoma, undiff.
		9083/3 Malignant teratoma, intermediate
		9084/3 Teratoma with malig. transformation
		9085/3 Mixed germ cell tumor
CRANIOPHARYNGIOMA	935	
		9350/1 Craniopharyngioma
		9351/1 Adamantinomatous craniopharyngioma
		9352/1 Papillary craniopharyngioma

CHORDOMA	937	
		9370/3 Chordoma
		9371/3 Chondroid chordoma
		9372/3 Dedifferentiated chordoma
NEUROBLASTOMA, NOS	950	
		9500/3 Neuroblastoma, NOS
		9501/3 Medulloepithelioma, NOS
		9502/3 Teratoid medulloepithelioma
		9503/3 Neuroepithelioma, NOS
		9505/3 Ganglioglioma, anaplastic
GRANULAR CELL TUMORS	958	
		9580/0 Granular cell tumor, NOS
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9699/3 Marginal zone B-cell lymphoma, NOS

PINEAL GLAND C753

NEOPLASM	800	
		8000/0 Neoplasm, benign
		8000/1 Neoplasm, uncertain whether benign or malignant
		8000/3 Neoplasm, malignant
		8001/0 Tumor cells, benign
		8001/1 Tumor cells, uncertain whether benign or malignant
		8001/3 Tumor cells, malignant
CARCINOMA, NOS	801	
		8010/0 Epithelial tumor, benign
DYSGERMINOMA	906	
		9060/3 Dysgerminoma

		9064/3 Germinoma
		9065/3 Germ cell tumor, nonseminomatous
EMBRYONAL CARCINOMA, NOS	907	
		9070/3 Embryonal carcinoma, NOS
		9071/3 Yolk sac tumor
		9072/3 Polyembryoma
TERATOMA, NOS	908	
		9080/0 Teratoma, NOS
		9080/3 Teratoma, malignant, NOS
		9081/3 Teratocarcinoma
		9082/3 Malignant teratoma, undiff.
		9083/3 Malignant teratoma, intermediate
		9084/0 Dermoid cyst, NOS
		9084/3 Teratoma with malig. transformation
		9085/3 Mixed germ cell tumor
PINEALOMA, MALIGNANT	936	
		9360/1 Pinealoma, NOS
		9361/1 Pineocytoma
		9362/3 Pineoblastoma
CHORDOMA	937	
		9370/3 Chordoma, NOS
		9371/3 Chondroid chordoma
		9372/3 Dedifferentiated chordoma
PRIMITIVE NEUROECTODERMAL	947	
		9473/3 Primitive neuroectodermal tumor, NOS
GANGLIONEUROBLASTOMA	949	
		9490/3 Ganglioneuroblastoma

		9492/0 Gangliocytoma
NEUROBLASTOMA, NOS	950	
		9500/3 Neuroblastoma, NOS
		9501/3 Medulloepithelioma, NOS
		9502/3 Teratoid medulloepithelioma
		9503/3 Neuroepithelioma, NOS
		9505/1 Ganglioglioma, NOS
		9505/3 Ganglioglioma, anaplastic
ML, LARGE B-CELL, DIFFUSE	968	
		9680/3 ML, large B-cell, diffuse
FOLLIC. & MARGINAL LYMPH, NOS	969	
		9699/3 Marginal zone B-cell lymphoma, NOS

Appendix W: Race and Nationality Descriptions

Appendix W

Appendix W consists of the Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics. This listing is an appendix to the 2004 SEER Race Coding Guidelines.

As a reminder, the CCR has added a new code, code 90 for Other South Asian. Please note that code 90 is not included in Appendix W because it is a code added by the CCR. Please refer Volume I, Section III.2.9 Race and Ethnicity for more detailed race coding information.

Races to be coded as 90 include:

Bangladeshi
Bhutanese
Nepalese
Sikkimese
Sri Lankan

Do not use code 96 as Appendix W indicates for the races listed above.

Appendix W.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)
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.

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